



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
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CERTIFIED MAIL: 7007 3020 0001 4038 9741

August 30, 2016

Kristin Buchanan, Administrator
Preferred Community Homes - Mallard
12553 W Explorer Dr Suite 190
Boise, ID 83713

RE: Preferred Community Homes - Mallard, Provider #13G032

Dear Ms. Buchanan:

Based on the Medicaid/Licensure survey completed at Preferred Community Homes - Mallard on August 17, 2016, we have determined that Preferred Community Homes - Mallard is out of compliance with the Medicaid Intermediate Care Facility for Individuals with Intellectual Disabilities(ICF/ID) Conditions of Participation of **Governing Body and Management (42 CFR 483.410)**, **Client Protections (42 CFR 483.420)** and **Active Treatment Services (42 CFR 483.440)**. To participate as a provider of services in the Medicaid program, an ICF/ID must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies which caused these Conditions to be unmet, substantially limit the capacity of Preferred Community Homes - Mallard to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). A similar form indicates State Licensure deficiencies.

You have an opportunity to make corrections of those deficiencies, which led to the finding of non-compliance with the Conditions of Participation referenced above by submitting a written Credible Allegation of Compliance/Plan of Correction.

Kristin Buchanan
August 30, 2016
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It is important that your Credible Allegation/Plan of Correction address each deficiency in the following manner:

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;
2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;
5. The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
6. Include dates when corrective action(s) will be completed.

Sign and date the form(s) in the space provided at the bottom of the first page.

Such corrections must be achieved and compliance verified by this office, before October 1, 2016. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than September 12, 2016.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **September 12, 2016.**

Failure to correct the deficiencies and achieve compliance will result in our recommending that the Medicaid Agency terminate your approval to participate in the Medicaid Program. If you fail to notify us, we will assume you have not corrected.

Also, pursuant to the provisions of IDAPA 16.03.11.320.04, Preferred Community Homes - Mallard ICF/ID is being issued a Provisional Intermediate Care Facility for People with Intellectual Disabilities license. The license is enclosed and is effective August 17, 2016, through December 15, 2016. The conditions of the Provisional License are as follows:

1. Post the provisional license.
2. Correct all cited deficiencies and maintain compliance.

Kristin Buchanan
August 30, 2016
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Please be aware that failure to comply with the conditions of the provisional license may result in further action being taken against the facility's license pursuant to IDAPA 16.03.11.350.

Be advised, that, consistent with IDAPA 16.05.03.300, you are entitled to request an administrative review regarding the issuance of the provisional license. To be entitled to an administrative review, you must submit a written request by **September 27, 2016**. The request must state the grounds for the facility's contention of the issuance of the provisional license. You should include any documentation or additional evidence you wish to have reviewed as part of the administrative review.

Your written request for administrative review should be addressed to:

Debra Ransom, R.N., RHIT
Licensing and Certification Administration, DHW
PO Box 83720
Boise, ID 83720-0009
Phone: (208)334-6626
Fax: (208)364-1888

If you fail to submit a timely request for administrative review, the Department of Health and Welfare's decision to issue the provisional license becomes final. Please note that issues, which are not raised at an administrative review, may not be later raised at higher level hearings (IDAPA 16.05.03.301).

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in the State Informal Dispute Resolution (IDR) Process which can be found on the Internet at:

www.icfmr.dhw.idaho.gov

Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

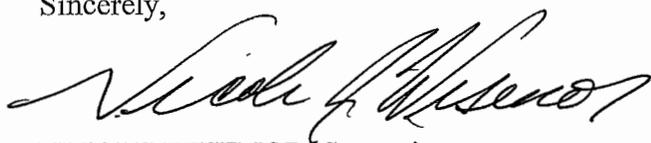
This request must be received by September 12, 2016. If a request for informal dispute resolution is received after September 12, 2016 the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Kristin Buchanan
August 30, 2016
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We urge you to begin correction immediately.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Dennis Kelly, RN or Nicole Wisenor, Co-Supervisors, Non-Long Term Care at (208) 334-6626, option 4.

Sincerely,

A handwritten signature in black ink, appearing to read "Nicole Wisenor". The signature is fluid and cursive, with a large initial "N" and "W".

NICOLE WISENOR, Supervisor
Non-Long Term Care

NW/pmt
Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/30/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/17/2016
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NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - MALLARD	STREET ADDRESS, CITY, STATE, ZIP CODE 699 SOUTH OTTER MERIDIAN, ID 83642
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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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W 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the recertification survey conducted from 8/8/16 to 8/17/16.</p> <p>The survey was conducted by:</p> <p>Jim Troutfetter, QIDP, Team Lead Autumn Bernal, RN, BSN, Nicole Wisenor, QIDP</p> <p>Common abbreviations used in this report are:</p> <p>ABC - Antecedent Behavior Consequence ADL - Activities of Daily Living CDC - Centers for Disease Control and Prevention CFA - Comprehensive Functional Assessment DCS - Direct Care Staff IDT - Interdisciplinary Team IPP - Individual Program Plan LPN - Licensed Practical Nurse MAR - Medication Administration Record OT - Occupational Therapist/Therapy PRN - As needed PT - Physical Therapy QIDP - Qualified Intellectual Disabilities Professional SAM - Self-administration of Medication SIB - Self-Injurious Behavior SLP - Speech Language Pathologist</p>	W 000		
W 102	<p>483.410 GOVERNING BODY AND MANAGEMENT</p> <p>The facility must ensure that specific governing body and management requirements are met.</p>	W 102		

RECEIVED
SEP 12 2016
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>W. Buchanan</i>	TITLE <i>Program Manager</i>	(X6) DATE <i>9/12/2016</i>
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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	W 102		
W 104	<p>This CONDITION is not met as evidenced by: Based on observation, policy review, record review, staff interview and a review of the facility's compliance history, it was determined the facility failed to ensure the governing body provided sufficient oversight and direction over the facility. This resulted in the governing body's ability to identify and resolve systematic problems of a serious and recurrent nature being significantly impeded. The findings include:</p> <p>1. Refer to W104 as it relates to the governing body's failure to ensure direction, monitoring and oversight was provided to the facility, necessary to ensure policies were sufficiently developed, implemented and monitored and that compliance with regulatory requirements was achieved and sustained. The governing body was previously cited at W104 during recertification surveys dated 8/8/14 and 6/25/15.</p> <p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>This STANDARD is not met as evidenced by: Based on policy review, record review and staff interview, it was determined the facility's governing body failed to provide sufficient monitoring and oversight that identified and resolved problems of a systematic and recurrent nature for 5 of 5 individuals (Individuals #1 - #5) residing at the facility. This resulted in individuals not receiving services necessary to meet their</p>	W 104		9/20/16

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W 104	<p>Continued From page 2 health, safety, active treatment and behavioral needs. The findings include:</p> <p>1. The facility's governing body failed to develop, implement and monitor systems to ensure the facility was able to achieve and sustain regulatory compliance, necessary to meet individuals' health, safety, active treatment, behavioral needs, as follows:</p> <p>a. Refer to W114 as it relates to the governing body's failure to ensure that all entries in the individuals' records were signed and dated. The facility was previously cited at W114 during an annual recertification survey dated 8/14/14.</p> <p>b. Refer to W122 Condition of Participation: Client Protections and associated standard level deficiencies as they relate to the governing body's failure to ensure policies and procedures for the prevention and detection of abuse, neglect and mistreatment were sufficiently implemented.</p> <p>c. Refer to W159 as it relates to the governing body's failure to ensure the QIDP provided sufficient monitoring and oversight. The facility was previously cited at W159 during an annual recertification surveys dated 8/14/14 and 6/25/15.</p> <p>d. Refer to W195 Condition of Participation: Active Treatment Services and associated standard level deficiencies as they relate to the governing body's failure to each individual was provided with active treatment in accordance with their individualized needs. The facility was previously cited at W195 during an annual recertification survey dated 8/14/14.</p> <p>e. Refer to W196 as it relates to the governing</p>	W 104		

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W 104	<p>Continued From page 3</p> <p>body's failure to ensure each individual was provided with continuous and consistent active treatment services. The facility was previously cited at W196 during an annual recertification survey dated 8/14/14.</p> <p>f. Refer to W214 as it relates to the governing body's failure to ensure behavior assessments contained comprehensive information. The facility was previously cited at W214 during annual recertification surveys dated 8/24/12, 10/3/13, 8/14/14 and 6/25/15.</p> <p>g. Refer to W227 as it relates to the governing body's failure to ensure each individual's IPP included specific objectives to meet the individual's needs. The facility was previously cited at W227 during an annual recertification survey dated 8/14/14.</p> <p>h. Refer to W239 as it relates to the governing body's failure to ensure replacement behavior training appropriately addressed individuals' maladaptive behaviors. The facility was previously cited at W239 during an annual recertification survey dated 6/25/15.</p> <p>i. Refer to W240 as it relates to the governing body's failure to ensure the individual program plans described relevant interventions to support individuals. The facility was previously cited at W240 during an annual recertification survey dated 6/25/15.</p> <p>j. Refer to W242 as it relates to the governing body's failure to ensure each individual received training in skills essential for independent living. The facility was previously cited at W242 during an annual recertification survey dated 8/14/14.</p>	W 104			

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W 104	<p>Continued From page 4</p> <p>k. Refer to W249 as it relates to the governing body's failure to ensure each individual received continuous active treatment services. The facility was previously cited at W249 during annual recertification surveys dated 8/14/14 and 6/25/15.</p> <p>l. Refer to W250 as it relates to the governing body's failure to ensure active treatment schedules were sufficient to direct staff. The facility was previously cited at W250 during an annual recertification survey dated 8/14/14.</p> <p>m. Refer to W289 as it relates to the governing body's failure to ensure techniques used to manage inappropriate behavior were sufficiently incorporated into individuals' program plans. The facility was previously cited at W289 during annual recertification surveys dated 8/24/12, 8/14/14 and 6/25/15.</p> <p>n. Refer to W322 as it relates to the governing body's failure to ensure individuals received adequate general and preventative medical care. The facility was previously cited at W322 during annual recertification surveys dated 7/13/11, 10/3/13, 8/14/14 and 6/25/15.</p> <p>o. Refer to W448 as it relates to the governing body's failure to ensure all problems with evacuation drills were investigated. The facility was previously cited at W448 during an annual recertification survey dated 6/25/15.</p> <p>p. Refer to W449 as it relates to the governing body's failure to ensure action was taken to correct problems that were identified during quarterly evacuation drills. The facility was previously cited at W448 during annual</p>	W 104		

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W 104	Continued From page 5 recertification surveys dated 10/3/13 and 6/25/15. The cumulative effect of these deficient practices significantly impeded the facility's ability to provide individuals' with adequate protections and habilitative services necessary to achieve and maintain optimal functional status and impeded the facility's ability to ensure each individual was provided with the opportunity to function with as much self-determination and independence as possible.	W 104			
W 114	483.410(c)(4) CLIENT RECORDS Any individual who makes an entry in a client's record must make it legibly, date it, and sign it. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure that all entries in the individuals' records were signed and dated for 3 of 3 individuals (Individuals #1, #2 and #4) whose records were reviewed. This resulted in a lack of information related to who completed the entries. The findings include: 1. The CFAs for Individuals #1, #2 and #4 were reviewed and contained multiple entries which were not dated or signed, as follows: a. Individual #4's IPP, dated 8/11/15, documented a 65 year old female whose diagnoses included profound intellectual disability. Her 8/6/15 CFA was reviewed. The CFA included hand-written entries that were not signed and dated. Examples include, but were not limited to, the following:	W 114		9/20/16	

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W 114	<p>Continued From page 6</p> <ul style="list-style-type: none"> - The Eating and Dining section had a hand-written entry stating "[Individual #4] will chew it up" in the column next to "sucks on hard piece of candy." Additionally, the corresponding prompt level had been changed from "N/A" to "4" without a signature or date. - The Eating and Dining section had a hand-written entry stating "However, [Individual #4] will immediately take it off" in the column next to "Takes head covering off head when eating." Additionally, the corresponding prompt level had been changed from "N/A" to "6" without a signature or date. - The SAM section had a hand-written entry stating "Staff provide hand-over-hand assistance" in the column next to "Ingests medications" that was not signed or dated. Additionally, the corresponding prompt level had been changed from "6" to "4" without a signature or date. - Numerous prompt levels had been changed without being signed or dated throughout the CFA. <p>b. Individual #2's 9/16/15 IPP documented a 67 year old male whose diagnoses included severe intellectual disability, urinary frequency, and a history of anxiety disorder with obsessive compulsive features. Individual #2's 9/10/14 CFA, revised 8/31/15, was reviewed. The CFA included hand-written entries that were not signed and dated. Examples included, but were not limited to, the following:</p> <ul style="list-style-type: none"> - The dressing section had two hand-written entries that did not contain a signature or date. One entry stated, "staff do not prompt [Individual 	W 114			

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W 114	<p>Continued From page 7</p> <p>#2] to wear different clothing for weather conditions, color, style or pattern, as he wears the same type (sweat pants/T-shirt) every day," that did not contain a signature or date. A second entry stated, "However [Individual #2] prefers to not wear socks."</p> <p>- The vocational skills section had a hand-written entry that stated "[Individual #2] would need physical assistance to stay on task for any length of time," which did not contain a signature or date.</p> <p>- Numerous prompt levels had been changed without being signed or dated throughout the CFA.</p> <p>c. Individual #1's 9/29/15 IPP stated he was a 55 year old male whose diagnoses included severe intellectual disability and autism spectrum disorder. His 9/17/15 CFA was reviewed. The CFA included hand-written entries that were not signed and dated. Examples include, but were not limited to, the following:</p> <p>- The Tooth Brushing section had a hand-written entry which stated "uses a toothette" and "has no teeth" in the column next to "brushes outside of the upper teeth" that was not signed or dated. Additionally, the prompt level next to "Rinses toothbrush" had been changed from "N/A" to "6" without a signature or date.</p> <p>- The Undressing section had a hand-written entry stating "[Individual #1] prefers to wear slip on shoes in the column next to "Pulls apart Velcro fasteners on shoes" that was not signed or dated. Additionally, the corresponding prompt level had been changed from "N/A" to "7" and from a "7" to</p>	W 114		
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W 114	Continued From page 8 a "6" without a signature or date. - The Clothing Care section had a hand-written entry stating "[Individual #1] has a washer/dryer in his home" in the column next to "Washes/dries clothes in a coin operated machine" that was not signed or dated. Additionally, the corresponding prompt level had been changed from "N/A" to "7" and from a "7" to a "6" without a signature or date. - Numerous prompt levels had been changed without being signed or dated throughout the CFA. When asked, during an interview on 8/15/16 beginning at 1:00 p.m., the QIDP stated the enteries should have been signed and dated. The facility failed to ensure all entries in individuals' records were signed and dated.	W 114			
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on policy review, record review, review of Incident Reports, Investigations, ABC logs, and staff interview, it was determined the facility failed to ensure policies and procedures for the prevention and detection of abuse, neglect and mistreatment were sufficiently implemented. This failure resulted in a lack of appropriate reporting, a lack of thorough investigations and a lack of appropriate corrective action being taken for	W 122		9/20/16	

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W 122	Continued From page 9 individuals who engaged in self-abuse. The findings include:	W 122			
W 149	<p>1. Refer to W149 as it relates to the facility's failure to ensure written policies and procedures that prohibited abuse, neglect and mistreatment were sufficiently implemented and monitored necessary to protect individuals from self-abuse.</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>This STANDARD is not met as evidenced by: Based on policy review, record review, review of Incident Reports, Investigations, ABC logs, and staff interview, it was determined the facility failed to ensure policies and procedures for the prevention and detection of abuse, neglect, and mistreatment were sufficiently implemented and monitored. That failure directly impacted 2 of 2 individuals (Individuals #1 and #2) reviewed, who engaged in self-abuse and had the potential to impact all individuals (Individuals #1 - #5) residing at the facility. This resulted in individuals being subjected to ongoing self-abuse without appropriate reporting, investigation and corrective action taking place. The findings include:</p> <p>1. Refer to W153 as it relates to the facility's failure to ensure all allegations of self-abuse were immediately reported to the Administrator.</p> <p>2. Refer to W154 as it relates to the facility's failure to ensure the abuse policy was sufficiently implemented necessary to ensure there was</p>	W 149		9/20/16	

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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 149	Continued From page 10 evidence that all alleged violations of abuse, neglect and/or mistreatment were thoroughly investigated.	W 149			
W 153	<p>3. Refer to W157 as it relates to the facility's failure to ensure the abuse policy was sufficiently developed and implemented necessary to ensure corrective action was taken to prevent reoccurrence of abuse, neglect, and mistreatment.</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS</p> <p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>This STANDARD is not met as evidenced by: Based on policy review, record review, review of Incident Reports, ABC logs, and staff interview, it was determined the facility failed to ensure all allegations of self-injurious behavior were immediately reported to the Administrator for 1 of 2 individuals (Individual #1) whose records were review and who engaged in self-abuse. This resulted in an individual engaging in ongoing self-abuse without investigation or intervention. The findings include:</p> <p>1. The facility's Abuse, Neglect, Mistreatment and Suspicious Injuries of an Unknown Source policy, revised 5/6/16, defined self-injurious behavior as "The behavior of an individual that threatens his/her own safety. This includes but is not limited to intentional injury to oneself resulting in</p>	W 153		9/20/16	

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W 153	<p>Continued From page 11</p> <p>tissue damage, head banging..." The policy stated "Self-injurious behavior is not abuse by definition. However, failure to prevent Self-injurious behavior could constitute neglect."</p> <p>The Notification Process section of the policy stated all employees were to immediately notify the Administrator, their designee, or the Administrator on Duty for "...all observed Abuse Neglect, Mistreatment, or Suspicious injuries of an Unknown Source," which included abuse, neglect and self-injurious behavior.</p> <p>Individual #1's 9/29/15 IPP stated he was a 55 year old male whose diagnoses included severe intellectual disability and autism spectrum disorder. His record included a Behavior Intervention Plan, revised 4/11/16, for self-injurious behavior, defined as "...hitting his head against walls or doors, hitting/slapping his head hard enough to leave a red mark or the general public would perceive painful [sic], biting his fingers, poking his chest, or repetitively hitting his shin with the other heel, or hitting his arm on an object, all causing a visible injury."</p> <p>Individual #1's raw behavior data from April 2016 to July 2016 was reviewed. The data included documented incidents of self-injurious behavior. However, documentation that the Administrator was immediately notified of the incidents could not be found, as follows:</p> <p>a. An ABC form, dated 4/21/16 at 8:00 a.m. documented injuries were noticed while Individual #1 was in the shower and that "Yesterday he was engaging in SIB behaviors." The form documented "Yesterday [Individual #1] was agitated [sic] - hitting himself he has a history of</p>	W 153			

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W 153	<p>Continued From page 12</p> <p>SIB injuries that match the sore on his head..."</p> <p>A corresponding Health Status Report, dated 4/21/16 at 8:00 a.m. stated Individual #1 had a sore and swelling behind his left ear, a sore on the knuckle of his left middle finger, and egg sized bruise on the right of his chest and a small 2 cm bruise on top of his right foot.</p> <p>However, an ABC report from 4/20/16, when the actual behaviors occurred and documentation that the incident had been immediately reported to the Administrator could not be found.</p> <p>b. An ABC form, dated 7/5/16, documented Individual #1 had a "...rub mark on his right index finger and that he had "a history of SIB."</p> <p>However, an ABC report documenting when the injury actually occurred and documentation that the incident had been immediately reported to the Administrator could not be found.</p> <p>c. An ABC form dated 7/5/16 at 10:35 a.m. documented "...[Individual #1] got extremely agitated, staff tried to redirect and do some sensory with him. He hit his head 46x within a half hour, screaming - yelling, biting his finger..."</p> <p>Documentation that the incident had been immediately reported to the Administrator could not be found.</p> <p>d. An ABC form dated 7/10/16 at 6:33 p.m. documented Individual #1 was in the bathtub and hit his right cheek with his hand three times and hit his left forearm against the bathtub.</p> <p>Documentation that the incident had been</p>	W 153		

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W 153	<p>Continued From page 13</p> <p>immediately reported to the Administrator could not be found.</p> <p>e. An ABC form dated 7/22/16 at 8:00 a.m. documented Individual #1 "...had a red rub mark on left ear. Has a history of SIB." The report documented Individual #1 "...might have done it during the night sometime."</p> <p>Documentation that the incident had been immediately reported to the Administrator could not be found.</p> <p>f. An ABC form dated 7/31/16 at 3:00 p.m. documented "When we came on shift they told us [Individual #1] has a red mark on cheek."</p> <p>However, documentation of Individual #1 engaging in SIB earlier in the day and documentation that the incident had been immediately reported to the Administrator could not be found.</p> <p>The ABC form further documented Individual #1 "...continued to hit his [left] cheek 18x..."</p> <p>An Incident Report, dated 8/1/16 at 12:30 p.m., documented the Administrator had been notified of Individual #1 having bruising and swelling on his face and a rub mark on his left forearm. However, documentation that the SIB had been immediately reported to the Administrator on 7/31/16 could not be found.</p> <p>When asked, during an interview on 8/15/16 beginning at 1:00 p.m., Program Manager A stated if the SIB met reporting criteria as stated in facility policy, then an incident report should be completed and the Administrator should be</p>	W 153		

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W 153	Continued From page 14 immediately notified.	W 153			
W 154	<p>The facility failed to ensure all incidents of Individual #1's self-injurious behaviors were immediately reported to the Administrator.</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>This STANDARD is not met as evidenced by: Based on review of the facility's policies, Incident Reports, Investigations, individual records, and staff interview, it was determined the facility failed to ensure thorough investigations were conducted. This failure directly impacted 2 of 2 individuals (Individuals #1 and #2) whose records were review and who engaged in self-abuse and had the potential to impact 5 of 5 individuals (Individuals #1 - #5) residing at the facility. This resulted in a lack of sufficient information being collected on which to base corrective action decisions. The findings include:</p> <p>1. The facility's Abuse, Neglect, Mistreatment and Suspicious Injuries of an Unknown Source policy, revised 5/6/16, defined self-injurious behavior as "The behavior of an individual that threatens his/her own safety. This includes but is not limited to intentional injury to oneself resulting in tissue damage, head banging..." The policy stated "Self-injurious behavior is not abuse by definition. However, failure to prevent Self-injurious behavior could constitute neglect."</p> <p>The Investigation Process section of the policy stated the Company and/or Administrator,</p>	W 154		9/20/16	

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W 154	<p>Continued From page 15</p> <p>Administrator Designee or Administrator on duty "...will ensure that all allegations of Abuse, Neglect, Mistreatment, and Suspicious Injuries of an Unknown Source are thoroughly investigated."</p> <p>Individual #1's 9/29/15 IPP stated he was a 55 year old male whose diagnoses included severe intellectual disability and autism spectrum disorder.</p> <p>His record included a Behavior Intervention Plan, revised 4/11/16, for self-injurious behavior, defined as "...hitting his head against walls or doors, hitting/slapping his head hard enough to leave a red mark or the general public would perceive painful [sic], biting his fingers, poking his chest, or repetitively hitting his shin with the other heel, or hitting his arm on an object, all causing a visible injury."</p> <p>a. Individual #1's raw behavior data from April 2016 to July 2016 was reviewed. The data included documented incidents of self-injurious behavior, which had not been reported.</p> <p>When asked, during an interview on 8/15/16 beginning at 1:00 p.m., the QIDP stated she reviewed all behavior data.</p> <p>However, the QIDP did not ensure appropriate documentation and investigation into Individual #1's incidents of SIB occurred. Examples included, but were not limited to, the following:</p> <p>i. An ABC form, dated 4/21/16 at 8:00 a.m. documented injuries were noticed while Individual #1 was in the shower and that "Yesterday he was engaging in SIB behaviors." The form documented "Yesterday [Individual #1] was</p>	W 154		

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W 154	<p>Continued From page 16</p> <p>aggitated [sic] - hitting himself he has a history of SIB injuries that match the sore on his head..."</p> <p>A corresponding Health Status Report, dated 4/21/16 at 8:00 a.m. stated Individual #1 had a sore and swelling behind his left ear, a sore on the knuckle of his left middle finger, and egg sized bruise on the right of his chest and a small 2 cm bruise on top of his right foot.</p> <p>However, an ABC report from 4/20/16, when the actual behaviors occurred and documentation that the incident had been investigated either at the time it occurred or at the time of the QIDP's behavior data review could not be found.</p> <p>ii. An ABC form dated 7/10/16 at 6:33 p.m. documented Individual #1 was in the bathtub and hit his right cheek with his hand three times and hit his left forearm against the bathtub.</p> <p>Documentation that the incident had been investigated either at the time it occurred or at the time of the QIDP's behavior data review could not be found.</p> <p>iii. An ABC form dated 7/22/16 at 8:00 a.m. documented Individual #1 "...had a red rub mark on left ear. Has a history of SIB." The report documented Individual #1 "...might have done it during the night sometime."</p> <p>Documentation that the incident had been investigated either at the time it occurred or at the time of the QIDP's behavior data review could not be found.</p> <p>iv. An ABC form dated 7/5/16 at 10:35 a.m. documented "...[Individual #1] got extremely</p>	W 154			

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W 154	<p>Continued From page 17</p> <p>agitated, staff tried to redirect and do some sensory with him. He hit his head 46x within a half hour, screaming - yelling, biting his finger..."</p> <p>Documentation that the incident had been investigated either at the time it occurred or at the time of the QIDP's behavior data review could not be found.</p> <p>When asked about the incident, during an interview on 8/15/16 beginning at 1:00 p.m., the QIDP stated she thought the staff had documented the incident inappropriately and that Individual #1 had probably engaged in self-stimulatory behavior rather than self-injurious behavior. When asked if the QIDP had investigated the incident or if the staff had been spoken to about the documentation, the QIDP stated "no."</p> <p>b. The facility's records did not include documentation that thorough investigations were conducted, as follows:</p> <p>i. An Incident Report, dated 8/1/16 at 12:30 p.m., documented the Administrator had been notified of Individual #1 having bruising and swelling on his face and a rub mark on his left forearm.</p> <p>An Investigation Report, dated 8/5/16, was attached to the Incident Report. The Investigation Report stated "...Staff noticed a red mark on his left cheek, staff thought it was from resting in his room. Later in the day mark [sic] didn't go away. Staff also found a rub mark on left forearm. Staff did note on health status from the night before that there was a red mark o [sic] left cheek that was little [sic] swollen possible bruising. Staff also noted the night before that</p>	W 154		

