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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS COMPLAINT SURVYEY EXTENDED TO CONDITION OF PARTICIPATION NOT MET FOR W102, W122, AND W266 Complaint#1694861/IL88007	W 000		
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: Based on record review, observation and interview, it was determined that the Governing Body failed to take action to identify and resolve a systematic problem of a reoccurring nature for 2 of 3 (R1 and R3) in the sample and 12 of 12 (R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15) out of the sample when the facility: 1. Failed to ensure clients R1, R3, and R4 through R15 were provided with sufficient safeguards to prevent injuries from physical aggression obtained from a peer living in the home. 2. Failed to protect all individuals living in the facility from further injuries. 3. Failed to have a procedure in place with clear directives to staff regarding supervising clients who display frequent and serious acts of both	W 102		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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W 102

Continued From page 1
physical and verbal aggression.

4. Failed to ensure that individual' s rights are not restricted to accommodate maladaptive behaviors displayed by a single resident.

Findings include:

Refer to deficiencies cited at:

W104: The governing Body will exercise policy and operating direction over the facility

W 104

483.410(a)(1) GOVERNING BODY

The governing body must exercise general policy, budget, and operating direction over the facility.

This STANDARD is not met as evidenced by:
Based on record review, observation, and interview, it was determined that the governing body failed to ensure that facility procedure provide guidance and clear directives to staff to ensure supervision was provided to clients who displayed acts of physical aggression to other individuals. This occurred to 1 of 1 (R1) in the sample who was hit in the head and 1 of 1 (R11) out of the sample who sustained a sprained ankle and has the potential to impact all individuals living in the home (R2 through R10 and R12 through R15.) The facility also failed to ensure that individual's rights are not restricted to accommodate maladaptive behaviors displayed by a single resident in the sample (R2). This has the potential to impact all individuals living in the home.

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Findings include:

Incident report dated 7/7/16 at 6:00pm states R2 pushed R11 and twisted her ankle resulting in 911 called and R11 was taken to emergency department. R11 was diagnosed with a sprained ankle.

Incident report dated 8/18/16 at 7:30pm states R2 "pushed " R1's wheelchair and then " hit her on the top of her head with an open hand." Instructions were given by E3, " (Registered Nurse) to monitor R1 throughout the night and check for marks and bruises. "

The 7/7/16 incident occurred at 6:00pm, after dinner and two (2) staff members were working. E10, (Direct Support Person/DSP) witnessed the incident. E10 worked 3:00pm to 9:51pm and was responsible for programming. E4, (DSP) and cook worked 11:15am to 7:04pm. The incident occurred at 6pm. The daily home schedule listed nine (9) residents should have been receiving programming at this time. Review includes two (2) staff for Nine (9) residents, 4 of the 9 residents utilize wheelchairs for mobility and 1 resident (R2) required line of sight supervision.

Behavior Report form dated 8/23/16 at 10:28am written by Z1 (DSP) states, "staff was helping individuals with activities with my back turned and R2 just came and punched me in my back."

Behavior Report form dated 8/19/16 at 11:37am written by Z2 (DSP) states, "R2 got up start yelling swearing pick up chair, pick up cup and threw at staff."

Behavior Report form dated 8/18/16 at 10:10am

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written by Z2 (DSP) states, R2 "start hitting staff".

Behavior Report form dated 8/12/16 at 11:47am written by Z3(DSP) states R2 "got up swearing and kicking at staff."

Review of R2's Behavior Management Program for last year 6/1/15 and current year 8/1/16 requires staff to remove all residents to another area if R2 becomes upset. Behavior Management program notes document, "If R2 is showing signs of physical aggression or agitation, other staff should assist individuals\peers to an activity in another area so they remain safe. R2 tends to lose focus on aggression toward peers, if they are out of her line of vision." The same program documents R2's level of supervision is line of sight while awake.

Review of a Special Staffing Meeting attended by E1 (Administrator), E2 (Qualified Intellectual Disability Professional), E5 (Direct Support Person), Z5 (Support Service Team/SST), and Z6 (guardian) dated 3/11/16 (4 months ago) includes documentation that R2's "behavior is sometimes harmful to others." and that R2 would have increased staff support if transferred to a CILA. Z6 agreed to follow up on this idea when he returned from vacation.

Review of an email dated 4/2016 from Z5/SST to E1, Administrator and E2, QIDP states when R2's guardian returned from vacation, E1 would show R2's guardian a CILA home. Z5 offers to write up tips for any new staff members working with R2 and that "R2 still has her moments" "she sometimes has problems with another resident there."

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The facility failed to show any evidence that any additional attempts to assess if the ICF is the correct placement for R2 due to her severe maladaptive behaviors of physical aggression and harming other residents in the home.

Review of nursing note dated 7/10/16 states "R2 was observed to be increasingly more agitated, aggressive, loud and disruptive to the house." "The other individuals are trying hard to avoid confrontation with her."

Review of nursing note dated 8/1/16 states, "she continues to be increasingly more agitated, aggressive, loud and disruptive to the house." "R2 is very impulsive."

Review of the psychiatrist, Z4 note dated 8/16/16 states "R2 is more impulsive, need redirection" "per staff hits people unprovoked." Please use 1:1 supervision (statement then crossed out and initiated by Z4) and replaced with "line of sight while awake."

Observations were made on 8/23/16 at 3:50pm of R2 entering the home from the back door of the home through the dining room. R2 was alone and unsupervised. Surveyor immediately went out the same door R2 entered to check if any staff was present and there were none. R1, R9, and R11 were outside alone sitting in the patio area where R2 had just appeared from.

Observations continued on 8/23/16 as R2 started yelling at a staff member, E4 (cook) and at 4:14pm R2 flipped over a wooden kitchen chair and continued to scream and yell for 20 minutes.

Observations were made on 8/23/16 at 3:30pm

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that R2's bedroom is approximately 20 feet from both R1 and R11's bedroom.

An interview was conducted with R11 on 8/23/16 at 4pm outside the facility on the patio where she remained sitting. R11 is ambulatory and verbalizes freely and without alteration. R11 immediately asked surveyor "can you help me, are you somebody who can help here, I have a problem, R2 is mean to me. She hits me mostly on my arm and shoulder. Nobody does anything about it. R2 was asked if she told staff this was happening and replied, "Yes, I told E5 (Direct Support Staff/DSP) and E8, (DSP), "they don't do nothing. I'm afraid to come out of my room. R2 tells me to shut up." When I tell the staff they tell me to stay in my room and she will leave me alone. E5 stated "One time she pushed me and E2, (Qualified Intellectual Disability Professional/QIDP) picked me up when I fell."

