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| W 000 | INITIAL COMMENTS<br><br>Incident Report Investigation<br><br>Incident of 8/4/16 / IL#87652 | W 000 | | |
| W 104 | 483.410(a)(1) GOVERNING BODY<br><br>The governing body must exercise general policy, budget, and operating direction over the facility.<br><br>This STANDARD is not met as evidenced by:<br>Based on interview and record review, the facility failed to ensure:<br>1. Incident of 8/4/16 where R1 (1 of 1 individual in the sample with a history of ingesting foreign objects and is on one-to-one supervision) had an abdomen x-ray that found zipper tab and metallic coin was identified as an event of neglect.<br>2. Relevant x-ray report and discharge summary report for R1 were maintained in R1's record.<br>3. Notification to staff who were not in the facility when in-services were provided to all staff regarding environmental sweeps, accountability and 1:1 supervision level was done in a timely manner.<br><br>Findings include:<br><br>1. Per Facility Policy #107 (Rev. 1/12) Reporting and Investigating Incidents and Allegations of Abuse and Neglect, neglect "means the failure of an employee or center to provide adequate medical or personal care or maintenance, and that as a consequence, causes a person pain, injury, emotional distress, or results in either a person's maladaptive behavior or the deterioration of a person's physical or mental | W 104 | | |

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

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| W 104 | Continued From page 1 | W 104 | | |

condition, or places a person's health or safety at substantial risk of possible injury, harm or death."

Per Facility Policy # 384 (Rev. 5/15) Client Protection Supervision Of Persons Served, III. Levels of Supervision C.4. One-to-one Supervision - the person must be within arms reach and under the direct vision of an assigned staff person at all times who has sole responsibility for this one person; including while the person is dressing, toileting, bathing, and sleeping. This applies to all in-home locations and out of home locations. Total privacy during toileting, dressing, bathing, and sleeping is not feasible since staff must be within arms reach for the safety and protection of the person or others. The only way one-to-one supervision can be provided at a distance greater than arms length is when there is stipulation specifically addressed in the text of the person's Behavior Intervention Program which has been approved by the Behavior Intervention Committee.

Per Facility's Reportable Event Five Day Review of event on 8/4/16, On 8/4/16 medical personnel ordered x-rays of R1's stomach from x-ray provider to consider lowering his level of supervision. On 8/5/16 x-ray results exhibited R1 had a metallic foreign object in the left upper quadrant of the abdomen (zipper). On 8/5/16 medical personnel wrote orders for R1 to be transported to local hospital for another x-ray/second opinion. R1's x-ray results displayed a rounded metallic foreign structure which had the appearance of a metallic coin. On 8/8/16, another x-ray to check, result exhibited that R1 had no foreign bodies in his abdomen. R1 has had no pica incident in the past six months. However, he has had multiple pica attempts.

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| W 104 | Continued From page 2<br>There does not appear to be any abuse/neglect or mistreatment involved.<br><br>On 8/15/16 approximately at 12:00 PM, facility presented documentation of in-services provided on 8/5/16 through 8/9/16 regarding 1:1 supervision accountability form, environmental sweeps and accountability and supervision of individuals served. Per E1 (Acting Assistant Center Director) all facility staff have been in-serviced. At 3:00 PM, E1 validated that 5 staff from R1's house were re-assigned to jobs without contact with individuals in the facility as result of the facility investigation of the 8/4/16 event of R1 (E15 through E19 were the last five staff assigned to provide 1:1 supervision to R1's x-ray on 8/4/16).<br><br>2. R1 is an individual with profound intellectual disability and identified target behaviors of pica (eating inedibles), pica attempts (attempts to eat inedibles) and rectal digging/smearing per the 7/11/16 Behavior Intervention Plan (BIP). R1's BIP and 5/5/16 Individual Support Plan (ISP) reports "in 9/2015, R1 had a CT scan of his abdomen for liver evaluation. An incidental finding from the scan were foreign objects in his digestive tract. The foreign objects were described as buttons and a rectangular metallic object and a ribbon-like object (not radiopaque). The Inter Disciplinary Team (IDT) met on 9/24/15 and decided to increase his level of supervision (LOS) to Visual Observation. This was increased to 1:1 (one to one) Supervision on 9/30/15 when he was discovered with pica items (string from clothes) while on visual observation. At the HRC (Human Rights Committee) Meeting on 10/19/15, it was recommended to continue 1:1 supervision due to continued attempts being documented | W 104 | | |