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W 154	<p>Continued From page 18</p> <p>[Individual #1] was very agitated because of having so much chocolate, he was running around the house and hitting his cheek many times. Staff gave [Individual #1] a lavender bath which seem [sic] to calm him down. Staff also noticed a red mark on left cheek at shift change and that's when they were told to do a health status."</p> <p>Attached to the Investigation were hand-written staff statements. Written statements were garnered from 4 staff. Three of the 4 statements documented staff had not seen anything. One staff hand-written statement, unsigned and undated, documented Individual #1 was "aggitated [sic]" and had calmed down 3 hours after his lavender bath.</p> <p>No additional staff statements were included with the investigation and documentation of record review, such as a review of Individual #1's behavior logs from 7/31/16 was documented.</p> <p>An ABC form dated 7/31/16 at 3:00 p.m. documented "When we came on shift they told us [Individual #1] has a red mark on cheek." The ABC form also documented Individual #1 "...continued to hit his [left] cheek 18x..."</p> <p>The corresponding 7/31/16 Health Status Report documented Nursing was contacted at 6:00 p.m. Staff were instructed to "...apply cool wash cloth, give tylenol [sic]...report bruising or other skin issues."</p> <p>However, a facility document, titled Neurological Assessments, undated, stated "Neuro checks must be done for the following reasons: If a resident hits/strikes his or her head, call Nursing</p>	W 154		

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W 154	<p>Continued From page 19 for further instructions...It is unlikely that a person would be able to hit themselves hard enough to do Neurological damage, however, this decision will be determined by Nursing if a Neurological check needs to be done."</p> <p>The investigation report did not include documentation that Nursing had been interviewed regarding what staff had reported and how the decision to not complete a neuro check had been made.</p> <p>The investigation report stated "This is the 5th incident of SIB this year for [Individual #1]..." The investigation listed the dates of prior incidents of SIB as 4/29/16, 5/23/16, 7/3/16 and 7/12/16.</p> <p>However, Individual #1's behavior logs documented he had also engaged in SIB on 7/5/16 at 10:35 a.m. and on 7/10/16 at 6:30 p.m. Further, a behavior log dated 4/21/16 documented he had an injury from SIB which stated Individual #1 "might have done it during the night sometime" and a 7/22/16 behavior log documented he had injuries from SIB "yesterday."</p> <p>Additionally, a 7/3/16 incident report documented Individual #1 had engaged in SIB by running towards the kitchen and hitting the dining room wall with his head and hands. The attached Investigation Report documented "This is the first incident this year with [Individual #1] hitting his head."</p> <p>The prior incidents of SIB, listed in the 8/5/16 Investigation Report were not accurate.</p> <p>The facility failed to ensure Individual #1's incidents of self-abuse were thoroughly</p>	W 154			

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W 154	<p>Continued From page 20 investigated.</p> <p>ii. An Incident Report dated 8/18/15 at 1:45 p.m., documented staff noticed Individual #1 had "broken blood vessels" on his right cheek. Attached to the incident report were hand-written statements from 3 staff. The 3 staff documented they did not know where the injury had come from but thought it was from Individual #1 engaging in SIB. One staff also documented he could not immediately report the injury because they were in the community and the "phone was dead."</p> <p>No additional staff statements were included with the investigation and documentation of record review, such as a review of Individual #1's behavior logs from 8/17/15 or earlier on 8/18/15 was documented.</p> <p>An 8/24/15 Investigation Report was attached to the incident report. The Investigation Report documented "[Individual #1] does self-stimulate by using his open hand to hit himself on body parts including his face. It is believed that he has broken blood vessels from engaging in this activity." The conclusions section of the report stated "[Individual #1] self-stimulates by open hand hitting areas of his body including his face. This is the most likely scenario of his receiving broken blood vessels in his right cheek." The corrective action section of the report stated "[Individual #1] does self-stimulate through striking his body with an open hand. The staff will continue to redirect [Individual #1] to other activities when he is noticed to be engaged in self-stimulation of striking his body."</p> <p>The investigation report did not include information related to the "dead" phone or why</p>	W 154		

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W 154	<p>Continued From page 21</p> <p>the incident was referred to as self-stimulatory behavior and not SIB as Individual #1 had injured himself.</p> <p>When asked, during an interview on 8/15/16 beginning at 1:00 p.m., the QIDP stated the incident met the definition of SIB.</p> <p>The facility failed to ensure all allegations of Individual #1's self-abuse were thoroughly investigated.</p> <p>iii. Individual #2's 9/16/15 IPP documented a 67 year old male whose diagnoses included severe intellectual disability, urinary frequency, and a history of anxiety disorder with obsessive compulsive features.</p> <p>The facility's Investigation Reports documented Individual #2 had an increase in SIB from 5/1/16 - 7/17/16. The reports did not include documentation of thorough investigation, as follows:</p> <ul style="list-style-type: none"> - A 5/1/16 Investigation Report stated, Individual #2 "hit his head open handed one time." The record review section of the report documented it was his first episode of SIB. - A 5/17/16 Investigation Report stated, Individual #2 "hit himself two times..." The record review section of the report documented he had "...hit himself in the forehead multiple times this year." - A 5/19/16 Investigation Report stated, Individual #2 "hit himself" one time. The record review section of the report documented he had "...hit his head multiple times this year. His mother passed recently so he has been hitting his head more 	W 154			

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W 154	<p>Continued From page 22 frequently."</p> <p>- A 5/21/16 Investigation Report stated staff noticed a bruise and swelling on the right side of his forehead, but staff "missed him going to his room this time but will be having a training to make sure that all staff follow [Individual #2's] guidelines when he goes back to his room." The record review section of the report documented he "...has been hitting his head a lot more frequently."</p> <p>- A 6/3/16 Investigation Report stated Individual #2 hit himself on the right side of his head leaving a red mark, following a dentist visit. The record review section of the report stated "This is the 5th incident of SIB hitting himself on his head. There was [sic] 4 other incidents this year of SIB..."</p> <p>- A 6/5/16 Investigation Report stated Individual #2 hit himself 2 times on the left side of his head. The record review section of the report stated "This is the 6th incident of SIB for this year..."</p> <p>- A 6/18/16 Investigation Report stated Individual #2 hit himself 1 time on the right side of his head. The record review section of the report stated "This is the 7th incident of SIB for this year..."</p> <p>- A 7/6/16 Investigation Report stated Individual #2 hit his head 4 times. The record review section of the report documented it was his 8th episode of SIB.</p> <p>- A 7/17/16 Investigation Report stated Individual #2 hit the right side of his forehead one time. The record review section of the report documented it was his 9th episode of SIB.</p>	W 154		

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W 154	Continued From page 23 Individual #2's 8/12/15 Functional Behavioral Assessment and his 9/16/15 self-injurious behavior intervention plan were reviewed. The assessment and the intervention plan did not include updated, accurate, comprehensive information related to his SIB. When asked about Individual #2's assessment and behavior intervention plan, during an interview on 8/15/16 beginning at 1:00 p.m., the QIDP stated the assessment and plan needed to be updated. However, none of the investigations conducted from 5/1/16 - 7/17/16 documented a thorough review of Individual #2's status, including a review of his behavior assessment and intervention plans. The facility failed to ensure all allegations of Individual #2's self-abuse were thoroughly investigated.	W 154		
W 157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. This STANDARD is not met as evidenced by: Based on review of investigations and policy, record review and staff interview, it was determined the facility failed to ensure appropriate corrective action was taken in response to all investigations. That failure directly impacted 1 of 2 individuals (Individual #2) whose records were review and who engaged in self-abuse and had the potential to impact 5 of 5 individuals (Individuals #1 - #5) residing at the	W 157		9/2/16

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W 157	<p>Continued From page 24 facility. This resulted in a lack of sufficient corrective action being identified and implemented. The findings include:</p> <p>1. The facility's Abuse, Neglect, Mistreatment and Suspicious Injuries of an Unknown Source policy, revised 5/6/16, defined self-injurious behavior as "The behavior of an individual that threatens his/her own safety. This includes but is not limited to intentional injury to oneself resulting in tissue damage, head banging..." The policy stated "Self-injurious behavior is not abuse by definition. However, failure to prevent Self-injurious behavior could constitute neglect."</p> <p>Individual #2's 9/16/15 IPP documented a 67 year old male whose diagnoses included severe intellectual disability, urinary frequency, and a history of anxiety disorder with obsessive compulsive features.</p> <p>Individual #2 had an increase in SIB from 5/1/16 - 7/17/16. The facility's Investigation Reports documented the following:</p> <p>- A 5/1/16 Investigation Report stated, Individual #2 "hit his head open handed one time." The corrective action taken stated, "The team has got together and decided it would be safer for [Individual #2] to prevent SIB if staff went back there with him when he goes to use the restroom."</p> <p>However, no other documentation was found that staff were instructed to implement the stated corrective action at that time. A copy of the facility's Staff Training, dated 5/11/16, did not include any directions related to Individual #2's SIB corrective action.</p>	W 157		

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W 157	<p>Continued From page 25</p> <p>- A 5/17/16 Investigation Report stated Individual #2 "hit himself in the forehead two times opened palmed." The corrective action taken stated, "Staff are making sure they are going back to the room with [Individual #2] for his safety, and making sure every time [Individual #2] hits himself that they are asking if he is in pain. Because [Individual #2]'s mom had passed the week before and [Individual #2] has been hitting his head more frequently the team has decided that it would be good for [Individual #2] to have a social story on feeling sad and feeling angry that staff will go over with him on routine bases [sic] daily."</p> <p>However, no other documentation was found that staff were instructed to implement the stated corrective action at that time. The Social Stories Service program about feeling sad or angry was not documented to be started until 6/6/16.</p> <p>- A 5/19/16 Investigation Report stated Individual #2 "has hit his head opened palmed one time," and the corrective action taken stated, "Staff are to follow [Individual #2] for his safety when he goes back to his room...The team is going to be putting social story in his program to go over feeling sad and feeling angry to help him through this hard time."</p> <p>However, no other documentation was found that staff were instructed to implement the stated corrective action at that time.</p> <p>- A 5/21/16 Investigation Report stated staff noticed a bruise and swelling on the right side of his forehead, but staff "missed him going to his room this time but will be having a training to make sure that all staff follow [Individual #2's]</p>	W 157			

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W 157	<p>Continued From page 26</p> <p>guidelines when he goes back to his room." The corrective action taken stated, "Staff are to follow [Individual #2] for his safety when he goes to his room."</p> <p>A 5/25/16 In-Service Training/Meeting Sign in Sheet, signed by 8 DCS instructed staff to follow Individual #2 to his room to prevent SIB and stated to fill out appropriate reporting if SIB occurs.</p> <p>- A 6/3/16 Investigation Report stated Individual #2 hit himself on the right side of his head leaving a red mark, following a dentist visit. The corrective action taken stated, "The team is getting together to discuss [sic] different way [sic] to keeping [sic] [Individual #2] safe," and stated staff are going to his room with him to prevent SIB.</p> <p>No documentation that the team discussed different ways to keep Individual #2 safe was found.</p> <p>- A 6/5/16 Investigation Report stated Individual #2 hit himself on the left side of his head leaving a nickel-sized lump. The corrective action taken documented, "The team will be getting together to discuss [sic] different ways to keep [Individual #2] safe... The team has gotten together to discuss [sic] what has been going on with [Individual #2], the team thinks that he is grieving at this time."</p> <p>However, no documentation that the team discussed different ways to keep Individual #2 safe or documentation that corrective action was taken could be found. Additionally, staff training notes, dated 6/9/16, did not include documentation about Individual #2's SIB or safety</p>	W 157			

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W 157	<p>Continued From page 27 interventions for SIB.</p> <p>- A 6/18/16 Investigation Report stated Individual #2 hit the right side of his head once and there was a lump at that site. The corrective action taken stated, "The team will be getting together to discus [sic] different ways to keep [Individual #2] safe."</p> <p>However, no documentation that the team discussed different ways to keep Individual #2 safe, or that corrective action was taken could be found.</p> <p>- A 7/6/16 Investigation Report stated Individual #2 hit his head 4 times. The corrective action taken stated "The team has put in place that if [Individual #2] goes to his room staff are to go with him to prevent SIB. [Individual #2] has been to the Dr. because the increase in SIB to his head. The Dr. has said there is no damage to his head at this time. The team will continue to discuss different ways to keep [Individual #2] safe."</p> <p>However, no documentation that the team discussed different ways to keep Individual #2 safe or documentation that corrective action was taken could be found.</p> <p>- A 7/17/16 Investigation Report stated Individual #2 hit the right side of his forehead one time. The corrective action taken stated "The team has put in place that staff are to go back to his room with him to prevent SIB. He has been to the Dr. 7/12/16 no concern at this time. The team will continue to discuss different ways to keep [Individual #2] safe if needed."</p>	W 157		
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W 157	Continued From page 28 A 7/19/17 Staff Training note stated "Any thoughts on [Individual #2's] SIB?" However, no documentation of thoughts or discussion was included in the notes. Documentation that corrective action was taken could not be found. However, the Documentation Process section of the facility's Abuse, Neglect, Mistreatment and Suspicious Injuries of an Unknown Source policy, stated the Administrator, Administrator Designee, Administrator on duty, or State Operations Manager will complete the Investigation Report on the back of the Incident/Accident Form, to include "...witness statement review, record review, conclusions, corrective action taken and notification documentation." When asked, during an interview on 8/15/16 beginning at 1:00 p.m., Program Manager A stated facility policy should be followed.	W 157		
W 159	483.430(a) QIDP Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the QIDP provided sufficient monitoring and oversight which directly impacted 5 of 5 individuals (Individuals #1 - #5) residing at the facility. This failure resulted in a lack of sufficient QIDP coordination, monitoring and oversight necessary to ensure individuals' rights were protected and	W 159		9/20/16

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W 159	<p>Continued From page 29 their active treatment and behavioral needs were met. The findings include:</p> <p>1. Individual #1's 9/29/15 IPP stated he was a 55 year old male whose diagnoses included severe intellectual disability and autism spectrum disorder.</p> <p>Individual #1's behavior program data summaries and QIDP progress notes for self-stimulatory and socially offensive behavior were reviewed. The notes documentation he had met criteria on the objectives in February 2016 and the objectives were revised on 4/11/16. For both objectives the criteria was extended from 6 to 12 months, as follows:</p> <p>i. Individual #1's IPP included an objective which stated he would "...reduce his self-stimulating behavior to 1185 or less per month for six consecutive months."</p> <p>Individual #1's QIDP monthly data summary for February 2016 stated Individual #1 had met criteria and the objective criteria would be revised. However, his March 2016 QIDP month data summaries stated "This was the 7th consecutive month that [Individual #1] was able to meet criteria. Therefore, I will revise the criteria."</p> <p>Individual #1's IPP documented the objective was revised on 4/11/16 to extend the criteria to 12 consecutive months. Individual #1's QIDP monthly summaries documented he had engaged in self-stimulatory behaviors at the following rates:</p> <p>October 2015: 662 times. November 2015: 509 times.</p>	W 159		

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W 159	<p>Continued From page 30 December 2015: 793 times. January 2016: 664 times. February 2016: 687 times. March 2016: 729 times.</p> <p>However, the QIDP summaries did not include information regarding why the number of consecutive months was extended rather than a reduction in the number of episodes based on his current status.</p> <p>ii. Individual #1's IPP included an objective which stated he would "...reduce his socially offensive behavior to 10 or less per month for six consecutive months."</p> <p>Individual #1's QIDP monthly data summary for February 2016 stated Individual #1 had met criteria and the objective criteria would be revised. However, his March 2016 QIDP month data summaries stated "This was the 7th consecutive month that [Individual #1] was able to meet criteria. Therefore, I will revise the criteria."</p> <p>Individual #1's IPP documented the objective was revised on 4/11/16 to extend the criteria to 12 consecutive months. Individual #1's QIDP monthly summaries documented he had engaged in socially offensive behaviors at the following rates:</p> <p>October 2015: 0 times. November 2015: 0 times. December 2015: 0 times. January 2016: 0 times. February 2016: 2 times. March 2016: 2 times.</p> <p>However, the QIDP summaries did not include</p>	W 159		

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W 159	<p>Continued From page 31</p> <p>information regarding why the number of consecutive months was extended rather than a reduction in the number of episodes based on his current status.</p> <p>When asked, during an interview on 8/15/16 beginning at 1:00 p.m., the QIDP stated she did not believe the data was accurate.</p> <p>However, the QIDP month notes did not include information regarding the accuracy of the data and there was no information explaining why the criteria had been revised if he had not actually met the stated objective.</p> <p>Additionally, Individual #1's IPP included an objective which stated he would "...decrease incidents of self-injurious behavior to 0 times per month for six consecutive months." Individual #1's QIDP monthly data summary for March 2016 stated he had displayed 1 episode of SIB in March and therefore, had not met criteria for the objective.</p> <p>However, his IPP documented the objective had been revised on 4/11/16 to extend the criteria to 12 consecutive months. Documentation regarding why the number of consecutive months was extended could not be found in Individual #1's record.</p> <p>When asked, during an interview on 8/15/16 beginning at 1:00 p.m., the QIDP stated she thought Individual #1 was doing well so she extended his criteria.</p> <p>However, the QIDP month notes did not include information regarding Individual #1 "doing well" and there was no information explaining why the</p>	W 159		

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W 159	<p>Continued From page 32 criteria had been revised.</p> <p>Further, Individual #1's 4/26/16 medication reduction plan documented he was receiving multiple behavior modifying medications (including Risperdal 2 mg each morning and 3 mg each evening, Zyprexa 5 mg each morning and 7.5 mg each evening, Zoloft 50 mg each morning and Clonidine .05 mg twice a day) to assist him in managing his self-injurious and self-stimulatory behaviors. The plan included reduction criteria of 0 incidents of SIB per month for 9 consecutive months and 1,300 incidents of self-stimulatory behavior per month for 3 consecutive months.</p> <p>Individual #1's record did not include documentation that the criteria established in the medication reduction plan had been re-evaluated or discussed given the QIDP's belief that the data collected was not accurate for self-stimulation and socially offensive behaviors, but that he was "doing well" in regard to his self-injurious behaviors.</p> <p>b. Individual #1's 8/29/15 Speech and Language Annual Review stated he was non-verbal and displayed "significantly limited communication skills." The recommendations section of the review stated he should be presented with an object during the initiation of all activities to help facilitate an object event connection. The objective included on the review stated he would "...select a desired event/object (by pointing, grabbing, looking, etc.) when give [sic] the choice of 2-3 event/objects with 80% accuracy when choices are provided."</p> <p>Individual #1's IPP included a corresponding</p>	W 159		

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W 159	<p>Continued From page 33</p> <p>communication objective to select a desired event/object by grabbing it when given a choice of 3 events/objects. Individual #1's QIDP summaries for May 2016 stated he had met criteria and completed his communication objective of self-initiating selecting a desired event/object by grabbing it when given a choice of 3 events/objects. The QIDP summary stated the QIDP would consult with the facility's SLP "to see is she has another objective for him."</p> <p>However, Individual #1's Communication program, revised 3/14/16, stated once Individual #1 completed the objective of making a choice, he would be working on engaging in the activity he choose for 5 consecutive minutes.</p> <p>When asked, during an interview on 8/15/16 beginning at 1:00 p.m., the QIDP stated she had not implemented the secondary communication objective for Individual #1 and that she had contacted the SLP and she would provide the documentation of the contact.</p> <p>An email communication between the SLP and the QIDP was provided via email on 8/16/16. However, the email communication between the SLP and the QIDP documented the most recent exchange had occurred on 10/29/15, 7 months prior to the QIDP's May 2016 monthly summary note.</p> <p>The QIDP failed to ensure documentation of communication with other IDT members was kept.</p> <p>c. Individual #1's IPP included a hygiene objective which stated he would "...self-initiate applying soap to his hands in 10 of 12 trials per month for</p>	W 159		

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W 159	<p>Continued From page 34 three consecutive months."</p> <p>However, Individual #1's 9/17/15 CFA stated he required light physical assistance to apply soap to his hands.</p> <p>When asked, during an interview on 8/15/16 beginning at 1:00 p.m., the QIDP stated the objective criteria was not correct.</p> <p>The facility failed to ensure the QIDP provided sufficient monitoring and oversight of Individual #1's active treatment program.</p> <p>2. Refer to W114 as it relates to the facility's failure to ensure that the QIDP ensured all entries in the individuals' records were signed and dated.</p> <p>3. Refer to W122 Condition of Participation: Client Protections and associated standard level deficiencies as they relate to the facility's failure to ensure the QIDP ensured policies and procedures for the prevention and detection of abuse, neglect and mistreatment were sufficiently implemented.</p> <p>a. Refer to W149 as it relates to the facility's failure to ensure that the QIDP ensured policies and procedures for the prevention and detection of abuse, neglect, and mistreatment were sufficiently implemented and monitored.</p> <p>b. Refer to W153 as it relates to the facility's failure to ensure the QIDP ensured all allegations of self-abuse were immediately reported to the Administrator.</p> <p>c. Refer to W154 as it relates to the facility's failure to ensure the QIDP ensured that all</p>	W 159			

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W 159	Continued From page 35 alleged violations of abuse, neglect and/or mistreatment were thoroughly investigated. d. Refer to W157 as it relates to the facility's failure to ensure the QIDP ensured that corrective action was taken to prevent reoccurrence of abuse, neglect, and mistreatment. 4. Refer to W195 Condition of Participation: Active Treatment Services and associated standard level deficiencies as they relate to the facility's failure to ensure the QIDP ensured that each individual was provided with active treatment in accordance with their individualized needs. a. Refer to W196 as it relates to the facility's failure to ensure the QIDP ensured each individual was provided with continuous and consistent active treatment services. b. Refer to W209 as it relates to the facility's failure to ensure the QIDP ensured an individual's legal guardian participated in the IPP process. c. Refer to W214 as it relates to the facility's failure to ensure the QIDP ensured that behavior assessments contained comprehensive information. d. Refer to W216 as it relates to the facility's failure to ensure the QIDP ensured individuals' comprehensive functional assessments include comprehensive health information. e. Refer to W224 as it relates to the facility's failure to ensure the QIDP ensured comprehensive functional assessments were reflective the each individual's needs.	W 159			

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W 159	Continued From page 36 f. Refer to W227 as it relates to the facility's failure to ensure the QIDP ensured each individual's IPP included specific objectives to meet the individual's needs. g. Refer to W232 as it relates to the facility's failure to ensure the QIDP ensured objectives were established based on the individuals' functional abilities and were designed to allow the individual to experience success in achieving those objectives. h. Refer to W239 as it relates to the facility's failure to ensure the QIDP ensured replacement behavior training appropriately addressed individuals' maladaptive behaviors. i. Refer to W240 as it relates to the facility's failure to ensure the QIDP ensured individual program plans described relevant interventions to support individuals. j. Refer to W242 as it relates to the facility's failure to ensure the QIDP ensured each individual received training in skills essential for independent living. k. Refer to W249 as it relates to the facility's failure to ensure the QIDP ensured each individual received continuous active treatment services. l. Refer to W250 as it relates to the facility's failure to ensure the QIDP ensured active treatment schedules were sufficient to direct staff. m. Refer to W252 as it relates to the facility's failure to ensure the QIDP ensured sufficient data	W 159			

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W 159	Continued From page 37 was collected to determine the efficacy of intervention strategies. n. Refer to W255 as it relates to the facility's failure to ensure the QIDP ensured programs were revised as appropriate when individuals had successfully completed objectives. o. Refer to W259 as it relates to the facility's failure to ensure the QIDP ensured assessments were updated as needed. 5. Refer to W289 as it relates to the facility's failure to ensure the QIDP ensured techniques used to manage inappropriate behavior were sufficiently incorporated into individuals' program plans. 6. Refer to W322 as it relates to the facility's failure to ensure the QIDP ensured individuals received adequate general and preventative medical care. 7. Refer to W325 as it relates to the facility's failure to ensure the QIDP ensured routine screening laboratory examinations were provided to individuals. 8. Refer to W368 as it relates to the facility's failure to ensure the QIDP ensured drugs were administered as ordered by the physician. 9. Refer to W369 as it relates to the facility's failure to ensure the QIDP ensured medications were administered without error. 10. Refer to W441 as it relates to the facility's failure to ensure the QIDP ensured evacuation drills were conducted under varied conditions.	W 159		

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W 159	Continued From page 38 11. Refer to W448 as it relates to the facility's failure to ensure the QIDP ensured all problems with evacuation drills were investigated. 12. Refer to W449 as it relates to the facility's failure to ensure the QIDP ensured action was taken to correct problems that were identified during quarterly evacuation drills. The cumulative effect of these deficient practices significantly impeded the facility's ability to provide individuals' with adequate protections and habilitative services necessary to achieve and maintain optimal functional status and impeded the facility's ability to ensure each individual was provided with the opportunity to function with as much self-determination and independence as possible.	W 159		
W 195	483.440 ACTIVE TREATMENT SERVICES The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: Based on observation, record review and staff interviews, it was determined the facility failed to ensure active treatment services were provided to each individual participating in the facility's program. This resulted in a lack of necessary services and supports being provided to individuals in order to adequately address their individualized needs. The findings include: 1. Refer to W196 as it relates to the facility's failure to ensure each individual was provided	W 195		9/20/16

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W 195	Continued From page 39 with continuous and consistent active treatment services in accordance with their assessed needs.	W 195			
W 196	483.440(a)(1) ACTIVE TREATMENT Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. This STANDARD is not met as evidenced by: Based on observation, record review and staff interviews, it was determined the facility failed to ensure individuals were provided with continuous and consistent active treatment services in accordance with their individualized needs for 3 of 4 individuals (Individuals #1, #2 and #4) whose IPPs were reviewed. That failure resulted in individuals not receiving services and supports necessary to meet their needs. The findings include: 1. Individual #4's IPP, dated 8/11/15, documented a 65 year old female whose diagnoses included profound intellectual disability. a. Individual #4 was observed at the facility on 8/8/16 from 1:45 - 2:45 p.m. During the 1 hour period, the following was observed:	W 196		9/20/16	

