STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G811	A. BUILDING 00 B. WING	06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES-CARE INC	1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for a pre-determined full recertification and state licensure survey. Dates of Survey: 5/31/22, 6/1/22, 6/2/22, 6/3/22, 6/6/22, 6/7/22, 6/8/22 and 6/9/22. Facility Number: 013405 Provider Number: 15G811 AIMS Number: 201267570 These deficiencies also reflect state findings in accordance with 410 IAC 16.2-5. Quality Review of this report completed by #15068 on 7/1/22.	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, record review and interview, the facility failed to meet the Condition of Participation: Governing Body for 4 of 4 sampled clients (#1, #2, #3 and #4), plus 16 additional clients (#5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20). The governing body failed to exercise policy, budget and operating direction over the facility by having clients #10, #17 and #20 pay medical bills which should have been paid by the facility, to ensure client #11's rights were not infringed upon after meeting discharge requirements for alternative placement options, to ensure clients #1, #14, #16, #18 and #20's bedroom windows had curtains and/or coverings to maintain their privacy from the outside, to ensure client #1's	W 0102	The business department was audited with the assistance of the Executive Director to assure that any clients that have been billed for a medical treatment, medication, procedure etc. has been identified and reimbursed in full. The business department has been in-serviced by the Executive Director that all medical bills are responsibility of the company to pay and are not to be charged to any client. If a medical charge or discrepancy is identified, the Executive Director will ensure that the client is reimbursed. Client appropriate window	07/08/2022

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

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

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	privacy was maintained during personal care for dressing, to ensure a complete and accurate accounting of clients #1 and #2's personal financial resources, to ensure the facility implemented its written policy and procedures to prevent and thoroughly investigate a pattern of incidents of physical aggression regarding clients #2, #5, #8, #16, #20, to report and thoroughly investigate an allegation of staff mistreatment regarding client #4, to investigate an injury of unknown origin regarding client #19, to prevent, report and thoroughly investigate an allegation of staff abuse regarding client #13, to investigate an injury of unknown origin regarding client #16, to prevent and thoroughly investigate a pattern of client #3's physical aggression towards his peers (#4, #5, #6, #7, #8, #9, #10, #13, #15, #17 and #19), to prevent client #1 from sustaining injury when left unsupervised during a bath and to prevent, report and investigate allegations regarding client #4's ingestion of two toy balls, to ensure the QIDP (Qualified Intellectual Disabilities Professional) integrated, coordinated and monitored clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20's active treatment programs, to ensure clients #1, #2, #4 and #11 received a continuous active treatment program including aggressive, consistent implementation of their program plans, to ensure staff implemented clients #1, #2, #4 and #11's program plans as written, to promote clients #1, #2, #4, #8, #10, #11, #17 and #18's dignity in regard to their appearance, to ensure clients #2, #3 and #9's adaptive equipment was available and in good repair and to ensure a sanitary environment for clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20 in regard to hand hygiene practices, clean table surfaces at meal time and clean food storage areas.		treatments are added to all client's windows either curtains or window film. All members of the Management team will be in-serviced by the Executive Director on the criteria requiring an investigation. Other Interdisciplinary Team members will be trained on the criteria requiring an investigation and during the review of all BDDS reports, a question will be added for clarity to the Interdisciplinary Team note asking whether the incident requires an investigation. All facility investigations will be completed by trained investigators. Investigation focus will include but not be limited to interviewing all potential witnesses and comparing documentary and testimonial evidence to identify and clarify discrepancies. Regional Operations Support Specialist is conducting a retraining on conducting investigations including but limited to analysis, findings, interviews potential witness and witnesses, and recommendations to be included. This training is to be completed by 7/22/2022 All staff trained via in-service on maintaining the privacy of clients during personal care. Program Manager will continue to communicate with guardians regarding the client's readiness for discharge. Program manager will continue to communicate with	

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	The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility met the Condition of Participation: Active Treatment Services for 3 of 4 sampled clients (#1, #2 and #4), plus 6 additional clients (#7, #8, #10, #11, #17 and #19). Findings include: 1. The governing body failed to exercise policy, budget and operating direction over the facility by having clients #10, #17 and #20 pay medical bills which should have been paid by the facility, to ensure client #11's rights were not infringed upon after meeting discharge requirements for alternative placement options, to ensure clients #1, #14, #16, #18 and #20's bedroom windows had curtains and/or coverings to maintain their privacy from the outside, to ensure client #1's privacy was maintained during personal care for dressing, to ensure a complete and accurate accounting of clients #1 and #2's personal financial resources, to ensure the facility implemented its written policy and procedures to prevent and thoroughly investigate a pattern of incidents of physical aggression regarding clients #2, #5, #8, #16, #20, to report and thoroughly investigate an allegation of staff mistreatment regarding client #4, to investigate an injury of unknown origin regarding client #19, to prevent, report and thoroughly investigate an allegation of staff abuse regarding client #13, to investigate an injury of unknown origin regarding client #16, to prevent and thoroughly investigate a pattern of client #3's physical aggression towards his peers (#4, #5, #6, #7, #8, #9, #10, #13, #15, #17 and #19), to prevent client #1 from sustaining injury when left unsupervised during a bath and to prevent, report and investigate allegations regarding client		BDDS, IDR, Executive team during monthly discharge meetings to request further assistance. The Administrative Team and other senior trained staff will conduct daily monitoring/intervention sessions on the units to model and assist staff in implementing aggressive and continuous active treatment. Grab bags for active treatment are being created for (client/development/interest specific) All staff will be trained on the implementation of Grab bags for active treatment activities. Sensory room will be completed and included in active treatment. Staff will be trained to use sensory room. All staff re-trained on prompting clients every 15 minutes for formal and informal active treatment opportunities. They were given examples of what active treatment looks like. All staff re-trained to complete adaptive equipment checklist, report all issues with adaptive equipment immediately to nursing when noted. Adaptive equipment will be replaced or repaired in a timely manner.	

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	#4's ingestion of two toy balls, to ensure the QIDP integrated, coordinated and monitored clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20's active treatment programs, to ensure clients #1, #2, #4 and #11 received a continuous active treatment program including aggressive, consistent implementation of their program plans, to ensure staff implemented clients #1, #2, #4 and #11's program plans as written, to promote clients #1, #2, #4, #8, #10, #11, #17 and #18's dignity in regard to their appearance, to ensure clients #2, #3 and #9's adaptive equipment was available and in good repair and to ensure a sanitary environment for clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20 in regard to hand hygiene practices, clean table surfaces at meal time and clean food storage areas. Please see W104. 2. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure met the Condition of Participation: Active Treatment Services for 3 of 4 sampled clients (#1, #2 and #4), plus 6 additional clients (#7, #8, #10, #11, #17 and #19). Please see W195.			
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), plus 16 additional clients (#5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20), the governing body failed to exercise policy, budget and operating direction over the facility by having clients #10, #17 and #20 pay medical bills	W 0104	The business department was audited with the assistance of the Executive Director to assure that any clients that have been billed for a medical treatment, medication, procedure etc has been identified and reimbursed in	07/09/2022

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	which should have been paid by the facility, to ensure client #11's rights were not infringed upon after meeting discharge requirements for alternative placement options, to ensure clients #1, #14, #16, #18 and #20's bedroom windows had curtains and/or coverings to maintain their privacy from the outside, to ensure client #1's privacy was maintained during personal care for dressing, to ensure a complete and accurate accounting of clients #1 and #2's personal financial resources, to ensure the facility implemented its written policy and procedures to prevent and thoroughly investigate a pattern of incidents of physical aggression regarding clients #2, #5, #8, #16, #20, to report and thoroughly investigate an allegation of staff mistreatment regarding client #4, to investigate an injury of unknown origin regarding client #19, to prevent, report and thoroughly investigate an allegation of staff abuse regarding client #13, to investigate an injury of unknown origin regarding client #16, to prevent and thoroughly investigate a pattern of client #3's physical aggression towards his peers (#4, #5, #6, #7, #8, #9, #10, #13, #15, #17 and #19), to prevent client #1 from sustaining injury when left unsupervised during a bath and to prevent, report and investigate allegations regarding client #4's ingestion of two toy balls, to ensure the QIDP (Qualified Intellectual Disabilities Professional) integrated, coordinated and monitored clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20's active treatment programs, to ensure clients #1, #2, #4 and #11 received a continuous active treatment program including aggressive, consistent implementation of their program plans, to ensure staff implemented clients #1, #2, #4 and #11's program plans as written, to promote clients #1, #2, #4, #8, #10, #11, #17 and #18's dignity in regard to their appearance, to ensure clients #2, #3		full. The business department has been in-serviced by the Executive Director that all medical bills are responsibility of the company to pay and are not to be charged to any client. If a medical charge or discrepancy is identified, the Executive Director will ensure that the client is reimbursed. Client appropriate window treatments are added to all client's windows either curtains or window film. All members of the Management team will be in-serviced by the Executive Director on the criteria requiring an investigation. Other Interdisciplinary Team members will be trained on the criteria requiring an investigation and during the review of all BDDS reports, a question will be added for clarity to the Interdisciplinary Team note asking whether the incident requires an investigation. All facility investigations will be completed by trained investigators. Investigation focus will include but not be limited to interviewing all potential witnesses and comparing documentary and testimonial evidence to identify and clarify discrepancies. Regional Operations Support Specialist is conducting a retraining on conducting investigations including but limited to analysis, findings, interviews potential witness and witnesses, and recommendations to be	

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	and #9's adaptive equipment was available and in good repair and to ensure a sanitary environment for clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20 in regard to hand hygiene practices, clean table surfaces at meal time and clean food storage areas. Findings include: 1. On 6/1/22 at 7:50 AM, client finances from 2/1/22 through 6/1/22 for all of the clients residing at the facility were reviewed and indicated the following: On 3/24/22, client #10 paid $35.00 for a "Medical Bill (unspecified)." On 3/24/22, client #17 paid $261.00 for a "Medical Bill (unspecified)." On 3/24/22, client #17 paid $115.00 for a "Medical Bill (unspecified)." On 3/24/22, client #20 paid $221.07 for a "Medical Bill (unspecified)." PM (Program Manager) was interviewed on 6/2/22 at 1:08 PM. PM indicated clients #10, #17 and #20 should not pay for their medical bills. 2. The governing body failed to exercise policy, budget and operating direction over the facility by failing to ensure client #11's rights were not infringed upon after meeting discharge requirements for alternative placement options. Please see W125. 3. The governing body failed to exercise policy, budget and operating direction over the facility by failing to ensure clients #1, #14, #16, #18 and #20's bedroom windows had curtains and/or coverings to maintain their privacy from the outside. Please		included. This training is to be completed by 7/22/2022 All staff trained via in-service on maintaining the privacy of clients during personal care. Program Manager will continue to communicate with guardians regarding the client's readiness for discharge. Program manager will continue to communicate with BDDS, IDR, Executive team during monthly discharge meetings to request further assistance. The Administrative Team and other senior trained staff will conduct daily monitoring/intervention sessions on the units to model and assist staff in implementing aggressive and continuous active treatment. Grab bags for active treatment are being created for (client/development/interest specific) All staff will be trained on the implementation of Grab bags for active treatment activities. Sensory room will be completed and included in active treatment. Staff will be trained to use sensory room. All staff re-trained on prompting clients every 15 minutes for formal and informal active treatment opportunities. They were given examples of what active treatment looks like. All staff re-trained to complete adaptive equipment checklist, report all issues with adaptive	

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	see W129. 4. The governing body failed to exercise policy, budget and operating direction over the facility by failing to ensure client #1's privacy was maintained during personal care for dressing. Please see W130. 5. The governing body failed to exercise policy, budget and operating direction over the facility by failing to ensure a complete and accurate accounting of clients #1 and #2's personal financial resources. Please see W140. 6. The governing body failed to exercise policy, budget and operating direction over the facility by failing to ensure the facility implemented its written policy and procedures to prevent and thoroughly investigate a pattern of incidents of physical aggression regarding clients #2, #5, #8, #16, #20, to report and thoroughly investigate an allegation of staff mistreatment regarding client #4, to investigate an injury of unknown origin regarding client #19, to prevent, report and thoroughly investigate an allegation of staff abuse regarding client #13, to investigate an injury of unknown origin regarding client #16, to prevent and thoroughly investigate a pattern of client #3's physical aggression towards his peers (#4, #5, #6, #7, #8, #9, #10, #13, #15, #17 and #19), to prevent client #1 from sustaining injury when left unsupervised during a bath and to prevent, report and investigate allegations regarding client #4 ingestion of two toy balls. Please see W149. 7. The governing body failed to exercise policy, budget and operating direction over the facility by failing to ensure allegations of staff abuse were reported to BDDS (Bureau of Developmental Disabilities Services) in a timely manner regarding		equipment immediately to nursing when noted. Adaptive equipment will be replaced or repaired in a timely manner.	

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clients #4 and #13 and to report an allegation regarding client #4 ingesting two toy balls. Please see W153.

8. The governing body failed to exercise policy, budget and operating direction over the facility by failing to thoroughly investigate a pattern of incidents of physical aggression regarding clients #2, #5, #8, #16, #20, to thoroughly investigate an allegation of staff mistreatment regarding client #4, to investigate an injury of unknown origin regarding client #19, to thoroughly investigate an allegation of staff abuse regarding client #13, to investigate an injury of unknown origin regarding client #16, to thoroughly investigate a pattern of client #3's physical aggression towards his peers (#4, #5, #6, #7, #8, #9, #10, #13, #15, #17 and #19) and investigate allegations regarding client #4's ingestion of two toy balls. Please see W154.

9. The governing body failed to exercise policy, budget and operating direction over the facility by failing to develop and implement effective measures to prevent a pattern of incidents of physical aggression regarding clients #2, #5, #8, #16, #20, an allegation of staff abuse regarding client #13 and a pattern of client #3's physical aggression towards his peers (#4, #5, #6, #7, #8, #9, #10, #13, #15, #17 and #19). Please see W157.

10. The governing body failed to exercise policy, budget and operating direction over the facility by failing to ensure the QIDP (Qualified Intellectual Disabilities Professional) integrated, coordinated and monitored clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20's active treatment programs, failed to ensure the programs were effectively developed by necessary recreational and activity director professionals, to ensure staff working in the home

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	were adequately trained to address clients #1, #2, #3, #4, #10, #12, #13, #15, and #19's behavioral needs, to ensure clients #1, #2, #4 and #11 received a continuous active treatment program including aggressive, consistent implementation of their program plans, to ensure staff implemented clients #1, #2, #4 and #11's program plans as written and to promote clients #1, #2, #4, #8, #10, #11, #17 and #18's dignity in regard to their appearance. Please see W159. 11. The governing body failed to exercise policy, budget and operating direction over the facility by failing to ensure clients #1, #2, #4 and #11 received a continuous active treatment program including aggressive, consistent implementation of their program plans. The governing body failed to ensure staff implemented clients #1, #2, #4 and #11's program plans as written. Please see W196. 12. The governing body failed to exercise policy, budget and operating direction over the facility by failing to promote clients #1, #2, #4, #8, #10, #11, #17 and #18's dignity in regard to their appearance. Please see W268. 13. The governing body failed to exercise policy, budget and operating direction over the facility by failing to ensure clients #2, #3 and #9's adaptive equipment was available and in good repair. Please see W436. 14. The governing body failed to exercise policy, budget and operating direction over the facility by failing to ensure a sanitary environment for clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20 in regard to hand hygiene practices, clean table surfaces at meal time and clean food storage areas. Please see W454.			

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W 0125 Bldg. 00	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.			
	Based on observation, record review and interview for 1 additional client (#11), the facility failed to ensure client #11's rights were not infringed upon after meeting discharge requirements for alternative placement options. Findings include: Observations were conducted at the facility on 5/31/22 from 2:15 PM through 3:26 PM, from 4:30 PM through 7:06 PM, on 6/1/22 from 10:45 AM through 11:24 AM, from 2:22 PM through 3:24 PM, and from 4:44 PM through 6:07 PM. During these observation at the facility client #11 engaged in eating meals, standing and/or sitting in the day room among his peers and would lay in his bed. Client #11 had limited social interactions with his peers during these observations. On 6/1/22 at 1:04 PM, a focused review of client #11's record was conducted. The review indicated the following: -Individual Support Plan (ISP) dated 8/11/21 indicated, "Individual Profile: ... [Client #11's] [family members] are deceased. He is 1 of 4 siblings. His oldest [family member] is his guardian ... [Client #11] lacks the ability to clearly verbalize his needs and wants. He can express his wants by yelling 'tea', 'coffee', 'coke', 'snack' and by grabbing staff to direct them to his desired	W 0125	Program Manager will continue to communicate with guardians regarding the client's readiness for discharge. Program manager will continue to communicate with BDDS, IDR, Executive team during monthly discharge meetings to request further assistance.	07/08/2022

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	location/item ... Discharge Criteria: The IDT (Interdisciplinary Team) agrees to review [client #11's] Discharge Criteria on a quarterly basis ...". -Interdisciplinary Team Meeting dated 8/11/21 indicated, "Purpose of Meeting: Annual Meeting ... Meeting Minutes: discussed ISP, goals, etc ... Behavioral Data: discussed, Medical High Risk Plans: discussed ... Recommendations: BDDS (Bureau of Developmental Disabilities Services) to send alternative placement info (information) ...". On 6/2/22 at 10:55 AM, the Director of Nursing (DON) was interviewed. The DON was asked about client #11's alternative placement options as indicated from the 8/11/21 annual team meeting. The DON stated, "We are trying to transfer him out. He (guardian) said he would get an attorney. We reached out last week and he's not answering his phone. I think he knows we're still trying to get that transition going. We have places identified". The DON was asked if client #11's current placement was required due to medical and/or behavioral needs. The DON stated, "No. We're trying to move him. The family will say he will try to run away". On 6/2/22 at 12:02 PM, staff #2 was interviewed. Staff #2 was asked about client #11's placement at the facility. Staff #2 stated, "I think he needs a place better than here. I think [client #11] has had 1 or 2 holds since I've been here". Staff #2 was asked to clarify the period of time for only "1 or 2 holds". Staff #2 stated, "I would say 4 years". On 6/2/22 at 12:53 PM, Residential Manager #2 (RM #2) was interviewed. The RM #2 was asked about client #11's placement at the facility. The RM #2 stated, "I wonder if he should be somewhere that can take care of his medical			

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	(needs). Behavior wise, he's only been in 1 supine (physical intervention), maybe 2, in two years". On 6/2/22 at 1:35 PM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked about client #11's placement being appropriate for his needs. The QIDP stated, "I would say no. He needs to be in a smaller venue". The QIDP was asked about client #11's need to be placed in a restrictive environment due to his behavior. The QIDP indicated he was newly employed (3 weeks) and learning about client #11 and stated, "Not in the time I've been here". On 6/2/22 at 2:55 PM, the Program Manager (PM) was interviewed. The PM was asked about client #11's status for alternative placement as indicated from the 8/11/21 annual team meeting. The PM stated, "He's due to discharge. His family is fighting with us. They feel he is safe and want to keep him here". The PM indicated the interdisciplinary team was in disagreement and the issue had risen to a level with legal counsel among client #11's team members. The PM was asked if client #11 had met his discharge criteria indicated from the 8/11/21 annual meeting. The PM stated, "Yes". The PM indicated further follow up was being pursued to determine an outcome for client #11's placement needs and options due to the conflict between interdisciplinary team members.			
W 0129 Bldg. 00	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must provide each client with the opportunity for personal privacy.			
	Based on observation and interview for 1 of 4 sampled clients (#1), and 4 additional clients (#14,	W 0129	Window covering and/or privacy film has been added to all client's	07/08/2022

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	#16, #18 and #20), the facility failed to ensure clients #1, #14, #16, #18 and #20's bedroom windows had curtains and/or coverings to maintain their privacy from the outside. Findings include: Observations were conducted on 5/31/22 from 4:30 PM through 7:06 PM and on 6/1/22 from 10:45 AM to 11:24 AM. The observations indicated clients #1, #14, #16, #18 and #20's bedroom windows did not have curtains and/or coverings to ensure their privacy from outside. On 5/31/22 at 5:03 PM, client #20 indicated he wanted to show the surveyor his bedroom. Upon entering client #20's bedroom, three out of four curtains were piled on the floor below his bedroom windows. Client #20 indicated his curtains would no longer stay up due to the Velcro lining being too weak to hold them in place. Client #20 indicated without his curtains over his windows, light entered his room making it difficult to sleep. On 6/1/22 at 10:52 AM, a review of the bedrooms down the Colts hallway indicated both clients #18 and #20's bedrooms were missing window coverings and/or curtains. Three out of four curtains remained piled up on the floor below client #20's bedroom windows. Client #18's bedroom was missing a window covering and/or curtain over his bedroom window. On 6/1/22 at 11:05 AM, a review of the bedrooms down the Pacer hallway indicated clients #1, #14 and #16's bedrooms were missing coverings and/or curtains. Client #1's bedroom window faced the back courtyard. Client #14's bedroom window faced a parking area and client #16's bedroom window also faced the same parking area.		windows.	

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On 6/2/22 at 12:02 PM, staff #2 was interviewed. Staff #2 was asked about the process for requesting repairs for client bedrooms to ensure privacy such as missing window coverings and/or curtains. Staff #2 stated, "Usually put a maintenance request in. If we need to, we talk to the Q (Qualified Intellectual Disabilities Professional). Even the clients talk to [maintenance person]. He gets to it when he can".

On 6/2/22 at 12:36 PM, the Residential Manager (RM #4) was interviewed. The RM #4 was asked about a process for requesting repairs to ensure privacy for missing window coverings and/or curtains. The RM #4 stated, "Yes, we have forms in the med (medication) room. We can always talk to [maintenance person]".
Observations were conducted in the group home on 5/31/22 from 11:20 am through 12:41 pm and from 4:30 pm through 7:10 pm, on 6/1/22 from 10:45 am through 11:22 am, from 2:22 pm through 3:20 pm, and from 4:45 pm through 6:08 pm. Clients #1, #14, #16, #18, and #20 were present in the home throughout the observation periods.

1. In client #1's bedroom two windows did not have coverings or privacy film.

2. In client #14's bedroom, one window did not have a covering or privacy film.

3. In client #16's bedroom, one window did not have a covering or privacy film.

4. In client #18's bedroom, two windows did not have coverings or privacy film and faced the public street.

5. In client #20's bedroom, there were no window

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	coverings. Client #20 was interviewed on 5/31/22 at 11:40 am and stated, "The curtains won't stay up. They're over there." Client #20 pointed to the floor near the window. There were curtains piled on client #20's personal possessions on the floor. Client #20 indicated the curtains were secured to the block wall using strips of Velcro. Client #20 indicated the curtains continually fell down. Direct Support Professional (DSP) #2 was interviewed on 6/2/22 at 11:53 am and stated, "Everyone should have privacy. We put in a maintenance form." Residential Manager (RM) #4 was interviewed on 6/2/22 at 12:36 pm and stated, "There should always be privacy. We report issues to maintenance. The RM fills out the request." RM #4 indicated some clients pull curtains down, so privacy film is used. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 6/2/22 at 1:34 pm and stated, "There is a form staff submit to maintenance." QIDP #1 indicated windows should be covered for privacy.			
W 0130 Bldg. 00	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. Based on observation and interview for 1 of 4 sampled clients (#1), the facility failed to ensure client #1's privacy was maintained during personal care for dressing. Findings include:	W 0130	All staff trained via in-service on maintaining the privacy of clients during personal care and how to maintain staff and client safety while privacy is being maintained. The Administrative Team and other senior trained staff will conduct	07/08/2022

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	An observation was conducted on 6/1/22 from 2:22 PM through 3:24 PM. Upon entering the facility at 2:22 PM, client #1 stood nude in his bedroom with the bedroom door open. Staff #14 assisted client #1 by handing him a gray adult incontinent brief to put on. Client #1's privacy was not ensured by leaving his bedroom door open during personal care for dressing. On 6/2/22 at 10:55 AM, the Director of Nursing (DON) was interviewed. The DON was asked about client #1's bedroom door being left open during personal care and the lack of privacy received. The DON stated, "Yes! We (management) heard about that. I couldn't even believe that". The DON indicated client #1's bedroom door should have been shut to ensure client #1's privacy had been maintained while dressing. On 6/1/22 at 2:22 pm, client #1 was in his bedroom with Direct Support Professional (DSP) #14. Client #1's bedroom door was open, and he was not wearing any clothing. DSP #14 assisted client #1 to put his disposable briefs on. DSP #14 stated, "Let me get you some clothes." DSP #14 assisted client #1 to put on a t-shirt and shorts. DSP #14 placed foam shoes on the floor in front of client #1 and directed him to put them on. DSP #14 stated, "Those are the wrong feet. It doesn't really matter. Go." Client #1 walked out of his bedroom. DSP #14 was interviewed on 6/1/22 at 2:31 pm and stated, "I don't feel comfortable with the door shut with [client #1]." DSP #2 was interviewed on 6/2/22 at 11:53 am and stated, "Doors should be shut for privacy. No one should be seeing a client naked. There is no reason for [client #1's] door to be open while he's		daily monitoring/intervention sessions on the units to model and assist staff in implementing aggressive and continuous active treatment.	

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	dressing." Residential Manager (RM) #4 was interviewed on 6/2/22 at 12:36 pm and stated, "Doors should be shut for privacy. Some of the others are nosy and will try to look through the doorway." RM #4 stated, "If a staff is uncomfortable, they could ask for a second staff to assist." Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 6/2/22 at 1:34 pm and stated, "If staff can't shut the door, there should be 2 staff with the door shut." Program Manager (PM) #1 was interviewed on 6/2/22 at 2:56 pm and stated, "Staff should close the door while providing personal care." Observations were completed on 5/31/22 from 10:45 am through 12:45 pm, from 3:50 pm through 5:05 pm, on 6/1/22 from 8:00 am through 9:00 am, and on 6/2/22 from 7:00 am through 8:30 am. On 6/1/22 at 2:30 pm, client #1 was in the hall with staff #14. Staff #14 assisted client #1 in to the shower room, turned the shower on and assisted client #1 with removing all of his clothes and adult brief. Client #1 had feces on his buttocks area. During this time, the shower room door was open, offering no privacy for client #1. Staff #14 was interviewed on 6/1/22 at 2:30 PM. Staff #14 indicated the shower room door should be closed to provide privacy for client #1.			
W 0140 Bldg. 00	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients.			

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	Based on record review and interview for 2 of 4 sampled clients (#1 and #2), the facility failed to ensure a complete and accurate accounting of clients #1 and #2's personal financial resources. Findings include: 1. Client #1's financial records were reviewed on 6/1/22 at 7:50 AM. Client #1's RFMS (Resident Fund Management Service) personal resources from 2/1/22 through 6/1/22 indicated the following: 5/2/22, weekly spending debit in the amount of $40.00. 4/6/22, weekly spending debit in the amount of $40.00 Client #1's weekly cash ledger dated 5/22 indicated on 5/2/22 client #1 had a beginning balance of $6.17. The ledger indicated client #1 had $10.00 weekly spending deposits on 5/2/22, 5/10/22, 5/17/22 and 5/23/22 for a total of $40.00. Client #1 had debits from fast food restaurants on 5/5/22 in the amount of $7.56, on 5/17/22 in the amount of $10.02 and on 5/26/22 in the amount of $9.62 for a total debits in the amount of $27.20. Client #1's total ending balance should be $18.97. Client #1's documented ending balance was $8.97. Client #1's ledger was not accurately reconciled with his credits and debits for the month of May 2022. Client #1's weekly cash ledger dated 4/22 indicated on 4/4/22 the beginning balance was $7.90. Client #1 had separate $10.00 credits to his weekly spending on 4/4/22, 4/13/22, 4/20/22 and on 4/26/22 for a total available balance of $47.90. Client #1 had debits for fast food purchases on 4/7/22 in the amount of $14.32, on 4/14/22 in the amount of $13.87, on 4/21/22 in the amount of	W 0140	Program Manager will audit/balance ledger once weekly and report findings to business manager and executive director weekly.	07/08/2022

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$9.50 and on 4/25/22 in the amount of $7.48 for a total debits of $45.17. Client #1's ending balance should be $2.73. Client #1's ending balance was documented as $6.17. Client #1's 4/22 ending balance was document on 5/22 at $6.17. Client #1's account was not accurately reconciled.

2. Client #2's RFMS personal resources dated 2/1/22 through 6/1/22 indicated the following:

4/6/22, Spending money in the amount of $40.00
5/2/22, Spending money in the amount of $40.00

Client #2's weekly cash ledger dated 5/22 indicated client #2's beginning balance was $7.60. Client #2 had separate $10.00 credits to his weekly spending ledger on 5/2/22, 5/10/22, 5/17/22 and 5/23/22. Client #2 had debits for fast food purchases on 5/4/22 in the amount of $9.06, on 5/18/22 in the amount of $9.39 and on 5/25/22 in the amount of $8.89 for a total debits in the amount of $27.34. Client #2's ending balance $47.60 - $27.34 should be $20.26. Client #2's ending balance was documented at $10.26. Client #2's account was not accurately reconciled.

Client #2's weekly cash ledger dated 4/22 indicated client #2's beginning balance was $7.39. Client #2 had separate $10.00 credits to his weekly spending ledger on 4/4/22, 4/12/22, 4/20/22 and 4/26/22. Client #2 had debits for fast food purchases on 4/6/22 in the amount of $7.39, on 4/13/22 in the amount of $9.68, on 4/20/22 in the amount of $9.61 and on 4/27/22 in the amount of $9.82 for $36.50 total debits. Client #2's ending balance ($47.39- $36.50) should be $10.89. Client #2's ending balance was documented at $7.60. Client #2's account was not accurately reconciled.

PM (Program Manager) was interviewed on 6/2/22

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	at 1:08 PM. PM indicated the agency debited clients' RFMS accounts once monthly and then added the weekly spending to client ledgers on a weekly basis. PM indicated clients #1 and #2's personal resources should be accounted for.			
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 observation, record review and interview for 3 of 4 sampled clients (#1, #2 and #4), plus 12 additional clients (#5, #6, #7, #8, #9, #10, #13, #15, #16, #17, #19 and #20), the facility neglected to implement its written policy and procedures to prevent and thoroughly investigate a pattern of incidents of physical aggression regarding clients #2, #5, #8, #16, #20, to report and thoroughly investigate an allegation of staff mistreatment regarding client #4, to investigate an injury of unknown origin regarding client #19, to prevent, report and thoroughly investigate an allegation of staff abuse regarding client #13, to investigate an injury of unknown origin regarding client #16, to prevent and thoroughly investigate a pattern of client #3's physical aggression towards his peers (#4, #5, #6, #7, #8, #9, #10, #13, #15, #17 and #19), to prevent client #1 from sustaining injury when left unsupervised during a bath and to prevent, report and investigate allegations regarding client #4's ingestion of two toy balls. Findings include: 1. The facility's BDDS (Bureau of Developmental Disabilities Services) reports and Investigations were reviewed on 5/31/22 at 10:54 AM. The review indicated the following:	W 0149	All members of the Management team will be in-serviced by the Executive Director on the criteria requiring an investigation. Other Interdisciplinary Team members will be trained on the criteria requiring an investigation. QA manager will review BDDS daily and consult with program manager and quality team to determine if an investigation is needed. All facility investigations will be completed by trained investigators. Investigation focus will include but not be limited to interviewing all potential witnesses and comparing documentary and testimonial evidence to identify and clarify discrepancies. Regional Operations Support Specialist is conducting a retraining on conducting investigations including but limited to analysis, findings, interviews potential witness and witnesses, and recommendations to be included. This training is to be completed by 7/22/2022 All staff were re-trained on writing	07/08/2022

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	-BDDS report dated 5/20/22 indicated, "On May 19, 2022, at 4:34 PM, while in the dayroom [client #2] was sitting next to [client #8] when without a precursor he punched [client #8] in the left side of his face using his right fist and then ran to his bedroom. Staff checked on [client #2], and he stated he was fine, and he was sorry. Both were assessed by nursing who noted no injuries. Both resumed normal programming and had no further issues." And, "Will continue to monitor for [client #8] any further injuries. Staff will continue to follow [client #2's] guardian and HRC (Human Rights Committee) approved BSP (Behavior Support Plan) and ISP (Individual Support Plan) regarding verbal and physical aggression, threats, YSIS (You're Safe, I'm Safe) (physical restraint) intervention, PRN (as needed) protocol and coping skills. Both clients report they feel safe and neither wished to file a grievance." -CCAI (client-to-client Aggression Investigation) dated 5/20/22 indicated the following: -"Describe behavior strategies followed (sic) Approved plans followed." -"Does the current behavior strategy address the above behaviors? Yes." -"Has there been a pattern of occurrences between these clients or history of occurrences by main aggressor? Yes- there has (sic) been previous incidents of aggression between [client #2] and [client #8]."		an incident report to include least restrictive measures taken prior to progressing to more restrictive measures. And to include what steps were taken to prevent consumer to consumer aggression. All staff were trained on the following: Staff must attempt to de-escalate the client prior to using escorts/physical redirection, de-escalation can include suggesting that the client go with staff to a different area to talk, offering to help the client with coping skills, offering the client a different activity, or switching out staff if the client is having conflict with a particular staff. All verbal redirection/de-escalation measures attempted before resorting to YSIS escorts should be mentioned in the incident report.	

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-"What steps were taken to ensure clients safety? Staff intervened and was able to verbally redirect both consumers."

-"How was the incident able to occur: [Client #8] and [client #2] were sitting in the dayroom when without a precursor [client #2] punched [client #8]."

The CCAI dated 5/20/22 did not specify which behavior strategies were implemented and reconcile behavior strategies with steps taken to ensure client safety regarding the implementation of client #2's BSP.

-BDDS report dated 5/16/22 indicated, "On May 15, 2022, at 6:57 PM, [client #2] was standing in the dayroom when without a precursor he used his right hand and hit [client #8] on his right arm. Afterwards [client #2] ran to his bedroom and threw his laundry basket. Staff was able to talk with [client #2] and assisted him with using his coping skills to calm down. Both were assessed by nursing who noted no injuries. At 7:58 PM, [client #2] and [client #8] were sitting in the dayroom, [client #8] began yelling for no reason, he was prompted to not yell but he was non-compliant and continued yelling. [Client #2] stood up from his seat and kicked [client #8] and then hit him on his right hand. [Client #2] ran to his bedroom, staff followed to ensure his safety. Once in his bedroom he calmed down and began talking about the movie he wanted to watch. Both were assessed by nursing again who reported no injuries. Both resumed normal programming and had no further issues."

And,

"Will continue to monitor for [client #8] any

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	further injuries. Staff will continue to follow [client #2's] guardian and HRC approved BSP and ISP regarding verbal and physical aggression, threats, YSIS intervention, PRN protocol and coping skills. Both clients report they feel safe and neither wished to file a grievance." -CCAI dated 5/16/22 indicated the following: -"Describe behavior strategies followed (sic) Approved plans followed." -"Does the current behavior strategy address the above behaviors? Yes." -"Were any behavior strategies not followed? If so, what behavior strategies were not followed? No." -"Has there been a pattern of occurrences between these clients or history of occurrences by main aggressor? Yes." -"What steps were taken to ensure clients safety? Staff intervened and was able to verbally redirect both consumers." -"How was the incident able to occur: At 6:57 PM- both were in the dayroom and without a precursor [client #2] hit [client #8]. At 7:58 PM- both were in the dayroom again and [client #8] began yelling and that is when [client #2] hit [client #8] due to no (sic) liking (sic) loud noises." The 5/16/22 CCAI did not reconcile steps staff took regarding client #2's BSP implementation to prevent client #2's physical aggression towards client #8. -BDDS report dated 5/12/22 indicated, "On May			

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11, 2022, at 3:57 PM as [client #5] was sitting on the couch [client #2] walked by and without a precursor he smacked [client #5] on the back of his head and took off running down to his bedroom. [Client #5] was assessed by nursing who noted no injuries. Staff went to check on [client #2] and he stated he was fine; nursing assessed him and reported no injuries. [Client #2] was educated on using his coping skills when he is upset or agitated. Both resumed normal programming."

And,

"Will continue to monitor for [client #5] any further injuries. Staff will continue to follow [client #2's] guardian and HRC approved BSP and ISP regarding verbal and physical aggression, threats, yelling, YSIS intervention, PRN protocol and coping skills. Both clients report they feel safe and neither wished to file a grievance.

-CCAI dated 5/12/22 indicated the following:

-"Does the current behavior strategy address the above behaviors? Yes."

-"Were any behavior strategies not followed? If so, what behavior strategies were not followed? No."

-"Has there been a pattern of occurrences between these clients or history of occurrences by main aggressor? Yes."

-"What steps were taken to ensure clients safety? Staff intervened and was able to verbally redirect both consumers."

-"How was the incident able to occur: [client #5]

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and [client #2] were both in the dayroom, [client #5] was sitting on the couch when without a precursor [client #2] walked by and smacked him in the back of the head."

The CCAI dated 5/12/22 does not reconcile the specific steps taken with client #2's BSP implementation to prevent client #2's physical aggression toward his peers.

-BDDS report dated 5/8/22 indicated, "On May 7, 2022, at 2:50 PM, [client #2] was walking down the hallway when the dayroom became louder causing him to become
agitated, at that time he turned to go back towards his bedroom and on the way down the hallway he hit [client #8] on the top of his head with his hand. Staff followed [client #2] to his room and educated him on using his coping skills when he becomes agitated. Both [client #8] and [client #2] were assessed by nursing who noted no injuries. [Client #8] resumed normal programming while [client #2] remained agitated in his bedroom. At 4:04 PM, staff observed [client #2] hit [client #8] on the top left side of his head with his right hand without a precursor and then ran to his bedroom and slammed his bedroom door. Staff followed [client #2] to his bedroom and educated him on using his coping skills and not hitting his peers. Both were assessed by the nurse who noted no injuries. Both resumed normal programming without any further issues."

And,

"Will continue to monitor for [client #8] any further injuries. Staff will continue to follow [client #2's] guardian and HRC approved BSP and ISP regarding verbal and physical aggression, threats, yelling, YSIS intervention, PRN protocol and

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coping skills. Both clients report they feel safe and neither wished to file a grievance."

-CCAI dated 5/9/22 indicated the following:

-Describe behavior strategies followed (sic) Approved plans followed

-"Does the current behavior strategy address the above behaviors? Yes."

-"Were any behavior strategies not followed? If so, what behavior strategies were not followed? No."

-"Has there been a pattern of occurrences between these clients or history of occurrences by main aggressor? Yes- there has (sic) been previous incidents of aggression between [client #2] and [client #8]."

-"What steps were taken to ensure clients safety? Staff intervened and was able to verbally redirect both consumers."

-"How was the incident able to occur: [Client #8] was sitting on the couch in the dayroom when [client #2] was going towards his bedroom because he was upset about the noise level; as he walked by [client #8] he smacked him on the top of his head."

The 5/9/22 CCAI did not specifically address how steps taken to prevent client #2's physical aggression reconciled with client #2's BSP strategies relate to noise in the environment. The investigation did not indicate documentation to determine if staff implemented client #2's BSP.

-BDDS report dated 5/6/22 indicated, "On May 5,

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2022, at 12:20 PM, while in the dayroom [client #2] walked past [client #5] and said hi to staff, then turned and used his right hand and smacked [client #5] on the right side of his face without a precursor. When [client #5] was smacked it caused him to fall onto the floor and hit the back side of his head. [Client #2] was educated on using his coping skills and not hitting his peers. [Client #5] was assessed by the nurse who noted a 5-centimeter red area to the back left side of his scalp. Neurological checks were initiated and have been within normal limits and no further complications. Both resumed normal programming."

And,

"Will continue to monitor for [client #5] any further injuries. Staff will continue to follow [client #2's] guardian and HRC approved BSP and ISP regarding verbal and physical aggression, threats, yelling, YSIS intervention, PRN protocol and coping skills. Both clients report they feel safe and neither wished to file a grievance."

-CCAI dated 5/6/22 indicated the following"

-"Describe behavior strategies followed (sic) Approved plans followed."

-"Does the current behavior strategy address the above behaviors? Yes."

-"Were any behavior strategies not followed? If so, what behavior strategies were not followed? No."

-"What steps were taken to ensure clients safety? Staff intervened and was able to verbally redirect both consumers."

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-"How was the incident able to occur: [client #5] and [client #2] were both in the dayroom, [client #2] said hi to staff then turned and smacked [client #5] in the face."

The 5/6/22 CCAI did not specifically reconcile the steps taken to ensure client safety with the effective implementation of client #2's BSP to prevent incidents of aggression towards his peers.

-BDDS report dated 4/29/22 indicated, "On 4/28/2022 at 03:24 PM, [client #2] and [client #5] were in the dayroom when without precursor, [client #2] used his left open hand to hit [client #5] in the left side of his face. Staff stepped between the two peers and redirected [client #2] to use his coping skills. [Client #2] then ran into his bedroom. [Client #5] stepped away and was assessed by the nurse who reported no injuries. Both individuals returned to normal programming."

And,

"Staff will continue to follow the guardian and HRC approved ISPs and BSPs for both [client #2] and [client #5] which addresses physical aggression and the use of coping skills to avoid physical aggression. Both clients report they feel safe and neither wished to file a grievance."

-client-to-client Aggression Investigation (CCAI) dated 4/29/22 indicated the following:

-"Describe behavior strategies followed (sic) Approved plans followed."

-"Has there been a pattern of occurrences

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between these clients or history of occurrences by main aggressor? Yes."

-"What steps were taken to ensure clients safety? Verbal redirection, separation (sic)"

-"How was the incident able to occur: Both clients are line of sight, staff tending to other individuals."

-"Recommendations:
Staff will continue to follow the guardian and HRC approved ISPs and BSPs for both [client #2] and [client #8] which addresses physical aggression and the use of coping skills to avoid physical aggression. Both clients report they feel safe and neither wished to file a grievance. Staff will encourage [client #2] to use coping skills and come to staff when agitated."

The CCAI dated 4/29/22 did not specifically document how staff followed client #2's BSP to prevent peer to peer aggression in common areas of the facility or address staff attending other individuals.

-BDDS report dated 4/13/22 indicated, "On 4/12/2022 at 04:19 PM, [client #2] and [client #16] were in the dayroom socializing together when without precursor, [client #2] used his open right hand to hit [client #16] in the right side of his face. Staff stepped between the two peers and redirected [client #2] to use his coping skills. [Client #2] then ran into his bedroom. [Client #16] stepped away and was assessed by the nurse who reported no injuries. Both individuals returned to normal programming."

And,

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"Staff will continue to follow the guardian and HRC approved ISPs and BSPs for both [client #2] and [client #16] which addresses (sic) physical aggression and the use of coping skills to avoid physical aggression. Both clients report they feel safe and neither wished to file a grievance."

-CCAI dated 4/13/22 indicated the following:

-"Describe behavior strategies followed (sic) Approved plans followed."

-"Does the current behavior strategy address the above behaviors? Yes."

-"Were any behavior strategies not followed? If so, what behavior strategies were not followed? No."

-"What steps were taken to ensure clients safety? Separation, verbal redirection."

-How was the incident able to occur: staff tending to other individuals."

The 4/13/22 CCAI did not reconcile steps taken with client #2's BSP to prevent client #2's physical aggression towards his peers. The 4/13/22 CCAI did not address if staffing levels at the time of the incident were sufficient to effectively implement client #2's BSP preventive strategies.

-BDDS report dated 4/12/22 indicated, "On 4/11/2022 at 08:39 PM, clients [client #2] and [client #20] were in the hallway near their rooms when without precursor, [client #2] used his left closed hand to hit [client #20] in the right side of his face. Staff stepped between the two peers and redirected [client #2] to use his coping skills. [Client #2] then ran into his bedroom. [Client #20]

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stepped away and was assessed by the nurse who reported no injuries. Both individuals returned to normal programming."

And,

"Staff will continue to follow the guardian and HRC approved ISPs and BSPs for both [client #2] and [client #20] which addresses physical aggression and the use of coping skills to avoid physical aggression. Both clients report they feel safe and neither wished to file a grievance."

-CCAI dated 4/12/22 indicated the following:

-"Describe behavior strategies followed (sic) Approved plans followed."
-"Were any behavior strategies not followed? If so, what behavior strategies were not followed? No."

-"Has there been a pattern of occurrences between these clients or history of occurrences by main aggressor? yes."

-"What steps were taken to ensure clients safety? Separation."

-"How was the incident able to occur: staff tending to other individuals."

