STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012934	A. BUILDING: _____ B. WING _____	C 02/28/2023

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TAYLORVILLE TERRACE	921 EAST MARKET STREET TAYLORVILLE, IL 62568

(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) COMPLETE DATE
Z 000	COMMENTS Investigation of Facility Reported Incident of 8/25/22/IL155870 Investigation of Facility Reported Incident of 10/17/22/IL155872 Complaint Investigation 2340839/IL155916	Z 000		
Z9999	FINDINGS Statement of Licensure Violations 350.620a) 350.1060e) 350.1610e)1) 350.3240a) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually Section 350.1060 Training and Habilitation Services e) An appropriate, effective and individualized program that manages residents' behaviors shall be developed and implemented for residents with aggressive or self-abusive behavior. Adequate, properly trained and supervised staff shall be available to administer these programs. Section 350.1610 Resident Record Requirements e) An ongoing resident record including	Z9999	**Attachment A** **Statement of Licensure Violations**	

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Z9999	Continued From page 1 progression toward and regression from established resident goals shall be maintained. 1) The progress record shall indicate significant changes in the resident's condition. Any significant change shall be recorded upon occurrence by the staff person observing the change. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These requirements are Not Met as evidenced by: Based on interview and record review, the facility failed to prevent multiple elopements (R2) and to prevent neglect for a change in medical condition (R1) and ingestion of floor cleaner (R3) by their failure to: - Put safeguards in place for 1 of 1 individual with elopement behaviors (R2); for 1 of 1 individual with falls related to a medical condition and behaviors requiring emergency services (R1) and for 1 of 1 individual who ingested floor cleaner (R3). - Ensure the IDT (Inter-Disciplinary Team) develops and implements preventative measures for elopement behaviors (R2), for R1's falls and behaviors and R3's PICA behaviors. - Ensure nursing is notified and an assessment was completed on 1 of 1 individual who eloped from the facility (R2) and R1's falls and behaviors. - Ensure staff are documenting behaviors and falls for R1 and R2 on GERs (General Event Reports) and BERs (Behavior Event Reports). Findings include:	Z9999		

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Z9999	Continued From page 2 The facility's policy titled "Abuse and Neglect Program", revised date March 2022, documents, "Neglect" as - "failure to provide goods and/or services necessary to avoid physical harm, mental anguish or mental illness." Facility protocol titled "Levels of Supervision" (undated) documents, "1. General Supervision: All staff is responsible for the CARE; WELFARE; SAFETY & SECURITY, for all residents this facility serves. It is your responsibility to know where the residents are that you are assigned to and what they are doing. It is also staff responsibility to ensure that their rights and dignity are upheld, and they are free from abuse and neglect. 2. Close Monitoring: This includes all of the above as well as keeping the resident whereabouts known at all times. The resident may move about independently, but staff will monitor through direct observation at a minimum every 15 minutes. (documentation may be assigned) 3.Visual Monitoring: This includes all of the above as well as keeping the resident's whereabouts known at all times. The resident needs to be within the direct view of a DSP, during waking hours..... 4. One-On-One Monitoring: A staff member will be assigned to do direct supervision and monitoring with one particular resident.... A resident must be within arm's reach of and under the direct vision of the staff person assigned to the resident at all times..... " 1. Per the 5/18/22 Individual Service Plan (ISP), R2 is a 62 year old female who functions in the Profound range of Intellectual Disabilities. In further review of the ISP, R2 is ambulatory and non-verbal.	Z9999		