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W 196	<p>Continued From page 40</p> <p>1:45 - 2:00 p.m.: Individual #4 was on the glider rocker on the back porch.</p> <p>2:00 - 2:15 p.m.: Individual #4 came inside and laid down on the couch. She then got up and walked with staff while vocalizing loudly.</p> <p>2:15 - 2:30 p.m.: Individual #4 walked with staff. Staff placed Individual #4 in her wheelchair and took her outside, where she remained until 2:42 p.m.</p> <p>2:42 - 2:45 p.m.: Individual #4 sat in her wheelchair, in the living room, flipping a small stuffed animal against her face.</p> <p>Individual #4 was not observed to be consistently engaged in functional, meaningful activity during the observation.</p> <p>b. Individual #4 was observed at the facility on 8/8/16 from 4:45 - 5:40 p.m. During the 55 minute period, the following was observed:</p> <p>4:45 - 5:15 p.m.: Individual #4 walked around the facility (to the dining area, to the couch, to her bedroom with staff and then back to the dining table).</p> <p>5:15 - 5:30 p.m.: Individual #4 sat at the table, ate dinner then left the table.</p> <p>5:30 - 5:40 p.m.: Individual #4 was walking with staff around the facility.</p> <p>Individual #4 was not observed to be consistently engaged in functional, meaningful activity during the observation.</p>	W 196		

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W 196	<p>Continued From page 41</p> <p>The facility failed to ensure Individual #4 was consistently encouraged or prompted to participate in functional, meaningful activities.</p> <p>2. Refer to W209 as it relates to the facility's failure to ensure an individual's legal guardian participated in the IPP process.</p> <p>3. Refer to W214 as it relates to the facility's failure to ensure behavior assessments contained comprehensive information.</p> <p>4. Refer to W216 as it relates to the facility's failure to ensure individuals' comprehensive functional assessments include comprehensive health information.</p> <p>5. Refer to W224 as it relates to the facility's failure to ensure comprehensive functional assessments were reflective the each individual's needs.</p> <p>6. Refer to W227 as it relates to the facility's failure to ensure each individual's IPP included specific objectives to meet the individual's needs.</p> <p>7. Refer to W232 as it relates to the facility's failure to ensure objectives were established based on the individuals' functional abilities and were designed to allow the individual to experience success in achieving those objectives.</p> <p>8. Refer to W239 as it relates to the facility's failure to ensure replacement behavior training appropriately addressed individuals' maladaptive behaviors.</p> <p>9. Refer to W240 as it relates to the facility's failure to ensure individual program plans</p>	W 196		
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W 196	Continued From page 42 described relevant interventions to support individuals. 10. Refer to W242 as it relates to the facility's failure to ensure each individual received training in skills essential for independent living. 11. Refer to W249 as it relates to the facility's failure to ensure each individual received continuous active treatment services. 12. Refer to W250 as it relates to the facility's failure to ensure active treatment schedules were sufficient to direct staff. 13. Refer to W252 as it relates to the facility's failure to ensure sufficient data was collected to determine the efficacy of intervention strategies. 14. Refer to W255 as it relates to the facility's failure to ensure programs were revised as appropriate when individuals had successfully completed objectives. 15. Refer to W259 as it relates to the facility's failure to ensure assessments were updated as needed.	W 196		
W 209	483.440(c)(2) INDIVIDUAL PROGRAM PLAN Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate. This STANDARD is not met as evidenced by: Based on record review and staff interview and guardian interview, it was determined the facility	W 209		9/20/16

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W 209	Continued From page 43 failed to ensure an individual's legal guardian participated in the IPP process for 1 of 4 individuals (Individual #2) whose records were reviewed. This failure had the potential for a guardian not to be informed of and contribute to the IPP process. The findings include: 1. Individual #2's 9/16/15 IPP documented a 67 year old male whose diagnoses included severe intellectual disability and a history of anxiety disorder. Individual #2's 9/16/15 IPP meeting, dated 9/9/15, included a sign in sheet that documented Individual #2's guardian had declined to attend. During an interview on 8/15/16 from 1:00 - 4:40 p.m., the QIDP stated Individual #2's guardian had declined to attend either by phone or in person. She further stated she had attempted to make alternative arrangements so that he could attend by phone by offering to change the meeting date or time, but he continued to decline. However, during an interview on 8/16/16 from 2:23 - 2:34 p.m., Individual #2's guardian stated he always tried to attend, and was not notified that an IPP meeting was conducted without him. Additionally, he stated he had always attended in the past by phone, and expressed that attending Individual #2's IPP meetings was important to him, and he would have wanted to attend. The facility failed to ensure Individual #2's legal guardian was afforded the opportunity to participate in the IPP process.	W 209			
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN	W 214		9/20/16	

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W 214	<p>Continued From page 44</p> <p>The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavior assessments contained comprehensive information for 2 of 3 individuals (Individuals #1 and 2) whose behavior assessments were reviewed. This resulted in a lack of information on which to base program intervention decisions. The findings include:</p> <p>1. Individual #2's 9/16/15 IPP documented a 67 year old male whose diagnoses included severe intellectual disability, urinary frequency, and a history of anxiety disorder with obsessive compulsive features.</p> <p>Individual #2's 8/12/15 Functional Behavioral Assessment did not include comprehensive information, as follows:</p> <p>a. The assessment stated his physical aggression "...tends to be his response to loud noises, chaotic environments or when he has soiled his clothes and needs to change them."</p> <p>i. The assessment stated the presumed function of the behavior was to avoid non-preferred tasks or staff-cueing, as he does not have a way to express his anger. The assessment did not include a presumed function of Individual #2 engaging in physical aggression in response to loud noises or chaotic environments.</p> <p>ii. The events following the behavior section of</p>	W 214			

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W 214	<p>Continued From page 45</p> <p>the assessment stated Individual #2 would go to his room or outside to take a break and/or his clothes would be laundered to get them clean after having an accident.</p> <p>However, Individual #2's physical aggression behavior intervention plan, revised 9/16/15, stated staff were to redirect Individual #2 to his next scheduled activity.</p> <p>The information in the plan and the assessment was not consistent.</p> <p>Additionally, the plan stated staff were to ask Individual #2 if he was in pain and attend to his pain needs. However, no information related to Individual #2's pain and its impacts on his physical aggression was included in his behavior assessment.</p> <p>iii. Individual #2's physical aggression plan stated he engaged in "Precursors" to becoming physically aggressive, which included staring, clenching his jaw, bending his fingers back, and being in pain.</p> <p>However, information related to the precursory behaviors was not included in his behavior assessment.</p> <p>When asked if the precursory behaviors should be included on Individual #2's behavior assessment, during an interview on 8/15/16 beginning at 1:00 p.m., the QIDP stated they should be.</p> <p>b. Individual #2's behavior assessment stated he engaged in self-injurious behavior, exhibited by picking his skin to the point of tissue damage, or</p>	W 214		

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W 214	<p>Continued From page 46 slapping (hitting) his head.</p> <p>i. The assessment stated his slapping his head may be maladaptive when he does not want to do a task. However, the assessment stated the presumed function of the behavior was "Sensory."</p> <p>When asked about the presumed function during an interview on 8/15/16 beginning at 1:00 p.m., the QIDP stated the sensory statement was not accurate.</p> <p>ii. The assessment stated "At other times, however, such as after a medical procedure... [Individual #2] may be experiencing pain and in such instances this is not considered to be maladaptive."</p> <p>However, the replacement behavior section of the assessment stated Individual #2 would sign "pain" after the sign was modeled by staff and to "see program for prompt level and criteria."</p> <p>However, Individual #2's IPP documented he had met criteria on the objective and it had been discontinued on 12/10/15.</p> <p>When asked, during an interview on 8/15/16 beginning at 1:00 p.m., the QIDP stated the assessment needed to be updated.</p> <p>Additionally, Individual #2's undated "Behavior Assessment: Pain" document stated Individual #2's self-injurious behavior was not related to chronic pain and that he was not being prescribed routine medications for pain.</p> <p>However, Appendix A of Individual #2's IPP</p>	W 214		

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W 214	<p>Continued From page 47</p> <p>documented he received 650 mg of Tylenol twice daily for arthritis.</p> <p>When asked about the assessment, on 8/17/16 at 9:02 a.m., the QIDP stated the information had not been updated and Individual #2 had not been re-assessed since 2014.</p> <p>iii. The behavior assessment stated events preceding self-injurious behavior included sitting on the couch or lying in bed, not being engaged in an activity and when he was in pain.</p> <p>However, his self-injurious behavior intervention plan, revised 9/16/15, listed precursors which included staring, clenching his jaw, and a change in his routine. The plan also stated he did not like loud noises or unfamiliar activity. The plan stated "This can tend to frustrate him or overstimulate him and maladaptive behaviors can occur."</p> <p>However, information related to the preceding events was not found on his behavioral assessment.</p> <p>When asked if the precursory behaviors should be included on Individual #2's behavior assessment, during an interview on 8/15/16 beginning at 1:00 p.m., the QIDP stated they should be.</p> <p>iv. The facility's Investigation Reports documented Individual #2 had an increase in SIB from 5/1/16 - 7/17/16. The reports documented the following:</p> <p>- A 5/1/16 Investigation Report stated, Individual #2 "hit his head open handed one time." The corrective action taken stated, "The team has got</p>	W 214		

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W 214	<p>Continued From page 48</p> <p>together and decided it would be safer for [Individual #2] to prevent SIB if staff went back there with him when he goes to use the restroom."</p> <p>- A 5/21/16 Investigation Report stated staff noticed a bruise and swelling on the right side of his forehead, but staff "missed him going to his room this time but will be having a training to make sure that all staff follow [Individual #2's] guidelines when he goes back to his room." The corrective action taken stated, "Staff are to follow [Individual #2] for his safety when he goes to his room."</p> <p>- A 6/3/16 Investigation Report stated Individual #2 hit himself on the right side of his head leaving a red mark, following a dentist visit. The corrective action taken stated, "The team is getting together to discuss [sic] different way [sic] to keeping [sic] [Individual #2] safe," and stated staff are going to his room with him to prevent SIB.</p> <p>- A 7/6/16 Investigation Report stated Individual #2 hit his head 4 times. The corrective action taken stated "The team has put in place that if [Individual #2] goes to his room staff are to go with him to prevent SIB. [Individual #2] has been to the Dr. because the increase in SIB to his head. The Dr. has said there is no damage to his head at this time. The team will continue to discuss different ways to keep [Individual #2] safe."</p> <p>- A 7/17/16 Investigation Report stated Individual #2 hit the right side of his forehead one time. The corrective action taken stated "The team has put in place that staff are to go back to his room with</p>	W 214		

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W 214	<p>Continued From page 49</p> <p>him to prevent SIB. He has been to the Dr. 7/12/16 no concern at this time. The team will continue to discuss different ways to keep [Individual #2] safe if needed."</p> <p>Further, a 5/25/16 In-Service Training/Meeting Sign in Sheet, signed by 8 DCS instructed staff to follow Individual #2 to his room to prevent SIB and stated to fill out appropriate reporting if SIB occurs.</p> <p>However, information related to the intervention was not included in Individual #2's behavior assessment.</p> <p>Additional Investigation reports documented Individual #2 was experiencing grief after the loss of his mother. The reports documented the following:</p> <ul style="list-style-type: none"> - A 5/17/16 Investigation Report stated Individual #2 "hit himself in the forehead two times opened palmed." The corrective action taken stated, "Staff are making sure they are going back to the room with [Individual #2] for his safety, and making sure every time [Individual #2] hits himself that they are asking if he is in pain. Because [Individual #2]'s mom had passed the week before and [Individual #2] has been hitting his head more frequently the team has decided that it would be good for [Individual #2] to have a social story on feeling sad and feeling angry that staff will go over with him on routine bases [sic] daily." - A 5/19/16 Investigation Report stated Individual #2 "has hit his head opened palmed one time," and the corrective action taken stated, "Staff are to follow [Individual #2] for his safety when he goes back to his room... The team is going to be 	W 214			

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W 214	<p>Continued From page 50 putting social story in his program to go over feeling sad and feeling angry to help him through this hard time."</p> <p>- A 6/5/16 Investigation Report stated Individual #2 hit himself on the left side of his head leaving a nickel-sized lump. The corrective action taken documented, "The team will be getting together to discuss [sic] different ways to keep [Individual #2] safe... The team has gotten together to discuss [sic] what has been going on with [Individual #2], the team thinks that he is grieving at this time."</p> <p>However, Individual #2's behavior assessment did not include information related to how his grief was impacting his maladaptive behaviors and no information related to the intervention strategies was present in the behavior assessment.</p> <p>When asked, during an interview on 8/15/16 beginning at 1:00 p.m., the QIDP stated the assessment needed to be updated.</p> <p>The facility failed to ensure Individual #2's behavior assessment included comprehensive, accurate information.</p> <p>2. Individual #1's 9/29/15 IPP stated he was a 55 year old male whose diagnoses included severe intellectual disability and autism spectrum disorder.</p> <p>Individual #1's 9/9/15 Functional Behavior Assessment was reviewed. The assessment did not include comprehensive information, as follows:</p> <p>a. Individual #1's behavior data was reviewed and documented he had engage in physically</p>	W 214			

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W 214	<p>Continued From page 51</p> <p>aggressive behavior. However, physical aggression was not identified or included on his behavior assessment.</p> <p>When asked, during an interview on 8/15/16 beginning at 1:00 p.m., the QIDP stated Individual #1 had just started engaging in physical aggression in July and the behavior had not yet been addressed.</p> <p>However, Individual #1's behavior data documented he had engaged in physical aggression, as follows:</p> <p>- 5/26/16 at 11:50 a.m.: staff documented 4 individuals and 2 staff "went on a van ride." Staff documented "[Individual #1] repeatedly pushed, hit and poked me from behind where I was sitting." The response to the behavior section of the form stated "We came back to the house and he went to his room to relax."</p> <p>6/10/16 at 8:30 a.m.: staff documented Individual #1 had just taken a bath and was getting dressed. Staff documented "I tried to hand him his socks and he threw them and then hit me in the chest with both hands." The response to the behavior section of the form stated "I told him that hitting was inappropriate and asked him to pick up his socks. He did but refused to put them on so I gave him space to calm down. He got dressed."</p> <p>7/5/16 at 6:15 p.m.: staff documented Individual #1 was in the community. Staff documented "...got back in van [sic]. On the way back he attempted to push peer 6x. Pushed staff 4x. Staff would redirect."</p> <p>7/22/16 at 1:02 p.m.: staff documented Individual</p>	W 214			

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W 214	<p>Continued From page 52</p> <p>#1 was in the community to get a haircut. Staff documented "Staff tried to encourage [Individual #1] to sit down in the barbers [sic] chair and he pushed staff and howled while putting his finger in his mouth." The response to the behavior section of the form stated "Staff brought [Individual #1] home. He calmed down once he got there."</p> <p>The facility failed to ensure Individual #1's behavior assessment included the identification and assessment of emerging maladaptive behaviors.</p> <p>b. The assessment stated Individual #1 engaged in self-injurious behavior, defined as "...hitting his head against walls or doors, hitting/slapping his head hard enough to leave a red mark or the general public would perceive painful [sic], biting his fingers, poking his chest, or repetitively hitting his shin with the other heel, or hitting his arm on an object, all causing a visible injury."</p> <p>i. The psychoactive medications listed to assist Individual #1 in managing his self-injurious behavior included Risperdal and Zyprexa. However, his 4/26/16 medication plan documented he also received Zolof and Clonidine to assist him in managing his self-injurious and self-stimulatory behaviors.</p> <p>ii. The events that precede the behavior section of the assessment stated "Having long hair touching his ears, long facial hair." No other preceding events were listed on the assessment.</p> <p>However, his self-injurious behavior intervention plan, revised 4/11/16, stated "[Individual #1] often engages in SIB after being easily distracted by small things such as, hair touching his ear or dry</p>	W 214			

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W 214	<p>Continued From page 53 skin on his fingers.</p> <p>c. The assessment stated Individual #1 engaged in self-stimulating behavior, defined as "...hitting/slapping his head without leaving a red mark, biting his fingers, poking his chest, gagging self, or repetitively hitting his shin with the other heel, or hitting his arm on an object, causing no visible injury."</p> <p>i. The psychoactive medications listed to assist Individual #1 in managing his self-stimulating behavior included Zoloft and Clonidine. However, his 4/26/16 medication plan documented he also received Risperdal and Zyprexa to assist him in managing his self-injurious and self-stimulatory behaviors.</p> <p>ii. The events that precede the behavior section of the assessment stated "...Due to concerns related to chronic pain, [Individual #1] was on routine pain medication (Tylenol/Ibuprofen) but they were discontinued in August. However, due to a history of family arthritis and continued concerns related to arthritic pain, in February routine medication was reinstated.</p> <p>However, Individual #1's undated "Behavior Assessment: Pain" only included information related to Individual #1's self-injurious behavior.</p> <p>When asked about the assessment, on 8/17/16 at 9:02 a.m., the QIDP stated the information had not been updated and Individual #1 had not been re-assessed since 2014.</p> <p>iii. The events that precede the behavior section of the assessment also stated "During unstructured leisure time, change of shift and</p>	W 214			

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W 214	Continued From page 54 while waiting for meals, [Individual #1] may engage in self-stimulating behaviors to get the sensory he needs." However, the analysis and recommendations section stated the presumed function of the behavior was "To escape/avoid and/or sensory." When asked, during an interview on 8/15/16 beginning at 1:00 p.m., the QIDP stated escape/avoid was not accurate. d. Individual #1's assessment stated he engaged in socially offensive behavior, defined as "...spitting and/or rubbing it on objects or himself and urinating in inappropriate places." i. The psychoactive medication listed to assist Individual #1 in managing his socially offensive behavior included Zolof. However, his 4/26/16 medication plan did not include information related to his socially offensive behavior. ii. The analysis and recommendations section stated the presumed function of the behavior was "sensory." When asked how Individual #1's urination in inappropriate places was related to meeting his sensory needs, on 8/15/16 beginning at 1:00 p.m., the QIDP stated she did not know. The facility failed to ensure Individual #1's behavior assessment included comprehensive, accurate information.	W 214			
W 216	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must	W 216		9/20/16	

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W 216	<p>Continued From page 55 include physical development and health.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure individuals' CFAs include comprehensive health information for 3 of 4 individuals (Individuals #1, #2, and 4), whose CFAs were reviewed. This resulted in a lack of information being available on which to base program intervention and health decisions. The findings include:</p> <p>1. Individual #1's 9/29/15 IPP stated he was a 55 year old male whose diagnoses included severe intellectual disability and autism spectrum disorder.</p> <p>Individual #1's 9/9/15 Functional Behavior Assessment stated in the self-stimulating behavior section that "Due to concerns related to chronic pain, [Individual #1] was on a routine pain medication (Tylenol/Ibuprofen) but they were discontinued in August. However, due to a history of family arthritis and continued concerns related to arthritic pain, in February routing pain medication was reinstated."</p> <p>Individual #1's July 2016 physician orders documented Individual #1 received acetaminophen 650 mg twice a day and Ibuprofen 600 mg once a day for pain relief. Additionally, Individual #1's Routine Standing Orders, dated 2/15/16, included a prn order for Ibuprofen 400 mg every 6 hours as needed for pain.</p> <p>However, Individual #1's CFA did not include</p>	W 216			

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W 216	<p>Continued From page 56</p> <p>information related to how he expressed pain or how pain impacted his behavior and functioning.</p> <p>When asked, during an interview on 8/15/16 beginning at 1:00 p.m., the Leadworker stated Individual #1 would become agitated when he was in pain, meaning he would run back and forth, spend long periods of time in the bathtub, etc. When asked if an assessment had been completed related to Individual #1's pain concerns, the QIDP stated she had completed one, but could not find it in his program book.</p> <p>On 8/17/16 the facility provided an undated document titled "Behavior Assessment: Pain." The assessment stated Individual #1's self-injurious behavior was not related to chronic pain, that no routine pain medications had been prescribed, but he received prn Tylenol of headaches and prn Ibuprofen for body aches.</p> <p>The assessment did not include information related to how Individual #1 expressed he was in pain and the assessment did not include an evaluation of pain on Individual #1's self-stimulating behavior.</p> <p>When asked about the assessment, on 8/17/16 at 9:02 a.m., the QIDP stated the information had not been updated and Individual #1 had not been re-assessed since 2014.</p> <p>The facility failed to ensure Individual #1's CFA included comprehensive, accurate information regarding his chronic pain.</p> <p>2. Individual #4's IPP, dated 8/11/15, documented a 65 year old female whose diagnoses included profound intellectual disability.</p>	W 216			

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W 216	<p>Continued From page 57</p> <p>During an observation on 8/8/16 from 1:15 - 2:45 p.m., Individual #4 was noted to be vocalizing loudly while being ambulated by staff.</p> <p>Individual #4's record was reviewed and no documentation related to the loud vocalization or what staff were to do when she engaged in loud vocalizations.</p> <p>When asked during an interview on 8/15/16 from 1:00 - 4:40 p.m., the QIDP stated she believed Individual #4's loud vocalizations were related to possible pain from dental issues.</p> <p>During a follow up interview on 8/18/16 at 11:57 a.m., Program Manager A stated there was no pain assessment completed for Individual #4.</p> <p>The facility failed to ensure individual#4 received an assessment for her possible pain issues.</p> <p>3. Individual #2's 9/16/15 IPP documented a 67 year old male whose diagnoses included severe intellectual disability, urinary frequency, and a history of anxiety disorder with obsessive compulsive features.</p> <p>Individual #2's 8/12/15 Functional Behavioral Assessment stated that he exhibited self-injurious behavior by picking his skin to the point of tissue damage, or slapping (hitting) his head. The assessment stated the presumed function of the behavior was "Pain" and at times, "...such as after a medical procedure...[Individual #2] may be experiencing pain and in such instances this is not considered to be maladaptive."</p> <p>However, Individual #2's undated "Behavior</p>	W 216		

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NAME OF PROVIDER OR SUPPLIER PREFERRED COMMUNITY HOMES - MALLARD			STREET ADDRESS, CITY, STATE, ZIP CODE 699 SOUTH OTTER MERIDIAN, ID 83642		
(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 216	Continued From page 58 Assessment: Pain" document stated Individual #2's self-injurious behavior was not related to chronic pain and that he was not being prescribed routine medications for pain. However, Appendix A of Individual #2's IPP documented he received 650 mg of Tylenol twice daily for arthritis. Further, Individual #2's physical aggression behavior intervention plan, revised 9/16/15, stated he engaged in "Precursors" to becoming physically aggressive, which included being in pain. However, no information related to how Individual #2's pain impacted his physical aggression was found on his "Behavior Assessment: Pain" document. When asked about the assessment, on 8/17/16 at 9:02 a.m., the QIDP stated the information had not been updated and Individual #2 had not been re-assessed since 2014.	W 216			
W 224	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include adaptive behaviors or independent living skills necessary for the client to be able to function in the community. This STANDARD is not met as evidenced by: Based on record review and staff interview, it	W 224		9/20/16	

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W 224	<p>Continued From page 59</p> <p>was determined the facility failed to ensure comprehensive functional assessments were reflective the each individual's needs for 2 of 4 individuals (Individuals #1 and #4) whose comprehensive functional assessments were reviewed. This resulted in individuals engaging in programming prior to the tasks being adequately assessed. Findings include:</p> <p>1. Individual #1's 9/29/15 IPP stated he was a 55 year old male whose diagnoses included severe intellectual disability and autism spectrum disorder.</p> <p>Individual #1's CFA, revised 9/17/15, was reviewed. The CFA did not include comprehensive assessment information prior to objectives being implemented. Examples, included, but were not limited to, the following:</p> <p>a. Individual #1's IPP included an objective which stated he would "...self-initiate taking his plate to the table in 10 of 12 trials for 3 consecutive months."</p> <p>However, Individual #1's CFA did not include assessment information related to Individual #1's ability to complete the task until 7/7/16.</p> <p>b. Individual #1's IPP included a hand-written self-feeding objective, undated, which stated he would place an item in the blender with a specific verbal prompt or better during 10 of 12 trials per month for 3 consecutive months.</p> <p>His QIDP monthly data summary for April 2016 stated "This was the 1st month of data on this new objective and it was implemented towards the end of the month." The corresponding</p>	W 224			

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W 224	<p>Continued From page 60 program plan included a start date of 4/28/16.</p> <p>However, Individual #1's CFA did not include assessment information related to Individual #1's ability to complete the task until 7/7/16.</p> <p>c. Individual #1's IPP included an objective for desensitization to medical procedures. The objective stated he would sit in a kitchen chair and "...leave his shoes on for 1 continuous minute with a non-specific verbal prompt in 10 of 12 trials per month for three consecutive months."</p> <p>However, assessment information related to the objective could not be found on his CFA.</p> <p>d. Individual #1's 9/29/15 IPP included an objective for choosing his socks prior to going to bed with a non-specific verbal prompt.</p> <p>However, his CFA did not include information related to his current ability to complete the task until 6/9/16.</p> <p>e. Individual #1's IPP included a dressing objective update, undated, which stated he would "...put his dirty clothes in the washer after getting ready for bed with a specific verbal prompt in 10 of 12 trials per month for 3 consecutive months."</p> <p>However, his CFA did not include information related to his current ability to complete the task.</p> <p>When asked, during an interview on 8/15/16 beginning at 1:00 p.m., Program Manager B stated needs should be assessed prior to objectives being developed.</p> <p>2. Individual #4's IPP, dated 8/11/15, documented</p>	W 224			

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W 224	<p>Continued From page 61</p> <p>a 65 year old female whose diagnoses included profound intellectual disability.</p> <p>Individual #4's CFA, revised 8/6/15, was reviewed. The CFA did not include comprehensive assessment information prior to objectives being implemented. Examples, included, but were not limited to, the following:</p> <p>a. Individual #4's IPP included a oral care objective which stated she would "... hand the toothpaste to staff with a non-specific verbal prompt 10 of 12 trials per month for three consecutive months."</p> <p>However, Individual #4's CFA did not include assessment information related to the task until 7/7/16.</p> <p>b. Individual #4's IPP included a hygiene objective which stated she would "... raise her right arm with a non-specific verbal prompt so staff can apply her deodorant in 10 of 12 trials per month for three consecutive months."</p> <p>However, Individual #4's CFA did not include assessment information related to the task until 7/7/16.</p> <p>c. Individual #4's IPP included a bathing objective which stated she would "... wet the wash cloth with a non-specific verbal prompt in 10 of 12 trials per month for three consecutive months."</p> <p>However, Individual #4's CFA did not include assessment information related to the task until 7/7/16.</p> <p>When asked, during an interview on 8/15/16</p>	W 224		

