STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G306	A. BUILDING _____ B. WING _____	09/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 000	INITIAL COMMENTS Annual Certification - Fundamental Survey Annual Licensure Inspection of Care	W 000		
W 149	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. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure for 2 of 3 in the sample (R2 and R3) and 3 of 3 outside the sample (R4, R5, and R6) that written policies and procedures prohibit abuse of the clients. Findings include: Per record review of the Facility Data Sheet dated 4-24-14, R1 functions in the Severe Range of Intellectual Disability. R2, R3, R4, R5, and R6 functions in the Profound Range of Intellectual Disability. Per record review of the Monthly Behavior Summary is as follows: 7-8-14 R1 walked up to female peer and pushed her down. 7-12-14 R1 had pushed on a female peer while she was sitting on the couch. 7-14-14 R1 had punched female peer on bus after day training. 7-15-14 R1 slammed doors all morning. threw a couple of chairs and pushed a peer down in the	W 149		

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

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W 149	Continued From page 1	W 149		

hallway.
7-16-14 R1 slammed doors from 7:15-8:15 this morning. R1 also pushed a peer to the ground when going out the door for work.
7-19-14 R1 yelled "I push you down" came out of kitchen and found R3 on the floor and R1 walking away.
7-25-14 was pushing a peer (unidentified) on the van on the way home yelling and cussing.
7-29-14 R1 shoved peer to the floor and screamed at her.

Per record review of the Monthly Behavior Summary dated 7-25-14 is written R1 was pushing a peer (unidentified) on the van on the way home yelling and cussing. This surveyor was not given any documentation that this incident was reported to Public Health or the Administrator on duty. The facility failed to investigate this incident.

Per interview with E4 (Qualified Intellectual Disability Professional) on 9-3-14 at 10:55 A.M. stated that there was no incident report on 7-25-14 for R1 pushing a peer (unidentified).

Per record review of the Incident / Accident Report is as follows:
9-5-13 R2 was walking to the garage door to leave for work, R1 was behind her and R1 pushed R2 causing her to fall to the floor.
3-5-14 R1 was pushing and yelling at R2 while on the van. R2 appeared to be upset because she was yelling.
3-11-14 While serving breakfast R1 let out a scream in the living room area. R1 pushed R2 down. R2 fell backwards on her bottom but did hit the recliner going down.
4-22-14 While driving R3 was just sitting in her

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W 149	Continued From page 2 seat riding to work when R1 grabbed her arm and started hitting her and shaking it for no apparent reason. 5-21-14 R1 yelled something and walked up to R4 and pushed her causing her to run into the wall and cabinet under the television. R4 yelled out because she seemed to be upset. 7-8-14 R1 came in from outside and into the living room. R1 walked up to R2 and pushed her causing her to fall down. R2 landed on her bottom, but hit her back on the stand under the television on the way down. 7-12-14 is written, while R3 was sitting on the couch R1 walked by leaned down and shoved R3 into the back of the couch. R1's right hand on R3's left shoulder. While doing so R1 was very close to R3's face and yelled. E6 (Direct Support Person) was unable to make out what R1 said. E6 asked R1 to leave R3 alone and E6 then checked to make sure R3 was ok. This incident was not documented as reported to the Administrator on duty at the time of the incident. 7-14-14 When unloading the bus after day training R1 repeatedly punched R3 in the left shoulder. 7-15-14 R3 was walking from the living room down the hallway to her bedroom when R1 pushed her into the wall causing her to fall to the floor. Checked R3 for injuries and found none but she was holding her head. 7-16-14 When going out the garage door to leave for work R1 turned around and pushed R2 to the floor. 7-19-14 While cooking lunch R1 yelled "I push you down" and found R2 on the floor and R1 walking away. 7-29-14 While R2 was walking in the living room R1 walked by her and pushed her down while screaming. R2 fell into the couch and then slid to	W 149		