An interview was conducted with R9 on 8/23/16 at 4:05pm , R9 states "she don't hit me every day but she does hit me sometimes, mostly yells at me and tell me to shut up. She takes stuff from my room she took my book and I told her to stop and she told me to shut up. I was taking a shower the other day and she came in the bathroom while I was naked and I told her to leave. She told me to shut up and left the door open. R9 was asked if there was staff around and replied "no".

An interview was conducted with R1 (utilize a wheelchair for mobility due to Cerebral Palsy and Quadriplegia) on 8/23/16 at 4:10pm, R1 states R2, "is hitting almost everybody really, mostly R11 and R9, she targets them. She always is looking for R11 and R9. She hits R5 too. We all moved to the front here because she was getting off the

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bus from workshop and we didn't want to be anywhere by her. She doesn't really bother me she just hit me in the head that one time I think it was last week."

An interview was conducted with R5 on 8/23/16 at 4:30pm, R5 was asked if R2 has ever hit him and replied "yeah" R5 did not answer any additional questions.

An interview was conducted with E1, Administrator on 8/23/16 regarding the above observations and interviews. E1 was also asked what safeguards have the facility put in place to protect the individuals from harm. E1 states R2 have seen the psychiatrist and had medication adjustments, the staff encourage R2 and the other clients to sit in separate areas, the SST (Support Service Team) is involved, and E1 states the level of supervisor is now "in line of sight while awake"'.

The surveyor informed E1, Administrator, the following current observations on 8/23/16 at 4:45pm:
15 residents currently in the home
3 of 15 (R1, R6, and R13) are wheelchair dependent for mobility.
E4, cook is passing medications and preparing dinner while assisting with supervising R2 all at once.

R2 is on special supervision of line of sight and is moving throughout the house constantly.
Several residents are asking various request of the only other staff member E7.

E1, Administrator states there is usually another staff member here and that E2, QIDP is on her

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way in. E1 confirmed the facility is not adequately staffed at the time of observations.

An interview was conducted on 8/25/16 at 8:45am with E9, Direct Support Staff who works the night shift 11:30pm to 9:30am and worked last night. E9 confirmed there is only one staff who works the night shift and she is responsible for:

A. monitoring all 15 residents throughout the night
B. getting all residents up starting at 5am. E9 states she usually get R2 up last but she is awake at the same time as other residents.
C. giving am medications
D. assisting two residents R1 and R6 (utilize wheelchairs) to get dressed.

E9 was asked how is she able to provide line of sight supervision to R2 while she is awake while performing the above duties. E9 states, "It ' s hard to keep an eye on her."

On 8/24/16, at 3:30pm E1, Administrator informed surveyor that the facility will assign a staff member specifically to R2.

W 122 483.420 CLIENT PROTECTIONS W 122

The facility must ensure that specific client protections requirements are met.

This CONDITION is not met as evidenced by:
Based on record review, observation, and interview, the facility failed to ensure adequate client protections for 2 of 2 (R1 and R3) in the sample and 12 of 12 (R4,R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15) residents living in

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W 122	Continued From page 8 the home, when they failed to: 1. Ensure safeguards were in place to prevent injuries and reoccurent injuries to R1, R9, and R11 and potentially all other residents that reside in the home. 2. Ensure that all residents are not restricted to isolated areas of the home in the event of an maladaptive behavior of a peer. Findings include: Refer to deficiencies cited under: W125 The facility must ensure that clients' rights are exercised and not restricted. W149 The facility must prohibit, mistreatment, neglect, and abuse to clients.	W 122		
W 125	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. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that individuals were able to exercise their rights and not having restrictions of free movement. This occurred to 2 of 3 (R1 and R3) in the sample, and 13 of 13 (R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15) outside the sample.	W 125		

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W 125	Continued From page 9 Findings include: Review of R2's Behavior Management Program for last year 6/1/15 and current year 8/1/16 requires staff to remove all residents to another area if R2 becomes upset, as follows, "If R2 is showing signs of physical aggression or agitation, other staff should assist individuals\peers to an activity in another area so they remain safe. R2 tends to lose focus on aggression toward peers, if they are out of her line of vision." The same program states R2's level of supervision is line of sight while awake. Incident report dated 7/7/16 at 6:00pm states R2 pushed R11 and twisted her ankle resulting in 911 called and R11 was taken to emergency department. Incident report dated 8/18/16 at 7:30pm states, R2, "pushed R1's wheelchair and then hit her on the top of her head with an open hand." Instructions given by E3, registered Nurse was to monitor R1 throughout the night and check for marks and bruises. An interview was conducted with R11 on 8/23/16 at 4pm outside the facility on the patio where she remained sitting. R11 is ambulatory and verbalizes freely and without alteration. R11 immediately asked surveyor "can you help me, are you somebody who can help here, I have a problem, R2 is mean to me. She hits me mostly on my arm and shoulder. Nobody does anything about it. R2 was asked if she told staff this was happening and replied, "Yes, I told E5 (Direct Support Staff/DSP) and E8, (DSP), "They don't do nothing. I'm afraid to come out of my room. R2 tells me to shut up. "When I tell the staff they tell	W 125		

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W 125	Continued From page 10 me to stay in my room and she will leave me alone. E5 told me that."One time she pushed me and E2, (Qualified Intellectual Disability Professional/QIDP) picked me up when I fell." An interview with E1 and E2, QIDP on 8/25/16 at 12:00pm confirmed residents living in the home are asked to move to a different area of the home if R2 displays a Behavior. E1 and E2 were asked what if the residents are eating, having a snack, or watching a television program, would they still be required to stop and be moved. E2 states for their safety, "yes".	W 125		
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, observation, and interview, the facility failed to ensure that individuals were free from abuse, neglect and mistreatment when the facility failed to implement written policies and procedures that prohibit abuse and neglect. This failure resulted in: Resident-on-resident abuses by R2 impacting two of three residents in the sample (R1 and R3) and 2 of 9 (R5 and R11) outside the sample; and potentially affecting eleven facility residents (R4, R6, R7, R8, R9, R10, R12, R13, R14, and R15). An incident management system that failed to thoroughly investigate all injuries to ensure corrective actions have been identified and implemented so that similar circumstances and injuries are not repeated.	W 149		

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A lack of adequate staff supervision to prevent resident-on-resident abuse; along with a failure to determine what additional supports and services are required to keep clients free from abuse.

Findings include:

Facility policy titled Physical Injury and Illness/Individual Medical Emergencies, policy number 5.57 states, "Neglect: Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."

Facility policy titled Administration/ Investigation Committee, policy number 5.24 states, "The investigation Committee shall be responsible for the following: A. To identify, review and determine if alleged violations of any individual rights, including abuse and neglect have occurred. "
" C. To protect individuals from further harm. "
4. The employee or agent will write a detailed, factual statement regarding the incident on a progress note.
H. "The committee shall meet on an as needed basis and reports of meetings shall contain findings, recommendations, and a plan for implementation, as appropriate."