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Z9999	Continued From page 3 R2's 5/18/22 ISP documents, "The Interdisciplinary Team assessed and determined I should continue with 24-hour continuous supervision.... The team agrees that I need level 5 level supervision: indicating regular personal care and/or close supervision." In review of the section titled " Capacity for Independent Living" R2 is total assistance for Community Access/Orientation. In an interview on 2/16/23 at 10:26 AM, when asked to define what 24-hour continuous supervision and Level 5 supervision means, E1 (Administrator) stated "I'm not sure what they mean. The prior Q (Qualified Intellectual Disabilities Professional) must have put that in. We don't have level numbers. Should be listed as "general" or what we have in our protocol." The Behavior Management Program (BMP) dated 12/14/22 verifies R2 has a program for attempting to leave the designated area, defined as attempting to or leaving the area without notifying staff, non-compliance, anxiety, and SIB. R2's BMP further documents, "... at any time R2 accesses the outdoors staff should visually monitor her to ensure she is not attempting to leave the area". R2's BMP dated 12/14/22 documents: 6/2014 - "implement BMP to address attempts of leaving designated area and incidents of noncompliance." 6/25/15 "Revised BMP to add "Staff will visually monitor R2 during mealtimes and when she is accessing the outdoors. Staff will redirect R2 to a domestic duty, filling the bird feeder with seed or place discarded food in designated container directly after a meal." 8/29/22, it was revised to add "visual monitoring while awake." 12/20/22, R2's "supervision level	Z9999		

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Z9999	Continued From page 4 was decrease from visual monitoring to 10-minute checks." On 12/29/22, R2's supervision was "decreased from 10-minute checks to 15-minute checks" and on 1/13/23, R2's supervision level was "increased from 15-minute checks to visual monitoring." There is no evidence documented for an incident occurring on 12/20/23. There is no evidence that R2's BMP addressing R2 shutting off the door alarms and unlocking the doors. In an interview on 2/2/23 at 2:05 PM, when asked what R2's supervision level is, E7 (DSP- Direct Service Person) stated that R2 "is pretty much a 1:1." In an interview on 2/15/23 at 2:20 PM, when asked for R2's level of supervision, E1 (Administrator) stated she is a 1:1 while awake. When asked when the 1:1 level of supervision started, E1 stated, on 2/6/23, after the elopement. In an interview on 2/16/23 at 10:26 AM, when asked if R2's BMP addresses R2 unlocking doors and turning off the alarms, E1 (Administrator) stated, "No." R2's Incidents reported to the Illinois Department of Public Health (IDPH) and the Behavior Event Reports (BER), were reviewed. IDPH notifications dated 8/15/22, R2 left the property, went across the street to pick up trash on 8/13/22 and on 8/14/22; and on 8/14/22, again R2 left the property, a neighbor came to the facility to inform them she was on their property feeding their dog. R2's supervision level was increased to 15-minute checks on each of the	Z9999		

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Z9999	Continued From page 5 above occurrences. IDPH notification dated 8/20/22, R2 left the property, went across the street to pick up trash. R2's supervision level was increased to 15-minute checks. (R2 was currently on 15-minute checks) IDPH notification dated 8/24/22, R2 left the property, went across the street to pick up trash. "Staff were reminded to keep doing 15-minute checks on R2." IDPH notification dated 8/25/22 documents the facility received a call from the Day Training that neighbor informed them that R2 left the property and was feeding a neighbor's dog. Staff reminded to keep doing 15-minute checks. BER (Behavior Event Reports) and IDPH notification on 8/29/22, E13 (RSD- Resident Services Director) was returning from lunch, and R2 was spotted a block away from the facility. Supervision level was increased to visual monitoring. (Visual Monitoring: This includes all of the above as well as keeping the resident's whereabouts known at all times. The resident needs to be within the direct view of a DSP, during waking hours." BER 9/10/22, R2 went outside after lunch with her plate, staff went to find her as R2 was crossing the street. BER 10/11/22, R2 was outside at the dumpster and stepped off the property on to the street. BER 10/21/22, R2 tried to leave the property, staff was with her. BER 11/5/22, R2 was on front porch, staff stepped away for a behavior with another individual, R2 left the property, went across the street and was picking up trash. BER'S dated 11/17/22 and 11/18/22, R2 left the property, went to a neighbor's yard, picking up trash. IDPH notification 1/13/23, R2 was found across	Z9999		