The 4/12/22 CCAI does not reconcile which steps were taken regarding client #2's BSP strategies to limit noise, rearranging client #2's environment, providing additional supervision when client #2 is in close proximity to his peers. The CCAI indicated there was a pattern between clients #2 and #20. The CCAI did not include recommendations for effective prevent of further incidents of client-to-client aggression. The

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	4/12/22 CCAI did not address if the staffing levels were sufficient to implement client #2's BSP to prevent aggression towards client #20. -BDDS report dated 4/11/22 indicated, "On April 9, 2022, at 4:50 PM, [client #2] was in the dayroom when he became agitated with the loud noises a peer was making. Staff noticed that he was becoming upset and prompted him to use his coping skills and asked if he wanted to go to his room and he replied yes, thank you. [Client #2] started walking to his room and as he walked past [client #8] he smacked him on the right side of his face. [Client #2] was educated on using his coping skills and not hitting his peers. [Client #2] and [client #8] were both assessed by nursing who noted no injuries. Both resumed normal programming without any further issues." And, "Will continue to monitor [client #8] for any further injuries. Staff will continue to follow [client #2's] guardian and HRC approved BSP and ISP regarding verbal and physical aggression, threats, YSIS intervention, PRN protocol and coping skills. Both clients report they feel safe and neither wished to file a grievance." -CCAI dated 4/11/22 indicated the following: -"Describe behavior strategies followed (sic) Approved plans followed." -"Does the current behavior strategy address the above behaviors? Yes." -"Were any behavior strategies not followed? If so, what behavior strategies were not followed? No."			

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-"Has there been a pattern of occurrences between these clients or history of occurrences by main aggressor? Yes- there has (sic) been previous incidents of aggression between [client #2] and [client #8]."

-"What steps were taken to ensure clients safety? Staff intervened and was able to verbally redirect both consumers."

-"How was the incident able to occur: [client #8] was sitting on the couch in the dayroom when [client #2] was going towards his bedroom because he was upset about the noise level; as he walked by [client #8] he smacked him."

The CCAI dated 4/11/22 did not specifically reconcile steps taken to prevent client #2's physical aggression with regard to the effective implementation of client #2's BSP.

Client #2's record was reviewed on 6/8/22 at 3:30 PM. Client #2's BSP dated 1/22/22 indicated the 1/22/22 date was the annual BSP review. Client #2's BSP was revised on 3/4/22, 3/29/22, 4/15/22, 4/27/22, 5/10/22 and 5/24/22.

Client #2's BSPs dated 1/18/22, 3/4/22, 3/29/22, 4/15/22, 4/27/22, 5/10/22 and 5/27/22 indicated the following:

-"He has demonstrated aggression while in loud and chaotic environments as well. Noise canceling headphones have been provided for him but he has refused to use them and has broken them in the past."

"[Client #2] is diagnosed with intermittent explosive disorder which means that he can

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engage in sudden bouts of aggression that seem unprovoked."

"He can be very sensitive to loud noises and these have often preceded acts of aggression. At times, he will engage in physical aggression that appears to be out of the blue as he can become overly stimulated without others knowing. Additionally, [client #2] can socialize and be friendly with those in the dayroom but may then strike a peer and run back to his room. These acts are often impulsive and they may appear to be out of the blue."

-"Physical Aggression: Any occurrence or attempts at hitting people, pinching others, spitting on them, kicking or scratching at others, using objects as weapons, pulling hair, or behaviors that produce or have the potential to produce an injury to others. [Client #2] can become physically aggressive after being let out of a AYSIS (sic) hold. He has engaged in very impulsive acts of physical aggression toward peers who aren't even interacting with him in common areas. Staff should pay close attention to the proximity of [client #2] and other clients when [client #2] is in the common areas due to [client #2's] impulsive acts of physical aggression toward clients in common areas. Also, he does not like peers hugging or touching him. Peers should be reminded to give him personal space. It has been observed on several occasions that [client #2] will engage in physical aggression toward a peer and will then engage in other acts of physically aggressive behaviors on the same day."

"Recommendations:
1) Try to keep the area calm, this could mean passing meds at a less chaotic time or even

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allowing med passes to take place in [client #2's] room.
2) If the area is overly chaotic, he should be allowed the option of eating meals in his bedroom. Peers should be reminded to give him space and staff need to be aware of [client #2's] proximity to his peers as he will often hit them when he comes to the dayroom.
3) [client #2] does not like help with showers and as much independence as possible should be offered even though he sometimes needs help with a proper shower.
4) Remind [client #2] that if he is feeling overwhelmed or if the area is too chaotic, he can always go back to his room to relax.
5) [Client #2] likes to have his DVDs on, he can engage in behaviors if they are not working property. Try to make sure he doesn't need help with his movies."

Client #2's BSP dated 5/24/22 indicated, "[Client #2] tends to target peer [client #8] when they are both in the dayroom together, staff should position themselves between [client #2] and [client #8] whenever possible when they are both in common areas together."

Client #2's IDT meeting dated 5/17/22 indicated, "Staff will be trained to stay between [client #8] and [client #2] when in common areas." Client #2's IDT met on 5/22/22, 5/27/22, 5/20/22, 5/4/22, 5/17/22, 5/12/22, 5/12/22, and 5/9/22. The IDT's recommendations included the 5/17/22 recommendation to train staff to physically position themselves between client #2 and his peer client #8, continue to follow his ISP, BSP, YSIS, PRN and coping skill interventions to prevent or reduce client #2's physical aggression incident towards his peers (clients #5, #8, #16 and #20).

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BC (Behavior Clinician) was interviewed on 6/2/22 at 11:40 AM. BC indicated staff should be positioned between client #2 and client #8. BC indicated client #2 could become physically aggressive towards client #8 or other peers in the dayroom without warning. BC indicated client #2's Clozaril (anti-psychotic) medication had been adjusted and was being monitored for effectiveness regarding reducing his physical aggression. BC indicated client #2's physical aggression was assessed as being an escape when over stimulated by his environment. BC indicated client #2 did not like noise. BC stated client #2's IDT had discussed possible "safe places" for client #2 to engage in activities of daily living and active treatment. BC indicated staff had been trained to implement client #2's BSP to prevent physical aggression towards his peers.

2. BDDS report dated 3/9/22 indicated, "On 3/8/22 an allegation of neglect was reported for [client #4]. Staff has been suspended pending investigation. Emotional support was offered to [client #4] during this time."

The BDDS report did not describe the circumstances or details of the allegation.

Investigation Summary dated 3/9/22 indicated the following:

-"On March 7, 2022 it was reported to [Waiver Area Supervisor (WAS)] by [staff #3] that on Saturday March 5, 2022 [staff #6] was [client #4's] one on one staff and during that time, [staff #6] would use his chair to block his door to prevent him from exiting his room. It was also alleged that [staff #3] had overheard that staff would take [client #4's] shoes and hide them but never

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personally saw anyone actually hide his shoes nor did she know who the staff was."

-"[Staff #3] witnessed this incident on Saturday, March 5, 2022 during her 8 a-4 shift. [Staff #3] stated that there was not a lot of staff that wanted to be [client #4's] one on one. [Staff #6] was his one on one at the time that [staff #3] was due to take over. She noted that [staff #6] was in [client #4's] room and [staff #3] went to tell [staff #6] that she would relieve her of one on one duties. When she got to the door, the door was closed and when she tried to open it there was something in the way. [Staff #3] stated that [staff #6] got up and came to the door. [Staff #3] witnessed a reclined chair blocking the door. [Staff #6] got up and moved the chair in order to open the door fully. [Staff #3] stated to [staff #6] that we could not lock him in his room and he needs to be offered to interact with staff and peers outside his room. [Staff #3] stated that [staff #6] was [client #4's] one to one for 8 hours despite [staff #3] offering to take her shift and [client #4] was only in the dayroom one time during the duration that [staff #6] was his one on one. [Staff #3] stated that [client #4] ate in his room Saturday but he doesn't usually eat in his room unless he refuses to come to the day room. [Staff #3] reported this to [WAS] on Monday night which [WAS] reported to investigator on Tuesday afternoon. [Staff #3] also stated that she has never visibly seen anyone take [client #4's] shoes to hide them from him."

The Investigation Summary did not indicate documentation of an interview with WAS. The Investigation Summary did not indicate documentation of analysis, findings or recommendations regarding staff #3 and WAS's failure to immediately report the allegation to the

administrator and BDDS.

3. BDDS report dated 5/8/22 indicated, "On May 7, 2022, at 12 PM, [client #19] reported to the nurse's station for his routine medication. While in the nurse's station he complained of right foot pain stating he had hurt (it) while playing, nurses instructed staff to transport [client #19] to [hospital] for an x-ray. X-ray confirmed a sprain of the talo-fibular ligament of the right ankle. [Client #19] was discharged and instructed to wear an air splint and was prescribed Naproxen 500 mg (milligrams) as needed for pain, and to follow up with his PCP (Primary Care Physician) in one week if not better."

The review did not indicate documentation of an investigation regarding the origin of client #19's unknown injury.

4. BDDS report dated 2/15/22 indicated, "On 2/14/22 during a routine quarterly meeting [client #13] made an allegation of physical and verbal abuse that had occurred on 2/12/22. Staff was suspended pending investigation. Emotional support was offered to [client #13] during this time."

The BDDS report did not describe the circumstances or details of who, when, where, why, how and what was heard and/or observed.

-Investigation Summary dated 2/15/22 indicated the following:

-"On February 14, 2022 during a quarterly meeting with [client #13] alleged that during his supine hold on February 12, 2022, [RM (Residential Manager) #3] was calling him names and telling him he would never get out of this place. He also

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	alleged that [RM #3] spit in his face, smeared It on his face and nose until his nose bled, and that he was choked by [RM #3]." -"[RM #3] is one of the 2nd shift RM's who worked the night of 2/12/22 and was a part of the YSIS supine hold with [client #13]. He was interviewed inside the QIDP office on 2/14/22. [RM #3] stated that he was the 1:1 staff with one of the consumers and was prompting him for snack and med's when he had prompted [client #19, client #16 and client #13] not to congregate in the Pacer's (unit name) hallway as it was a fire hazard. The consumers responded with [RM #7] said we could. [RM #3] stated that he had corrected them and stated that the rules are no hanging out in the hallways in groups as it could be a fire hazard. They were prompted to go to the dayroom if they wanted to hang out. [RM #3] stated that [client #19 and client #16] complied with no issues but [client #13] had become upset and agitated. He stated that then [RM #7] took [client #16 and client #13] out for their scheduled smoke break and when they returned inside, he threw the telephone, slammed his bedroom (sic) and was upsetting a peer. [RM #3] stated he overheard [client #13] yelling to [RM #7] and [staff #14] about how [RM #3] thinks he's the boss, [RM #7] corrected [client #13] and stated that [RM #3] was the boss. [RM #3] overheard and went down there and stated, 'correction we are both the boss'. [RM #3] stated that [client #13] became more upset and then he tried referring back to an earlier conversation with [client #13] about the changes he was talking about making and the ways to get out of here. [RM #3] stated that [client #13] started arguing with him and when he was trying to talk with him [client #13] became upset and swung on him. When he attempted to swing on him [RM #3, RM			

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#7, staff #15 and staff #14] attempted a supine which started on the bed and transitioned to the floor. He stated that [RM #7] had his right arm, [RM #3] had his left arm and [staff #14] was on the legs and that [client #13] was able to grab a hold of his left torso/ribs area and pinch him. [RM #3] stated that [client #13] spit in his face and to get the spit off him he turned his head and blew to get it off his mouth area. [RM #3] stated he did not call [client #13] any names. [Staff #15] then switched with [RM #3] to finish the hold and [RM #3] left the room."

-"[Staff #15] stated that he didn't know what started the behavior but he had seen [RM #7 and staff #14] down by [client #13's] bedroom and he was talking about [RM #3] and then he saw [RM #3] go down there so [staff #15] went down there also as he heard [RM #3] talking to [client #13] about the proper way to treat people and not being a punk.... (sic)"

-"[Staff #14] stated the behavior started because [clients #19, #13 and #16] asked [RM #7] if they could hang out in the Pacer's hallway together and he stated 'yes'; but they were prompted 2 times by other staff and [RM #3] stating they could not hang out by the door as it is blocking the exit and it was a fire hazard. [Staff #14] stated that [RM #3] told the guys that if they had to be prompted a 3rd time that an ABC (antecedent behavior consequence) tracking would be completed for non-compliance due to it being a fire hazard. [Client #13] became upset and agitated by [RM #3] stating a tracking would be completed and that he had went (sic) to his room, slammed his bedroom door, started throwing his objects around and became verbally aggressive. [Staff #14] stated that him (sic) and [RM #7] went in to [client #13's] room to prompt him to use his

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	coping skills to calm down. [RM #3] heard that conversation taking place and went came (sic) to [client #13's] bedroom and [client #13] threatened to hit [RM #3]. [Staff #14] stated that [staff #15] was standing outside of [client #13's] bedroom as [RM #3] was explaining ways for [client #13] to be successful and get out of the ICF (agency) like he wants and that upset [client #13] and he attempted to hit [RM #3] but hit [staff #14] in the process and that's when the supine was imitated." -"[RM #7] states that there were some words between [client #13] and [RM #3] but he didn't hear what was said because he was so focused on ensuring [client #13] didn't hit anyone because he was making threats of violence." -"[RM #7] stated that once the hold was over he had staff take [client #13] to the gym for some 1:1 so [client #13] could calm down and that's when [RM #7] had went (sic) to the gym to check on [client #13] he stated that he felt unsafe around [RM #3] and that he wanted to file a grievance so he helpe d him fill one out. [RM #7] stated that to ensure that [client #13] felt safe he had a staff be with [client #13] in his room or even outside the door."The Investigation Summary factual findings does not address RM #3's behavior intervention methods leading up to the behavior incident. The Investigation does not reconcile RM #3 or staff #14, staff #15 or RM #7's implementation of client #13's BSP strategies to de-escalate client #13's behavior. The Investigation summary does not address or reconcile client #13's			

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	allegations regarding RM #3 reported to RM #7 on 2/12/22. Client #13's record was reviewed on 6/8/22 at 4:00 PM. Client #13's BSP revised date 5/13/22 indicated the following:-"Behavioral issues from [client #13] should not end with [client #13] getting special privileges such as walks with staff or other rewarding attention. It has been observed that [client #13] will seek out individual time with staff after behaviors and this time is typically spent glorifying behaviors that have taken place. [Client #13] should get individual time with staff when behaving appropriately so that he doesn't get accustomed to having staff's undivided attention only for (or following) bad behaviors."-"[Client #13] will sometime engage in aggression toward himself or others in order to maintain the center of attention as he likes to have staff giving him individualized attention in his room. His behaviors in the dayroom or common areas also are maintained by [client #13's] significant image issues causing him to try to demonstrate how tough and intimidating he is. Minimizing the audience when possible should take place so that [client #13] has fewer people to act out for."-"Verbal aggression including rocking back and forth between his right and left feet could be identified as a precursor to other behavioral issues. When he engages in this behavior			

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	staff will:-Remain calm in tone and volume, do not react with emotion or irritation-Ignore threats and verbal abuse - do not get into a back-and-forth power struggle-Try to minimize his audience -Ask him how you can help. He is more likely to be able to calm down if he feels supported and liked by his staff-Remind him that we are here to help him so that he can reach his goals of moving to waiver-Tell him that you want to help him but can only do so if he is talking calmly- do not give unnecessary attention/reaction to verbal aggression -If he continues to yell, with as little reaction that you can use, repeat that you want to help him but that you can only do so if he is talking calmly."Client #13's BSP did not indicate client #13's presence in the Pacer's hallway was a fire hazard. 5. BDDS report dated 5/19/22 indicated, "On May 18, 2022, at 11:02 PM, [client #16] reported to staff that while he was in the bathroom he had fallen and hit his head on the toilet. He was taken to nursing to be assessed and she discovered small amount of blood on his forehead and a slight indention (sic), she cleaned the area and noticed 1 cm abrasion, nurse requested he be taken to [emergency room]. While at the emergency room a CT scan was completed and there were no issues. [Client #16] was discharged from [hospital] with a diagnosis of minor closed head injury with single			

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	superficial abrasion to forehead."The review did not indicate documentation of an investigation regarding client #16's injury of unknown origin. 6. Client #3's record was reviewed on 6/8/22 at 4:15 PM. Client #3's BSP revised date 4/4/22 indicated, "He was often non-compliant with most chores and tasks and would engage in physical aggression or property destruction in order to avoid doing undesirable tasks. [Client #3] can be very aggressive with peers and staff and some of his behaviors appear to take place without warning. He spits on others when he is upset and he may engage in this behavior without others knowing why he is upset. Target behaviors for [client #3] include verbal and physical aggression, property destruction, bolting, non-compliance, self injury, allegations of abuse and neglect, sexually inappropriate behaviors, and instigation. This plan will address these target behavior."Client #3's BSP revised date 4/18/22 indicated, "At this time, [client #3] will have 1:1 staffing due to his numerous client-to-client behaviors. The 1:1 is in place to prevent [client #3] from being able to hit/kick/spit at other clients. Staff should try to stay in between [client #3] and any peers that he may hit."Client #3's BSP revised date 4/29/22 indicated, "Due to his numerous acts of physical aggression toward peers, he was assigned a 1:1 staff for			

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	a period of time."Client #3's BSP revised date 4/29/22 indicated, "At this time, [client #3] will have 1:1 staffing due to his numerous client-to-client behaviors. The 1:1 is in place to prevent [client #3] from being able to hit/kick/spit at other clients. Staff should try to stay in between [client #3] and any peers that he may hit."Client #3's BSP revised date 5/13/22 (4/29/22) indicated, "Due to his numerous acts of physical aggression toward peers, he was assigned a 1:1 staff for a period of time. [Client #3] was prescribed Lithium in order to help stabilize his moods and there has been an improvement in his behaviors since starting this medication. It has also shown to be beneficial for [client #3] to utilize other areas of campus such as the gym, courtyard, front porch, etc. in order to take a break from the residential hall." Client #3's BSP revised dates 5/26/22, 5/13/22 (4/29/22) indicated, "If [client #3] is exhibiting agitation or has engaged in physical aggression to peers, a 1:1 staff can be put in place for the protection of other clients. This would be at the discretion of the admin on call. If the 1:1 is in place, the 1:1 is to prevent [client #3] from being able to hit/kick/spit at other clients. If the 1:1 is in place, the 1:1 staff should try to stay in between [client #3] and any peers that he may hit and should remain within approximate arm's reach of [client			

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	#3]."The facility's BDDS reports and Investigations were reviewed on 5/31/22 at 10:54 AM. The review indicated the following from 4/1/22 through the 5/31/22 (date of review) client #3 had 27 separate incidents of physical aggression towards peers (#4, #5, #6, #7, #8, #9, #10, #13, #15, #17 and #19). The review indicated the facility completed CCAI investigations regarding the incidents of client #3's physically aggressive behaviors towards his peers. The CCAI's indicated the investigations document staff implemented client #3's BSP. The CCAI's do not reconcile or document client #3's preventative strategies to implement 1:1 supervision or to physically stand between client #3 and his peers to prevent physical aggression. PM (Program Manager) was interviewed on 6/2/22 at 1:08 PM indicated staff are trained to implement clients BSP's. PM indicated staff should offer coping skills and strategies in each client's BSP to prevent incident from escalating to physical aggression towards staff or peers. PM indicated the abuse and neglect policy should be implemented. PM indicated allegations of abuse and neglect should be immediately reported to the administrator and to BDDS within 24 hours. PM indicated reporting of allegations should describe the circumstances of the incident, the who, what,			

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	when, where and how of the alleged event. PM indicated allegations should be investigated to develop and implement corrective measures to prevent recurrence.The facility's policy and procedures were reviewed on 5/31/22 at 10:00 AM. The facility's Abuse, Neglect and Exploitation policy dated 11/24/18 indicated the following:-"ResCare will· Ensure all persons served are treated with dignity and respect.· Ensure that all persons served are free from abuse, neglect, or exploitation.· Establish a protocol for reporting all incidents of abuse, neglect andexploitation to the ResCare Critical Incident Database.· Ensure all incidents of abuse, neglect, and exploitation are reported to theappropriate authority as defined by state and local regulations."-"ResCare does not tolerate abuse, neglect, or exploitation of any persons served. Allemployees are required to report allegations or suspected incidents of abuse, neglect, and exploitation. Supervisors, managers, or employees are not permitted to engage in retaliation, retribution, or any form of harassment directed against any employee who, in good faith, reports allegations or suspected incidents or abuse, neglect or exploitation. All alleged or suspected abuse, neglect, and/or exploitation will be immediately investigated. Appropriate corrective action			

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	will be taken to ensure prevention of any further occurrence."-"Abuse means the infliction of physical or psychological harm, unreasonable confinement, intimidation, punishment with resulting physical harm, pain or mental anguish or deprivation of goods or services that are necessary to meet essential needs or to avoid physical or psychological harm."-"Neglect means the failure of an individual to provide the treatment, care, goods or services that are necessary to maintain the health or safety of a person we support."-"All employees will immediately report any allegation or suspicion of abuse, neglect or exploitation or any bruising or injury of unknown source to the first supervisor in the chain of command that is not involved in the incident. After reporting internally, proceed with external reporting."7. Client #1's record was reviewed on 6/1/22 at 1:52 pm.Client #1's Behavior Support Plan (BSP) dated 5/26/22 indicated the following:"Target Behaviors and Goals....Anal Digging/Smearing Feces:....[Client #1] will sometimes reach back toward his anal area right after having a bowel movement, and it has been helpful for staff to hold his hands after a bowel movement, so that he is not tempted to do this. [Client #1] may engage in this behavior to upset staff, so that they just give in to what he wants.... Includes attempts to eat			

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	his feces. [Client #1] may engage in this behavior to get a reaction out of staff, and staff should respond with as little reaction or emotion as possible. If he sees that it upsets or flusters you, he will do it more. He likes the reaction....Restrictions:- [Client #1] will have an assigned staff across all shifts....- Staff will remain in the doorway when [client #1] bathes due to a history of unhygienic behaviors in the tub such as defecating and playing with his feces. Showers should be encouraged instead of baths due to [client #1's] aggressive thrashing in the bath tub and his history of defecating in the tub and playing with it....Preventative Procedures:- He should be encouraged to take showers rather than baths due to his history of violently thrashing around in the tub causing bruising to himself....- [Client #1] seeks a reaction from staff and has had behaviors in the past in order to get a reaction out of staff. Don't react emotionally to his behaviors by being shocked, grossed out, or upset. Act almost as if the behavior did not just happen. ALL staff need to be on board with this intervention in order to decrease these types of behaviors."On 6/1/22 at 2:30 pm, an interview was conducted with Licensed Practical Nurse (LPN) #1. LPN #1 indicated she knew of an incident where client #4 had 2 green toy balls in his incontinence brief covered with feces. LPN			

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	#1 stated "I know there was an incident where they found green balls in his [incontinence brief]. They were bigger than a ping pong ball. There is no way he could have swallowed 2 of them without choking. He always plays with his hands in his [incontinence brief]."An observation was conducted on 5/31/22 from 4:30 PM through 7:06 PM. At 6:20 PM, client #1 walked out of a bathroom nude and into the hallway, turned and reentered the bathroom. No staff was present and/or provided redirection to client #1. At 6:22 PM, client #1 walked out of the bathroom a second time nude and returned to the bathroom and got into a bathtub filled with brownish green water. No staff was present in the bathroom or in the hallway to provide redirection to client #1. At this time, a second surveyor noted client #1 was exhibiting rectal digging and putting his hands up to his mouth while in the bathtub. At 6:23 PM, staff #7 was informed client #1 was in the bathroom unattended and was exhibiting rectal digging and putting his hands up to his mouth. At 6:24 PM, staff #7 indicated assistance was needed through use of a handheld radio. Staff #2 responded to staff #7's radio request for assistance and brought a white sheet to the bathroom. At 6:26 PM, LPN #3 (licensed practical nurse) entered the bathroom briefly before client #1, staff #7			

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	and LPN #3 left the bathroom to go to a second bathroom using the white sheet to wrap around client #1 as he ambulated through the hallways. At 6:27 PM, the Nurse was asked why staff #7 had requested her to come to the bathroom. The LPN #3 stated, "Because he has an abrasion". At 6:33 PM, the LPN #3, client #1 and the Residential Manager (RM #1) entered the medication administration room. The LPN #3 stated, "I'm going to have to measure it (abrasion)". At 6:35 PM, the LPN #3 stated, "Left side 30 cm (centimeters) by 14 cm and the right side 2 (areas of abrasion), first 5 cm by 3 cm, the right second (area) 6 cm by 2 cm". On 5/31/22 at 6:39 PM, the LPN #3 and RM #1 were interviewed. The LPN #3 and RM #1 were asked if client #1 could bathe independently or if client #1 required staff assistance. Both the LPN #3 and RM #1 stated simultaneously, "staff assistance". The LPN #3 stated, "He cannot regulate his water". At 6:41 PM, the RM #1 responded to LPN #3's statement and stated, "I started it (bath water) and told staff he was in there. He usually showers. Staff is usually in there".On 6/3/22 at 9:30 AM, a review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports and accompanying investigation summaries was conducted. The review indicated the			

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	following incident which affected client #1.BDDS Report dated 6/1/22 indicated, "On 5/31/22 at 6:25 PM, [client #1] was in the bathtub without staff supervision. While in the bathtub he began thrashing around and pulled down the shower curtain and rod causing redness to his back. Staff assisted [client #1] to the Nurse's station to be assessed. Nursing assessed and noted red skin abrasions noted on back, left side back measuring 30 cm x 14 cm, left (sic) side of back measuring 5 cm x 3 cm and 6 cm x 2 cm; bacitracin applied". Investigation summary in process. On 6/2/22 at 12:02 PM, staff #2 was interviewed. Staff #2 was asked about client #1's supports needed during bathing and/or showering. Staff #2 stated, "He usually doesn't go to that one (bathroom). He usually takes a shower in the other one". Staff #2 was asked if client #1 should have been left unattended during his bathing and/or showering. Staff #2 stated, "Staff stands in the door". Staff #2 indicated client #1 should not be left unattended during his bathing and/or showering supports.On 6/2/22 at 12:36 PM, a second Residential Manager (RM #4) was interviewed. The RM #4 was asked about client #1's bathing and/or showering support needs. The RM #4 stated, "I would have to check. I stress getting him into the standup shower. When he first got here he had a couple baths. That			

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	did not work". The RM #4 indicated client #1 would thrash around when given a bath and stated it would "leave marks. It was bad. He likes to flop up and down". The RM #4 was asked if client #1 required staff supervision during his bath and/or shower. The RM #4 stated, "Yes, really you should be arms reach".On 6/2/22 at 12:53 PM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked if client #1 should be left unattended during a bath and/or shower. The QIDP stated, "He should not be left alone". On 6/2/22 at 2:55 PM, the Program Manager (PM) was interviewed. The PM was asked if client #1 should be left unattended during a bath and/or shower. The PM stated, "He should be encouraged to shower, and staff should be at the door with him". The PM was asked if client #1 should be left unattended. The PM stated, "No, not left alone". The PM was asked when did the incident of client #1 being left alone to bathe which resulted in an abrasion became a allegation of neglect. The PM stated, "When she (RM #1) walked away". The PM indicated RM #1 was suspended and an ongoing investigation into client #1 being left unattended during his bath on 5/31/22 was in process. 8. An initial observation was conducted on 5/31/22 from 2:15 PM through 3:16 PM. During the observation,			

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	client #4 was in the common living area of the home referred to as the day room. At 2:20 PM, client #4 was seated on a sofa in the day room and staff #2 was seated next to him. At 2:25 PM, client #4 repositioned to a different sofa in the day room. Staff #2 followed client #4 and again sat beside him. At 3:10 PM, client #4 stood and entered the kitchen area and reached into a trash can. The RM #2 used verbal redirection with client #4 to prompt him to return to the day room and stated, "Hey, whoever has [client #4] needs to watch him". On 5/31/22 at 3:14 PM, the RM #2 was interviewed. The RM #2 was asked if client #4 was on a one-to-one staff assignment. The RM #2 stated, "He is. I didn't realize [staff #2] went to move the van. They parked it in a bad spot". The RM #2 was asked if client #4 was on a one-to-one staff assignment because of behavioral challenges such as eating inedible items (PICA). The RM #2 stated, "Basically. That and he would go into everyone's room. [Staff #6] has him now. Once he had a wrapper from a depends (incontinent brief) in his mouth and I had to get that out of his mouth. A couple weeks ago he had a ball in his feces". The RM #2 was asked to describe the size of the ball she was referring too. The RM #2 used her right index finger and drew a circle shape in the palm of her left hand the size of a quarter			

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	and stated, "I would say the size of the center of my palm". The RM #2 was asked if client #4 ingested this ball. The RM #2 stated, "I don't know, but it was mixed in with his feces in his depends. Some people think he stuck it in his brief, but I don't see how that's possible". On 6/1/22 at 11:42 AM, client #4's record was reviewed. The record indicated the following:-Behavioral Support Plan (BSP) dated 5/23/22 indicated, "Target Behavior... Eating Non-Edible/Non-Food Items: any time he ingests or tries to ingest a non-food item. According to previous providers, he will eat paper or string or any other item that he can get his hands on...".-Nursing Note dated 5/19/22 at 11 AM indicated, "Found II (two) toy balls in client's (client #4) BM (bowel movement). Examined anus with 0 tears, 0 bleeding, and 0 S/S (signs and symptoms) of discomfort...".On 6/2/22 at 2:55 PM, the Program Manager (PM) was interviewed. The PM was asked about client #4's alleged ingestion of two toy balls found in adult incontinent brief. The PM stated, "We're not sure if he stuck it in his pants. We're not sure if he consumed it or if he stuck it in there". The PM indicated client #4 was assessed for injury by nursing staff and no injuries were found. The PM was asked if client B had a history of putting objects in his adult incontinent brief. The PM stated,			

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	"No. I know he'll pick stuff up off the floor and put it into his mouth". On 6/3/22 at 9:30 AM, a review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports and accompanying investigation summaries was conducted. The review did not indicate documentation client #4's 5/19/22 alleged incident was reported to BDDS or investigated.			
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 2 of 3 allegations of staff abuse reviewed, the facility failed to ensure allegations of staff abuse were reported to BDDS (Bureau of Developmental Disabilities Services) in a timely manner regarding clients #4 and #13 and to report an allegation regarding client #4 ingesting two toy balls. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports and Investigations were reviewed on 5/31/22 at 10:54 AM. The review indicated the following: 1. BDDS report dated 3/9/22 indicated, "On 3/8/22 an allegation of neglect was reported for [client #4]. Staff has been suspended pending investigation. Emotional support was offered to [client #4] during this time."	W 0153	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. Specifically, direct support and supervisory staff will be retrained regarding required reporting criteria and timelines. All staff that submit BDDS were trained in the information to include in BDDS report. All members of the Management team will be in-serviced by the Executive Director on the criteria requiring an investigation. Other Interdisciplinary Team members will be trained on the criteria	07/08/2022

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	The BDDS report did not describe the circumstances or details of the allegation. 2. BDDS report dated 2/15/22 indicated, "On 2/14/22 during a routine quarterly meeting [client #13] made an allegation of physical and verbal abuse that had occurred on 2/12/22. Staff was suspended pending investigation. Emotional support was offered to [client #13] during this time." The BDDS report did not describe the circumstances or details of who, when, where, why, how and what was heard and/or observed. PM (Program Manager) was interviewed on 6/2/22 at 1:08. PM indicated allegations of abuse and neglect should be immediately reported to the administrator and to BDDS within 24 hours. PM indicated reporting of allegations should describe the circumstances of the incident, the who, what, when, where and how of the alleged event. 3. An initial observation was conducted on 5/31/22 from 2:15 PM through 3:16 PM. During the observation, client #4 was in the common living area of the home referred to as the day room. At 2:20 PM, client #4 was seated on a sofa in the day room and staff #2 was seated next to him. At 2:25 PM, client #4 repositioned to a different sofa in the day room. Staff #2 followed client #4 and again sat beside him. At 3:10 PM, client #4 stood and entered the kitchen area and reached into a trash can. The RM #2 used verbal redirection with client #4 to prompt him to return to the day room and stated, "Hey, whoever has [client #4] needs to watch him". On 5/31/22 at 3:14 PM, the RM #2 was interviewed. The RM #2 was asked if client #4 was on a one-to-one staff assignment. The RM #2		requiring an investigation and during the review of all BDDS reports, a question will be added for clarity to the Interdisciplinary Team note asking whether the incident requires an investigation. All staff retrained on the Abuse Neglect and Exploitation policy and the reporting process.	

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	stated, "He is. I didn't realize [staff #2] went to move the van. They parked it in a bad spot". The RM #2 was asked if client #4 was on a one-to-one staff assignment because of behavioral challenges such as eating inedible items (PICA). The RM #2 stated, "Basically. That and he would go into everyone's room. [Staff #6] has him now. Once he had a wrapper from a depends (incontinent brief) in his mouth and I had to get that out of his mouth. A couple weeks ago he had a ball in his feces". The RM #2 was asked to describe the size of the ball she was referring too. The RM #2 used her right index finger and drew a circle shape in the palm of her left hand the size of a quarter and stated, "I would say the size of the center of my palm". The RM #2 was asked if client #4 ingested this ball. The RM #2 stated, "I don't know, but it was mixed in with his feces in his depends. Some people think he stuck it in his brief, but I don't see how that's possible". On 6/1/22 at 11:42 AM, client #4's record was reviewed. The record indicated the following: -Behavioral Support Plan (BSP) dated 5/23/22 indicated, "Target Behavior... Eating Non-Edible/Non-Food Items: any time he ingests or tries to ingest a non-food item. According to previous providers, he will eat paper or string or any other item that he can get his hands on...". -Nursing Note dated 5/19/22 at 11 AM indicated, "Found II (two) toy balls in client's (client #4) BM (bowel movement). Examined anus with 0 tears, 0 bleeding, and 0 S/S (signs and symptoms) of discomfort...". On 6/2/22 at 2:55 PM, the Program Manager (PM) was interviewed. The PM was asked about client #4's alleged ingestion of two toy balls found in			

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	adult incontinent brief. The PM stated, "We're not sure if he stuck it in his pants. We're not sure if he consumed it or if he stuck it in there". The PM indicated client #4 was assessed for injury by nursing staff and no injuries were found. The PM was asked if client B had a history of putting objects in his adult incontinent brief. The PM stated, "No. I know he'll pick stuff up off the floor and put it into his mouth". On 6/3/22 at 9:30 AM, a review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports and accompanying investigation summaries was conducted. The review did not indicate documentation client #4's 5/19/22 alleged ingestion was reported to BDDS.			
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 2 of 4 sampled clients (#2 and #4), plus 12 additional clients (#5, #6, #7, #8, #9, #10, #13, #15, #16, #17, #19 and #20), the facility failed to thoroughly investigate a pattern of incidents of physical aggression regarding clients #2, #5, #8, #16, #20, to thoroughly investigate an allegation of staff mistreatment regarding client #4, to investigate an injury of unknown origin regarding client #19, to thoroughly investigate an allegation of staff abuse regarding client #13, to investigate an injury of unknown origin regarding client #16, to thoroughly investigate a pattern of client #3's physical aggression towards his peers (#4, #5, #6, #7, #8, #9, #10, #13, #15, #17 and #19) and investigate allegations regarding client #4's ingestion of two toy balls. Findings include:	W 0154	All facility investigations will be completed by trained investigators. Investigation focus will include but not be limited to interviewing all potential witnesses and comparing documentary and testimonial evidence to identify and clarify discrepancies. All members of the Management team will be in-serviced by the Executive Director on the criteria requiring an investigation. Other Interdisciplinary Team members will be trained on the criteria requiring an investigation and during the review of all BDDS reports, a question will be added for clarity to the Interdisciplinary Team note asking whether the	07/08/2022

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	1. The facility's BDDS (Bureau of Developmental Disabilities Services) reports and Investigations were reviewed on 5/31/22 at 10:54 AM. The review indicated the following: -BDDS report dated 5/20/22 indicated, "On May 19, 2022, at 4:34 PM, while in the dayroom [client #2] was sitting next to [client #8] when without a precursor he punched [client #8] in the left side of his face using his right fist and then ran to his bedroom. Staff checked on [client #2], and he stated he was fine, and he was sorry. Both were assessed by nursing who noted no injuries. Both resumed normal programming and had no further issues." And, "Will continue to monitor for [client #8] any further injuries. Staff will continue to follow [client #2's] guardian and HRC (Human Rights Committee) approved BSP (Behavior Support Plan) and ISP (Individual Support Plan) regarding verbal and physical aggression, threats, YSIS (You're Safe, I'm Safe) (physical restraint) intervention, PRN (as needed) protocol and coping skills. Both clients report they feel safe and neither wished to file a grievance." -CCAI (client-to-client Aggression Investigation) dated 5/20/22 indicated the following: -"Describe behavior strategies followed (sic) Approved plans followed." -"Does the current behavior strategy address the above behaviors? Yes." -"Has there been a pattern of occurrences		incident requires an investigation. All staff that submit BDDS were trained in the information to include in BDDS report. All staff retrained on the following: Staff must attempt to de-escalate the client prior to using escorts/physical redirection, de-escalation can include suggesting that the client go with staff to a different area to talk, offering to help the client with coping skills, offering the client a different activity, or switching out staff if the client is having conflict with a particular staff. All verbal redirection/de-escalation measures attempted before resorting to YSIS escorts should be mentioned in the incident report. All staff retrained on the Abuse Neglect and Exploitation policy and the reporting process	

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	between these clients or history of occurrences by main aggressor? Yes- there has (sic) been previous incidents of aggression between [client #2] and [client #8]." -"What steps were taken to ensure clients safety? Staff intervened and was able to verbally redirect both consumers." -"How was the incident able to occur: [Client #8] and [client #2] were sitting in the dayroom when without a precursor [client #2] punched [client #8]." The CCAI dated 5/20/22 did not specify which behavior strategies were implemented and reconcile behavior strategies with steps taken to ensure client safety regarding the implementation of client #2's BSP. -BDDS report dated 5/16/22 indicated, "On May 15, 2022, at 6:57 PM, [client #2] was standing in the dayroom when without a precursor he used his right hand and hit [client #8] on his right arm. Afterwards [client #2] ran to his bedroom and threw his laundry basket. Staff was able to talk with [client #2] and assisted him with using his coping skills to calm down. Both were assessed by nursing who noted no injuries. At 7:58 PM, [client #2] and [client #8] were sitting in the dayroom, [client #8] began yelling for no reason, he was prompted to not yell but he was non-compliant and continued yelling. [Client #2] stood up from his seat and kicked [client #8] and then hit him on his right hand. [Client #2] ran to his bedroom, staff followed to ensure his safety. Once in his bedroom he calmed down and began talking about the movie he wanted to watch. Both were assessed by nursing again who reported no injuries. Both resumed normal programming and			

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had no further issues."

And,

"Will continue to monitor for [client #8] any further injuries. Staff will continue to follow [client #2's] guardian and HRC approved BSP and ISP regarding verbal and physical aggression, threats, YSIS intervention, PRN protocol and coping skills. Both clients report they feel safe and neither wished to file a grievance."

-CCAI dated 5/16/22 indicated the following:

-"Describe behavior strategies followed (sic) Approved plans followed."

-"Does the current behavior strategy address the above behaviors? Yes."

-"Were any behavior strategies not followed? If so, what behavior strategies were not followed? No."

-"Has there been a pattern of occurrences between these clients or history of occurrences by main aggressor? Yes."

-"What steps were taken to ensure clients safety? Staff intervened and was able to verbally redirect both consumers."

-"How was the incident able to occur: At 6:57 PM- both were in the dayroom and without a precursor [client #2] hit [client #8]. At 7:58 PM- both were in the dayroom again and [client #8] began yelling and that is when [client #2] hit [client #8] due to no (sic) liking (sic) loud noises."

The 5/16/22 CCAI did not reconcile steps staff

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took regarding client #2's BSP implementation to prevent client #2's physical aggression towards client #8.

-BDDS report dated 5/12/22 indicated, "On May 11, 2022, at 3:57 PM as [client #5] was sitting on the couch [client #2] walked by and without a precursor he smacked [client #5] on the back of his head and took off running down to his bedroom. [Client #5] was assessed by nursing who noted no injuries. Staff went to check on [client #2] and he stated he was fine; nursing assessed him and reported no injuries. [Client #2] was educated on using his coping skills when he is upset or agitated. Both resumed normal programming."

And,

"Will continue to monitor for [client #5] any further injuries. Staff will continue to follow [client #2's] guardian and HRC approved BSP and ISP regarding verbal and physical aggression, threats, yelling, YSIS intervention, PRN protocol and coping skills. Both clients report they feel safe and neither wished to file a grievance.

-CCAI dated 5/12/22 indicated the following:

-"Does the current behavior strategy address the above behaviors? Yes."

-"Were any behavior strategies not followed? If so, what behavior strategies were not followed? No."

-"Has there been a pattern of occurrences between these clients or history of occurrences by main aggressor? Yes."

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-"What steps were taken to ensure clients safety? Staff intervened and was able to verbally redirect both consumers."

-"How was the incident able to occur: [client #5] and [client #2] were both in the dayroom, [client #5] was sitting on the couch when without a precursor [client #2] walked by and smacked him in the back of the head."

The CCAI dated 5/12/22 does not reconcile the specific steps taken with client #2's BSP implementation to prevent client #2's physical aggression toward his peers.

-BDDS report dated 5/8/22 indicated, "On May 7, 2022, at 2:50 PM, [client #2] was walking down the hallway when the dayroom became louder causing him to become
agitated, at that time he turned to go back towards his bedroom and on the way down the hallway he hit [client #8] on the top of his head with his hand. Staff followed [client #2] to his room and educated him on using his coping skills when he becomes agitated. Both [client #8] and [client #2] were assessed by nursing who noted no injuries. [Client #8] resumed normal programming while [client #2] remained agitated in his bedroom. At 4:04 PM, staff observed [client #2] hit [client #8] on the top left side of his head with his right hand without a precursor and then ran to his bedroom and slammed his bedroom door. Staff followed [client #2] to his bedroom and educated him on using his coping skills and not hitting his peers. Both were assessed by the nurse who noted no injuries. Both resumed normal programming without any further issues."

And,

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"Will continue to monitor for [client #8] any further injuries. Staff will continue to follow [client #2's] guardian and HRC approved BSP and ISP regarding verbal and physical aggression, threats, yelling, YSIS intervention, PRN protocol and coping skills. Both clients report they feel safe and neither wished to file a grievance."

-CCAI dated 5/9/22 indicated the following:

-Describe behavior strategies followed (sic) Approved plans followed

-"Does the current behavior strategy address the above behaviors? Yes."

-"Were any behavior strategies not followed? If so, what behavior strategies were not followed? No."

-"Has there been a pattern of occurrences between these clients or history of occurrences by main aggressor? Yes- there has (sic) been previous incidents of aggression between [client #2] and [client #8]."

-"What steps were taken to ensure clients safety? Staff intervened and was able to verbally redirect both consumers."

-"How was the incident able to occur: [Client #8] was sitting on the couch in the dayroom when [client #2] was going towards his bedroom because he was upset about the noise level; as he walked by [client #8] he smacked him on the top of his head."

The 5/9/22 CCAI did not specifically address how steps taken to prevent client #2's physical aggression reconciled with client #2's BSP

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strategies relate to noise in the environment. The investigation did not indicate documentation to determine if staff implemented client #2's BSP.

-BDDS report dated 5/6/22 indicated, "On May 5, 2022, at 12:20 PM, while in the dayroom [client #2] walked past [client #5] and said hi to staff, then turned and used his right hand and smacked [client #5] on the right side of his face without a precursor. When [client #5] was smacked it caused him to fall onto the floor and hit the back side of his head. [Client #2] was educated on using his coping skills and not hitting his peers. [Client #5] was assessed by the nurse who noted a 5-centimeter red area to the back left side of his scalp. Neurological checks were initiated and have been within normal limits and no further complications. Both resumed normal programming."

And,

"Will continue to monitor for [client #5] any further injuries. Staff will continue to follow [client #2's] guardian and HRC approved BSP and ISP regarding verbal and physical aggression, threats, yelling, YSIS intervention, PRN protocol and coping skills. Both clients report they feel safe and neither wished to file a grievance."

-CCAI dated 5/6/22 indicated the following"

-"Describe behavior strategies followed (sic) Approved plans followed."

-"Does the current behavior strategy address the above behaviors? Yes."

-"Were any behavior strategies not followed? If so, what behavior strategies were not followed?

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No."

-"What steps were taken to ensure clients safety? Staff intervened and was able to verbally redirect both consumers."

-"How was the incident able to occur: [client #5] and [client #2] were both in the dayroom, [client #2] said hi to staff then turned and smacked [client #5] in the face."