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| W 104 | Continued From page 3 | W 104 | | |

while on 1:1 supervision. In an STM (Special Team Meeting) on 6/29/16, the IDT decided to initiate a gradual reduction of R1's LOS to one slightly less restrictive than a 1:1. Before this could be fully initiated an x-ray was done that found a foreign object in his digestive tract.

Discharge Summary on 9/30/15 includes report "foreign body ingestion: colonoscopic removal of 3 buttons and a rectangular metallic (sic) object 9/29/15. A button like foreign body noted on KUB. Passed a ribbon like object (not radiopaque) with NO BRBPR (bright red blood per rectum) today. No peritoneal signs. On admission incidental finding on outpatient CT abdomen for liver evaluation, possibly a razor.

Abdomen X-ray on 10/17/15 conclusion - no radiopaque foreign body noted.

R1's record did not contain the x-ray report on 10/17/15 until it was provided by Lead physician E2 on 8/16/16 approximately at 2:00 PM. E2 validated this copy was searched by E2 from the system database and by asking other medical personnel. E2 validated it should be in R1's record.

R1's record did not contain the dishcarge summary on 9/30/15. Lead physician E2 provided copy to surveyor on 8/17/16 approximately at 10:30 AM. E2 validated she obtained a copy from physician E22. E2 validated this copy should have been in R1's record.

3. Per Facility's Reportable Event Five Day Review of event on 8/4/16, On 8/4/16 medical personnel ordered x-rays of R1's stomach from x-ray provider to consider lowering his level of

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| W 104 | Continued From page 4 | W 104 | | |

supervision. On 8/5/16 x-ray results exhibited R1 had a metallic foreign object in the left upper quadrant of the abdomen (zipper). On 8/5/16 medical personnel wrote orders for R1 to be transported to local hospital for another x-ray/second opinion. R1's x-ray results displayed a rounded metallic foreign structure which had the appearance of a metallic coin. On 8/8/16, another x-ray to check, result exhibited that R1 had no foreign bodies in his abdomen. R1 has had no pica incident in the past six months. However, he has had multiple pica attempts. There does not appear to be any abuse/neglect or mistreatment involved.

On 8/15/16 approximately at 12:00 PM, facility presented documentation of in-services provided on 8/5/16 through 8/9/16 regarding 1:1 supervision accountability form, environmental sweeps and accountability and supervision of individuals served. Per E1 (Acting Assistant Center Director) all facility staff have been in-serviced. At 3:00 PM, E1 validated that 5 staff from R1's house were re-assigned to jobs without contact with individuals in the facility as result of the facility investigation of the 8/4/16 event of R1 (E15 through E19 were the last five staff assigned to provide 1:1 supervision to R1's x-ray on 8/4/16).

Telephone interview with R1's Habilitation Program Coordinator E21 on 8/16/15 from 3:15 PM through 3:45 PM validate E21 left for vacation on 8/4/16 through 8/15/16 and has not been notified of need to attend in-service training. E21 reported having heard from others that R1 had a metallic object found in his abdomen.

