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J. IVERSON RIDDLE DEVELOPMENTAL CENTER	300 ENOLA ROAD MORGANTON, NC 28655

(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 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) 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 verified by interview, the interdisciplinary team failed to provide needed interventions and services to address the needs for two sampled clients (#4 and #6) regarding refusal of medications and socialization/leisure needs. The findings are: A. The Person Center Plan (PCP) for 1 of 2 sampled client (#4) residing in Hemlock area failed to include interventions to address the client's needs regarding medication non-compliance/medication refusal. For example: Observation in Hemlock on 5/21/18 at 8:30 AM revealed client #4 sitting in the medication administration room eating potato chips. Further observations at 8:32 AM revealed the facility nurse handing client #4 approximately 4 ounces of strawberry Ensure drink that contained her morning medications in a liquid form per the facility nurse. Interview with the facility nurse revealed these morning medications included Lamictal 100 mg, Keppra 1000 mg, Synthroid 0.15, Synthroid 12.5 mcg, and Depakene 1,000	W 249	**W249** **For the individuals noted in this citation continuous active treatment will be provided consisting of the interventions and services needed to support the achievement of identified objectives in the IPP:** *To address medication non-compliance / medication refusals* A. Specific to Client #4 By June 30, 2018, Hemlock client #4 will have her medication non-compliance / medication refusals evaluated and guidelines for support developed by psychology staff and incorporated into her IPP. By July 13, 2018, all staff working with client #4 at medication administration will receive training on these guidelines. Training will be conducted by the Psychology staff and documented on a training record. Ongoing monitoring will be conducted with each staff assisting Client #4 with medication administration by Psychology staff, Nurse Supervisor and Hemlock QIDP Responsible Person: Hemlock Behavior Program Specialist, Nurse Supervisor, QIDP	6/30/18 7/13/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Facility Director | (X6) DATE: 6/8/18

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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mg. Further observations revealed client #4 handed the drink that contained her medications back to the facility nurse after holding the drink for approximately 30 seconds.

Continued observations at 8:34 AM and 8:36 AM revealed the facility nurse again handing client #4 her strawberry drink containing her medications and asking client #4, "Would you like a drink?" Continued observations revealed client #4 refusing the strawberry drink of Ensure which contained her morning medications each time she was offered. Subsequent observation at 8:38 AM revealed after the third attempt to administer the medications in the drink, to client #4, the facility nurse documented that client #4 would not drink her strawberry drink which contained her morning medications. Client #4 then exited the medication administration room with a staff member.

Record review on 5/23/18 for client #6 revealed a PCP dated 3/1/18. Review of the PCP revealed no objective training or programming to address medication non-compliance/refusal. Further review of the PCP revealed a Pharmacy note dated 10/4/17 stating "the treatment team switched all medications to liquids." Continued review of the PCP for client #4 revealed under Safety/Medical Guidelines on 3/1/18 "client #4 has a seizure disorder increasing her potential for injury, administer anti-convulsants as order, and wear a fanny pack with magnet for a vagal nerve stimulator."

Further review of the PCP under Safety /Medical revealed a statement on 3/1/18 "nursing will attempt to administer the medications 3xs and if unsuccessful, hand over hand restraint will be

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used to redirect or hold client #4's hands from slapping or scratching the nurse." Further record review on 5/23/18 for client #4 revealed a physician's order and note dated 4/30/18 stating "due to increases with medication non-compliance, attempt medication administration 3xs with 3 refusals, try again in one hour, if medication then refused, omit dose."

Interview with the facility nurse at 8:45AM on 5/21/18 revealed client #4 has become non-compliant with her medication administration over the last several months beginning approximately in October 2017. As result, the team met on 10/17/17 and agreed to switched her medications to liquid forms, and to omit all non-essential medications. Further interview with the facility nurse revealed that client #4's medications have been administered in her drink by restraining her hands and tipping her chin to administer the medications. On 4/17/18, at the quarterly team meeting it was decided this practice to administer medications to be ineffective and unpleasant for all involved .