The 5/6/22 CCAI did not specifically reconcile the steps taken to ensure client safety with the effective implementation of client #2's BSP to prevent incidents of aggression towards his peers.

-BDDS report dated 4/29/22 indicated, "On 4/28/2022 at 03:24 PM, [client #2] and [client #5] were in the dayroom when without precursor, [client #2] used his left open hand to hit [client #5] in the left side of his face. Staff stepped between the two peers and redirected [client #2] to use his coping skills. [Client #2] then ran into his bedroom. [Client #5] stepped away and was assessed by the nurse who reported no injuries. Both individuals returned to normal programming."

And,

"Staff will continue to follow the guardian and HRC approved ISPs and BSPs for both [client #2] and [client #5] which addresses physical aggression and the use of coping skills to avoid physical aggression. Both clients report they feel safe and neither wished to file a grievance."

-client-to-client Aggression Investigation (CCAI) dated 4/29/22 indicated the following:

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-"Describe behavior strategies followed (sic) Approved plans followed."

-"Has there been a pattern of occurrences between these clients or history of occurrences by main aggressor? Yes."

-"What steps were taken to ensure clients safety? Verbal redirection, separation (sic)"

-"How was the incident able to occur: Both clients are line of sight, staff tending to other individuals."

-"Recommendations:
Staff will continue to follow the guardian and HRC approved ISPs and BSPs for both [client #2] and [client #8] which addresses physical aggression and the use of coping skills to avoid physical aggression. Both clients report they feel safe and neither wished to file a grievance. Staff will encourage [client #2] to use coping skills and come to staff when agitated."

The CCAI dated 4/29/22 did not specifically document how staff followed client #2's BSP to prevent peer to peer aggression in common areas of the facility or address staff attending other individuals.

-BDDS report dated 4/13/22 indicated, "On 4/12/2022 at 04:19 PM, [client #2] and [client #16] were in the dayroom socializing together when without precursor, [client #2] used his open right hand to hit [client #16] in the right side of his face. Staff stepped between the two peers and redirected [client #2] to use his coping skills. [Client #2] then ran into his bedroom. [Client #16] stepped away and was assessed by the nurse

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who reported no injuries. Both individuals returned to normal programming."

And,

"Staff will continue to follow the guardian and HRC approved ISPs and BSPs for both [client #2] and [client #16] which addresses (sic) physical aggression and the use of coping skills to avoid physical aggression. Both clients report they feel safe and neither wished to file a grievance."

-CCAI dated 4/13/22 indicated the following:

-"Describe behavior strategies followed (sic) Approved plans followed."

-"Does the current behavior strategy address the above behaviors? Yes."

-"Were any behavior strategies not followed? If so, what behavior strategies were not followed? No."

-"What steps were taken to ensure clients safety? Separation, verbal redirection."

-How was the incident able to occur: staff tending to other individuals."

The 4/13/22 CCAI did not reconcile steps taken with client #2's BSP to prevent client #2's physical aggression towards his peers. The 4/13/22 CCAI did not address if staffing levels at the time of the incident were sufficient to effectively implement client #2's BSP preventive strategies.

-BDDS report dated 4/12/22 indicated, "On 4/11/2022 at 08:39 PM, clients [client #2] and [client #20] were in the hallway near their rooms

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when without precursor, [client #2] used his left closed hand to hit [client #20] in the right side of his face. Staff stepped between the two peers and redirected [client #2] to use his coping skills. [Client #2] then ran into his bedroom. [Client #20] stepped away and was assessed by the nurse who reported no injuries. Both individuals returned to normal programming."

And,

"Staff will continue to follow the guardian and HRC approved ISPs and BSPs for both [client #2] and [client #20] which addresses physical aggression and the use of coping skills to avoid physical aggression. Both clients report they feel safe and neither wished to file a grievance."

-CCAI dated 4/12/22 indicated the following:

-"Describe behavior strategies followed (sic) Approved plans followed."
-"Were any behavior strategies not followed? If so, what behavior strategies were not followed? No."

-"Has there been a pattern of occurrences between these clients or history of occurrences by main aggressor? yes."

-"What steps were taken to ensure clients safety? Separation."

-"How was the incident able to occur: staff tending to other individuals."

The 4/12/22 CCAI does not reconcile which steps were taken regarding client #2's BSP strategies to limit noise, rearranging client #2's environment, providing additional supervision when client #2 is

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in close proximity to his peers. The CCAI indicated there was a pattern between clients #2 and #20. The CCAI did not include recommendations for effective prevent of further incidents of client-to-client aggression. The 4/12/22 CCAI did not address if the staffing levels were sufficient to implement client #2's BSP to prevent aggression towards client #20.

-BDDS report dated 4/11/22 indicated, "On April 9, 2022, at 4:50 PM, [client #2] was in the dayroom when he became agitated with the loud noises a peer was making. Staff noticed that he was becoming upset and prompted him to use his coping skills and asked if he wanted to go to his room and he replied yes, thank you. [Client #2] started walking to his room and as he walked past [client #8] he smacked him on the right side of his face. [Client #2] was educated on using his coping skills and not hitting his peers. [Client #2] and [client #8] were both assessed by nursing who noted no injuries. Both resumed normal programming without any further issues."

And,

"Will continue to monitor [client #8] for any further injuries. Staff will continue to follow [client #2's] guardian and HRC approved BSP and ISP regarding verbal and physical aggression, threats, YSIS intervention, PRN protocol and coping skills. Both clients report they feel safe and neither wished to file a grievance."

-CCAI dated 4/11/22 indicated the following:

-"Describe behavior strategies followed (sic) Approved plans followed."

-"Does the current behavior strategy address the

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above behaviors? Yes."

-"Were any behavior strategies not followed? If so, what behavior strategies were not followed? No."

-"Has there been a pattern of occurrences between these clients or history of occurrences by main aggressor? Yes- there has (sic) been previous incidents of aggression between [client #2] and [client #8]."

-"What steps were taken to ensure clients safety? Staff intervened and was able to verbally redirect both consumers."

-"How was the incident able to occur: [client #8] was sitting on the couch in the dayroom when [client #2] was going towards his bedroom because he was upset about the noise level; as he walked by [client #8] he smacked him."

The CCAI dated 4/11/22 did not specifically reconcile steps taken to prevent client #2's physical aggression with regard to the effective implementation of client #2's BSP.

Client #2's record was reviewed on 6/8/22 at 3:30 PM. Client #2's BSP dated 1/22/22 indicated the 1/22/22 date was the annual BSP review. Client #2's BSP was revised on 3/4/22, 3/29/22, 4/15/22, 4/27/22, 5/10/22 and 5/24/22.

Client #2's BSPs dated 1/18/22, 3/4/22, 3/29/22, 4/15/22, 4/27/22, 5/10/22 and 5/27/22 indicated the following:

-"He has demonstrated aggression while in loud and chaotic environments as well. Noise canceling headphones have been provided for him but he

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has refused to use them and has broken them in the past."

"[Client #2] is diagnosed with intermittent explosive disorder which means that he can engage in sudden bouts of aggression that seem unprovoked."

"He can be very sensitive to loud noises and these have often preceded acts of aggression. At times, he will engage in physical aggression that appears to be out of the blue as he can become overly stimulated without others knowing. Additionally, [client #2] can socialize and be friendly with those in the dayroom but may then strike a peer and run back to his room. These acts are often impulsive and they may appear to be out of the blue."

-"Physical Aggression: Any occurrence or attempts at hitting people, pinching others, spitting on them, kicking or scratching at others, using objects as weapons, pulling hair, or behaviors that produce or have the potential to produce an injury to others. [Client #2] can become physically aggressive after being let out of a AYSIS (sic) hold. He has engaged in very impulsive acts of physical aggression toward peers who aren't even interacting with him in common areas. Staff should pay close attention to the proximity of [client #2] and other clients when [client #2] is in the common areas due to [client #2's] impulsive acts of physical aggression toward clients in common areas. Also, he does not like peers hugging or touching him. Peers should be reminded to give him personal space. It has been observed on several occasions that [client #2] will engage in physical aggression toward a peer and will then engage in other acts of physically aggressive behaviors on the same

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day."

"Recommendations:
1) Try to keep the area calm, this could mean passing meds at a less chaotic time or even allowing med passes to take place in [client #2's] room.
2) If the area is overly chaotic, he should be allowed the option of eating meals in his bedroom. Peers should be reminded to give him space and staff need to be aware of [client #2's] proximity to his peers as he will often hit them when he comes to the dayroom.
3) [client #2] does not like help with showers and as much independence as possible should be offered even though he sometimes needs help with a proper shower.
4) Remind [client #2] that if he is feeling overwhelmed or if the area is too chaotic, he can always go back to his room to relax.
5) [Client #2] likes to have his DVDs on, he can engage in behaviors if they are not working property. Try to make sure he doesn't need help with his movies."

Client #2's BSP dated 5/24/22 indicated, "[Client #2] tends to target peer [client #8] when they are both in the dayroom together, staff should position themselves between [client #2] and [client #8] whenever possible when they are both in common areas together."

Client #2's IDT meeting dated 5/17/22 indicated, "Staff will be trained to stay between [client #8] and [client #2] when in common areas." Client #2's IDT met on 5/22/22, 5/27/22, 5/20/22, 5/4/22, 5/17/22, 5/12/22, 5/12/22, and 5/9/22. The IDT's recommendations included the 5/17/22 recommendation to train staff to physically position themselves between client #2 and his

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peer client #8, continue to follow his ISP, BSP, YSIS, PRN and coping skill interventions to prevent or reduce client #2's physical aggression incident towards his peers (clients #5, #8, #16 and #20).

BC (Behavior Clinician) was interviewed on 6/2/22 at 11:40 AM. BC indicated staff should be positioned between client #2 and client #8. BC indicated client #2 could become physically aggressive towards client #8 or other peers in the dayroom without warning. BC indicated client #2's Clozaril (anti-psychotic) medication had been adjusted and was being monitored for effectiveness regarding reducing his physical aggression. BC indicated client #2's physical aggression was assessed as being an escape when over stimulated by his environment. BC indicated client #2 did not like noise. BC stated client #2's IDT had discussed possible "safe places" for client #2 to engage in activities of daily living and active treatment. BC indicated staff had been trained to implement client #2's BSP to prevent physical aggression towards his peers.

2. BDDS report dated 3/9/22 indicated, "On 3/8/22 an allegation of neglect was reported for [client #4]. Staff has been suspended pending investigation. Emotional support was offered to [client #4] during this time."

Investigation Summary dated 3/9/22 indicated the following:

-"On March 7, 2022 it was reported to [Waiver Area Supervisor (WAS)] by [staff #3] that on Saturday March 5, 2022 [staff #6] was [client #4's] one on one staff and during that time, [staff #6] would use his chair to block his door to prevent him from exiting his room. It was also alleged that

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[staff #3] had overheard that staff would take [client #4's] shoes and hide them but never personally saw anyone actually hide his shoes nor did she know who the staff was."

-"[Staff #3] witnessed this incident on Saturday, March 5, 2022 during her 8 a-4 shift. [Staff #3] stated that there was not a lot of staff that wanted to be [client #4's] one on one. [Staff #6] was his one on one at the time that [staff #3] was due to take over. She noted that [staff #6] was in [client #4's] room and [staff #3] went to tell [staff #6] that she would relieve her of one on one duties. When she got to the door, the door was closed and when she tried to open it there was something in the way. [Staff #3] stated that [staff #6] got up and came to the door. [Staff #3] witnessed a reclined chair blocking the door. [Staff #6] got up and moved the chair in order to open the door fully. [Staff #3] stated to [staff #6] that we could not lock him in his room and he needs to be offered to interact with staff and peers outside his room. [Staff #3] stated that [staff #6] was [client #4's] one to one for 8 hours despite [staff #3] offering to take her shift and [client #4] was only in the dayroom one time during the duration that [staff #6] was his one on one. [Staff #3] stated that [client #4] ate in his room Saturday but he doesn't usually eat in his room unless he refuses to come to the day room. [Staff #3] reported this to [WAS] on Monday night which [WAS] reported to investigator on Tuesday afternoon. [Staff #3] also stated that she has never visibly seen anyone take [client #4's] shoes to hide them from him."

The Investigation Summary did not indicate documentation of an interview with WAS. The Investigation Summary did not indicate documentation of analysis, findings or

recommendations regarding staff #3 and WAS's failure to immediately report the allegation to the administrator and BDDS.

3. BDDS report dated 5/8/22 indicated, "On May 7, 2022, at 12 PM, [client #19] reported to the nurse's station for his routine medication. While in the nurse's station he complained of right foot pain stating he had hurt (it) while playing, nurses instructed staff to transport [client #19] to [hospital] for an x-ray. X-ray confirmed a sprain of the talo-fibular ligament of the right ankle. [Client #19] was discharged and instructed to wear an air splint and was prescribed Naproxen 500 mg (milligrams) as needed for pain, and to follow up with his PCP (Primary Care Physician) in one week if not better."

The review did not indicate documentation of an investigation regarding the origin of client #19's unknown injury.

4. BDDS report dated 2/15/22 indicated, "On 2/14/22 during a routine quarterly meeting [client #13] made an allegation of physical and verbal abuse that had occurred on 2/12/22. Staff was suspended pending investigation. Emotional support was offered to [client #13] during this time."

-Investigation Summary dated 2/15/22 indicated the following:

-"On February 14, 2022 during a quarterly meeting with [client #13] alleged that during his supine hold on February 12, 2022, [RM (Residential Manager) #3] was calling him names and telling him he would never get out of this place. He also alleged that [RM #3] spit in his face, smeared It on his face and nose until his nose bled, and that he

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	was choked by [RM #3]." -"[RM #3] is one of the 2nd shift RM's who worked the night of 2/12/22 and was a part of the YSIS supine hold with [client #13]. He was interviewed inside the QIDP office on 2/14/22. [RM #3] stated that he was the 1:1 staff with one of the consumers and was prompting him for snack and med's when he had prompted [client #19, client #16 and client #13] not to congregate in the Pacer's (unit name) hallway as it was a fire hazard. The consumers responded with [RM #7] said we could. [RM #3] stated that he had corrected them and stated that the rules are no hanging out in the hallways in groups as it could be a fire hazard. They were prompted to go to the dayroom if they wanted to hang out. [RM #3] stated that [client #19 and client #16] complied with no issues but [client #13] had become upset and agitated. He stated that then [RM #7] took [client #16 and client #13] out for their scheduled smoke break and when they returned inside, he threw the telephone, slammed his bedroom (sic) and was upsetting a peer. [RM #3] stated he overheard [client #13] yelling to [RM #7] and [staff #14] about how [RM #3] thinks he's the boss, [RM #7] corrected [client #13] and stated that [RM #3] was the boss. [RM #3] overheard and went down there and stated, 'correction we are both the boss'. [RM #3] stated that [client #13] became more upset and then he tried referring back to an earlier conversation with [client #13] about the changes he was talking about making and the ways to get out of here. [RM #3] stated that [client #13] started arguing with him and when he was trying to talk with him [client #13] became upset and swung on him. When he attempted to swing on him [RM #3, RM #7, staff #15 and staff #14] attempted a supine which started on the bed and transitioned to the			

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	floor. He stated that [RM #7] had his right arm, [RM #3] had his left arm and [staff #14] was on the legs and that [client #13] was able to grab a hold of his left torso/ribs area and pinch him. [RM #3] stated that [client #13] spit in his face and to get the spit off him he turned his head and blew to get it off his mouth area. [RM #3] stated he did not call [client #13] any names. [Staff #15] then switched with [RM #3] to finish the hold and [RM #3] left the room." -"[Staff #15] stated that he didn't know what started the behavior but he had seen [RM #7 and staff #14] down by [client #13's] bedroom and he was talking about [RM #3] and then he saw [RM #3] go down there so [staff #15] went down there also as he heard [RM #3] talking to [client #13] about the proper way to treat people and not being a punk.... (sic)" -"[Staff #14] stated the behavior started because [clients #19, #13 and #16] asked [RM #7] if they could hang out in the Pacer's hallway together and he stated 'yes'; but they were prompted 2 times by other staff and [RM #3] stating they could not hang out by the door as it is blocking the exit and it was a fire hazard. [Staff #14] stated that [RM #3] told the guys that if they had to be prompted a 3rd time that an ABC (antecedent behavior consequence) tracking would be completed for non-compliance due to it being a fire hazard. [Client #13] became upset and agitated by [RM #3] stating a tracking would be completed and that he had went (sic) to his room, slammed his bedroom door, started throwing his objects around and became verbally aggressive. [Staff #14] stated that him (sic) and [RM #7] went in to [client #13's] room to prompt him to use his coping skills to calm down. [RM #3] heard that conversation taking place and went came (sic) to			

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	[client #13's] bedroom and [client #13] threatened to hit [RM #3]. [Staff #14] stated that [staff #15] was standing outside of [client #13's] bedroom as [RM #3] was explaining ways for [client #13] to be successful and get out of the ICF (agency) like he wants and that upset [client #13] and he attempted to hit [RM #3] but hit [staff #14] in the process and that's when the supine was imitated." -"[RM #7] states that there were some words between [client #13] and [RM #3] but he didn't hear what was said because he was so focused on ensuring [client #13] didn't hit anyone because he was making threats of violence." -"[RM #7] stated that once the hold was over he had staff take [client #13] to the gym for some 1:1 so [client #13] could calm down and that's when [RM #7] had went (sic) to the gym to check on [client #13] he stated that he felt unsafe around [RM #3] and that he wanted to file a grievance so he helped him fill one out. [RM #7] stated that to ensure that [client #13] felt safe he had a staff be with [client #13] in his room or even outside the door." The Investigation Summary factual findings does not address RM #3's behavior intervention methods leading up to the behavior incident. The Investigation does not reconcile RM #3 or staff #14, staff #15 or RM #7's implementation of client #13's BSP strategies to de-escalate client #13's behavior. The Investigation summary does not address or reconcile client #13's allegations regarding RM #3 reported to RM #7 on 2/12/22. Client #13's record was reviewed on 6/8/22 at 4:00 PM. Client #13's BSP revised date 5/13/22 indicated			

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	the following:-"Behavioral issues from [client #13] should not end with [client #13] getting special privileges such as walks with staff or other rewarding attention. It has been observed that [client #13] will seek out individual time with staff after behaviors and this time is typically spent glorifying behaviors that have taken place. [Client #13] should get individual time with staff when behaving appropriately so that he doesn't get accustomed to having staff's undivided attention only for (or following) bad behaviors."-"[Client #13] will sometime engage in aggression toward himself or others in order to maintain the center of attention as he likes to have staff giving him individualized attention in his room. His behaviors in the dayroom or common areas also are maintained by [client #13's] significant image issues causing him to try to demonstrate how tough and intimidating he is. Minimizing the audience when possible should take place so that [client #13] has fewer people to act out for."-"Verbal aggression including rocking back and forth between his right and left feet could be identified as a precursor to other behavioral issues. When he engages in this behavior staff will:-Remain calm in tone and volume, do not react with emotion or irritation-Ignore threats and verbal abuse - do not get into a back-and-forth power struggle-Try to			

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	minimize his audience -Ask him how you can help. He is more likely to be able to calm down if he feels supported and liked by his staff-Remind him that we are here to help him so that he can reach his goals of moving to waiver-Tell him that you want to help him but can only do so if he is talking calmly- do not give unnecessary attention/reaction to verbal aggression -If he continues to yell, with as little reaction that you can use, repeat that you want to help him but that you can only do so if he is talking calmly."Client #13's BSP did not indicate client #13's presence in the Pacer's hallway was a fire hazard. 5. BDDS report dated 5/19/22 indicated, "On May 18, 2022, at 11:02 PM, [client #16] reported to staff that while he was in the bathroom he had fallen and hit his head on the toilet. He was taken to nursing to be assessed and she discovered small amount of blood on his forehead and a slight indention (sic), she cleaned the area and noticed 1 cm abrasion, nurse requested he be taken to [emergency room]. While at the emergency room a CT scan was completed and there were no issues. [Client #16] was discharged from [hospital] with a diagnosis of minor closed head injury with single superficial abrasion to forehead."The review did not indicate documentation of an investigation regarding client #16's injury of unknown origin. 6. Client #3's record was			

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	reviewed on 6/8/22 at 4:15 PM. Client #3's BSP revised date 4/4/22 indicated, "He was often non-compliant with most chores and tasks and would engage in physical aggression or property destruction in order to avoid doing undesirable tasks. [Client #3] can be very aggressive with peers and staff and some of his behaviors appear to take place without warning. He spits on others when he is upset and he may engage in this behavior without others knowing why he is upset. Target behaviors for [client #3] include verbal and physical aggression, property destruction, bolting, non-compliance, self injury, allegations of abuse and neglect, sexually inappropriate behaviors, and instigation. This plan will address these target behavior."Client #3's BSP revised date 4/18/22 indicated, "At this time, [client #3] will have 1:1 staffing due to his numerous client-to-client behaviors. The 1:1 is in place to prevent [client #3] from being able to hit/kick/spit at other clients. Staff should try to stay in between [client #3] and any peers that he may hit."Client #3's BSP revised date 4/29/22 indicated, "Due to his numerous acts of physical aggression toward peers, he was assigned a 1:1 staff for a period of time."Client #3's BSP revised date 4/29/22 indicated, "At this time, [client #3] will have 1:1 staffing due to his numerous client-to-client behaviors. The 1:1			

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	is in place to prevent [client #3] from being able to hit/kick/spit at other clients. Staff should try to stay in between [client #3] and any peers that he may hit."Client #3's BSP revised date 5/13/22 (4/29/22) indicated, "Due to his numerous acts of physical aggression toward peers, he was assigned a 1:1 staff for a period of time. [Client #3] was prescribed Lithium in order to help stabilize his moods and there has been an improvement in his behaviors since starting this medication. It has also shown to be beneficial for [client #3] to utilize other areas of campus such as the gym, courtyard, front porch, etc. in order to take a break from the residential hall." Client #3's BSP revised dates 5/26/22, 5/13/22 (4/29/22) indicated, "If [client #3] is exhibiting agitation or has engaged in physical aggression to peers, a 1:1 staff can be put in place for the protection of other clients. This would be at the discretion of the admin on call. If the 1:1 is in place, the 1:1 is to prevent [client #3] from being able to hit/kick/spit at other clients. If the 1:1 is in place, the 1:1 staff should try to stay in between [client #3] and any peers that he may hit and should remain within approximate arm's reach of [client #3]."The facility's BDDS reports and Investigations were reviewed on 5/31/22 at 10:54 AM. The review indicated the following from 4/1/22 through the 5/31/22			

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	(date of review) client #3 had 27 separate incidents of physical aggression towards peers (#4, #5, #6, #7, #8, #9, #10, #13, #15, #17 and #19). The review indicated the facility completed CCAI investigations regarding the incidents of client #3's physically aggressive behaviors towards his peers. The CCAI's indicated the investigations document staff implemented client #3's BSP. The CCAI's do not reconcile or document client #3's preventative strategies to implement 1:1 supervision or to physically stand between client #3 and his peers to prevent physical aggression. PM (Program Manager) was interviewed on 6/2/22 at 1:08 PM indicated staff are trained to implement clients BSP's. PM indicated staff should offer coping skills and strategies in each client's BSP to prevent incident from escalating to physical aggression towards staff or peers. PM indicated allegations should be investigated.7. On 6/1/22 at 2:30 pm, an interview was conducted with Licensed Practical Nurse (LPN) #1. LPN #1 indicated she knew of an incident where client #4 had 2 green toy balls in his incontinence brief covered with feces. LPN #1 stated "I know there was an incident where they found green balls in his [incontinence brief]. They were bigger than a ping pong ball. There is no way he could			

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	have swallowed 2 of them without choking. He always plays with his hands in his [incontinence brief]."An initial observation was conducted on 5/31/22 from 2:15 PM through 3:16 PM. During the observation, client #4 was in the common living area of the home referred to as the day room. At 2:20 PM, client #4 was seated on a sofa in the day room and staff #2 was seated next to him. At 2:25 PM, client #4 repositioned to a different sofa in the day room. Staff #2 followed client #4 and again sat beside him. At 3:10 PM, client #4 stood and entered the kitchen area and reached into a trash can. The RM #2 used verbal redirection with client #4 to prompt him to return to the day room and stated, "Hey, whoever has [client #4] needs to watch him". On 5/31/22 at 3:14 PM, the RM #2 was interviewed. The RM #2 was asked if client #4 was on a one-to-one staff assignment. The RM #2 stated, "He is. I didn't realize [staff #2] went to move the van. They parked it in a bad spot". The RM #2 was asked if client #4 was on a one-to-one staff assignment because of behavioral challenges such as eating inedible items (PICA). The RM #2 stated, "Basically. That and he would go into everyone's room. [Staff #6] has him now. Once he had a wrapper from a depends (incontinent brief) in his mouth and I had to get that out of his mouth. A couple weeks			

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	ago he had a ball in his feces". The RM #2 was asked to describe the size of the ball she was referring too. The RM #2 used her right index finger and drew a circle shape in the palm of her left hand the size of a quarter and stated, "I would say the size of the center of my palm". The RM #2 was asked if client #4 ingested this ball. The RM #2 stated, "I don't know, but it was mixed in with his feces in his depends. Some people think he stuck it in his brief, but I don't see how that's possible". On 6/1/22 at 11:42 AM, client #4's record was reviewed. The record indicated the following:-Behavioral Support Plan (BSP) dated 5/23/22 indicated, "Target Behavior... Eating Non-Edible/Non-Food Items: any time he ingests or tries to ingest a non-food item. According to previous providers, he will eat paper or string or any other item that he can get his hands on...".-Nursing Note dated 5/19/22 at 11 AM indicated, "Found II (two) toy balls in client's (client #4) BM (bowel movement). Examined anus with 0 tears, 0 bleeding, and 0 S/S (signs and symptoms) of discomfort...".On 6/2/22 at 2:55 PM, the Program Manager (PM) was interviewed. The PM was asked about client #4's alleged ingestion of two toy balls found in adult incontinent brief. The PM stated, "We're not sure if he stuck it in his pants. We're not sure if he consumed it or if he			

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	stuck it in there". The PM indicated client #4 was assessed for injury by nursing staff and no injuries were found. The PM was asked if client B had a history of putting objects in his adult incontinent brief. The PM stated, "No. I know he'll pick stuff up off the floor and put it into his mouth". On 6/3/22 at 9:30 AM, a review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports and accompanying investigation summaries was conducted. The review did not indicate documentation client #4's 5/19/22 alleged incident was reported to BDDS or Investigated.			
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 2 of 4 sampled clients (#2 and #4), plus 12 additional clients (#5, #6, #7, #8, #9, #10, #13, #15, #16, #17, #19 and #20), the facility failed to develop and implement effective measures to prevent a pattern of incidents of physical aggression regarding clients #2, #5, #8, #16, #20, an allegation of staff abuse regarding client #13 and a pattern of client #3's physical aggression towards his peers (#4, #5, #6, #7, #8, #9, #10, #13, #15, #17 and #19). Findings include: 1. The facility's BDDS (Bureau of Developmental Disabilities Services) reports and Investigations were reviewed on 5/31/22 at 10:54 AM. The review indicated the following: -BDDS report dated 5/20/22 indicated, "On May	W 0157	All members of the Management team will be in-serviced by the Executive Director on the criteria requiring an investigation. Other Interdisciplinary Team members will be trained on the criteria requiring an investigation and during the review of all BDDS reports, a question will be added for clarity to the Interdisciplinary Team note asking whether the incident requires an investigation. The Interdisciplinary Team has developed a comprehensive list of client specific triggers, precursors, and coping skills for each client. The list currently in each clients programing binder on the unit. All staff have been in-serviced on the	07/08/2022

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	19, 2022, at 4:34 PM, while in the dayroom [client #2] was sitting next to [client #8] when without a precursor he punched [client #8] in the left side of his face using his right fist and then ran to his bedroom. Staff checked on [client #2], and he stated he was fine, and he was sorry. Both were assessed by nursing who noted no injuries. Both resumed normal programming and had no further issues." And, "Will continue to monitor for [client #8] any further injuries. Staff will continue to follow [client #2's] guardian and HRC (Human Rights Committee) approved BSP (Behavior Support Plan) and ISP (Individual Support Plan) regarding verbal and physical aggression, threats, YSIS (You're Safe, I'm Safe) (physical restraint) intervention, PRN (as needed) protocol and coping skills. Both clients report they feel safe and neither wished to file a grievance." -CCAI (client-to-client Aggression Investigation) dated 5/20/22 indicated the following: -"Describe behavior strategies followed (sic) Approved plans followed." -"Does the current behavior strategy address the above behaviors? Yes." -"Has there been a pattern of occurrences between these clients or history of occurrences by main aggressor? Yes- there has (sic) been previous incidents of aggression between [client #2] and [client #8]." -"What steps were taken to ensure clients safety? Staff intervened and was able to verbally redirect		updated comprehensive list and where to find it on the unit for reference.	

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both consumers."

-"How was the incident able to occur: [Client #8] and [client #2] were sitting in the dayroom when without a precursor [client #2] punched [client #8]."

The CCAI dated 5/20/22 did not specify which behavior strategies were implemented and reconcile behavior strategies with steps taken to ensure client safety regarding the implementation of client #2's BSP.

-BDDS report dated 5/16/22 indicated, "On May 15, 2022, at 6:57 PM, [client #2] was standing in the dayroom when without a precursor he used his right hand and hit [client #8] on his right arm. Afterwards [client #2] ran to his bedroom and threw his laundry basket. Staff was able to talk with [client #2] and assisted him with using his coping skills to calm down. Both were assessed by nursing who noted no injuries. At 7:58 PM, [client #2] and [client #8] were sitting in the dayroom, [client #8] began yelling for no reason, he was prompted to not yell but he was non-compliant and continued yelling. [Client #2] stood up from his seat and kicked [client #8] and then hit him on his right hand. [Client #2] ran to his bedroom, staff followed to ensure his safety. Once in his bedroom he calmed down and began talking about the movie he wanted to watch. Both were assessed by nursing again who reported no injuries. Both resumed normal programming and had no further issues."

And,

"Will continue to monitor for [client #8] any further injuries. Staff will continue to follow [client #2's] guardian and HRC approved BSP and ISP

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regarding verbal and physical aggression, threats, YSIS intervention, PRN protocol and coping skills. Both clients report they feel safe and neither wished to file a grievance."

-CCAI dated 5/16/22 indicated the following:

-"Describe behavior strategies followed (sic) Approved plans followed."

-"Does the current behavior strategy address the above behaviors? Yes."

-"Were any behavior strategies not followed? If so, what behavior strategies were not followed? No."

-"Has there been a pattern of occurrences between these clients or history of occurrences by main aggressor? Yes."

-"What steps were taken to ensure clients safety? Staff intervened and was able to verbally redirect both consumers."

-"How was the incident able to occur: At 6:57 PM- both were in the dayroom and without a precursor [client #2] hit [client #8]. At 7:58 PM- both were in the dayroom again and [client #8] began yelling and that is when [client #2] hit [client #8] due to no (sic) liking (sic) loud noises."

The 5/16/22 CCAI did not reconcile steps staff took regarding client #2's BSP implementation to prevent client #2's physical aggression towards client #8.

-BDDS report dated 5/12/22 indicated, "On May 11, 2022, at 3:57 PM as [client #5] was sitting on the couch [client #2] walked by and without a

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precursor he smacked [client #5] on the back of his head and took off running down to his bedroom. [Client #5] was assessed by nursing who noted no injuries. Staff went to check on [client #2] and he stated he was fine; nursing assessed him and reported no injuries. [Client #2] was educated on using his coping skills when he is upset or agitated. Both resumed normal programming."

And,

"Will continue to monitor for [client #5] any further injuries. Staff will continue to follow [client #2's] guardian and HRC approved BSP and ISP regarding verbal and physical aggression, threats, yelling, YSIS intervention, PRN protocol and coping skills. Both clients report they feel safe and neither wished to file a grievance.

-CCAI dated 5/12/22 indicated the following:

-"Does the current behavior strategy address the above behaviors? Yes."

-"Were any behavior strategies not followed? If so, what behavior strategies were not followed? No."

-"Has there been a pattern of occurrences between these clients or history of occurrences by main aggressor? Yes."

-"What steps were taken to ensure clients safety? Staff intervened and was able to verbally redirect both consumers."

-"How was the incident able to occur: [client #5] and [client #2] were both in the dayroom, [client #5] was sitting on the couch when without a

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	precursor [client #2] walked by and smacked him in the back of the head." The CCAI dated 5/12/22 does not reconcile the specific steps taken with client #2's BSP implementation to prevent client #2's physical aggression toward his peers. -BDDS report dated 5/8/22 indicated, "On May 7, 2022, at 2:50 PM, [client #2] was walking down the hallway when the dayroom became louder causing him to become agitated, at that time he turned to go back towards his bedroom and on the way down the hallway he hit [client #8] on the top of his head with his hand. Staff followed [client #2] to his room and educated him on using his coping skills when he becomes agitated. Both [client #8] and [client #2] were assessed by nursing who noted no injuries. [Client #8] resumed normal programming while [client #2] remained agitated in his bedroom. At 4:04 PM, staff observed [client #2] hit [client #8] on the top left side of his head with his right hand without a precursor and then ran to his bedroom and slammed his bedroom door. Staff followed [client #2] to his bedroom and educated him on using his coping skills and not hitting his peers. Both were assessed by the nurse who noted no injuries. Both resumed normal programming without any further issues." And, "Will continue to monitor for [client #8] any further injuries. Staff will continue to follow [client #2's] guardian and HRC approved BSP and ISP regarding verbal and physical aggression, threats, yelling, YSIS intervention, PRN protocol and coping skills. Both clients report they feel safe and neither wished to file a grievance."			

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-CCAI dated 5/9/22 indicated the following:

-Describe behavior strategies followed (sic) Approved plans followed

-"Does the current behavior strategy address the above behaviors? Yes."

-"Were any behavior strategies not followed? If so, what behavior strategies were not followed? No."

-"Has there been a pattern of occurrences between these clients or history of occurrences by main aggressor? Yes- there has (sic) been previous incidents of aggression between [client #2] and [client #8]."

-"What steps were taken to ensure clients safety? Staff intervened and was able to verbally redirect both consumers."

-"How was the incident able to occur: [Client #8] was sitting on the couch in the dayroom when [client #2] was going towards his bedroom because he was upset about the noise level; as he walked by [client #8] he smacked him on the top of his head."

The 5/9/22 CCAI did not specifically address how steps taken to prevent client #2's physical aggression reconciled with client #2's BSP strategies relate to noise in the environment. The investigation did not indicate documentation to determine if staff implemented client #2's BSP.

-BDDS report dated 5/6/22 indicated, "On May 5, 2022, at 12:20 PM, while in the dayroom [client #2] walked past [client #5] and said hi to staff, then

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turned and used his right hand and smacked [client #5] on the right side of his face without a precursor. When [client #5] was smacked it caused him to fall onto the floor and hit the back side of his head. [Client #2] was educated on using his coping skills and not hitting his peers. [Client #5] was assessed by the nurse who noted a 5-centimeter red area to the back left side of his scalp. Neurological checks were initiated and have been within normal limits and no further complications. Both resumed normal programming."

And,

"Will continue to monitor for [client #5] any further injuries. Staff will continue to follow [client #2's] guardian and HRC approved BSP and ISP regarding verbal and physical aggression, threats, yelling, YSIS intervention, PRN protocol and coping skills. Both clients report they feel safe and neither wished to file a grievance."

-CCAI dated 5/6/22 indicated the following"

-"Describe behavior strategies followed (sic) Approved plans followed."

-"Does the current behavior strategy address the above behaviors? Yes."

-"Were any behavior strategies not followed? If so, what behavior strategies were not followed? No."

-"What steps were taken to ensure clients safety? Staff intervened and was able to verbally redirect both consumers."

-"How was the incident able to occur: [client #5]

and [client #2] were both in the dayroom, [client #2] said hi to staff then turned and smacked [client #5] in the face."

The 5/6/22 CCAI did not specifically reconcile the steps taken to ensure client safety with the effective implementation of client #2's BSP to prevent incidents of aggression towards his peers.

-BDDS report dated 4/29/22 indicated, "On 4/28/2022 at 03:24 PM, [client #2] and [client #5] were in the dayroom when without precursor, [client #2] used his left open hand to hit [client #5] in the left side of his face. Staff stepped between the two peers and redirected [client #2] to use his coping skills. [Client #2] then ran into his bedroom. [Client #5] stepped away and was assessed by the nurse who reported no injuries. Both individuals returned to normal programming."

And,

"Staff will continue to follow the guardian and HRC approved ISPs and BSPs for both [client #2] and [client #5] which addresses physical aggression and the use of coping skills to avoid physical aggression. Both clients report they feel safe and neither wished to file a grievance."

-client-to-client Aggression Investigation (CCAI) dated 4/29/22 indicated the following:

-"Describe behavior strategies followed (sic) Approved plans followed."

-"Has there been a pattern of occurrences between these clients or history of occurrences by main aggressor? Yes."

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-"What steps were taken to ensure clients safety? Verbal redirection, separation (sic)"

-"How was the incident able to occur: Both clients are line of sight, staff tending to other individuals."

-"Recommendations:
Staff will continue to follow the guardian and HRC approved ISPs and BSPs for both [client #2] and [client #8] which addresses physical aggression and the use of coping skills to avoid physical aggression. Both clients report they feel safe and neither wished to file a grievance. Staff will encourage [client #2] to use coping skills and come to staff when agitated."

The CCAI dated 4/29/22 did not specifically document how staff followed client #2's BSP to prevent peer to peer aggression in common areas of the facility or address staff attending other individuals.

-BDDS report dated 4/13/22 indicated, "On 4/12/2022 at 04:19 PM, [client #2] and [client #16] were in the dayroom socializing together when without precursor, [client #2] used his open right hand to hit [client #16] in the right side of his face. Staff stepped between the two peers and redirected [client #2] to use his coping skills. [Client #2] then ran into his bedroom. [Client #16] stepped away and was assessed by the nurse who reported no injuries. Both individuals returned to normal programming."

And,

"Staff will continue to follow the guardian and HRC approved ISPs and BSPs for both [client #2]

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	and [client #16] which addresses (sic) physical aggression and the use of coping skills to avoid physical aggression. Both clients report they feel safe and neither wished to file a grievance." -CCAI dated 4/13/22 indicated the following: -"Describe behavior strategies followed (sic) Approved plans followed." -"Does the current behavior strategy address the above behaviors? Yes." -"Were any behavior strategies not followed? If so, what behavior strategies were not followed? No." -"What steps were taken to ensure clients safety? Separation, verbal redirection." -How was the incident able to occur: staff tending to other individuals." The 4/13/22 CCAI did not reconcile steps taken with client #2's BSP to prevent client #2's physical aggression towards his peers. The 4/13/22 CCAI did not address if staffing levels at the time of the incident were sufficient to effectively implement client #2's BSP preventive strategies. -BDDS report dated 4/12/22 indicated, "On 4/11/2022 at 08:39 PM, clients [client #2] and [client #20] were in the hallway near their rooms when without precursor, [client #2] used his left closed hand to hit [client #20] in the right side of his face. Staff stepped between the two peers and redirected [client #2] to use his coping skills. [Client #2] then ran into his bedroom. [Client #20] stepped away and was assessed by the nurse who reported no injuries. Both individuals			

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returned to normal programming."

And,

"Staff will continue to follow the guardian and HRC approved ISPs and BSPs for both [client #2] and [client #20] which addresses physical aggression and the use of coping skills to avoid physical aggression. Both clients report they feel safe and neither wished to file a grievance."

-CCAI dated 4/12/22 indicated the following:

-"Describe behavior strategies followed (sic) Approved plans followed."
-"Were any behavior strategies not followed? If so, what behavior strategies were not followed? No."

-"Has there been a pattern of occurrences between these clients or history of occurrences by main aggressor? yes."

-"What steps were taken to ensure clients safety? Separation."

-"How was the incident able to occur: staff tending to other individuals."

The 4/12/22 CCAI does not reconcile which steps were taken regarding client #2's BSP strategies to limit noise, rearranging client #2's environment, providing additional supervision when client #2 is in close proximity to his peers. The CCAI indicated there was a pattern between clients #2 and #20. The CCAI did not include recommendations for effective prevent of further incidents of client-to-client aggression. The 4/12/22 CCAI did not address if the staffing levels were sufficient to implement client #2's BSP to

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prevent aggression towards client #20.

-BDDS report dated 4/11/22 indicated, "On April 9, 2022, at 4:50 PM, [client #2] was in the dayroom when he became agitated with the loud noises a peer was making. Staff noticed that he was becoming upset and prompted him to use his coping skills and asked if he wanted to go to his room and he replied yes, thank you. [Client #2] started walking to his room and as he walked past [client #8] he smacked him on the right side of his face. [Client #2] was educated on using his coping skills and not hitting his peers. [Client #2] and [client #8] were both assessed by nursing who noted no injuries. Both resumed normal programming without any further issues."

And,

"Will continue to monitor [client #8] for any further injuries. Staff will continue to follow [client #2's] guardian and HRC approved BSP and ISP regarding verbal and physical aggression, threats, YSIS intervention, PRN protocol and coping skills. Both clients report they feel safe and neither wished to file a grievance."

-CCAI dated 4/11/22 indicated the following:

-"Describe behavior strategies followed (sic) Approved plans followed."

-"Does the current behavior strategy address the above behaviors? Yes."

-"Were any behavior strategies not followed? If so, what behavior strategies were not followed? No."

-"Has there been a pattern of occurrences

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between these clients or history of occurrences by main aggressor? Yes- there has (sic) been previous incidents of aggression between [client #2] and [client #8]."

-"What steps were taken to ensure clients safety? Staff intervened and was able to verbally redirect both consumers."

-"How was the incident able to occur: [client #8] was sitting on the couch in the dayroom when [client #2] was going towards his bedroom because he was upset about the noise level; as he walked by [client #8] he smacked him."

The CCAI dated 4/11/22 did not specifically reconcile steps taken to prevent client #2's physical aggression with regard to the effective implementation of client #2's BSP.

Client #2's record was reviewed on 6/8/22 at 3:30 PM. Client #2's BSP dated 1/22/22 indicated the 1/22/22 date was the annual BSP review. Client #2's BSP was revised on 3/4/22, 3/29/22, 4/15/22, 4/27/22, 5/10/22 and 5/24/22.

Client #2's BSPs dated 1/18/22, 3/4/22, 3/29/22, 4/15/22, 4/27/22, 5/10/22 and 5/27/22 indicated the following:

-"He has demonstrated aggression while in loud and chaotic environments as well. Noise canceling headphones have been provided for him but he has refused to use them and has broken them in the past."

"[Client #2] is diagnosed with intermittent explosive disorder which means that he can engage in sudden bouts of aggression that seem unprovoked."

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"He can be very sensitive to loud noises and these have often preceded acts of aggression. At times, he will engage in physical aggression that appears to be out of the blue as he can become overly stimulated without others knowing. Additionally, [client #2] can socialize and be friendly with those in the dayroom but may then strike a peer and run back to his room. These acts are often impulsive and they may appear to be out of the blue."

-"Physical Aggression: Any occurrence or attempts at hitting people, pinching others, spitting on them, kicking or scratching at others, using objects as weapons, pulling hair, or behaviors that produce or have the potential to produce an injury to others. [Client #2] can become physically aggressive after being let out of a AYSIS (sic) hold. He has engaged in very impulsive acts of physical aggression toward peers who aren't even interacting with him in common areas. Staff should pay close attention to the proximity of [client #2] and other clients when [client #2] is in the common areas due to [client #2's] impulsive acts of physical aggression toward clients in common areas. Also, he does not like peers hugging or touching him. Peers should be reminded to give him personal space. It has been observed on several occasions that [client #2] will engage in physical aggression toward a peer and will then engage in other acts of physically aggressive behaviors on the same day."

"Recommendations:
1) Try to keep the area calm, this could mean passing meds at a less chaotic time or even allowing med passes to take place in [client #2's] room.

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2) If the area is overly chaotic, he should be allowed the option of eating meals in his bedroom. Peers should be reminded to give him space and staff need to be aware of [client #2's] proximity to his peers as he will often hit them when he comes to the dayroom.
3) [client #2] does not like help with showers and as much independence as possible should be offered even though he sometimes needs help with a proper shower.
4) Remind [client #2] that if he is feeling overwhelmed or if the area is too chaotic, he can always go back to his room to relax.
5) [Client #2] likes to have his DVDs on, he can engage in behaviors if they are not working property. Try to make sure he doesn't need help with his movies."

Client #2's BSP dated 5/24/22 indicated, "[Client #2] tends to target peer [client #8] when they are both in the dayroom together, staff should position themselves between [client #2] and [client #8] whenever possible when they are both in common areas together."