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Z9999	Continued From page 6 the street picking up trash. IDPH notification 1/25/23, R2 left the property, and an investigation was started. The investigation documents that E5 (DSP-Direct Service Person) documented that a man in a wheelchair came to the kitchen door and said that R2 was down the street sometime last week. The investigation concluded that R2 left the property on an unknown date. IDPH notification for 2/6/23 at approximately 6:00 PM, the local Police Department brought R2 home, she was located a block over from the facility. In review of the Police Report for 2/6/23, the officers were dispatched at 5:54 PM to a female wondering the streets in a pink shirt, PJ pants, carrying a toy, with no coat on. The officers documented they went to the facility to verify their headcount and verified it was R2. Documentation of the weather for the town per "Weather Range " for 2/6/23 is 48 degrees from 5:55 PM to 6:15 PM. R2 walked 0.2 miles from the facility before the police arrived on scene. In an interview on 2/8/23 at 11:13 AM, E5 (DSP-Direct Service Person) stated that on 2/6/23 there were only 2 staff working the evening shift and the police came knocking on the door because they found a female walking down the street a couple blocks away. It was R2. R2 turns off the alarms. E5 stated her and E8 (DSP) were giving showers and did not know she had left. R2 was on 15-minute checks. There is no evidence of any nursing assessments after R2's elopements. In an interview on 2/8/23 at 9:12 AM, when asked if the nurse is to be notified of elopements and assessments to be done, E3 RN-T (Registered	Z9999		

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Z9999	Continued From page 7 Nurse-Trainer) stated "yes." There is a discrepancy with staff regarding R2's level of supervision. In an interview on 2/1/23 at 2:40 PM, when asked what R2's level of supervision is, E2 (Resident Services Director - RSD) stated she "is currently visual monitoring, she has to be kept in sight." R2's SST (Support Services Team) Action Plan dated 6/9/22, it documents, R1 was "referred on 5/13/22 due to elopement behavior. This behavior is defined as leaving the designated area to obtain objects. R2 has started to elope further from the designated area outside to obtain objects and has also run from staff who attempt to transition her back to the designated area. Staff also reported engagement in self-injurious behaviors after being blocked from eloping outside designated area." SST recommends "frequency data is collected on elopement behavior." Under the section titled 1. "Skills Acquisition", it documents "Functional Communication Training - Due to the lack of expressive communication, staff are often unable to identify R2's wants and needs. SST recommends functional communication training to allow R2 to adaptively request what she wants and needs. Specifically, SST recommends that staff work with R2 to appropriately request or indicate when she wants to leave the designated area. For example, this can be done through the use of a visual that depicts picking up trash on the street. When requesting to leave a designated area, staff should provide redirection when necessary or appropriate supervision for activities that could pose any safety risk. Date Implemented: 9/1/22. Updated Note (10/11/2022) - SST is currently working with R2 to present a	Z9999		

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Z9999	Continued From page 8 communication card to request when she wants to leave the designated area to pick up trash. SST is also modeling this implementation for staff and will provide additional training before closure. Under the "Scheduled Trash Pick Up - SST recommends that R2 is provided with scheduled times for trash pick up to provide R2 with reassurance that she will have the opportunity to complete this activity throughout the day. SST recommends that staff create a visual schedule that indicated scheduled times to pick up trash with staff supervising for approximately 5 minutes every 2-3 hours. This schedule will work as a deterrent for leaving the designated area without staff present to supervise. Updated Note (10/11/2022) - Staff have continued to schedule times to check for trash and to take R2 on walks to pick up trash. Staff reported that they survey the area frequency. It was reported that elopements far from the designated area have reduced in frequency." Under the section 2. "Staff/Family Training: Functional Communication Training - SST recommends training on the functional communication strategies used with R2 to ensure that staff are consistent in implementation and treatment drift does not occur. It is important that all new staff working with R2 are trained on these procedures. Date Provided: TBD (To Be Determined) 3. Pharmacy/Medical Consultation: A pharmacy and/or medical consultation are not deemed necessary at this time. SST can complete these at any point during their involvement. 4. Environmental Modifications: Frequency Tracking - SST recommends tracking elopement behaviors to measure the effectiveness of the skill acquisitions. Date Implemented: June 2022, Updated Note (10/11/2022) - Staff stopping using frequency tracking for elopement behaviors after September of 2022 since the behaviors occurred	Z9999		