Continued interview with the facility nurse revealed the team requested a medical order on 4/17/18 to allow client #4 to self- administer her medications by choosing to drink her strawberry Ensure with her medications in it, independently, or to refuse them. Further interview with the facility nurse revealed that since these changes were made client #4's refusal of her medications have increased. Continued interview revealed that in this month of 5/2018 client #4 has refused her morning medications 11 days out of 22 days this month. Continued interview with the facility nurse revealed client #4's seizure activity has increased with these medications refusals,

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W 249	Continued From page 3 resulting in 11 seizures thus far from 5/2/18-5/22/18. Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 5/23/18 confirmed that client #4 has been non-compliant with her medication administration for several months, with the non-compliance escalating over the past 6-7 months in particular. Further interview with the QIDP confirmed that the treatment team met in 10/3/17 and on 4/17/18 to discuss this identified need for client #4, however no programming was put in place for client #4 to address this identified need as a result of these meetings. Subsequent interview with the QIDP revealed the team planned to meet again in July 2018 at their quarterly meeting to further assess this need for client #4. B. The PCPs for 1 of 2 sampled clients (#6) residing in Maple failed to include needed interventions and services to address identified needs regarding socialization/leisure skills. For example: Observation in Maple on 5/21/18 at 12:35 PM revealed client #6 sitting in the common area with a magazine. Client #6 was observed to hold the magazine while hitting the padded laptop tray of his wheelchair multiple times without intervention from staff. Observation of client #6 during the dinner meal on 5/21/18 revealed the client to sit in his wheelchair at the table while self feeding with 1:1 staff supervision. Continued observation at 6:10 PM revealed client #6 to refuse swallowing his meal while hoarding food in his mouth requiring multiple and ongoing prompts from staff to swallow his food.	W 249	B. Specific to Client #6 *To address socialization / leisure skills* By July 1, 2018, Maple client #6 will have his socialization/leisure skills assessed and behavior guidelines for socialization developed by the Behavior Program Specialist. By July 15, 2018, all staff working with client #6 will receive competency based training of the guidelines. Training will be conducted by the Behavior Program Specialist and documented on the Staff Development Training record. Monitoring will be conducted until each staff working with Client #6 on socialization/leisure skills exhibits competency. Monitoring will be conducted by Maple Behavior Support Specialist, QIDP, and Home Supervisors. Responsible Persons: Maple Behavior Program Specialist, QIDP and Home Supervisors	7/01/18 7/15/18

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W 249	Continued From page 4 Observation on 5/22/18 at 11:38 AM revealed client #6 to sit in the common area of his living area with two other clients with no staff supervision. Further observation revealed client #6 to sit in his wheelchair with a magazine on his laptray and to grab another client multiple times while the client leaned away from client #6 trying to pull away. At 11:45 AM the QIDP entered the common area and supervised the area, engaging with client #6 and other clients. Observation on 5/23 at 8:19 AM revealed client #6 to enter the common area of his residence and bite his right hand various times with staff's verbal prompts to go to the kitchen for breakfast. Continued observation revealed client #6 to refuse verbal and physical prompts from staff for breakfast until 8:50 AM. Review of record for client #6 on 5/23/18 revealed a PCP dated 11/21/17. Review of the PCP revealed no objective training or programming to address hitting/slapping behavior of tabletop, non-compliance or touching/grabbing others. Continued record review revealed a behavior evaluation dated 4/30/18 identifying client #6 to have self stimulation behaviors to include hitting/slapping tabletop, pinching, touching and squeezing others. Further review of the behavior evaluation revealed client #6 seems socially withdrawn from peers/staff and behavior interventions focused on teaching or reinforcing new leisure skills as well as reinforcing social engagement could increase engagement with surroundings and decreasing self stimulation behavior. Subsequent review of the behavior evaluation revealed recommendations relative to mild/infrequent aggression to include a communication program to provide an appropriate behavior for refusing activities with	W 249		

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W 249	Continued From page 5 developing interventions aimed at increasing social engagement and leisure skills. Additional record review revealed no team meeting had occurred to address the behaviors of client #6 or the recommendations of the behavior evaluation on 4/30/18. Interview on 5/21/18 with the guardian of client #6 revealed the client has struggled to engage positively with others and likes to isolate. The guardian further stated the facility had contacted him recently for support with identifying leisure interests of client #6 due to the client seeming more depressed over the last couple weeks. Interview with staff on 5/21/18 revealed client #6 has a pattern of refusing to swallow food at meal times and the behavior is more behavioral than a medical issue. Interview with additional staff on 5/23/18 revealed client #6 can be non-compliant at meal times and sometimes does refuse to eat although there seemed to be an increase in behavior over the past couple weeks. Staff further reported that data is recorded to track the client's non-compliance with meals. Interview with the QIDP on 5/23/18 revealed client #6 does attempt grabbing behavior at times or inappropriately touching others although there has been no injuries related to the behavior. Interview with the behaviorist on 5/23/18 revealed client #6 has socialization deficits with a history of pinching, biting arm and touching others. Further interview with the behaviorist revealed client #6 did not have a behavior plan or guidelines to address inappropriate behaviors and currently has no socialization goals to address socialization behaviors although data is currently taken to monitor rates of all behaviors. The behaviorist further reported she planned to discussthe	W 249	*To address mealtime non-compliance* By July 1, 2018, Maple client #6 will have his refusal to swallow food at meal times re-evaluated by the SLP and a training program implemented. By July 15, 2018, all staff working with client #6 will receive competency based training of the designed program. Program implementation will be monitored at least weekly using the Program Observation and Feedback tool. Program progress will be monitored at least monthly in progress notes. Responsible Person: Maple SLP, QIDP and Home Supervisors	7/01/18 7/15/18