Client #2's IDT meeting dated 5/17/22 indicated, "Staff will be trained to stay between [client #8] and [client #2] when in common areas." Client #2's IDT met on 5/22/22, 5/27/22, 5/20/22, 5/4/22, 5/17/22, 5/12/22, 5/12/22, and 5/9/22. The IDT's recommendations included the 5/17/22 recommendation to train staff to physically position themselves between client #2 and his peer client #8, continue to follow his ISP, BSP, YSIS, PRN and coping skill interventions to prevent or reduce client #2's physical aggression incident towards his peers (clients #5, #8, #16 and #20).

BC (Behavior Clinician) was interviewed on 6/2/22

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at 11:40 AM. BC indicated staff should be positioned between client #2 and client #8. BC indicated client #2 could become physically aggressive towards client #8 or other peers in the dayroom without warning. BC indicated client #2's Clozaril (anti-psychotic) medication had been adjusted and was being monitored for effectiveness regarding reducing his physical aggression. BC indicated client #2's physical aggression was assessed as being an escape when over stimulated by his environment. BC indicated client #2 did not like noise. BC stated client #2's IDT had discussed possible "safe places" for client #2 to engage in activities of daily living and active treatment. BC indicated staff had been trained to implement client #2's BSP to prevent physical aggression towards his peers.

2. BDDS report dated 2/15/22 indicated, "On 2/14/22 during a routine quarterly meeting [client #13] made an allegation of physical and verbal abuse that had occurred on 2/12/22. Staff was suspended pending investigation. Emotional support was offered to [client #13] during this time."

-Investigation Summary dated 2/15/22 indicated the following:

-"On February 14, 2022 during a quarterly meeting with [client #13] alleged that during his supine hold on February 12, 2022, [RM (Residential Manager) #3] was calling him names and telling him he would never get out of this place. He also alleged that [RM #3] spit in his face, smeared It on his face and nose until his nose bled, and that he was choked by [RM #3]."

-"[RM #3] is one of the 2nd shift RM's who worked the night of 2/12/22 and was a part of the

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	YSIS supine hold with [client #13]. He was interviewed inside the QIDP office on 2/14/22. [RM #3] stated that he was the 1:1 staff with one of the consumers and was prompting him for snack and med's when he had prompted [client #19, client #16 and client #13] not to congregate in the Pacer's (unit name) hallway as it was a fire hazard. The consumers responded with [RM #7] said we could. [RM #3] stated that he had corrected them and stated that the rules are no hanging out in the hallways in groups as it could be a fire hazard. They were prompted to go to the dayroom if they wanted to hang out. [RM #3] stated that [client #19 and client #16] complied with no issues but [client #13] had become upset and agitated. He stated that then [RM #7] took [client #16 and client #13] out for their scheduled smoke break and when they returned inside, he threw the telephone, slammed his bedroom (sic) and was upsetting a peer. [RM #3] stated he overheard [client #13] yelling to [RM #7] and [staff #14] about how [RM #3] thinks he's the boss, [RM #7] corrected [client #13] and stated that [RM #3] was the boss. [RM #3] overheard and went down there and stated, 'correction we are both the boss'. [RM #3] stated that [client #13] became more upset and then he tried referring back to an earlier conversation with [client #13] about the changes he was talking about making and the ways to get out of here. [RM #3] stated that [client #13] started arguing with him and when he was trying to talk with him [client #13] became upset and swung on him. When he attempted to swing on him [RM #3, RM #7, staff #15 and staff #14] attempted a supine which started on the bed and transitioned to the floor. He stated that [RM #7] had his right arm, [RM #3] had his left arm and [staff #14] was on the legs and that [client #13] was able to grab a hold of his left torso/ribs area and pinch him. [RM			

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	#3] stated that [client #13] spit in his face and to get the spit off him he turned his head and blew to get it off his mouth area. [RM #3] stated he did not call [client #13] any names. [Staff #15] then switched with [RM #3] to finish the hold and [RM #3] left the room." -"[Staff #15] stated that he didn't know what started the behavior but he had seen [RM #7 and staff #14] down by [client #13's] bedroom and he was talking about [RM #3] and then he saw [RM #3] go down there so [staff #15] went down there also as he heard [RM #3] talking to [client #13] about the proper way to treat people and not being a punk.... (sic)" -"[Staff #14] stated the behavior started because [clients #19, #13 and #16] asked [RM #7] if they could hang out in the Pacer's hallway together and he stated 'yes'; but they were prompted 2 times by other staff and [RM #3] stating they could not hang out by the door as it is blocking the exit and it was a fire hazard. [Staff #14] stated that [RM #3] told the guys that if they had to be prompted a 3rd time that an ABC (antecedent behavior consequence) tracking would be completed for non-compliance due to it being a fire hazard. [Client #13] became upset and agitated by [RM #3] stating a tracking would be completed and that he had went (sic) to his room, slammed his bedroom door, started throwing his objects around and became verbally aggressive. [Staff #14] stated that him (sic) and [RM #7] went in to [client #13's] room to prompt him to use his coping skills to calm down. [RM #3] heard that conversation taking place and went came (sic) to [client #13's] bedroom and [client #13] threatened to hit [RM #3]. [Staff #14] stated that [staff #15] was standing outside of [client #13's] bedroom as [RM #3] was explaining ways for [client #13] to be			

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successful and get out of the ICF (agency) like he wants and that upset [client #13] and he attempted to hit [RM #3] but hit [staff #14] in the process and that's when the supine was imitated."

-"[RM #7] states that there were some words between [client #13] and [RM #3] but he didn't hear what was said because he was so focused on ensuring [client #13] didn't hit anyone because he was making threats of violence."

-"[RM #7] stated that once the hold was over he had staff take [client #13] to the gym for some 1:1 so [client #13] could calm down and that's when [RM #7] had went (sic) to the gym to check on [client #13] he stated that he felt unsafe around [RM #3] and that he wanted to file a grievance so he helped him fill one out. [RM #7] stated that to ensure that [client #13] felt safe he had a staff be with [client #13] in his room or even outside the door."

The Investigation Summary factual findings does not address RM #3's behavior intervention methods leading up to the behavior incident. The Investigation does not reconcile RM #3 or staff #14, staff #15 or RM #7's implementation of client #13's BSP strategies to de-escalate client #13's behavior. The Investigation summary does not address or reconcile client #13's allegations regarding RM #3 reported to RM #7 on 2/12/22.

Client #13's record was reviewed on 6/8/22 at 4:00 PM. Client #13's BSP revised date 5/13/22 indicated the following:

-"Behavioral issues from [client #13] should not end with [client #13] getting special privileges such as walks with staff or other rewarding attention. It has been observed that [client #13]

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will seek out individual time with staff after behaviors and this time is typically spent glorifying behaviors that have taken place. [Client #13] should get individual time with staff when behaving appropriately so that he doesn't get accustomed to having staff's undivided attention only for (or following) bad behaviors."

-"[Client #13] will sometime engage in aggression toward himself or others in order to maintain the center of attention as he likes to have staff giving him individualized attention in his room. His behaviors in the dayroom or common areas also are maintained by [client #13's] significant image issues causing him to try to demonstrate how tough and intimidating he is. Minimizing the audience when possible should take place so that [client #13] has fewer people to act out for."

-"Verbal aggression including rocking back and forth between his right and left feet could be identified as a precursor to other behavioral issues. When he engages in this behavior staff will:
-Remain calm in tone and volume, do not react with emotion or irritation
-Ignore threats and verbal abuse - do not get into a back-and-forth power struggle
-Try to minimize his audience
-Ask him how you can help. He is more likely to be able to calm down if he feels supported and liked by his staff
-Remind him that we are here to help him so that he can reach his goals of moving to waiver
-Tell him that you want to help him but can only do so if he is talking calmly- do not give unnecessary attention/reaction to verbal aggression
-If he continues to yell, with as little reaction that you can use, repeat that you want to help him but

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that you can only do so if he is talking calmly."

Client #13's BSP did not indicate client #13's presence in the Pacer's hallway was a fire hazard.

3. Client #3's record was reviewed on 6/8/22 at 4:15 PM. Client #3's BSP revised date 4/4/22 indicated, "He was often non-compliant with most chores and tasks and would engage in physical aggression or property destruction in order to avoid doing undesirable tasks. [Client #3] can be very aggressive with peers and staff and some of his behaviors appear to take place without warning. He spits on others when he is upset and he may engage in this behavior without others knowing why he is upset. Target behaviors for [client #3] include verbal and physical aggression, property destruction, bolting, non-compliance, self injury, allegations of abuse and neglect, sexually inappropriate behaviors, and instigation. This plan will address these target behavior."

Client #3's BSP revised date 4/18/22 indicated, "At this time, [client #3] will have 1:1 staffing due to his numerous client-to-client behaviors. The 1:1 is in place to prevent [client #3] from being able to hit/kick/spit at other clients. Staff should try to stay in between [client #3] and any peers that he may hit."

Client #3's BSP revised date 4/29/22 indicated, "Due to his numerous acts of physical aggression toward peers, he was assigned a 1:1 staff for a period of time."
Client #3's BSP revised
date 4/29/22 indicated, "At this time, [client #3] will have 1:1 staffing due to his numerous client-to-client behaviors. The 1:1 is in place to prevent [client #3] from being

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	able to hit/kick/spit at other clients. Staff should try to stay in between [client #3] and any peers that he may hit."Client #3's BSP revised date 5/13/22 (4/29/22) indicated, "Due to his numerous acts of physical aggression toward peers, he was assigned a 1:1 staff for a period of time. [Client #3] was prescribed Lithium in order to help stabilize his moods and there has been an improvement in his behaviors since starting this medication. It has also shown to be beneficial for [client #3] to utilize other areas of campus such as the gym, courtyard, front porch, etc. in order to take a break from the residential hall." Client #3's BSP revised dates 5/26/22, 5/13/22 (4/29/22) indicated, "If [client #3] is exhibiting agitation or has engaged in physical aggression to peers, a 1:1 staff can be put in place for the protection of other clients. This would be at the discretion of the admin on call. If the 1:1 is in place, the 1:1 is to prevent [client #3] from being able to hit/kick/spit at other clients. If the 1:1 is in place, the 1:1 staff should try to stay in between [client #3] and any peers that he may hit and should remain within approximate arm's reach of [client #3]."The facility's BDDS reports and Investigations were reviewed on 5/31/22 at 10:54 AM. The review indicated the following from 4/1/22 through the 5/31/22 (date of review) client #3 had 27 separate			

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	incidents of physical aggression towards peers (#4, #5, #6, #7, #8, #9, #10, #13, #15, #17 and #19). The review indicated the facility completed CCAI investigations regarding the incidents of client #3's physically aggressive behaviors towards his peers. The CCAI's indicated the investigations document staff implemented client #3's BSP. The CCAI's do not reconcile or document client #3's preventative strategies to implement 1:1 supervision or to physically stand between client #3 and his peers to prevent physical aggression. PM (Program Manager) was interviewed on 6/2/22 at 1:08 PM indicated staff are trained to implement clients BSP's. PM indicated staff should offer coping skills and strategies in each client's BSP to prevent incident from escalating to physical aggression towards staff or peers. PM indicated allegations should be investigated to develop and implement corrective measures to prevent recurrence.			
W 0159 Bldg. 00	483.430(a) QIDP Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who-			
	Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), plus 16 additional clients (#5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20), the QIDP (Qualified Intellectual Disabilities	W 0159	The Administrative Team and other senior trained staff will conduct daily monitoring/intervention sessions on the units to model and assist staff in implementing	07/08/2022

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	Professional) failed to integrate, coordinate, and monitor clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20's active treatment programs to ensure they were effectively developed by necessary recreational and activity director professionals, to ensure staff working in the home were adequately trained to address clients #1, #2, #3, #4, #10, #12, #13, #15, and #19's behavioral needs, to ensure clients #1, #2, #4 and #11 received a continuous active treatment program including aggressive, consistent implementation of their program plans, to ensure staff implemented clients #1, #2, #4 and #11's program plans as written and to promote clients #1, #2, #4, #8, #10, #11, #17 and #18's dignity in regard to their appearance. Findings include: 1. The QIDP failed to integrate, coordinate, and monitor clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20's active treatment programs to ensure they were effectively developed by necessary recreational and activity director professionals. Please see W164. 2. The QIDP failed to integrate, coordinate, and monitor clients #1, #2, #3, #4, #10, #12, #13, #15, and #19's active treatment programs by failing to ensure staff working in the home were adequately trained to address clients #1, #2, #3, #4, #10, #12, #13, #15, and #19's behavioral needs. Please see W191. 3. The QIDP failed to integrate, coordinate, and monitor clients #1, #2, #4 and #11's active treatment programs by failing to ensure clients #1, #2, #4 and #11 received a continuous active treatment program including aggressive,		aggressive and continuous active treatment. Grab bags for active treatment are being created for (client/development/interest specific) All staff will be trained on the implementation of Grab bags for active treatment activities. Sensory room will be competed and included in active treatment. Staff will be trained to use sensory room. All staff re-trained on prompting clients every 15 minutes for formal and informal active treatment opportunities. They were given examples of what active treatment looks like.	

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	consistent implementation of their program plans. Please see W196. 4. The QIDP failed to integrate, coordinate, and monitor clients #1, #2, #4, #8, #10, #11, #17 and #18's active treatment programs by failing to promote clients #1, #2, #4, #8, #10, #11, #17 and #18's dignity in regard to their appearance. Please see W268.			
W 0164 Bldg. 00	483.430(b)(1) PROFESSIONAL PROGRAM SERVICES Each client must receive the professional program services needed to implement the active treatment program defined by each client's individual program plan. Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), plus 16 additional clients (#5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20), the facility failed to ensure clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20's active treatment programs were effectively developed by necessary recreational and activity director professionals. Findings include: 1. ARC (Activity Recreation Coordinator) was interviewed on 6/3/22 at 9:30 AM. ARC indicated she was not a degreed or certified activity director or recreational therapist. ARC indicated she was responsible for completing the in-house activity schedule and community based activity schedule for clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20. ARC indicated she completed activities and programming for the life skills groups. ARC indicated not all clients participated in life skills	W 0164	Activities Recreation Coordinator is enrolled in training for certification.	07/08/2022

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groups. ARC indicated some clients prefer to stay in the residential unit or bedrooms and not come to the activity building on the campus. ARC indicated she had not participated in individual client IDT (Interdisciplinary Team) meetings to develop specific programs or activities for clients not engaged in formal programming opportunities in the activity building of the campus.

Regional Director (RD) was interviewed on 6/3/22 at 11:20 AM. RD indicated the former PM was supposed to have started the process of having ARC (Activity Recreation Coordinator) complete courses for certification prior to his leaving employment with the agency.

BC (Behavior Clinician) was interviewed on 6/7/22 at 12:49 PM.

BC indicated the facility utilized an activity building for additional waiver clients who did not reside at the agency. BC indicated some of the waiver clients had previously been residential clients. BC indicated waiver clients with a recreational therapist were engaged in activities and participating. BC indicated these waiver clients were former residential clients who did not participate or engage. BC indicated current residential clients would benefit from a recreational therapist. BC indicated the residential program did not have a recreational therapist. BC indicated the current ARC had not participated in the IDT to develop specific individual strategies to engage lower functioning clients who had reluctance or non-compliance with leaving the residential building.

PM (Program Manager) was interviewed on 6/7/22 at 2:15 PM. PM indicated the facility did not have a recreational therapist for the residential clients.

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	PM indicated she had previously worked with a recreational therapist in other settings. PM indicate a recreational therapist took clients out into the community, did preferred activities and went to the library with clients. PM indicated ARC was her direct report. PM indicated ARC had not participated in client IDT's. PM indicated the IDT had discussed having the ARC create more specific activity calendars for the lower functioning clients. PM indicated strategies for lower functioning clients might include additional opportunities for walks around campus or van rides. PM indicated she was unsure if ARC had met the certification or educational requirements to be an activity director or recreational therapist. 2. Based on observation, record review and interview for 3 of 4 sampled clients (#1, #2 and #4), and 1 additional client (#11), the facility failed to ensure clients #1, #2, #4 and #11 received a continuous active treatment program including aggressive, consistent implementation of their program plans. The facility failed to ensure staff implemented clients #1, #2, #4 and #11's program plans as written. Please see W196.			
W 0191 Bldg. 00	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' behavioral needs. Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), and 6 additional clients (#10, #11, #12, #13, #15 and #19), the facility failed to ensure staff working in the home were adequately trained to address clients #1, #2, #3, #4, #10, #12, #13, #15, and #19's behavioral needs. Findings include:	W 0191	All members of the Management team will be in-serviced by the Executive Director on the criteria requiring an investigation. Other Interdisciplinary Team members will be trained on the criteria requiring an investigation and during the review of all BDDS reports, a question will be added	07/08/2022

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	Observations were conducted on 5/31/22 from 4:30 PM through 7:06 PM, on 6/1/22 from 2:22 PM through 3:24 PM, and 4:44 PM through 6:07 PM. The observations indicated the following which affected clients #1, #2, #4, #10, #11 and #12: 1. An observation was conducted on 5/31/22 from 4:30 PM through 7:06 PM. At 6:20 PM, client #1 walked out of a bathroom nude and into the hallway, turned and reentered the bathroom. No staff was present and/or provided redirection to client #1. At 6:22 PM, client #1 walked out of the bathroom a second time nude and returned to the bathroom and got into a bathtub filled with a brownish green water. No staff was present in the bathroom or in the hallway to provide redirection to client #1. At this time, a second surveyor noted client #1 was exhibiting rectal digging and putting his hands up to his mouth while in the bathtub. At 6:23 PM, staff #7 was informed client #1 was in the bathroom unattended and was exhibiting rectal digging and putting his hands up to his mouth. At 6:24 PM, staff #7 indicated assistance was needed through use of a handheld radio. Staff #2 responded to staff #7's radio request for assistance and brought a white sheet to the bathroom. At 6:26 PM, LPN #3 (licensed practical nurse) entered the bathroom briefly before client #1, staff #7 and LPN #3 left the to go to a second bathroom using the white sheet to wrap around client #1 as he ambulated through the hallways. At 6:27 PM, the Nurse was asked why staff #7 had requested her to come to the bathroom. The LPN #3 stated, "Because he has an abrasion". At 6:33 PM, the LPN #3, client #1 and the Residential Manager (RM #1) entered the medication administration room. The LPN #3 stated, "I'm going to have to measure it (abrasion)". At 6:35 PM, the LPN #3 stated, "Left side 30 cm		for clarity to the Interdisciplinary Team note asking whether the incident requires an investigation All staff will be retrained on client #1's BSP. BC updated BSP to indicate client is not to take baths at this time due to overstimulation from baths resulting in aggressive thrashing and anal digging in the tub. Staff will remain in the doorway when client #1's showers due to a history of unhygienic behaviors in the shower such as defecating and playing with his feces. All staff were trained regarding appropriate redirection when clients are engaging in horseplay. And to redirect clients when they are invading other clients' boundaries. Educated staff to model appropriate interactions and boundaries. All staff were trained in all staff meeting the following: In order to avoid isolation client #4 should not eat in his room unless he wants to. He should be encouraged to eat at the couch or at his chair in the dayroom. Retrained all staff via in-service regarding responsibilities of 1:1 staff. (I need to write this one) All staff were trained to provide re-direction by way of alternative activities to all clients involved in a situation instead of being reactive to behaviors. The Interdisciplinary Team has developed a comprehensive list of	

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	(centimeters) by 14 cm and the right side 2 (areas of abrasion), first 5 cm by 3 cm, the right second (area) 6 cm by 2 cm". On 5/31/22 at 6:39 PM, the LPN #3 and RM #1 were interviewed. The LPN #3 and RM #1 were asked if client #1 could bathe independently or if client #1 required staff assistance. Both the LPN #3 and RM #1 stated simultaneously, "staff assistance". The LPN #3 stated, "He cannot regulate his water". At 6:41 PM, the RM #1 responded to LPN #3's statement and stated, "I started it (bath water) and told staff he was in there. He usually showers. Staff is usually in there". On 6/3/22 at 9:30 AM, a review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports and accompanying investigation summaries was conducted. The review indicated the following incident which affected client #1. -BDDS Report dated 6/1/22 indicated, "On 5/31/22 at 6:25 PM, [client #1] was in the bathtub without staff supervision. While in the bathtub he began thrashing around and pulled down the shower curtain and rod causing redness to his back. Staff assisted [client #1] to the Nurse's station to be assessed. Nursing assessed and noted red skin abrasions noted on back, left side back measuring 30 cm x 14 cm, left (sic) side of back measuring 5 cm x 3 cm and 6 cm x 2 cm; bacitracin applied". On 6/2/22 at 12:02 PM, staff #2 was interviewed. Staff #2 was asked about client #1's supports needed during bathing and/or showering. Staff #2 stated, "He usually doesn't go to that one (bathroom). He usually takes a shower in the other one". Staff #2 was asked if client #1 should have been left unattended during his bathing and/or		client specific triggers, precursors, and coping skills for each client. The list currently in each clients programing binder on the unit. All staff have been in-serviced on the updated comprehensive list and where to find it on the unit for reference. All staff retrained that staff are to interact with clients and follow through with what they say they will do. And educated about how not doing so can cause conflict and behaviors.	

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showering. Staff #2 stated, "Staff stands in the door". Staff #2 indicated client #1 should not be left unattended during his bathing and/or showering supports.

On 6/2/22 at 12:36 PM, Residential Manager (RM #4) was interviewed. The RM #4 was asked about client #1's bathing and/or showering support needs. The RM #4 stated, "I would have to check. I stress getting him into the standup shower. When he first got here he had a couple baths. That did not work". The RM #4 indicated client #1 would thrash around when given a bath and stated it would "leave marks. It was bad. He likes to flop up and down". The RM #4 was asked if client #1 required staff supervision during his bath and/or shower. The RM #4 stated, "Yes, really you should be arms reach".

On 6/2/22 at 12:53 PM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked if client #1 should be left unattended during a bath and/or shower. The QIDP stated, "He should not be left alone".

On 6/2/22 at 2:55 PM, the Program Manager (PM) was interviewed. The PM was asked if client #1 should be left unattended during a bath and/or shower. The PM stated, "He should be encouraged to shower, and staff should be at the door with him". The PM was asked if client #1 should be left unattended. The PM stated, "No, not left alone". The PM was asked when did the incident of client #1 being left alone to bathe which resulted in an abrasion became an allegation of neglect. The PM stated, "When she (RM #1) walked away". The PM indicated RM #1 was suspended and an ongoing investigation into client #1 being left unattended during his bath on 5/31/22 was in process.

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On 5/31/22 at 7:01 pm, client #1 got up from the dining table, walked to client #3's table and grabbed a handful of french fries. Client #1 ate some fries and dropped some on the floor and table. Staff did not address client #1. At 7:02 pm, client #1 walked to client #6's table and grabbed a handful of french fries from his plate. Client #6 protested verbally, but staff in the dining area did not respond to client #1. At 7:04 pm, client #1 went to client #9's table and tried to grab food from client #9's plate. Residential Manager (RM) #4 covered client #9's plate with her hands. When client #1 reached for client #9's plate, he pushed RM #4's hands into client #9's food.
- Staff did not redirect client #1 away from the dining area.

Client #1's record was reviewed on 6/1/22 at 1:52 pm.
Client #1's Behavior Support Plan (BSP) dated 5/26/22 indicated the following:
"Target Behaviors and Goals....
Anal Digging/Smearing Feces:....
[Client #1] will sometimes reach back toward his anal area right after having a bowel movement, and it has been helpful for staff to hold his hands after a bowel movement, so that he is not tempted to do this. [Client #1] may engage in this behavior to upset staff, so that they just give in to what he wants.... Includes attempts to eat his feces. [Client #1] may engage in this behavior to get a reaction out of staff, and staff should respond with as little reaction or emotion as possible. If he sees that it upsets or flusters you, he will do it more. He likes the reaction....
Restrictions:
- Staff will remain in the doorway when [client #1] bathes due to a history of unhygienic behaviors in the tub such as defecating and playing with his

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	feces. Showers should be encouraged instead of baths due to [client #1's] aggressive thrashing in the bath tub and his history of defecating in the tub and playing with it.... Preventative Procedures: - He should be encouraged to take showers rather than baths due to his history of violently thrashing around in the tub causing bruising to himself.... - [Client #1] seeks a reaction from staff and has had behaviors in the past in order to get a reaction out of staff. Don't react emotionally to his behaviors by being shocked, grossed out, or upset. Act almost as if the behavior did not just happen. ALL staff need to be on board with this intervention in order to decrease these types of behaviors." Client #1's BSP indicated the following: "Inappropriate Access to Food: any time [client #1] obtains food items by 'stealing' them off of his peer's plates, digging the food items out of the trash, or eating food items that have been found/left on the floor. It would not be uncommon for [client #1] to circle the dining tables of his peers in an effort to take leftover food items off of the table.... Restrictions: - [Client #1 will have an assigned staff across all shifts.... The assigned staff is responsible for the following: - Meal/snack supervision.... Preventative Procedures: - [Client #1] will circle the dining hall area and will attempt to steal food from the plates of others. Verbal redirection rarely helps in this situation, and it is more effective to be preventative by redirecting [client #1] out of the immediate dining area when he is done eating. He should not stand near peers who are eating, and he should not circle the dining area because he is looking for			

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items to steal. He can be encouraged to leave the residence in order to take a walk. He can be given time in his room with his tablet, etc....
Reactive Procedures:
- The best way to handle this behavior from [client #1] is to be preventative so that he cannot try to get food in the first place.
- When [client #1] is done eating, he should not be able to circle the dining tables or stand next to peers who are eating.
- [Client #1] likes walks, encourage him to go for a short walk in order to get him out of the dining area and to get him interested in a different activity.
- If you cannot avoid this behavior, reassure the other peer that we will take care of it and get them a new food item.
- Educate [client #1] that if he wants seconds, he can let staff know so they can help him...."

DSP #2 was interviewed on 6/2/22 at 11:53 am and stated, "Staff should redirect client [client #1] away from the dining area when he's done eating."

2. Observation was conducted on 6/1/22 from 2:22 PM through 3:24 PM. At 2:32 PM, client #2 was seated in the common living area referred to as the day room with a group of his peers. At 2:38 PM, client #15 verbally prompted client #2 indicating he was going to use his "tickle finger". At 2:42 PM, client #2 followed the Residential Manager (RM #2) throughout the day room at which point client #15 stated to client #2 to make a vocalization using his lips referred to as "raspberries". Client #2 followed RM #2 throughout the day room making this vocalization with his lips. At 2:43 PM, client #15 placed his hands under client #2's armpits in a hugging position. Staff #2 verbally prompted client #15 by

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	stating, "[Client #15] no, [client #15], no". Client #2 then ran down the hallway toward his bedroom. At 2:46 PM, client #2 returned to the day. The RM #2 stated, "He's playing Tigger (jumping up and down)". At 2:48 PM, client #2 attempted to lick RM #2 while in the day room. The RM #2 responded to this by running down a hallway and into a bedroom. Staff #14 verbally redirected client #2 to which bedroom the RM #2 had ran into. The RM #2 came out of an adjacent bedroom and ran toward the kitchen and then down the pacer hallway and back to the day room. At 3:04 PM, client #15 was seated at the dining room table preparing to consume a milkshake. At 3:12 PM, the RM #2 began passing milkshakes out to a group of clients #2 and #15's peers. On 6/1/22 at 4:16 PM, a focused review client #2's record was conducted. The record indicated the following: -Behavior Support Plan (BSP) dated 5/25/22 indicated, "Non-Compliance: any time he (client #2) is not engaging in programmatic requests, within three verbal prompts spaced out at least 15 minutes apart (when appropriate) ... Based upon the nature of the non-compliance, it is not always appropriate to wait 15 minutes in between prompts (for example, if he is being prompted for portions at mealtimes or if there is a safety issue, staff would not wait 15 minutes in between prompts) ...Preventative Procedures: When giving him instructions/requests they should be: 1) Given in a clear and concise manner/one step at a time. 2) Done in the form of a question and not a demand. 3) Give him time to respond. 4) Frequently bring up positive aspects about his behavior...". On 6/1/22 at 4:14 PM a focused review of client #15's record was conducted. The record indicated			

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the following:

-Behavior Support Plan dated 5/19/22 indicated, "Non-Compliance: anytime he (client #15) is not engaging in programmatic requests, within three verbal prompts spaced out at least 15 minutes apart. Based upon the nature of the non-compliance, it is not always appropriate to wait 15 minutes in between prompts (for example, if he is being prompted for portions at mealtimes or if there is a safety issue, staff would not wait 15 minutes in between prompts) ...

Inappropriate Sexual Behaviors: defined as ...touching others' private areas, rubbing himself on others, or making verbalizations/gestures of a sexual nature to others in a common area ...

Preventative Procedures: ... Do not talk down to [client #15] or boss him around, speak to him as you would any other adult ... Speak to him in a calm, neutral-toned voice at all times ... Staff will model appropriate social interactions and boundaries ... Anytime he is engaging in appropriate behaviors provide abundant specific praise ... When giving him instructions/requests they should be: a. Broken down very simply - one step at a time, b. Done in the form of a question or suggestion ...".

On 6/2/22 at 11:53 AM, staff #2 was interviewed. Staff #2 was asked about the horseplay between client #2 and client #15 and staff redirection. Staff #2 stated, "Yesh, the tongue thing. That's not appropriate". Staff #2 indicated client #2 and client #15 had a prior acquaintance from a previous placement when they were younger and stated, "It was not appropriate. I should have said something. I did, but I did not want to make a big deal of it". Staff #2 was asked about modeling

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appropriate interactions with clients #2 and #15. Staff #2 stated, "[Client #15] is pretty understanding. You can educate him on what his plan says".

On 6/1/22 at 12:36 PM, Residential Manager (RM #4) was interviewed. The RM #4 was asked about the horseplay between client #2 and client #15 and staff redirection. The RM #4 stated, "[Client #2] does like the raspberries. We should prompt. Most of them have a personal space (intervention) in their plan. I would have to check". The RM #4 was asked if horseplay such as tickling, running in and out rooms and/or playing tag should be encouraged and meaningful with clients #2 and #15. The RM #4 stated, "I would not recommend it. I try to discourage the tag and hide and seek". The RM #4 was asked if horseplay as described, was inappropriate activity with clients #2 and #15. The RM #4 stated, "Yes, absolutely".

On 6/2/22 at 1:35 PM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked about client #2 and client #15's horseplay and a lack of staff redirection. The QIDP stated, "The tickling and inappropriate touch should not (occur). That can trigger a lot. It might be a joke to one and not the other. It's staff responsibility to redirect". The QIDP was asked about modeling appropriate behavioral interactions by the staff. The QIDP stated, "We're here to help people grow and provide a secure environment".

On 6/2/22 at 2:55 PM, the Program Manager (PM) was interviewed. The PM asked about the horseplay between clients #2 and #15 and a lack of staff redirection. The PM indicated clients #2 and #15's horseplay should have been redirected

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	appropriately and stated, "Offer activities, get them away from each other, redirection and deescalate". The PM was asked if horseplay such as hide and seek should be encouraged with clients #2 and #15. The PM stated, "No. We don't encourage clients to go into other's rooms". The PM was asked about the appropriateness of a game referred to as the "raspberries". The PM stated, "No. They should be redirected from that. They shouldn't do that either". The PM was asked if clients #2 and #15 should be engaging in the act of tickling and physical touching. The PM stated, "No. They should not do that". The PM was asked about if staff should model appropriate behavioral interactions. The PM stated, "Yes, staff should redirect". 3. Observations were conducted on 5/31/22 from 4:30 PM through 7:06 PM and on 6/1/22 from 4:44 PM through 6:07 PM. On 5/31/22 at 4:41 PM, client #4 paced throughout the day room. As client #4 went past his peers in the day room, client #4 would touch them on their shoulder and arm. Staff #10 intervened with the use of physical redirection and stated, "Hey buddy, we don't hit our peers". At 4:41 PM, client #4 sat down on a sofa next to client #12. Client #4 reached over and touched client #12 on the leg. Client #12 used a closed fist to hit client #4 three times on his left shoulder blade on his back. Staff #10 stated, "Hey [client #12], we don't hit others". Client #12 stated in response to staff #10's verbal redirection, "He hit me first". At 4:42 PM, client #4 stood from the sofa next to client #12 and walked down the pacer hallway and into a bedroom. Staff #10 verbally redirected client #4 and stated, "That's not your room, let's go to your room". Client #4 returned to day room and sat down beside client #12 a second time. No redirection			

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	was provided to separate client #4 and client #12. At 4:47 PM, client #4 attempted to enter another bedroom. Staff #10 used a touch cue followed by verbal redirection and stated, "No, we don't go into other people's bedroom". Client #4 entered the bedroom and stood next to the curtain briefly before leaving. At 4:51 PM, client #4 reentered the day room at which point Residential Manager (RM #1) stated, "[Client #4] gave him (client #10) a slap on his way through". At 4:55 PM, staff #10 requested staff #2 give him a break as the assigned one-to-one staffing with client #4. Staff #2 left client #4's bedroom to obtain a gray adult incontinent brief and returned. Staff #2 stated to staff #10, "He (client #4) can put it on". Client #4 remained in his room for a period of time and no longer engaged in client-to-client physical interactions with his peers. At 5:24 PM, client #4 was seated in the day room among his peers waiting for the evening meal. Client #4 would sit, stand and move to different sofas located in day room. Staff #2 followed client #4 when he switched locations to remain close to him. At 6:44 PM, client #4's peers gathered in day room and around the dining room tables in preparation for the evening meal. Client #4 was no longer in day room or seated around the dining room tables with his peers. At 6:50 PM, many of client #4's peers began eating their evening meal which consisted of a cheeseburger, french-fries, coleslaw, pudding and pink lemonade to drink. Client #4 was not in day room or the dining room among his peers during the evening meal. At 6:56 PM, staff #2 was asked where client #4 was. Staff #2 stated, "He's in his room. He eats at a different time than everyone else. He steals their food". Client #4's bedroom door was closed. At 6:58 PM, client #4 exited his bedroom with staff #6. Client #4 went into the day room while staff #6 took his			

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plate and utensils to the kitchen. At 6:59 PM, staff #6 was asked why client #4 ate his meal inside his bedroom. Staff #6 stated, "Sometimes he prefers to eat in his room. He likes to steal foods. Even if you're sitting beside him, he doesn't care. He is quick. Like a flash". Staff #6 was asked if client #4 ate all of his evening meal in his bedroom. Staff #6 stated, "Yes. Sometimes he will feed himself. Sometimes he will not. He will eat off the floor".

Second evening meal:

On 6/1/22 at 5:45 PM, staff #2 verbally redirected client #4 to sit in his chair in his bedroom for his evening meal. The evening meal consisted of fish, mixed-vegetables and macaroni and cheese. At 5:47 PM, the Residential Manager (RM #4) brought a black television stand to client #4's bedroom. Client #4 used the tray to rest his plate and utensils on while he ate his meal inside his bedroom. Client #4 continued to eat his meal in his bedroom until finished at 5:51 PM.

On 6/1/22 at 11:42 AM, client #4's record was reviewed. The record indicated the following:

-Individual Support Plan (ISP) dated 2/10/22 indicated, "He (client #4) requires a 1:1 (one-to-one) staff during all waking hours and while eating ... [Client #4] has a history of physical aggression ... stealing, non-compliance ...

Goal: To improve mealtime skills thus increasing independence. Objective: [Client #4] will take small bites and eat at a slow pace with 3 verbal prompts 70% of opportunities per month across 12 consecutive months by 2/10/2023 ...

Goal: To increase knowledge of Emotional Regulation. Objective: [Client #4] will participate

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	with staff in training session learning about appropriate ways to cope with anxiety and/or stress with 3 verbal prompts 70% of opportunities across 12 consecutive months by 2/10/2023. Methodology: 1) Staff will talk with him in a quiet area (a place where [client #4] is comfortable and work on coping skills). 2) Staff will teach/demonstrate appropriate ways to deal with anxiety/stress- Counting, Walking, Deep Breathing, Listening to Calm Music, use of stress ball. 3) Staff will praise [client #4] when he demonstrates other options available to him, other than physical aggression ... 4) Staff will accentuate the positive in [client #4's] life. Always be upbeat and use praise when talking with him. 5) A successful trial will be recorded if [client #4] participates in the teaching session with 3 or less verbal prompts. 6) Verbal Praise for all efforts ...". -Behavior Support Plan (BSP) dated 5/23/22 indicated, "Target Behaviors: ... Physical Aggression: Any occurrence or attempts at hitting people ... or behaviors that produce or have the potential to produce an injury to others ... Goal: [Client #4] will demonstrate 2 or fewer acts of this target behavior per month for 3 consecutive months by 5/22 ... Eating Non-Edible/Non-Food Items (target behavior): any time he ingests or tries to ingest a non-food item... Historically this shas (sic) been a frequent issue but he has not demonstrated significant problems with this target behavior so far. Goal: [Client #4] will demonstrate 0 acts of this target behavior per month for 3 consecutive months by 5/22 ... Inappropriate Access to Food (target behavior):			

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Any time he (client #4) takes items from others including their personal items or their food. He will attempt to grab any food items that are within arm's reach. [Client #4] has taken food off of peer's plates during meals and snacks. He seems to prefer "stealing" food from peers as opposed to eating his own food from his plate even though they are the same foods. Goal: [client #4] will demonstrate 0 acts of this target behavior per month for 3 consecutive months by 5/22 ...

Reactive Procedures (Physical Aggression): 1) Immediately ensure the health and safety of everybody in the immediate environment. 2) Redirect him (client #4) and/or others to a different area of the environment. 3) Tell him to stop the behavior. 4) If he stops the behavior, redirect him to a safe location and problem solve with him and praise him for doing this with us. 5) If the behavior continues, block all attempts of aggression and attempt to redirect, if the behavior continues and he is placing himself or others in danger, implement You're Safe I'm Safe (YSIS) beginning with the least restrictive measures ...

Reactive Procedures (For Eating Non-Food Items): 1) Verbally prompt [client #4] to stop. Immediately remove the non-food item that he is trying to consume ...Educate [client #4] that eating these items will make him sick and remind him that this item is not food ...".

On 6/1/22 at 4:29 PM, a focused review of client #12's record was conducted. The record indicated the following:

-Behavior Support Plan (BSP) dated 4/1/22 indicated, "Physical Aggression defined as: any occurrence of hitting with open or closed hand ... Preventative Procedures: Boredom leads to

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behaviors ... Chaos or an unstructured environment can add stress to [client #12], try to keep [client #12] occupied with a preferred activity ... [Client #12] can be over stimulated in chaotic environments... Try to avoid over-stimulation by preparing for such things as transitions or changes in the schedule ...".

Based on the observations and interviews, staff failed to consistently implement client #4's ISP methodologies and reactive procedures such as talking with him in a quiet area, demonstrate appropriate ways to deal with anxiety/stress, to accentuate the positive in [client #4's] life and remain upbeat and provide verbal praise for all of client #4's efforts. Staff failed to recognize elements of client #12's prevention strategies indicated within his BSP for unstructured environments add stress and need to keep occupied with preferred activity and did not prompt client #4 not to sit next to client #12 prior to the physical aggression and then a second time immediately after when client #4 returned and sat next to client #12. In addition, client #4's ISP and BSP did not indicate a strategy to isolate client #4 to his bedroom during evening meals, to prevent client #4 from stealing the foods of his peers as indicated in staff interviews. Client #4's ISP and BSP did not support the staff's implementation for eating evening meals in his bedroom and staff did not redirect client #4 to the day room and/or dining room.

On 6/2/22 at 10:55 AM, the Director of Nursing (DON) was interviewed. The DON was asked about client #4's behavioral strategies for meals and the observations of him eating in his bedroom. The DON stated, "They (interdisciplinary team) talked about making him a spot, eating at different times and locations.

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	That's (eating in his bedroom) not something I'm aware of. I would have to talk to [Program Manager]. We talked about how to not reach other people's stuff (foods). To eat in his room, that's not something we do". The Nurse indicated a strategy to use client #4's bedroom as a location to support him during mealtimes was not agreed upon area of client #4's interdisciplinary team and further review as to why staff members would implement such strategy required further review. On 6/2/22 at 12:36 PM, Residential Manager (RM #4) was interviewed. RM #4 was asked about client #4's reactive strategies for client-to-client interactions and the practice of client #4 eating his meals within his bedroom. The RM #4 stated, "A lot of them have the same type of goals. One of his (client #4) is taking people's foods. His one-to-one (staffing) needs to be with him. He eats in his room. He can eat away from his peers". The RM #4 was asked if client #4's eating in his bedroom was identified in his ISP and/or BSP. The RM #4 stated, "That was recently added". The RM #4 was asked if client #4's behavior was influenced by the number of peers present in the day room. The RM #4 stated, "Absolutely. When they are in the day room it adds to the behavior". The RM #4 was asked about redirection to prevent an increased situation of client-to-client behavior such as structured activities. The RM #4 stated, "We do have Life Skills Schedule to refer to". The RM #4 indicated client #4 should be prompted and redirected to prevent client-to-client physical interactions. The RM #4 indicated the more client #4's peers were located in the day room increased the probability for client-to-client instigation and inappropriate physical interactions. The RM #4 indicated client #4's plans indicated a recent change which included the practice of client #4's use of his bedroom as a			

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strategy during mealtime, which was found unsupported from the record review process and interviews the DON, QIDP, PM and Behavior Specialist.

On 6/2/22 at 1:35 PM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked about client #4's implementation of reactive strategies to prevent instigation and physical interactions with other clients. The QIDP stated, "Be proactive rather than reactive. The more active and the more you get them involved the less attention seeking behavior". The QIDP was asked how staff should intervene. The QIDP stated, "If you see that happening, ask if there is something else they would want to do or be more direct to what would you like to do". The QIDP was asked what the redirection should be. The QIDP stated, "Reviewing with [client #4] and explaining to [client #12]. I would have separated them for a while, worked on skill building". The QIDP was asked about client #4's alternative activity and mealtime strategy to eat his meals alone in his room. The QIDP stated, "I think that's training. Sensory issues could be going on".

On 6/2/22 at 2:55 PM, the Program Manager (PM) was interviewed. The PM was asked about client #4's reactive strategies for client-to-client interactions and the practice of client #4 eating his meals within his bedroom. The PM stated, "Offering activities, get them away from one another, redirecting and deescalating". The PM was asked if client #4's staff members should provide redirection. The PM stated, "There is an expectation. There are skills they should work on". The PM was asked about client #4's dining location and the observation with staff feedback of client #4's mealtime strategy to eat within his

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	room to prevent him from stealing foods. The PM indicated client #4 should have opportunity to sit at the dining room table. The PM indicated client #4 plans indicated the use of a TV (television) tray in the day room adjacent to the dining room. The PM was asked if staff implementation for the use of the TV tray could be within client #4's bedroom. The PM stated, "I would have to find out on that one. Staff should be in there regardless". The PM indicated staff members should provide redirection to client #4 when engaging in client-to-client physical interactions according to his strategies outlined in his plans. The PM indicated further review and follow-up was needed concerning the practice of client #4 eating his meals in his bedroom. On 6/2/22 at 3:20 PM, the Behavior Clinician (BC) was interviewed. The BC was asked about staff implementation for redirection to prevent situations of client-to-client physical interactions. The BC indicated staff should implement proactive and the reactive strategies outlined within client #4's BSP to prevent and deescalate any client-to-client physical interactions. The BC was asked about client #4's dining location within his bedroom to isolate and prevent him from access to other peers food items. The BC stated, "It's (dining supports) confusing. When we first started staff told me he didn't like the table. At first, we were going to move the table to where the activity cabinet is located. He would not sit there. We modified his plan to use a TV tray and at the couch". The BC was asked if staff implementation to use his bedroom as the dining location to prevent opportunities to steal food was supported by client #4's plans. The BC stated, "No, that's not in there". 5. On 5/31/22 at 11:56 am client #10 was sitting on a sofa in the day room while waiting for lunch to			

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	be served. Client #13 walked behind the sofa and client #10 screamed. Client #13 and client #10 shouted at one another. Client #10 yelled, "He hit me." RM #2 separated clients #10 and #13. At 12:15 pm, clients #10 and #13 were seated at separate tables waiting for lunch to be served. Client #10's back was to client #13, and client #13 was facing client #10. Client #13 began banging his fist on the table. Client #10 stated, "Please stop." Client #13 continued banging on the table with his fist. Client #10 shouted, "Stop." Client #13 shouted, "Shut the f*** up." Client #10 shouted, "You shut up." RM #2 stated, "[Client #10], just ignore him. You have an outing. He's not worth losing an outing." RM #2 did not address client #13. Client #13 continued banging on the table. Clients #10 and #13 continued shouting at one another. Client #10 put his fingers in his ears and began screaming. Client #13 shouted, "F*** you." Client #10 shouted, "Stop, please stop." RM #2 prompted client #10 to get his noise canceling headphones. Client #10 stated, "I'll go get my headphones. Client #10 got up from the table and left the room. When client #10 left the room, client #13 stopped banging on the table. Client #10 returned with his noise canceling headphones. When client #10 entered the day room and was within sight of client #13, client #13 resumed banging his fist on the table. When client #10 returned to the table, client #15 was in the seat client #10 had left. Client #10 protested and asked client #15 to move.			