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W 224	Continued From page 62 beginning at 1:00 p.m., Program Manager B stated needs should be assessed prior to objectives being developed.	W 224		
W 227	The facility failed to ensure comprehensive assessment information was garnered prior to the development of individuals' objectives. 483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure each individual's IPP included objectives to meet the needs of 1 of 4 individuals (Individual #1), whose IPPs were reviewed. This resulted in a lack of program plans designed to promote an individual's independence and maximize his developmental potential in areas most likely to impact his daily life. The findings include: 1. Individual #1's 9/29/15 IPP stated he was a 55 year old male whose diagnoses included severe intellectual disability and autism spectrum disorder. Individual #1's objectives were not consistently developed or designed to promote his independence. Examples included, but were not limited to, the following: a. Individual #1's IPP included a grooming objective which stated he would "...apply deodorant with a light physical prompt in 10 of 12	W 227	9/20/16	

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W 227	Continued From page 63 trials per month for three consecutive months." However, his 9/17/15 CFA stated he was already able to complete the task with light physical assistance. Additionally, Individual #1's IPP included a household task objective which stated he would "...take out the trash with a light physical prompt in 10 of 12 trials per month for three consecutive months." However, his 9/17/15 CFA stated he was already able to complete the task with light physical assistance. When asked, during an interview on 8/15/16 beginning at 1:00 p.m., the QIDP stated the criteria given in the objectives was incorrect.	W 227		
W 232	483.440(c)(4)(iv) INDIVIDUAL PROGRAM PLAN The objectives of the individual program plan must be organized to reflect a developmental progression appropriate to the individual. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure IPPs included objectives were organized to reflect a logical developmental progression for 2 of 4 individuals (Individuals #1 and #4) whose IPPs were reviewed. This resulted in a lack of	W 232		9/20/16

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W 232	<p>Continued From page 64</p> <p>appropriate planning to support individuals toward maximizing their developmental potential. The findings include:</p> <p>1. Individual #4's IPP, dated 8/11/15, documented a 65 year old female whose diagnoses included profound intellectual disability.</p> <p>Individual #4's ADL programs included a current primary objective and a secondary objective which was to be implemented after she had met criteria on the primary objective. However, the secondary objectives were not consistently organized to reflect a logical developmental progression based on her individualized needs. Examples included, but were not limited to, the following:</p> <p>a. Individual #4's current Toileting program stated "[Individual #4] will self-initiate sit on [sic] the toilet for 30 seconds in 10 of 12 trials..." The objective that was to be implemented upon completion of sitting on the toilet stated "[Individual #4] will pull her pants down."</p> <p>b. Individual #4's current Grooming program stated "[Individual #4] will hand staff her comb/brush with a gesture prompt in 10 of 12 trials..." The objective that was to be implemented upon completion of handing the staff her comb/brush stated "[Individual #4] will comb/brush the left side of her hair."</p> <p>c. Individual #4's current Self Feeding 2 program stated "[Individual #4] will self-initiate wipe her [sic] mouth with a napkin in 10 of 12 trials..." The objective that was to be implemented upon completion of wiping her mouth with a napkin stated "[Individual #4] will place the entree on her</p>	W 232			

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W 232	<p>Continued From page 65 plate."</p> <p>When asked, during an interview on 8/15/16 from 1:00 - 4:40 p.m., how objectives were established and prioritized, Program Manager B stated they were discussed during the IPP meetings and secondary objectives should be included on the individuals' program plans.</p> <p>The facility failed to ensure Individual #4's secondary objectives were consistently organized and implemented to reflect a logical developmental progression based on her individualized needs.</p> <p>2. Individual #1's 9/29/15 IPP stated he was a 55 year old male whose diagnoses included severe intellectual disability and autism spectrum disorder.</p> <p>Individual #1's ADL programs included a current primary objective and a secondary objective which was to be implemented after he had met criteria on the primary objective. However, the secondary objectives were not consistently organized to reflect a logical developmental progression based on his individualized needs. Examples included, but were not limited to, the following:</p> <p>a. Individual #1's "Toileting" program, revised 7/7/16, stated he was working on replacing the toilet paper roll. The "Staff Notes" section of the plan stated "Make sure the toilet paper that [Individual #1] is replacing in his bathroom. The next step for [Individual #1] after completing this objective is to start using toilet paper."</p> <p>b. Individual #1's Oral Care program, revised</p>	W 232			

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W 232	<p>Continued From page 66</p> <p>6/6/16, stated he was working on applying a small amount of toothpaste to his toothette. The plan stated "Upon completion of this objective, [Individual #1] will wipe his face off after brushing his gums."</p> <p>Individual #1's 9/17/15 CFA did not include information related to his ability to brush his gums. However, the status section of his oral care plan stated he required full physical assistance to brush his gums.</p> <p>The plan did not include information related to when or if Individual #1 would learn to brush his gums, prior to wiping his face "after brushing his gums."</p> <p>c. Individual #1's grooming program, revised 4/11/16, stated he was working on applying deodorant. The plan stated "Upon completion of this objective, [Individual #1] will apply cologne after shaving."</p> <p>His 9/17/15 CFA documented Individual #1 required full physical assistance to shave his face. However, the status section of his grooming plan stated he "...does not have facial hair and does not have the need to shave."</p> <p>d. Individual #1's dressing program, revised 3/14/16, stated he was working on choosing a pair of socks to wear before going to bed. The plan stated "Upon completion of this objective, [Individual #1] will choose a pair of pants to wear for the day."</p> <p>Individual #1's QIDP summaries for June 2016 stated he had met criteria for choosing his socks. However, his IPP documented he was working on</p>	W 232		

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W 232	Continued From page 67 placing his dirty clothes in the washer rather than choosing a pair of pants, per the documented planned sequence on his dressing program. When asked, during an interview on 8/15/16 beginning at 1:00 p.m., the QIDP stated when an individual completed a program she would conduct an observation and then choose another objective for the individual to work on. The QIDP stated an objective for Individual #1 to choose his pants had not been developed or implemented. When asked, during an interview on 8/15/16 beginning at 1:00 p.m., how objectives were established and prioritized, Program Manager B stated they were discussed during the IPP meetings and secondary objectives should be included on the individuals' program plans. The facility failed to ensure Individual #1's secondary objectives were consistently organized and implemented to reflect a logical developmental progression based on his individualized needs.	W 232		
W 239	483.440(c)(5)(vi) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure	W 239		9/20/16

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W 239	<p>Continued From page 68</p> <p>replacement behavior training appropriately addressed maladaptive behaviors for 1 of 3 individuals (Individual #2) whose behavior plans were reviewed. This resulted in an individual not receiving functional training related to maladaptive behaviors. The findings include:</p> <p>1. Individual #2's 9/16/15 IPP documented a 67 year old male whose diagnoses included severe intellectual disability, urinary frequency, and a history of anxiety disorder with obsessive compulsive features.</p> <p>Individual #2's 8/12/15 Functional Behavioral Assessment stated his physical aggression "...tends to be his response to loud noises, chaotic environments or when he has soiled his clothes and needs to change them." The assessment stated the presumed function of the behavior was to avoid non-preferred tasks or staff-cueing, as he does not have a way to express his anger.</p> <p>The assessment did not include a presumed function of Individual #2 engaging in physical aggression in response to loud noises or chaotic environments.</p> <p>The replacement behavior section of the assessment stated "[Individual #2] will put his dirty clothes in the washer."</p> <p>The assessment did not explain how placing his clothes in the washer was functionally related to the escape/avoid function or how the facility was teaching Individual #2 appropriate way to express his anger.</p> <p>When asked about the replacement behavior,</p>	W 239			

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W 239	Continued From page 69 during an interview on an interview on 8/15/16 beginning at 1:00 p.m., the Leadworker stated having Individual #2 place his clothes in the washer was an effective strategy. However, placing his clothes in the washer was a reactive strategy and no information regarding what proactive strategies (e.g. teaching implemented to replace Individual #2's need to become physically assaultive) was found.	W 239		
W 240	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The facility failed to identify and provide functional training related to Individual #2's physically assaultive behavior. The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview it was determined the facility failed to ensure the individual program plans described relevant interventions to support 3 of 4 individuals (Individuals #1, #2 and #4) whose IPPs and programs were reviewed. This resulted in a lack of consistent information being available to staff regarding what services were to be provided to individuals. The findings include: 1. Individual #1's 9/29/15 IPP stated he was a 55 year old male whose diagnoses included severe intellectual disability and autism spectrum disorder. a. Individual #1's IPP included an Occupational	W 240		9/20/16

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W 240	<p>Continued From page 70 Therapy Service plan and a Sensory Activities Service plan, both revised 9/29/15.</p> <p>The service plans were reviewed. Both included instructions to staff to provide "Rhythm Activities," warm baths, and warm clothing/bedding. The Occupational Therapy Service plan also included engaging Individual #1 in activities such as "...meal preparation, making his bed, assisting with dishes, etc." and the Sensory Activities Service plan include providing Individual #1 with a deep pressure massager. Beyond the activities and the deep pressure, the programs' instructions were identical.</p> <p>In the warm baths section, both plans stated "Ensure you are monitoring [Individual #1] while he is taking his bath by checking on him every 15 minutes."</p> <p>However, his Supervision while taking a bath service plan, revised 9/29/15 stated "If [Individual #1] is CALM and is requesting a bath, staff can assist him to get in the tub then do 5 Minute Checks while he is bathing. If at any time, [Individual #1] begins to engage in hitting his arm on the side of the tub, staff will stay with him until he has finished his bath to ensure his safety."</p> <p>Individual #1's service plans were not consistent in providing staff direction.</p> <p>b. Individual #1's IPP included a "Leisure Activities Service" program, revised 9/29/15. The program stated he was to be assisted to participate in leisure activities such as TV, listening to music, going on van rides, all of his sensory items, and being outside.</p>	W 240			

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W 240	<p>Continued From page 71</p> <p>When asked about Individual #1's leisure activities, during an interview on 8/15/16 beginning at 1:00 p.m., the Leadworker stated he did not like sensory items, but he did like warm baths.</p> <p>Individual #1's leisure activity data sheets, from April 2016 to July 2016 were reviewed and documented he primarily engaged in "warm bath/warm clothes" as a leisure activity, as follows:</p> <ul style="list-style-type: none"> - April 2016: Warm bath and/or warm clothes was documented in 29 of the 30 data probes. - May 2016: Warm bath and/or warm clothes was documented in 29 of the 32 data probes. - June 2016: Warm bath and/or warm clothes was documented in 31 of the 31 data probes. - July 2016: Warm bath and/or warm clothes was documented in 25 of the 31 data probes. <p>However, warm baths, were activities that were to be provided as part of Individual #1's Occupational Therapy Service plan and his Sensory Activities Service plan.</p> <p>When asked, during an interview on 8/15/16 beginning at 1:00 p.m., the QIDP stated providing Individual #1 with a warm bath or clothes would count toward implementing all 3 service objectives (his Leisure, Occupational Therapy, and Sensory Activities service plans).</p> <p>However, the "Leisure Activities Service" program did not include information regarding the relationship between the service objectives.</p>	W 240			

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W 240	<p>Continued From page 72</p> <p>Further, the leisure service plan did not include comprehensive instructions to staff. The plan's instruction stated the following:</p> <p>"Throughout [Individual #1's] day, during leisure times as indicated on the active treatment schedule, staff will offer [Individual #1] a leisure activity that he enjoys."</p> <p>"Staff will document what leisure activity [Individual #1] participated in and the duration of his participation on the leisure activities on the data sheet [sic]."</p> <p>"Staff will also document on the service sheet that [Individual #1] was offered a leisure activity and is he participated."</p> <p>Individual #1's 9/17/15 CFA included an activities profile which listed activities he would participate in and a separate activities section which assessed the level of assistance he required to participate in the activity. The CFA documented Individual #1 required full physical assistance to participate in all leisure activities with the exceptions of selecting something to do at home for fun when given a choice (which he could do independently), playing an active game with others (which required specific verbal prompting), and trying new leisure activities (which required light physical prompting).</p> <p>However, no further instructions to staff regarding what type of assistance Individual #1 required based on which activity he choose, was present in his leisure service plan. As stated, Individual #1 was not provided with services which fully supported his participation in varied leisure activities and was not being provided with training</p>	W 240			

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W 240	<p>Continued From page 73</p> <p>which would promote his opportunities to participate in leisure activities with greater independence.</p> <p>2. Individual #4's IPP, dated 8/11/15, documented a 65 year old female whose diagnoses included profound intellectual disability.</p> <p>Individual #4's IPP included a service objective which stated she would participate in leisure activities daily. The corresponding "Leisure Activities Service" plan, revised 8/18/15, stated she was to be assisted to participate in leisure activities such as TV, listening to music, "all of her sensory stuff," going on van rides, sitting in the recliner or chair, and being outside. The plan did not give additional information related to what Individual #4's sensory "stuff" was, or what, if anything, she was to be engage in when she went on a van ride, went outside or was sitting in the recliner or chair.</p> <p>Individual #4's CFA, revised 8/6/15, included an activities profile which listed activities she would participate in and a separate activities section which assessed the level of assistance she required to participate in the activity. The CFA stated "It is difficult to determine if [Individual #4] has any interest in this area, but she does not seem willing to participate in much." The section stated she would participate in cooking, walks, and listening to music. The CFA also documented she required full physical assistance to participate in all leisure activities with the exceptions of selecting something to do at home for fun when given a choice, which she could do independently.</p> <p>However, no further instructions to staff regarding</p>	W 240		

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W 240	<p>Continued From page 74</p> <p>what type of assistance Individual #4 required based on which activity she choose, was present in her leisure service plan. As stated, Individual #4 was not provided with services which fully supported her participation in varied leisure activities and was not being provided with training which would promote her opportunities to participate in leisure activities with greater independence.</p> <p>2. Individual #2's 9/16/15 IPP documented a 67 year old male whose diagnoses included severe intellectual disability, urinary frequency, and a history of anxiety disorder with obsessive compulsive features.</p> <p>a. During observations conducted on 8/9/16 from 10:00 - 10:45 a.m., Individual #2 was noted to leave the facility by van to participate in Meals on Wheels services. During that time 3 deliveries observed. Individual #2 was not observed to get out of van, the DCS loaded and delivered the meals to various locations.</p> <p>Individual #2's Active Treatment Schedule listed "Retirement Activities" and "Leisure" in the time block for Monday - Friday from 10:00 a.m. - 12:00 p.m.</p> <p>Individual #2's IPP included "Vocational/Retirement" information under his skills for activities of daily living, that stated he was retired and he would participate in retirement activities such as, "going out for coffee, going to the park (to people watch) and going out for lunch."</p> <p>Individual #2's IPP included a "Retirement Activities Service" program, revised 9/16/15. The</p>	W 240			

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W 240	<p>Continued From page 75</p> <p>program stated he was to be assisted to participate in retirement activities and instructed staff to find activities, such as going for a walk on the green belt, an Arts and Craft fair, etc. that he may enjoy participating in.</p> <p>Review of Individual #2's Retirement Activities logs did not reflect his stated interventions for that program as follows:</p> <ul style="list-style-type: none"> - The March 2016 log listed a "magazine" activity recorded 6 times, a Meals on Wheels activity recorded 3 times, a "movies" activity recorded once, accounting for 10 of the 23 documented activities. - The April 2016 log listed a "magazine" activity that occurred 3 times, and a Meals on Wheels activity that occurred 2 times accounting for 5 of the 16 documented activities. - May 2016 log listed a Meals on Wheels activity that occurred 6 times and a "magazine" activity that occurred 3 times, accounting for 9 of the 20 documented activities. - June 2016 log listed a Meals on Wheels activity that occurred 8 times, a "relaxed on the patio" activity that occurred 2 times, a "ate lunch on the patio" 1 time, and a "magazine" activity 1 time, accounting for 12 of the 18 documented activities <p>When asked about Individual #2's Retirement Activities Service program, during an interview on 8/15/16 beginning at 1:00 p.m., the QIDP stated he participated in the Meals on Wheels as a part of his retirement activities. In addition, she stated Meals on Wheels was not listed on his IPP or Retirement Activities Service program. The QIDP</p>	W 240		

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W 240	<p>Continued From page 76</p> <p>also stated that his retirement activities should be done out of the home, so looking at magazines, or being out on the patio at home should not be considered his retirement activity.</p> <p>However, Individual #2's Retirement Activities Service program failed to describe which activities should not be considered retirement activities and it did not list Meals on Wheels as being a part of that program.</p> <p>b. Individual #2's IPP included an "Occupation Therapy" program, revised 9/16/15. The program included a "Matching," activity with instructions that stated staff were to offer matching activities for him to participate in by matching items by color, shape, and size.</p> <p>His Occupational Therapy Report, dated 8/29/15, recommended Individual #2 continue to engage in matching a variety of items in order to provide functional interactions and to continue desired fine motor activities to increase hand skills.</p> <p>No further instructions on what type of objects or supplies to use was listed. Further, no instructions on which objective (matching by color, shape or size) Individual #2 was currently working on or preferred was present.</p> <p>On 8/12/16 from 1:35 - 1:52, 3 DCS were asked to describe what Individual #2's OT matching activity involved. DCS A stated his OT matching activity involved choosing any item, or game from the facility's activity closet and having him match like items. DCS B stated his OT matching activity involved using a "Dora" matching game. DCS C stated she did not know what his OT matching activity was and she had never done that program</p>	W 240			

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W 240	Continued From page 77 with him. According to Individual #2's QIDP monthly summaries, he had not been successfully completing this service as follows, and it was unclear if they were not offered or refused: - 8/2015 he completed 2 of 31 trials. - 9/2015 he completed 0 of 20 trials. - 10/2015 he completed 0 of 30 trials. - 11/2015 he completed 0 of 30 trials. - 12/2015 he completed 1 of 25 trails. - 1/2016 he completed 0 of 30 trials. - 2/2016 he completed 0 trials. - 3/2016 he completed 13 of 25 trials. - 4/2016 he completed 0 trials. - 5/2016 he completed 0 of 29 trials. - 6/2016 he completed 2 of 28 trails. - 7/2016 he completed 3 of 28 trails. When asked about Individual #2's OT matching program, during an interview on 8/15/16 beginning at 1:00 p.m., the QIDP stated he matched "bears." When asked why the service was rarely completed, the QIDP stated he refused and staff had required re-training to remember to specify refusals for data collection. When asked if she had investigated why the program was refused, or if she had considered revising the instructions or activity to better meet Individual #2's needs, she stated she had not. The facility failed to ensure sufficient information was provided to staff necessary to ensure he was supported towards independence.	W 240			
W 242	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN The individual program plan must include, for	W 242		9/20/16	

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W 242	<p>Continued From page 78</p> <p>those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure each individual received training in skills essential for independent living for 1 of 4 individuals (Individual #1) whose training objectives were reviewed. This resulted in a lack of training programs designed to meet an individual's basic needs. The findings include:</p> <p>1. Individual #1's 9/29/15 IPP stated he was a 55 year old male whose diagnoses included severe intellectual disability and autism spectrum disorder.</p> <p>a. Individual #1's 9/17/15 CFA stated he was "...independent in using the restroom so staff are not sure each time he has a BM [bowel movement]." However, the CFA also documented Individual #1 required full physical assistance to wipe himself thoroughly.</p> <p>The CFA did not include documentation to clarify how Individual #1 was considered independent in toileting if he could not wipe himself thoroughly.</p> <p>Additionally, Individual #1's "Toileting" program, revised 7/7/16, stated he was working on replacing the toilet paper roll. The "Staff Notes"</p>	W 242		
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W 242	<p>Continued From page 79</p> <p>section of the plan stated "Make sure the toilet paper that [Individual #1] is replacing in his bathroom. The next step for [Individual #1] after completing this objective is to start using toilet paper."</p> <p>When asked about the objective, during an interview on 8/15/16 beginning at 1:00 p.m., the QIDP stated Individual #1 was working on replacing the toilet paper roll and did not have an objective for wiping himself thoroughly.</p> <p>The facility failed to ensure Individual #1 was provided with training essential to meet his basic toileting needs.</p> <p>b. The "Toileting" section of Individual #1's 9/17/15 CFA, documented "[Individual #1's] team feels that [Individual #1's] privacy will be provided by his staff."</p> <p>However, the "Private Versus Public Behavior" section of the CFA stated he would sometimes close the bathroom door when appropriate for privacy.</p> <p>When asked about an objective to teach Individual #1 to protect his own privacy, during an interview on 8/15/16 beginning at 1:00 p.m., the QIDP stated Individual #1 would shut his bedroom door, but would leave his bathroom door open. When asked about using other bathrooms, the QIDP stated Individual #1 did not use other bathrooms. When asked about bathroom use in the community, the Program Supervisor stated Individual #1 would be prompted to use the bathroom prior to leaving the facility and did not use community restrooms.</p>	W 242		

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W 242	Continued From page 80 However, during observations conducted 8/8/16 at 2:00 p.m., it was noted the facility consisted of four bedrooms. Bedroom #1 (occupied by Individual #4) and bedroom #2 (shared by Individual #1 and Individual #5) were accessed from the left side of the main hallway off of the living room and were connected by a shared bathroom. It was not evident how Individual #1 would ensure his own privacy if he only closed his bedroom door. Further, no documentation was present in Individual #1's record which explained why he was precluded from using community restrooms. The facility failed to ensure Individual #1 was provided with training essential to meet his basic privacy needs.	W 242		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure individuals received services consistent with their IPPs for 3 of 4 individuals (Individuals #1, #2 and #4) whose records were reviewed. This resulted in inconsistent implementation of	W 249		9/20/16

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W 249	<p>Continued From page 81</p> <p>interventions designed to support individuals toward greater independence. The findings include:</p> <p>1. Individual #4's IPP, dated 8/11/15, documented a 65 year old female whose diagnoses included profound intellectual disability.</p> <p>Her record contained an Occupational Therapy Report, dated 5/25/16, that documented "When [Individual #4] is ambulating with CGA [Contact, Guard, Assist], place one hand on the side of the belt closest to you and the other on the back of the gait belt...".</p> <p>The report also documented she was to be CGA with the gait belt at all times she was ambulating.</p> <p>However, Individual #4 was noted to be ambulating in the home without CGA during the following observations:</p> <ul style="list-style-type: none"> - 8/8/16 at 4:55 p.m. - 8/8/16 at 5:30 p.m. - 8/9/16 at 7:35 a.m. <p>When asked during an interview on 8/15/16 from 1:00 - 4:40 p.m., the QIDP stated Individual #4 should have been CGA during the observations.</p> <p>The facility failed to ensure Individual #4's gait belt was used per OT recommendation.</p> <p>2. Individual #1's 9/29/15 IPP stated he was a 55 year old male whose diagnoses included severe intellectual disability and autism spectrum disorder.</p> <p>a. Individual #1's 8/29/15 Speech and Language Annual Review stated he was non-verbal and displayed "significantly limited communication</p>	W 249		

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W 249	<p>Continued From page 82</p> <p>skills." The recommendations section of the review stated he should be presented with an object during the initiation of all activities to help facilitate an object event connection. The objective included on the review stated he would "...select a desired event/object (by pointing, grabbing, looking, etc.) when give [sic] the choice of 2-3 event/objects with 80% accuracy when choices are provided."</p> <p>Individual #1's IPP included a corresponding communication objective to select a desired event/object by grabbing it when given a choice of 3 events/objects. Individual #1's QIDP summaries for May 2016 stated he had met criteria and completed his communication objective of self-initiating selecting a desired event/object by grabbing it when given a choice of 3 events/objects. The QIDP summary stated the QIDP would consult with the facility's SLP "to see is she has another objective for him."</p> <p>However, Individual #1's QIDP summaries for June 2016 and July 2016, stated "Communication: [Individual #1] will have a new IPP in September."</p> <p>When asked, during an interview on 8/15/16 beginning at 1:00 p.m., the QIDP stated Individual #1 did not currently have a formal communication program.</p> <p>The QIDP failed to ensure Individual #1's active treatment program was not suspended while awaiting his IPP.</p> <p>b. Individual #1's IPP included an objective which stated he would "...self-initiate taking his plate to the table in 10 of 12 trials for 3 consecutive</p>	W 249		

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W 249	<p>Continued From page 83 months."</p> <p>Individual #1's QIDP monthly data summary for February 2016 stated Individual #1 was able to meet criteria for the objective. The QIDP note stated "I will re-assess to determine another need in this domain."</p> <p>However, Individual #1's QIDP monthly data summary for March 2016 stated "A new program will be written and data will be reported next month."</p> <p>Further, Individual #1's IPP included a hygiene objective which stated he would "...self-initiate applying soap to his hands in 10 of 12 trials per month for three consecutive months."</p> <p>Individual #1's QIDP monthly data summary for February 2016 stated he had met criteria on the objective. The QIDP note stated "I will re-assess to determine another need in this domain." However, his QIDP monthly data summary for March 2016 stated "Another objective will be written and data will be reported next month."</p> <p>When asked, during an interview on 8/15/16 beginning at 1:00 p.m., about the facility's expectations for implementing additional objectives when an individual met criteria, Program Manager B stated new programs were to be implemented in the same month that objectives were met.</p> <p>The QIDP failed to ensure Individual #1's was provided with continuous services to meet his needs.</p> <p>c. Individual #1's record included a Behavior</p>	W 249			

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W 249	<p>Continued From page 84</p> <p>Intervention Plan, revised 4/11/16, for socially offensive behavior, defined as "...spitting and/or rubbing it on objects or himself and urinating in inappropriate places. Individual #1's plan stated staff were to offer interventions, which included the following:</p> <p>If Individual #1 spit and/or rubbed spit on objects, staff were to "...call his name and tell him not to spit," have Individual #1 wipe off the surface he spit on and offer him a sensory item.</p> <p>The program stated staff were to document on an ABC form each time Individual #1 engaged in socially offensive behavior.</p> <p>Individual #1's ABC data for April 2016 - July 2016 was reviewed. The data did not include information which supported that interventions were being consistently implemented. Examples included, but were not limited to, the following:</p> <p>- 4/8/16 at 12:43 p.m., staff documented Individual #1 spit on the table and rubbed it in a circle. Staff documented they had sprayed the table, and had Individual #1 clean it up and place the rag in the laundry.</p> <p>The documentation did not support that Individual #1 was asked to stop or was offered a sensory item, per his behavior intervention plan.</p> <p>- 4/13/16 at 8:30 a.m., staff documented Individual #1 spit on the table and he cleaned it up.</p> <p>The documentation did not support that Individual #1 was asked to stop or was offered a sensory item, per his behavior intervention plan.</p>	W 249			