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Z9999	Continued From page 9 less frequently and SST determined that it was no longer necessary. 5. Linkage: Psychiatric Second Opinion - SST recommends discussing with the attending psychiatrist/physician about the possibility of an obsessive-compulsive disorder (OCD) diagnosis to ensure that R2 is being supported appropriately. Updated Note (10/11/2022) - Pending appointment." In an interview on 2/9/23 at 12:39 PM, Z1 (SST-Clinical Case Manager) stated "on 6/7/22, did an intake meeting which is an information gathering." Z1 further stated SST "implemented behavior tracking, we backed off then met yesterday, 2/8/23, to re-start tracking." In an interview on 2/15/23 at 2:20 PM, when asked if R2 is currently on a 1:1 monitoring, E1 (Administrator) stated "yes, while she is awake." When asked when the 1:1 monitoring started, E1 stated the evening of 2/6/23, after the elopement. In an interview on 2/1/23 at 10:20 AM, E1 (Administrator) stated R2 was "put on visual monitoring in August 2022, R2 has been to her Psychiatrist. E1 stated the facility reached back out to SST (Support Service Team) for help. R2 was placed on 15-minute monitoring checks and no incidents of leaving the property from August 30th to January 13th. " In an interview on 2/16/23 at 10:26 AM, when asked about the comment of no incidents of elopement from 8/30/22 to 2/13/23, E1 (Administrator) stated, there were no documented incidents on the computer system. Staff were documenting tally marks on the behavior tracking sheets that SST were having staff mark on, and staff were not documenting in the computer system as they should have. E1 stated that R2's	Z9999		

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Z9999	Continued From page 10 behaviors started out with dumping her plate of food out the door, then she went out to the back yard to dump it, R2 was dumping it over the fence then she went across the street. When asked why SST backed off, E1 stated that R2's behaviors had improved and less incidents occurred. In an interview on 2/1/23 at 1:45 PM, E4 (Direct Service Person - DSP) stated R2 is on "visual monitoring, she has to be in staff eyesight. We follow her, sometimes we can detour her, sometimes not." In an interview on 2/3/23 at 6:46 PM, E5 (DSP) stated R2's supervision level is "visual monitoring. E5 stated it is exhausting, R2 has gotten to the point where she checks to see if staff are busy, and she would leave. R2 knows how to unlock the doors and turn off the alarms." In an interview on 2/3/23 at 6:34 PM, E6 (DSP) stated R2 is "visual monitoring/check her every 15 minutes." In an interview on 2/3/23 at 7:30 PM, E8 (DSP) stated R2 is "visual monitoring, keep in sight." In an interview on 2/8/23 at 10:56 AM, E10 (DSP) stated R2 is "now a 1:1 when she is awake, just started on Monday 2/6 or Tuesday 2/7. R2 was on 15-minute checks." During review of the staff schedules from August 22 to current, there is only one staff person on the third shift from 12:00 AM to 7:00 AM. In an interview on 2/17/23 at 4:58 PM, E14 (DSP) stated he is the only person working the third shift. E13 further stated that R2 sleeps all night	Z9999		