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	RM #2 stated, "[Client #10], [client #15] was there first. Go to another table." Client #10 moved to a another table and took off his noise canceling headphones. Client #13 resumed banging his fist on the table. Client #10 shouted, "Please stop."6. On 5/31/22 at 5:03 pm clients #3 and #13 were in the day room waiting for dinner to be served. Client #3 was in the kitchen watching staff preparing the meal. Client #3 walked out of the kitchen. Client #13 stood in the doorway of the kitchen and used his arms to block the doorway. Client #3 walked up to client #13 and looked at him. Client #3 attempted to step around client #13 to enter the kitchen. Client #13 blocked client #3. Clients #3 and #13 stared at one another. Client #3 poked client #13's glasses. Client #13 slapped client #3's hand away. Client #19 walked up to the kitchen door and client #13 moved away to let him pass. Client #3 attempted to follow client #19, and client #13 blocked him. DSP #2 walked to the kitchen door, and client #13 moved out of the way. Client #3 followed client #19 into the kitchen. Client #13 followed client #3 into the kitchen. Clients #3 and #13 stood facing one another and stared at one another. DSP #10 stated, "Hey, don't start." Client #1 walked into the kitchen, and client #13 grabbed each of his elbows from behind and pushed client #1 out of the kitchen.			

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	Client #13 left the kitchen. DSP #10 followed client #13 and spoke with him in the hallway away from client #3. Client #3 remained in the kitchen.Client #13's record was reviewed on 6/1/22 at 4:15 pm.Client #13's BSP dated 5/13/22 indicated the following:"Target Behaviors:Instigation: [Client #13] can engage in provoking/instigation type behaviors towards others and he has demonstrated that he will bully or even engage in aggression toward peers who are much lower functioning than him. If a peer is being loud, [client #13] may go after that peer or may threaten to hurt that peer....Reactive Procedures:For Instigation:- If he is taunting a peer, firmly but calmly tell him that the behavior is not appropriate but do not give excess attention to him for the undesired behavior.- Redirect him or the peer who is being instigated with a different activity or to a different area.- If he is engaging in instigation in view of a peer, remain between the two peers."DSP #2 was interviewed on 6/2/22 at 11:53 am and stated, "[Client #13] does the fist pounding to instigate. We're supposed to try to correct him. He says he's bored. He stares at his peers and makes it know he's try to get them worked up." DSP #2 stated, "[Client #13] isn't supposed to touch anyone. If he's acting as staff, we're supposed to correct him. We tell him not to			

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	touch his peers. He should be written up for physical, and staff should redirect him."7. On 5/31/22 at 5:50 pm, clients #3, #7, #8 #9, and #19 were waiting for the evening meal to be served. Client #19 stated to client #8, "Do you want to go outside?" Client #19 was holding a football and a pair of cleats. Client #19 gathered clients #7, #8, and #9 and stated, "This is the only time we'll get to go outside today. Come on, let's go." Clients #7, #8, #9, and #19 walked to the end of the hallway and congregated at the door. Client #3 followed. At 5:53 pm, client #19 walked up the hallway to the day room, approached DSP #7 who was leaning on the kitchen door and stated, "Will you take us out? [DSP #10] said he would, but I don't know where he went." DSP #7 refused client #19 but did not give a reason. DSP #7 turned away from client #19 and walked outside through the kitchen door. DSP #10 was standing in the pantry inside the kitchen. Client #19 walked back down the hallway and stood with clients #3, #7, #8, and #9 by the exit door. At 5:56 pm, client #7 was at the far end of the hallway by the exit door. DSP #2 was in the day room at the opposite end of the hallway. Client #7 shouted to DSP #2, "[client #3] is threatening people." DSP #2 shouted back, I'm the only staff in the day room, and I'm 1:1 for [client #4]. I can't help you." DSP			

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	#2 called DSP #10 from the kitchen and stated, "Can you deal with [client #3]? I guess he's threatening people." DSP #10 walked to the end of the hallway and began conversing with client #3. DSP #2 stated, "They were going to go out with [DSP #10], but he was in the kitchen. I don't know why he didn't take them out." At 6:06 pm, client #9 left the group at the door and went to the dining area to sit down. Clients #7 and #19 sat down on the floor with their backs against the floor. Client #8 wandered away. DSP #10 continued talking with client #3. DSP #10 directed clients #7 and #19 to leave the area.Client #19 was interviewed on 5/31/22 at 6:08 pm and stated, "We couldn't go out because [client #3] had a behavior. [DSP #10] said he would take us."DSP #10 was interviewed on 5/31/22 at 6:51 pm and stated, "[Client #3] was being verbally aggressive towards the others. It progressed and he prolonged until dinner was done, so they didn't have time to go outside." When asked why he didn't take the clients outside when they were ready, DSP #10 stated, "I got distracted talking to other staff."DSP #2 was interviewed on 6/2/22 at 11:53 am and stated, "Staff should follow through. We shouldn't say we'll do something then not do it. If [DSP #10] had done what he said, there wouldn't have been an issue."RM #4 was interviewed on 6/2/22			

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	at 12:36 pm and stated, "If they ask to go somewhere, staff should just go. They shouldn't make them wait. Just go with them. They stand at the door and bicker."Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 6/2/22 at 1:34 pm and stated, "Staff shouldn't make a promise without a plan and a set time. Staff should be aware of what is happening before they say they'll do something. Staff shouldn't send [client #19] to get a group together. If the staff couldn't take them, he shouldn't have sent [client #19] to get a group."Behavior Clinician (BC) #1 was interviewed on 6/2/22 at 3:20 pm and stated, "Staff caused that behavior. Staff should follow through on what they say they'll do."Client #3's record was reviewed on 5/31/22 at 1:38 pm.Client #3's BSP dated 5/26/22 indicated the following:"Target Behaviors and Goals:Verbal Aggression: any time he is yelling at others, cursing, threatening others, using profanity, etc....Instigation: Includes attempts to get peers upset or to get peers to engage in target behaviors....Precursors:Verbal aggression could be identified as a precursors to other behavioral issues. When he engages in this behavior, staff will:- Remain calm in tone and volume, do not react with emotion or irritation.- Ignore threats and verbal abuse -			

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	do not get into a back-and-forth power struggle....Preventative Procedures:- [Client #3] should have opportunities throughout the day to leave the residential hall and go to the yard/gym/etc.- Give [client #3] choices whenever possible, he does best when he feels like he has some control over his situation...."8. Client #2's record was reviewed on 6/1/22 at 4:15 pm.Client #2's BSP dated 5/25/22 indicated the following:"Target Behaviors and Goals:....Physical Aggression: Any occurrence or attempts at hitting people, pinching others, spitting on them, kicking, or scratching at others, using objects as weapons, pulling hair, or behaviors that produce or have the potential to produce an injury to others.... He has engaged in very impulsive acts of physical aggression to peers who aren't even interacting with him in common areas. Staff should pay close attention to the proximity of [client #2] and other clients when [client #2] is in the common areas. Also, he does not like peers hugging or touching him. Peers should be reminded to give him personal space.... [Client #2] will often be pleasant in the day room but will then hit a peer and then run back to his bedroom and then slam the door...."Client #15's record was reviewed on 6/1/22 at 4:20 pm.Client #15's BSP dated 5/19/22 indicated the			

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	following:"Inappropriate Sexual Behaviors: .... rubbing himself on others....Preventative Procedures:- Staff will model appropriate social interactions and boundaries...."DSP #2 was interviewed on 6/2/22 at 11:53 am and stated, "That behavior is not appropriate. They're friends from [previous facility]. Staff should have said something. [Client #15] will usually listen and can be directed. He should be educated on what his plan says. Staff shouldn't allow tickling."RM #4 was interviewed on 6/2/22 at 12:36 pm and stated, "[Clients #2 and #15] need to give each other more personal space. Most have a personal space goal. Playing tag with staff should not be happening. Staff should not encourage that behavior."QIDP #1 was interviewed on 6/2/22 at 1:34 pm and stated, "Tickling and touching shouldn't happen. It can trigger past trauma. It is staff's responsibility to redirect. They could prompt for a side hug. The staff are here to help the clients grow and become independent as a service. Allowing that behavior is not helping them to develop themselves."Program Manager #1 was interviewed on 6/2/22 at 2:56 pm and stated, "There should be no horseplay. Some even have a BSP for horseplay. Staff shouldn't be hiding in bedrooms. It's inappropriate. Staff should redirect. It could cause behaviors. It's not			

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	developmentally or age appropriate behaviors. Staff should not encourage hugs. They should redirect and model appropriate behaviors."BC #1 was interviewed on 6/2/22 at 3:20 pm and stated, "That behavior is not appropriate for [client #2]. He's unpredictable. No one should be hugging him. He will act like he having fun then will pop you. Grown men don't tickle. Staff should follow the plans."			
W 0195 Bldg. 00	483.440 ACTIVE TREATMENT SERVICES The facility must ensure that specific active treatment services requirements are met. Based on observation, record review and interview the facility failed to meet the Condition of Participation: Active Treatment Services for 3 of 4 sampled clients (#1, #2 and #4), plus 6 additional clients (#7, #8, #10, #11, #17 and #19). The facility failed to ensure clients #1, #2, #4 and #11 received a continuous active treatment program including aggressive, consistent implementation of their program plans. The facility failed to ensure staff implemented clients #1, #2, #4 and #11's program plans as written, to ensure client #4 was assessed for the appropriateness of his diet and client #11 was assessed for his skills, eating habits, and preferences associated with eating his pureed food items, to ensure a goal to address client #2, #8 and #10's drooling was part of the clients' plans, to ensure clients #7, #8, #17 and #19 had opportunities for choice regarding their preferred vocational programs and to ensure clients #1, #2, #4 and #11's ISP (Individual Support Plans), BSP (Behavior Support Plans) and Health Risk Plans were implemented during formal and informal opportunities.	W 0195	The Administrative Team and other senior trained staff will conduct daily monitoring/intervention sessions on the units to model and assist staff in implementing aggressive and continuous active treatment. Grab bags for active treatment are being created for (client/development/interest specific) All staff will be trained on the implementation of Grab bags for active treatment activities. Sensory room will be competed and included in active treatment. Staff will be trained to use sensory room. All staff re-trained on prompting clients every 15 minutes for formal and informal active treatment opportunities. They were given examples of what active treatment looks like. Goals were added to address	07/08/2022

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	Findings include: 1. The facility failed to ensure clients #1, #2, #4 and #11 received a continuous active treatment program including aggressive, consistent implementation of their program plans. The facility failed to ensure staff implemented clients #1, #2, #4 and #11 program plans as written. Please see W196. 2. The facility failed to ensure client #4 was assessed for the appropriateness of his diet and client #11 was assessed for his skills, eating habits, and preferences associated with eating his pureed food items. Please see W217. 3. The facility failed to ensure a goal to address client #2, #8 and #10's drooling was part of the clients' plans. Please see W227. 4. The facility failed to ensure clients #7, #8, #17 and #19 had opportunities for choice regarding their preferred vocational programs. Please see W247. 5. The facility failed to ensure clients #1, #2, #4 and #11's ISPs, BSPs and Health Risk Plans were implemented during formal and informal opportunities. Please see W249.		drooling for clients #2, #8, and # 10. Meal prep training conducted to assure all ISP, BSP, and High-risk plans are followed.	
W 0196 Bldg. 00	483.440(a)(1) ACTIVE TREATMENT Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward:			

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	(i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status.			
	Based on observation, record review and interview for 3 of 4 sampled clients (#1, #2 and #4), and 1 additional client (#11), the facility failed to ensure clients #1, #2, #4 and #11 received a continuous active treatment program including aggressive, consistent implementation of their program plans. Findings include: 1a. Observations were conducted at the facility on 5/31/22 from 2:15 PM through 3:26 PM, from 4:30 PM through 7:06 PM, on 6/1/22 from 10:45 AM through 11:24 AM, from 2:22 PM through 3:24 PM, and from 4:44 PM through 6:07 PM. During the observations, the following issues were noted: On 5/31/22 from 2:15 PM through 3:26 PM: Client #1 remained to himself in the day room. Client #1 was not prompted to engage in formal or informal active treatment activities. Client #1 was not offered or prompted to engage in activities by the staff working in the facility. At 2:50 PM, client #1 walked down the hallway toward the laundry room. The Residential Manager (RM #2) ran toward client #1 and stated, "No [client #1], [No [client #1]". Client #1 returned to the day room and went without an activity offered by staff. Client #4 remained to himself in the day room. Client #4 was not prompted to engage in formal or informal active treatment activities. Client #4 was not offered or prompted to engage in activities by	W 0196	The Administrative Team and other senior trained staff will conduct daily monitoring/intervention sessions on the units to model and assist staff in implementing aggressive and continuous active treatment. All staff re-trained on prompting clients every 15 minutes for formal and informal active treatment opportunities. They were given examples of what active treatment looks like. They were also educated to use the Activities building more often including completing part of meal prep in the recreation room kitchen. All staff will be retrained on client #1's BSP. BC updated BSP to indicate client is not to take baths at this time due to overstimulation from baths resulting in aggressive thrashing and anal digging in the tub. Staff will remain in the doorway when client #1's showers due to a history of unhygienic behaviors in the shower such as defecating and playing with his feces. Grab bags for active treatment are being created for clients. All staff will be trained on the implementation of Grab bags.	07/08/2022

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	the staff working in the facility. At 2:25 PM, client #4 moved to a different location in the day room to sit. Client #4 was not wearing socks and/or shoes. Staff #2 followed client #4 when he changed location in the day room and did not offer an activity to client #4. At 2:32 PM, client #4 sat on the arm of a sofa in the day room. Client #4 went without an activity offered to him. Client #11 remained to himself in the day room and stood near the dining room tables. Client #11 was not prompted to engage in formal or informal active treatment activities. Client #11 was not offered or prompted to engage in activities by the staff working in the facility. At 2:32 PM, client #11 entered the kitchen. The RM #2 followed client #11 into the kitchen and assisted him with obtaining a cup of tea to drink. At 2:55 PM, client #11 was in his bedroom lying in his bed. Client #11 went without an activity offered to him except for when he entered the kitchen and RM #2 assisted him with obtaining tea to drink. 1b. On 5/31/22 from 4:30 PM through 7:06 PM: Client #1 remained to himself in the day room. Client #1 was not prompted to engage in formal or informal active treatment activities. Client #1 was not offered or prompted to engage in activities by the staff working in the facility. At 5:18 PM, client #1 stood in the day room and stared at a peer seated at a dining table eating food brought back from the community. Client #1 was not prompted and went without an activity offered to him. At 5:47 PM, client #1 was seated in a dining room chair. Client #1 went without an activity offered to him. At 5:53 PM, client #1 paced throughout the day room and hallways. Client #1 went without an activity offered to him. At 6:20 PM, client #1 walked out of a bathroom nude and returned. No		Sensory room will be competed and included in active treatment. Staff will be trained to use sensory room. Management staff are scheduled to complete administration monitoring/intervention sheet. This will be completed once per shift each day. Meal prep training conducted to assure all ISP, BSP, and High-risk plans are followed. This applies to meals and snacks. To assure clients are being prompted to assist with meal prep and clean up per their goals and ability level. Including offering all utensils (unless restricted per BSP) and well as napkins and drinks. All staff retrained on family style dining including having clients serve themselves. Client # 11 now has physicians' orders for divided plate, and this will be added to dining plan. Staff will be trained. All staff were trained to provide re-direction by way of offering alternative activities to all clients involved in a situation. All staff were trained during all staff meeting on the following: If a client refuses to attend their personal shopping outing, they should be offered another activity to participate in with staff. This could include staff bringing the client to the rec room to eat their meal or offering to complete another activity with the client	

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	staff prompting was provided to client #1 as he reentered the bathroom to take a bath. At 6:22 PM, client #1 exited the bathroom a second time nude and walked down the hallways a few feet and returned to get into the tub. No staff prompting was provided to client #1 as he reentered the bathroom. At 6:23 PM, staff #7 was informed client #1 was left unattended in the bathroom and had exhibited rectal digging and was placing his hands up to his mouth. Client #1 then received supports and services provided by staff #7, LPN #3 (licensed practical nurse) and Residential Manager (RM #1) to finish his bathing and receive medical assessment in the medication administration room. Client #4 paced throughout the day room and engaged in physical aggression with his peers. Client #4 paced throughout the common living area referred to as the day room. As client #4 went past some of his peers, he would engage in physical interaction by hitting a peer. Staff #10 intervened with the use of physical redirection and stated, "Hey buddy, we don't hit our peers". At 4:41 PM, client #4 sat down on a sofa next to a peer. Client #4 reached over and touched the peer on the leg and the peer responded by hitting client #4 with a closed fist three times on his left shoulder blade area of his back. Staff #10 stated, "Hey [client #12], we don't hit others". At 4:42 PM, client #4 stood from the sofa and walked down the pacer hallway into a bedroom. Staff #10 verbally redirected client #4 and stated, "That's not your room, let's go to your room". Client #4 returned to day room and sat down beside the peer who hit him three times. No redirection by staff was provided to separate client #4 from the peer who had just hit him three times. At 4:47 PM, client #4 attempted to enter another bedroom. Staff #10 used a touch cue followed by verbal		(example: sitting outside with Client #8 or throwing the football with client #4). Staff should also document the client's refusal to attend the outing and what was done instead. All staff trained via in-service on maintaining the privacy of clients during personal care and how to maintain staff and client safety while privacy is being maintained. All staff were trained in all staff meeting of the following: Staff are to verbally redirect clients who are engaging in horseplay or boundary violations. Staff should not engage in horseplay with clients. Clients should not be giving each other "raspberries" or tickling one another due to the potential for a client to become upset. Goals were added to address drooling for clients #2, #8, and # 10. All staff were trained on new goals. All staff were trained to prompt (and assist when necessary) clients to change clothing when soiled or worn incorrectly (inside out, backwards, shoes on the wrong feet, etc). Also, to prompt clients for personal hygiene and putting clean clothes daily.	

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	redirection and stated, "No, we don't go into other people's bedroom". Client #4 was not offered or prompted to engage in activities by staff #10. Client #4 entered the bedroom and stood next to the curtain briefly before leaving to return to the day room. At 4:51 PM, client #4 reentered the day room and Residential Manager (RM #1) stated, "[Client #4] gave him (peer) a slap on his way through". Client #4 was not offered or prompted to engage in activities by the RM #1 or staff #10. At 4:55 PM, staff #10 requested staff #2 give him a break as the assigned one-to-one staffing with client #4. Staff #2 left client #4's bedroom to obtain a gray adult incontinent brief and returned. Staff #2 stated to staff #10, "He (client #4) can put it on". Client #4 then remained in his room for a period of time and no longer engaged in client-to-client physical interactions with his peers. At 5:24 PM, client #4 was seated in the day room among his peers waiting for the evening meal. Client #4 was not offered or prompted to engage in activities by staff. Client #4 would sit, stand and move to different sofas located in day room. Staff #2 followed client #4 when he switched locations to remain close to him, but client #4 was not offered or prompted to engage in activities by staff #2. At 6:44 PM, client #4's peers gathered in the day room and around the dining room tables in preparation for the evening meal. Client #4 was no longer in day room or with his peers seated around the dining room tables. At 6:50 PM, many of client #4's peers began eating their evening meal which consisted of a cheeseburger, french-fries, coleslaw, pudding and pink lemonade to drink. Client #4 was not in day room or the dining room among his peers during the evening meal. At 6:56 PM, staff #2 was asked where client #4 was. Staff #2 stated, "He's in his room. He eats			

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	at a different time than everyone else. He steals their food". Client #4's bedroom door was closed. At 6:58 PM, client #4 exited his bedroom with staff #6. Client #4 went into the day room while staff #6 took his plate and utensils to the kitchen. At 6:59 PM, staff #6 was asked why client #4 ate his meal inside his bedroom. Staff #6 stated, "Sometimes he prefers to eat in his room. He likes to steal food. Even if you're sitting beside him, he doesn't care. He is quick. Like a flash". Client #4 was not redirected and prompted to activities. Staff responded to client #4's behavior and movements in a reactive manner rather than redirection and prompts to replace physical interactions with his peers. Client #4's evening meal occurred in his bedroom, isolated and away from his peers during the mealtime. Client #11 remained to himself in the day room and stood near the dining room tables. Client #11 was not prompted to engage in formal or informal active treatment activities. Client #11 was not offered or prompted to engage in activities by the staff working in the facility. At 5:00 PM client #11 continued to stand near the dining room tables and paced from side to side. At 5:22 PM, client #11 continued to stand and pace side to side near the dining room tables. Client #11 was not prompted or offered an activity to engage in by the facility staff. At 5:47 PM, client #11 continued to pace in front of the dining room tables from side to side. Client #11 was not prompted or offered an activity to engage in by facility staff. At 6:17 PM, client #11 was seated at the table waiting for his evening meal. Client #11 was not prompted or offered an activity to engage in by facility staff. At 6:44 PM, client #11 continued to be seated at the table and wait for the evening meal. Client #11 was not prompted or offered an activity to engage in by facility staff. At 6:50 AM,			

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client #11 was eating. Client #11 ate his pureed food that spilled from a regular plate onto the dining room tabletop surface. Staff #2 was asked what food item client #11 was eating. Staff #2 stated, "Coleslaw". Client #11 was not provided and/or prompted to use a different plate or bowl during his evening meal. At 6:54 PM, client #11 finished eating and returned to his bedroom and laid down in his bed. Client #11 was not prompted or encouraged to stay upright for the 30 to 60 minutes as indicated within his health risk plan. Client #11 remained in his bed throughout the remainder of the observation ending at 7:06 PM.

1c. On 6/1/22 from 10:45 AM through 11:24 AM:

Client #1 remained to himself and was lying in his bed. Client #1 was not prompted to engage in formal or informal active treatment activities. Client #1 was not offered or prompted to engage in activities by the staff working in the facility. Client #1 stayed in his in his bed and went without an activity prompted to engage in.

Client #4 remained to himself in the day room. Client #4 was not prompted to engage in formal or informal active treatment activities. Client #4 was not offered or prompted to engage in activities by the staff working in the facility.

Client #11 was finishing a snack with pudding from 10:45 AM until 10:49 AM. At 10:49 AM, client #11 returned to his bedroom and laid down in his bed. Client #11 was not prompted or encouraged to stay upright for the 30 to 60 minutes as indicated within his health risk plan. Client #11 remained in his bed throughout the remainder of the observation ending at 11:24 AM. Client #11 was not offered or prompted to by facility staff to engage in activities.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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1d. On 6/1/22 from 2:22 PM through 3:24 PM:

At 2:22 PM, client #1's bedroom door was open and client #1 stood nude as staff #14 assisted client #1 with dressing. Client #1's bedroom door remained open while staff #14 assisted him with dressing. At 2:32 PM, client #1 was in the day room. Client #1 was not prompted to engage in formal or informal active treatment activities. Client #1 was not offered or prompted to engage in activities by the staff working in the facility. At 2:34 PM, client #1 went out onto the porch with group of his peers. Staff #6 sat between client #1 and a peer on the porch. Client #1 was not offered or prompted to engage in meaningful activities and by 2:55 PM, client #1 returned to the day room. At 3:04 PM, client #1 was seated at a dining room table. Client #1 was not offered or prompted to engage in activities. Staff #14 stated, "Ice cream is here. You guys need to sit down". At 3:12 PM, the Residential Manager (RM #2) started reviewing the orders for the milkshakes and passing them out. Client #1 was not offered or prompted to engage in activities by the staff working in the facility until the milkshake order had arrived.

Client #4 remained to himself in the day room. Client #4 was not prompted to engage in formal or informal active treatment activities. Client #4 was not offered or prompted to engage in activities by the staff working in the facility. At 2:22 PM, client #4 was seated in the day room without socks and shoes on and holding a small football. At 2:32 PM, client #4 remained seated in the day room without sock and shoes on holding the small football. At 2:40 PM, client #4 continued to be seated in the day room with no socks and shoes on holding small football. Client #4 was not offered or

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	prompted to engage in activity with the football by facility staff. Client #4 remained to himself while seated in the day room. At 2:44 PM, client #4 began slapping his left and right hands together making a vocalization. Client #4 was not offered or prompted to engage in activities. At 2:52 PM, client #4 was seated in the day room with his legs crossed. Client #4 was not offered or prompted to engage in activities. At 2:55 PM, client #4 remained in the day room and was not offered or prompted to engage in activities. At 2:59 PM, client #4 continued to sit with his legs crossed in the day room. Client #4 was not offered or prompted to engage in activities. At 3:00 PM, staff #14 stated, "He's harmless (client #4). He's my favorite." Client #4 was making vocalizations and swinging his arms. Client #4 was not offered or prompted to engage in activities. At 3:04 PM, staff #14 stated, "Ice cream is here. You guys need to sit down". At 3:06 PM, staff #10 brought milkshakes into the day room. At this time, staff #6 spoke to client #4 and used sign language and stated, "Sit down". At 3:14 PM, staff #14 was asked about activity participation at the facility. Staff #14 stated, "When I get here we do laundry. The sleep patterns are different for each. Most of them don't want to get up. They want to play games. We can't make them go to Life Skills (day service activities). At 2:30 PM they go to the Library. We try to include them, like throwing balls, community outings". Client #4 was not encouraged or offered to throw the football he had been holding or engage in an activity using it. Client #4 was not prompted or redirected from the sensory stimulation when he made vocalizations and rapid hand movements. Client #11 remained to himself in his bedroom and lying in his bed. Client #11 was not prompted to engage in formal or informal active treatment			

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	activities. Client #11 was not offered or prompted to engage in activities by the staff working in the facility. At 2:22 PM, client #11 was in his bed and made a vocalization indicating he was asleep. At 2:50 PM, client #11 walked out of his bedroom and into the day room. At 2:53 PM, client #11 verbalized to Residential Manager (RM #2) the word "tea". The RM #2 verbally redirected client #11 and indicated he should wait because ice cream would be arriving soon and he could drink his tea with his ice cream. Client #11 remained in the day room and went without an activity offered to him. At 2:55 PM, client #11 remained in the day room. At 3:00 PM, client #11 was at the dining room table drinking tea from his cup. At 3:03 PM, client #11 stood and returned to his bedroom and laid down in his bed. Client #11 was not prompted to engage in formal or informal active treatment activities. Client #11 was not offered or prompted to engage in activities by the staff working in the facility. At 3:06 PM, staff #10 brought milkshakes into the day room. Client #11 remained in his room and was not prompted or offered a milkshake or ice cream as the RM #2 had indicated to client #11 was coming. At 3:20 PM, client #11 remained in his bedroom and went without activities offered to him. Staff #14 was asked if client #11 got a milkshake. Staff #14 stated, "Did [client #11] get a milkshake"! At 3:21 PM, staff #14 entered client #11's bedroom and verbally prompted client #11 to come out to the day room to get his milkshake. At 3:23 PM, staff #14 was verbally prompting client #11 to try his milkshake and then stated, "I knew he would refuse. He only likes tea". 1e. On 6/1/22 from 4:44 PM through 6:07 PM: At 4:44 PM, client #1 was outside with the Program Manager and Qualified Intellectual Disabilities Professional (QIDP). At 4:50 PM,			

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	client #1 returned inside and went to his room and then the day room and sat on a sofa. At 5:06 PM, client #1 was walking with Residential Manager (RM #4) and entered a bathroom. At 5:07 PM, the RM #4 was asked about client #1. RM #4 stated, "[Client #1] is not soiled, but he has a lot of energy. It's just easier to change him in the bathroom". At 5:22 PM, client #1 was pacing and went into client #11's bedroom. The RM #4 followed client #1 into client #11's bedroom. Client #1 returned to the day room and went without an activity offered to him. At 5:27 PM, client #1 went up to a window behind the dining room tables, opened it, tapped the right corner and turned toward the day room and jumped up and down and paced throughout the day room toward the kitchen. At 5:30 PM, the Program Manager brought shoes to client #1. At 5:32 PM, the Program Manager took client #1 outside. At 5:38 PM, a peer of client #1 announced in the day room that client #1 was "naked outside". The RM #4 then went outside. At 5:41 PM, the Behavior Clinician entered the facility and went into client #1's bedroom and obtained an adult incontinent brief. At 5:54 PM, staff #10 brought a tray of food over to the dining room table and RM #4 stated, "[Client #1] is not made up yet". Client #1 was in the dining room and waited for RM #4 to put a plate of fish, macaroni and cheese and mixed vegetables together for him. During the observation, client #1 received prompting and redirection from staff in a reactive manner to his pacing, jumping, and the energy level indicated by RM #4. Client #1 was not offered an activity until taken outside. Client #4 remained to himself between his bedroom and the day room. Client #4 was not prompted to engage in formal or informal active treatment activities. Client #4 was not offered or			

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prompted to engage in activities by the staff working in the facility. At 4:44 PM, client #4 was sitting on his bed. Staff #10 was in client #4's bedroom with him. Client #4 was not engaged in an activity. Client #4's television was on, but he was not watching it. At 5:05 PM, client #4 continued to sit on his bed. Residential Manager #3 was in client #4's bedroom. Client #4 was not engaged in an activity. Client #4's television was on, but he was not watching it. At 5:12 PM, client #4 came out of his bedroom and into the day room. Staff #2 followed client #4 as he entered the day room. At 5:22 PM, client #4 was sitting on a sofa in the day room. Client #4 used his right hand to repeatedly hit his face. Client #4 was not provided redirection or offered an activity. At 5:41 PM, client #1 had returned to his bedroom. Client #4 was sitting on his bed. Client #4 was not engaged in an activity. At 5:45 PM, staff #2 verbally prompted client #4 to sit down in his chair in his room to prepare to eat his evening meal. At 5:47 PM, the RM #4 brought a tray with client #4's foods to him in his bedroom. Client #4 was served fish, macaroni and cheese and mixed vegetables. Client #4 remained in his bedroom during his meal until finished at 5:51 PM. During observation, client #4 was not offered or engaged in activities. Client #4 remained in his bedroom during most of the observation period which included his evening meal away from his peers in the dining room. Client #4 was not prompted to engage in formal or informal active treatment activities.

Client #11 remained to himself in the day room and stood near the dining room tables. Client #11 was not prompted to engage in formal or informal active treatment activities. Client #11 was not offered or prompted to engage in activities by the staff working in the facility. At 4:44 PM, client #11

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	stood near the dining room tables. Client #11 was not engaged in an activity. At 5:10 PM, client #11 continued to stand near the dining room tables and paced from side to side. Client #11 was not offered or engaged in an activity. Client #11 was not prompted to engage in formal or informal active treatment activities. At 5:22 PM, client #11 stood near the dining room tables and paced side to side. Client #11 was not offered or engaged in an activity. Client #11 was not prompted to engage in formal or informal active treatment activities. At 5:54 PM, staff #10 brought a tray with food and sat it down at the table where client #11 eats his meals. Client #11's high sided divided plate had one single pureed food item. At 5:56 PM, staff #10 was asked what client #11 was being served for his evening meal. Staff #10 stated, "Looks like vegetables". At 6:03 PM, client #11 finished eating and stood up from the table. Client #11 returned to his bedroom and laid down in his bed. Client #11 was not prompted or encouraged to stay upright for 30 to 60 minutes after eating his meal as indicated in his health risk plan. At 6:05 PM, RM #3 was asked about client #11's pureed food served to him and what it consisted of. The RM #3 stated, "He had mixed vegetables, fish and mac (macaroni) and cheese. I was the one that prepared his plate. It was all mixed as one together. At times he can be particular if things are touching. That way he's not missing eating something". Client #11's dining plan did not indicate food preferences. Client #11's dining plan did not indicate the use of a high sided divided plate. The two observations of client #11's evening meals indicated an inconsistency with the preparation of client #11's pureed foods as individual items and/or what could be mixed based on preference of client #11, an inconsistency with the use of a regular plate or high side divided plate and how to prevent spilled			

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foods, and a failure on staff's part to prompt and encourage client #11 to remain upright 30 to 60 minutes as indicated within client #11's health risk plan.

1f. On 6/1/22 at 11:42 AM, client #4's record was reviewed. The record indicated the following:

-Individual Support Plan (ISP) dated 2/10/22 indicated the following needs:

"Needs to improve money skills
Needs to improve bathing skills unassisted
Needs to improve toileting skills unassisted
Needs to improve dressing skills unassisted
Needs to improve hygiene skills unassisted
Needs to initiate own activities
Needs assistance to schedule and keep appointments
Needs supervision
Needs to improve leisure skills
Needs to improve cooking skills
Needs to learn responsibility
Needs to improve kitchen safety skills
Needs to learn shopping skills
Needs to improve communication skills
Needs to improve socialization skills
Needs to learn responsibility
Needs to improve social skills
Needs to learn to use postal services
Needs to learn about welfare facilities
Needs to learn to use banking facilities
Needs to learn to budget money
Needs to improve social interaction
Needs to learn appropriate interaction with women
Needs to learn to fill out main items on an application
Needs to learn to initiate tasks
Needs to learn to perform a job requiring use of tools or machinery

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	Needs to learn to have active interest in a hobby Needs to learn to initiate group activities Needs to learn multiplication and division Needs to improve adding and subtracting skills Needs to improve how to use table ware correctly." The ISP indicated client #4's "Priority Objectives" as: "Self-Medication Skills Oral Hygiene Skills Mealtime Skills Personal Hygiene Skills Emotional Regulation Social Interaction Laundry Room Access Money Management Reporting Abuse, Neglect, Exploitation, Mistreatment and Avoiding False Allegations". Client #4's undated active treatment schedule indicated the following schedule: "Saturday and Sunday: 6:00 am - sleep, 7:00 am - am hygiene and breakfast, 8:00 am - am hygiene/breakfast, 9:00 am - clean up and church (Sunday), 9:00 am - room clean up (Saturday), 10:00 am - life skills, 11:00 am - leisure time/meal prep, 12:00 pm - lunch, meds (medications)/ clean up, 1:00 pm - clean up/leisure, 2:00 pm - activity of choice/snack, 3:00 pm - van ride/activity of choice, 4:00 pm - physical activity in gym, 5:00 pm - meal prep (preparation), 6:00 pm - dinner/clean up, 7:00 pm - recreation time, 8:00 pm - meds (medication), 9:00 pm - pm hygiene/leisure, 10:00 pm - quiet time. Monday, Tuesday, Wednesday, Thursday, and Friday - 6:00 am - sleep, 7:00 am - am hygiene/breakfast, 8:00 am - am hygiene/breakfast,			

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	9:00 am - room clean up, 10:00 am - life skills, 11:00 am - leisure time/meal prep, 12:00 pm - lunch, meds/clean up, 1:00 pm - life skills, 2:00 pm - activity of choice/snack, 3:00 pm - van ride/activity of choice, 4:00 pm - physical activity in gym, 5:00 pm - meal prep, 6:00 pm - dinner/clean up, 7:00 pm - recreation time, 8:00 pm - meds, 9:00 pm - pm hygiene/leisure, 10:00 pm - quiet time". -Behavior Support Plan (BSP) dated 5/23/22 indicated, "Target Behaviors:... Physical Aggression: Any occurrence or attempts at hitting people... or behaviors that produce or have the potential to produce an injury to others ... Goal: [Client #4] will demonstrate 2 or fewer acts of this target behavior per month for 3 consecutive months by 5/22... Reactive Procedures (Physical Aggression): 1) Immediately ensure the health and safety of everybody in the immediate environment. 2) Redirect him (client #4) and/or others to a different area of the environment. 3) Tell him to stop the behavior. 4) If he stops the behavior, redirect him to a safe location and problem solve with him and praise him for doing this with us. 5) If the behavior continues, block all attempts of aggression and attempt to redirect, if the behavior continues and he is placing himself or others in danger, implement You're Safe I'm Safe (YSIS) beginning with the least restrictive measures ...". 1g. On 6/1/22 at 1:04 PM, a focused review of client #11's record was conducted. The record indicated the following: -Individual Support Plan (ISP) dated 8/11/21 indicated, "Adaptive Equipment: Wedge cup set to half open. Adaptive Utensils: Smaller spoon ... Area: Adaptive Equipment. Goal: To improve			

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adaptive equipment skills thus increasing independence. Objective: [Client #11] will use his small spoon during meals independently 100% of opportunities per month for 12 months by 8/11/22
...

ISP indicated the following needs:

"Needs to improve self-toileting skills
Needs to improve money skills
Needs to initiate own activities
Needs assistance to schedule and keep appointments
Needs supervision
Needs to use appropriate tone of voice when speaking
Needs to improve leisure skills
Needs to improve cooking
Needs to learn responsibility
Needs to improve kitchen safety skills
Needs to learn shopping skills
Needs to improve communication skills
Needs to socialization skills
Needs to learn to use postal services
Needs to learn about welfare services
Needs to use banking facilities
Needs to learn to budget money
Need to improve social interaction
Needs to fill out main items on an application
Needs to learn to initiate task
Needs to learn to perform a job requiring use of tools or machinery
Needs to learn to have an active interest in a hobby
Needs to learn to initiate group activities
Needs to learn multiplication and division
Needs to improve adding and subtracting
Needs to improve how to use table ware correctly."

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The ISP indicated client #11's "Priority Objectives" as:

Self-medication skills
Oral hygiene skills
Domestics
Personal safety
Personal hygiene
Reporting ANEM (abuse, neglect, exploitation and mistreatment)
Adaptive equipment
Social interaction
Safety".

-Health Risk Plan dated 5/19/21 indicated, "Dysphagia (swallowing difficulty), Aspiration (foreign object in lung), Potential for GERD (gastroesophageal reflux disease) ... Actions: 6. Sit upright while eating and have (sic) encourage him to sit up for 30-60 minutes after meals ...".

Client #11's undated active treatment schedule indicated the following schedule:

"Saturday and Sunday: 6:00 am - sleep, 7:00 am - am hygiene and breakfast, 8:00 am - am hygiene/breakfast, 9:00 am - clean up and church (Sunday), 9:00 am - room clean up (Saturday), 10:00 am - life skills, 11:00 am - leisure time/meal prep, 12:00 pm - lunch, meds (medications)/ clean up, 1:00 pm - clean up/leisure, 2:00 pm - activity of choice/snack, 3:00 pm - van ride/activity of choice, 4:00 pm - physical activity in gym, 5:00 pm - meal prep (preparation), 6:00 pm - dinner/clean up, 7:00 pm - recreation time, 8:00 pm - meds (medication), 9:00 pm - pm hygiene/leisure, 10:00 pm - quiet time.

Monday, Tuesday, Wednesday, Thursday, and Friday - 6:00 am - sleep, 7:00 am - am hygiene/breakfast, 8:00 am - am hygiene/breakfast,

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	9:00 am - room clean up, 10:00 am - life skills, 11:00 am - leisure time/meal prep, 12:00 pm - lunch, meds/clean up, 1:00 pm - life skills, 2:00 pm - activity of choice/snack, 3:00 pm - van ride/activity of choice, 4:00 pm - physical activity in gym, 5:00 pm - meal prep, 6:00 pm - dinner/clean up, 7:00 pm - recreation time, 8:00 pm - meds, 9:00 pm - pm hygiene/leisure, 10:00 pm - quiet time". On 6/2/22 at 1:35 PM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked about implementation of active treatment and how staff should provide redirection. The QIDP stated, "Every 15 minutes the individuals should be engaged for the goals in their plans". The QIDP was asked about implementation of goals. The QIDP stated, "Goals are pretty much daily". The QIDP was asked about implementation of schedules. The QIDP indicated schedules should be followed and stated, "Yes". The QIDP was asked if both in formal and formal training and teachable moments should be prompted and encouraged by staff. The QIDP stated, "There is an expectation. There are skills that they (staff) should work on (with clients). Yes". On 6/2/22 at 2:55 PM, the Program Manager (PM) was interviewed. The PM asked about implementation of active treatment and how staff should provide redirection. The PM indicated staff should and stated, "Getting them (clients) engaged". The PM was asked about if active treatment schedules should be followed. The PM stated, "Yes. They (staff) can offer activities here on campus. There are games, movies room, Library and also activities on the unit". The PM was asked how staff should prompt to encourage implementation of goals, plans, and schedules to ensure active treatment was being provided. The			

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

PM stated, "We try to get them (staff) to prompt every 15 minutes".
2. Observations were conducted in the group home on 5/31/22 from 11:20 am through 12:41 pm and from 4:30 pm through 7:10 pm, on 6/1/22 from 10:45 am through 11:22 am, from 2:22 pm through 3:20 pm, and from 4:45 pm through 6:08 pm.

On 5/31/22 at 11:20 am, client #10 was in the gymnasium with Direct Support Professional (DSP) #15. Client #10 was wearing a polo shirt inside out, black sneakers with the tongue of the the left shoe pushed down into the toe of the shoe and no socks. When asked about his shoes and socks, client #10's response was unrelated. Direct Support Professional (DSP) #15 indicated staff should prompt client #10 to fix his shoes. DSP #15 stated, "When you go back inside [client #10], you need to put on socks."

At 11:35 am, there were no clients in the recreation room, movie room, library, or art room of the activity building.

From 11:53 am until 12:41 pm, client #3 was seated at a table in the corner of the dining room. Client #3 was not approached by any staff and did not engage with any clients. Client #3 sat silently and observed the room.

At 11:53 am, client #7 was setting the tables for lunch. Residential Manager (RM) #1 was mopping the floor in the dining area. RM #1 did not prompt any clients to assist with cleaning the floor. In the main living area (day room) and dining area, clients were wandering around without directed activity. The room was loud and chaotic. At 11:54 am, client #6 approached the surveyor and stated, "All of this yelling makes me mad."