On 8/16/16 at 4:10 PM E3 validated that Quality

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| W 104 | Continued From page 5<br>Assurance Department is responsible for ensuring E21 gets the in-services provided to staff from 8/5/16 through 8/9/16. | W 104 | | |
| W 149 | 483.420(d)(1) STAFF TREATMENT OF CLIENTS<br><br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to ensure staff implemented procedure recently reviewed during in-services regarding preventing potential foreign body ingestion when:<br>1. R1's, 1 of 1 individual inthe sample who is on one-to-one supervision and has history of ingesting foreign body, abdomen x-ray on 8/4/16 showed a zipper tab and metallic coin.<br>2. Staff broke the direct visual observation for 1 of 1 individual in the sample who has a history of ingesting foreign body and is on 1:1 supervision level, R1, on 8/16/16.<br>3. R1 was observed wearing socks with dime-sized hole on the way to the on-site workshop on 8/16/16.<br>4. A jagged wood piece was found on 8/16/16 by the window of the workshop classroom R1 attends.<br><br>Findings include:<br><br>1.2.3.4. Per Facility Policy #107 (Rev. 1/12) Reporting and Investigating Incidents and Allegations of Abuse and Neglect, neglect "means the failure of an employee or center to provide adequate medical or personal care or | W 149 | | |

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| W 149 | Continued From page 6 | W 149 | | |

maintenance, and that as a consequence, causes a person pain, injury, emotional distress, or results in either a person's maladaptive behavior or the deterioration of a person's physical or mental condition, or places a person's health or safety at substantial risk of possible injury, harm or death."

Per Facility Policy # 384 (Rev. 5/15) Client Protection Supervision Of Persons Served, III. Levels of Supervision C.4. One-to-one Supervision - the person must be within arms reach and under the direct vision of an assigned staff person at all times who has sole responsibility for this one person; including while the person is dressing, toileting, bathing, and sleeping. This applies to all in-home locations and out of home locations. Total privacy during toileting, dressing, bathing, and sleeping is not feasible since staff must be within arms reach for the safety and protection of the person or others. The only way one-to-one supervision can be provided at a distance greater than arms length is when there is stipulation specifically addressed in the text of the person's Behavior Intervention Program which has been approved by the Behavior Intervention Committee.

R1 is an individual with profound intellectual disability and identified target behaviors of pica (eating inedibles), pica attempts (attempts to eat inedibles) and rectal digging/smearing per the 7/11/16 Behavior Intervention Plan (BIP). R1's BIP and 5/5/16 Individual Support Plan (ISP) reports "in 9/2015, R1 had a CT scan of his abdomen for liver evaluation. An incidental finding from the scan were foreign objects in his digestive tract. The foreign objects were described as buttons and a rectangular metallic

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| W 149 | Continued From page 7 | W 149 | | |

object and a ribbon-like object (not radiopaque). The Inter Disciplinary Team (IDT) met on 9/24/15 and decided to increase his level of supervision (LOS) to Visual Observation. This was increased to 1:1 (one to one) Supervision on 9/30/15 when he was discovered with pica items (string from clothes) while on visual observation. At the HRC (Human Rights Committee) Meeting on 10/19/15, it was recommended to continue 1:1 supervision due to continued attempts being documented while on 1:1 supervision. In an STM (Special Team Meeting) on 6/29/16, the IDT decided to initiate a gradual reduction of R1's LOS to one slightly less restrictive than a 1:1. Before this could be fully initiated an x-ray was done that found a foreign object in his digestive tract.

Abdomen X-ray on 8/8/16 findings- no radiopaque foreign bodies in the projection of the abdomen.

Abdomen X-ray on 8/5/16 findings - suggestive of a metallic coin in the region of the ascending colon.

Abdomen X-ray on 8/4/16 results - metallic foreign body left upper quadrant, zipper in the left lower quadrant.

Abdomen CT scan on 9/22/15 findings - A thin metallic density object is present in the right, mid small bowel, measuring up to 2.4 cm transversely. Impression: 2. Metallic-density foreign body within the small bowel lumen. Consider ingested razor blade. The scout radiograph demonstrates an additional small radiopacity projected over the sacrum near the midline, possibly an additional small foreign body."