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Z9999	Continued From page 11 with her door shut. E13 stated that a day or two after the 2/6/23 incident, he was gathering trash around 1-2 AM, heard the door alarm went out and R2 was going outside to the dumpster, E13 stated that he followed R2 back into the building and to her room. E13 stated this is the only time this has happened. 2. R1 is a 49 year old female with diagnoses of Severe Intellectual Disabilities, Mood Disorder, Bipolar, Depression with Anxious and Obsessive Compulsive Features, and Anxiety per the 4/14/22 ISP (Individual Service Plan). R1 is ambulatory and verbal. R1 is 5'4" in height. In further review of R1's BMP (Behavior Management Plan), it documents R1's behaviors is documented as property destruction, physical aggression, non-compliance and self-injurious behavior. R1 also engages in attention seeking behaviors that can escalate into other behaviors. R1's "Quarterly Nursing Physical Assessment" dated 1/5/23 documents R1's weight as 192 pounds. R1's Incident Reports to the Illinois Department of Public Health and the Facility's GERs (General Event Report) and BERs (Behavior Event Report) for R1, the following events were documented. GER dated 12/5/22 documents: R1 was walking slowly, started to lean backwards, grabbed the doorframe and went down on her butt. No injuries were reported. GER dated 12/12/22 documents, picked her right middle finger making it bleed. GER dated 12/27/22, R1 stubbed her right foot. To ER, diagnosed with a fracture at the base of her right pinky toe. GER dated 1/10/23, R1 was yelling in her room	Z9999		

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Z9999	Continued From page 12 stated she fell out of bed. In a report to IDPH, 911 was called for a lift assist. No injuries reported. In a report to IDPH dated 1/17/23, it documents, that on 1/16/23 and 1/17/23, R1 was having a behavior, threw herself to the floor and began banging her head on the closet. This report further documents that EMS (Emergency Medical Services) was called on 1/16/23 and R1 refused to go to the ER. No injuries reported. 1/17/23 R1 again displayed these behaviors, R1 was taken to the ER by ambulance. R1 had a bruise and an abrasion to her right knee. R1 returned home with diagnoses of Cellulitis of the right knee, Acute Urinary Tract Infection (UTI) with Cystitis and Hematuria. Antibiotics were prescribed. GER and IDPH Notification dated 1/18/23 documents that R1 was found sitting on the floor with a scrape to her left elbow. IDPH Notification dated 1/21/23, documents that on 1/20/23 R1 was acting abnormal, vitals were outside her normal, R1 was transported to the ER. R1 was prescribed more antibiotics for the UTI. A GER dated 1/20/23 documents that R1 was on the floor and an old scab on her left elbow was found. BER and GER dated 1/21/23 documents E11 (DSP) was standing next to R1 when R1 threw herself on the floor. No injuries were reported. IDPH Notification dated 1/23/23 and 1/24/23 documents R1 was acting abnormally, nurse notified, vitals outside normal range, R1 transported to the ER and admitted to the hospital. On 1/24/23, R1 was discharged back to the facility. IDPH Notification dated 1/26/23 documents that on 1/25/23 R1 had altered mental status and a fall, nurse notified and instructed to call 911. R1 was transported to hospital via ambulance. On 1/27/23, R1 was discharged from the hospital to a Rehabilitation Center.	Z9999		

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Z9999	Continued From page 13 In a statement from E3 (RN-T - Registered Nurse -Trainer), it documents that "On 1-23-23 at approximately 930am, this nurse received a call from (facility RSD) E2 that (R1) wasn't acting like her "normal self". E2 reported that R1 was hard to arouse, wouldn't hold her head up, wasn't fighting back with staff when asked to perform commands (per usual), hadn't voided since 1-22-23 at approximately 6pm and mumbling incoherently. Her blood pressure was 160's/114 and spO2 unable to obtain. This nurse gave instructions to call 911 and have resident sent to the ER (Emergency Room) via ambulance due to altered mental status and inability to obtain an oxygen level. E2 (RSD), returned call at 950am and stated "E1 (Administrator) told me I wasn't allowed to call 911 and to put R1 in the facility vehicle and drive her to the ER". This nurse then questioned E2 on the condition of R1 and E2 stated "we are stuck by a train, and she isn't any better, she won't hold her head". I questioned E2 on how was breathing and whether or not she was having labored breathing, shortness of breath, decline in consciousness, or distress and E2 stated "she won't hold her head up". This nurse called E1 (Administrator) to question her reasoning for not following instructions given by this nurse to call 911 and she stated "because R1 refused to let the ambulance take her last time and I wanted them to take her by car". E1 then stated "R1 has been refusing to walk and has been behavioral and we always have trouble getting her spO2". This nurse then stated that her decision to not call 911 was unacceptable and if R1 required oxygen on the way to the ER, staff wouldn't be able to provide that in the company car and if she was in respiratory distress this could be detrimental". At approximately 1015am, E2 reported to this nurse that the ER doctor had a	Z9999		