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	At 11:56 am client #10 was sitting on a sofa in the day room while waiting for lunch to be served. Client #13 walked behind the sofa and client #10 screamed. Client #13 and client #10 shouted at one another. Client #10 yelled, "He hit me." RM #2 separated clients #10 and #13. At 12:15 pm, clients #10 and #13 were seated at separate tables waiting for lunch to be served. Client #10's back was to client #13, and client #13 was facing client #10. Client #13 began banging his fist on the table. Client #10 stated, "Please stop." Client #13 continued banging on the table with his fist. Client #10 shouted, "Stop." Client #13 shouted, "Shut the f*** up." Client #10 shouted, "You shut up." RM #2 stated, "[Client #10], just ignore him. You have an outing. He's not worth losing an outing." RM #2 did not address client #13. Client #13 continued banging on the table. Clients #10 and #13 continued shouting at one another. Client #10 put his fingers in his ears and began screaming. Client #13 shouted, "F*** you." Client #10 shouted, "Stop, please stop." RM #2 prompted client #10 to get his noise canceling headphones. Client #10 stated, "I'll go get my headphones." Client #10 got up from the table and left the room. When client #10 left the room, client #13 stopped banging on the table. Client #10 returned with his noise canceling headphones. When			

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	client #10 entered the day room and was within sight of client #13, client #13 resumed banging his fist on the table. When client #10 returned to the table, client #15 was in the seat client #10 had left. Client #10 protested and asked client #15 to move. RM #2 stated, "[Client #10], [client #15] was there first. Go to another table." Client #10 moved to another table and took off his noise canceling headphones. Client #13 resumed banging his fist on the table. Client #10 shouted, "Please stop."At 12:15 pm, client #8 stated, "I'm getting fried chicken and french fries. I'm getting [fast food restaurant]." At 12:22 pm, Residential Manager (RM) #2 stated, "Today is [client #8's] outing. He's getting [fast food restaurant]. He's waiting for [client #5] and [Direct Support Professional (DSP) #6] went to get it." When asked why client #5 went on client #8's outing, RM #2 stated, "[Client #8] doesn't like to go on the van."DSP #6 was interviewed on 6/2/22 at 2:30 pm and stated, "Sometimes [client #8] will go on an outing. Sometimes he'll refuse. He doesn't like hills or going fast in the van. It scares him. We could offer a 1 on 1 activity here. He does enjoy the meal, he just doesn't want to go pick it up." DSP #6 stated, "I don't know if we'd offered other activities."At 12:23 pm, pizza and vegetables were served. At 12:26 pm, DSP #2 was			

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	seated in a metal chair outside of client #2's bedroom. DSP #2 stated, "[Client #2] has been throwing up his food. We have to watch him eat. The nurses are concerned he's choking." DSP #2 indicated client #2 spent most of his time in his bedroom and usually ate in his bedroom. DSP #2 stated, "He doesn't like loud noises. He stays in his room." When asked if there were quiet activities planned for client #2, DSP #2 stated, "We ask if he wants to come hang out with everyone else." When asked again if there were quiet activities planned for client #2, DSP #2 stated, "No. There isn't anything planned for him." DSP #2 stated, "He likes [client #15]. They know each other from [another facility], but he prefers to be in his room."RM #1 was interviewed at 12:35 pm. RM #1 was asked if any clients were not eating with the group. RM #1 stated, "Today is [client #11's] outing day. Sometimes he'll go to get it, but if he's asleep we don't wake him up. We go get it and bring it back here. He's full puree, so he always eats here." RM #1 stated, "[Client #12] isn't out here. A lot of times he'll sleep through meals. He leaves for good tomorrow, so we're letting him sleep."At 12:40 pm, client #13 walked past client #10 and clapped his hands loudly. Client #10 screamed, "Stop." Client #13 stated, "Shut up."At 4:31 pm, client #3 was standing in the			

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	corner of the dining room. Most of the clients were in the day room and were not engaged in any organized activity. At 4:32 pm, client #8 approached the surveyor and stated, "Take me to the porch." The surveyor indicated she could not take client #8 outside and advised him to ask his staff. Client #8 approached DSP #6 and asked to go outside. DSP #6 stated, "I will in a minute." At 4:34 pm, client #8 approached the survey and stated, "Please take me to the porch, ma'am." The surveyor indicated she could not take client #8 out of the building and advised him to ask staff. Client #8 approached DSP #6 and asked to go outside. DSP #6 stated, "In a minute." At 4:34 pm, client #3 was standing at the front door, looking out the window.At 4:40 pm, client #3 was standing in the kitchen, watching staff and client #14 prepare the evening meal. Client #8 followed the surveyor into the kitchen and again asked to go outside. Client #10 was lying on the sofa. Client #4 came near to client #10, and client #10 screamed. RM #2 stated in a loud voice, "How does it help if you scream, too?" Clients #4 and #10 were not redirected to other activities.At 4:43 pm, client #3 was standing by the kitchen door.At 4:48 pm, [client #12] asked RM #2, "What's for dinner?" RM #2 stated, "You just hit [client #4], what are you asking			

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	me questions for?"At 4:51 pm, client #3 was standing inside the kitchen. Client #4 ran past client #10. Client #10 yelled, "He hit me." RM #2 stated, "Everybody knows, [client #10]." Client #3 stood outside the kitchen door. Clients #4 and #10 were not redirected to another activity.At 4:54 pm client #3 went back inside the kitchen to watch staff cook. DSP #9 stated, "He likes to stand in here. Sometimes we ask him to help, but he doesn't do much."On 5/31/22 at 5:03 pm clients #3 and #13 were in the day room waiting for dinner to be served. Client #3 was in the kitchen watching staff preparing the meal. Client #3 walked out of the kitchen. Client #13 stood in the doorway of the kitchen and used his arms to block the doorway. Client #3 walked up to client #13 and looked at him. Client #3 attempted to step around client #13 to enter the kitchen. Client #13 blocked client #3. Clients #3 and #13 stared at one another. Client #3 poked client #13's glasses. Client #13 slapped client #3's hand away. Client #19 walked up to the kitchen door and client #13 moved away to let him pass. Client #3 attempted to follow client #19, and client #13 blocked him. DSP #2 walked to the kitchen door, and client #13 moved out of the way. Client #3 followed client #19 into the kitchen. Client #13 followed client #3 into the kitchen. Clients #3 and #13			

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	stood facing one another and stared at one another. DSP #10 stated, "Hey, don't start." Client #1 walked into the kitchen, and client #13 grabbed each of his elbows from behind and pushed client #1 out of the kitchen. Client #13 left the kitchen. DSP #10 followed client #13 and spoke with him in the hallway away from client #3. Client #3 remained in the kitchen. Clients #3, #19, and #1 were not redirected to other activities.Client #13's record was reviewed on 6/1/22 at 4:15 pm.Client #13's BSP dated 5/13/22 indicated the following:"Target Behaviors:Instigation: [Client #13] can engage in provoking/instigation type behaviors towards others and he has demonstrated that he will bully or even engage in aggression toward peers who are much lower functioning than him. If a peer is being loud, [client #13] may go after that peer or may threaten to hurt that peer....Reactive Procedures:For Instigation:- If he is taunting a peer, firmly but calmly tell him that the behavior is not appropriate but do not give excess attention to him for the undesired behavior.- Redirect him or the peer who is being instigated with a different activity or to a different area.- If he is engaging in instigation in view of a peer, remain between the two peers."DSP #2 was interviewed on 6/2/22 at 11:53 am and stated, "[Client #13] does the fist pounding			

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	to instigate. We're supposed to try to correct him. He says he's bored. He stares at his peers and makes it know he's try to get them worked up." DSP #2 stated, "[Client #13] isn't supposed to touch anyone. If he's acting as staff, we're supposed to correct him. We tell him not to touch his peers. He should be written up for physical, and staff should redirect him."At 5:06 pm Licensed Practical Nurse (LPN) #3 stated, "Come on [client #10]. Let's go outside for a walk." Clients #19 and #8 followed LPN #3 and went outside with her. Client #3 was standing in the kitchen.RM #2 was interviewed at 5:09 pm and stated, "There is no schedule or activity right now. We're waiting for dinner."Client #6 came out of the kitchen with a individual serving of green beans. Client #6 sat down at a table and began eating the green beans by pouring them into his mouth. Client #6 did not have a utensil.On 5/31/22 at 5:18 pm, client #16 returned to the facility from an outing. Client #16 sat down at a table in the dining room with a bag from a fast food restaurant. Client #16 opened 2 burritos and a soft taco and ate them over a paper wrapper. Client #16 did not have a drink with his meal. Client #16 stopped eating several times to lick sauce from his fingers. Client #16 stated, "I was supposed to have a drink, but I guess I didn't get one." Staff did not			

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	prompt client #16 to use a napkin.Client #19 was interviewed at 5:20 pm and stated, "I like to go to any restaurant. I go every Wednesday. I always bring it back here to eat. We're not supposed to go into the restaurant because of COVID. We did go to the movies last week. It was like 5 people." DSP #2 overheard the conversation with client #19 and stated, "They only go on outings on weekends." Client #19 stated, "I used to work at [workshop]. I don't work there anymore. They won't renew the contract." Client #19 indicated he would like to have a job, so he would have more money.At 5:22 pm, client #3 was standing in the kitchen watch staff prepare the evening meal.At 5:25 pm, client #3 walked up to client #16. DSP #2 walked between the two and did not say anything. Client #3 walked away. Clients #16 and #3 were not redirected to another activity. DSP #14 was interviewed at 5:30 pm and stated, "[Client #16] went through the drive through. He also went to [thrift store]."At 5:33 pm, client #19 yelled, "Back up. Back up, [client #3]. He grabbed my shoulder." DSP #2 stepped between clients #3 and #19. Client #3 approached client #19. Client #19 made an unheard remark. Client #3 shouted, "Do it. I'm not scared of you." Client #19 turned and walked down the hallway. Client #19 was called to the			

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	medication room. Client #19 turned and walked back down the hall towards the medication room and client #3. Client #3 stated, "I'll come at you." Client #19 stated, "Do it." LPN #3 stepped between clients #3 and #19 and directed client #19 inside the medication room." Client #3 turned to client #8 and the two stared at one another. DSP #2 stepped between them. Client #3 was not redirected to another activity.At 5:45 pm, client #6 approached the surveyor and said something. Client #6 could not be heard over the noise in the day room. The surveyor asked client #6 to repeat what he said. Client #6 shouted, but the surveyor could not hear him well enough to understand what he said.At 5:48 pm, client #8 poked client #5 on the top of his head. Client #5 swatted client #8's hand away. RM #2 stated to client #8, "What's wrong with you? Don't do that."At 5:50 pm, clients #3, #7, #8 #9, and #19 were waiting for the evening meal to be served. Client #19 stated to client #8, "Do you want to go outside?" Client #19 was holding a football and a pair of cleats. Client #19 gathered clients #7, #8, and #9 and stated, "This is the only time we'll get to go outside today. Come on, let's go." Clients #7, #8, #9, and #19 walked to the end of the hallway and congregated at the door. Client #3 followed. At 5:53 pm, client #19 walked up			

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	the hallway to the day room, approached DSP #7 who was leaning on the kitchen door and stated, "Will you take us out? [DSP #10] said he would, but I don't know where he went." DSP #7 refused client #19 but did not give a reason. DSP #7 turned away from client #19 and walked outside through the kitchen door. DSP #10 was standing in the pantry inside the kitchen. Client #19 walked back down the hallway and stood with clients #3, #7, #8, and #9 by the exit door. At 5:56 pm, client #7 was at the far end of the hallway by the exit door. DSP #2 was in the day room at the opposite end of the hallway. Client #7 shouted to DSP #2, "[client #3] is threatening people." DSP #2 shouted back, I'm the only staff in the day room, and I'm 1:1 for [client #4]. I can't help you." DSP #2 called DSP #10 from the kitchen and stated, "Can you deal with [client #3]? I guess he's threatening people." DSP #10 walked to the end of the hallway and began conversing with client #3. DSP #2 stated, "They were going to go out with [DSP #10], but he was in the kitchen. I don't know why he didn't take them out." At 6:06 pm, client #9 left the group at the door and went to the dining area to sit down. Clients #7 and #19 sat down on the floor with their backs against the floor. Client #8 wandered away. DSP #10 continued talking with client #3. DSP #10			

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	directed clients #7 and #19 to leave the area. Clients #7, #8, #9, and #19 were not redirected to another activity.Client #19 was interviewed on 5/31/22 at 6:08 pm and stated, "We couldn't go out because [client #3] had a behavior. [DSP #10] said he would take us."DSP #10 was interviewed on 5/31/22 at 6:51 pm and stated, "[Client #3] was being verbally aggressive towards the others. It progressed and he prolonged until dinner was done, so they didn't have time to go outside." When asked why he didn't take the clients outside when they were ready, DSP #10 stated, "I got distracted talking to other staff."DSP #2 was interviewed on 6/2/22 at 11:53 am and stated, "Staff should follow through. We shouldn't say we'll do something then not do it. If [DSP #10] had done what he said, there wouldn't have been an issue."RM #4 was interviewed on 6/2/22 at 12:36 pm and stated, "If they ask to go somewhere, staff should just go. They shouldn't make them wait. Just go with them. They stand at the door and bicker."Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 6/2/22 at 1:34 pm and stated, "Staff shouldn't make a promise without a plan and a set time. Staff should be aware of what is happening before they say they'll do something. Staff shouldn't send [client #19] to get a group together. If			

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	the staff couldn't take them, he shouldn't have sent [client #19] to get a group."Behavior Clinician (BC) #1 was interviewed on 6/2/22 at 3:20 pm and stated, "Staff caused that behavior. Staff should follow through on what they say they'll do."At 5:50 pm, client #18 sat down at a dining table with small prepackaged container of green beans. Client #18 peeled back the plastic cover and began drinking the juice from the cup. Client #18 then dumped the contents of the cup into his mouth and ate them. Client #18 indicated he was eating green beans because he was hungry and the evening meal was not ready. Client #18 indicated staff gave him the snack. Client #18 indicated he was not offered a utensil. Staff did not prompt client #18 to use a utensil.At 6:05 pm, clients #10 and #14 returned to the facility from an outing. Clients #10 and #14 sat down at a table in the dining room with bags from a fast food restaurant and a gas station. Clients #10 and #14 were not provided with plates, utensils, or napkins. Clients #10 and #14 had slushies to drink. Client #10 dumped a burrito and a doughnut onto the bare table and proceeded to eat them with his fingers. Staff did not prompt clients #10 or #14 to use napkins or to place their food items onto a plate. When clients #10 and #14 got up from the table, there was lettuce and donut			

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	icing scattered across one half of the table and on the floor where they had been sitting.At 6:12 pm, client #8 charged at client #5 and yelled loudly. RM #2 stated, "Hey, don't do that." RM #2 did not redirect client #8 to an activity.At 6:51 pm, client #7 was seated at a dining table. Client #7 stood and shouted at an unidentified clients, "You're not going to do anything. Shut the f*** up." DSP #9 stated, "Why are you antagonizing him?"At 6:57 pm, client #4 sat on a sofa in the day room and picked up client #10's glasses. DSP #2 stated, "Whose are those?" DSP #2 gave the glasses to client #10 and instructed him to put them on.DSP #9 began serving cheese burgers and french fries. DSP #9 had all of the food on a cart and served each client using tongs. DSP #9 gave each client french fries then a burger patty then a bun. DSP #9 stated, "I'll bring condiments around after everyone has a sandwich. Throughout the meal, client #10 was screaming and making loud vocalizations. RM #2 stated, "You had [fast food restaurant], now you're ruining everyone else's dinner."At 6:58 pm, client #1 got up from the dining table, walked to client #3's table and grabbed a handful of french fries. Client #1 ate some fries and dropped some on the floor and table. Staff did not address client #1. At 7:00 pm, client #3 asked for more french fries. DSP #7 stated,			

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	"Do you want more?" Client #3 stated, "Yes." DSP #7 stated, "What do you say?" Client #3 stated, "Please, please, please." DSP #7 stated, "You only have to say it one time. You need to be patient." Client #7 walked past client #3, and client #3 reached out to slap client #7. Client #7 dodged the slap and continued on.At 7:02 pm, client #1 walked to client #6's table and grabbed a handful of french fries from his plate. Client #6 protested verbally, but staff in the dining area did not respond to client #1.At 7:03 pm, client #3 went to the kitchen and asked for more french fries. DSP #7 redirected client #3 to his table and stated, "You have to be patient." At 7:04 pm, client #19 brought a bowl of french fries to client #3 and dumped them onto his plate.At 7:04 pm, client #1 went to client #9's table and tried to grab food from client #9's plate. Residential Manager (RM) #4 covered client #9's plate with her hands. When client #1 reached for client #9's plate, he pushed RM #4's hands into client #9's food.- Staff did not redirect client #1 away from the dining area.DSP #2 was interviewed on 6/2/22 at 11:53 am and stated, "Staff should redirect client [client #1] away from the dining area when he's done eating."On 6/1/22 from 10:45 am through 11:07 am, clients #1, #2, and #17 were in their beds sleeping.On 6/1/22 at 2:22 pm, client #1 was in his			

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	bedroom with Direct Support Professional (DSP) #14. Client #1's bedroom door was open, and he was not wearing any clothing. DSP #14 assisted client #1 to put his disposable briefs on. DSP #14 stated, "Let me get you some clothes." DSP #14 assisted client #1 to put on a t-shirt and shorts. DSP #14 placed foam shoes on the floor in front of client #1 and directed him to put them on. DSP #14 stated, "Those are the wrong feet. It doesn't really matter. Go." Client #1 walked out of his bedroom.DSP #14 was interviewed on 6/1/22 at 2:31 pm and stated, "I don't feel comfortable with the door shut with [client #1]."DSP #2 was interviewed on 6/2/22 at 11:53 am and stated, "Doors should be shut for privacy. No one should be seeing a client naked. There is no reason for [client #1's] door to be open while he's dressing."Residential Manager (RM) #4 was interviewed on 6/2/22 at 12:36 pm and stated, "Doors should be shut for privacy. Some of the others are nosy and will try to look through the doorway." RM #4 stated, "If a staff is uncomfortable, they could ask for a second staff to assist."Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 6/2/22 at 1:34 pm and stated, "If staff can't shut the door, there should be 2 staff with the door shut."Program Manager (PM) #1 was			

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	interviewed on 6/2/22 at 2:56 pm and stated, "Staff should close the door while providing personal care."At 2:22 pm, client #11 was asleep in his bed. Client #2 was sitting at a dining table with a milkshake. Client #3 was outside on the porch with staff.At 2:27 pm, client #8 was standing the day room. A string of drool had fallen from client #8's chin and was on his shirt. The front of client #8's shirt was wet. DSP #14 stated, "[Client #8], you go potty. I'll get you a drink." Client #8 was not prompted to wipe his mouth or to change his shirt.At 2:30 pm, client #2 finished drinking his milkshake. DSP #14 stated, "I'll clean up your mess. You can go." DSP #14 cleared client #2's place at the table.At 2:41 pm, clients #1, #2, #4, and #15 were in the day room with RM #1 and DSPs #2 and #14. Client #2 was walking up the hallway from his bedroom, and client #15 approached with his arms outstretched. Client #15 wiggled his fingers towards client #2 and stated, "Here comes the tickle monster." Client #2 laughed and ran from client #15. Client #2 and #15 hugged and tickled one another. Client #2 began running down the hallway, and client #15 chased after him. Client #2 went into his bedroom, and client #15 returned to the day room. Client #2 returned to the day room. Clients #2 and #15 stood face to face. Client #2 put his			

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	tongue between his lips and blew out causing a vibrating sound and causing saliva to fly into client #15's face. Client #15 laughed and stated, "You're blowing raspberries." Client #15 returned the gesture and both laughed. Client #2 repeated the gesture, again causing saliva to fly into client #15's face. RM #1 stated, "[Client #15]." Client #15 stated, "I'm good. I'm used to it." Client #15 stated to client #2, "Show her," and indicated the surveyor. Client #2 turned towards the surveyor, and DSP #2 stated, "No. Don't do that." Client #2 began chasing RM #1 around the room, and RM #1 ran from him. Client #2 was not redirected from chasing RM #1. Client #15 approached client #2 from behind, placed his arms under client #2's arms and gave him a full body hug. Staff did not redirect clients #2 and #15 from the hug. At 2:45 pm, client #2 down the hallway towards his bedroom. Client #15 shouted after him, "Run [client #2], run." RM #1 stated to client #15, "As long as he's not hitting people. He slammed me into the thing yesterday." Client #2 returned from his bedroom. There was saliva dripping from his chin onto his shirt. Client #2 was not prompted to wipe his face or to change his shirt. RM #1 ran down the hallway and into a bedroom. Client #2 chased after RM #1 and went into client #9's bedroom then into clients #19 and			

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	#15's bedroom. Clients #15 and #2 went into both bedrooms to look for RM #1. Client #15 and DSP #14 encouraged client #2 to continue chasing RM #1 and to look for her. RM #1 came out from a bedroom while client #2 was not looking and ran into the kitchen. Client #2 followed, and RM #1 ran down the other hallway with client #2 in pursuit. RM #1 ran back up the hallway and stated, "I don't want to be licked." RM #1 used her key card to enter the medication room and shut the door. Client #2 was not able to follow RM #1. RM #1 came out of the medication room, and client #2 continued attempting to chase her. RM #1 prompted client #2 to dance.DSP #2 was interviewed on 6/2/22 at 11:53 am and stated, "That behavior is not appropriate. They're friends from [previous facility]. Staff should have said something. [Client #15] will usually listen and can be directed. He should be educated on what his plan says. Staff shouldn't allow tickling."RM #4 was interviewed on 6/2/22 at 12:36 pm and stated, "[Clients #2 and #15] need to give each other more personal space. Most have a personal space goal. Playing tag with staff should not be happening. Staff should not encourage that behavior."QIDP #1 was interviewed on 6/2/22 at 1:34 pm and stated, "Tickling and touching shouldn't happen. It can trigger past trauma. It is			

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	staff's responsibility to redirect. They could prompt for a side hug. The staff are here to help the clients grow and become independent as a service. Allowing that behavior is not helping them to develop themselves."Program Manager #1 was interviewed on 6/2/22 at 2:56 pm and stated, "There should be no horseplay. Some even have a BSP for horseplay. Staff shouldn't be hiding in bedrooms. It's inappropriate. Staff should redirect. It could cause behaviors. It's not developmentally or age appropriate behaviors. Staff should not encourage hugs. They should redirect and model appropriate behaviors."BC #1 was interviewed on 6/2/22 at 3:20 pm and stated, "That behavior is not appropriate for [client #2]. He's unpredictable. No one should be hugging him. He will act like he having fun then will pop you. Grown men don't tickle. Staff should follow the plans."DSP #2 was interviewed at 2:56 pm and stated, "There is no organized or planned activity right now. We're waiting for DSP #10 to return with ice cream. There was a van ride for life skills with 11 or 12 people. The rest are here. Some sleep or are on the couch socializing. There is no second option besides the van ride.RM #1 was interviewed at 3:03 pm and stated, "The life skills group goes on a van ride. They take as many as			

possible. The drive through [town]. They just drive. Sometimes they go up to the highway. There are no goals or activities. They just ride around on the van." RM #1 stated, "If we have adequate staff, we'll do games with the ones who are left. [Client #2] likes to be out here during this time. We most focus on interaction [client #2]. He's not bothered by the noise at this time." RM #1 stated, "[Clients #15 and #19] like to do tickle monster with [client #2]. They run back and forth. Usually, [client #15] is not awake at this time of day."At 3:07 pm, client #10 returned from a van ride. Client #10 was not wearing his glasses or socks.At 4:45 pm, clients #10, #11, #13, #15, and #20 were standing in the day room. The clients were pacing through the room and congregating around staff. Staff did not redirect the clients to an activity. DSP #6 was outside with client #3. DSP #6 opened the door and asked client #15 to get a game from a cabinet. Client #15 took the game to DSP #6. DSP #6 set the game up on the front porch and attempted to engage client #3 with the game. No other clients were prompted to engage in activities. There were pots on the stove with vegetables cooking. No clients were prompted to assist with preparing the evening meal.At 4:55 pm, DSP #2 indicated there were 3 DSPs, 2 RMs, and 4 administrative staff in

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	the facility at the time of the observation. DSP #2 indicated clients #1, #2, #3, #4, #5, #8, #10, #11, #13, #17, #18, and #20 were still at the facility, and the remaining clients were on a community outing. DSP #2 indicated there were not planned activities for the clients who did not go on the community outing.At 5:00 pm, DSP #6 was outside with clients #3 and #17. At 5:04 pm, DSP #10 stated, "[Client #20], I'm going to sweep the day room into a pile. Will you help me sweep it up?" Client #20 stated, "Yeah."At 5:09 pm, RM #4 prompted client #20 to the kitchen. Client #2 came from his bedroom to the day room. RM #4 set the tables in the dining room and did not prompt any clients to assist her. Program Manager (PM) #1 was assigned to one on one status with client #1. PM #1 followed client #1 around the facility and took him outside.At 5:16 pm, DSP #10 put cups on the tables. No clients were prompted to assist.At 5:19 pm, Qualified Intellectual Disabilities Professional (QIDP) #1 brought a rolling speaker from client #13's bedroom and took it outside to listen to music with clients #3 and #17.At 5:18 pm, client #1 was pacing through the day room with DSP #10 as his one to one staff. DSP #10 followed client #1 through the home and did not attempt to engage him in an activity. Client #4 sat on a sofa in the day			

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	room. Staff did not attempt to engage him in an activity. Client #2 was in his bedroom with his door closed.At 5:30 pm, clients #11, #13, and #20 were pacing through the day room. Clients #4 and #18 were sitting on sofas in the day room. There was a radio prompt for staff and clients to complete handwashing.At 5:45 pm, client #13 walked up behind client #3 and clapped his hands loudly by client #3's ear. DSP #10 stated, "Let's not do that. Don't antagonize your peers." Client #10 was not wearing his glasses.At 5:50 pm, RM #3 brought a tray of food to clients #10 and #13's table. At 5:53 pm, client #15 approached DSP #10 and stated, "They need help in client #18's room."At 5:54 pm, DSP #10 brought a tray of food to clients #1, #11, and #15's table.At 5:57 pm, DSP #6 brought a tray of food to client #2's table.At 5:58 pm, client #3 was sitting at a table alone. Client #3 had not been served. Client #3 began repeating, "Where's [QIDP #1]?" DSP #2 stated, "[Client #3] does that every time [QIDP #1] leaves the building. Sometimes he has a behavior over it. Client #1 got up from the table and began hopping up and down the halls.At 6:00 pm, client #1 was served his meal. QIDP walked through the building and took client #13's speaker back to his bedroom. Client #3 followed QIDP #1. Client #3 shoved client #10 out of the			

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	way and yelled down the hallway, "[QIDP #1], I want chocolate milk." RM #3 blocked client #3 and stated, "We don't have any." QIDP prompted client #3 to return to his seat and sat with client #3 while he ate.At 6:06 pm, client #1 was running up and down the hallways, through the day room, and into the kitchen. Client #2 was in his bedroom with the door closed.On 6/1/22 at 10:20 am, a note posted on the wall in the office indicated the following:"Active Treatment means we are interacting with every client every minutes:- Running goals.- Offering activities.- Suggesting games.- Helping with laundry.- Helping tidy bedrooms.- Movie room.- Prepping meals.- Working on clean-up.- Working on hygiene. - Outside exercise.- Art in the art room.- Offering sensory items."On 6/1/22 at 12:00 pm, an activity schedule posted on the wall indicated the following activities:"5/31/22 - Good job on the garden!6/1/22 - Capture the flag, Leadership skills, 3 pm van ride, Off campus: swimming at [town] aquatic center.6/2/22 - Sign language, oral hygiene, [state park], 3 pm van ride."Client #1's record was reviewed on 6/1/22 at 1:52 pm.Client #1's Behavior Support Plan (BSP) dated 5/26/22 indicated the following:"Target Behaviors and Goals....Anal Digging/Smearing Feces:.... [Client #1] will sometimes reach back			

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	toward his anal area right after having a bowel movement, and it has been helpful for staff to hold his hands after a bowel movement, so that he is not tempted to do this. [Client #1] may engage in this behavior to upset staff, so that they just give in to what he wants.... Includes attempts to eat his feces. [Client #1] may engage in this behavior to get a reaction out of staff, and staff should respond with as little reaction or emotion as possible. If he sees that it upsets or flusters you, he will do it more. He likes the reaction....Restrictions:- Staff will remain in the doorway when [client #1] bathes due to a history of unhygienic behaviors in the tub such as defecating and playing with his feces. Showers should be encouraged instead of baths due to [client #1's] aggressive thrashing in the bath tub and his history of defecating in the tub and playing with it....Preventative Procedures:- He should be encouraged to take showers rather than baths due to his history of violently thrashing around in the tub causing bruising to himself....- [Client #1] seeks a reaction from staff and has had behaviors in the past in order to get a reaction out of staff. Don't react emotionally to his behaviors by being shocked, grossed out, or upset. Act almost as if the behavior did not just happen. ALL staff need to be on board with this intervention in order to decrease			

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	these types of behaviors."Client #1's BSP indicated the following:"Inappropriate Access to Food: any time [client #1] obtains food items by 'stealing' them off of his peer's plates, digging the food items out of the trash, or eating food items that have been found/left on the floor. It would not be uncommon for [client #1] to circle the dining tables of his peers in an effort to take leftover food items off of the table....Restrictions:-			
W 0217 Bldg. 00	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include nutritional status. Based on observation, record review and interview for 1 of 4 sampled clients (#4), and 1 additional client (#11), the facility failed to ensure client #4 was assessed for the appropriateness of his diet and client #11 was assessed for his skills, eating habits, and preferences associated with eating his pureed food items. Findings include: 1) On 6/1/22 at 5:45 PM, an evening meal was prepared which consisted of fish, mixed-vegetables and macaroni and cheese. Staff #2 verbally redirected client #4 to sit in his chair in his bedroom. At 5:47 PM, the Residential Manager (RM #4) brought a black television tray to client #4's bedroom. Client #4 used the tray to rest his plate and utensils on while he ate his meal inside his bedroom. At 5:50 PM, staff #2 was asked if client #4 was on special diet. Staff #4 stated, "Yeah it's ground. So, the fish is chopped. The mac (Macaroni) and cheese is soft". Client #4	W 0217	Client #4 and #11 will be reassessed for appropriateness of diets. Client #11 will be assessed for skills, eating habits and preferences. All staff will be trained on the outcome of assessment and any changes made to the dietary orders. Client #4 was moved in on 2/10/2022. His previous placement placed him with orders for a pureed diet. This plan was continued until further evaluation can be obtained. Nursing has contacted physician and physician approved and will provide referral. All staff were trained on the following: In order to avoid isolation, client #4 should not eat his meals in his bedroom unless he wants to. He should be	07/08/2022

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	continued to eat his meal in his bedroom until finished at 5:51 PM. On 6/1/22 at 11:42 AM, client #4's record was reviewed. The record indicated the following: -Dining Plan dated 4/5/22 indicated, "Food Texture: 1/4 (inch) chopped food. Food should be moist, tender and appropriate the width of a #2 pencil ... Fluid Texture: honey thickened liquids ... Eating: ... Staff must cut his food to ¼ inch. Staff use hand over hand to assist [client #4] in eating when he does not initiate eating himself ...". -Dietary consult dated 2/25/22 indicated, "Resident (client #4) new admit nutrition assessment. Regular diet PO (by mouth) intake/fluids mtg (meeting) needs ...". -Speech Evaluation, was not available for review. -Swallow Evaluation, was not available for review. On 6/2/22 at 10:55 AM, the Director of Nursing (DON) was interviewed. The DON was asked about client #4's nutritional needs and if an assessment for his diet order could be provided for review. The DON stated, "I did tell her (facility nurse) to schedule an evaluation. He did not have a speech eval (evaluation) for the swallow eval. He came in (admitted to services) with the diet he had". The DON indicated further follow up being pursued to obtain a speech evaluation to ensure client #4 was not being restricted to a special diet order without his needs being assessed. 2) Observations were conducted on 5/31/22 from 4:30 PM to 7:06 PM and on 6/1/22 from 4:44 PM through 6:07 PM. The observation indicated the following which affected client #11:		encouraged to eat at the couch or at his chair in the dayroom. Client # 11 now has physicians' orders for divided plate, and this will be added to dining plan. Staff will be trained. Staff were trained on pureeing each food item separately with appropriate liquid for thinning as needed (not water).	

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On 5/31/22 at 6:50 PM, client #11 was seated in the dining room with his peers for the evening meal. The evening meal consisted of cheeseburger, french-fries, coleslaw, pudding and pink lemonade to drink. Client #11's food was served pureed on a regular plate which had spilled off onto the dining room table and was around his entire plate. Client #11 used his spoon to scoop the spilled pureed food from the table as he ate. At 6:52 PM, staff #2 was asked what food item client #11 was eating. Staff #2 stated "coleslaw".

On 6/1/22 at 5:54 PM, staff #10 sat a tray down onto the dining room table where client #11 was seated. Client #11 was served a single food item in high sided divided plate. At 5:56 PM, staff #10 was asked what food item client #11 was eating. Staff #10 stated, "Looks like vegetables". Staff #10 indicated would need to verify the single pureed food item client #11 was served with Residential Manager (RM #3), as RM #3 had prepared client #11's evening meal. Client #11 finished his evening meal and drinking his tea at 6:03 PM.

On 6/1/22 at 6:05 PM, the RM #3 was interviewed. The RM #3 was asked what client #11 was served for his evening meal, if it was pureed as a single item combined, and the use of the high sided divided plate. The RM #3 stated, "he had mixed vegetables, fish, and mac (macaroni) and cheese. I was the one who prepared his plate. It was all mixed as one together. At times he can be particular of things touching. That way he is not missing on eating something". The RM #3 indicated client #11's food was pureed as a single item and served using a high sided divided plate to ensure food was not touching and/or client #11 would not refuse to eat.

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On 6/1/22 at 1:04 PM, a focused review of client #11's record was conducted. The record indicated the following:

-Individual Support Plan (ISP) dated 8/11/21 indicated, "Adaptive Equipment: Wedge cup set to half open. Adaptive Utensils: Smaller spoon ... Area: Adaptive Equipment. Goal: To improve adaptive equipment skills thus increasing independence. Objective: [Client #11] will use his small spoon during meals independently 100% of opportunities per month for 12 months by 8/11/22 ...".

-Dining Plan dated 5/19/22 indicated, "Mealtime Adaptive Equipment: Baby spoon, Wedge cup ½ open. Eating: [Client #11] eats independently. Staff monitor and encourage [client #11] to drink slowly to prevent chocking (sic)...".

Based on the observations and record review, client #11's assessed nutritional needs did not support the use of high sided divided plate to keep foods from spilling and/or touching as described by staff interviews. The assessed nutritional needs did indicate preferences for serving plates or bowls to prevent pureed food items from spilling. During observations, an inconsistency with the use of various plates and the practice of pureeing food items together to prevent foods from touching was not indicated in client #11's plans and contraindicated to client #11's ISP goal for increasing independence with the use of his spoon.

On 6/2/22 at 10:55 AM, the Director of Nursing (DON) was interviewed. The DON was asked about client #11's skills associated with eating and the use of a regular plate when his pureed foods

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	spilled off onto the table. The DON stated, "I would have expected it to be in a bowl. I have no idea why they would do that (serve pureed food on a regular plate)". The Nurse was asked if client #11 should be served his pureed food items in a divided plate. The Nurse stated, "That would require an order. It depends if they bought it from a store. If it was served on a plate (regular plate), I can see that (pureed foods spilled). I don't know why they would do that". The DON was asked if client #11's pureed food items should be served mixed as a single item. The DON stated, "No". The DON was asked how client #11's food items should be served. The DON stated, "He should have had them pureed in separate containers. If he does not like them touching, I would say 3 separate bowls". The DON indicated further follow up was needed to ensure client #11 eating habits and preferences were identified. On 6/2/22 at 12:02 PM, staff #2 was interviewed. Staff #2 was asked about client #11's skills associated with eating and the use of a regular plate when his pureed foods spilled off onto the table. Staff #2 stated, "He's supposed to have a divided plate". On 6/2/22 at 12:36 PM, the Residential Manager (RM #4) was interviewed. The RM #4 was asked about client #11's skills associated with eating and the use of a regular plate when his pureed foods spilled off onto the table. The RM #4 stated, "Usually he uses a divided plate. He'll have foods mixed. If it's touching he'll refuse. He's very particular about his foods touching". On 6/2/22 at 1:35 PM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked about client #11's skills associated with eating and the use of a regular			

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	plate when his pureed foods spilled off onto the table. The QIDP stated, "He uses a plate like everyone else, it's a divided". The QIDP indicated client #11 used an adaptive cup for liquids. The QIDP was asked if the use of high sided plate was in client #11's dining plan. The QIDP stated, "I don't know, the cup is". The QIDP was asked if client #11's pureed food items should be served mixed as a single food item. The QIDP stated, "It should be separated. It should be individual items". On 6/2/22 at 2:25 PM, the Program Manager (PM) was interviewed. The PM asked about client #11's skills associated with eating and the use of a regular plate when his pureed foods spilled off onto the table and if food items should be mixed together as a single item to prevent them from touching. The PM stated, "No, they should puree everything individually". The PM was asked about the use of a divided plate. The QIDP stated, "Divided plate, they should follow his plan". The PM indicated further follow up was needed to ensure client #11's eating habits and preferences were identified.			
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, interview and record review for 1 of 4 sampled clients (client #2), plus 2 additional clients (clients #8 and #10), the facility failed to ensure a goal to address client #2, #8 and #10's drooling was part of the clients' plans. Findings include:	W 0227	Goals were added to address drooling for clients #2, #8, and # 10. All staff were trained on new goals. Clients will be promoted to use cloth to wipe their face. All staff were trained to prompt (and assist when necessary)	07/08/2022

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	Observations were completed in the facility on 5/31/22 from 10:45 am through 12:45 pm, from 3:50 pm through 5:05 pm, on 6/1/22 from 8:00 am through 9:00 am, and on 6/2/22 from 7:00 am through 8:30 am. On 5/31/22 at 3:50 pm, client #10 had drool on the chest of his shirt. Client #10 was not prompted to change his shirt until 4:25 pm when staff prompted him to change his shirt for an outing. At 4:43 pm, client #2 was sitting in the day room. Client #2 had drool coming from his bottom lip on to his shirt. Throughout the evening observation, client #2 was not prompted to wipe his chin or change his shirt. On 6/2/22 at 7:30 am, client #2 had drool and food on the chest area of his shirt. Staff did not prompt client to change his shirt or offer to assist him. On 6/2/22 at 7:30 am, Client #8 was in the day room; his orange shirt was on backwards and there was drool on the chest area. At 8:00 am, staff #15 stated to client #8 "your shirt's on backwards." Staff #15 did not prompt the client to turn his shirt around or offer to assist him. Client #2 had drool and food on the chest area of his shirt. Staff did not prompt client to change his shirt or offer to assist him. On 5/31/22 at 2:30 pm, client #2's record was reviewed. An Individual Support Plan (ISP) dated 1/14/22 indicated client #2 did not have a goal to address his drooling behaviors. A comprehensive functional assessment dated 3/29/21 indicated client #2 "wears dirty or soiled clothing if not prompted."		clients to change clothing when soiled or worn incorrectly (inside out, backwards, shoes on the wrong feet, etc). Also to prompt clients for personal hygiene and putting on clean clothes daily.	

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On 6/2/22 at 2:30 pm, client #8's record was reviewed. An ISP dated 10/21/21 indicated client #8 did not have a goal to address his drooling behaviors.

On 6/2/22 at 2:45 pm, client #10's record was reviewed. An ISP dated 6/7/21 indicated client #10 did not have a goal to address his drooling behaviors.

An interview was conducted with staff #2 on 6/1/22 at 11:30 am. Staff #2 stated "most clients take a bath and dress themselves." Staff #2 stated client #2's goals included "dignity, hygiene, social interaction, showering, brushing teeth." Staff #2 indicated client #2 should be prompted to change his shirt if it is soiled. Staff #2 indicated client #2 should have a plan for this behavior.

An interview was conducted with RM #2 on 6/1/22 at 12:00 pm. RM #2 indicated clients should appear clean. RM #2 indicated staff should prompt clients with soiled clothing to change. RM #2 indicated clients should have a plan for drooling behavior.

An interview was conducted with Licensed Practical Nurse (LPN) #1 on 6/1/22 at 2:30 pm. LPN #1 indicated all clients are encouraged to bathe daily. LPN #1 indicated all clients have a hygiene goal. LPN #1 indicated staff should prompt clients to change soiled clothing or fix clothing that is out of place. LPN #1 indicated clients should have a plan for their drooling behavior.