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W 249	Continued From page 6 behavior evaluation at the next quarterly team meeting for client #6.	W 249		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the specially constituted committee, designated as the Human Rights Committee (HRC), failed to ensure restrictive interventions for 5 of 28 sampled clients (#1, #2, #3, #7 and #8) were conducted only with the written informed consent of the guardians. The findings are: A. In the Summit area, the HRC failed to ensure restrictive interventions related to a locked personal closet, a motion alarm, a bedroom door alarm, behavioral medications and a restraint were conducted with written informed consent of the guardians for 3 of 9 sampled clients (#1, #2, and #3). Examples include: 1. Observations on 5/23/18 in Elm revealed client #3's bedroom to have a Visaplex motion bed alarm system, a bedroom door alarm and a locking closet. Review of the record for client #3 on 5/23/18 revealed a person centered plan (PCP) dated 9/6/17. Review of the PCP revealed a current behavior support plan which included night time restrictive procedures for client #3 when in the bed because of Pica behavior. The procedures included a bed alarm (Visaplex) and a	W 263	**W263** **For the individuals noted in this citation restrictive interventions will be conducted with written informed consent of the guardians.** For Clients #1, #2, #3, #7 and #8 as described in W263 A.1-2; B. 1-2; and C. *A. To address restrictive interventions being conducted only with the written information consent of the guardians.* 1. By July 23, 2018, written guardian consent will be obtained for the use of a Visaplex motion bed alarm system, a bedroom door alarm and a locking closet for Client #3. *Responsible Persons: Psychology staff and Elm QIDP*	7/23/18

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W 263	Continued From page 7 door alarm to alert staff when the client gets out of bed or leaves the bedroom and a closet to be locked at night. Further review of the PCP did not reveal written informed consent from the guardian for these restrictive interventions. Interview with the qualified intellectual disabilities professional (QIDP) on 5/23/18 confirmed the restrictive interventions were in place for client #3 to alert staff to potential Pica behavior at night . The QIDP also confirmed that written guardian consents for these restrictive interventions had not been obtained. 2. In the Birch Home, 2 of 2 sampled clients (#1 and #2) failed to have written informed consent for a locking wheelchair lap restraint and behavioral medications. Examples include: a. Observations in the Redwood Worksite Academy classroom on 5/21/18 at 3:08 PM revealed two staff members preparing to assist client #2 with transferring from a wheelchair to a standing position. A staff member was observed unlocking a wheelchair lap belt with a key, so the client could transfer out of the wheelchair. Review of the record for client #2 on 5/23/18 revealed a PCP dated 6/26/17. The PCP indicated the client has poor balance/gait when ambulating and has a history of crawling on the floor and sustaining serious injury to his knees and face. Continued review of the PCP revealed a behavior support plan (BSP) dated 8/17/17. Review of the BSP revealed client #2's target behaviors included self injurious behavior, aggression, spitting, crawling and Pica. Continued review of the BSP revealed restrictive interventions for the target behaviors to include a	W 263	2. *Specific to resident #2* a. By July 23, 2018, written guardian consent will be obtained for a locking wheelchair lap restraint for Client #2. *Responsible Persons: Psychology staff and Birch QIDP*	7/23/18