Facility Policy titled Behavior Program Development and Management, policy number 6.29 states, "in the effort to improve such behaviors and their effects, individuals will not be subjected to procedures that will limit their freedom or rights without prior approval of the Human Rights and Behavior Management committees, the Individual Development Team and the individual or guardian.

C. To ensure that behavior interventions

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implemented are appropriate to the problems created by the behavior, so that rights are not restricted unnecessarily or to a greater extent than the problem should dictate."

Incident report dated 7/7/16 at 6:00pm states R2 pushed R11 and twisted her ankle resulting in 911 called and R11 was taken to emergency department.

Incident report dated 8/18/16 at 7:30pm states R2 "pushed R1's wheelchair and then hit her on the top of her head with an open hand." Instructions given by E3, registered Nurse was to monitor R1 throughout the night and check for marks and bruises.

The 7/7/16 incident occurred at 6:00pm after dinner, include 2 staff members working. E10, Direct Support Person/DSP witnessed the incident worked 3:00pm to 9:51pm and was responsible for programming. E4, DSP and cook worked 11:15am to 7:04pm. The incident occurred at 6pm. The daily home schedule documents 9 residents should have been receiving programming at this time. Review includes 2 staff for 9 residents, 4 of the 9 residents utilize wheelchairs for mobility and 1 resident (R2) required line of sight supervision.

The 8/18/16 incident included 1 staff member , E6, Direct Support Person who witnessed the incident was still in training at the time of the incident. This left one staff member for the entire second shift There are 15 residents living in the home and 3 of the 15 utilize wheelchairs for mobility. 1 of the 15 residents wanders throughout the house constantly (R15) and R2 is line of sight supervision.

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Behavior Report form dated 8/12/16 at 11:47am written by Z3 states R2 "got up swearing and kicking at staff."
Behavior Report form dated 8/18/16 at 10:10am written by Z2 states R2 "start hitting staff".
Behavior Report form dated 8/19/16 at 11:37am written by Z2 states "R2 got up start yelling swearing pick up chair, pick up cup and throw at staff."
Behavior Report form dated 8/23/16 at 10:28am written by Z1 states "staff was helping individuals with activities with my back turned and R2 just came and punched me in my back."

Review of R2's Behavior Management Program list diagnoses of Moderate level of Intellectual Functioning, Bipolar Disorder, Schizoaffective Disorder, Impulse Control, Obsessive Compulsive Disorder, and Anxiety. For last year 6/1/15 and current year 8/1/16 requires staff to remove all residents to another area if R2 becomes upset, as follows, "If R2 is showing signs of physical aggression or agitation, other staff should assist individuals\peers to an activity in another area so they remain safe." "R2 tends to lose focus on aggression toward peers, if they are out of her line of vision." This same program states R2's level of supervision is line of sight while awake.

Review of nursing note dated 7/10/16 states "R2 was observed to be increasingly more agitated, aggressive, loud and disruptive to the house." "The other individuals are trying hard to avoid confrontation with her."

Review of nursing note states 8/1/16 states, "She continues to be increasingly more agitated,

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aggressive, loud and disruptive to the house. R2 is very impulsive."

Review of the psychiatrist, Z4 note dated 8/16/16 states, "R2 is more impulsive, needs redirection, per staff hits people unprovoked. Please use 1:1 supervision (statement then crossed out and initiated by Z4 at facility request) and replaced with "line of sight while awake."

Review of the Safety Committee report dated 7/9/16 states the findings for the 7/7/16 incident, "Summary of incident: R11 was pushed by R2 and twisted her ankle." "Committee Findings: "R11 was pushed by R2 and twisted her ankle. Committee Considerations, 1. R2 will see her psychiatrist and 2. Keep R2 and R11 separated."

Review of the Safety Committee report dated 8/22/16 states the findings for the 8/18/16 incident, "Summary of incident: R2 pushed R1." "Committee findings states, "R1 was pushed and hit by R2. Committee Considerations: 1. a special staffing will be held for R2 2. Keep R2 and R1 separated. 3. Keep R2 in line of sight."

The facility failed to shoe evidence of a special staffing that was held as of survey date 8/29/16. Review of documents includes the last Special Team Meeting for R2 was 3/11/16.

The same above reports failed include if an investigation was conducted to ascertain if sufficient staff was working when the incident occurred, interviews of staff to check if procedures were followed prior to during and after the incident occurred, or to give clear directives on how staff should keep R2 and R11 separated

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Observations were made on 8/23/16 at 3:30pm that R2's bedroom is approximately 20 feet from both R1 and R11's bedroom.

On 8/23/16 at 3:50pm observation was made of R2 entering the home from the back door of the home through the dining room. R2 was alone and unsupervised. Surveyor immediately went out the same door and verified no staff were present. R1, R9, and R11 were outside alone sitting in the patio area where R2 had just entered from. Then R2 was observed yelling at a staff member, E4 (cook) and at 4:14pm R2 flipped over a wooden kitchen chair and continued to scream and yell for 20 minutes.

An interview was conducted with R11 on 8/23/16 at 4pm outside the facility on the patio where she remained sitting. R11 is ambulatory and verbalizes freely and without alteration. R11 immediately asked surveyor "can you help me, I have a problem, R2 is mean to me. She hits me mostly on my arm and shoulder. Nobody does anything about it." R11 was asked if she told staff this was happening and replied; "Yes, I told E5 (Direct Support Staff/DSP) and E8, (DSP) they don't do nothing. I'm afraid to come out of my room. R2 "tells me to shut up. When I tell the staff they tell me to stay in my room and she will leave me alone [E5] told me that. One time she pushed me and E2 (Qualified Intellectual Disability Professional/QIDP) picked me up when I fell."

An interview was conducted with R9 on 8/23/16 at 4:05pm. R9 stated; "she doesn ' t hit me every day but she does hit me sometimes, mostly yell at me and tell me to shut up. She takes stuff from my room she took my book and I told her to stop

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and she told me to shut up. I was taking a shower the other day and she came in the bathroom while I was naked and I told her to leave. She told me to shut up and left the door open." R9 was asked if there was staff around and R9 replied "no".

On 8/23/16 at 4:10pm an interview was conducted with R1 (utilize a wheelchair for mobility due to Cerebral Palsy and Quadriplegia). R1 stated; "(R2) is hitting almost everybody really, mostly R11 and R9, she targets them. She always looks for R11 and R9. She hits R5 too. We all moved to the front here because she was getting off the bus from workshop and we didn't want to be anywhere by her. She doesn't really bother me she just hit me in the head that one time I think it was last week."