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W 249	Continued From page 85 When asked, during an interview on 8/15/16 beginning at 1:00 p.m., the QIDP stated she reviewed all behavior data. However, no documentation was present in the facility's records which demonstrated the QIDP had recognized and addressed the lack of program implementation. The facility failed to ensure Individual #1 was provided with consistent active treatment services. 3. Individual #2's 9/16/15 IPP documented a 67 year old male whose diagnoses included severe intellectual disability, urinary frequency, and a history of anxiety disorder with obsessive compulsive features. a. Individual #2's record included a Behavior Intervention Plan, revised 9/16/15, for physical aggression, defined as hitting others and/or throwing objects towards them. The plan stated staff were to offer interventions, which included the following: - If Individual #2 hit with his hands, staff were to block the attempt and redirect him to his next scheduled activity. - If he became aggressive toward others, staff were to step in between Individual #2 and the person he was attempting to assault. Staff were to ask for another staff member to remove the person Individual #2 was attempting to assault, then redirect Individual #2 to his next scheduled activity. The plan stated if he could not be redirected, staff were to prompt him to take a break.	W 249			

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W 249	<p>Continued From page 86</p> <p>- Positive interventions were included with the following instructions:</p> <p>"Reduce demands - Keep choices/requests simple with [Individual #2]. Don't over cue...If he does not want to do something do not attempt to argue or force him to do it."</p> <p>The program stated staff were to document on an ABC form each time Individual #2 engaged in physical aggression.</p> <p>Individual #2's ABC data from 6/2/16 - 7/23/16 was reviewed. The data did not include information which supported interventions were being consistently implemented. Examples included, but were not limited to, the following:</p> <p>- 7/23/16 at 5:00 p.m.: staff documented Individual #2 was doing his PT activity and then walked away. Staff cued him to resume the activity, which he responded to by hitting staff, shoving staff to the leave area, and throwing dishes. Antecedent events were documented as "possibly tired or overcued [sic]."</p> <p>There was no indication the positive interventions of reducing demands, avoiding over cueing, or avoiding forcing him to do a task he does not want to were implemented according to his behavior program.</p> <p>Staff documented they "gave space" and "redirection" for interventions or responses to the behavior.</p> <p>There was no indication if the person he had hit had been removed, if he was redirected to his next scheduled activity, or was offered to take a</p>	W 249		

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W 249	<p>Continued From page 87 break as indicated in his behavior plan.</p> <p>b. Individual #2's record included a Behavior Intervention Plan, revised 9/16/15, for self-injurious behavior, defined as picking his skin to the point of tissue damage, or slapping (hitting) his head. The plan stated staff were to offer interventions, which included the following:</p> <ul style="list-style-type: none"> - If Individual #2 was picking at his skin, staff were to redirect him to his program to put lotion on his hands or redirect to the next scheduled activity. The plan stated if he could not be redirected, staff were to prompt him to take a break. - If Individual #2 hit his head, staff were to ask him to stop, assess if he was having pain, and if needed provide soft surface to block direct head hits (pillow or hand). The plan stated staff were to then redirect him to his next scheduled activity. If he could not be redirected, staff were to prompt him to take a break. - Positive interventions were included with the following instructions: "Reduce demands - Keep choices/requests simple with [Individual #2]. Don't over cue...If he does not want to do something do not attempt to argue or force him to do it." <p>The program stated staff were to document on an ABC form each time Individual #2 engaged in self-injurious behavior.</p> <p>Individual #2's ABC data from 6/2/16 - 7/23/16 was reviewed. The data did not include information which supported interventions were being consistently implemented. Examples</p>	W 249			

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W 249	<p>Continued From page 88 included, but were not limited to, the following:</p> <p>- 6/3/16 at 10:11 a.m.: staff documented Individual #2 hit his head twice after he had just had a dentist appointment. Interventions to the behavior were documented as, "Re-directed [sic] him to wash his hands. Then we went out to the van."</p> <p>The documentation did not support that Individual #2 was asked to stop, assessed for pain or asked to take a break, per his behavior intervention plan.</p> <p>- 7/7/16 at 7:25 p.m.: staff documented Individual #2 hit his head once after he was repetitively cued for a PT activity and then dinner.</p> <p>The section for positive prevention and intervention techniques, was blank and there was no evidence that his behavior program positive interventions were implemented to avoid over cueing and reduce demands.</p> <p>Staff described the interventions or responses to the behavior as "checked every 15" and "encouraged him."</p> <p>The documentation did not support that Individual #2 was asked to stop, assessed for pain, redirected to his next activity, or asked to take a break, per his behavior intervention plan.</p> <p>When asked, during an interview on 8/15/16 beginning at 1:00 p.m., the QIDP stated she reviewed all behavior data.</p> <p>However, no documentation was present in the facility's records which demonstrated the QIDP</p>	W 249		

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W 249	Continued From page 89 had recognized and addressed the lack of program implementation. The facility failed to ensure Individual #2 was provided with consistent active treatment services.	W 249		
W 250	483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview it was determined the facility failed to develop active treatment schedules sufficient to direct staff for 3 of 4 individuals, (Individuals #1, #2 and #4) whose active treatment schedules were reviewed. Failure to ensure schedules were sufficient and flexible enough to direct staff in their efforts to address the individuals' active treatment needs seriously impeded the staffs' ability to provide such services. Findings include: 1. Individual #1's 9/29/15 IPP stated he was a 55 year old male whose diagnoses included severe intellectual disability and autism spectrum disorder. His "Weekday Residential Active Treatment Schedule," revised 6/14/16, listed activities in 1 hour to 3 hour time blocks. The schedule was not sufficiently developed to direct the staff in the implementation of Individual #1's active treatment program. Examples included, but were not limited to, the following: During an observation conducted on 8/8/16 from 2:00 - 2:45 p.m., Individual #1 was noted to	W 250		9/20/16

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W 250	<p>Continued From page 90 engage in the following:</p> <p>2:00 - 2:10 p.m.: Individual #1 was in his bedroom, lying on his bed.</p> <p>2:10 - 2:25 p.m.: Individual #1 went from his bedroom to the living room and sat in a chair. Staff intermittently interacted with him, providing him with hand and back slaps. Individual #1 communicated break, one time, and staff discontinued slapping his back and walked away. A short time later, staff returned and resumed intermittently interacting with him and providing him with hand and back slaps. Individual #1 went to the bathroom, took the trash out, went in his room, laid on his bed then returned to the chair in the living room.</p> <p>2:25 - 2:40 p.m.: Staff intermittently interacted with him, providing him with hand and back slaps. Until he was prompted to go outside, which he did. Individual #1 remained outside on the back porch, until 2:40 p.m. He entered the kitchen, threw away a piece of trash and returned to the chair in the living room, where he remained when the observation ended.</p> <p>Individual #1's Active Treatment Schedule listed "Communication" and "Leisure" in the time block for Monday - Friday from 2:00 - 3:00 p.m.</p> <p>a. Individual #1's QIDP summaries for May 2016 stated he had met criteria and completed his communication objective of self-initiating selecting a desired event/object by grabbing it when given a choice of 3 events/objects.</p> <p>When asked, during an interview on 8/15/16 beginning at 1:00 p.m., the QIDP stated Individual</p>	W 250			

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W 250	<p>Continued From page 91</p> <p>#1 did not have a communication program in place and the schedule had not been updated.</p> <p>b. Individual #1's IPP included a "Leisure Activities Service" program, revised 9/29/15. The program stated he was to be assisted to participate in leisure activities such as TV, listening to music, going on van rides, all of his sensory items, and being outside.</p> <p>Being outside was the only leisure activity Individual #1 was noted to be offered during the observation. While the TV was on and playing music, Individual #1 was not observed to be interested in either watching or listening. Further, Individual #1 was not offered a van ride, sensory items, or other activities which were leisure oriented.</p> <p>Additionally, Individual #1's leisure activity data sheets, from April 2016 to July 2016 were reviewed and documented he primarily engaged in "warm bath/warm clothes" as a leisure activity, as follows:</p> <ul style="list-style-type: none"> - April 2016: Warm bath and/or warm clothes was documented in 29 of the 30 data probes. - May 2016: Warm bath and/or warm clothes was documented in 29 of the 32 data probes. - June 2016: Warm bath and/or warm clothes was documented in 31 of the 31 data probes. - July 2016: Warm bath and/or warm clothes was documented in 25 of the 31 data probes. <p>When asked about Individual #1's leisure activities, during an interview on 8/15/16</p>	W 250		

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W 250	<p>Continued From page 92 beginning at 1:00 p.m., the Leadworker stated he did not like sensory items, but he did like warm baths.</p> <p>However, providing him with warm baths and warm clothes was included in both, his Occupational Therapy Service plan and his Sensory Activities Service plan, both revised 9/29/15.</p> <p>When asked, during an interview on 8/15/16 beginning at 1:00 p.m., the QIDP stated providing Individual #1 with a warm bath or clothes would count toward implementing all 3 service objectives (his Leisure, Occupational Therapy, and Sensory Activities service plans).</p> <p>Individual #1's Active Treatment Schedule did not include information related to when his Occupational Therapy Service objective was to be implemented. The Active Treatment Schedule included the following:</p> <p>7:00 - 10:00 a.m.: Get out of bed, shower, grooming, oral care, self-administration of medication, hygiene, communication, eat breakfast (self-feeding and follow dietary guidelines) and clean up.</p> <p>12:00 - 2:00 p.m.: Hygiene, prepare lunch, eat lunch (self-feeding and follow dietary guidelines), clean up (household task), medical desensitization, and leisure.</p> <p>2:00 - 3:00 p.m.: Communication and leisure.</p> <p>3:00 - 5:00 p.m.: PT program, communication, hygiene, sensory and leisure.</p>	W 250		

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W 250	<p>Continued From page 93</p> <p>5:00 - 6:45 p.m.: Prepare dinner, eat dinner (self-feeding and follow dietary guidelines) and clean up (household task).</p> <p>6:45 - 8:00 p.m.: Community access, money management and leisure.</p> <p>8:00 - 10:00 p.m.: Self-administration of medication, oral care and "Go to be when ready."</p> <p>As stated, it was possible for Individual #1 to engage in showering during the 7:00 - 10:00 a.m. time block, and then be in the bath during the 12:00 - 2:00 p.m. time block, the 2:00 - 3:00 p.m. time block, the 3:00 - 5:00 p.m. time block, and the 6:45 - 8:00 p.m. time block.</p> <p>c. Individual #1's IPP also included a Sleep Hygiene Service plan, dated 6/6/16, A Supervision while taking a bath Service plan, revised 9/29/15, and a toileting training plan, revised 7/7/16. However, his Active Treatment Schedule did not include information related to implementing the plans.</p> <p>During an interview on 8/15/16 beginning at 1:00 p.m., the Leadworker reviewed Individual #1's Active Treatment Schedule and stated Individual #1 did "way more" than what was included on the schedule.</p> <p>The facility failed to ensure Individual #1's Active Treatment Schedule was sufficiently developed to direct the staff in the implementation of his active treatment program.</p> <p>2. Individual #4's IPP, dated 8/11/15, documented a 65 year old female whose diagnoses included profound intellectual disability.</p>	W 250		

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W 250	<p>Continued From page 94</p> <p>Her record contained an Occupational Therapy Report, dated 5/25/16, that had a recommendation that stated "Build swinging into her schedule throughout the day to meet her increased vestibular stimulation needs."</p> <p>However, her Active Treatment Schedule, undated, had not incorporated scheduled times for her to be on the swing.</p> <p>When asked during an interview on 8/15/16 from 1:00 - 4:40 p.m., the QIDP stated Individual #4's active treatment schedule should have been updated.</p> <p>The facility failed to ensure Individual #4's Active Treatment Schedule was sufficiently developed to direct the staff in the implementation of her active treatment program.</p> <p>3. Individual #2's 9/16/15 IPP documented a 67 year old male whose diagnoses included severe intellectual disability, urinary frequency, and a history of anxiety disorder with obsessive compulsive features. His "Weekday Active Treatment Schedule," revised 6/14/16, listed activities in 1 hour to 3 hour time blocks. The schedule was not sufficiently developed to direct the staff in the implementation of Individual #2's active treatment program. Examples included, but were not limited to, the following:</p> <p>a. Individual #2's Social Stories Service plan, dated 6/6/16, stated he was to be assisted to read 2 social stories daily. However, the activity was not included in any time block on his Active Treatment Schedule.</p>	W 250		

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W 250	<p>Continued From page 95</p> <p>b. Individual #2's Active Treatment Schedule stated from 2:00 - 3:00 p.m. he was to engage in the following: community access, money management and leisure. In addition to the 2:00 - 3:00 p.m. time block, community access and money management were also listed on Individual #2's Active Treatment Schedule in the 6:45 - 8:00 p.m. time block.</p> <p>However, Individual #2's IPP included a community access service objective which stated he would be assisted into the community not less than 8 times per month and a money management training objective which stated he would hand the cashier his payment in 3 out of 4 trials per month. Although the activities were listed in the 2:00 - 3:00 p.m. time and the 6:45 - 8:00 p.m. time block Monday - Friday, Individual #2 did not engage in the programming at that frequency.</p> <p>c. Individual #2's Active Treatment Schedule stated from 10:00 a.m. - 12:00 p.m. he was to engage in the following: retirement activities and leisure.</p> <p>Individual #2's IPP included a "Retirement Activities Service" program, revised 9/16/15. The program stated he was to be assisted to participate in retirement activities and instructed staff to find activities, such as going for a walk on the green belt, an Arts and Craft fair, etc. that he may enjoy participating in.</p> <p>However, the "Recreational, Leisure, & Retirement" section of his CFA, revised 8/31/15, stated he would participate in volunteer work sites, community events, spectator sporting events and socials.</p>	W 250		

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W 250	<p>Continued From page 96</p> <p>Individual #2's Retirement Activities Service program and Active Treatment Schedule did not include additional information regarding which activities he was interested in and enjoyed doing.</p> <p>Additionally, Individual #2's Retirement Activities logs did not reflect his stated interventions for that program as follows:</p> <ul style="list-style-type: none"> - The March 2016 log listed a "magazine" activity recorded 6 times, a Meals on Wheels activity recorded 3 times, a "movies" activity recorded once, accounting for 10 of the 23 documented activities. - The April 2016 log listed a "magazine" activity that occurred 3 times, and a Meals on Wheels activity that occurred 2 times accounting for 5 of the 16 documented activities. - May 2016 log listed a Meals on Wheels activity that occurred 6 times and a "magazine" activity that occurred 3 times, accounting for 9 of the 20 documented activities. - June 2016 log listed a Meals on Wheels activity that occurred 8 times, a "relaxed on the patio" activity that occurred 2 times, a "ate lunch on the patio" 1 time, and a "magazine" activity 1 time, accounting for 12 of the 18 documented activities <p>It was not clear which activities constituted "Retirement Activities" in accordance with his Activities Service program.</p> <p>Further, Individual #2's IPP included a service objective which stated he would participate in leisure activities daily. The corresponding</p>	W 250			

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W 250	<p>Continued From page 97</p> <p>"Leisure Activities Service" program, revised 9/16/15 stated he was to be assisted to participate in leisure activities such as TV, van ride, looking at magazines, sitting outside and having coffee.</p> <p>The plan did not give additional information related to what, if anything, Individual #2 was to be engaged in when he went on a van ride or was sitting outside.</p> <p>However, the "Activity Profile" section of his CFA, revised 8/31/15, stated he would participate in movies, field trips, walks, TV/videos, community activities, and books/magazines.</p> <p>His CFA likes and interests were not consistently reflected in either the leisure activities service plan or his Active Treatment Schedule, which included leisure activities in the 10:00 a.m. - 12:00 p.m. time block listed above, the 2:00 - 3:00 p.m. time block, and the 6:45 - 8:00 p.m. time block.</p> <p>When asked about Individual #2's Retirement Activities Service program and the Leisure Activities Service program, during an interview on 8/15/16 beginning at 1:00 p.m., the QIDP stated he participated in the Meals on Wheels as a part of his retirement activities. In addition, she stated Meals on Wheels was not listed on his IPP or Retirement Activities Service program. The QIDP also stated that his retirement activities should be done out of the home, so looking at magazines, or being out on the patio at home should not be considered his retirement activity.</p> <p>However, Individual #2's service objectives and Active Treatment Schedule did not provide</p>	W 250			

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W 250	Continued From page 98 clarification regarding the activities Individual #2 was to be engaged in.	W 250			
W 252	The facility failed to ensure Individual #2's Active Treatment Schedule was sufficiently developed to direct the staff in the implementation of his active treatment program. 483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure sufficient data was collected to determine the efficacy of intervention strategies for 2 of 4 individuals (Individuals #1 and #2) whose program data was reviewed. That failure had the potential to impede the ability of the IDT in evaluating the effectiveness of programmatic techniques. The findings include: 1. Individual #1's 9/29/15 IPP stated he was a 55 year old male whose diagnoses included severe intellectual disability and autism spectrum disorder. a. Individual #1's record included a Behavior Intervention Plan, revised 4/11/16, for self-injurious behavior, defined as "...hitting his head against walls or doors, hitting/slapping his head hard enough to leave a red mark or the general public would perceive painful [sic], biting	W 252		9/20/16	

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W 252	<p>Continued From page 99</p> <p>his fingers, poking his chest, or repetitively hitting his shin with the other heel, or hitting his arm on an object, all causing a visible injury." Individual #1's plan stated staff were to offer interventions, which included the following:</p> <ul style="list-style-type: none"> - If Individual #1 was engaged in head hitting, staff were to "deflect and redirect his hurtful attempts." - If Individual #1 engaged in attempts to bite his fingers, poke his chest, hit his shin with his other foot, and/or hit his arm on an object, staff were to ask him to stop. If he did not, staff were to ""deflect and redirect his hurtful attempts." <p>The program stated staff were to document on an ABC form each time Individual #1 engaged in self-injurious behavior.</p> <p>Individual #1's ABC data from April 2016 - July 2016 was reviewed. The data did not provide sufficient information related to Individual #1's maladaptive behavior, or staff's response, to evaluate the efficacy of the program. Examples included, but were not limited to, the following:</p> <ul style="list-style-type: none"> - 7/5/16 at 10:35 a.m.: staff documented "We were picking up the food for Meals on Wheels. [Individual #1] was in bed, acting ok." <p>It antecedent events were not clear.</p> <p>Staff documented "...[Individual #1] got extremely agitated, staff tried to redirect and do some sensory with him. He hit his head 46x within a half hour, screaming - yelling, biting his finger. Staff called [Program Supervisor] and took him back home. [Individual #1] seems to not be</p>	W 252		
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W 252	<p>Continued From page 100 feeling good today. In bed a lot [sic] and sleeping."</p> <p>The response to the behavior section of the form stated "redirect (-)...sensory (-)...bring back home (+)."</p> <p>The documentation did not provide information related to which interventions were used for which behaviors, which sensory items were attempted, at what point each intervention was attempted, or Individual #1's response to the interventions. Further, there was no indication that Individual #1's head hits were "deflected" to ensure his was protected from self-harm.</p> <p>- 7/31/16 at 3:00 p.m.: staff documented in the events before the behavior section that "When we came on shift they told us [Individual #1] has a red mark on cheek." The behavior section of the form stated "[Individual #1] was aggitiated [sic] and continued to hit his [left] cheek 18x and deflect and redirect 15x." The response to the behavior section of the form stated "redirect...sensory...warm bath and clothes."</p> <p>The documentation did not provide information related to which sensory items were attempted, when they were attempted, or what Individual #1's response was.</p> <p>Additionally, a Health Status Report, dated 4/21/16 at 8:00 a.m. stated Individual #1 had a sore and swelling behind his left ear, a sore on the knuckle of his left middle finger, and egg sized bruise on the right of his chest and a small 2 cm bruise on top of his right foot.</p> <p>An ABC form, dated 4/21/16 at 8:00 a.m.</p>	W 252		

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W 252	<p>Continued From page 101</p> <p>documented the injuries were noticed while Individual #1 was in the shower and that "Yesterday he was engaging in SIB behaviors." The form documented "Yesterday [Individual #1] was aggitated [sic] - hitting himself he has a history of SIB injuries that match the sore on his head..."</p> <p>However, an ABC report from 4/20/16, when the actual behaviors occurred, could not be found.</p> <p>Without sufficient documentation the facility would not be able to demonstrate staff were appropriately implementing Individual #1's Behavior Intervention Plan or evaluate the effectiveness of the plan.</p> <p>b. Individual #1's record included a Behavior Intervention Plan, revised 4/11/16, for socially offensive behavior, defined as "...spitting and/or rubbing it on objects or himself and urinating in inappropriate places. Individual #1's plan stated staff were to offer interventions, which included the following:</p> <p>If Individual #1 urinated in an inappropriate area, staff were to "Cue [Individual #1] to stop and use the restroom." Once he had finished urinating, staff were to have him clean the area that he urinated on.</p> <p>The program stated staff were to document on an ABC form each time Individual #1 engaged in socially offensive behavior.</p> <p>Individual #1's ABC data for April 2016 - July 2016 was reviewed. The data did not provide sufficient information related to Individual #1's maladaptive behavior, or staff's response, to evaluate the</p>	W 252			

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W 252	<p>Continued From page 102 efficacy of the program. Examples included, but were not limited to, the following:</p> <ul style="list-style-type: none"> - 7/4/16 at 8:55 p.m.: the description of the behavior section stated he was incontinent and staff assisted him with clean up. Assisted with clean up was also documented in the response to the behavior section. No other information, such as what happened before the behavior was present on the form. - 7/29/16 at 6:00 a.m.: the setting event section of the form stated "[Individual #1] was wet." No other information, such as what happened after the behavior was present on the form. - 7/30/16 at 6:00 a.m.: the setting event section of the form stated "Woke up wet." No other information, such as what happened after the behavior was present on the form. <p>During an interview on 8/15/16 beginning at 1:00 p.m., the QIDP stated all sections of the ABC sheets were to be completed.</p> <p>The facility failed to ensure Individual #1's ABC data provided sufficient information to evaluate the efficacy of his Behavior Intervention Plan.</p> <p>2. Individual #2's 9/16/15 IPP documented a 67 year old male whose diagnoses included severe intellectual disability, urinary frequency, and a history of anxiety disorder with obsessive compulsive features.</p> <p>a. Individual #2's record included a Behavior Intervention Plan, revised 9/16/15, for physical aggression, defined as hitting others and/or throwing objects towards them. The plan stated</p>	W 252		

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W 252	<p>Continued From page 103</p> <p>staff were to offer interventions, which included the following:</p> <ul style="list-style-type: none"> - If Individual #2 hit with his hands, staff were to block the attempt and redirect him to his next scheduled activity. - If he became aggressive toward others, staff were to step in between Individual #2 and the person he was attempting to assault. Staff were to ask for another staff member to remove the person Individual #2 was attempting to assault, then redirect Individual #2 to his next scheduled activity. The plan stated if he could not be redirected, staff were to prompt him to take a break. <p>The program stated staff were to document on an ABC form each time Individual #2 engaged in physical aggression.</p> <p>Individual #2's ABC data from 6/2/16 - 7/23/16 was reviewed. The data did not provide sufficient information related to Individual #2's maladaptive behavior, or staff's response, to evaluate the efficacy of the program. Examples included, but were not limited to, the following:</p> <ul style="list-style-type: none"> - 7/23/16 at 5:00 p.m.: staff documented Individual #2 hit staff after being cued to resume a task and stated antecedent events were "possibly tired or overcued [sic]." <p>Antecedent events were not clear. There was no indication of how many times he was cued or why he was perceived as being "possibly tired."</p> <p>Staff documented they "gave space" and "redirection" for interventions or responses to the</p>	W 252			

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W 252	<p>Continued From page 104 behavior.</p> <p>The methods of how staff "gave space" and "redirected" (e.g., what type of redirection was implemented such as asking him to stop, providing an alternate task, etc.) was not clear.</p> <p>b. Individual #2's record included a Behavior Intervention Plan, revised 9/16/15, for self-injurious behavior, defined as picking his skin to the point of tissue damage, or slapping (hitting) his head. The plan stated staff were to offer interventions, which included the following:</p> <ul style="list-style-type: none"> - If Individual #2 was picking at his skin, staff were to redirect him to his program to put lotion on his hands or redirect to the next scheduled activity. The plan stated if he could not be redirected, staff were to prompt him to take a break. - If Individual #2 hit his head, staff were to ask him to stop, assess if he was having pain, and if needed provide soft surface to block direct head hits (pillow or hand). The plan stated staff were to then redirect him to his next scheduled activity. If he could not be redirected, staff were to prompt him to take a break. <p>The program stated staff were to document on an ABC form each time Individual #2 engaged in self-injurious behavior.</p> <p>Individual #2's ABC data from 6/2/16 - 7/23/16 was reviewed. The data did not provide sufficient information related to Individual #2's maladaptive behavior, or staff's response, to evaluate the efficacy of the program. Examples included, but were not limited to, the following:</p>	W 252			

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W 252	<p>Continued From page 105</p> <p>- 6/5/16 at 4:00 p.m.: staff documented Individual #2 hit his forehead twice in his bathroom and staff noticed incontinence on his clothing at that time. What happened prior to the behavior was documented as "sitting on couch."</p> <p>Three section of the form were blank, including sections that were intended to describe positive prevention and intervention techniques used, setting events that may have lead to the behavior, and antecedent events occurring immediately before the behavior.</p> <p>- 7/17/16 at 4:05 p.m.: staff documented Individual #2 hit his forehead once on the toilet. Under the section to describe what happened before the behavior staff documented "ATS."</p> <p>There was no other description of what type of activity Individual #2 was engaged in prior to the behavior.</p> <p>Staff documented interventions taken were pain medication administered, neurological check done, and "checked every 15 mins [sic]."</p> <p>There was no further description of the interventions that were implemented (e.g., what was checked every 15 minutes, how he exhibiting symptoms of pain, if any, etc.).</p> <p>During an interview on 8/15/16 beginning at 1:00 p.m., the QIDP stated all sections of the ABC sheets were to be completed.</p> <p>The facility failed to ensure Individual #2's ABC data provided sufficient information to evaluate the efficacy of his Behavior Intervention Plan.</p>	W 252		