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W 149	Continued From page 3 the floor. Per record review of the Incident Report dated 7-12-14 is written R1 walked by R3 who was sitting on the sofa and pushed her back on the sofa. R1 was redirected. This incident of peer to peer was reported to Public Health on on 7-17-14. Per interview with E1 (Administrator) on 9-2-14 at 3:15 P.M. stated that the incident on 7-12-14 was not reported to the Administrator on Duty and was a late report to public health. Per record review of the Abuse and Neglect Prevention Policy dated 10/2013 is written the facility will protect the individuals right to live a free life, free of abuse and neglect. In compliance with this policy, all personnel will be trained and made familiar with prevention practices established regarding abuse and neglect. All employees are responsible for immediate intervention on behalf of individual in potential or actual abuse situations, and will report these interventions and concerns following agency guidelines. Failure to report abuse or neglect is not acceptable and is subject to discipline. All employees are expected to follow the reporting guidelines. All alleged acts of abuse or neglect will be promptly and thoroughly investigated. This facility policy was not implemented when R1 pushed an unidentified peer and this was not investigated and reported to whom the peer was and also when R1 pushed R3 with facility staff not reporting this incident immediately to the administrator.	W 149		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS	W 153		

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W 153	Continued From page 4 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. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure for 1 of 3 in the sample (R3) that all allegations of abuse are reported immediately to the administrator and to other officials in accordance to state law. Findings include: Per record review of the Facility Data Sheet dated 4-24-14, R1 functions in the Severe Range of Intellectual Disability. R3 functions in the Profound Range of Intellectual Disability. Per record review of the Incident/ Accident Report dated 7-12-14 is written, while R3 was sitting on the couch R1 walked by leaned down and shoved R3 into the back of the couch. R1's right hand on R3's left shoulder. While doing so R1 was very close to R3's face and yelled. E6 (Direct Support Person) was unable to make out what R1 said. E6 asked R1 to leave R3 alone and E6 then checked to make sure R3 was ok. This incident was not documented as reported to the Administrator on duty at the time of the incident. Per record review of the Incident Report dated 7-12-14 is written R1 walked by R3 who was sitting on the sofa and pushed her back on the sofa. R1 was redirected. This incident of peer to peer was reported to Public Health on on	W 153		

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W 153	Continued From page 5 7-17-14. Per record review of the Monthly Behavior Summary dated 7-25-14 is written R1 was pushing a peer (unidentified) on the van on the way home yelling and cussing. This surveyor was not given any documentation that this incident was reported to Public Health or the Administrator on duty. Per interview with E1 (Administrator) on 9-2-14 at 3:15 P.M. stated that the incident on 7-12-14 was not reported to the Administrator on Duty and was a late report to public health. Per interview with E4 (Qualified Intellectual Disability Professional) on 9-3-14 at 10:55 A.M. stated that there was no incident report on 7-25-14 for R1 pushing a peer (unidentified).	W 153		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure for two of three in the sample (R2 and R3) and 3 of 3 outside the sample (R4, R5, and R6) that all alleged violations are thoroughly investigated. Findings include: Per record review of the Facility Data Sheet dated 4-24-14, R1 functions in the Severe Range of Intellectual Disability. R2, R3, R4, R5, and R6 functions in the Profound Range of Intellectual	W 154		

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W 154	Continued From page 6 Disability. Per record review of the Monthly Behavior Summary dated 7-25-14 is written R1 was pushing a peer (unidentified) on the van on the way home yelling and cussing. This surveyor was not given any documentation that this incident was reported to Public Health or the Administrator on duty. This record review did not identify the peer that was pushed by R1. Per interview with E4 (Qualified Intellectual Disability Professional) on 9-3-14 at 10:55 A.M. stated that they do not know who R1 pushed.	W 154		
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observations and interview the facility failed to ensure 2 of 2 clients outside the sample, (R4 & R5), were encouraged in their opportunities for client choice and self management. Findings include: During morning observations on 9-3-14 at 7:15am R4 was given her breakfast on a plate with a plateguard. At 7:20am R5 was given her breakfast on a divided plate. Both women ate their breakfasts independently. Neither was encouraged to help set their places at the table, prepare their breakfast, choose whether or not they wanted specific items, or to serve their own portions.	W 247		

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W 247	Continued From page 7 At 7:31am DSP E7 took R5's plate and handed it to DSP E5 who put it in the kitchen. At 7:33am E7 took R4's plate away from her as she was spilling it onto the floor and E7 put it in the kitchen. E7 then reached over and took R5's coffee cup from in front of her and took it into the kitchen. Neither woman was encouraged to clean up her own breakfast dishes. During an interview on 9-3-14 at 2:37pm QIDP E4 was informed of the aforementioned situation and said that she understood that the clients should have been encouraged. During a review of R4's Person Centered Plan it states that R4 can "help with meal preparation by doing such things as bringing an item to the table..." It also notes that R4 can independently take her dishes to the kitchen. R4 was not encouraged to practice her skills to increase her independence.	W 247		
W 274	483.450(b)(1) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The facility must develop and implement written policies and procedures that govern the management of inappropriate client behavior. This STANDARD is not met as evidenced by: Based on observation, record review, and interview the facility failed to ensure for one of one clients (R4)that uses a harness for vehicle restraint that the facility implement policies and procedures for the management of inappropriate client behavior.	W 274		