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Discharge Summary on 9/30/15 includes report "foreign body ingestion: colonoscopic removal of 3 buttons and a rectangular metallic (sic) object 9/29/15. A button like foreign body noted on KUB. Passed a ribbon like object (not radiopaque) with NO BRBPR (bright red blood per rectum) today. No peritoneal signs. On admission incidental finding on outpatient CT abdomen for liver evaluation, possibly a razor.

Abdomen X-ray on 10/17/15 conclusion - no radiopaque foreign body noted.

9/24/15 Special Team Meeting (STM) regarding R1's unscheduled hospital visit/level of supervision increase reports "the CT scan showed a foreign objected found in R1's digestive system. R1 was sent to local emergency room and at 12 midnight on 9/23/15 admitted into the hospital with diagnosis of foreign body ingestion. The plan of treatment for R1 is to promote the successful expulsion of the object naturally via 'go lightly.' R1 already had a BIP with pica as target behavior and data shows no incidents of actual pica in over 6 months."

10/1/15 STM regarding R1's post hospitalization reports "Additional X-rays of R1's abdomen were taken to assess the position of the foreign body as it moved, and additional foreign bodies were subsequently identified in the small bowel and rectum. On 9/29/15 a colonoscopy was ordered and performed, during which the foreign bodies were removed from R1's rectum. R1 was then listed as stable on 9/30/15 and was cleared for discharge back to the facility.

Per Facility's Reportable Event Five Day Review

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of event on 8/4/16, On 8/4/16 medical personnel ordered x-rays of R1's stomach from x-ray provider to consider lowering his level of supervision. On 8/5/16 x-ray results exhibited R1 had a metallic foreign object in the left upper quadrant of the abdomen (zipper). On 8/5/16 medical personnel wrote orders for R1 to be transported to local hospital for another x-ray/second opinion. R1's x-ray results displayed a rounded metallic foreign structure which had the appearance of a metallic coin. On 8/8/16, another x-ray to check, result exhibited that R1 had no foreign bodies in his abdomen. R1 has had no pica incident in the past six months. However, he has had multiple pica attempts. There does not appear to be any abuse/neglect or mistreatment involved.

Per R1's 8/12/16 Behavior Drill, "one-to-one supervision meaning that R1 must be within arms length and under the direct vision of an assigned person at all times who has sole responsibility for R1 only, including while (R1) is dressing, tilting, bathing and sleeping. This applies to all in-home and out of home locations. Pica Sweeps - environmental sweeps will be done every 30 minutes and documented on Pica Sweep sheets...Sweeps are done to ensure that there are no inedible objects especially metal objects, paper, buttons, lint and strings from clothing."

On 8/15/16 approximately at 12:00 PM, facility presented documentation of in-services provided on 8/5/16 through 8/9/16 regarding 1:1 supervision accountability form, environmental sweeps and accountability and supervision of individuals served. Per E 1 (Acting Assistant Center Director) all facility staff have been in-serviced. At 3:00 PM, E1 validated that 5 staff

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from R1's house were re-assigned to jobs without contact with individuals in the facility as result of the facility investigation of the 8/4/16 event of R1.

On 8/16/16 in house 6 from approximately 9:45 AM through 10:10 AM, R1 was provided the 1:1 supervision by E9, Technician 2. Surveyor spoke with E9 and E10 (Technician 3) who were in the living/dining area of house 6. E9 was observed within arms length of R1 but did not provide direct visual supervision of R1 at all times. E9 was observed looking to the side of or away from R1. R1 was seated facing the door and E9 was seated in another chair facing the windows with her knees to the right side of R1's body. Approximately at 10:15 AM, R1, E9, surveyor and E11 (Technician 2) walked to house 13 for on-site workshop. During this walk, R1's socks were noted to have holes and loose fibers from the holes. R1 arrived in house 13 and was seated with E9. Surveyor looked at the first window to the left upon entry into the classroom. This window sill had a large missing piece of wood and a remaining loose piece with jagged edge was noted. Surveyor asked E11 about the loose piece and was able to very easily pull out the loose jagged piece of wood that measured about 2.5 inches long and about 1/2 inch in diameter. E11 reported the loose wood to Instructor E4. E4 validated with surveyor at 10:30 AM that R1 should not have holes in his clothes. E4 directed E9 to ensure R1 wears socks without holes. E9 stated that those are one of R1's best socks and E9 did not assist R1 with dressing this morning. E4 also validated that she was unaware of the loose wood piece until surveyor brought it to her attention. E4 stated she called Head Engineer E13 who was close by and saw the issue that will be addressed.