An interview was conducted with R5 on 8/23/16 at 4:30pm. R5 was asked if R2 has ever hit him and replied "yeah". R5 did not answer any additional questions.

An interview was conducted with E1 (Administrator) on 8/23/16 regarding the above observations and interviews. Surveyor pointed out to E1 the following current observations on 8/23/16 at 4:45pm: 15 residents currently in the home; 2 of 15 residents (R1 and R6) are wheelchair dependent for mobility; E4 (cook) is passing medications and preparing dinner while assisting with supervising R2 all at once; R2 is on special supervision of line of sight and is moving throughout the house constantly; and several residents are asking various request of the only other staff member (E7).

E1 was also asked what safeguards have the

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facility put in place to protect the individuals from harm. E1 states R2 have seen the psychiatrist and had medication adjustments, the staff encourage R2 and the other clients to sit in separate areas, the SST (Support Service Team) is involved, and E1 states the level of supervision is now "in line of sight while awake".
E1 (Administrator) states there is usually another staff member here and that E2 (QIDP) is on her way in. E1 confirmed the facility is not adequately staffed at the time of observations.

An interview was conducted on 8/25/16 at 8:45am with E9 (Direct Support Staff/DSP) who works the night shift 11:30pm to 9:30am and worked last night. E9 confirmed there is only one staff who works the night shift and she is responsible for: Monitoring all 15 residents throughout the night; getting all residents up starting at 5am., E9 states she usually get R2 up last but she is awake at the same time as other residents; giving am medications; and assisting two residents R1 and R6 (utilize wheelchairs) to get dressed. E9 was asked how is she able to provide line of sight supervision to R2 while she is awake while performing the above duties; E9 stated "it's hard to keep an eye on her".

An interview with E1 (Administrator) and E2 (QIDP) on 8/25/16 at 12:00pm confirmed residents living in the home are asked to move to a different area of the home if R2 displays a Behavior. E1 and E2 were asked what if the residents are eating, having a snack, or watching a television program, would they still be required to stop and be moved. E2 stated; "for their safety yes". R2 is not supervised at all times which leaves other residents in the home at further risk of harm.

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An interview was conducted with Z5, Licensed Clinical Social Worker and Support Services Service Team member on 8/29/16 at 12:18pm. Z5 states she has worked with R2 for over a year and part of her role is to provide support to the staff regarding R2's Behavior Management. Z5 was asked if new staff such as E4, E6, and E10 (now terminated) should have received training in management of physical aggression displayed by R2 as related to preventative measures and management in the aftermath of this aggression. Z5 states, the facility usually tells her if there is new staff and that yes the staff would benefit from training from physical management.

Surveyor asked Z5 if she reviewed the psychiatrist visit report for R2 on 8/16/16 which recommend 1:1 supervision for R2 but was crossed out and replaced with line of sight supervision. Z5 states no she had not seen the report but confirmed she should be informed of psychiatrist visits with R2.

Z5 reviewed the report and states, "the facility cannot do 1:1 supervision because it is an Intermediate Care Facility" and when asked why, states, "Because they don't get paid for it."

Z5 states during the same interview that this facility "is not the appropriate placement for R2".

W 186 483.430(d)(1-2) DIRECT CARE STAFF W 186

The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.

Direct care staff are defined as the present

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W 186	Continued From page 19 on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on record review, observation, and interview the facility failed to provide sufficient staff to manage and supervise clients in accordance with individuals program plans which required individuals with inappropriate behaviors receive specialized staff attention. This impacted 2 of 3 (R1 and R3) individuals in the sample and 12 of 12 (R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15) outside the sample. Findings include: Incident report dated 7/7/16 at 6:00pm states R2 pushed R11 and twisted her ankle resulting in 911 called and R11 was taken to emergency department and diagnosed with a sprained ankle. Incident report dated 8/18/16 at 7:30pm documents R2 "pushed R1's wheelchair and then hit her on the top of her head with an open hand." Instructions given by E3, registered Nurse was to monitor R1 throughout the night and check for marks and bruises. Behavior Report form dated 8/23/16 at 10:28am written by Z1 (DSP) states, "staff was helping individuals with activities with my back turned and R2 just came and punched me in my back." Behavior Report form dated 8/19/16 at 11:37am written by Z2 (DSP) states, "R2 got up start yelling swearing pick up chair, pick up cup and threw at staff."	W 186		

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Behavior Report form dated 8/18/16 at 10:10am written by Z2 (DSP) states, R2 "start hitting staff".

Behavior Report form dated 8/12/16 at 11:47am written by Z3(DSP) states R2 "got up swearing and kicking at staff."

Review of R2's Behavior Management Program for the last year 6/1/15 and current year 8/1/16 requires staff to remove all residents to another area if R2 becomes upset, as follows, "If R2 is showing signs of physical aggression or agitation, other staff should assist individuals\peers to an activity in another area so they remain safe. R2 tends to lose focus on aggression toward peers, if they are out of her line of vision." The same program documents R2's level of supervision is line of sight while awake.

Review of nursing note written by E3 (Registered Nurse) and dated 7/10/16 states "R2 was observed to be increasingly more agitated, aggressive, loud and disruptive to the house. The other individuals are trying hard to avoid confrontation with her."

Review of nursing note dated 8/1/16 and written by E3 8/1/16 documents, "she continues to be increasingly more agitated, aggressive, loud and disruptive to the house. R2 is very impulsive."

Review of the psychiatrist, Z4's note dated 8/16/16 documents "R2 is more impulsive, need redirection" "per staff hits people unprovoked." Please use 1:1 supervision (statement then crossed out and initiated by Z4) and replaced with "line of sight while awake."

Observations were made on 8/23/16 at 3:50pm of

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R2 entering the home from the back door of the home through the dining room. R2 was alone and unsupervised. Surveyor immediately went out the same door R2 entered to check if any staff was present and there were none. R1, R9, and R11 were outside alone sitting in the patio area where R2 had just appeared from.

Observations continued on 8/23/16 as R2 started yelling at a staff member, E4 (cook) and at 4:14pm R2 flipped over a wooden kitchen chair and continued to scream and yell for 20 minutes.

Observations were made on 8/23/16 at 3:30pm that R2's bedroom is approximately 20 feet from both R1 and R11's bedroom.

An interview was conducted with E1, Administrator on 8/23/16 regarding the above observations and interviews. E1 states R2's level of supervision is now "in line of sight."
Surveyor reviewed with E1 the following current observations at 4:45pm:

15 residents currently in the home
3 of 15 R1, R6, and R13 are wheelchair dependent
R15 who have a diagnosis of Autism and Anxiety is constantly moving in and outside the home and requesting some form of assistance regarding cookies, a sweater, and pop.
E4, cook is passing medications, preparing dinner, and supervising R2 all at once.
R2 is on special supervision of line of sight and is moving throughout the house constantly.
Several residents are asking various requests of the only other staff member E7.