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W 255	<p>483.440(f)(1)(i) PROGRAM MONITORING & CHANGE</p> <p>The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on policy and record review, and staff interview, it was determined the facility failed to ensure programs were revised as appropriate for 2 of 4 individuals (Individual #1 and #4) whose IPPs and program revisions were reviewed. This resulted in individuals continuing to receive formal training on objectives they had successfully completed. The findings include:</p> <p>The facility's Active Treatment/Growth and Development policy, revised 7/1/16, stated "The Individual Program Plan will be reviewed by the QIDP and Monthly Summaries completed by the 10th of each month (all revisions are to be completed by the end of the month), including, but not limited to situations in which the individual: ...Has successfully completed an objective or objectives identified in the Individual Program Plan."</p> <p>The policy was not implemented, as follows:</p> <p>1. Individual #1's 9/29/15 IPP stated he was a 55 year old male whose diagnoses included severe intellectual disability and autism spectrum disorder.</p> <p>a. Individual #1's ADL programs stated staff were to follow the prompt hierarchy in order to assist him to complete the tasks identified in the</p>	W 255		9/20/16	

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W 255	<p>Continued From page 107 objectives. The prompt hierarchy specified in Individual #1's programs included the following:</p> <p>SI - Self initiate G - Gesture NV - Non-Specific Verbal SV - Specific Verbal LP - Light Physical FP - Full Physical R - Resident refuses</p> <p>Individual #1's QIDP summaries, dated 9/2015 - 7/2016, were reviewed. The summaries documented Individual #1 met criteria on established objectives without program revisions being made that were reflective of his demonstrated ability. Examples included, but were not limited to, the following:</p> <p>i. Individual #1's IPP included a communication objective which stated he would "...select a desired event/object by grabbing it when given a choice of 3 event/objects with a non-specific verbal prompt in 10 out of 12 trials per month for three consecutive months."</p> <p>Individual #1's QIDP monthly data summary for November 2015 stated he had met criteria for the objective and the prompt level would be revised to a gesture prompt.</p> <p>Individual #1's raw communication data was reviewed and documented he could complete the task, as follows:</p> <p>September 2015: Individual #1 self-initiated completing the task in 13 out of 13 documented trials.</p>	W 255			

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W 255	<p>Continued From page 108</p> <p>October 2015: Individual #1 self-initiated completing the task in 12 out of 12 documented trials.</p> <p>November 2015: Individual #1 self-initiated completing the task in 12 out of 12 documented trials.</p> <p>However, the QIDP summaries did not include information regarding why the prompt level was revised to a gestural prompt when Individual #1 had demonstrated he could complete the task independently.</p> <p>Additionally, Individual #1's QIDP monthly data summary for February 2016 stated he had met criteria for the objective and the prompt level would be revised to self-initiate.</p> <p>Individual #1's raw communication data was reviewed and documented he could complete the task, as follows:</p> <p>December 2015: Individual #1 self-initiated completing the task in 12 out of 12 documented trials.</p> <p>January 2016: Individual #1 self-initiated completing the task in 12 out of 12 documented trials.</p> <p>February 2016: Individual #1 self-initiated completing the task in 12 out of 12 documented trials.</p> <p>However, the QIDP summaries did not include information regarding why the prompt level was revised to self-initiation when Individual #1 had demonstrated self-initiated completion in 100% of</p>	W 255			

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W 255	<p>Continued From page 109 the documented trials for 6 consecutive months.</p> <p>ii. Individual #1's IPP included an objective for desensitization to medical procedures. The objective stated he would sit in a kitchen chair and "...leave his shoes on for 1 continuous minute with a non-specific verbal prompt in 10 of 12 trials per month for three consecutive months."</p> <p>Individual #1's QIDP monthly data summary for November 2015 stated he had met criteria on the objective and the prompt level would be revised to a gestural prompt.</p> <p>Individual #1's raw data for the objective was reviewed and documented he could complete the task, as follows:</p> <p>September 2015: Individual #1 required 1 specific verbal prompt, 2 gestural prompts and self-initiated completing the task 11 times of the 14 documented trials.</p> <p>October 2015: Individual #1 self-initiated completing the task in 12 out of 12 documented trials.</p> <p>November 2015: Individual #1 self-initiated completing the task in 12 out of 12 documented trials.</p> <p>However, the QIDP summaries did not include information regarding why the prompt level was revised to a gestural prompt when Individual #1 had demonstrated he could complete the task independently.</p> <p>Additionally, Individual #1's QIDP monthly data summary for February 2016 stated he had met</p>	W 255			

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W 255	<p>Continued From page 110</p> <p>criteria for the objective and the prompt level would be revised to self-initiate.</p> <p>Individual #1's raw data for the objective was reviewed and documented he could complete the task, as follows:</p> <p>December 2015: Individual #1 required 1 specific verbal prompt and self-initiated completing the task 11 times of the 12 documented trials.</p> <p>January 2016: Individual #1 required 1 specific verbal prompt, 1 gestural prompt, and self-initiated completing the task 10 times of the 12 documented trials.</p> <p>February 2016: Individual #1 required 2 gestural prompts and self-initiated completing the task 10 times of the 12 documented trials.</p> <p>However, the QIDP summaries did not include information regarding why the prompt level was revised to self-initiation in 10 of 12 trials per month for three consecutive months, when Individual #1 had previously demonstrated his ability to meet the goal for the past 6 consecutive months.</p> <p>iii. Individual #1's 9/29/15 IPP included an objective for choosing his socks prior to going to bed with a non-specific verbal prompt.</p> <p>Individual #1's QIDP monthly data summary for November 2015 stated he had met criteria for the objective and the prompt level would be revised to a gesture prompt.</p> <p>Individual #1's raw dressing data was reviewed and documented he could complete the task, as</p>	W 255			

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W 255	<p>Continued From page 111 follows:</p> <p>September 2015: Individual #1 required 1 non-specific verbal prompt and self-initiated completing the task 13 times of the 14 documented trials.</p> <p>October 2015: Individual #1 self-initiated completing the task in 12 out of 12 documented trials.</p> <p>November 2015: Individual #1 required 2 gestural prompts and self-initiated completing the task 10 times of the 12 documented trials.</p> <p>However, the QIDP summaries did not include information regarding why the prompt level was revised to a gestural prompt when Individual #1 had demonstrated he could complete the task independently.</p> <p>Additionally, Individual #1's QIDP monthly data summary for February 2016 stated he had met criteria for the objective and the prompt level would be revised to self-initiate.</p> <p>Individual #1's raw dressing data was reviewed and documented he could complete the task, as follows:</p> <p>December 2015: Individual #1 self-initiated completing the task in 12 out of 12 documented trials.</p> <p>January 2016: Individual #1 required 1 gestural prompt and self-initiated completing the task 11 times of the 12 documented trials.</p> <p>February 2016: Individual #1 required 2 gestural</p>	W 255			

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W 255	<p>Continued From page 112</p> <p>prompts and self-initiated completing the task 10 times of the 12 documented trials.</p> <p>However, the QIDP summaries did not include information regarding why the prompt level was revised to self-initiation in 10 of 12 trials per month for three consecutive months, when Individual #1 had previously demonstrated his ability to meet the goal for the past 6 consecutive months.</p> <p>When asked, during an interview on 8/15/16 beginning at 1:00 p.m., the QIDP stated programs should be revised to reflect actual performance.</p> <p>b. Individual #1's behavior program data summaries and QIDP progress notes were reviewed. The notes did not include documentation that objectives were revised as appropriate, as follows:</p> <p>i. Individual #1's IPP included an objective which stated he would "...reduce his self-stimulating behavior to 1185 or less per month for six consecutive months."</p> <p>Individual #1's QIDP monthly data summary for February 2016 stated Individual #1 had met criteria and the objective criteria would be revised. However, his March 2016 QIDP month data summaries stated "This was the 7th consecutive month that [Individual #1] was able to meet criteria. Therefore, I will revise the criteria."</p> <p>The QIDP failed to ensure Individual #1's objective was revised in a timely manner.</p> <p>Further, Individual #1's IPP documented the objective was revised on 4/11/16 to extend the</p>	W 255			

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W 255	<p>Continued From page 113</p> <p>criteria to 12 consecutive months. Individual #1's QIDP monthly summaries documented he had engaged in self-stimulatory behaviors at the following rates:</p> <p>October 2015: 662 times. November 2015: 509 times. December 2015: 793 times. January 2016: 664 times. February 2016: 687 times. March 2016: 729 times.</p> <p>However, the QIDP summaries did not include information regarding why the number of consecutive months was extended rather than a reduction in the number of episodes based on his current status.</p> <p>ii. Individual #1's IPP included an objective which stated he would "...reduce his socially offensive behavior to 10 or less per month for six consecutive months."</p> <p>Individual #1's QIDP monthly data summary for February 2016 stated Individual #1 had met criteria and the objective criteria would be revised. However, his March 2016 QIDP month data summaries stated "This was the 7th consecutive month that [Individual #1] was able to meet criteria. Therefore, I will revise the criteria."</p> <p>The QIDP failed to ensure Individual #1's objective was revised in a timely manner.</p> <p>Further, Individual #1's IPP documented the objective was revised on 4/11/16 to extend the criteria to 12 consecutive months. Individual #1's QIDP monthly summaries documented he had engaged in socially offensive behaviors at the</p>	W 255		

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W 255	<p>Continued From page 114 following rates:</p> <p>October 2015: 0 times. November 2015: 0 times. December 2015: 0 times. January 2016: 0 times. February 2016: 2 times. March 2016: 2 times.</p> <p>However, the QIDP summaries did not include information regarding why the number of consecutive months was extended rather than a reduction in the number of episodes based on his current status.</p> <p>When asked, during an interview on 8/15/16 beginning at 1:00 p.m., the QIDP stated she did not believe the data was accurate.</p> <p>However, no additional information was found in the QIDP monthly summary notes which reflected the QIDP rational for extending the criteria on the objectives, given her belief that the data was not accurate.</p> <p>The QIDP failed to ensure Individual #1's objectives were revised based on his actual performance.</p> <p>2. Individual #4's IPP, dated 8/11/15, documented a 65 year old female whose diagnoses included profound intellectual disability.</p> <p>Individual #4's QIDP summaries, dated 9/2015 - 7/2016, were reviewed. The summaries documented Individual #4 met criteria on established objectives without program revisions being made that were reflective of her demonstrated ability. Examples included, but</p>	W 255		

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W 255	<p>Continued From page 115 were not limited to, the following:</p> <p>a. Individual #4's IPP included an oral care objective which stated she would "...hand the toothpaste to staff with a non-specific verbal prompt 10 of 12 trials per month for three consecutive months."</p> <p>Individual #4's raw oral care data was reviewed and documented she could complete the task, as follows:</p> <p>November 2015: Individual #4 self-initiated completing the task in 11 of the 12 documented trials.</p> <p>December 2015: Individual #4 self-initiated completing the task in 12 out of 12 documented trials.</p> <p>January 2016: Individual #4 self-initiated completing the task in 12 out of 12 documented trials.</p> <p>February 2016: Individual #4 self-initiated completing the task in 12 out of 12 documented trials.</p> <p>However, the QIDP summaries did not include information regarding why the prompt level was revised to a gestural prompt when Individual #4 had demonstrated she could complete the task independently.</p> <p>b. Individual #4's IPP included a communication objective which stated "When given a 2 choice selection with real object manipulatives, [Individual #4] will make a choice by grabbing the item with a non-specific verbal prompt 10 of 12</p>	W 255		

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W 255	<p>Continued From page 116 trials per month for three consecutive months."</p> <p>Individual #4's QIDP monthly data summary for February 2016 stated she had met criteria for the objective and the prompt level would be revised to a gesture prompt.</p> <p>Individual #4's raw communication data was reviewed and documented she could complete the task, as follows:</p> <p>November 2015: Individual #4 self-initiated completing the task in 12 out of 12 documented trials.</p> <p>December 2015: Individual #4 self-initiated completing the task in 12 out of 12 documented trials.</p> <p>January 2016: Individual #4 self-initiated completing the task in 12 out of 12 documented trials.</p> <p>February 2016: Individual #4 self-initiated completing the task in 12 out of 12 documented trials.</p> <p>However, the QIDP summaries did not include information regarding why the prompt level was revised to a gestural prompt when Individual #4 had demonstrated she could complete the task independently.</p> <p>c. Individual #4's IPP included a Hygiene objective which stated "[Individual #4] will raise her right arm non-specific verbal prompt 10 of 12 trials per month for three consecutive months."</p> <p>Individual #4's QIDP monthly data summary for</p>	W 255			

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W 255	<p>Continued From page 117</p> <p>February 2016 stated her prompt level had been revised to non-specific verbal as she had met criteria for the specific verbal prompt level.</p> <p>Individual #4's raw hygiene data was reviewed and documented she could complete the task, as follows:</p> <p>November 2015: Individual #4 self-initiated completing the task in 12 out of 12 documented trials.</p> <p>December 2015: Individual #4 self-initiated completing the task in 11 out of 12 documented trials.</p> <p>January 2016: Individual #4 self-initiated completing the task in 12 out of 12 documented trials.</p> <p>February 2016: Individual #4 self-initiated completing the task in 12 out of 12 documented trials.</p> <p>However, the QIDP summaries did not include information regarding why the prompt level was revised to a non-specific verbal prompt from a specific verbal prompt when Individual #4 had demonstrated she could complete the task independently.</p> <p>When asked, during an interview on 8/15/16 beginning at 1:00 p.m., the QIDP stated programs should be revised to reflect actual performance.</p> <p>The QIDP failed to ensure Individual #4's objectives were revised based on her actual performance.</p>	W 255			

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W 255	<p>Continued From page 118</p> <p>3. Individual #2's 9/16/15 IPP documented a 67 year old male whose diagnoses included severe intellectual disability, urinary frequency, and a history of anxiety disorder with obsessive compulsive features.</p> <p>Individual #2's QIDP summaries, dated 9/2015 - 7/2016, were reviewed. The summaries documented Individual #2 met criteria on established objectives without program revisions being made that were reflective of his demonstrated ability. Examples included, but were not limited to, the following:</p> <p>a. Individual #2's IPP included a laundry objective which stated he would "...put his dirty clothes in the washer with a light physical prompt 10 of 12 trials per month for three consecutive months."</p> <p>Individual #2's QIDP monthly data summary for December 2015 stated he had met criteria for the objective and the prompt level would be revised to a specific verbal prompt.</p> <p>Individual #2's raw laundry data was reviewed and documented he could complete the task, as follows:</p> <p>October 2015: Individual #2 self-initiated completing the task in 12 out of 12 documented trials.</p> <p>November 2015: Individual #2 self-initiated completing the task in 12 out of 12 documented trials.</p> <p>December 2015: Individual #2 required 1 specific verbal prompt and self-initiated completing the task 11 times of the 12 documented trials.</p>	W 255			

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W 255	<p>Continued From page 119</p> <p>However, the QIDP summaries did not include information regarding why the prompt level was revised to a specific verbal prompt when Individual #2 had demonstrated he could complete the task independently.</p> <p>Individual #2's QIDP monthly data summary for March 2016 stated he had met criteria for the objective and the prompt level would be revised to a gestural prompt.</p> <p>Individual #2's raw laundry data was reviewed and documented he could complete the task, as follows:</p> <p>January 2016: Individual #2 required 1 gestural prompt and self-initiated completing the task 11 times of the 12 documented trails.</p> <p>February 2016: Individual #2 required 1 gestural prompt and self-initiated completing the task 11 times of the 12 documented trails.</p> <p>March 2016: Individual #2 required 1 gestural prompt and self-initiated completing the task 11 times of the 12 documented trails.</p> <p>However, the QIDP summaries did not include information regarding why the prompt level was revised to a gestural prompt when Individual #2 had demonstrated he could complete the task independently.</p> <p>Individual #2's QIDP monthly data summary for June 2016 stated he had met criteria for the objective and the prompt level would be revised to self-initiate.</p>	W 255		

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W 255	<p>Continued From page 120</p> <p>However, the QIDP summaries did not include information regarding why the prompt level was revised to self-initiation when Individual #2 had demonstrated self-initiated completion for 6 consecutive months.</p> <p>b. Individual #2's IPP included a meal prep objective which stated he would "... put a scoop of coffee in the coffee filter with a light physical prompt in 10 of 12 trials per month for three consecutive months."</p> <p>Individual #2's QIDP monthly data summary for November 2015 stated he had met criteria for the objective and the prompt level would be revised to a specific verbal prompt.</p> <p>Individual #2's raw meal prep data was reviewed and documented he could complete the task, as follows:</p> <p>October 2015: Individual #2 self-initiated completing the task in 12 out of 12 documented trials.</p> <p>November 2015: Individual #2 self-initiated completing the task in 12 out of 12 documented trials.</p> <p>However, the QIDP summaries did not include information regarding why the prompt level was revised to a specific verbal prompt when Individual #2 had demonstrated he could complete the task independently.</p> <p>Individual #2's QIDP monthly data summary for February 2016 stated he had met criteria for the objective and the prompt level would be revised to self-initiate.</p>	W 255		

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W 255	Continued From page 121 Individual #2's raw meal prep data was reviewed and documented he could complete the task, as follows: December 2015: Individual #2 self-initiated completing the task in 12 of the 12 documented trials. January 2016: Individual #2 self-initiated completing the task in 12 of the 12 documented trails. February 2016: Individual #2 self-initiated completing the task in 12 of the 12 documented trails. However, the QIDP summaries did not include information regarding why the prompt level was revised to self-initiation when Individual #2 had demonstrated self-initiated completion for 5 consecutive months. When asked, during an interview on 8/15/16 beginning at 1:00 p.m., the QIDP stated programs should be revised to reflect actual performance. The QIDP failed to ensure Individual #2's objectives were revised based on his actual performance.	W 255			
W 259	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed.	W 259		9/20/16	

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W 259	<p>Continued From page 122</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure assessments were updated as needed for 2 of 4 individuals (Individuals #1 and #4) whose assessments were reviewed. This resulted in assessment information which was not reflective of individuals' actual performance. The findings include:</p> <p>1. Individual #1's 9/29/15 IPP stated he was a 55 year old male whose diagnoses included severe intellectual disability and autism spectrum disorder.</p> <p>Individual #1's CFA, revised 9/17/15, was reviewed and had not been revised to reflect his current status. Examples included, but were not limited to, the following:</p> <p>a. Individual #1's IPP included a self-administration of medication objective which stated he would "...punch out 1 of his medications for the day with a non-specific verbal prompt in 10 of 12 trials per month for three consecutive months."</p> <p>Individual #1's QIDP monthly data summary for January 2016 stated he had met criteria for the objective and the prompt level would be revised to a gesture prompt. However, his CFA was not updated to reflect the change until 7/7/16.</p> <p>b. Individual #1's IPP included a showering objective which stated he would "...apply the shampoo to his head with a light physical prompt in 10 of 12 trials per month for three consecutive months."</p>	W 259		
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W 259	<p>Continued From page 123</p> <p>His QIDP monthly data summary for December 2015 stated he had met criteria on the objective and the prompt level would be revised to a specific verbal prompt. Additionally, his QIDP monthly data summary for March 2016 stated he had again met criteria on the objective and the prompt level would be revised to a gestural prompt.</p> <p>However, his CFA was not updated to reflect his progress until 7/7/16.</p> <p>c. Individual #1's IPP included a grooming objective which stated he would "...apply deodorant with a light physical prompt in 10 of 12 trials per month for three consecutive months."</p> <p>Individual #1's QIDP monthly data summary for December 2015 stated he had met criteria on the objective and the prompt level would be revised to a specific verbal prompt. Additionally, his QIDP monthly data summary for March 2016 stated he had again met criteria on the objective and the prompt level would be revised to a non-specific verbal prompt.</p> <p>However, his CFA was not updated to reflect his progress until 7/7/16.</p> <p>d. Individual #1's IPP included an objective which stated he would follow a 2 step direction while delivering Meals on Wheels, with a light physical prompt.</p> <p>Individual #1's QIDP monthly data summary for December 2015 stated he had met criteria for the program and the prompt level would be revised to a specific verbal prompt. Further, his QIDP monthly data summary for March 2016 stated he</p>	W 259			

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W 259	<p>Continued From page 124</p> <p>had again met criteria and the prompt level would be revised to a non-specific verbal prompt.</p> <p>However, his CFA was not updated to reflect his progress until 7/7/16.</p> <p>e. Individual #1's IPP included an Oral Care objective which stated he was to "...place a small amount of toothpaste on his toothette with a light physical prompt.."</p> <p>His QIDP monthly data summary for November 2015 stated he had met criteria on the objective and the prompt level would be revised to a specific verbal prompt. Additionally, his QIDP monthly data summary for May 2016 stated he had again met criteria on the objective and the prompt level would be revised to a gestural prompt.</p> <p>However, his CFA was not updated to reflect his progress.</p> <p>When asked, during an interview on 8/15/16 beginning at 1:00 p.m., Program Manager B stated individuals' CFAs should be updated as they progressed.</p> <p>2. Individual #4's IPP, dated 8/11/15, documented a 65 year old female whose diagnoses included profound intellectual disability.</p> <p>Individual #4's CFA, revised 8/6/15, was reviewed and had not been revised to reflect her current status. Examples included, but were not limited to, the following:</p> <p>a. Individual #4's IPP included a oral care objective which stated she would "...hand the</p>	W 259		

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W 259	<p>Continued From page 125</p> <p>toothpaste to staff with a non-specific verbal prompt 10 of 12 trials per month for 3 consecutive months."</p> <p>Individual #4's QIDP monthly data summary for February 2016 documented she had met criteria for the objective and the prompt level would be revised to a gesture prompt. However, her CFA had not been updated to reflect the change until 7/7/16.</p> <p>b. Individual #4's IPP included a Hygiene 1 objective that stated "[Individual #4] will raise her right arm with a non-specific verbal prompt so staff can apply her deodorant in 10 of 12 trials per month for 3 consecutive months."</p> <p>Individual #4's QIDP monthly data summary for February 2016 documented her current prompt level was a non-specific verbal prompt. However, her CFA, updated 7/7/16, documented she required a specific verbal prompt.</p> <p>c. Individual #4's IPP included a Bathing objective that stated "[Individual #4] will wet the wash cloth with a non-specific verbal prompt in 10 of 12 trials per month for 3 consecutive months."</p> <p>Individual #4's QIDP monthly data summary for February 2016 documented her current prompt level was a non-specific verbal prompt. However, her CFA, updated 7/7/16, documented she required a light physical prompt.</p> <p>When asked, during an interview on 8/15/16 from 1:00 - 4:40 p.m., Program Manager B stated individuals' CFAs should be updated as they progressed.</p>	W 259			

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W 289 W 289	Continued From page 126 483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure techniques used to manage inappropriate behavior were sufficiently incorporated into the program plans for 2 of 3 individuals (Individuals #1 and #2) whose behavior interventions were reviewed. This resulted in a lack of appropriate interventions being in place to ensure individuals' behavioral needs were met. The findings include: 1. Individual #2's 9/16/15 IPP documented a 67 year old male whose diagnoses included severe intellectual disability, urinary frequency, and a history of anxiety disorder with obsessive compulsive features. Individual #2's Behavior Intervention Plans were reviewed. The plans did not include sufficient information to staff, as follows: a. Individual #2's 8/12/15 behavior assessment stated he engaged in physical aggression, exhibited by hitting others and throwing objects towards them. i. The assessment stated his physical aggression "...tends to be his response to loud noises,	W 289 W 289		9/20/16

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W 289	<p>Continued From page 127</p> <p>chaotic environments or when he has soiled his clothes and needs to change them."</p> <p>However, his physical aggression Behavior Intervention Plan, revised 9/16/15, did not include instructions to staff regarding how staff should intervene if Individual #2 engaged in physical aggression when asked to change his clothes.</p> <p>When asked, during an interview on 8/15/16 beginning at 1:00 p.m., the QIDP stated that Individual #2's laundry program was implemented as a way to assist Individual #2 to change out of his soiled clothing, as a way of cuing him to take his soiled clothes off by putting them in the washer.</p> <p>Individual #2's laundry program, revised 7/7/16, contained the objective "[Individual #2] will self-initiate putting his dirty clothes in the washer in 10 of 12 trials per month for three consecutive months."</p> <p>The status section of his laundry program stated, "[Individual #2] will independently take his dirty clothes to the hamper and neatly arranges [sic] his shoes. However, when [Individual #2]'s clothing (pants) are soiled and he needs to change, he gets frustrated and this can lead to him engaging in a maladaptive behavior." The staff notes section stated, "When [Individual #2]'s clothes (pants) are soiled he does not like to change them. This program is a replacement behavior to teach [Individual #2] that it's OK to put his dirty clothes in the washer so they can be clean for him to wear later."</p> <p>However, there were no directions for DCS on how to get Individual #2 to change out of his</p>	W 289			

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W 289	<p>Continued From page 128</p> <p>soiled clothing, or what to do if he refused to change out of his dirty clothes. Further, it was not clear if the program was intended to get him to place the soiled clothes he was currently wearing into the washer or his soiled clothes from his dirty laundry hamper.</p> <p>Additionally, the staff notes section of the laundry program stated, "Before [Individual #2] goes to bed each night, staff will have [Individual #2] put his clothes in the washer."</p> <p>However, there were no directions for DCS on what to do if he needed to change out of his soiled clothing during the day.</p> <p>ii. Individual #2's behavior assessment included an intervention history section which stated asking him to place his hands in his pocket and using lotion on his hands were effective interventions. However, the interventions were not incorporated into Individual #2's behavior intervention plan.</p> <p>iii. Individual #2's behavior intervention plan also stated if Individual #2 was engaging in precursory behaviors to physical aggression, including staring, clenching his jaw, and bending his fingers back, staff were to ask him if he was in pain. The plan stated "[Individual #2] has a formal training program to learn to sign pain when he is having it.</p> <p>However, Individual #2's IPP documented he had met criteria on the objective and it had been discontinued on 7/7/16.</p> <p>iv. Individual #2's behavior intervention plan stated if he threw an object, staff were to try and redirect him to his next scheduled activity. The</p>	W 289		

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W 289	<p>Continued From page 129</p> <p>plan stated "If [Individual #2] can not be redirected, refer to his replacement behavior to take a break."</p> <p>However, his behavior assessment stated his replacement behavior was placing his dirty clothes in the washer.</p> <p>When asked about Individual #2's behavior intervention plan, during an interview on 8/15/16 beginning at 1:00 p.m., the QIDP stated the plan needed to be updated.</p> <p>b. Individual #2's behavior assessment stated he engaged in self-injurious behavior, exhibited by picking his skin to the point of tissue damage, or slapping (hitting) his head.</p> <p>i. The replacement behavior section of the assessment stated Individual #2 would sign "pain" after the sign was modeled by staff and to "see program for prompt level and criteria."</p> <p>However, Individual #2's IPP documented he had met criteria on the objective and it had been discontinued on 12/10/15.</p> <p>ii. The intervention history section of the assessment stated asking him to place his hands in his pockets, was an effective intervention strategy. However, the intervention was not found in his self-injurious behavior intervention plan, revised 9/16/15.</p> <p>iii. The assessment stated events following self-injurious behavior included applying lotion to his hands or providing an item he could fidget with.</p>	W 289			