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| W 149 | Continued From page 11<br><br>Technician E12 was in the classroom where R1 is assigned. E12 validated that in-service was received regarding environmental sweeps. E4, E9, E10, E11 all validated that in-services were received regarding increase environmental sweep to every 30 minutes to ensure no potential items to be ingested is in the environment and maintaining arms length for clients on 1:1 supervision.<br><br>Telephone interviews with Psychologist E20 and Habilitation Program Coordinator E21 on 8/16/15 from 3:15 PM through 3:45 PM validate that R1 is on a 1:1 supervision level at all times of day and night as described in R1's BIP and ISP. E20 and E21 validate that R1 should not have worn socks that have holes. E20 and E21 validate that once 1:1 staff breaks direct visual of R1 then R1's 1:1 supervision is not provided. E20 and E21 validated that R1 does not have a history of ingesting wood but the loose wood piece by the window in R1's workshop classroom should have been picked up by staff who performed environmental sweep. E21 validated that he left for vacation on 8/4/16 through 8/15/16 and has not been notified of need to attend in-service training.<br><br>At Daily Status Meetings on 8/15/16 and 8/16/16, Acting Assistant Center Director E1 and Residential Services Director E14 validated on 8/15/16 at 3:30 PM that five staff (E15, E16, E17, E18 and E19) were re-assigned to facility jobs without contact with individuals as a result of their investigation of the 8/4/16 event of R1 (E15 through E19 were the last five staff assigned to provide 1:1 supervision to R1's x-ray on 8/4/16). | W 149 | | |

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| W 149 | Continued From page 12<br>Acting Center Director E3, E1 and E14 validated on 8/16/16 at 4:10 PM that when direct vision of the individual provided with 1:1 supervision is broken by staff who is at arms length, then the 1:1 supervision is not maintained. E3, E1 and E14 validated that R1 should not have worn socks that have holes and staff should have picked up the loose wood by the window in R1's classroom in the workshop.<br><br>E3 validated that Quality Assurance Department is responsible for ensuring E21 gets the in-services provided to staff from 8/5/16 through 8/9/16. | W 149 | | |
| W 249 | 483.440(d)(1) PROGRAM IMPLEMENTATION<br><br>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to implement identified interventions to ensure no foreign body ingestion occurs for 1 of 1 individual in the sample with known history of ingesting foreign objects, R1.<br><br>Findings include:<br><br>Per Facility Policy #107 (Rev. 1/12) Reporting and Investigating Incidents and Allegations of Abuse | W 249 | | |

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and Neglect, neglect "means the failure of an employee or center to provide adequate medical or personal care or maintenance, and that as a consequence, causes a person pain, injury, emotional distress, or results in either a person's maladaptive behavior or the deterioration of a person's physical or mental condition, or places a person's health or safety at substantial risk of possible injury, harm or death."

R1 is an individual with profound intellectual disability and identified target behaviors of pica (eating inedibles), pica attempts (attempts to eat inedibles) and rectal digging/smearing per the 7/11/16 Behavior Intervention Plan (BIP). R1's BIP and 5/5/16 Individual Support Plan (ISP) reports "in 9/2015, R1 had a CT scan of his abdomen for liver evaluation. An incidental finding from the scan were foreign objects in his digestive tract. The foreign objects were described as buttons and a rectangular metallic object and a ribbon-like object (not radiopaque). The Inter Disciplinary Team (IDT) met on 9/24/15 and decided to increase his level of supervision (LOS) to Visual Observation. This was increased to 1:1 (one to one) Supervision on 9/30/15 when he was discovered with pica items (string from clothes) while on visual observation. At the HRC (Human Rights Committee) Meeting on 10/19/15, it was recommended to continue 1:1 supervision due to continued attempts being documented while on 1:1 supervision. In an STM (Special Team Meeting) on 6/29/16, the IDT decided to initiate a gradual reduction of R1's LOS to one slightly less restrictive than a 1:1. Before this could be fully initiated an x-ray was done that found a foreign object in his digestive tract.