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W 263	Continued From page 8 wrap restraint board, hand mitts and wrist restraints in the wheelchair, all to be used if necessary as directed by the BSP. Further review of the BSP did not include a locking wheelchair lap belt as a restrictive intervention. Further review of the PCP also did not reveal written guardian consent for the use of this restrictive intervention. Interview with the QIDP on 5/23/18, confirmed client #2 has a locking wheelchair lap belt because the client has a history of removing the lap belt, especially when the wheelchair is moving, and attempting to get out of the wheelchair. Continued review with the QIDP confirmed the PCP did not contain written informed consent from the guardian for the use of this restrictive intervention. b. Review of the record for client #1 on 5/23/18 revealed a PCP dated 1/24/18. Review of the PCP revealed a BSP dated 9/28/17 which addressed severe self- injurious behaviors of striking head or face with fist, knee, or object, dropping to the floor and striking head on the floor, furniture or wall, diving to the floor head first, and falling to the floor on knees or bottom. Further review of the PCP revealed a physician's order dated 2/15/18 for Trazadone 75 mg. at bedtime for client #1. Continued review of the record for client #1 revealed no guardian consent was available for the use of Trazadone for client #1. Interview with the QIDP conducted on 5/23/18 revealed no written informed consent for the use of Trazadone 75 mg was available. B. In the Lakeside area, the HRC failed to ensure restrictive interventions related to a locked personal closet and a bicycle were conducted	W 263	b. By July 23, 2018, written guardian consent will be obtained for behavioral medications for Client #1. *Responsible Persons: Psychology staff and Birch QIDP*	7/23/18

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W 263	Continued From page 9 with written informed consent of the guardian for 1 of 2 sampled clients (#7) in Mulberry. Examples include: 1. Review of records for client #7 on 5/23/18 revealed an occupational therapy assessment dated 10/30/17 referencing a locked personal closet of client #7 due to inappropriate flushing of items in the toilet. Further record review revealed a BSP dated 10/18/17 for target behaviors of physical/verbal aggression, self injurious behavior, agitation, fixation on upcoming events and property destruction. Review of the BSP did not include the use of locking the client's personal closet to address flushing of inappropriate items. Review of current service consents revealed no consent by the guardian for locking client #7's closet to address inappropriate flushing of items. Interview with the QIDP on 5/23/18 verified client #7 has a behavior history of flushing inappropriate items and his personal closet is currently kept locked due to the identified behavior. The QIDP further verified locking the client's personal closet is a restrictive intervention and written consent from the guardian should have been obtained. 2. Interview with the QIDP on 5/22/18 revealed the bicycles for multiple residents of Mulberry were kept locked due to the behavior of a client with a target behavior of leaving the property without permission. The QIDP stated clients could get staff assistance with unlocking their bicycles during leisure times of their daily schedule. The QIDP further verified client #7 has a personal bicycle purchased by his guardian that is kept locked due to the behavior concerns of another resident and client #7 requires staff assistance with getting access to his bicycle.	W 263	B. 1. By July 23, 2018, written guardian consent will be obtained for the use of a locked personal closet for Client #7. *Responsible Persons: Psychology staff and Mulberry QIDP* 2. By July 23, 2018, written guardian consent will be obtained for the use of a locked bicycle for Client #7. *Responsible Persons: Mulberry Social Worker and QIDP* *To ensure access to his personal locked Bicycle.* By July 01, 2018, Client #7's key usage will be assessed and a training program to access his locked bike will be implemented.	7/23/18 7/23/18 7/01/18

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W 263	Continued From page 10 Subsequent interview with the QIDP revealed written consent from the guardian of client #7 had not been obtained for locking the client's bicycle. Review of records for client #7 on 5/23/18 verified no consent by the guardian for locking client #7's bicycle. C. In Cedar/Willow/Evergreen area, the HRC failed to ensure written informed consents were obtained for the use of a jump suit for 1 of 2 sampled clients (#8) residing in the Honeysuckle of North Willow. Observations during the 5/22-5/23/18 survey, verified by interviews with the area director and the behavior program specialist, revealed client #8 wears a one piece jump suit that buttoned up the back. Continued observations during the survey, confirmed by interview with the area director, revealed the client was also wearing a vest over top of the jump suit. Additional interviews with the area director, behavior program specialist and the area nursing supervisor revealed the one piece jump suit is used due to the client's PICA behavior. Further interview with the behavior program specialist, substantiated by review of the12/15/17 PCP, revealed behavior guidelines for the client to wear one piece suite made of tightly woven fabric to reduce tearing, fraying and string availability to reduce incidents of PICA was present in the records. However, continued interviews, verified by additional review of the PCP for client #8, revealed no formal programing has been implemented to address the PICA behavior or the use of the restrictive techniques of using a one piece jump suit to assist in the control of the inappropriate behavior.	W 263	By July 10, 2018, all staff working with Client #7 will receive competency based training of the designed program. Program implementation will be monitored at least weekly using the Program Observation and Feedback Tool. Program progress will be monitored at least monthly in progress notes. *Responsible Persons: Mulberry QIDP and Mulberry Supervisors.* C. By July 23, 2018, written guardian consent will be obtained for the use of a single piece jump suit for Client #8. *Responsible Persons: Psychology staff and North Willow QIDP* **To address inclusion of written consents for all residents:** Quarterly, information will be provided to the Human Rights Committee including informed consent requests made to guardians, consents received, and any declinations of consent and the team follow-up regarding these. *Responsible Persons: Area Directors, Director of Residential Services, Director of Program Administration*	7/10/18 7/23/18