E1 confirmed the home is not staffed sufficiently

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and that E2, QIDP is on her way.

An interview was conducted with R11 on 8/23/16 at 4pm outside the facility on the patio where she was sitting. R11 is ambulatory, verbalizes freely, and without alteration. R11 immediately asked surveyor "can you help me, are you somebody who can help here, I have a problem, R2 is mean to me . She hits me mostly on my arm and shoulder. Nobody does anything about it. R2 was asked if she told staff this was happening and replied, "Yes, I told E5 (Direct Support Staff/DSP) and E8, (DSP) "they don't do nothing. I'm afraid to come out of my room. R2 tells me to shut up." When I tell the staff they tell me to stay in my room and she will leave me alone. E5 told me that." One time she (R2) pushed me and E2, (Qualified Intellectual Disability Professional/QIDP) picked me up when I fell."

An interview was conducted with R9 on 8/23/16 at 4:05pm, R9 states "she don't hit me every day but she does hit me sometimes, mostly yell at me and tell me to shut up. She takes stuff from my room, she took my book and I told her to stop and she told me to shut up. I was taking a shower the other day and she came in the bathroom while I was naked and I told her to leave. She told me to shut up and left the door open. R9 was asked if there was staff around and replied "no."

An interview was conducted with R1 (utilize a wheelchair for mobility due to Cerebral Palsy and Quadriplegia) on 8/23/16 at 4:10pm, R1 states R2, "is hitting almost everybody really, mostly R11 and R9, she targets them. She always looks for R11 and R9. She hits R5 too. We all moved to the front here because she was getting off the bus from workshop and we didn't want to be

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anywhere by her in case she comes back out. She doesn't really bother me she just hit me in the head that one time I think it was last week."

An interview was conducted with R5 on 8/23/16 at 4:30pm, R5 was asked if R2 has ever hit him and replied "yeah" R5 did not answer any additional questions.

An interview was conducted with E1, Administrator on 8/23/16 regarding the above observations and interviews. E1 was also asked what safeguards have the facility put in place to protect the individuals from harm. E1 states R2 have seen the psychiatrist and had medication adjustments, the staff encourage R2 and the other clients to sit in separate areas, the SST (Support Service Team) is involved, and E1 states the level of supervisor is now "in line of sight while awake."

An interview was conducted on 8/25/16 at 8:45am with E9; Direct Support Staff who works the night shift 11:30pm to 9:30am and worked last night. E9 confirmed there is only one staff who works the night shift and she is responsible for:

A. monitoring all 15 residents throughout the night
B. getting all residents up starting at 5am. E9 states she usually get R2 up last but she is awake at the same time as other residents.
C. giving am medications
D. assisting two residents R1 and R6 (utilize wheelchairs) to get dressed.

E9 was asked how is she able to provide line of sight supervision to R2 while she is awake while performing the above duties. E9 states, "It ' s hard to keep an eye on her."

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W 186	Continued From page 24 On 8/24/16 (day 2 of the survey), at 3:30pm E1, Administrator informed the surveyor that the facility will assign a staff member specifically to R2. R2 is not supervised at all times which leaves other residents in the home at further risk of harm.	W 186		
W 264	483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the specially constituted committees monitor behavior management practices which restrict individual's rights. This impacted 2 of 2 (R1 and R3) individuals in the sample and 12 of 12 (R4 through R15) individuals outside the sample. Findings include: Review of R2's Behavior Management Program/BMP for the last year 6/1/15 and current year 8/1/16 requires staff to remove all residents to another area if R2 becomes upset, as follows,	W 264		

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"If R2 is showing signs of physical aggression or agitation, other staff should assist individuals\peers to an activity in another area" "R2 tends to lose focus on aggression toward peers, if they are out of her line of vision."

Review of maladaptive behaviors for R2 include the following data/frequency of behaviors that could impact the potential amount of times that other clients living in the home could have their rights restricted by having to move to another area of the home as directed above in the BMP:

June 2016 - Agitation - 35 episodes

July 2016 - Verbal Aggression, Cursing, Yelling - 20 episodes, Physical Aggression - 4 episodes
August 2016 - Data not available to surveyor for 8/1 through 8/16/16 however; 8/16/16 to 8/29/16 Physical Aggression - 1 episode at home and 8 episodes at day training

Review of the Human Rights committee meeting minutes for January, April and July 2016 failed to include evidence that the restrictions in the Behavior Program for R2 were reviewed. The HRC failed to address restrictions on the other residents living in the home R1, R3 and R4 through R15 to be moved by staff to another area in the event R2 displays an inappropriate behavior.

An interview with E1, Facility Administrator and E2, Qualified Intellectual Disability Professional on 8/25/16 at 12:00pm confirmed residents living in the home are asked to move to a different area of the home if R2 displays a Behavior. E1 and E2 were asked what if the residents are eating, having a snack, or watching a television program,

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W 264	Continued From page 26 would they still be required to stop and be moved. E2 states for their safety, "yes".	W 264		
W 266	483.450 CLIENT BEHAVIOR & FACILITY PRACTICES The facility must ensure that specific client behavior and facility practices requirements are met. This CONDITION is not met as evidenced by: Based on record review, observations, and interview, the facility failed to ensure that specific client behavior and facility practices requirements are met when the rights of several clients living in the facility were restricted for freedom of movement in their living space. This occurred for 2 of 3 individuals in the sample (R1 and R3) and 12 of 12 (R4 through R15) outside the sample when they failed to: 1. Monitor individuals to prevent physical harm. 2. Ensure restrictions are not used on individuals when not warranted. 3. Ensure that clients with known maladaptive behaviors of physical aggression to other individuals receive follow up to recommendations from support services. Findings include: Refer to deficiencies cited under: W274 - The facility must develop and implement written policies and procedure that govern the management of inappropriate client behavior. W276 - The facility must ensure all interventions both positive and intrusive to manage	W 266		

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inappropriate client behavior are clearly stated in its policy.

W278 - The facility must ensure prior to the use of more restrictive techniques, that client's record documents programs incorporating the use of least intrusive or more positive techniques have been tried systematically.

W285 - The facility must ensure that interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare, civil and human rights of clients are adequately protected.

W 274 483.450(b)(1) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR W 274

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 record review, observation, and interview, the facility failed to implement its written policy and procedures that govern the management of inappropriate client behavior. This occurred when the facility failed to ensure that least intrusive measures are utilized when the rights of 2 of 2 (R1 and R3) individuals in the sample and 12 of 12 (R4-R15) residents outside the sample were restricted due to inappropriate behavior of one individual (R2.)