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W 289	<p>Continued From page 130</p> <p>However, his self-injurious behavior intervention plan, revised 9/16/15, did not include the use of "fidget" items.</p> <p>When asked about Individual #2's behavior intervention plan, during an interview on 8/15/16 beginning at 1:00 p.m., the QIDP stated the plan needed to be updated.</p> <p>2. Individual #1's 9/29/15 IPP stated he was a 55 year old male whose diagnoses included severe intellectual disability and autism spectrum disorder.</p> <p>Individual #1's Behavior Intervention Plans were reviewed. The plans did not include sufficient information to staff, as follows:</p> <p>a. Individual #1's 9/9/15 Functional Behavior Assessment stated he engaged in self-injurious behavior, defined as "...hitting his head against walls or doors, hitting/slapping his head hard enough to leave a red mark or the general public would perceive painful [sic], biting his fingers, poking his chest, or repetitively hitting his shin with the other heel, or hitting his arm on an object, all causing a visible injury."</p> <p>The events that typically follow the behavior section of the assessment stated "Staff engage in sensory or rhythm activities."</p> <p>However, his self-injurious behavior intervention plan, stated staff were to ask him to stop, "deflect and redirect" and ask him to clap his hands. The plan's instructions included a "Replacement behavior" section which directed staff to implement his "sensory activities" plan. However, the plan did not specify when the "Replacement</p>	W 289		
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W 289	<p>Continued From page 131</p> <p>behavior" was to be implemented or if it was to be implemented in response to his self-injurious behavior.</p> <p>b. Individual #1's behavior assessment stated he engaged in self-stimulating behavior, defined as "...hitting/slapping his head without leaving a red mark, biting his fingers, poking his chest, gagging self, or repetitively hitting his shin with the other heel, or hitting his arm on an object, causing no visible injury."</p> <p>i. The events that precede the behavior section of the assessment stated "...Due to concerns related to chronic pain, [Individual #1] was on routine pain medication (Tylenol/Ibuprofen) but they were discontinued in August. However, due to a history of family arthritis and continued concerns related to arthritic pain, in February routine medication was reinstated.</p> <p>However, Individual #1's self-stimulatory behavior intervention plan did not include information to staff regarding assessing for pain or how to intervene if Individual #1 was engaging in the behavior due to experiencing pain.</p> <p>ii. The events that precede the behavior section of the assessment also stated "During unstructured leisure time, change of shift and while waiting for meals, [Individual #1] may engage in self-stimulating behaviors to get the sensory he needs."</p> <p>However, Individual #1's self-stimulatory behavior intervention plan did not include information to staff regarding what to do to assist Individual #1 during change of shift or while he was waiting for meals.</p>	W 289			

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W 289	Continued From page 132 When asked, during an interview on 8/15/16 beginning at 1:00 p.m., if preventative interventions related to transition times should be included in the intervention plan, the QIDP stated "probably."	W 289			
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility failed to ensure comprehensive information was included in Individual #1's behavior intervention plans. The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure adequate general and preventative medical care was provided for 1 of 4 individuals (Individual #4) whose medical records were reviewed. This resulted an individual not receiving an occult blood test as recommended. The findings include: 1. Individual #4's IPP, dated 8/11/15, documented a 65 year old female whose diagnoses included profound intellectual disability. Individual #4's record was reviewed and did not contain documentation she had received an occult blood test. The CDC recommends regular colorectal cancer screening beginning at age 50 and the United States Preventive Services Task Force	W 322		9/20/16	

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W 322	Continued From page 133 recommends screening for colorectal cancer using high-sensitivity fecal occult blood testing beginning at age 50 years and continuing until age 75. When asked during an interview on 8/15/16 from 1:00 - 4:40 p.m., the LPN stated Individual #4 had not received an occult blood test.	W 322			
W 325	The facility failed to ensure individual#4 received an occult blood test as recommended. 483.460(a)(3)(iii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure routine screening laboratory examinations were provided to 1 of 4 individuals (Individual #3) whose laboratory records were reviewed. This resulted in the potential for medical concerns to go undetected. The findings include: 1. Individual #3's IPP, dated 5/20/16, documented he was a 39 year old male whose diagnoses included moderate intellectual disability. His record contained a lab report, dated 6/26/15, which documented he had an elevated prolactin level. The report also had a hand-written note for a follow up level in three months.	W 325		9/20/16	

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W 325	Continued From page 134 However, no follow up prolactin levels could be found in Individual #3's record. Additionally, Individual #3's Physician History and Physical Examination Report, dated 5/2/16, documented "Prolactin monitored Q [once] 3 months done - 6/26/15." During an interview on 8/15/16 from 1:00 - 4:40 p.m., the LPN stated the prolactin levels had not been taken, but should have been. The facility failed to ensure Individual #3 received prolactin lab levels as ordered.	W 325			
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to administer drugs as ordered by the physician for 3 of 4 individuals (Individuals #1 - #3) whose medical records were reviewed. This resulted in individuals not receiving medications in a manner consistent with physician orders. The findings include: 1. Individual #2's 9/16/15 IPP documented a 67 year old male whose diagnoses included severe intellectual disability and a history of anxiety disorder. Individual #2's August 2016 MAR was reviewed and documented he had received Deep Sea	W 368		9/20/16	

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W 368	<p>Continued From page 135</p> <p>nasal spray 0.65%, two spray in each nostril, four times a day from 8/1/16 - 8/16/16.</p> <p>However, when individual #2's Physician's Orders were reviewed, no order for the nasal spray could be found.</p> <p>When asked during an interview on 8/10/16 at 3:20 p.m., the LPN stated there was no physician's order for the ongoing administration of Deep Sea nasal spray and that it should have been given PRN per the routine standing orders.</p> <p>The facility failed to ensure Individual #2 had a physician's order prior to administering Deep Sea nasal spray on a ongoing basis.</p> <p>2. The individuals' MARs were reviewed. The back of the MARs documented that medications were "out of stock" or "not available" resulting in individuals not receiving medications as ordered. Examples included, but were not limited to, the following:</p> <p>a. Individual #3's 5/20/16 IPP stated he was a 39 year old male whose diagnoses included moderate intellectual disability.</p> <p>Individual #3's MARs documented medications which were not given. Examples included, but were not limited to, the following:</p> <p>2/27/16 - 2/18/16 and 2/20/16: Bag Balm was out of stock.</p> <p>6/22/16: Mouthwash was out of stock.</p> <p>7/31/16: Doxycycline was not available.</p>	W 368			

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W 368	Continued From page 136 b. Individual #1's 9/29/15 IPP stated he was a 55 year old male whose diagnoses included severe intellectual disability and autism spectrum disorder. Individual #1's MARs documented medications which were not given. Examples included, but were not limited to, the following: 2/10/16 - 2/11/16 and 2/14/16 - 2/15/16: Cetaphil was out of stock. 5/28/16 - 5/31/16: Sudogest 120 mg was out of stock. When asked about the medications, during an interview on 8/15/16 beginning at 1:00 p.m., the LPN stated there were various reasons for running out of medications. She stated it would sometimes take 8 - 10 days to obtain medications from the pharmacy and sometimes it was a nursing error and sometimes nursing staff were not notified or not notified in a timely manner when medications were running low.	W 368		
W 369	483.460(k)(2) DRUG ADMINISTRATION The facility failed to administer drugs as ordered by the physician. The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure medications were administered without	W 369		9/20/16

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W 369	<p>Continued From page 137</p> <p>error for 1 of 3 individuals (Individual #2) observed to take medications. This resulted in an individual's medication not being properly administered. The findings include:</p> <p>1. Individual #2's IPP, dated 9/16/15, documented a 67 year old male whose diagnoses included profound intellectual disability.</p> <p>During a medication administration observation on 8/9/16 from 7:15 - 7:28 a.m., the DCS was noted to spray one spray of Deep Sea nasal spray, 0.65%, in each nostril.</p> <p>His MAR was reviewed and documented he was to receive two sprays in each nostril four times a day.</p> <p>When asked, the DCS assisting Individual #2 with the medication administration stated he should have received two sprays in each nostril.</p> <p>However, when individual #2's Physician's Orders were reviewed, no order for the nasal spray could be found.</p> <p>Additionally, Individual #2's MARs were reviewed from 5/27/16 - 8/16/16 and documented he had received Deep Sea nasal spray four times a day during that period.</p> <p>When asked during an interview on 8/10/16 at 3:20 p.m., the LPN stated there was no physician's order for ongoing administration and it should have been given PRN per the routine standing orders.</p> <p>The facility failed to ensure Individual #2 had a physician's order prior to administering Deep Sea</p>	W 369		

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W 369	Continued From page 138 nasal spray on an ongoing basis.	W 369			
W 441	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure all drills were conducted under varied conditions for 5 of 5 individuals (Individuals #1 - #5) residing in the facility. This resulted in the facility not being able to determine staff and individuals' responses or identify problem areas. The findings include: 1. The facility's Emergency Evacuation Drill Reports were reviewed and the night shift evacuation reports did not have adequate variation of times as follows: - On 9/7/15 at 11:15 p.m. - On 12/18/15 at 11:05 p.m. - On 3/23/16 at 11:05 p.m. - On 6/17/16 at 11:30 p.m. When asked, during an interview on 8/15/16 beginning at 1:00 p.m., Program Manager A stated that the night shift evacuation drill times should be varied and were not. The facility failed to ensure evacuation drills were conducted under varied times.	W 441		9/20/16	
W 448	483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with evacuation drills, including accidents.	W 448		9/20/16	

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W 448	Continued From page 139 This STANDARD is not met as evidenced by: Based on review of the facility's evacuation reports and staff interview, it was determined the facility failed to ensure all problems with evacuation drills were investigated for 1 of 5 individuals (Individual #5) residing in the facility. This resulted in an individual refusing to participate in evacuation drills without the problem being investigated. The findings include: 1. The facility's census documented Individual #5 had a diagnosis of severe intellectual disability. The facility's Emergency Evacuation Drill Reports, dated 9/7/15 - 6/17/16, were reviewed and documented Individual #5 refused to participate in following evacuation drills: - 9/7/15 at 11:15 p.m. - 12/8/15 at 11:05 p.m. - 3/23/16 at 11:05 p.m. - 6/17/16 at 11:30 p.m. When asked, during an interview on 8/15/16 beginning at 1:00 p.m., the QIDP stated that the issue was just investigated and staff were trained during the July 2016 meeting on the prompting level of Individual #5. When asked if the problem had been investigated prior to July, the QIDP stated she was not aware that Individual #5 had been refusing all year. The facility failed to ensure all problems with evacuation drills were investigated.	W 448			
W 449	483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with	W 449		9/20/16	

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W 449	<p>Continued From page 140 evacuation drills and take corrective action.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to take actions to correct problems that were identified during quarterly evacuation drills for 1 of 5 individuals (Individual #5) residing at the facility, and had the potential to affect all individuals (Individuals #1 - #5) residing at the facility. This resulted in the potential for identified problems continuing with no corrective action taken. The findings include:</p> <p>1. The facility census documented Individual #5 had a diagnosis of severe intellectual disability.</p> <p>The facility's Emergency Evacuation Drill Reports, from 9/7/15 - 6/17/16, were reviewed and documented Individual #5 refused to participate in the following evacuation drills:</p> <ul style="list-style-type: none"> - 9/7/15 at 11:15 p.m. - 12/8/15 at 11:05 p.m. - 3/23/16 at 11:05 p.m. - 6/17/16 at 11:30 p.m. <p>When asked, during an interview on 8/15/16 beginning at 1:00 p.m., the QIDP stated that a corrective action was just implemented and staff were trained during the July 2016 meeting on the prompting level of Individual #5.</p> <p>A Staff Training document, dated 7/16/16, stated "Graveyard Fire Drill, do not ask [Individual #5] if he wants to participate. Let him know he needs to get up to do the fire drill and assist him."</p> <p>When asked, during the interview on 8/15/16, if</p>	W 449			

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W 449	Continued From page 141 corrective action had been taken prior to July, the QIDP stated she was not aware that Individual #5 had been refusing all year. The facility failed to ensure action was taken to correct problems identified during evacuation drills.	W 449			

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M 000	<p>16.03.11 Initial Comments</p> <p>The following deficiencies were cited during the state licensure survey conducted from 8/8/16 to 8/17/16.</p> <p>The surveyors conducting your survey were:</p> <p>Jim Troutfetter, QIDP, Team Lead Autumn Bernal, RN, BSN, Nicole Wisenor, QIDP</p>	M 000		
MM080	<p>16.03.11100 Governing Body and Management</p> <p>The requirements of Sections 100 through 199 of these rules are modifications or additions to the requirements in 42 CFR 483.410 - 483.410(e), Condition of Participation: Governing Body and Management incorporated in Section 004 of these rules.</p> <p>This Rule is not met as evidenced by: Refer to W102, W104 and W114.</p>	MM080		
MM134	<p>16.03.11200 Client Protections</p> <p>The requirements of Sections 200 through 299 of these rules are modifications and additions to the requirements in 42 CFR 483.420 - 483.420(d)(4), Condition of Participation: Client Protections incorporated in Section 004 of these rules.</p> <p>This Rule is not met as evidenced by: Refer to W122, W149, W153, W154 and W157.</p>	MM134		

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Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: W. P. Scherman TITLE: Program Manager (X6) DATE: 9/12/16

Bureau of Facility Standards

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MM155	Continued From page 1	MM155		
MM155	16.03.11300 Facility Staffing The requirements of Sections 300 through 399 of these rules are modifications and additions to the requirements in 42 CFR 483.430 - 483.430(e)(4), Condition of Participation: Facility Staffing incorporated in Section 004 of these rules This Rule is not met as evidenced by: Refer to W159.	MM155		9/20/16
MM159	16.03.11400 Active Treatment Services The requirements of Sections 400 through 499 of these rules are modifications and additions to the requirements in 42 CFR 483.440 - 483.440(f)(4), Condition of Participation: Active Treatment Services incorporated in Section 004 of these rules. This Rule is not met as evidenced by: Refer to W195, W196, W209, W214, W216, W224, W227, W232, W239, W240, W242, W249, W250, W252 and W259.	MM159		9/20/16
MM162	16.03.11500 Client Behavior and Facility Practices The requirements of Sections 500 through 599 of these rules are modifications and additions to the requirements in 42 CFR 483.450 - 483.450(e)(4) (iii), Condition of Participation: Client Behavior and Facility Practices incorporated in Section 004 of these rules.	MM162		9/20/16

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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) COMPLETE DATE
MM162	Continued From page 2 This Rule is not met as evidenced by: Refer to W289.	MM162		
MM166	16.03.11600 Health Care Services The requirements of Sections 600 through 699 of these rules are for modifications and additions to the requirements in 42 CFR 483.460 - 483.460(n) (2), Condition of Participation: Health Care Services incorporated in Section 004 of these rules. This Rule is not met as evidenced by: Refer to W322, W325, W368 and W369.	MM166		9/20/16
MM169	16.03.11700 Physical Environment The requirements of Sections 700 through 799 of these rules are modifications and additions to the requirements in 42 CFR 483.470 - 483.470(1)(4), Condition of Participation: Physical Environment, incorporated in Section 004 of these rules. Other documents incorporated in Section 004 of these rules related to an ICF/ID physical environment are the NFPA's Life Safety Code and IDAPA 07.03.01, "Rules of Building Safety." This Rule is not met as evidenced by: Refer to W441, W448 and W449.	MM169		9/20/16



September 19, 2016

Jim Troutfetter
Health Facility Surveyor
Non-Long Term Care
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009

RECEIVED

SEP 19 2016

FACILITY STANDARDS

RE: Mallard Landing, Provider #13G032

Dear Jim Troutfetter:

Thank you for giving us the opportunity to correct the following deficiencies that were found during the recent annual Medicaid/Licensure Survey for Mallard Landing. Please see our responses below for each citation and give us a call if you have any questions or concerns.

W102

Please see the response given under W104 as it relates to systematic changes ensuring oversight is provided to the facility.

W104

1. A team meeting has been scheduled to review all 5 individuals' health, safety, active treatment and behavioral needs. Areas identified where an individual was not receiving services necessary to meet their needs will be corrected.
2. A team meeting has been scheduled to review all 5 individuals' health, safety, active treatment and behavioral needs. Areas identified where an individual was not receiving services necessary to meet their needs will be corrected.
3. Aspire Human Services Boise has made the systemic change of having two Program Manager. Each Program Manager will oversee four facilities; including the following facilities personnel; QIDP, Program Supervisor, Nurse, Lead Worker(s), and Direct Support Professionals. This provides more time for the Program Manager to be involved with the daily operations, oversight and monitoring (including health, safety, active treatment, and behavioral needs), training, and to be involved in Individual Program Plans. A QIDP manual has been written, this will provide guidance for the QIDP on how to assist Individuals in having all of their health, safety, active treatment and behavior needs met.
4. QIDP case files are now stored at the Boise office. At any given moment all case files (Nursing, Q book, and INA's) can be pulled together for verification or review for any individual living at Aspire Human Services. Aspire Human Services has scheduled a minimum of two Internal Reviews annually for each individual served. The current

Internal Review schedule includes a file review with a minimum of four individuals every month within all of Aspire Human Services. The Program Manager receives the completed Internal Review form. The Program Manager will have a meeting monthly with their facility QIDP, Program Supervisor, and Facility Nurse. During these monthly meetings, the Program Manager will verify that corrections have been made for current Internal Reviews. The Program Manager will also ensure that POC's per the Form CMS-2567 are corrected and implemented. Mallard's team will meet at a minimum of once a month to review each individual's progress towards their Individual Program Plan.

5. Person Responsible: Program Manager, Program Supervisor, Facility Nurse, and QIDP
6. Completion Date: October 2, 2016

Please see the responses given under W114, W122, W159, W195, W196, W214, W227, W239, W240, W242, W249, W250, W289, W322, W448, and W449.

W114

1. Individuals #1, #2, and #4's records (CFA and IPP) will be reviewed by another QIDP for legible, dated, and signed entries. Upon review entries found without a date or signature will immediately be dated and signed reflecting the review date.
2. Individual's #3 and #5's records will be reviewed for legible dates and signed entries. Upon review entries found without a date or signature will immediately be dated and signed.
3. Aspire Human Services has scheduled a minimum of two Internal Reviews annually for each individual served. The current Internal Review schedule includes a file review with a minimum of four individuals every month. QIDP's will review all entries in the chart to ensure they are legible and have a date and signature. Additionally, a QIDP manual has been written, this manual provides the instructions that all entries in an individual's records and indicates they must have a legible signature and date. The QIDP manual is a tool the Q's reference.
4. The Program Manager receives the completed Internal Review form. The Program Manager meets monthly with their facilities Interdisciplinary Teams. During these monthly meetings, the Program Manager will verify that corrections have been made for current Internal Reviews. The Program Manager will also ensure that POC's per the Form CMS-2567 are corrected and implemented.
5. Person Responsible: Program Manager and QIDP
6. Completion Date: October 2, 2016

W122

Please see the response given under W149.

W149

1. Employees from across the state who work for Aspire Human Services met on 9/7/2016 to review and make necessary changes to the policy that prohibits mistreatment, neglect or abuse of the individual. This will directly impact individuals #1 and #2 and potentially impact individuals' 3 - #5.
2. The Program Supervisor, QIDP, LNP, and Direct Support Professionals will be retrained on the Abuse, Neglect, and Mistreatment policy. The training will cover all members of

the Interdisciplinary Team and their role to prevent ongoing self-abuse including appropriate reporting, investigation and corrective action occurring.

3. Mallard Landing has hired a second Lead Worker. This additional team member will help provide oversight on appropriate reporting.
4. The Program Manager, QIDP, Program Supervisor, and Lead Workers are reviewing Incident Reports, Investigation, and ABC logs assisting in the prevention of ongoing self-abuse without appropriate reporting, investigation, and corrective action taking place.
5. Person Responsible: Program Manager, Program Supervisor, Facility Nurse, QIDP, and Lead Worker
6. Completion Date: October 2, 2016

Please refer to the responses given under W153, W154 and W157.

W153

1. Direct Support Professionals will be retrained on reporting procedures for all allegations of mistreatment, neglect, abuse, or injuries of an unknown source to the Program Manager (Administrator) / Designee. This will ensure all incidents of self-injurious behaviors are reported to the Program Manager (Administrator) / Designee immediately impacting Individual #1.
2. By retraining the DSPs and Lead Workers on the reporting of all allegations it will ensure all incidents of self-injurious behaviors are reported to the Program Manager immediately impacting Individuals #2 - #5.
3. Mallard Landing has hired a second Lead Worker. This additional team member will help provide oversight on appropriate reporting.
4. The Program Manager, QIDP, Program Supervisor, and Lead Workers are reviewing Incident Reports, Investigation, and ABC logs to assist in the prevention of ongoing self-abuse without appropriate reporting.
5. Person Responsible: Program Manager, Program Supervisor, Facility Nurse, QIDP, Lead Worker, and Direct Support Professionals
6. Completion Date: October 2, 2016

W154

1. A training has been scheduled for the Program Supervisor and Lead Worker at Mallard, which training will focus on completion of a thorough investigation. Specifically, ensuring all allegations of self-abuse are thoroughly investigated, impacting Individuals #1 and #2.
2. After the training has occurred, the Program Manager, Program Supervisor, and Lead Worker will review all investigations and ABC logs to ensure all allegations have been thoroughly investigated. Missing investigations will be documented immediately.
3. The Program Manager and Program Supervisor currently meet weekly to review investigations ensuring all allegations of self-abuse are thoroughly investigated.
4. All investigations will be audited weekly by another Program Supervisor to ensure they are thorough and all concerns have been addressed. Any identified concerns will be addressed by the Program Manager immediately. Additionally a second review will be conducted during monthly IDT team meeting.
5. Person Responsible: Program Manager, Program Supervisor, and Lead Worker

6. Completion Date: October 2, 2016

W157

1. A training has been scheduled for the Program Supervisor on abuse, neglect and mistreatment and thorough investigations. The training will focus on appropriate corrective action being taken in response to Individual #2's ongoing incidents of self-abuse. Potentially impacting Individuals #1, #3, #four and #5.
2. Individuals #1, #3, #4 and #5's current INA's will be reviewed for appropriate corrective actions.
3. Currently Aspire Human Services has scheduled a minimum of two Internal Reviews annually for each individual served. The Internal Review has been revised to include a review of all current INA's to verify company policy has been implemented as written.
4. Program Supervisors currently meet at least weekly and audit each incident report to verify that a thorough investigation has occurred including appropriate corrective actions. Deficiencies will be corrected during the meeting along with any training as needed.
5. Person Responsible: Program Manager and Program Supervisor
6. Completion Date: October 2, 2016

W159

1. Individual #1's had an IPP on 9/13/2016. His behavior intervention plan and secondary objectives were discussed during his IPP and decided on as a whole. Individuals' #2 - #5 QIDP charts will be audited by another QIDP. Active treatment and behavior needs will be reviewed to ensure individuals' rights are being protected, needs are being met, and documentation between IDT members is occurring. In addition, a staff meeting has been scheduled to discuss and brainstorm ideas impacting all individuals.
2. Training has been scheduled on the active treatment loop with Program Supervisor, QIDP, LPN, and Direct Support Professionals.
3. Aspire Human Services Boise has made the systemic change of having two Program Managers. Each Program Manager will oversee four facilities; including the following facilities personal; QIDP, Program Supervisor, Nurse, Lead Worker(s), and Direct Support Professionals. This provides more time for the Program Manager to be involved with the daily operations, oversight, monitoring (including active treatment and behavioral needs), and training. This systemic change will provide Aspire Human Services the ability to ensure individual's active treatment and behavioral needs are being met.
4. Mallard's team will meet at a minimum of once a month to review each individual's plan and health care needs. Prior to each team meeting two active treatment observations will be completed. Observations will be discussed at each team meeting. Through consistently meeting each month the facility will be able to provide all five individuals with adequate protection and the habilitative services necessary to achieve and maintain optimal functional status and improve the facility's ability to ensure each individual is provided with the opportunity to function with as much self-determination and independence as possible.
5. Person Responsible: Program Manager, Program Supervisor, Facility Nurse, QIDP, Lead Workers, and Direct Support Professionals
6. Completion Date: October 2, 2016

Please refer to the responses given under W114, W122, W149, W153, W154, W157, W195, W196, W209, W214, W216, W224, W227, W232, W239, W240, W242, W249, W250, W252, W255, W259, W289, W322, W325, W368, W369, W441, W448, and W449.

W195

Please refer to the response given under W196.

W196

1. Peer observations will be completed through the month by another QIDP and Program Supervisor, and which will include active treatment observations to assist in ensuring Individuals #1, #2, and #4 receive continuous and consistent active treatment services. During observations if concerns or areas identified needing training will occur immediately. At Friday's team meeting observations will be reviewed.
2. A staff meeting has been scheduled to discuss and brainstorm ideas for functional, meaningful activities and how AHS can provide continuous and consistent active treatment opportunities to all individuals.
3. Aspire Human Services Boise has made the systemic change of having two Program Managers. Each Program Manager will oversee four facilities. This provides more time for the Program Manager to be connected with the daily operations, oversight and monitoring, and to be involved in Individual Program Plans.
4. Mallard's team meets at a minimum of once a month to review each individual's plan and health care needs. Prior to each team meeting two active treatment observations are completed. Observations are discussed at each team meeting.
5. Person Responsible: Program Manager, Program Supervisor, Facility Nurse, and QIDP
6. Completion Date: October 2, 2016

Please refer to the responses given under W209, W214, W216, W224, W227, W232, W239, W240, W242 W249, W250, W252, W255 and W259.

W209

1. Individual #2 had an IPP meeting on 9/6/2016 where his guardian participated by phone.
2. All Individuals IPP's sign in sheet will be reviewed for guardian participation. If a guardian was not present, a member of the Interdisciplinary Team will reach out to the legal guardian and review the Individuals Program Plan giving them the opportunity to contribute to the IPP. Revisions will be made immediately or a team meeting will be scheduled.
3. The QIDP will notify the Program Manager when a legal guardian is unable to participate in the IPP process. The Program Manager will reach out to the legal guardian to determine if can do anything to reschedule and elicit their participation in the IPP process.
4. The Program Manager attends annual IPP's for their four facilities. If a legal guardian is not present it would be recognized at the start of the IPP if the notification to the Program Manager was missed. Efforts in reaching the guardian will be made to reschedule at that time for their participation.