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W 263	Continued From page 11 Additional review of the records verified by interviews, revealed no evidence of a signed written consent to address the client restriction of wearing a one piece jump suit to assist in the decrease of the PICA behavior was present in client #8's record.	W 263		
W 289	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(4) 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: The team failed to ensure techniques to manage inappropriate behaviors are incorporated into the person centered plans (PCP) for 1 of 2 sampled clients (#8) residing in the Honeysuckle, one of 2 sampled clients (#2) in Birch and 1 of 2 sampled clients (#7) residing in Mulberry as evidenced by observations, interviews and review of records. The findings are: A. The team failed to ensure the use of a one piece jump suit for client #8 residing in the Honeysuckle cottage of North Willow was used only as a integral part of the 12/15/17 PCP. Observations during the 5/22-5/23/18 survey, verified by interviews with the area director and the behavior program specialist, revealed client #8 wears a one piece jump suit that buttoned up	W 289	**W289** **For the individuals noted in this citation the use of systematic interventions to manage inappropriate behavior will be incorporated into their individual program plan.** For Clients #8, #2 and #7 as described in W289 A.; B.; and C. A. Specific to Client #8 By June 30, 2018, a BSP will be developed for Client #8 to address pica behavior that includes the use of a single piece jump suit. Procedures will be included and monitored monthly by psychology staff and North Willow QIDP. By July 20, 2018, an in-service on the BSP will be conducted by Psychology staff for all staff working with Client #8 and documented on a training record.	6/30/18 7/20/18

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W 289	Continued From page 12 the back. Continued observations during the survey, confirmed by interview with the area director, revealed the client was also wearing a vest over top of the jump suit. Additional interviews with the area director, behavior program specialist and the area nursing supervisor revealed the one piece jump suit is used due to the client's PICA behavior. Further interview with the behavior program specialist, substantiated by review of the12/15/17 PCP, revealed behavior guidelines for the client to wear one piece suite made of tightly woven fabric to reduce tearing, fraying and string availability to reduce incidents of PICA was present in the records. However, continued interviews and verified by additional review of the PCP for client #8, revealed no formal programing has been implemented to address the PICA behavior or the use of the restrictive techniques of using a one piece jump suit to assist in the control of the inappropriate behavior. B. The team failed to ensure techniques to manage inappropriate behaviors were incorporated into the PCP for 1 of 2 sampled clients (#2) residing in the Birch, related to a locking wheelchair lap belt. Observations in the Redwood Worksite Academy classroom on 5/21/18 at 3:08 PM revealed two staff members preparing to assist client #2 with transferring from a wheelchair to a standing position. A staff member was observed unlocking a wheelchair lap belt with a key, so the client could transfer out of the wheelchair. Review of the record for client #2 on 5/23/18 revealed a PCP dated 6/26/17. The PCP	W 289	By July 23, 2018, HRC approval will be obtained for BSP for Client #8. Program progress will be monitored at least monthly in progress notes. *Responsible Persons: North Willow QIDP, Behavior Program Specialist, CWE Senior Psychologist* B. Specific to Client #2 By June 30, the BSP for Client #2 will be addended to include the locking wheelchair lap belt. Procedures will be included and monitored monthly by Birch Behavior Program Specialist and QIDP. By July 20, 2018, an in-service on the BSP will be conducted by the Birch Program Specialist for all staff working with Client #2 and documented on a training record. By July 23, 2018, HRC approval will be obtained for addended BSP for Client #2.	7/23/18 6/30/18 7/20/18 7/23/18