Abdomen X-ray on 8/8/16 findings- no

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radiopaque foreign bodies in the projection of the abdomen.

Abdomen X-ray on 8/5/16 findings - suggestive of a metallic coin in the region of the ascending colon.

Abdomen X-ray on 8/4/16 results - metallic foreign body left upper quadrant, zipper in the left lower quadrant.

Abdomen CT scan on 9/22/15 findings - A thin metallic density object is present in the right, mid small bowel, measuring up to 2.4 cm transversely. Impression: 2. Metallic-density foreign body within the small bowel lumen. Consider ingested razor blade. The scout radiograph demonstrates an additional small radiopacity projected over the sacrum near the midline, possibly an additional small foreign body."

Discharge Summary on 9/30/15 includes report "foreign body ingestion: colonoscopic removal of 3 buttons and a rectangular metallic (sic) object 9/29/15. A button like foreign body noted on KUB. Passed a ribbon like object (not radiopaque) with NO BRBPR (bright red blood per rectum) today. No peritoneal signs. On admission incidental finding on outpatient CT abdomen for liver evaluation, possibly a razor.

Abdomen X-ray on 10/17/15 conclusion - no radiopaque foreign body noted.

9/24/15 Special Team Meeting (STM) regarding R1's unscheduled hospital visit/level of supervision increase reports "the CT scan showed a foreign objected found in R1's digestive

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system. R1 was sent to local emergency room and at 12 midnight on 9/23/15 admitted into the hospital with diagnosis of foreign body ingestion. The plan of treatment for R1 is to promote the successful expulsion of the object naturally via 'go lightly.' R1 already had a BIP with pica as target behavior and data shows no incidents of actual pica in over 6 months."

10/1/15 STM regarding R1's post hospitalization reports "Additional X-rays of R1's abdomen were taken to assess the position of the foreign body as it moved, and additional foreign bodies were subsequently identified in the small bowel and rectum. On 9/29/15 a colonoscopy was ordered and performed, during which the foreign bodies were removed from R1's rectum. R1 was then listed as stable on 9/30/15 and was cleared for discharge back to the facility.

Per Facility's Reportable Event Five Day Review of event on 8/4/16, On 8/4/16 medical personnel ordered x-rays of R1's stomach from x-ray provider to consider lowering his level of supervision. On 8/5/16 x-ray results exhibited R1 had a metallic foreign object in the left upper quadrant of the abdomen (zipper). On 8/5/16 medical personnel wrote orders for R1 to be transported to local hospital for another x-ray/second opinion. R1's x-ray results displayed a rounded metallic foreign structure which had the appearance of a metallic coin. On 8/8/16, another x-ray to check, result exhibited that R1 had no foreign bodies in his abdomen. R1 has had no pica incident in the past six months. However, he has had multiple pica attempts. There does not appear to be any abuse/neglect or mistreatment involved.

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Per R1's 8/12/16 Behavior Drill, "one-to-one supervision meaning that R1 must be within arms length and under the direct vision of an assigned person at all times who has sole responsibility for R1 only, including while (R1) is dressing, tilting, bathing and sleeping. This applies to all in-home and out of home locations. Pica Sweeps - environmental sweeps will be done every 30 minutes and documented on Pica Sweep sheets...Sweeps are done to ensure that there are no inedible objects especially metal objects, paper, buttons, lint and strings from clothing."