An interview was conducted with the Director of Nursing (DON) on 6/1/22 at 4:05 pm. The DON stated "clients should always appear clean and neat, especially if they are going out." The DON

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	indicated staff should prompt clients to wear clothing appropriately. The DON indicated clients should have a plan that addresses drooling behavior.			
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 and interview for 4 additional clients (#7, #8, #17 and #19), the facility failed to ensure clients #7, #8, #17 and #19 had opportunities for choice regarding their preferred vocational and leisure programs. Findings include: Observations were conducted in the group home on 5/31/22 from 11:20 am through 12:41 pm and from 4:30 pm through 7:10 pm, on 6/1/22 from 10:45 am through 11:22 am, from 2:22 pm through 3:20 pm, and from 4:45 pm through 6:08 pm. Clients #7, #8, and #19 were present in the home throughout the observation periods. 1. Client #7 was interviewed on 5/31/22 at 11:20 am and stated, "I applied for a job at [fast food restaurant]. I had an interview, but [Program Manager (PM) #1] said I couldn't go because they couldn't get a hold of my guardian. I'm bored sitting around all day. I want to work. [Workshop] quit taking us. We only get $10 a week here. That's what we get every week. I want to buy [video game system] and movies." 2. Client #19 was interviewed on 5/31/22 at 5:22 pm and stated, "I used to work at [workshop]. I don't work there anymore. They won't renew the contract." Client #19 indicated he wanted a job,	W 0247	Vocational Rehabilitation came to the facility to evaluate #19 for services on 5/19/2022. His vocational rehabilitation case was closed due to his required supervision level in the community. He has been offered workshop as they have re-opened, but he reported that he did not want to return to the workshop. Program manager will check in with client #19 quarterly to determine if he wants to go to workshop. If he requests to go to workshop prior to quarterly program manager will arrange an intake. Client #7 Guardian is not permitting him to gain employment. He is enrolled to attend workshop 3 times per week as they have reopened. He is prompted on scheduled days to attend workshop and taken when he does not refuse. A goal was added 7/1/2022 for client to desensitize client #8 to van rides as he is current fearful. A goal has been added to complete his outing. If a client refuses to	07/08/2022

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	so he could have more money. 3. On 5/31/22 at 12:15 pm, client #8 stated, "I'm getting fried chicken and french fries. I'm getting [fast food restaurant]." At 12:22 pm, Residential Manager (RM) #2 stated, "Today is [client #8's] outing. He's getting [fast food restaurant]. He's waiting for [client #5] and [Direct Support Professional (DSP) #6] went to get it." When asked why client #5 went on client #8's outing, RM #2 stated, "[Client #8] doesn't like to go on the van." DSP #6 was interviewed on 6/2/22 at 2:30 pm and stated, "Sometimes [client #8] will go on an outing. Sometimes he'll refuse. He doesn't like hills or going fast in the van. It scares him. We could offer a 1 on 1 activity here. He does enjoy the meal, he just doesn't want to go pick it up." DSP #6 stated, "I don't know if we'd offered other activities." 4. Observations were completed in the group home on 5/31/22 from 10:45 am through 12:45 pm, from 3:50 pm through 5:05 pm, on 6/1/22 from 8:00 am through 9:00 am, and on 6/2/22 from 7:00 am through 8:30 am. On 6/1/22 at 8:00 am, client #17 stated "I'm going on an outing today. I'm going to eat chinese buffet." Client #17 checked with the Residential Manager (RM) #6 and then stated "my outing is at 11:00." On 6/2/22 at 8:15 am, client #17 indicated he did not go on his outing to the chinese buffet. Client #17 stated, "the others wanted to go somewhere else."		attend their personal shopping outing, they should be offered another activity to participate in with staff. This could include staff bringing the client to the rec room to eat their meal or offering to complete another activity with the client. Staff have been trained to document.	
W 0249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active			

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	treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.			
	Based on observation, record review and interview for 3 of 4 sampled clients (#1, #2 and #4), and 1 additional client (#11), the facility failed to ensure clients #1, #2, #4 and #11's ISP (Individual Support Plans), BSP (Behavior Support Plans) and Health Risk Plans were implemented during formal and informal opportunities. Findings include: 1a. Observations were conducted at the facility on 5/31/22 from 2:15 PM through 3:26 PM, from 4:30 PM through 7:06 PM, on 6/1/22 from 10:45 AM through 11:24 AM, from 2:22 PM through 3:24 PM, and from 4:44 PM through 6:07 PM.. During the observations, the following issues were noted: On 5/31/22 from 2:15 PM through 3:26 PM: Client #1 remained to himself in the day room. Client #1 was not prompted to engage in formal or informal active treatment activities. Client #1 was not offered or prompted to engage in activities by the staff working in the facility. At 2:50 PM, client #1 walked down the hallway toward the laundry room. The Residential Manager (RM #2) ran toward client #1 and stated, "No [client #1], [No [client #1]". Client #1 returned to the day room and went without an activity offered by staff. Client #4 remained to himself in the day room. Client #4 was not prompted to engage in formal or informal active treatment activities. Client #4 was not offered or prompted to engage in activities by	W 0249	All facility direct support and supervisory staff will be retrained regarding proper implementation of all clients' prioritized learning objectives and target behavior interventions and the need to provide continuous skills training at formal and informal opportunities. Training will include examples of informal training opportunities, and the need to keep individuals engaged in functional activities throughout the day and evening. Specifically, all staff will be retrained on client #1, #2, #4 and #11 BSP/ISP and HRP's. Management staff are scheduled to complete administration monitoring/intervention sheet. This will be completed once per shift each day. All staff re-trained on prompting clients every 15 minutes for formal and informal active treatment opportunities. They were given examples of what active treatment looks like. They were also educated to use the Activities building more often including completing part of meal prep in the recreation room kitchen. All staff were trained to provide re-direction by way of alternative activities to all clients involved in a	07/08/2022

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	the staff working in the facility. At 2:25 PM, client #4 moved to a different location in the day room to sit. Client #4 was not wearing socks and/or shoes. Staff #2 followed client #4 when he changed location in the day room and did not offer an activity to client #4. At 2:32 PM, client #4 sat on the arm of a sofa in the day room. Client #4 went without an activity offered to him. Client #11 remained to himself in the day room and stood near the dining room tables. Client #11 was not prompted to engage in formal or informal active treatment activities. Client #11 was not offered or prompted to engage in activities by the staff working in the facility. At 2:32 PM, client #11 entered the kitchen. The RM #2 followed client #11 into the kitchen and assisted him with obtaining a cup of tea to drink. At 2:55 PM, client #11 was in his bedroom lying in his bed. Client #11 went without an activity offered to him except for when he entered the kitchen and RM #2 assisted him with obtaining tea to drink. 1b. On 5/31/22 from 4:30 PM through 7:06 PM: Client #1 remained to himself in the day room. Client #1 was not prompted to engage in formal or informal active treatment activities. Client #1 was not offered or prompted to engage in activities by the staff working in the facility. At 5:18 PM, client #1 stood in the day room and stared at a peer seated at a dining table eating food brought back from the community. Client #1 was not prompted and went without an activity offered to him. At 5:47 PM, client #1 was seated in a dining room chair. Client #1 went without an activity offered to him. At 5:53 PM, client #1 paced throughout the day room and hallways. Client #1 went without an activity offered to him. At 6:20 PM, client #1 walked out of a bathroom nude and returned. No		situation. Avoid saying ‘no’ or ‘stop’. All staff were trained to prompt clients to wear appropriate attire including socks and shoes. The Interdisciplinary Team has developed a comprehensive list of client specific triggers, precursors, and coping skills for each client. The list currently in each clients programing binder on the unit. All staff have been in-serviced on the updated comprehensive list and where to find it on the unit for reference. Meal prep training conducted to assure all ISP, BSP, and High-risk plans are followed. This applies to meals and snacks. To assure clients are being prompted to assist with meal prep and clean up per their goals and ability level. Including offering all utensils (unless restricted per BSP) and well as napkins and drinks. All staff were in-serviced on clients that need to remain upright following meals. All staff trained via in-service on maintaining the privacy of clients during personal care. Staff were trained on pureeing each food item separately with appropriate liquid for thinning as needed (not water). All staff were trained to prompt (and assist when necessary) clients to change clothing when soiled or worn incorrectly (inside	

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	staff prompting was provided to client #1 as he reentered the bathroom to take a bath. At 6:22 PM, client #1 exited the bathroom a second time nude and walked down the hallways a few feet and returned to get into the tub. No staff prompting was provided to client #1 as he reentered the bathroom. At 6:23 PM, staff #7 was informed client #1 was left unattended in the bathroom and had exhibited rectal digging and was placing his hands up to his mouth. Client #1 then received supports and services provided by staff #7, LPN #3 (licensed practical nurse) and Residential Manager (RM #1) to finish his bathing and receive medical assessment in the medication administration room. Client #4 paced throughout the day room and engaged in physical aggression with his peers. Client #4 paced throughout the common living area referred to as the day room. As client #4 went past some of his peers, he would engage in physical interaction by hitting a peer. Staff #10 intervened with the use of physical redirection and stated, "Hey buddy, we don't hit our peers". At 4:41 PM, client #4 sat down on a sofa next to a peer. Client #4 reached over and touched the peer on the leg and the peer responded by hitting client #4 with a closed fist three times on his left shoulder blade area of his back. Staff #10 stated, "Hey [client #12], we don't hit others". At 4:42 PM, client #4 stood from the sofa and walked down the pacer hallway into a bedroom. Staff #10 verbally redirected client #4 and stated, "That's not your room, let's go to your room". Client #4 returned to day room and sat down beside the peer who hit him three times. No redirection by staff was provided to separate client #4 from the peer who had just hit him three times. At 4:47 PM, client #4 attempted to enter another bedroom. Staff #10 used a touch cue followed by verbal		out, backwards, shoes on the wrong feet, etc). Also, to prompt clients for personal hygiene and putting clean clothes daily. New noise canceling headphones have been purchased for client #2 despite him refusing to wear them and breaking 4 pairs. All staff were trained during all staff meeting on the following: If a client refuses to attend their personal shopping outing, they should be offered another activity to participate in with staff. This could include staff bringing the client to the rec room to eat their meal or offering to complete another activity with the client (example: sitting outside with Client #8 or throwing the football with client #4). Staff should also document the client's refusal to attend the outing and what was done instead. A goal was added 7/1/2022 for client to desensitize client #8 to van rides as he is current fearful. A goal has been added to complete his outing. If a client refuses to attend their personal shopping outing, they should be offered another activity to participate in with staff. This could include staff bringing the client to the rec room to eat their meal or offering to complete another activity with the client. Staff have been trained to document. Vocational Rehabilitation came to the facility to evaluate #19 for	

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	redirection and stated, "No, we don't go into other people's bedroom". Client #4 was not offered or prompted to engage in activities by staff #10. Client #4 entered the bedroom and stood next to the curtain briefly before leaving to return to the day room. At 4:51 PM, client #4 reentered the day room and Residential Manager (RM #1) stated, "[Client #4] gave him (peer) a slap on his way through". Client #4 was not offered or prompted to engage in activities by the RM #1 or staff #10. At 4:55 PM, staff #10 requested staff #2 give him a break as the assigned one-to-one staffing with client #4. Staff #2 left client #4's bedroom to obtain a gray adult incontinent brief and returned. Staff #2 stated to staff #10, "He (client #4) can put it on". Client #4 then remained in his room for a period of time and no longer engaged in client-to-client physical interactions with his peers. At 5:24 PM, client #4 was seated in the day room among his peers waiting for the evening meal. Client #4 was not offered or prompted to engage in activities by staff. Client #4 would sit, stand and move to different sofas located in day room. Staff #2 followed client #4 when he switched locations to remain close to him, but client #4 was not offered or prompted to engage in activities by staff #2. At 6:44 PM, client #4's peers gathered in the day room and around the dining room tables in preparation for the evening meal. Client #4 was no longer in day room or with his peers seated around the dining room tables. At 6:50 PM, many of client #4's peers began eating their evening meal which consisted of a cheeseburger, french-fries, coleslaw, pudding and pink lemonade to drink. Client #4 was not in day room or the dining room among his peers during the evening meal. At 6:56 PM, staff #2 was asked where client #4 was. Staff #2 stated, "He's in his room. He eats		services on 5/19/2022. His vocational rehabilitation case was closed due to his required supervision level in the community. He has been offered workshop as they have re-opened, but he reported that he did not want to return to the workshop. Program manager will check in with client #19 quarterly to determine if he wants to go to workshop. If he requests to go to workshop prior to quarterly program manager will arrange an intake. All staff retrained that staff are to interact with clients and follow through with what they say they will do. And educated about how not doing so can cause conflict and behaviors. All staff retrained on family style dining including having clients serve themselves. Goals were added to address drooling for clients #2, #8, and # 10. All staff were trained regarding appropriate redirection when clients are engaging in horseplay. And to redirect clients when they are invading other clients' boundaries. Educated staff to model appropriate interactions and boundaries. All staff were in-serviced on the following: Staff approach and redirection. This training included: Staff should always remain respectful and professional when	

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	at a different time than everyone else. He steals their food". Client #4's bedroom door was closed. At 6:58 PM, client #4 exited his bedroom with staff #6. Client #4 went into the day room while staff #6 took his plate and utensils to the kitchen. At 6:59 PM, staff #6 was asked why client #4 ate his meal inside his bedroom. Staff #6 stated, "Sometimes he prefers to eat in his room. He likes to steal food. Even if you're sitting beside him, he doesn't care. He is quick. Like a flash". Client #4 was not redirected and prompted to activities. Staff responded to client #4's behavior and movements in a reactive manner rather than redirection and prompts to replace physical interactions with his peers. Client #4's evening meal occurred in his bedroom, isolated and away from his peers during the mealtime. Client #11 remained to himself in the day room and stood near the dining room tables. Client #11 was not prompted to engage in formal or informal active treatment activities. Client #11 was not offered or prompted to engage in activities by the staff working in the facility. At 5:00 PM client #11 continued to stand near the dining room tables and paced from side to side. At 5:22 PM, client #11 continued to stand and pace side to side near the dining room tables. Client #11 was not prompted or offered an activity to engage in by the facility staff. At 5:47 PM, client #11 continued to pace in front of the dining room tables from side to side. Client #11 was not prompted or offered an activity to engage in by facility staff. At 6:17 PM, client #11 was seated at the table waiting for his evening meal. Client #11 was not prompted or offered an activity to engage in by facility staff. At 6:44 PM, client #11 continued to be seated at the table and wait for the evening meal. Client #11 was not prompted or offered an activity to engage in by facility staff. At 6:50 AM,		redirecting clients. Staff training to occur on tone of voice, avoiding power struggles and support clients to control themselves. Staff training to occur regarding active listening, not arguing, assist client with finding best solutions and providing the client with support. Staff training regarding referring to BSP when a client is wanting to go against their restrictions. Show them the document, explain it to them so they understand	

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	client #11 was eating. Client #11 ate his pureed food that spilled from a regular plate onto the dining room tabletop surface. Staff #2 was asked what food item client #11 was eating. Staff #2 stated, "Coleslaw". Client #11 was not provided and/or prompted to use a different plate or bowl during his evening meal. At 6:54 PM, client #11 finished eating and returned to his bedroom and laid down in his bed. Client #11 was not prompted or encouraged to stay upright for the 30 to 60 minutes as indicated within his health risk plan. Client #11 remained in his bed throughout the remainder of the observation ending at 7:06 PM. 1c. On 6/1/22 from 10:45 AM through 11:24 AM: Client #1 remained to himself and was lying in his bed. Client #1 was not prompted to engage in formal or informal active treatment activities. Client #1 was not offered or prompted to engage in activities by the staff working in the facility. Client #1 stayed in his in his bed and went without an activity prompted to engage in. Client #4 remained to himself in the day room. Client #4 was not prompted to engage in formal or informal active treatment activities. Client #4 was not offered or prompted to engage in activities by the staff working in the facility. Client #11 was finishing a snack with pudding from 10:45 AM until 10:49 AM. At 10:49 AM, client #11 returned to his bedroom and laid down in his bed. Client #11 was not prompted or encouraged to stay upright for the 30 to 60 minutes as indicated within his health risk plan. Client #11 remained in his bed throughout the remainder of the observation ending at 11:24 AM. Client #11 was not offered or prompted to by facility staff to engage in activities.			

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1d. On 6/1/22 from 2:22 PM through 3:24 PM:

At 2:22 PM, client #1's bedroom door was open and client #1 stood nude as staff #14 assisted client #1 with dressing. Client #1's bedroom door remained open while staff #14 assisted him with dressing. At 2:32 PM, client #1 was in the day room. Client #1 was not prompted to engage in formal or informal active treatment activities. Client #1 was not offered or prompted to engage in activities by the staff working in the facility. At 2:34 PM, client #1 went out onto the porch with group of his peers. Staff #6 sat between client #1 and a peer on the porch. Client #1 was not offered or prompted to engage in meaningful activities and by 2:55 PM, client #1 returned to the day room. At 3:04 PM, client #1 was seated at a dining room table. Client #1 was not offered or prompted to engage in activities. Staff #14 stated, "Ice cream is here. You guys need to sit down". At 3:12 PM, the Residential Manager (RM #2) started reviewing the orders for the milkshakes and passing them out. Client #1 was not offered or prompted to engage in activities by the staff working in the facility until the milkshake order had arrived.

Client #4 remained to himself in the day room. Client #4 was not prompted to engage in formal or informal active treatment activities. Client #4 was not offered or prompted to engage in activities by the staff working in the facility. At 2:22 PM, client #4 was seated in the day room without socks and shoes on and holding a small football. At 2:32 PM, client #4 remained seated in the day room without sock and shoes on holding the small football. At 2:40 PM, client #4 continued to be seated in the day room with no socks and shoes on holding small football. Client #4 was not offered or

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	prompted to engage in activity with the football by facility staff. Client #4 remained to himself while seated in the day room. At 2:44 PM, client #4 began slapping his left and right hands together making a vocalization. Client #4 was not offered or prompted to engage in activities. At 2:52 PM, client #4 was seated in the day room with his legs crossed. Client #4 was not offered or prompted to engage in activities. At 2:55 PM, client #4 remained in the day room and was not offered or prompted to engage in activities. At 2:59 PM, client #4 continued to sit with his legs crossed in the day room. Client #4 was not offered or prompted to engage in activities. At 3:00 PM, staff #14 stated, "He's harmless (client #4). He's my favorite." Client #4 was making vocalizations and swinging his arms. Client #4 was not offered or prompted to engage in activities. At 3:04 PM, staff #14 stated, "Ice cream is here. You guys need to sit down". At 3:06 PM, staff #10 brought milkshakes into the day room. At this time, staff #6 spoke to client #4 and used sign language and stated, "Sit down". At 3:14 PM, staff #14 was asked about activity participation at the facility. Staff #14 stated, "When I get here we do laundry. The sleep patterns are different for each. Most of them don't want to get up. They want to play games. We can't make them go to Life Skills (day service activities). At 2:30 PM they go to the Library. We try to include them, like throwing balls, community outings". Client #4 was not encouraged or offered to throw the football he had been holding or engage in an activity using it. Client #4 was not prompted or redirected from the sensory stimulation when he made vocalizations and rapid hand movements. Client #11 remained to himself in his bedroom and lying in his bed. Client #11 was not prompted to engage in formal or informal active treatment			

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activities. Client #11 was not offered or prompted to engage in activities by the staff working in the facility. At 2:22 PM, client #11 was in his bed and made a vocalization indicating he was asleep. At 2:50 PM, client #11 walked out of his bedroom and into the day room. At 2:53 PM, client #11 verbalized to Residential Manager (RM #2) the word "tea". The RM #2 verbally redirected client #11 and indicated he should wait because ice cream would be arriving soon and he could drink his tea with his ice cream. Client #11 remained in the day room and went without an activity offered to him. At 2:55 PM, client #11 remained in the day room. At 3:00 PM, client #11 was at the dining room table drinking tea from his cup. At 3:03 PM, client #11 stood and returned to his bedroom and laid down in his bed. Client #11 was not prompted to engage in formal or informal active treatment activities. Client #11 was not offered or prompted to engage in activities by the staff working in the facility. At 3:06 PM, staff #10 brought milkshakes into the day room. Client #11 remained in his room and was not prompted or offered a milkshake or ice cream as the RM #2 had indicated to client #11 was coming. At 3:20 PM, client #11 remained in his bedroom and went without activities offered to him. Staff #14 was asked if client #11 got a milkshake. Staff #14 stated, "Did [client #11] get a milkshake"! At 3:21 PM, staff #14 entered client #11's bedroom and verbally prompted client #11 to come out to the day room to get his milkshake. At 3:23 PM, staff #14 was verbally prompting client #11 to try his milkshake and then stated, "I knew he would refuse. He only likes tea".

1e. On 6/1/22 from 4:44 PM through 6:07 PM:

At 4:44 PM, client #1 was outside with the Program Manager and Qualified Intellectual Disabilities Professional (QIDP). At 4:50 PM,

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	client #1 returned inside and went to his room and then the day room and sat on a sofa. At 5:06 PM, client #1 was walking with Residential Manager (RM #4) and entered a bathroom. At 5:07 PM, the RM #4 was asked about client #1. RM #4 stated, "[Client #1] is not soiled, but he has a lot of energy. It's just easier to change him in the bathroom". At 5:22 PM, client #1 was pacing and went into client #11's bedroom. The RM #4 followed client #1 into client #11's bedroom. Client #1 returned to the day room and went without an activity offered to him. At 5:27 PM, client #1 went up to a window behind the dining room tables, opened it, tapped the right corner and turned toward the day room and jumped up and down and paced throughout the day room toward the kitchen. At 5:30 PM, the Program Manager brought shoes to client #1. At 5:32 PM, the Program Manager took client #1 outside. At 5:38 PM, a peer of client #1 announced in the day room that client #1 was "naked outside". The RM #4 then went outside. At 5:41 PM, the Behavior Clinician entered the facility and went into client #1's bedroom and obtained an adult incontinent brief. At 5:54 PM, staff #10 brought a tray of food over to the dining room table and RM #4 stated, "[Client #1] is not made up yet". Client #1 was in the dining room and waited for RM #4 to put a plate of fish, macaroni and cheese and mixed vegetables together for him. During the observation, client #1 received prompting and redirection from staff in a reactive manner to his pacing, jumping, and the energy level indicated by RM #4. Client #1 was not offered an activity until taken outside. Client #4 remained to himself between his bedroom and the day room. Client #4 was not prompted to engage in formal or informal active treatment activities. Client #4 was not offered or			

prompted to engage in activities by the staff working in the facility. At 4:44 PM, client #4 was sitting on his bed. Staff #10 was in client #4's bedroom with him. Client #4 was not engaged in an activity. Client #4's television was on, but he was not watching it. At 5:05 PM, client #4 continued to sit on his bed. Residential Manager #3 was in client #4's bedroom. Client #4 was not engaged in an activity. Client #4's television was on, but he was not watching it. At 5:12 PM, client #4 came out of his bedroom and into the day room. Staff #2 followed client #4 as he entered the day room. At 5:22 PM, client #4 was sitting on a sofa in the day room. Client #4 used his right hand to repeatedly hit his face. Client #4 was not provided redirection or offered an activity. At 5:41 PM, client #1 had returned to his bedroom. Client #4 was sitting on his bed. Client #4 was not engaged in an activity. At 5:45 PM, staff #2 verbally prompted client #4 to sit down in his chair in his room to prepare to eat his evening meal. At 5:47 PM, the RM #4 brought a tray with client #4's foods to him in his bedroom. Client #4 was served fish, macaroni and cheese and mixed vegetables. Client #4 remained in his bedroom during his meal until finished at 5:51 PM. During observation, client #4 was not offered or engaged in activities. Client #4 remained in his bedroom during most of the observation period which included his evening meal away from his peers in the dining room. Client #4 was not prompted to engage in formal or informal active treatment activities.

Client #11 remained to himself in the day room and stood near the dining room tables. Client #11 was not prompted to engage in formal or informal active treatment activities. Client #11 was not offered or prompted to engage in activities by the staff working in the facility. At 4:44 PM, client #11

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	stood near the dining room tables. Client #11 was not engaged in an activity. At 5:10 PM, client #11 continued to stand near the dining room tables and paced from side to side. Client #11 was not offered or engaged in an activity. Client #11 was not prompted to engage in formal or informal active treatment activities. At 5:22 PM, client #11 stood near the dining room tables and paced side to side. Client #11 was not offered or engaged in an activity. Client #11 was not prompted to engage in formal or informal active treatment activities. At 5:54 PM, staff #10 brought a tray with food and sat it down at the table where client #11 eats his meals. Client #11's high sided divided plate had one single pureed food item. At 5:56 PM, staff #10 was asked what client #11 was being served for his evening meal. Staff #10 stated, "Looks like vegetables". At 6:03 PM, client #11 finished eating and stood up from the table. Client #11 returned to his bedroom and laid down in his bed. Client #11 was not prompted or encouraged to stay upright for 30 to 60 minutes after eating his meal as indicated in his health risk plan. At 6:05 PM, RM #3 was asked about client #11's pureed food served to him and what it consisted of. The RM #3 stated, "He had mixed vegetables, fish and mac (macaroni) and cheese. I was the one that prepared his plate. It was all mixed as one together. At times he can be particular if things are touching. That way he's not missing eating something". Client #11's dining plan did not indicate food preferences. Client #11's dining plan did not indicate the use of a high sided divided plate. The two observations of client #11's evening meals indicated an inconsistency with the preparation of client #11's pureed foods as individual items and/or what could be mixed based on preference of client #11, an inconsistency with the use of a regular plate or high side divided plate and how to prevent spilled			

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foods, and a failure on staff's part to prompt and encourage client #11 to remain upright 30 to 60 minutes as indicated within client #11's health risk plan.

1f. On 6/1/22 at 11:42 AM, client #4's record was reviewed. The record indicated the following:

-Individual Support Plan (ISP) dated 2/10/22 indicated the following needs:

"Needs to improve money skills
Needs to improve bathing skills unassisted
Needs to improve toileting skills unassisted
Needs to improve dressing skills unassisted
Needs to improve hygiene skills unassisted
Needs to initiate own activities
Needs assistance to schedule and keep appointments
Needs supervision
Needs to improve leisure skills
Needs to improve cooking skills
Needs to learn responsibility
Needs to improve kitchen safety skills
Needs to learn shopping skills
Needs to improve communication skills
Needs to improve socialization skills
Needs to learn responsibility
Needs to improve social skills
Needs to learn to use postal services
Needs to learn about welfare facilities
Needs to learn to use banking facilities
Needs to learn to budget money
Needs to improve social interaction
Needs to learn appropriate interaction with women
Needs to learn to fill out main items on an application
Needs to learn to initiate tasks
Needs to learn to perform a job requiring use of tools or machinery

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	Needs to learn to have active interest in a hobby Needs to learn to initiate group activities Needs to learn multiplication and division Needs to improve adding and subtracting skills Needs to improve how to use table ware correctly." The ISP indicated client #4's "Priority Objectives" as: "Self-Medication Skills Oral Hygiene Skills Mealtime Skills Personal Hygiene Skills Emotional Regulation Social Interaction Laundry Room Access Money Management Reporting Abuse, Neglect, Exploitation, Mistreatment and Avoiding False Allegations". -Behavior Support Plan (BSP) dated 5/23/22 indicated, "Target Behaviors:... Physical Aggression: Any occurrence or attempts at hitting people... or behaviors that produce or have the potential to produce an injury to others ... Goal: [Client #4] will demonstrate 2 or fewer acts of this target behavior per month for 3 consecutive months by 5/22... Reactive Procedures (Physical Aggression): 1) Immediately ensure the health and safety of everybody in the immediate environment. 2) Redirect him (client #4) and/or others to a different area of the environment. 3) Tell him to stop the behavior. 4) If he stops the behavior, redirect him to a safe location and problem solve with him and praise him for doing this with us. 5) If the behavior continues, block all attempts of aggression and attempt to redirect, if the behavior continues and			

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he is placing himself or others in danger, implement You're Safe I'm Safe (YSIS) beginning with the least restrictive measures ...".

1g. On 6/1/22 at 1:04 PM, a focused review of client #11's record was conducted. The record indicated the following:

-Individual Support Plan (ISP) dated 8/11/21 indicated, "Adaptive Equipment: Wedge cup set to half open. Adaptive Utensils: Smaller spoon ... Area: Adaptive Equipment. Goal: To improve adaptive equipment skills thus increasing independence. Objective: [Client #11] will use his small spoon during meals independently 100% of opportunities per month for 12 months by 8/11/22 ...

ISP indicated the following needs:

"Needs to improve self-toileting skills
Needs to improve money skills
Needs to initiate own activities
Needs assistance to schedule and keep appointments
Needs supervision
Needs to use appropriate tone of voice when speaking
Needs to improve leisure skills
Needs to improve cooking
Needs to learn responsibility
Needs to improve kitchen safety skills
Needs to learn shopping skills
Needs to improve communication skills
Needs to socialization skills
Needs to learn to use postal services
Needs to learn about welfare services
Needs to use banking facilities
Needs to learn to budget money
Need to improve social interaction

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Needs to fill out main items on an application
Needs to learn to initiate task
Needs to learn to perform a job requiring use of tools or machinery
Needs to learn to have an active interest in a hobby
Needs to learn to initiate group activities
Needs to learn multiplication and division
Needs to improve adding and subtracting
Needs to improve how to use table ware correctly."

The ISP indicated client #11's "Priority Objectives" as:

Self-medication skills
Oral hygiene skills
Domestics
Personal safety
Personal hygiene
Reporting ANEM (abuse, neglect, exploitation and mistreatment)
Adaptive equipment
Social interaction
Safety".

-Health Risk Plan dated 5/19/21 indicated, "Dysphagia (swallowing difficulty), Aspiration (foreign object in lung), Potential for GERD (gastroesophageal reflux disease) ... Actions: 6. Sit upright while eating and have (sic) encourage him to sit up for 30-60 minutes after meals ...".

On 6/2/22 at 1:35 PM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked about implementation of active treatment and how staff should provide redirection. The QIDP stated, "Every 15 minutes the individuals should be engaged for the goals in their plans". The QIDP was asked about

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	implementation of goals. The QIDP stated, "Goals are pretty much daily". The QIDP was asked about implementation of schedules. The QIDP was asked if both in formal and formal training and teachable moments should be prompted and encouraged by staff. The QIDP stated, "There is an expectation. There are skills that they (staff) should work on (with clients). Yes". On 6/2/22 at 2:55 PM, the Program Manager (PM) was interviewed. The PM was asked how staff should prompt to encourage implementation of goals, plans, and schedules to ensure active treatment was being provided. The PM stated, "We try to get them (staff) to prompt every 15 minutes".2. Observations were conducted at the facility on 5/31/22 from 11:20 am through 12:41 pm and from 4:30 pm through 7:10 pm, on 6/1/22 from 10:45 am through 11:22 am, from 2:22 pm through 3:20 pm, and from 4:45 pm through 6:08 pm. On 5/31/22 at 11:20 am, client #10 was in the gymnasium with Direct Support Professional (DSP) #15. Client #10 was wearing a polo shirt inside out, black sneakers with the tongue of the the left shoe pushed down into the toe of the shoe and no socks. When asked about his shoes and socks, client #10's response was unrelated. Direct Support Professional (DSP) #15 indicated staff should prompt client #10 to fix his shoes. DSP #15 stated, "When you go back inside [client #10], you need to put on socks." At 11:35 am, there were no clients in the recreation room, movie room, library, or art room of the activity building. From 11:53 am until 12:41 pm, client #3 was seated at a table in the corner of the dining room. Client #3 was not approached by any staff and did not			

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engage with any clients. Client #3 sat silently and observed the room.

At 11:53 am, client #7 was setting the tables for lunch. Residential Manager (RM) #1 was mopping the floor in the dining area. RM #1 did not prompt any clients to assist with cleaning the floor. In the main living area (day room) and dining area, clients were wandering around without directed activity. The room was loud and chaotic. At 11:54 am, client #6 approached the surveyor and stated, "All of this yelling makes me mad."

At 11:56 am client #10 was sitting on a sofa in the day room while waiting for lunch to be served. Client #13 walked behind the sofa and client #10 screamed. Client #13 and client #10 shouted at one another. Client #10 yelled, "He hit me." RM #2 separated clients #10 and #13. At 12:15 pm, clients #10 and #13 were seated at separate tables waiting for lunch to be served. Client #10's back was to client #13, and client #13 was facing client #10. Client #13 began banging his fist on the table. Client #10 stated, "Please stop." Client #13 continued banging on the table with his fist. Client #10 shouted, "Stop." Client #13 shouted, "Shut the f*** up." Client #10 shouted, "You shut up." RM #2 stated, "[Client #10], just ignore him. You have an outing. He's not worth losing an outing." RM #2 did not address client #13. Client #13 continued banging on the table. Clients #10 and #13 continued shouting at one another. Client #10 put his fingers in his ears and began screaming. Client #13 shouted, "F*** you." Client #10 shouted, "Stop, please stop." RM #2 prompted client #10 to get his noise canceling headphones. Client #10 stated, "I'll go get my headphones." Client #10 got up from the table and left the room. When client #10 left the

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room, client #13 stopped banging on the table. Client #10 returned with his noise canceling headphones. When client #10 entered the day room and was within sight of client #13, client #13 resumed banging his fist on the table. When client #10 returned to the table, client #15 was in the seat client #10 had left. Client #10 protested and asked client #15 to move. RM #2 stated, "[Client #10], [client #15] was there first. Go to another table." Client #10 moved to another table and took off his noise canceling headphones. Client #13 resumed banging his fist on the table. Client #10 shouted, "Please stop."

At 12:15 pm, client #8 stated, "I'm getting fried chicken and French fries. I am getting [fast food restaurant]." At 12:22 pm, Residential Manager (RM) #2 stated, "Today is [client #8's] outing. He's getting [fast food restaurant]. He's waiting for [client #5] and [Direct Support Professional (DSP) #6] went to get it." When asked why client #5 went on client #8's outing, RM #2 stated, "[Client #8] doesn't like to go on the van."
DSP #6 was interviewed on 6/2/22 at 2:30 pm and stated, "Sometimes [client #8] will go on an outing. Sometimes he'll refuse. He doesn't like hills or going fast in the van. It scares him. We could offer a 1 on 1 activity here. He does enjoy the meal, he just doesn't want to go pick it up." DSP #6 stated, "I don't know if we'd offered other activities."

At 12:23 pm, pizza and vegetables were served.

At 12:26 pm, DSP #2 was seated in a metal chair outside of client #2's bedroom. DSP #2 stated, "[Client #2] has been throwing up his food. We have to watch him eat. The nurses are concerned he's choking." DSP #2 indicated client #2 spent most of his time in his bedroom and usually ate in

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	his bed room. DSP #2 stated, "He doesn't like loud noises. He stays in his room." When asked if there were quiet activities planned for client #2, DSP #2 stated, "We ask if he wants to come hang out with everyone else." When asked again if there were quiet activities planned for client #2, DSP #2 stated, "No. There isn't anything planned for him." DSP #2 stated, "He likes [client #15]. They know each other from [another facility], but he prefers to be in his room."RM #1 was interviewed at 12:35 pm. RM #1 was asked if any clients were not eating with the group. RM #1 stated, "Today is [client #11's] outing day. Sometimes he'll go to get it, but if he's asleep we don't wake him up. We go get it and bring it back here. He's full puree, so he always eats here." RM #1 stated, "[Client #12] isn't out here. A lot of times he'll sleep through meals. He leaves for good tomorrow, so we're letting him sleep."At 12:40 pm, client #13 walked past client #10 and clapped his hands loudly. Client #10 screamed, "Stop." Client #13 stated, "Shut up."At 4:31 pm, client #3 was standing in the corner of the dining room. Most of the clients were in the day room and were not engaged in any organized activity. At 4:32 pm, client #8 approached the surveyor and stated, "Take me to the porch." The			

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	surveyor indicated she could not take client #8 outside and advised him to ask his staff. Client #8 approached DSP #6 and asked to go outside. DSP #6 stated, "I will in a minute." At 4:34 pm, client #8 approached the survey and stated, "Please take me to the porch, ma'am." The surveyor indicated she could not take client #8 out of the building and advised him to ask staff. Client #8 approached DSP #6 and asked to go outside. DSP #6 stated, "In a minute." At 4:34 pm, client #3 was standing at the front door, looking out the window.At 4:40 pm, client #3 was standing in the kitchen, watching staff and client #14 prepare the evening meal. Client #8 followed the surveyor into the kitchen and again asked to go outside. Client #10 was lying on the sofa. Client #4 came near to client #10, and client #10 screamed. RM #2 stated in a loud voice, "How does it help if you scream, too?" Clients #4 and #10 were not redirected to other activities.At 4:43 pm, client #3 was standing by the kitchen door.At 4:48 pm, [client #12] asked RM #2, "What's for dinner?" RM #2 stated, "You just hit [client #4], what are you asking me questions for?"At 4:51 pm, client #3 was standing inside the kitchen. Client #4 ran past client #10. Client #10 yelled, "He hit me." RM #2 stated, "Everybody knows, [client #10]." Client #3 stood outside the			

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	kitchen door. Clients #4 and #10 were not redirected to another activity.At 4:54 pm client #3 went back inside the kitchen to watch staff cook. DSP #9 stated, "He likes to stand in here. Sometimes we ask him to help, but he doesn't do much."On 5/31/22 at 5:03 pm clients #3 and #13 were in the day room waiting for dinner to be served. Client #3 was in the kitchen watching staff preparing the meal. Client #3 walked out of the kitchen. Client #13 stood in the doorway of the kitchen and used his arms to block the doorway. Client #3 walked up to client #13 and looked at him. Client #3 attempted to step around client #13 to enter the kitchen. Client #13 blocked client #3. Clients #3 and #13 stared at one another. Client #3 poked client #13's glasses. Client #13 slapped client #3's hand away. Client #19 walked up to the kitchen door and client #13 moved away to let him pass. Client #3 attempted to follow client #19, and client #13 blocked him. DSP #2 walked to the kitchen door, and client #13 moved out of the way. Client #3 followed client #19 into the kitchen. Client #13 followed client #3 into the kitchen. Clients #3 and #13 stood facing one another and stared at one another. DSP #10 stated, "Hey, don't start." Client #1 walked into the kitchen, and client #13 grabbed each of his elbows from behind and pushed client #1 out of the kitchen.			

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	Client #13 left the kitchen. DSP #10 followed client #13 and spoke with him in the hallway away from client #3. Client #3 remained in the kitchen. Clients #3, #19, and #1 were not redirected to other activities.Client #13's record was reviewed on 6/1/22 at 4:15 pm.Client #13's BSP dated 5/13/22 indicated the following:"Target Behaviors:Instigation: [Client #13] can engage in provoking/instigation type behaviors towards others and he has demonstrated that he will bully or even engage in aggression toward peers who are much lower functioning than him. If a peer is being loud, [client #13] may go after that peer or may threaten to hurt that peer....Reactive Procedures:For Instigation:- If he is taunting a peer, firmly but calmly tell him that the behavior is not appropriate but do not give excess attention to him for the undesired behavior.- Redirect him or the peer who is being instigated with a different activity or to a different area.- If he is engaging in instigation in view of a peer, remain between the two peers."DSP #2 was interviewed on 6/2/22 at 11:53 am and stated, "[Client #13] does the fist pounding to instigate. We're supposed to try to correct him. He says he's bored. He stares at his peers and makes it know he's try to get them worked up." DSP #2 stated, "[Client #13] isn't supposed to touch			

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	anyone. If he's acting as staff, we're supposed to correct him. We tell him not to touch his peers. He should be written up for physical, and staff should redirect him."At 5:06 pm Licensed Practical Nurse (LPN) #3 stated, "Come on [client #10]. Let's go outside for a walk." Clients #19 and #8 followed LPN #3 and went outside with her. Client #3 was standing in the kitchen.RM #2 was interviewed at 5:09 pm and stated, "There is no schedule or activity right now. We're waiting for dinner."Client #6 came out of the kitchen with a individual serving of green beans. Client #6 sat down at a table and began eating the green beans by pouring them into his mouth. Client #6 did not have a utensil.On 5/31/22 at 5:18 pm, client #16 returned to the facility from an outing. Client #16 sat down at a table in the dining room with a bag from a fast food restaurant. Client #16 opened 2 burritos and a soft taco and ate them over a paper wrapper. Client #16 did not have a drink with his meal. Client #16 stopped eating several times to lick sauce from his fingers. Client #16 stated, "I was supposed to have a drink, but I guess I didn't get one." Staff did not prompt client #16 to use a napkin.Client #19 was interviewed at 5:20 pm and stated, "I like to go to any restaurant. I go every Wednesday. I always bring it back here to eat. We're not supposed to go into the			

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	restaurant because of COVID. We did go to the movies last week. It was like 5 people." DSP #2 overheard the conversation with client #19 and stated, "They only go on outings on weekends." Client #19 stated, "I used to work at [workshop]. I don't work there anymore. They won't renew the contract." Client #19 indicated he would like to have a job, so he would have more money.At 5:22 pm, client #3 was standing in the kitchen watch staff prepare the evening meal.At 5:25 pm, client #3 walked up to client #16. DSP #2 walked between the two and did not say anything. Client #3 walked away. Clients #16 and #3 were not redirected to another activity. DSP #14 was interviewed at 5:30 pm and stated, "[Client #16] went through the drive through. He also went to [thrift store]."At 5:33 pm, client #19 yelled, "Back up. Back up, [client #3]. He grabbed my shoulder." DSP #2 stepped between clients #3 and #19. Client #3 approached client #19. Client #19 made an unheard remark. Client #3 shouted, "Do it. I'm not scared of you." Client #19 turned and walked down the hallway. Client #19 was called to the medication room. Client #19 turned and walked back down the hall towards the medication room and client #3. Client #3 stated, "I'll come at you." Client #19 stated, "Do it." LPN #3 stepped between clients			

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	#3 and #19 and directed client #19 inside the medication room." Client #3 turned to client #8 and the two stared at one another. DSP #2 stepped between them. Client #3 was not redirected to another activity.At 5:45 pm, client #6 approached the surveyor and said something. Client #6 could not be heard over the noise in the day room. The surveyor asked client #6 to repeat what he said. Client #6 shouted, but the surveyor could not hear him well enough to understand what he said.At 5:48 pm, client #8 poked client #5 on the top of his head. Client #5 swatted client #8's hand away. RM #2 stated to client #8, "What's wrong with you? Don't do that."At 5:50 pm, clients #3, #7, #8 #9, and #19 were waiting for the evening meal to be served. Client #19 stated to client #8, "Do you want to go outside?" Client #19 was holding a football and a pair of cleats. Client #19 gathered clients #7, #8, and #9 and stated, "This is the only time we'll get to go outside today. Come on, let's go." Clients #7, #8, #9, and #19 walked to the end of the hallway and congregated at the door. Client #3 followed. At 5:53 pm, client #19 walked up the hallway to the day room, approached DSP #7 who was leaning on the kitchen door and stated, "Will you take us out? [DSP #10] said he would, but I don't know where he went." DSP #7 refused client #19			

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	but did not give a reason. DSP #7 turned away from client #19 and walked outside through the kitchen door. DSP #10 was standing in the pantry inside the kitchen. Client #19 walked back down the hallway and stood with clients #3, #7, #8, and #9 by the exit door. At 5:56 pm, client #7 was at the far end of the hallway by the exit door. DSP #2 was in the day room at the opposite end of the hallway. Client #7 shouted to DSP #2, "[client #3] is threatening people." DSP #2 shouted back, I'm the only staff in the day room, and I'm 1:1 for [client #4]. I can't help you." DSP #2 called DSP #10 from the kitchen and stated, "Can you deal with [client #3]? I guess he's threatening people." DSP #10 walked to the end of the hallway and began conversing with client #3. DSP #2 stated, "They were going to go out with [DSP #10], but he was in the kitchen. I don't know why he didn't take them out." At 6:06 pm, client #9 left the group at the door and went to the dining area to sit down. Clients #7 and #19 sat down on the floor with their backs against the floor. Client #8 wandered away. DSP #10 continued talking with client #3. DSP #10 directed clients #7 and #19 to leave the area. Clients #7, #8, #9, and #19 were not redirected to another activity.Client #19 was interviewed on 5/31/22 at 6:08 pm and stated, "We couldn't go out because [client			

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	#3] had a behavior. [DSP #10] said he would take us."DSP #10 was interviewed on 5/31/22 at 6:51 pm and stated, "[Client #3] was being verbally aggressive towards the others. It progressed and he prolonged until dinner was done, so they didn't have time to go outside." When asked why he didn't take the clients outside when they were ready, DSP #10 stated, "I got distracted talking to other staff."DSP #2 was interviewed on 6/2/22 at 11:53 am and stated, "Staff should follow through. We shouldn't say we'll do something then not do it. If [DSP #10] had done what he said, there wouldn't have been an issue."RM #4 was interviewed on 6/2/22 at 12:36 pm and stated, "If they ask to go somewhere, staff should just go. They shouldn't make them wait. Just go with them. They stand at the door and bicker."Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 6/2/22 at 1:34 pm and stated, "Staff shouldn't make a promise without a plan and a set time. Staff should be aware of what is happening before they say they'll do something. Staff shouldn't send [client #19] to get a group together. If the staff couldn't take them, he shouldn't have sent [client #19] to get a group."Behavior Clinician (BC) #1 was interviewed on 6/2/22 at 3:20 pm and stated, "Staff caused that behavior. Staff			

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	should follow through on what they say they'll do."At 5:50 pm, client #18 sat down at a dining table with small prepackaged container of green beans. Client #18 peeled back the plastic cover and began drinking the juice from the cup. Client #18 then dumped the contents of the cup into his mouth and ate them. Client #18 indicated he was eating green beans because he was hungry and the evening meal was not ready. Client #18 indicated staff gave him the snack. Client #18 indicated he was not offered a utensil. Staff did not prompt client #18 to use a utensil.At 6:05 pm, clients #10 and #14 returned to the facility from an outing. Clients #10 and #14 sat down at a table in the dining room with bags from a fast food restaurant and a gas station. Clients #10 and #14 were not provided with plates, utensils, or napkins. Clients #10 and #14 had slushies to drink. Client #10 dumped a burrito and a doughnut onto the bare table and proceeded to eat them with his fingers. Staff did not prompt clients #10 or #14 to use napkins or to place their food items onto a plate. When clients #10 and #14 got up from the table, there was lettuce and donut icing scattered across one half of the table and on the floor where they had been sitting.At 6:12 pm, client #8 charged at client #5 and yelled loudly. RM #2 stated, "Hey, don't do that." RM #2 did not redirect client			

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	#8 to an activity.At 6:51 pm, client #7 was seated at a dining table. Client #7 stood and shouted at an unidentified clients, "You're not going to do anything. Shut the f*** up." DSP #9 stated, "Why are you antagonizing him?"At 6:57 pm, client #4 sat on a sofa in the day room and picked up client #10's glasses. DSP #2 stated, "Whose are those?" DSP #2 gave the glasses to client #10 and instructed him to put them on.DSP #9 began serving cheeseburgers and French fries. DSP #9 had all of the food on a cart and served each client using tongs. DSP #9 gave each client French fries then a burger patty then a bun. DSP #9 stated, "I'll bring condiments around after everyone has a sandwich. Throughout the meal, client #10 was screaming and making loud vocalizations. RM #2 stated, "You had [fast food restaurant], now you're ruining everyone else's dinner."At 6:58 pm, client #1 got up from the dining table, walked to client #3's table and grabbed a handful of French fries. Client #1 ate some fries and dropped some on the floor and table. Staff did not address client #1. At 7:00 pm, client #3 asked for more French fries. DSP #7 stated, "Do you want more?" Client #3 stated, "Yes." DSP #7 stated, "What do you say?" Client #3 stated, "Please, please, please." DSP #7 stated, "You only have to say it one time. You need to be patient."			

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	Client #7 walked past client #3, and client #3 reached out to slap client #7. Client #7 dodged the slap and continued on.At 7:02 pm, client #1 walked to client #6's table and grabbed a handful of French fries from his plate. Client #6 protested verbally, but staff in the dining area did not respond to client #1.At 7:03 pm, client #3 went to the kitchen and asked for more French fries. DSP #7 redirected client #3 to his table and stated, "You have to be patient." At 7:04 pm, client #19 brought a bowl of French fries to client #3 and dumped them onto his plate.At 7:04 pm, client #1 went to client #9's table and tried to grab food from client #9's plate. Residential Manager (RM) #4 covered client #9's plate with her hands. When client #1 reached for client #9's plate, he pushed RM #4's hands into client #9's food.- Staff did not redirect client #1 away from the dining area.DSP #2 was interviewed on 6/2/22 at 11:53 am and stated, "Staff should redirect client [client #1] away from the dining area when he's done eating."On 6/1/22 from 10:45 am through 11:07 am, clients #1, #2, and #17 were in their beds sleeping.On 6/1/22 at 2:22 pm, client #1 was in his bedroom with Direct Support Professional (DSP) #14. Client #1's bedroom door was open, and he was not wearing any clothing. DSP #14 assisted client #1 to put his disposable briefs on. DSP #14 stated, "Let			

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	me get you some clothes." DSP #14 assisted client #1 to put on a t-shirt and shorts. DSP #14 placed foam shoes on the floor in front of client #1 and directed him to put them on. DSP #14 stated, "Those are the wrong feet. It doesn't really matter. Go." Client #1 walked out of his bedroom.DSP #14 was interviewed on 6/1/22 at 2:31 pm and stated, "I don't feel comfortable with the door shut with [client #1]."DSP #2 was interviewed on 6/2/22 at 11:53 am and stated, "Doors should be shut for privacy. No one should be seeing a client naked. There is no reason for [client #1's] door to be open while he's dressing."Residential Manager (RM) #4 was interviewed on 6/2/22 at 12:36 pm and stated, "Doors should be shut for privacy. Some of the others are nosy and will try to look through the doorway." RM #4 stated, "If a staff is uncomfortable, they could ask for a second staff to assist."Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 6/2/22 at 1:34 pm and stated, "If staff can't shut the door, there should be 2 staff with the door shut."Program Manager (PM) #1 was interviewed on 6/2/22 at 2:56 pm and stated, "Staff should close the door while providing personal care."At 2:22 pm, client #11 was asleep in his bed. Client #2 was sitting at a dining table with a milkshake.			