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Z9999	Continued From page 14 difficult time getting resident to open her eyes and had to pry them open to check her pupils and also stated that the doctor stated R1 must be sick because she wasn't fighting back like her usual self." In an interview on 2/8/23 at 9:12 AM, E3 (RN-T) stated that R1 declined very rapidly, went to the ER several times recently. E3 further stated that on 1/23/23 she was notified of R1's condition and instructed staff to call 911. E3 stated that E2 (RSD) called her back and was told that E1 (Administrator) refused to allow 911 to be called and to transport R1 to the ER by the facility van. R1 was admitted overnight and returned to the facility on 1/24/23. E3 stated that R1 was left lying on the floor for hours, scouting herself around. E3 stated that she was in contact with R1's physician on 1/24/23 and R1 was sent back to the hospital. E3 stated she was in the facility on 1/24/23 and assisted staff to get R1 off the floor and R1 was a 2-person assist, R1 was using a wheelchair. E3 also stated that facility staff are being told not to call the nurse so there is no follow up with nursing or assessments being done. E3 stated that R1 was then sent to ER by 911 on 1/25/23. There is no evidence of any special team meetings for R1's behavior or medical concerns. There is no evidence that staff are documenting consistently on R1's falls. In an interview on 2/1/23 at 10:20 AM, E1 (Administrator) stated R1 had fallen a couple of times, then she started to throw herself/put herself on the floor. She was having behaviors and when 911 was called, she would fight them and refuse to go to the ER. E1 stated that is why we transported her to the ER.	Z9999		

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Z9999	Continued From page 15 In an interview on 2/16/23 at 10:26 AM, when asked if R1 has a history of falls prior to the 12/5/22 fall, or of throwing herself on the floor, E1 (Administrator) stated, "No," the behavior started after the first fall, when the ambulance came R1 received attention and liked it. In an interview on 2/2/23 at 12:37 PM, E1 (Administrator) stated that R1 was discharged to a nursing home on 1/30/23. In an interview on 2/1/23 at 2:40 PM, E2 (RSD) stated R1's behavior escalated after Christmas, she is not sleeping, screaming during the night. There were two times we didn't call 911 because we transported her to the ER. R1 would laugh at staff after she put herself on the floor. SST (Support Services Team) was involved, and changes are in her BMP (Behavior Management Plan). In an interview on 2/9/23 at 12:39 PM, Z1 (SST-Clinical Case Manager) stated the October meeting on R1 was an intake of gathering information on R1. No other information was given. Z1 stated she would email what information she had on R1 to the surveyor. In an email dated 2/13/23 from Z1, it is documented that no plan has been developed for R1 because she is currently in a Nursing Home. In an interview on 2/1/23 at 1:45 PM, E4 (DSP) stated R1's behaviors of throwing herself on the floor. E4 stated staff were told in a meeting to ignore her behavior, it was attention-seeking. (E4 would not clarify by whom). In an interview on 2/3/23 at 6:34 PM, E6 (DSP) stated, "We were told not to call 911 by E1	Z9999		