Findings include:

Facility Policy titled Behavior Program

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W 274	Continued From page 28	W 274		

Development and Management policy number 6.29, states "In the effort to improve such behaviors and their effects, individuals will not be subjected to procedures that will limit their freedom or rights without prior approval of the Human Rights and Behavior Management Committees, the Individual Developmental Team and the Individual or guardian.

B. Behaviors for which interventions are indicated or identified by the Community Support Team as problematic will be studied through baseline or existing data to determine cases. Such study should include the consideration of antecedents to the behavior," "including duration, intensity, setting and others involved."

Review of R2's Behavior Management Program for the last year 6/1/15 and current year 8/1/16 requires staff to remove all residents to another area if R2 becomes upset, as follows, "If R2 is showing signs of physical aggression or agitation, other staff should assist individuals\peers to an activity in another area so they remain safe." "R2 tends to lose focus on aggression toward peers, if they are out of her line of vision." The same program states R2's level of supervision is line of sight while awake.

Review of a Special Staffing Meeting attended by E1 (Administrator), E2 (Qualified Intellectual Disability Professional), E5 (Direct Support Staff), Z5(Support Service Team/SST), and Z6 (guardian) dated 3/11/16 includes documentation that R2's "behavior is sometimes harmful to others." and that R2 would have increased staff

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W 274	Continued From page 29 support if transferred to a CILA. Z6 agreed to follow up on this idea when he returned from vacation. Review of an email dated 4/5/16 (4 months ago) from Z5 from SST to E1, Administrator and E2, QIDP states when R2's guardian returned from vacation, E1 would show Z5 a CILA home. Z5 offers to write up tips for any new staff members working with R2 and that "R2 still has her moments" "she sometimes has problems with another resident there." On 8/23/16 at 3:50pm observation was made of R2 entering the home from the back door of the home through the dining room. R2 was alone and unsupervised. Surveyor immediately went out the same door and verified no staff were present. R1, R9, and R11 were outside alone sitting in the patio area where R2 had just entered from. Then R2 was observed yelling at a staff member, E4 (cook) and at 4:14pm R2 flipped over a wooden kitchen chair and continued to scream and yell for 20 minutes. The facility failed to show any evidence that any additional attempts were made to assess if the ICF is the correct placement for R2 due to her severe maladaptive behaviors of physical aggression and harming other residents in the home.	W 274		

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An interview was conducted with R11 on 8/23/16 at 4pm outside the facility on the patio where she was sitting. R11 is ambulatory and verbalizes freely and without alteration. R11 immediately asked surveyor "can you help me, are you somebody who can help here, I have a problem, R2 is mean to me . She hits me mostly on my arm and shoulder. Nobody does anything about it. R2 was asked if she told staff this was happening and replied, "Yes, I told E5 (Direct Support Staff/DSP) and E8, DSP. "they don't do nothing. I'm afraid to come out of my room. R2 tells me to shut up." " When I tell the staff they tell me to stay in my room and she will leave me alone. E5 told me that."

An interview with E1, Facility Administrator and E2, Qualified Intellectual Disability Professional on 8/25/16 at 12:00pm confirmed residents living in the home are asked to move to a different area of the home if R2 displays a Behavior. E1 and E2 were asked what if the residents are eating, having a snack, or watching a television program, would they still be required to stop and be moved. E2 states for their safety , "yes"

An interview was conducted with Z5, Licensed Clinical Social Worker and Support Services Service Team member on 8/29/16 at 12:18pm. Z5 states she have worked with R2 for over a year and part of her role is to provide support to the staff regarding R2's Behavior Management. Z5 was asked if new staff such as E4, E6, and E10 (now terminated) should have received training in

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 274	Continued From page 31 management of physical aggression displayed by R2 as related to preventative measures and management in the aftermath of this aggression. Z5 states, the facility usually tell her if there is new staff and that yes the staff would benefit from training from physical management. Surveyor asked Z5 if she reviewed the psychiatrist visit report for R2 on 8/16/16 which recommend 1:1 supervision for R2 but was crossed out and replaced with line of sight supervision. Z5 states no she had not seen the report but confirmed she should be informed of psychiatrist visits with R2. Z5 reviewed the report and states, "the facility cannot do 1:1 supervision because it is an Intermediate Care Facility" and when asked why, states, "because they don't get paid for it." Z5 states during the same interview that this facility "is not the appropriate placement for R2."	W 274		
W 276	483.450(b)(1)(i) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Policies and procedures that govern the management of inappropriate client behavior must specify all facility approved interventions to manage inappropriate client behavior. This STANDARD is not met as evidenced by: Based on record review, observation, and interview, the facility failed to implement its policy for management of all residents living in the home during inappropriate client behavior. This failure to give clear directives to staff resulted in interventions utilized that restrict the rights of 2 of 3 (R1 and R3) individuals in the sample and 12 of 12 (R4, R3, R4, R5, R6, R7, R8, R9, R10, R11,	W 276		

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R12, R13, R14, R15) individuals outside the sample.

Findings include:

Facility Policy titled Behavior Program Development and Management, policy number 6.29 states, "in the effort to improve such behaviors and their effects, individuals will not be subjected to procedures that will limit their freedom or rights without prior approval of the Human Rights and Behavior Management committees, the Individual Development Team and the individual or guardian. "
" C. To ensure that behavior interventions implemented are appropriate to the problems created by the behavior, so that rights are not restricted unnecessarily or to a greater extent than the problem should dictate."

Review of R2's Behavior Management Program list the following diagnoses Moderate level of Intellectual Functioning, Bipolar Disorder, Schizoaffective Disorder, Impulse Control, Obsessive Compulsive Disorder, and Anxiety. The last year 6/1/15 and current year 8/1/16 requires staff to remove all residents to another area if R2 becomes upset, as follows, "If R2 is showing signs of physical aggression or agitation, other staff should assist individuals\peers to an activity in another area so they remain safe." "R2 tends to lose focus on aggression toward peers, if they are out of her line of vision." The same program states R2's level of supervision is line of sight while awake.

Incident report dated 7/7/16 at 6:00pm states R2 pushed R11 and twisted her ankle resulting in 911 called and R11 was taken to emergency

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W 276	Continued From page 33 department and diagnosed with sprained ankle. Incident report dated 8/18/16 at 7:30pm states R2 "pushed R1's wheelchair and then hit her on the top of her head with an open hand." Instructions given by E3, Registered Nurse was to monitor R1 throughout the night and check for marks and bruises. Behavior Report form dated 8/23/16 at 10:28am written by Z1 (DSP) states, "staff was helping individuals with activities with my back turned and R2 just came and punched me in my back." Behavior Report form dated 8/19/16 at 11:37am written by Z2 (DSP) states, "R2 got up start yelling swearing pick up chair, pick up cup and threw at staff." Behavior Report form dated 8/18/16 at 10:10am written by Z2 (DSP) states, R2 "start hitting staff". Behavior Report form dated 8/12/16 at 11:47am written by Z3(DSP) states R2 "got up swearing and kicking at staff."	W 276		
W 278	483.450(b)(1)(iii) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Procedures that govern the management of inappropriate client behavior must insure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective. This STANDARD is not met as evidenced by:	W 278		

W 278

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W 278

Based on record review and interview, the facility failed to assure restrictive programs were used only after less intrusive programs were systematically tried and demonstrated to be ineffective. 2 of 2 (R1 and R3) individuals in the sample and 12 of 12 (R4 through R15) outside the sample who were required to relocate to a different area in the event a resident displayed a maladaptive behavior.