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	Client #3 was outside on the porch with staff.At 2:27 pm, client #8 was standing the day room. A string of drool had fallen from client #8's chin and was on his shirt. The front of client #8's shirt was wet. DSP #14 stated, "[Client #8], you go potty. I'll get you a drink." Client #8 was not prompted to wipe his mouth or to change his shirt.At 2:30 pm, client #2 finished drinking his milkshake. DSP #14 stated, "I'll clean up your mess. You can go." DSP #14 cleared client #2's place at the table.At 2:41 pm, clients #1, #2, #4, and #15 were in the day room with RM #1 and DSPs #2 and #14. Client #2 was walking up the hallway from his bedroom, and client #15 approached with his arms outstretched. Client #15 wiggled his fingers towards client #2 and stated, "Here comes the tickle monster." Client #2 laughed and ran from client #15. Client #2 and #15 hugged and tickled one another. Client #2 began running down the hallway, and client #15 chased after him. Client #2 went into his bedroom, and client #15 returned to the day room. Client #2 returned to the day room. Clients #2 and #15 stood face to face. Client #2 put his tongue between his lips and blew out causing a vibrating sound and causing saliva to fly into client #15's face. Client #15 laughed and stated, "You're blowing raspberries." Client #15 returned the gesture and both			

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	laughed. Client #2 repeated the gesture, again causing saliva to fly into client #15's face. RM #1 stated, "[Client #15]." Client #15 stated, "I'm good. I'm used to it." Client #15 stated to client #2, "Show her," and indicated the surveyor. Client #2 turned towards the surveyor, and DSP #2 stated, "No. Don't do that." Client #2 began chasing RM #1 around the room, and RM #1 ran from him. Client #2 was not redirected from chasing RM #1. Client #15 approached client #2 from behind, placed his arms under client #2's arms and gave him a full body hug. Staff did not redirect clients #2 and #15 from the hug. At 2:45 pm, client #2 down the hallway towards his bedroom. Client #15 shouted after him, "Run [client #2], run." RM #1 stated to client #15, "As long as he's not hitting people. He slammed me into the thing yesterday." Client #2 returned from his bedroom. There was saliva dripping from his chin onto his shirt. Client #2 was not prompted to wipe his face or to change his shirt. RM #1 ran down the hallway and into a bedroom. Client #2 chased after RM #1 and went into client #9's bedroom then into clients #19 and #15's bedroom. Clients #15 and #2 went into both bedrooms to look for RM #1. Client #15 and DSP #14 encouraged client #2 to continue chasing RM #1 and to look for her. RM #1 came out from a bedroom			

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	while client #2 was not looking and ran into the kitchen. Client #2 followed, and RM #1 ran down the other hallway with client #2 in pursuit. RM #1 ran back up the hallway and stated, "I don't want to be licked." RM #1 used her key card to enter the medication room and shut the door. Client #2 was not able to follow RM #1. RM #1 came out of the medication room, and client #2 continued attempting to chase her. RM #1 prompted client #2 to dance.DSP #2 was interviewed on 6/2/22 at 11:53 am and stated, "That behavior is not appropriate. They're friends from [previous facility]. Staff should have said something. [Client #15] will usually listen and can be directed. He should be educated on what his plan says. Staff shouldn't allow tickling."RM #4 was interviewed on 6/2/22 at 12:36 pm and stated, "[Clients #2 and #15] need to give each other more personal space. Most have a personal space goal. Playing tag with staff should not be happening. Staff should not encourage that behavior."QIDP #1 was interviewed on 6/2/22 at 1:34 pm and stated, "Tickling and touching shouldn't happen. It can trigger past trauma. It is staff's responsibility to redirect. They could prompt for a side hug. The staff are here to help the clients grow and become independent as a service. Allowing that behavior is not helping them to develop			

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	themselves."Program Manager #1 was interviewed on 6/2/22 at 2:56 pm and stated, "There should be no horseplay. Some even have a BSP for horseplay. Staff shouldn't be hiding in bedrooms. It's inappropriate. Staff should redirect. It could cause behaviors. It's not developmentally or age appropriate behaviors. Staff should not encourage hugs. They should redirect and model appropriate behaviors."BC #1 was interviewed on 6/2/22 at 3:20 pm and stated, "That behavior is not appropriate for [client #2]. He's unpredictable. No one should be hugging him. He will act like he having fun then will pop you. Grown men don't tickle. Staff should follow the plans."DSP #2 was interviewed at 2:56 pm and stated, "There is no organized or planned activity right now. We're waiting for DSP #10 to return with ice cream. There was a van ride for life skills with 11 or 12 people. The rest are here. Some sleep or are on the couch socializing. There is no second option besides the van ride.RM #1 was interviewed at 3:03 pm and stated, "The life skills group goes on a van ride. They take as many as possible. The drive through [town]. They just drive. Sometimes they go up to the highway. There are no goals or activities. They just ride around on the van." RM #1 stated, "If we have adequate staff, we'll do			

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	games with the ones who are left. [Client #2] likes to be out here during this time. We most focus on interaction [client #2]. He's not bothered by the noise at this time." RM #1 stated, "[Clients #15 and #19] like to do tickle monster with [client #2]. They run back and forth. Usually, [client #15] is not awake at this time of day."At 3:07 pm, client #10 returned from a van ride. Client #10 was not wearing his glasses or socks.At 4:45 pm, clients #10, #11, #13, #15, and #20 were standing in the day room. The clients were pacing through the room and congregating around staff. Staff did not redirect the clients to an activity. DSP #6 was outside with client #3. DSP #6 opened the door and asked client #15 to get a game from a cabinet. Client #15 took the game to DSP #6. DSP #6 set the game up on the front porch and attempted to engage client #3 with the game. No other clients were prompted to engage in activities. There were pots on the stove with vegetables cooking. No clients were prompted to assist with preparing the evening meal.At 4:55 pm, DSP #2 indicated there were 3 DSPs, 2 RMs, and 4 administrative staff in the facility at the time of the observation. DSP #2 indicated clients #1, #2, #3, #4, #5, #8, #10, #11, #13, #17, #18, and #20 were still at the facility, and the remaining clients were on a community outing. DSP #2			

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	indicated there were not planned activities for the clients who did not go on the community outing.At 5:00 pm, DSP #6 was outside with clients #3 and #17. At 5:04 pm, DSP #10 stated, "[Client #20], I'm going to sweep the day room into a pile. Will you help me sweep it up?" Client #20 stated, "Yeah."At 5:09 pm, RM #4 prompted client #20 to the kitchen. Client #2 came from his bedroom to the day room. RM #4 set the tables in the dining room and did not prompt any clients to assist her. Program Manager (PM) #1 was assigned to one on one status with client #1. PM #1 followed client #1 around the facility and took him outside.At 5:16 pm, DSP #10 put cups on the tables. No clients were prompted to assist.At 5:19 pm, Qualified Intellectual Disabilities Professional (QIDP) #1 brought a rolling speaker from client #13's bedroom and took it outside to listen to music with clients #3 and #17.At 5:18 pm, client #1 was pacing through the day room with DSP #10 as his one to one staff. DSP #10 followed client #1 through the home and did not attempt to engage him in an activity. Client #4 sat on a sofa in the day room. Staff did not attempt to engage him in an activity. Client #2 was in his bedroom with his door closed.At 5:30 pm, clients #11, #13, and #20 were pacing through the day room. Clients #4 and #18 were sitting			

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	on sofas in the day room. There was a radio prompt for staff and clients to complete handwashing.At 5:45 pm, client #13 walked up behind client #3 and clapped his hands loudly by client #3's ear. DSP #10 stated, "Let's not do that. Don't antagonize your peers." Client #10 was not wearing his glasses.At 5:50 pm, RM #3 brought a tray of food to clients #10 and #13's table. At 5:53 pm, client #15 approached DSP #10 and stated, "They need help in client #18's room."At 5:54 pm, DSP #10 brought a tray of food to clients #1, #11, and #15's table.At 5:57 pm, DSP #6 brought a tray of food to client #2's table.At 5:58 pm, client #3 was sitting at a table alone. Client #3 had not been served. Client #3 began repeating, "Where's [QIDP #1]?" DSP #2 stated, "[Client #3] does that every time [QIDP #1] leaves the building. Sometimes he has a behavior over it. Client #1 got up from the table and began hopping up and down the halls.At 6:00 pm, client #1 was served his meal. QIDP walked through the building and took client #13's speaker back to his bedroom. Client #3 followed QIDP #1. Client #3 shoved client #10 out of the way and yelled down the hallway, "[QIDP #1], I want chocolate milk." RM #3 blocked client #3 and stated, "We don't have any." QIDP prompted client #3 to return to his seat and sat with client #3 while			

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	he ate.At 6:06 pm, client #1 was running up and down the hallways, through the day room, and into the kitchen. Client #2 was in his bedroom with the door closed.Client #1's record was reviewed on 6/1/22 at 1:52 pm.Client #1's Behavior Support Plan (BSP) dated 5/26/22 indicated the following:"Target Behaviors and Goals....Anal Digging/Smearing Feces:.... [Client #1] will sometimes reach back toward his anal area right after having a bowel movement, and it has been helpful for staff to hold his hands after a bowel movement, so that he is not tempted to do this. [Client #1] may engage in this behavior to upset staff, so that they just give in to what he wants.... Includes attempts to eat his feces. [Client #1] may engage in this behavior to get a reaction out of staff, and staff should respond with as little reaction or emotion as possible. If he sees that it upsets or flusters you, he will do it more. He likes the reaction....Restrictions:- Staff will remain in the doorway when [client #1] bathes due to a history of unhygienic behaviors in the tub such as defecating and playing with his feces. Showers should be encouraged instead of baths due to [client #1's] aggressive thrashing in the bath tub and his history of defecating in the tub and playing with it....Preventative Procedures:- He should be encouraged to take showers			

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	rather than baths due to his history of violently thrashing around in the tub causing bruising to himself....- [Client #1] seeks a reaction from staff and has had behaviors in the past in order to get a reaction out of staff. Don't react emotionally to his behaviors by being shocked, grossed out, or upset. Act almost as if the behavior did not just happen. ALL staff need to be on board with this intervention in order to decrease these types of behaviors."Client #1's BSP indicated the following:"Inappropriate Access to Food: any time [client #1] obtains food items by 'stealing' them off of his peer's plates, digging the food items out of the trash, or eating food items that have been found/left on the floor. It would not be uncommon for [client #1] to circle the dining tables of his peers in an effort to take leftover food items off of the table....Restrictions:- [Client #1 will have an assigned staff across all shifts.... The assigned staff is responsible for the following: - Meal/snack supervision....Preventative Procedures:- [Client #1] will circle the dining hall area and will attempt to steal food from the plates of others. Verbal redirection rarely helps in this situation, and it is more effective to be preventative by redirecting [client #1] out of the immediate dining area when he is done eating. He should not stand near peers who are eating, and he should not			

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	circle the dining area because he is looking for items to steal. He can be encouraged to leave the residence in order to take a walk. He can be given time in his room with his tablet, etc....Reactive Procedures:- The best way to handle this behavior from [client #1] is to be preventative so that he cannot try to get food in the first place.- When [client #1] is done eating, he should not be able to circle the dining tables or stand next to peers who are eating.- [Client #1] likes walks, encourage him to go for a short walk in order to get him out of the dining area and to get him interested in a different activity.- If you cannot avoid this behavior, reassure the other peer that we will take care of it and get them a new food item.- Educate [client #1] that if he wants seconds, he can let staff know so they can help him...."Client #2's record was reviewed on 6/1/22 at 4:15 pm.Client #2's BSP dated 5/25/22 indicated the following:"Target Behaviors and Goals:....Physical Aggression: Any occurrence or attempts at hitting people, pinching others, spitting on them, kicking, or scratching at others, using objects as weapons, pulling hair, or behaviors that produce or have the potential to produce an injury to others.... He has engaged in very impulsive acts of physical aggression to peers who aren't even interacting with him in common areas. Staff should pay close			

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	attention to the proximity of [client #2] and other clients when [client #2] is in the common areas. Also, he does not like peers hugging or touching him. Peers should be reminded to give him personal space.... [Client #2] will often be pleasant in the day room but will then hit a peer and then run back to his bedroom and then slam the door...."Client #3's record was reviewed on 5/31/22 at 1:38 pm.Client #3's BSP dated 5/26/22 indicated the following:"Target Behaviors and Goals:Verbal Aggression: any time he is yelling at others, cursing, threatening others, using profanity, etc....Instigation: Includes attempts to get peers upset or to get peers to engage in target behaviors....Precursors:Verbal aggression could be identified as a precursors to other behavioral issues. When he engages in this behavior, staff will:- Remain calm in tone and volume, do not react with emotion or irritation.- Ignore threats and verbal abuse - do not get into a back-and-forth power struggle....Preventative Procedures:- [Client #3] should have opportunities throughout the day to leave the residential hall and go to the yard/gym/etc.- Give [client #3] choices whenever possible, he does best when he feels like he has some control over his situation...."Client #10's record was reviewed on 5/31/22 at 2:45 pm.Client			

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	#10's BSP dated 4/14/22 indicated the following:"Target Behaviors and Goals....Disruptive Yelling: Defined as any time [client #10] is yelling or shouting in common areas that is not related to playing with peers or asking for help....Precursors:- Assess the environment? Is there a lack of interesting activity to participate in? Has it be			
W 0268 Bldg. 00	483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client.			
	Based on observation, record review and interview for 3 of 4 sampled clients (clients #1, #2 and #4), plus 5 additional clients (#8, #10, #11, #17 and #18), the facility failed to promote clients #1, #2, #4, #8, #10, #11, #17 and #18's dignity in regard to their appearance. Findings include: Observations were completed in the facility on 5/31/22 from 10:45 am through 12:45 pm, from 3:50 pm through 5:05 pm, on 6/1/22 from 8:00 am through 9:00 am, and on 6/2/22 from 7:00 am through 8:30 am. On 5/31/22 at 12:34 pm, client #11 was in the day room eating lunch. When client #2 stood up from his meal, both of his pants pockets were inside out. Staff did not prompt client #11 to place the pockets back in his pants. At 4:15 pm, client #11's pockets were still inside out. Staff did not prompt client #11 to place the pockets back in his pants. At 3:50 pm, client #10 had drool on the chest of his T-shirt. Client #10 was not prompted to change his shirt until 4:25 pm when RM #2	W 0268	Goals were added to address drooling for clients #2, #8, and # 10. Staff are trained in new goals. All staff were trained to prompt (and assist when necessary) clients to change clothing when soiled or worn incorrectly (inside out, backwards, shoes on the wrong feet, etc). Also, to prompt clients for personal hygiene and putting on clean clothes daily. All staff trained to at all opportunities to follow the BSP and ISP. Encouraged when in doubt look it up in program books. All staff were trained in all staff meeting to encourage client # 4 to wear socks and shoes, but if he doesn't wear socks and shoes to wipe his feet throughout the day with cleansing wipes.	07/08/2022

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	prompted him to change his shirt for an outing. At 4:43 pm, client #2 was sitting in the day room. Client #2 had drool coming from his mouth on to his shirt. Throughout the observation, client #2 was not prompted to wipe his chin or change his shirt. On 6/1/22 at 8:15 am, client #1 was pacing the unit. Client #1's shirt was on backwards. At 8:25 am, Residential Manager (RM) #2 stated to client #1 "your shirt's on backwards." The RM did not prompt or offer to assist client #1 in turning his shirt around. At 8:22 am, client #18 came to the dining area for breakfast. Client #18's pants were sitting lower than his natural waist, exposing half of his buttocks. Staff #14 served client #18 his breakfast. Staff #14 did not prompt client #18 to pull his pants up. On 6/2/22 at 7:15 am, client #4 was in the day room walking with his 1:1 staff #12. Client #4's shorts were wet on the back side and were sitting lower than his natural waist, exposing half of his adult brief. Staff #12 did not prompt client #4 or assist with changing his shorts. Client #17 was wearing the same tie-dyed shirt and gray sweat pants for day #3. At 7:30 am, Client #8 was in the day room, his orange shirt was on backwards and there was drool on the chest area. At 8:00 am, staff #15 stated to client #8 "your shirt's on backwards." Staff #15 did not prompt the client to turn his shirt around or offer to assist him. Client #2 had drool and food on the chest area of his shirt. Staff did not prompt client to change his shirt or offer to assist him. On 5/31/22 at 2:30 pm, client #2's record was reviewed. A comprehensive functional			

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	assessment dated 3/29/21 indicated client #2 "wears dirty or soiled clothing if not prompted." On 6/3/22 at 8:30 am, client #1's record was reviewed. An ISP dated 9/27/21 indicated clients #1's "Strengths: Dresses and undresses self independently. Needs: Needs to learn to initiate tasks." On 6/3/22 at 9:00 am, client #4's record was reviewed. An ISP dated 2/10/22 indicated "[Client #4] is unable to provide basic health, safety, and nutritional needs without continuous supervision, training and staff support." On 6/3/22 at 9:30 am, client #8's record was reviewed. An ISP dated 6/7/21 indicated "Strengths: Dresses and undresses with assistance. Needs: Needs to learn to initiate tasks." On 6/3/22 at 9:45 am, client #10's record was reviewed. An ISP dated 10/10/21 indicated "He can put his shirt and pants on independently, but his shirt will often times be put on backwards. Strengths: Dresses and undresses self independently Needs: Needs improvement in Personal Hygiene Skills." On 6/3/22 at 10:00 am, client #11's record was reviewed. A Behavior Support Plan (BSP) dated 5/17/22 indicated, "[Client #11] is largely non-verbal and needs assistance throughout his day to complete his activities of daily living. He often needs reminders to wipe his face after meals and snacks." On 6/3/22 at 10:15 am, client #17's record was reviewed. An ISP dated 6/15/21 indicated "[Client #17] is independent in his daily hygiene tasks of			

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	toileting, bathing, oral care, grooming and dressing but he does require prompts to initiate these tasks at times. Dresses and undresses self independently. Goals: Personal Dignity. GOAL: To increase responsibility for personal appearance and communication thus increasing social acceptance and independence. OBJECTIVE: [Client #17] will carry his handkerchief and use it to wipe his mouth as needed independently for 3 consecutive months by 06/01/2022. INTERMEDIATE OBJECTIVE: [client #17] will carry his handkerchief and use it to wipe his mouth as needed with 1 verbal prompts 75% of all opportunities for 3 consecutive months by 06/01/2022. METHODOLOGY: 1. Staff will prompt [client #17] to carry his handkerchief. 2. Staff will prompt [client #17] to use his handkerchief as needed when drooling. 3. If [client #17] refuses, staff will encourage him to use the handkerchief so his clothes stay clean and he is appropriate in public spaces and being sanitary. 4. A successful trial will be recorded when [client #17] wipes his mouth with his handkerchief with 1 or fewer verbal prompts. 5. Verbal praise and recognition will be given for all efforts." On 6/3/22 at 9:15 am, client #18's record was reviewed. An ISP dated 9/20/21 indicated "[Client #18] may need assistance with ADL's (activities of daily living) such as brushing his teeth, changing his clothes, and showering. Strengths: Can dress with assistance, understand and follow verbal commands. Needs: Needs supervision, Needs to learn to initiate tasks." An interview was conducted with staff #2 on 6/1/22 at 11:30 am. Staff #2 stated "most clients take a bath and dress themselves." Staff #2 stated client #2's goals included "dignity, hygiene, social			

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interaction, showering, brushing teeth." Staff #2 indicated client #2 should be prompted to change his shirt if it is soiled. Staff #2 stated client #2 having drool or food on his shirt was "a dignity issue."

An interview was conducted with RM #2 on 6/1/22 at 12:00 pm. RM #2 stated "all clients should be treated with dignity and respect." RM #2 indicated clients should appear clean. RM #2 indicated staff should prompt clients with soiled clothing to change for dignity purposes.

An interview was conducted with Licensed Practical Nurse (LPN) #1 on 6/1/22 at 2:30 pm. LPN #1 indicated all clients are encouraged to bathe daily. LPN #1 indicated all clients have a hygiene goal. LPN #1 indicated staff should prompt clients to change soiled clothing or fix clothing that is out of place. LPN #1 indicated it is a dignity issue to allow clients to wear soiled clothing.

An interview was conducted with the Director of Nursing (DON) on 6/1/22 at 4:05 pm. The DON stated "clients should always appear clean and neat, especially if they are going out." The DON indicated staff should prompt clients to wear clothing appropriately. The DON stated "we always want to treat our clients with dignity."
Observations were conducted at the facility on 5/31/22 from 2:15 PM through 3:26 PM, from 4:30 PM through 7:06 PM, on 6/1/22 from 2:22 PM through 3:24 PM, and from 4:44 PM through 6:07 PM. The observations indicated the following which affected clients #1, #2, #4, #8 and #10:

On 5/31/22 at 2:25 PM, client #4 sat down on a sofa in common living area referred to as the day room. Client #4 was not wearing socks or shoes

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	and the bottom of client #4's feet were black from being soiled with dirt and debris. At 2:26 PM, client #17 was wearing a black pair of athletic pants and white tie dye tank top shirt. Client #17 bent over to sit on a sofa in the day room and his buttock was exposed. At 2:55 PM, client #17 was in the day room and his pants were low which exposed his buttocks. At 4:57 PM, staff #10 verbally prompted client #4 to put his shoes on. Client #4 sat down on his bed put a pair of shoes on his feet. The bottom of client #4's feet were black from being soiled with dirt and debris. On 6/1/22 at 2:22 client #4 was seated on a sofa in the day room. Client #4 was not wearing socks or shoes and the bottom of his feet were black from being soiled with dirt and debris. At 2:34 PM, client #17 walked out into the day room. Client #17 wore the same black athletic pants and white tie dye tank top from the day prior. Client #17 was not prompted to change his clothing. At 2:40 PM, client #4 held a small football in his hands and was seated with his legs crossed. Client #4 bottoms of his feet were black from being soiled with dirt and debris. Client #4 was not prompted to clean his feet, put socks and/or shoes on. At 2:42 PM, client #17 returned to his bedroom. At 2:59 PM, client #4 sat down on a sofa in the day room with his legs crisscrossed. The bottoms of client #4's feet were black from being soiled with dirt and debris. At 5:15 PM, client #14 was outside playing a game of cornhole. Client #17 was wearing the same black athletic pants and white tie dye tank top. Client #17 bent over to pick up an object in the yard and his buttocks was exposed. At 5:33 PM, client #17 had switched games to badminton. Client #17 continued to wear the same clothing and when he bent over to pick up an object from the yard, his buttocks was exposed. At 5:35 PM, client #17 pulled his pants up and			

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pulled his tank top down to cover his midsection.

On 6/2/22 at 10:55 AM, the Director of Nursing (DON) was interviewed. The DON was asked about ensuring the dignity of clients #4 and #17. The DON indicated clients should be prompted by staff and supported to prevent dignity issues such as wearing the same clothing and exposure of body parts. The DON was asked about client #4's feet being black from soiled dirt and debris from walking without socks and/or shoes. The DON stated, "That's sad. I know we prompt him to put socks and shoes on". The DON indicated further follow up was required to ensure the dignity of clients #4 and #17 was being maintained.

On 6/2/22 at 12:02 PM, staff #2 was interviewed. Staff #2 was asked about prompting to ensure dignity was maintained. Staff #2 indicated prompts should be provided when staff identified issues and stated, "we prompt to change clothes or put them on the right way". Staff #2 indicated staff should prompt clients #4 and #17 if a dignity issue was identified.

On 6/2/22 at 12:36 PM, Residential Manager (RM #4) was interviewed. RM #4 was asked about prompting to ensure dignity was maintained. The RM indicated prompts by staff should be provided whenever dignity issues were identified. The RM #4 stated, "We try to prompt. We try to prompt, like coming out in layers (clothes) or backwards. We'll prompt for that". The RM indicated staff should prompt clients #4 and #17 to address dignity issues.

On 6/2/22 at 1:35 PM the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP about prompting to ensure dignity was

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	maintained. The QIDP indicated prompting by staff should be provided to address dignity issues such as wearing clothing repeatedly, clothing not fitting and/or an issue with dignity from being soiled. The QIDP stated, "I think it goes back to redirection and prompting". When the QIDP was asked what should staff do to address a dignity issue the QIDP stated, "Prompt the person". When the QIDP was asked about skills training and the opportunity to improve upon dignity issues, the QIDP stated, "Skills training should happen all the time". The QIDP indicated further follow up was needed to ensure the dignity of clients #4 and #17 was being maintained. On 6/2/22 at 2:25 PM, the Program Manager (PM) was interviewed. The PM was asked about prompting to ensure dignity was maintained. The PM indicated staff should be prompting to address dignity issues identified. The PM was asked about dignity issues such as wearing clothing repeatedly, clothing not fitting and/or an issue with dignity from being soiled. The PM stated, "Redirection to change. They should be prompting for that". The PM indicated further follow up was needed to ensure the dignity of clients #4 and #17 was being maintained. Observations were conducted in the group home on 5/31/22 from 11:20 am through 12:41 pm and from 4:30 pm through 7:10 pm, on 6/1/22 from 10:45 am through 11:22 am, from 2:22 pm through 3:20 pm, and from 4:45 pm through 6:08 pm. Clients #1, #2, #7, #8, and #10 were present in the home throughout the observation periods. 1. On 5/31/22 at 11:20 am, client #7 greeted the surveyor in the gymnasium. Client #7 did not close his mouth or swallow while conversing with the surveyor. While client #7 spoke with the surveyor, drool was dripping from his mouth and			

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chin and onto his shirt and the floor. Throughout the observation periods, client #7 had drool dripping onto his clothing and the floor. Staff did not prompt client #7 to wipe his mouth or to change his shirt.

2. On 5/31/22 at 11:20 am, Client #10 greeted the surveyor in the gymnasium. Client #10's shirt was inside out. Client #10 was wearing black sneakers with no socks. The tongue of client #10's left shoe was stuffed down into the toe of his shoe. When asked about his shoes and socks, client #10's response was unrelated. Direct Support Professional (DSP) #15 indicated staff should prompt client #10 to fix his shoes. DSP #15 stated, "When you go back inside [client #10], you need to put on socks."
At 4:43 pm, client #10's shirt was inside out. Client #10 was wearing black sneakers on the wrong feet. Client #10 was not wearing socks. Throughout the observation period, staff did not prompt client #10 to fix his shirt or his shoes. At 3:16 pm, client #10 returned to the facility from an outing. Client #10 was wearing black sneakers without socks.

Residential Manager (RM) #1 was interviewed on 5/31/22 at 5:09 pm and stated, "Staff should prompt [client #10] for his shirt and shoes. Staff is supposed to tell him."

3. On 5/31/22 at 12:07 pm, client #8 had drool dripping from his mouth. The drool pooled in client #8's facial hair before dripping onto his shirt. The front of client #8's shirt was wet from the collar to the middle of his shirt. On 6/1/22, at 2:30 pm, client #8 had strings of drool dripping from both sides of his face onto his shirt. The front of client #8's shirt was wet from the collar to the middle of the shirt. DSP #14 approached client

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#8 and stated, "[client #8], you go potty. I'll get you a drink." DSP #14 did not prompt client #8 to wipe his face or to change his shirt. At 3:16 pm, RM #2 prompted client #8 to sit at a table for a milkshake. Drool was dripping from client #8's mouth onto his shirt and the floor. RM #2 did not prompt client #8 to wipe his mouth or to change his shirt.

4. On 6/1/22 at 2:22 pm, DSP #14 was assisting client #1 with dressing in his bedroom. DSP #14 put client #1's foam, slip-on shoes on the floor. Client #1 stepped into the shoes with the wrong feet. DSP #14 stated, "That's the wrong feet. It doesn't matter. Go." DSP #14 did not prompt or assist client #1 to put his shoes on the correct feet.

5. On 6/1/22 at 2:45 pm, client #2 was in the day room chasing RM #2 and client #15. Drool was dripping from client #2's mouth onto his shirt. RM #2 did not prompt client #2 to wipe his mouth or to change his shirt. At 5:15 pm, drool was dripping from client #2's mouth onto his shirt and the floor.

DSP #2 was interviewed on 6/2/22 at 11:53 pm and stated, "When [client #10] doesn't have socks, or his shoes are the wrong feet, or his clothes aren't right, we send him to his room to fix it. If he comes back, and it's still not right, we go with him to fix it." DSP #2 stated, "Some of the guys are supposed to have handkerchiefs. [Client #8] won't keep it. He'll set it down somewhere and lose it. He will suck it back in or wipe it on his shirt. We prompt him to change his shirt." DSP #2 stated, "We prompt them to wipe their faces or to change their shirts."

DSP #6 was interviewed on 6/2/22 at 2:30 pm and

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	stated, "They all have drooling rags. Staff prompt them to use it. We prompt them to wash their hands and to change their shirts." RM #4 was interviewed on 6/2/22 at 12:36 pm and stated, "For drooling, we prompt them to keep a handkerchief. [Client #7] is really good about wiping his mouth if he is prompted. We prompt [client #8 to change his clothing." Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 6/2/22 at 1:34 pm and stated, "Staff should assist with drooling. They should prompt the clients to wipe their faces or ask if the client will allow the staff to do it. Everyone should be clean and dressed every day. Staff should prompt for clothing to be put on correctly and should document refusals." Program Manager (PM) #1 was interviewed on 6/2/22 at 2:56 pm and stated, "Staff should prompt clients to change their shirts or to wipe their mouths. Their shoes should be on the right feet, and they should have socks. Staff should be prompting and assisting." Registered Nurse (RN) #1 was interviewed on 6/2/22 at 11:06 pm and stated, "We've tried several medications for some of the guys for the drooling. We now have doctor's orders and HRC (Human Rights Committee) approval for clothing protectors." RN #1 stated, "Staff should be prompting them to wipe their mouths or to change their shirts."			
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,			

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	eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, interview and record review for 2 of 4 sampled clients (#2 and #3), plus one additional client (#9), the facility failed to ensure clients #2, #3 and #9's adaptive equipment was available and in good repair. Findings include: 1. Observations were completed in the facility on 5/31/22 from 10:45 am through 12:45 pm, from 3:50 pm through 5:05 pm, on 6/1/22 from 8:00 am through 9:00 am, and on 6/2/22 from 7:00 am through 8:30 am. On 5/31/22 at 4:41 pm, client #9 was sitting on the couch in the day room with his walker in front of him. The walker had a basket hanging from it. The walker had a ski missing on one of the back legs. At 4:43 pm, client #2 was sitting in the day room on a couch. The day room environment was loud as staff and clients were preparing to eat a meal. Client #2 was not wearing his noise canceling headphones. Staff did not prompt client #2 to wear his noise canceling headphones. On 6/1/22 at 8:00 am, an interview was conducted with Residential Manager (RM) #5. RM #5 stated "a noisy day room is a precursor for [client #2]. Per his plan we try to put him in a quiet area or construct the day room so it is quiet and no one is near him." RM #5 indicated client #2 has noise canceling headphones in his plan. RM #5 indicated staff should prompt client #2 to wear the noise canceling headphones. On 6/1/22 at 10:00 am, an interview was conducted	W 0436	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. Specifically, client #2, #3 and #9 adaptive equipment is available and in good repair. New noise canceling headphones have been purchased for client #2 despite him refusing to wear them and breaking 4 pairs. All staff will be retrained in prompting client #2 to use noise canceling headphones. All staff re-trained to complete adaptive equipment checklist, report all issues with adaptive equipment immediately to nursing when noted. Adaptive equipment will be replaced or repaired in a timely manner.	07/08/2022

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	with staff #2. Staff #2 stated client #2 is "big on noise" and "it's usually hectic in here." Staff #2 further stated client #2 is "supposed to have headphones but he broke them or they're lost." On 6/1/22 at 2:30 pm, an interview was conducted with Licensed Practical Nurse (LPN) #1. LPN #1 indicated client #2's adaptive equipment included a padded cap and noise reducing headphones. LPN #1 stated client #9's adaptive equipment included "a walker, leg braces, glasses, basket on the walker, and a sippy cup." LPN #1 indicated staff should report missing or broken equipment to the nurse and the nurse would have it repaired or replaced. LPN #1 indicated clients' adaptive equipment should be available and in good repair at all times. On 6/1/22 at 4:00 pm, an interview was conducted with the Director of Nursing (DON). The DON indicated adaptive equipment for client #2 included glasses, a rib cap and headphones. The DON stated, "the headphones he won't wear. The behavioral consultant has bought him several pairs, she has tried several things." The DON indicated client #2 should have noise reducing headphones available. The DON stated client #9's walker "is in good repair, I just talked to him today." When it was pointed out to the DON that a ski was missing from his walker, the DON stated, "it shouldn't be missing, we have extra skis over there." The DON stated client #9's walker should be in good repair to "help decrease his falls." On 6/2/22 at 11:45 am, and interview was conducted with the Behavioral Consultant (BC). The BC indicated per client #2's plan he is to use noise canceling headphones. The BC stated "I have replaced the headphones four times. He is always breaking them." The BC indicated client			

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	#2's headphones should be available for use. On 5/31/22 at 2:30 pm, client #2's record was reviewed. An Individual Support Plan (ISP) dated 1/14/22 indicated client #2's adaptive equipment included, "helmet as needed for head banging, noise canceling headphones and communication cards." On 6/2/22 at 12:30 pm, client #9's record was reviewed. A Fall Risk Plan dated 1/16/22 indicated, "[Client #9] is to use his walker with skis when he is walking. The walker legs should be on the floor at all times and he should scoot the walker in front of him...".An observation was conducted on 5/31/22 from 4:30 PM through 7:06 PM. At 6:44 PM, client #9 was in common living area referred to as the day room. Client #9 was seated on a sofa and had his walker positioned adjacent to him. A bottom leg of client #9's walker was a missing ski to aid in client #9 use of the walker during ambulation. On 6/1/22 at 4:36 PM, a focused review of client #9's record was conducted. The record review indicated the following: Fall Risk Plan dated 1/16/22 indicated, "Falls:... Actions... 3) [Client #9] is to use his walker with skis when he is waking. The walker legs should be on the floor at all times and he should scoot the walker in front of him..."2. Observations were conducted on 5/31/22 from 11:20 am through 12:41 pm and from 4:31 pm through 7:05 pm, on 6/1/22 from 10:45 am through 11:22 am, and from 2:22 pm through 3:20 pm. Client #3 was present in the home throughout the observation periods and was not wearing his glasses. Client #3's record was reviewed on 5/31/22 at 1:38			

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	pm. A optometrist note dated 11/23/21 indicated the following: "Description: Myopia, both eyes. Assessment: Exam reveals Myopia (nearsightedness) in both eyes. Plan: Described Myopic Condition - New RX (prescription) Prescribed. Description: Regular Astigmatism (causes blurry vision), both eyes. Assessment: Exam reveals Regular Astigmatism in both eyes. Plan: Described Astigmatic Correction - New RX Prescribed." Registered Nurse (RN) #1 was interviewed on 6/2/22 at 11:06 am and stated, "[Client #3] has not worn glasses since he got here. I don't know if he has them or brought them with him from [former facility]. If there is a prescription, he should have them."			
W 0454 Bldg. 00	483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. Based on observation and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), plus 16 additional clients (#5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20), the facility failed to ensure a sanitary environment for clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20 in regard to hand hygiene practices, clean table surfaces at meal time and clean food storage areas. Findings include:	W 0454	All staff were trained to clean tables before meals and to assure all clients wash or sanitize their hands before meals and snack. Staff to inspect food storage areas and clean spills and messes as they occur. All staff were re-trained in proper food storage including properly sealing dating any opened items. Refrigerators checked for cleanliness daily. Seal replacement for the	07/08/2022

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	1. Observations were completed in the facility on 5/31/22 from 10:45 am through 12:45 pm, from 3:50 pm through 5:05 pm, on 6/1/22 from 8:00 am through 9:00 am, and on 6/2/22 from 7:00 am through 8:30 am. On 5/31/22 at 11:10 am, the refrigerator in the pantry had spilled juice that had dried on all three shelves as well as the bottom of the refrigerator. Two drawers in the refrigerator had dried juice on the bottom and food debris. The seal had an 8 inch split and had dried debris on it. There were 5 bowls of cut up raw vegetables with a plastic wrap covering and no date marked. The freezer had a bag of 2 hamburger patties with no date marked and there was a large bag of ham pieces with no date marked. Staff #4 stated, "I think the cook saves the ham to make bean soup." On 6/2/22, the spilled juice and debris remained in the refrigerator as well as the bowls of cut up raw vegetables. Residential Manager (RM) #6 stated, "Third shift cleans the refrigerator and throws food out." RM #6 indicated the refrigerator should be kept clean. RM #6 indicated undated food and the refrigerator not being kept clean could be an infection control risk. On 5/31/22 at 11:05am, Residential Manager (RM) #2 stated, "We're having snack, some of the guys just came back from life skills." At 11:20 am, the counter by the sink had two buckets of liquid. Staff #4 stated, "There is sanitizer in them to clean the counters, tables and stove. We change the sanitizer after each meal." At 11:55am, client #14 set the table for lunch. Client #14 was not prompted by staff to wipe the table before setting it. At 12:22pm, staff served clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20 lunch. Clients were not prompted to wash or sanitize their hands before		refrigerator has been ordered and will be installed when it arrives. Client # 11 now has physicians' orders for divided plate, and this will be added to dining plan. Staff will be trained. Meal prep training conducted to assure all ISP, BSP, and High-risk plans are followed. This applies to meals and snacks. To assure clients are being prompted to assist with meal prep and clean up per their goals and ability level. Including offering all utensils (unless restricted per BSP) and well as napkins and drinks.	

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the meal was served.

On 5/31/22 at 4:27 pm, client #4 was in the kitchen unsupervised. Client #4 took a piece of paper towel out of the trash container, placed it in his mouth, chewed it and swallowed it. Staff #9 came in to the kitchen to redirect client #4. Staff #9 stated, "we have to watch him, he likes to eat everything." Staff #9 indicated the client eating items from the trash was an infection control issue.

On 6/2/22 at 7:45 am, clients #7, #8 and #17 sat down at the dining room table for breakfast and were not prompted by staff to wash their hands. At 8:10am, client #1 sat down at the table and staff #15 served him breakfast. Client #1 was not prompted to wash his hands before the meal.

On 6/1/22 at 2:30pm, Licensed Practical Nurse (LPN) #1 was interviewed. LPN #1 stated clients should wash or sanitize their hands "before meals and meds." LPN #1 indicated staff should should prompt clients to wash their hands before meals. LPN #1 stated, "tables should be cleaned before and after meals, any time anyone sits there and there may be drool." LPN #1 indicated hand hygiene is the number one way to prevent the spread of viruses.

On 6/1/22 at 4:05pm, the Director of Nursing (DON) was interviewed. The DON indicated all food storage areas should be kept clean. The DON indicated tables should be cleaned before serving meals. The DON stated clients should "always be prompted to sanitize their hands before eating." The DON indicated these were infection control issues.
2. An observation was conducted on 5/31/22 from 4:30 PM to 7:06 PM. The observation indicated

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the following which affected client #11:

At 6:50 PM, client #11 was seated in the dining room with his peers for the evening meal. The evening meal consisted of cheeseburger, french-fries, coleslaw, pudding and pink lemonade to drink. Client #11's food was served pureed on a regular plate which had spilled off onto the dining room table and was around his entire plate. Client #11 used his spoon to scoop the spilled pureed food from the table as he ate. At 6:52 PM, staff #2 was asked what food item client #11 was eating. Staff #2 stated "coleslaw".

On 6/1/22 at 1:04 PM, a focused review of client #11's record was conducted. The record indicated the following:

-Individual Support Plan (ISP) dated 8/11/21 indicated, "Adaptive Equipment: Wedge cup set to half open. Adaptive Utensils: Smaller spoon ... Area: Adaptive Equipment. Goal: To improve adaptive equipment skills thus increasing independence. Objective: [Client #11] will use his small spoon during meals independently 100% of opportunities per month for 12 months by 8/11/22 ...".

-Dining Plan dated 5/19/22 indicated, "Mealtime Adaptive Equipment: Baby spoon, Wedge cup ½ open. Eating: [Client #11] eats independently. Staff monitor and encourage [client #11] to drink slowly to prevent chocking (sic) ...".

On 6/2/22 at 10:55 AM, the Director of Nursing (DON) was interviewed. The DON was asked about client #11 eating his spilled pureed food from the table and infection control practices. The DON indicated client #11 should not eat spilled food from the dining room tabletop. The DON was

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	asked how often the dining room tables should be sanitized. The DON stated, "Well, before and after (meals/snacks). They've been in-serviced on that". The DON of was asked if client #11 should have eaten spilled pureed foods from the dining room table's surface. The DON stated, "No". On 6/2/22 at 12:36 PM, the Residential Manager (RM #4) was interviewed. The RM #4 was asked about sanitation of the dining room tables. The RM #4 stated, "After every meal. We have dawn (soap) in a bucket. If they (table surface) have not been wiped down before, we do it as much as possible". The RM #4 indicated client #11 should not have eaten spilled pureed foods from the tabletop surface. 3a. On 5/31/22 at 11:53 am, client #7 set the table for lunch. The tables were not sanitized before the places were set. On 5/31/22 at 12:23 pm, lunch was served. Clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #13, #14, #15, #16, #17, #18, #19, and #20 were not prompted to wash or sanitize their hands before lunch. 3b. On 5/31/22 at 5:18 pm, client #16 had burritos from a fast food restaurant. Client #16 was not prompted to wash or sanitize his hands before eating. Client #16's table was not sanitized before he began eating. 3c. On 5/31/22 at 6:05 pm, clients #10 and #14 had burritos and doughnuts from the community. Clients #10 and #14 were not prompted to wash or sanitize their hands before eating. Client #10 dumped his burrito and doughnut out of the packaging and ate them from the table surface. The table surface was not sanitized before clients #10 and #14 began eating.			

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	3d. On 5/31/22 at 6:51 pm, clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #11, #12, #13, #15, #16, #17, #18, #19, and #20 were not prompted to wash or sanitize their hands before they ate their evening meal. 3e. On 6/1/22 at 3:08 pm, RM #1 sorted milkshakes for clients #1, #2, #3, #4, #5, #8, #9, #10, #11, #15, #17, and #20. Client #1, #2, #3, #4, #5, #8, #9, #10, #11, #15, #17, and #20 were not prompted to wash or sanitize their hands. RM #1 did not wash or sanitize her hands before handling the milkshakes. RM #1 removed each milkshake lid with bare hands and put her face to each one to smell what flavor it was before passing the milkshakes to the intended clients.			
W 0475 Bldg. 00	483.480(b)(2)(iv) MEAL SERVICES Food must be served with appropriate utensils. Based on observation and interview for 4 additional clients (#10, #14, #16 and #18), the facility failed to ensure clients #10, #14, #16, and #18 had plates, utensils, a napkin, and drinks with their meal. Findings include: Observations were conducted on 5/31/22 from 4:31 pm through 7:05 pm. Clients #10, #14, and #16 were present in the home throughout the observation period. 1. On 5/31/22 at 5:18 pm, client #16 returned to the facility from an outing. Client #16 sat down at a table in the dining room with a bag from a fast food restaurant. Client #16 opened 2 burritos and a soft taco and ate them over a paper wrapper.	W 0475	Meal prep training conducted to assure all ISP, BSP, and High-risk plans are followed. This applies to meals and snacks. To assure clients are being prompted to assist with meal prep and clean up per their goals and ability level. Including offering plates, cups, all utensils (unless restricted per BSP) and well as napkins and drinks. All staff trained that food is not to be placed on the table to eat. If a client brings home food from an outing a plate, cup, utensils, napkins must be offered.	07/08/2022

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Client #16 did not have a drink with his meal. Client #16 stopped eating several times to lick sauce from his fingers. Client #16 stated, "I was supposed to have a drink, but I guess I didn't get one." Staff did not prompt client #16 to use a napkin. 2. On 5/31/22 at 5:50 pm, client #18 sat down at a dining table with small prepackaged container of green beans. Client #18 peeled back the plastic cover and began drinking the juice from the cup. Client #18 then dumped the contents of the cup into his mouth and ate them. Client #18 indicated he was eating green beans because he was hungry and the evening meal was not ready. Client #18 indicated staff gave him the snack. Client #18 indicated he was not offered a utensil. Staff did not prompt client #18 to use a utensil. 3. On 5/31/22 at 6:05 pm, clients #10 and #14 returned to the facility from an outing. Clients #10 and #14 sat down at a table in the dining room with bags from a fast food restaurant and a gas station. Clients #10 and #14 were not provided with plates, utensils, or napkins. Clients #10 and #14 had slushies to drink. Client #10 dumped a burrito and a doughnut onto the bare table and proceeded to eat them with his fingers. Staff did not prompt clients #10 or #14 to use napkins or to place their food items onto a plate. When clients #10 and #14 got up from the table, there was lettuce and donut icing scattered across one half of the table and on the floor where they had been sitting. Residential Manager (RM) #1 was interviewed on 6/2/22 at 12:36 pm and stated, "Everyone should have a plate, napkin, silverware, and a cup at meals. They should have a drink."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G811	A. BUILDING 00 B. WING	06/09/2022

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	Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 6/2/22 at 1:34 pm and stated, "Dining should be developmentally appropriate. They should have a cup, utensils, a napkin, and a second napkin for their lap. Staff should be practicing with them how to dine properly." Registered Nurse (RN) #1 was interviewed on 6/2/22 at 11:06 am and stated, "A place setting should include a fork and a spoon, a cup, a plate, and a napkin. They should have a drink with their meals."			