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W 274	Continued From page 8 Findings include: Per record review of the Facility Data Sheet dated 4-24-14, R4 functions in the Profound Range of Intellectual Disability. During observations on 9-2-14 at 3:00 P.M. this surveyor observed R4 enter the facility with an adaptive harness with a zipper on the back side inaccessible by R4. R4 was redirected by E3 (House Supervisor) to assist in taking off the harness. Per record review of the Policy and Procedure for Behavior Development dated 5/2013 is written that the use of mechanical restraints are prohibited except as prescribed by a physician and approved through a behavior medical plan. Note the Physician must approve the use of a harness type of seat belt. Per interview with E4 (Qualified Intellectual Disability Professional) on 9-2-14 at 3:10 P.M. stated that the harness is used for R4 in the vehicle so that she can not unbuckle herself from the chair. Per interview with E4 (Qualified Intellectual Disability Professional) on 9-3-14 at 2:30 P.M. stated that the harness for R4 is not under the Physician Order Sheet as stated in the facility policy and that they do not have a physician order for the use of the harness.	W 274		
W 280	483.450(b)(1)(iv)(B) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Procedures that govern the management of inappropriate client behavior must address the	W 280		

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W 280	Continued From page 9 use of physical restraints. This STANDARD is not met as evidenced by: Based on observations, record review and interview the facility failed to ensure that procedures that govern the management of inappropriate client behavior address the use of physical restraints for 1 of 1 clients outside the sample, R4, who uses a harness in her daily trips to and from her work area. Findings include: On 9-2-14 at 3:05pm R4 came home from her work area. R4 had a "harness" made up of a series of straps and fasteners across her torso horizontally and vertically. Staff in the home unfastened the harness from the back and took it off R4 and hung it on a doorknob in the attached garage. On 9-2-14 at 3:07pm QIDP E4 escorted this surveyor to the van and explained the harness set-up. The harness that R4 had on hooks into 4 areas that are attached to a seat in the van. E4 explained that this harness is used in place of a seat belt. R4 continually removed her seat belt and would lay down on the seat while the van was in motion. R4 does not do that with this harness. On 9-2-14 at 2:05pm E4 said that they had tried other bus situations including a larger bus with an extra staff person but that it had not worked either. R4 had become more aggressive with the additional staff. During a review of Policy and Procedure entitled "Behavior Development" with a most recent	W 280		

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W 280	Continued From page 10 revision date of May 2013 it states "The use of mechanical restraints are prohibited except as prescribed by a physician and approved through a behavior or medical plan. Note: the client's physician must approve the use of a harness type of seat belt." These policies do not explicitly describe the harness that R4 was wearing as a restraint. Also the facility does not have a physicians order for R4's harness either.	W 280		
W 303	483.450(d)(4) PHYSICAL RESTRAINTS A record of restraint checks and usage must be kept. This STANDARD is not met as evidenced by: Based on observation, record review, and interview the facility failed to ensure for one of one client (R4) that uses a vehicle harness that a record of the restraint and usage is kept. Findings include: Per record review of the Facility Data Sheet dated 4-24-14, R4 functions in the Profound Range of Intellectual Disability. During observations on 9-2-14 at 3:00 P.M. this surveyor observed R4 enter the facility with an adaptive harness with a zipper on the back side inaccessible by R4. R4 was redirected by E3 (House Supervisor) to assist in taking off the harness. Per record review of the Provider meeting Notes dated 4-17-14 is written the meeting was called to discuss implementing the use of a seatbelt harness for R4 due to ongoing behavioral safety	W 303		

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W 303	Continued From page 11 issues in the bus. Formal tracking of this behavior will be added to R4's behavior plan at next annual review. Per interview with E4 Qualified Intellectual Disability Professional) on 9-3-14 at 2:40 P.M. stated that they did not have a record for the checks and usage of the harness.	W 303		