Findings Include:

Facility Policy titled Behavior Program Development and Management, policy number 6.29 states, "in the effort to improve such behaviors and their effects, individuals will not be subjected to procedures that will limit their freedom or rights without prior approval of the Human Rights and Behavior Management committees, the Individual Development Team and the individual or guardian. C. To ensure that behavior interventions implemented are appropriate to the problems created by the behavior, so that rights are not restricted unnecessarily or to a greater extent than the problem should dictate."

Review of R2's Behavior Management Program for last year 6/1/15 and current year 8/1/16 requires staff to remove all residents to another area if R2 becomes upset, as follows, "If R2 is showing signs of physical aggression or agitation, other staff should assist individuals\peers to an activity in another area so they remain safe." "R2 tends to lose focus on aggression toward peers, if they are out of her line of vision." The same program states R2's level of supervision is line of sight while awake.

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Review of maladaptive behaviors for R2 include the following data/frequency of behaviors that could impact the potential amount of times that other clients living in the home could have their rights restricted by having to move to another area of the home as directed above in the BMP:

June 2016 - Agitation - 35 episodes

July 2016 - Verbal Aggression, Cursing, Yelling - 20 episodes, Physical Aggression - 4 episodes
August 2016 - Data not available to surveyor for 8/1 through 8/16/16 however; 8/16/16 to 8/29/16 Physical Aggression - 1 episode at home and 8 episodes at day training.

Incident report dated 7/7/16 at 6:00pm states R2 pushed R11 and twisted her ankle resulting in 911 called and R11 was taken to emergency department and diagnosed with a sprained ankle.

Incident report dated 8/18/16 at 7:30pm states R2 "pushed R1's wheelchair and then hit her on the top of her head with an open hand." Instructions given by E3, Registered Nurse was to monitor R1 throughout the night and check for marks and bruises.

Behavior Report form dated 8/23/16 at 10:28am written by Z1 (DSP) states, "staff was helping individuals with activities with my back turned and R2 just came and punched me in my back."

Behavior Report form dated 8/19/16 at 11:37am written by Z2 (DSP) states, "R2 got up start yelling swearing pick up chair, pick up cup and threw at staff."

Behavior Report form dated 8/18/16 at 10:10am

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written by Z2 (DSP) states, R2 "start hitting staff".

Behavior Report form dated 8/12/16 at 11:47am written by Z3(DSP) states R2 "got up swearing and kicking at staff."

Review of nursing note written by E3, Registered Nurse dated 7/10/16 states "R2 was observed to be increasingly more agitated, aggressive, loud and disruptive to the house." "The other individuals are trying hard to avoid confrontation with her."

Review of nursing note written by E3 dated 8/1/16 states, "she continues to be increasingly more agitated, aggressive, loud and disruptive to the house." "R2 is very impulsive."

Review of the psychiatrist, Z4 note dated 8/16/16 states "R2 is more impulsive, need redirection" "per staff hits people unprovoked." Please use 1:1 supervision (statement then crossed out and initiated by Z4) and replaced with "line of sight while awake."

An interview was conducted with E1, Administrator on 8/23/16 regarding the above observations and interviews. E1 was also asked what safeguards have the facility put in place to protect the individuals from harm. E1 states R2 have seen the psychiatrist and had medication adjustments, the staff encourage R2 and the other clients to sit in separate areas. E1 states the level of supervisor is now "in line of sight while awake"'.

An interview with E1, Facility Administrator and E2, Qualified Intellectual Disability Professional on 8/25/16 at 12:00pm confirmed residents living

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in the home are asked to move to a different area of the home if R2 displays a Behavior. E1 and E2 were asked what if the residents are eating, having a snack, or watching a television program, would they still be required to stop and be moved. E2 states for their safety, "yes"

An interview was conducted with Z5, Licensed Clinical Social Worker and Support Services Service Team member on 8/29/16 at 12:18pm. Z5 states she has worked with R2 for over a year and part of her role is to provide support to the staff regarding R2's Behavior Management. Z5 was asked if new staff such as E4, E6, and E10 (now terminated) should have received training in management of physical aggression displayed by R2 as related to preventative measures and management in the aftermath of this aggression. Z5 states, the facility usually tell her if there is new staff and that yes the staff would benefit from training from physical management.
Surveyor asked Z5 if she reviewed the psychiatrist visit report for R2 on 8/16/16 which recommend 1:1 supervision for R2 but was crossed out and replaced with line of sight supervision. Z5 states no she had not seen the report but confirmed she should be informed of psychiatrist visits with R2.

Z5 reviewed the report and states, "the facility cannot do 1:1 supervision because it is an Intermediate Care Facility" and when asked why, states, "Because they don't get paid for it."

Z5 states during the same interview that this facility "is not the appropriate placement for R2."

W 285	483.450(b)(2) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR	W 285		

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Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected.

This STANDARD is not met as evidenced by:
Based on record review and interview, the facility failed to ensure the specially constituted committee monitors practices which restrict client's rights. Furthermore the committee failed to ensure Behavior Program Plans do not include resident rights restrictions without appropriate review and consent. This impacted 2 of 2 (R1 and R3) individuals in the sample and 12 of 12 (R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15) individuals outside the sample who are required to move to another area of the home each time a resident (R2) display a maladaptive behavior.

Findings include:

Facility Policy titled Behavior Program Development and Management, policy number 6.29 states, "in the effort to improve such behaviors and their effects, individuals will not be subjected to procedures that will limit their freedom or rights without prior approval of the Human Rights and Behavior Management committees, the Individual Development Team and the individual or guardian. C. To ensure that behavior interventions implemented are appropriate to the problems created by the behavior, so that rights are not restricted unnecessarily or to a greater extent than the problem should dictate."

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Review of R2's Behavior Management Program for last year 6/1/15 and current year 8/1/16 requires staff to remove all residents to another area if R2 becomes upset, as follows, "If R2 is showing signs of physical aggression or agitation, other staff should assist individuals\peers to an activity in another area so they remain safe." "R2 tends to lose focus on aggression toward peers, if they are out of her line of vision." The same program states R2's level of supervision is line of sight while awake.