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Z9999	Continued From page 16 (Administrator), it was just behaviors. Sometimes R1 would get up sometimes not. We were told to ignore R1 when she was on the floor."	Z9999		
	In an interview on 2/3/23 at 7:30 PM, E8 (DSP) stated staff "were told to ignore R1 when she was on the floor and not call 911 by E1 (Administrator). Make sure she is not hurt, leave her alone. R1 was putting herself on the floor." 3. In review of a facility reported incident dated 10/17/22, the facility reported to the Illinois Department of Public Health (IDPH), that R3 was seen drinking from a bottle of floor cleaner. R3 was taken to the Emergency Room (ER). Poison Control was notified, R3 was given water, monitored and then released back home. Per the 2/17/22 (Individual Service Plan - ISP), R3 functions in the Profound Range of Intellectual Disability and has a Behavior Management Program (BMP) for PICA-like behavior. R3's 12/14/22 BMP documents the following: "R3 currently displays PICA-like behaviors. R3 went for a long time without exhibiting this behavior; however, she has had a few incidents within the last year. Per R3's PCP (Primary Care Physician), R3 will not have access to any jewelry." "PICA-like behavior is defined as eating or attempting to eat inedible objects" Documentation: "All incidents of PICA-like behaviors will be documented on a BER (Behavior Event Report). A GER (General Event Report) will be completed anytime R3 is observed to ingest a non-edible or is suspected to have ingested a non-edible. Safety Sweep documentation will be completed on a PICA Safety Sweep form provided for any			

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Z9999	Continued From page 17 environments that R3 frequents or is able to access." "Environmental Indicators of Behaviors: R3 may try to eat inedible objects i.e.: jewelry, gloves, etc. without notice or reason. If R3 is seen pacing by the kitchen, staff will offer her a snack." "Preventative Measures: PICA sweeps will be completed to ensure that R3's environment is free from PICA concerns." Method: PICA-like behavior: 1. Staff will ensure that R3's immediate environment is free of any inedible items/objects that she has been known to place in her mouth. Staff will complete visual checks of all areas R3 explores daily, including drawers, cabinets, purses; jacket and coat pockets that R3 frequents to ensure that there are no small known non-edibles available for her pickup on an on-going basis. 2. Staff will avoid throwing away potential small non-edibles in trash cans without lids that R3 may see and be tempted to pick out to place in her mouth. This includes larger objects that may have smaller removable pieces or parts. 3. R3 is generally monitored throughout the day, in addition staff will check her room thoroughly multiple times daily with visual and/or physical sweeps to ensure that R3 has not taken items to her room to shred or attempt to ingest later. 4. Staff will ensure R3 is in activities to promote positive interaction and tactile stimulation. 5. Gloves will be stored in the storage room or the medication room and no gloves will be disposed of in the restroom or R3's bedroom trash cans, if they are disposed of in the trash cans, the bag needs to be removed from the trash can and place a new bag in the trash can. 6. Staff will offer R3 a snack periodically between meals or if she attempts to eat	Z9999		

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Z9999	Continued From page 18 something non-edible. 7. Staff will praise R3 for eating well at mealtimes and when she eats a snack instead of attempting to eat an inedible item. 8. If R3 is seen attempting to ingest a non-edible item, staff will remove the item and offer her a snack. 9. If it is suspected that R3 has ingested a non-edible item, the RN (Registered Nurse) and RSD/ADM (Resident Services Director/Administrator) will be notified immediately for further instruction. "Training and Adaptive Behavior: On a formal daily basis, staff will offer R3 snacks between meals. Extra snacks are offered to R3 during her break times at the workshop and between meals on weekend and any time she is seen attempting to ingest non-edible objects, i.e.: beaded jewelry, rubber gloves, etc. Staff will keep lids on garbage cans where food is disposed of and monitor during all meal times that any food spillage in disposed of properly. Staff will monitor environment to be sure it is free of known non-edibles, i.e. beaded jewelry and rubber gloves by completing a safety sweep." R3's BMP documents on 6/10, "New BMP to address PICA-like behaviors." On 2/28/14, "Revised to add changes from IPP. Staff will monitor environment to be sure it is free of known non-edibles, i.e. beaded jewelry, rubber gloves by completing safety sweep." On 10/26/21, "Updated to a Non-Edible Awareness Plan due to no formal PICA diagnosis." There is no evidence that R3's BMP, ISP, or interventions has been updated since the 10/17/22 incident of ingesting floor cleaner.	Z9999		

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Z9999	Continued From page 19 The facility failed to implement the interventions in R3's BMP. In an interview on 2/2/23 at 2:15 PM, E1 stated there is no documentation of a Team Meeting on R3's ingestion incident or any changes to R3's BMP. (A)	Z9999		