On 8/15/16 approximately at 12:00 PM, facility presented documentation of in-services provided on 8/5/16 through 8/9/16 regarding 1:1 supervision accountability form, environmental sweeps and accountability and supervision of individuals served. Per E 1 (Acting Assistant Center Director) all facility staff have been in-serviced. At 3:00 PM, E1 validated that 5 staff from R1's house were re-assigned to jobs without contact with individuals in the facility as result of the facility investigation of the 8/4/16 event of R1.

On 8/16/16 in house 6 from approximately 9:45 AM through 10:10 AM, R1 was provided the 1:1 supervision by E9, Technician 2. Surveyor spoke with E9 and E10 (Technician 3) who were in the living/dining area of house 6. E9 was observed within arms length of R1 but did not provide direct visual supervision of R1 at all times. E9 was observed looking to the side of or away from R1. R1 was seated facing the door and E9 was seated in another chair facing the windows with her knees to the right side of R1's body. Approximately at 10:15 AM, R1, E9, surveyor and E11 (Technician 2) walked to house 13 for on-site workshop. During this walk, R1's socks were

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noted to have holes and loose fibers from the holes. R1 arrived in house 13 and was seated with E9. Surveyor looked at the first window to the left upon entry into the classroom. This window sill had a large missing piece of wood and a remaining loose piece with jagged edge was noted. Surveyor asked E11 about the loose piece and was able to very easily pull out the loose jagged piece of wood that measured about 2.5 inches long and about 1/2 inch in diameter. E11 reported the loose wood to Instructor E4. E4 validated with surveyor at 10:30 AM that R1 should not have holes in his clothes. E4 directed E9 to ensure R1 wears socks without holes. E9 stated that those are one of R1's best socks and E9 did not assist R1 with dressing this morning. E4 also validated that she was unaware of the loose wood piece until surveyor brought it to her attention. E4 stated she called Head Engineer E13 who was close by and saw the issue that will be addressed.

Technician E12 was in the classroom where R1 is assigned. E12 validated that in-service was received regarding environmental sweeps. E4, E9, E10, E11 all validated that in-services were received regarding increase environmental sweep to every 30 minutes to ensure no potential items to be ingested is in the environment and maintaining arms length for clients on 1:1 supervision.

Telephone interviews with Psychologist E20 and Habilitation Program Coordinator E21 on 8/16/15 from 3:15 PM through 3:45 PM validate that R1 is on a 1:1 supervision level at all times of day and night as described in R1's BIP and ISP. E20 and E21 validate that R1 should not have worn socks that have holes. E20 and E21 validate that once

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| W 249 | Continued From page 18<br>1:1 staff breaks direct visual of R1 then R1's 1:1 supervision is not provided. E20 and E21 validated that R1 does not have a history of ingesting wood but the loose wood piece by the window in R1's workshop classroom should have been picked up by staff who performed environmental sweep. E21 validated that he left for vacation on 8/4/16 through 8/15/16 and has not been notified of need to attend in-service training.<br><br>At Daily Status Meetings on 8/15/16 and 8/16/16, Acting Assistant Center Director E1 and Residential Services Director E14 validated on 8/15/16 at 3:30 PM that five staff (E15, E16, E17, E18 and E19) were re-assigned to facility jobs without contact with individuals as a result of their investigation of the 8/4/16 event of R1 (E15 through E19 were the last five staff assigned to provide 1:1 supervision to R1's x-ray on 8/4/16).<br><br>Acting Center Director E3, E1 and E14 validated on 8/16/16 at 4:10 PM that when direct vision of the individual provided with 1:1 supervision is broken by staff who is at arms length, then the 1:1 supervision is not maintained. E3, E1 and E14 validated that R1 should not have worn socks that have holes and staff should have picked up the loose wood by the window in R1's classroom in the workshop.<br><br>E3 validated that Quality Assurance Department is responsible for ensuring E21 gets the in-services provided to staff from 8/5/16 through 8/9/16. | W 249 | | |