Review of the number of times R2 displayed agitation and physical aggression and the potential number of times residents living in the home could be moved to another area is as follows:

June 2016 - Agitation - 35 episodes

July 2016 - Verbal Aggression, Cursing, Yelling - 20 episodes
Physical Aggression - 4 episodes

August 2016 - Data not available to surveyor for 8/1 through 8/16/16 however; 8/16/16 to 8/29/16 Physical Aggression - 1 episode at home and 8 episodes at day training

Review of the records for R1, R3, and R4 through R15 failed to include guardian consents to having the residents moved to another area in the event of physical aggression or agitation.

Review of the Human Rights Committee/HRC meeting minutes for January, April and July 2016 does include review of restrictions included in the Behavior Program for R2. The HRC failed to

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

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address right restrictions on the other residents living in the home R1 and R3 and R4 through R15 to be moved by staff to another area in the event R2 displays an inappropriate behavior.

An interview with E1, Facility Administrator and E2, Qualified Intellectual Disability Professional on 8/25/16 at 12:00pm confirmed residents living in the home are asked to move to a different area of the home if R2 displays a Behavior. E1 and E2 were asked what if the residents are eating, having a snack, or watching a television program, would they still be required to stop and be moved. E2 states for their safety, "yes." E1 was not able to produce any additional information of HRC involvement in the residents restrictions outlined in the Behavior Management Program for R2.

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483.450(b)(3) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR

Techniques to manage inappropriate client behavior must never be used for the convenience of staff.

This STANDARD is not met as evidenced by:
Based on record review, observation, and interview, the facility failed to use techniques to manage inappropriate client behavior that did not restrict clients ability to move freely throughout their home. Furthermore the facility utilized a practice of having all clients (R1 through R15) go to bed at the same time in the evening.

Findings include:

Facility Policy titled Behavior Program Development and Management, policy number

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	14G203	A. BUILDING ______ B. WING ______	C 09/06/2016

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6.29 states, "in the effort to improve such behaviors and their effects, individuals will not be subjected to procedures that will limit their freedom or rights without prior approval of the Human Rights and Behavior Management committees, the Individual Development Team and the individual or guardian.
C. To ensure that behavior interventions implemented are appropriate to the problems created by the behavior, so that rights are not restricted unnecessarily or to a greater extent than the problem should dictate."

Review of R2's Behavior Management Program Moderate level of Intellectual Functioning, Bipolar Disorder, Schizoaffective Disorder, Impulse Control, Obsessive Compulsive Disorder, and Anxiety. For last year 6/1/15 and current year 8/1/16 requires staff to remove all residents to another area if R2 becomes upset, as follows, "If R2 is showing signs of physical aggression or agitation, other staff should assist individuals\peers to an activity in another area" "R2 tends to lose focus on aggression toward peers, if they are out of her line of vision.

Review of the Human Rights committee meeting minutes for January, April and July 2016 does include the Behavior Program for R2. The HRC failed to address restrictions on the other residents living in the home R1 and R3 - R15 to be moved by staff to another area in the event R2 displays an inappropriate behavior.

On 8/23/16 at 3:50pm observation was made of R2 entering the home from the back door of the home through the dining room. R2 was alone and unsupervised. Surveyor immediately went out the same door and verified no staff was present. R1,

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R9, and R11 were outside alone sitting in the patio area where R2 had just entered from. Then R2 was observed yelling at a staff member, E4 (cook) and at 4:14pm R2 flipped over a wooden kitchen chair and continued to scream and yell for 20 minutes.

An interview was conducted with R11 on 8/23/16 at 4pm outside the facility on the patio where she remained sitting. R11 is ambulatory and verbalizes freely and without alteration. R11 immediately asked surveyor "can you help me ... I have a problem, R2 is mean to me . She hits me mostly on my arm and shoulder. Nobody does anything about it."
R11 was asked if she told staff this was happening and replied; "Yes, I told E5 (Direct Support Staff/DSP) and E8, DSP ... they don't do nothing. I'm afraid to come out of my room. R2 tells me to shut up ... When I tell the staff they tell me to stay in my room and she will leave me alone [E5] told me that ... One time she pushed me and E2 (Qualified Intellectual Disability Professional/QIDP) picked me up when I fell."

An interview with E1, Facility Administrator and E2, Qualified Intellectual Disability Professional on 8/25/16 at 12:00pm confirmed residents living in the home are asked to move to a different area of the home if R2 displays a Behavior. E1 and E2 were asked what if the residents are eating, having a snack, or watching a television program, would they still be required to stop and be moved. E2 states for their safety , "yes"

An interview was conducted with E2, Qualified Intellectual Disability Professional on 8/25/16 at 3:30pm. E2 was asked about the staff schedule for 8/16/16 (the day R11 was injured by R2). The

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W 287	Continued From page 43 schedule list two Direct Support Staff both shift ending at 7pm which according to the schedule left two staff working. E2 was asked if enough staff was scheduled to attend to the needs of all individuals in the home R1-R10 and R12 - R15. E2 then stated yes and that all 14 of the individuals went to bed at 7pm that day. Surveyor inquired why would all 14 individuals go to bed at the same time at 7pm and E2 states the individuals were all very tired. An interview was conducted with E4, Cook on 8/24/16 at 3:30pm, E6, Direct Support Person on 8/25/16 by telephone at 1:23pm and again on 8/29/16 at 9:30am, and E9, DSP on 8/25/16 at 9:00am. All were asked if they had training in physical management of R2 regarding both her verbal and physical aggressive behaviors. E4 states her last training for physical aggression was 1 and a half year ago. An interview was conducted with Z5, Licensed Clinical Social Worker and Support Services Service Team member on 8/29/16 at 12:18pm. Z5 states she has worked with R2 for over a year and part of her role is to provide support to the staff regarding R2's Behavior Management. Z5 was asked if new staff such as E4, E6, and E10 (now terminated) should have received training in management of physical aggression displayed by R2 as related to preventative measures and management in the aftermath of this aggression. Z5 states, the facility usually tell her if there is new staff and that yes the staff would benefit from training from physical management. Surveyor asked Z5 if she reviewed the psychiatrist visit report for R2 on 8/16/16 which recommend 1:1 supervision for R2 but was crossed out and	W 287		

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W 287	Continued From page 44 replaced with line of sight supervision. Z5 states no she had not seen the report but confirmed she should be informed of psychiatrist visits with R2. Z5 reviewed the report and states, "the facility cannot do 1:1 supervision because it is an Intermediate Care Facility" and when asked why, states, "Because they don't get paid for it." Z5 states during the same interview that this facility "is not the appropriate placement for R2."	W 287		