5. Person Responsible: Program Manager, Program Supervisor, and QIDP
6. Completion Date: October 2, 2016

W214

1. Individuals #1 and #2's Functional Behavior Assessment and Behavior Intervention Plan will be reviewed for consistent information including precursor behaviors. AHS will review current behavior definitions in relation to raw data of ABC logs and INA's for comprehensive accurate information as well as emerging maladaptive behavior patterns. Areas identified will be corrected immediately.
2. Individual's #3 - #5 Functional Behavior Assessment and Behavior Intervention Plan will be reviewed for consistent information including precursor behaviors. AHS will review current behavior definitions in relation to raw data of ABC logs and INA's for comprehensive accurate information as well as emerging maladaptive behavior patterns.
3. A manual has been created for the QIDP position that provides guidance on comprehensive and consistent information regarding the individual's maladaptive behavior patterns.
4. Mallard's team meets at a minimum of once a month to review each individual's plan (Behavior Intervention Plan and Functional Behavior Assessment) and health care needs.
5. Person Responsible: Program Manager, Program Supervisor, Facility Nurse, and QIDP
6. Completion Date: October 2, 2016

W216

1. Individual #1's CFA will be revised to include comprehensive, accurate information regarding his chronic pain. Individual #4 will have an assessment completed for her possible pain issues. Individual #2's CFA will be revised to include comprehensive, accurate information.
2. The Mallard team will review CFA's for Individuals #3, and #5 ensuring comprehensive, accurate information regarding pain is included if applicable.
3. Aspire Human Services Boise has made the systemic change of having two Program Managers. Each Program Manager will oversee four facilities. This provides more time for the Program Manager to be involved with the daily operations, oversight and monitoring, and to be connected in Individual Program Plans. Additionally, Aspire Human Services has scheduled a minimum of two Internal Reviews annually for each individual served including a review of the CFA for comprehensive information.
4. The Program Manager receives the completed Internal Review form. The Program Manager will have a meeting monthly with their facility QIDP, Program Supervisor, and Facility Nurse. During these monthly meetings, the Program Manager will verify that corrections have been made for current Internal Reviews. The Program Manager will also ensure that POC's per the Form CMS-2567 are corrected and implemented. Mallard's team meets at a minimum of once a month to review each individual's progress towards their Individual Program Plan.
5. Person Responsible: Program Manager and QIDP
6. Completion Date: October 2, 2016

W224

1. Individual's #1 and #4 charts will be reviewed to assure that each individual is being assessed prior to the development of objectives. Discrepancies are to be addressed immediately.
2. Individuals' #2, #3, and #5 will be reviewed to assure that each individual is being assessed prior to the development of objectives. Discrepancies are to be addressed immediately.
3. A QIDP manual has been written. The purpose of the Q Manual is to provide instruction and guidance on how to do the QIDP job. One section in this manual provides instructions on assessing an individual prior to the development of objectives. Aspire Human Services has also made changes to assist in providing oversight on the implementation of program plans. Case files are now stored at the Boise office.
4. The Program Manager receives the completed Internal Review form. The Program Manager will have a meeting monthly with their facility QIDP, Program Supervisor, and Facility Nurse. During these monthly meetings, the Program Manager will verify that corrections have been made for current Internal Reviews. The Program Manager will also ensure that POC's per the Form CMS-2567 are corrected and implemented. Mallard's team meets at a minimum of once a month to review each individual's progress towards their Individual Program Plan.
5. Person Responsible: Program Manager and QIDP
6. Completion Date: October 2, 2016

W227

1. Individual #1's CFA and formal programs will be reviewed to ensure program plans are designed to promote independence and maximize his development potential in areas most likely to affect his daily life. Discrepancies are to be addressed immediately.
2. Individual #two - #5's CFA and formal programs will be reviewed to ensure program plans are designed to promote independence and maximize development potential in areas most likely to influence each individual's daily life. Areas identified will be corrected immediately.
3. A QIDP manual has been written. The purpose of the Q Manual is to provide instruction and guidance on how to do the QIDP job. This manual provides instructions on assessing an individual prior to the development of objectives. Aspire Human Services has also made changes to assist in providing oversight on the implementation of program plans by storing Case files at the Boise office.
4. The Program Manager is connected with the daily operations, oversight and monitoring, and involved in Individual Program Plans. The current Internal Review schedule includes a file review with a minimum of four individuals every month within all of Aspire Human Services. The Program Manager receives the completed Internal Review form. The Program Manager will have a meeting monthly with their facility QIDP, Program Supervisor, and Facility Nurse. During these monthly meetings, the Program Manager will verify that corrections have been made for current Internal Reviews. The Program Manager will also ensure that POC's per the Form CMS-2567 are corrected and implemented. Mallard's team will meet at a minimum of once a month to review each individual's progress towards their Individual Program Plan.
5. Person Responsible: Program Manager, Program Supervisor, Facility Nurse, and QIDP

6. Completion Date: October 2, 2016

Please refer to the response given under W242.

W232

1. Individuals' #1 and 4's secondary objectives will be consistently organized and implemented to reflect logical developmental progression based on their individualized needs. Individual #1 had an IPP on 9/13/2016 and Individuals #4 had an IPP on 9/6/2016.
2. Individual #2, #3 and #5's secondary objectives will be reviewed to reflect logical developmental progression based on their individualized needs.
3. A QIDP manual has been written, this manual provides instructions on the development of secondary objectives. The purpose of the Q Manual is to provide instruction and guidance on how to do the QIDP job. Aspire Human Services has also made changes to assist in providing oversight on the implementation of program plans by storing case files at the Boise office.
4. The Program Manager is connected with the daily operations, oversight and monitoring, and involved in Individual Program Plans. The current Internal Review schedule includes a file review with a minimum of four individuals every month within all of Aspire Human Services. The Program Manager receives the completed Internal Review form. The Program Manager will have a meeting monthly with their facility QIDP, Program Supervisor, and Facility Nurse. During these monthly meetings, the Program Manager will verify that corrections have been made for current Internal Reviews. The Program Manager will also ensure that POC's per the Form CMS-2567 are corrected and implemented. Mallard's team will meet at a minimum of once a month to review each individual's progress towards their Individual Program Plan.
5. Person Responsible: Program Manager, Program Supervisor, Facility Nurse, and QIDP
6. Completion Date: October 2, 2016

W239

1. Individual #2's replacement behavior programs will be revised to functional training that relates to their physically assaultive behavior.
2. Individual #1 and #3 - #5 replacement behavior programs will be reviewed to ensure they are functional training programs related to their Functional Behavior Assessment.
3. A QIDP manual has been written, this manual provides instructions on replacement behaviors ensuring that each individual is provided functional training related to each individuals maladaptive behaviors. The purpose of the Q Manual is to provide instruction and guidance on how to do the QIDP job. Aspire Human Services has also made changes to assist in providing oversight on the implementation of program plans by storing case files at the Boise office.
4. The Program Manager is connect with the daily operations, oversight and monitoring, and involved in Individual Program Plans. The current Internal Review schedule includes a file review with a minimum of four individuals every month within all of Aspire Human Services. The Program Manager receives the completed Internal Review form. The Program Manager will have a meeting monthly with their facility QIDP, Program Supervisor, and Facility Nurse. During these monthly meetings, the Program

Manager will verify that corrections have been made for current Internal Reviews. The Program Manager will also ensure that POC's per the Form CMS-2567 are corrected and implemented. Mallard's team will meet at a minimum of once a month to review each individual's progress towards their Individual Program Plan as a whole.

5. Person Responsible: Program Manager, Program Supervisor, Facility Nurse, and QIDP
6. Completion Date: October 2, 2016

W240

1. Individuals #1, #2 and #4's Leisure, Retirement and Sensory service programs will be revised to include sufficient information for staff necessary to ensure individuals are receiving support towards independence.
2. Individuals #3 and #5's Leisure, Retirement and Sensory services programs will be revised to include sufficient information for staff necessary to ensure they are receiving support towards independence.
3. Aspire Human Services Boise has made the systemic change of having two Program Managers. Each Program Manager will oversee four facilities. This provides more time for the Program Manager to be connected with the daily operations, oversight and monitoring, and to be involved in Individual Program Plans. A QIDP manual has been written, this manual provides instructions on service programs and data collection. Aspire Human Services has also made changes to assist in providing oversight on the implementation of program plans by storing case files at the Boise office. The purpose of the Q Manual is to provide instruction and guidance on how to do the QIDP job.
4. Mallard's team will meet at a minimum of once a month to review each individual's plan and health care needs. Prior to each team meeting two active treatment observations are completed. Observations are discussed at each team meetings. Through observation and team meetings, the facility will ensure sufficient information is provided to staff necessary to assist individuals towards independence.
5. Person Responsible: Program Manager, Program Supervisor, Facility Nurse, QIDP, Lead Worker and Direct Support Professional
6. Completion Date: October 2, 2016

W242

1. Individuals #1 will be provided with formal training essential to meet his basic toileting and privacy needs.
2. Individuals #2 - #5's CFA's will be reviewed for basic training and privacy needs. Areas identified will be corrected immediately.
3. Aspire Human Services Boise has made the systemic change of having two Program Managers. Each Program Manager will oversee four facilities. This provides more time for the Program Manager to be involved with the daily operations, oversight and monitoring, and to be connected in Individual Program Plans. A QIDP manual has been written, this manual provides instructions on basic training needs. The purpose of the Q Manual is to provide instruction and guidance on how to do the QIDP job. Aspire Human Services has also made changes to assist in providing oversight on the implementation of program plans. Case files are now stored at the Boise office.
4. Mallard's team will meet at a minimum of once a month to review each individual's plan and health care needs. Prior to each team meeting two active treatment observations are

completed. Observations are discussed at each team meetings. Through observation and team meetings the facility will ensure sufficient information is provided to staff necessary to assist individuals towards independence.

5. Person Responsible: Program Manager, Program Supervisor, Facility Nurse, QIDP, Lead Worker and Direct Support Professional
6. Completion Date: October 2, 2016

W249

1. Individual #1 had his annual IPP on 9/13/2016. Their new plan will be reviewed prior to implementation to ensure there is continuous service meeting his needs including consistent active treatment services. Training is scheduled with the QIDP to ensure active treatment programs are not suspended while awaiting a new IPP. Individual #2 had his annual IPP meeting on 9/6/2016. Their new plan will be reviewed prior to implementation ensuring consistent active treatment services. Individual #4's use of a gait belt per OT instructions will be a training topic during the staff meeting, 9/13/2016.
2. Individuals #3 and #5's plans will be reviewed for consistent active treatment. Areas identified will be corrected immediately. A staff meeting is scheduled for 9/13/2016 to retrain on the active treatment process.
3. Aspire Human Services Boise has made the systemic change of having two Program Managers. Each Program Manager will oversee four facilities. This provides more time for the Program Manager to be involved with the daily operations, oversight and monitoring, and to be connected in Individual Program Plans. A QIDP manual has been written, this manual provides instructions on consistent active treatment. Aspire Human Services has also made changes to assist in providing oversight on the implementation of program plans by storing case files at the Boise office.
4. There will be a minimum training of one staff meeting a month, two active treatment observations, and in-services as needed to assist in program plans being consistently implemented impacting all of the individuals. The QIDP, Program Supervisor, facility Nurse, Program Manager, or designee will train in the moment when witnessing a program being ran inconsistently.
5. Person Responsible: Program Manager, Program Supervisor, Facility Nurse, QIDP, Lead Workers, and Direct Support Professionals
6. Completion Date: October 2, 2016

W250

1. Individual #1 had his annual IPP on 9/13/2016. Individual #2 has his IPP on 9/6/2016. Prior to their new plan being implemented the active treatment schedule will be reviewed ensuring it has been sufficiently developed to instruct staff in the implementation of his active treatment program. Individual #4's active treatment schedule will be revised to include sufficient information to instruct staff on the implementation of their active treatment program.
2. Individual #3 and #5's active treatment schedules will be reviewed to ensure that there is sufficient information developed to instruct staff in the implementation of active treatment programming. Areas identified will be corrected immediately.
3. Aspire Human Services Boise has made the systemic change of having two Program Managers. Each Program Manager will oversee four facilities. This provides more time

for the Program Manager to be connected with the daily operations, oversight and monitoring, and to be involved in Individual Program Plans. A QIDP manual has been written, this manual provides instructions on developing a sufficient active treatment program to instruct staff. Aspire Human Services has also made changes to assist in providing oversight on the implementation of program plans. Case files are now stored at the Boise office.

4. There will be a minimum training of one staff meeting a month, two active treatment observations, and in-services as needed to assist in program plans being consistently implemented impacting all of the individuals. The QIDP, Program Supervisor, facility Nurse, Program Manager, or designee will train in the moment when witnessing a program being ran inconsistently.
5. Person Responsible: Program Manager, Program Supervisor, Facility Nurse, QIDP, and Lead Worker
6. Completion Date: October 2, 2016

W252

1. Individual #1 had his annual IPP on 9/13/2016. Individual #2 had his annual IPP on 9/6/2016. Prior to their new plan being implemented staff will be trained on their Behavior Intervention Plan, ensuring is it implemented appropriately. Mallard also has a staff meeting scheduled on documentation related to ABC logs and Behavior Intervention Plan documentation. With both steps being completed, the facility can ensure ABC data will provide sufficient information to evaluate the efficacy of their BIP.
2. Direct support professionals will be provided training related to sufficient data collection for all individuals residing in the facility.
3. Aspire Human Services Boise has made the systemic change of having two Program Managers. Each Program Manager will oversee four facilities. This provides more time for the Program Manager to be connected with the daily operations, oversight and monitoring, and to be involved in Individual Program Plans. A QIDP manual has been written, this manual provides instructions on developing a sufficient active treatment program to direct staff. The purpose of the Q Manual is to provide instruction and guidance on how to do the QIDP job. Aspire Human Services has also made changes to assist in providing oversight on the implementation of program plans. Case files are now stored at the Boise office.
4. There will be a minimum training of one staff meeting a month, two active treatment observations, and in-services as needed to assist in program plans being consistently implemented impacting all of the individuals. The QIDP, Program Supervisor, facility Nurse, Program Manager, or designee will train in the moment when witnessing a program being ran inconsistently.
5. Person Responsible: Program Manager, Program Supervisor, Facility Nurse, QIDP, Lead Workers, and Direct Support Professionals
6. Completion Date: October 2, 2016

W255

1. Individual #1 had his annual IPP on 9/13/2016. Individual #two had his annual IPP on 9/6/2016. Future revisions for Individuals #1 and #2 will be revised in a timely manner and based on actual performance. Individual #4's chart will be reviewed to ensure

revisions are based on actual performance. Areas identified will be corrected immediately.

2. Individuals #3, and #5's charts will be reviewed to ensure that programs are revised in a timely manner and based on actual performance. Areas identified will be corrected immediately.
3. Aspire Human Services Boise has made the systemic change of having two Program Managers. Each Program Manager will oversee four facilities. This provides more time for the Program Manager to be connected with the daily operations, oversight and monitoring, and to be involved in Individual Program Plans. A QIDP manual has been written, this manual provides instructions on program review and revision being done in a timely manner that are based on actual client performance. Aspire Human Services has also made changes to assist in providing oversight on the implementation of program plans by storing case files at the Boise office.
4. The current Internal Review schedule includes a file review with a minimum of four individuals every month within all of Aspire Human Services. The Program Manager receives the completed Internal Review form. The Program Manager will have a meeting monthly with their facility QIDP, Program Supervisor, and Facility Nurse. During these monthly meetings, the Program Manager will verify that corrections have been made for current Internal Reviews. The Program Manager will also ensure that POC's per the Form CMS-2567 are corrected and implemented. Mallard's team meets at a minimum of once a month to review each individual's progress towards their Individual Program Plan.
5. Person Responsible: Program Manager and QIDP
6. Completion Date: October 2, 2016

W259

1. Individuals #1 and #4's Comprehensive Functional Assessments will be reviewed by the interdisciplinary team for relevancy and updated as needed, which will capture information that is reflective of the individuals' actual performance. Areas identified will be corrected immediately.
2. Individuals #2, #3, and #5's Comprehensive Functional Assessments will be reviewed by the interdisciplinary team for relevancy and updated as needed, which will capture information that is reflective of the individuals' actual performance. Areas identified will be corrected immediately.
3. Aspire Human Services Boise has made the systemic change of having two Program Managers. Each Program Manager will oversee four facilities. This provides more time for the Program Manager to be connected with the daily operations, oversight and monitoring, and to be involved in Individual Program Plans. A QIDP manual has been written, this manual provides instructions on completing the comprehensive functional assessment with relevant information and procedures for updating as needed. Aspire Human Services has also made changes to assist in providing oversight on the implementation of program plans by storing case files at the Boise office.
4. The current Internal Review schedule includes a file review with a minimum of four individuals every month within all of Aspire Human Services. The Program Manager receives the completed Internal Review form. The Program Manager will have a meeting monthly with their facility QIDP, Program Supervisor, and Facility Nurse. During these monthly meetings, the Program Manager will verify that corrections have been made for

current Internal Reviews. The Program Manager will also ensure that POC's per the Form CMS-2567 are corrected and implemented. Mallard's team meets at a minimum of once a month to review each individual's progress towards their Individual Program Plan.

5. Person Responsible: Program Manager, Program Supervisor, Facility Nurse, and QIDP
6. Completion Date: October 2, 2016

W289

1. Individual #1 and #2' behavior intervention plans will be reviewed to ensure that techniques used to manage inappropriate behaviors are included, which will include appropriate interventions to ensure individuals' behavioral needs are being met. Areas identified will be corrected immediately.
2. Individuals #3, #four, and #5's program plans will be reviewed to ensure that techniques used to manage inappropriate behaviors are included, which will include appropriate interventions to ensure individuals' behavioral needs are being met. Areas identified will be corrected immediately.
3. Aspire Human Services Boise has made the systemic change of having two Program Managers. Each Program Manager will oversee four facilities. This provides more time for the Program Manager to be involved with the daily operations, oversight and monitoring, and to be connected in Individual Program Plans. A QIDP manual has been written, this manual provides instructions on behavior management review and completing the behavior management programs. Aspire Human Services has also made changes to assist in providing oversight on the implementation of program plans. Case files are now stored at the Boise office.
4. The current Internal Review schedule includes a file review with a minimum of four individuals every month within all of Aspire Human Services. The Program Manager receives the completed Internal Review form. The Program Manager will have a meeting monthly with their facility QIDP, Program Supervisor, and Facility Nurse. During these monthly meetings, the Program Manager will verify that corrections have been made for current Internal Reviews. The Program Manager will also ensure that POC's per the Form CMS-2567 are corrected and implemented. Mallard's team meets at a minimum of once a month to review each individual's progress towards their Individual Program Plan.
5. Person Responsible: Program Manager, Program Supervisor, Facility Nurse, and QIDP
6. Completion Date: October 2, 2016

W322

1. Individual #4 has received an occult blood test.
2. All individuals' medical files will be reviewed to ensure that adequate general and preventative medical care is being provided, including verification that all recommended screenings and tests have been administered. If screenings or tests have been missed, appointments will be scheduled immediately.
3. A training has been scheduled for the nursing team at Aspire Human Services, the training will focus on assuring that all recommended screening and tests occur as scheduled. In addition, at the Boise location an additional nursing aid has been added to the team to assist in assuring all follow up recommendations occur as recommended.
4. Currently Aspire Human Services has scheduled at a minimum of 2 Internal Reviews annually for each individual served. The Program Manager receives the completed

Internal Review form. The Program Manager meets monthly with the Mallard team after completing Form CMS-2567. Areas identified will be corrected immediately.

5. Person Responsible: Program Manager, Facility Nurse, and Nursing Assistant
6. Completion Date: October 2, 2016

W325

1. Individual #3 will receive their routine screening laboratory examinations by 9/20/16 and monitored every 3 months.
2. All individual's medical files will be reviewed to ensure that routine laboratory screenings are occurring as ordered.
3. Aspire Human Services has created a tracking sheet noting any additional follow-ups required from an appointment. This will ensure routine laboratory screenings are occurring as ordered.
4. The current Internal Review schedule includes a file review with a minimum of four individuals every month within all of Aspire Human Services. The Program Manager receives the completed Internal Review form. The Program Manager will have a meeting monthly with their facility QIDP, Program Supervisor, and Facility Nurse. During these monthly meetings, the Program Manager will verify that corrections have been made for current Internal Reviews. The Program Manager will also ensure that POC's per the Form CMS-2567 are corrected and implemented. Mallard's team meets at a minimum of once a month to review each individual's progress towards their Individual Program Plan.
5. Person Responsible: Program Manager, Facility Nurse, and Nursing Assistant
6. Completion Date: October 2, 2016

W368

1. Individual #2's Deep Sea nasal spray will be administered as a PRN per the routine standing orders. A physician's order will be obtained. Individual #1 and #3 medications will be reviewed at the facility. Medications will be ordered prior to the last 7 doses ensuring none are missed.
2. Individual's #4 and #5 medications at the facility will be reviewed and compared to physicians order. Medications will be ordered prior to the last 7 doses ensuring none are missed.
3. Aspire Human Services will complete a weekly inventory off the MARS in home and medications available. Medications will be ordered prior to the last 7 doses ensuring none are missed.
4. Currently Aspire Human Services has scheduled at a minimum of two Internal Reviews annually for each individual served. The Program Manager receives the completed Internal Review form. The Program Manager meets monthly with the Mallard team after completing Form CMS-2567. Areas identified will be corrected immediately.
5. Person Responsible: Program Manager, Facility Nurse, and Nursing Assistant
6. Completion Date: October 2, 2016

W369

1. Individual #two's Deep Sea nasal spray will be administered as a PRN per the routine standing orders. A physician's order will be obtained if needed for daily use or a PRN.

2. Individuals #1 and #3 - #5 medications at the facility will be compared to the MARS then to physicians order to ensure they are being administered correctly.
3. Each month, during cycle fill, the nursing department compares all medications to each individual's physicians order. Aspire Human Services complete two SAM's observations a month. The observation is brought to the monthly team meeting and discussed. If training is needed during the observation it will occur in the moment.
4. Currently Aspire Human Services has scheduled at a minimum of two Internal Reviews annually for each individual served. The Program Manager receives the completed Internal Review form. The Program Manager meets monthly with the Mallard team after completing Form CMS-2567. Areas identified will be corrected immediately
5. Person Responsible: Program Manager, Facility Nurse, and Nursing Assistant
6. Completion Date: October 2, 2016

W441

1. All staff at Mallard Landing have been trained on varying the time of Emergency Evacuation Drills impacting Individuals #1 - #5.
2. All staff at Mallard Landing have been trained on varying the time of Emergency Evacuation Drills impacting Individuals #1 - #5.
3. Aspire Human Services has revised the Emergency Evacuation Report form to be reviewed by the QIDP and Program Supervisor each month by signing the form.
4. The current Internal Review schedule includes a file review with a minimum of four individuals every month within all of Aspire Human Services; including fire drills. The Program Manager receives the completed Internal Review form. The Program Manager will have a meeting monthly with their facility QIDP, Program Supervisor, and Facility Nurse. During these monthly meetings, the Program Manager will verify that corrections have been made for current Internal Reviews. The Program Manager will also ensure that POC's per the Form CMS-2567 are corrected and implemented. Mallard's team meets at a minimum of once a month to review each individual's progress towards their Individual Program Plan.
5. Person Responsible: Program Manager, Program Supervisor, Facility Nurse, QIDP, Lead Worker, and Direct Support Professionals
6. Completion Date: October 2, 2016

W448

1. A staff meeting was held in August. Training with staff occurred on problem solving issues that could occur or have occurred during an emergency evacuation drill. This impacted all individuals.
2. A staff meeting was held in August. Training with staff occurred on problem solving issues that could occur or have occurred during an emergency evacuation drill. This impacted all individuals.
3. Aspire Human Services has revised the Emergency Evacuation Report form to be reviewed by the QIDP and Program Supervisor each month by signing the form. This will ensure that all problems with evacuation drills are investigated.
4. The current Internal Review schedule includes a file review with a minimum of four individuals every month within all of Aspire Human Services; including fire drills. The Program Manager receives the completed Internal Review form. The Program Manager

will have a meeting monthly with their facility QIDP, Program Supervisor, and Facility Nurse. During these monthly meetings, the Program Manager will verify that corrections have been made for current Internal Reviews. The Program Manager will also ensure that POC's per the Form CMS-2567 are corrected and implemented. Mallard's team meets at a minimum of once a month to review each individual's progress towards their Individual Program Plan.

5. Person Responsible: Program Manager, Program Supervisor, Facility Nurse, QIDP, Lead Workers, and Direct Support Professionals
6. Completion Date: October 2, 2016

W449

1. A staff meeting was held in August. Training with staff occurred on problem solving issues that could occur or have occurred during an emergency evacuation drill. This impacted all individuals.
2. A staff meeting was held in August. Training with staff occurred on problem solving issues that could occur or have occurred during an emergency evacuation drill. This impacted all individuals.
3. Aspire Human Services has revised the Emergency Evacuation Report form to be reviewed by the QIDP and Program Supervisor each month by signing the bottom of the form. This will ensure that all problems with evacuation drills are investigated and action is taken to correct identified problems.
4. The current Internal Review schedule includes a file review with a minimum of four individuals every month within all of Aspire Human Services. The Program Manager receives the completed Internal Review form. The Program Manager will have a meeting monthly with their facility QIDP, Program Supervisor, and Facility Nurse. During these monthly meetings, the Program Manager will verify that corrections have been made for current Internal Reviews. The Program Manager will also ensure that POC's per the Form CMS-2567 are corrected and implemented. Mallard's team meets at a minimum of once a month to review each individual's progress towards their Individual Program Plan.
5. Person Responsible: Program Manager, Program Supervisor, Facility Nurse, QIDP, Lead Workers, and Direct Support Professionals
6. Completion Date: October 2, 2016

MM080

Please see the responses given under W102, W104 and W114.

MM134

Please see the responses given under W122, W149, W153, W154 and W157.

MM155

Please see the response given under W159.

MM159

Please see the responses given under W195, W196, W209, W214, W216, W224, W227, W232, W239, W240, W242, W249, W250, W252 and W259.

MM162

Please see the response given under W289.

MM166

Please see the responses given under W322, W325, W368 and W369.

MM169

Please see the responses given under W441, W448 and W449.

Kristin Buchanan
Program Manager