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W 289	Continued From page 13 indicated the client has poor balance/gait when ambulating and has a history of crawling on the floor and sustaining serious injury to his knees and face. Continued review of the PCP revealed a behavior support plan (BSP) dated 8/17/17. Review of the BSP revealed client #2's target behaviors included self injurious behavior, aggression, spitting, crawling and Pica. Continued review of the BSP revealed restrictive interventions for the target behaviors to include a wrap restraint board, hand mitts and wrist restraints in the wheelchair, all to be used if necessary as directed by the BSP. Further review of the BSP did not include a locking wheelchair lap belt as a restrictive intervention. Interview with the qualified intellectual disabilities professional (QIDP) on 5/23/18, confirmed client #2 has a locking wheelchair lap belt because the client has a history of removing the lap belt, especially when the wheelchair is moving, and attempting to get out of the wheelchair. Continued review with the QIDP confirmed the BSP did not contain the locking wheelchair lap belt as a restrictive intervention. C. The team failed to ensure techniques to manage inappropriate behaviors were incorporated into the PCP for 1 of 2 sampled clients (#7) in Mulberry relative to a locked personal closet. Review of records for client #7 on 5/23/18 revealed an occupational therapy assessment dated 10/30/17 referencing a locked personal closet of client #7 due to inappropriate flushing of items in the toilet. Further record review revealed a BSP dated 10/18/17 for target behaviors of physical/verbal aggression, self injurious	W 289	Program progress will be monitored at least monthly in progress notes. *Responsible Persons: Birch QIDP, Behavior Program Specialist, Summit Supervising Psychologist* C. Specific to Client #7 By June 30, 2018, the BSP for Client #7 will be addended to include the locking of his personal closet to address flushing of inappropriate items. Procedures will be included and monitored monthly by Mulberry Psychologist and QIDP. By July 20, 2018, an in-service on the BSP will be conducted by Psychology staff for all staff working with Client #7 and documented on a training record. By July 23, 2018, HRC approval will be obtained for addended BSP for Client #7.	6/30/18 7/20/18 7/23/18

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W 289	Continued From page 14 behavior, agitation, fixation on upcoming events and property destruction. Review of the BSP did not include the use of locking the clients personal closet to address flushing of inappropriate items as a prevention strategy for any identified target behavior. Interview with the QIDP on 5/23/18 verified client #7 has a behavior history of flushing inappropriate items and his personal closet is currently kept locked due to the identified behavior. The QIDP further verified locking the clients personal closet is a restrictive intervention that should be integrated into the BSP.	W 289	Program progress will be monitored at least monthly in progress notes. *Responsible Persons: Mulberry QIDP, Psychologist, Lakeside Senior Psychologist* **To address inclusion of the use of systematic interventions to manage inappropriate behavior into the clients' IPP for all residents:** Compliance to having the use of systematic interventions incorporated in their IPP will be monitored by the team at the time of the annual PCP, during Quarterly Drug Regimen reviews and annual BSP reviews. *Responsible Persons: Home QIDP Psychology staff*	
W 312	DRUG USAGE CFR(s): 483.450(e)(2) Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record review and interview, the team failed to ensure medications to control inappropriate behaviors were used only as an integral part of the person centered plan (PCP) for 3 of 9 sampled clients (#1, #2 and #5) residing in the Summit. The finding are: A. Review of the record for client #5 on 5/23/18, who resides in the Pine Home #2, revealed a PCP dated 11/21/17. Review of the PCP revealed current physician orders dated 5/18/18 which included Zyprexa (anti-psychotic) 5mg daily	W 312	**W312** For the individuals noted in this citation the use of drugs for control of inappropriate behavior will be incorporated into their individual program plan. For Clients #1, #2, and #5 as described in W312 A. and B. 1-2. A. By June 30, 2018, the BSP for Client #5 will be addended to include to use of Zyprexa as a part of his plan. *Responsible Persons: Pine QIDP, Behavior Program Specialist, Summit Supervising Psychologist*	6/30/18

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W 312	Continued From page 15 at 8 PM. Continued review of the PCP revealed a behavior support plan (BSP) dated 12/1/17, which included target behaviors of Pica disruptive behavior, aggression and self injurious behavior. Continued review of the BSP did not reveal Zyprexa to be included as a part of the plan to control inappropriate behaviors. Further review of the record PCP revealed a guardian consent for the Zyprexa dated 12/14/17. The consent indicated the Zyprexa would be added to the BSP. Interview with the qualified intellectual disabilities professional (QIDP) on 5/23/18 revealed client #5 had been prescribed Zyprexa since 12/16. The QIDP confirmed the behavioral medication had not been added to the BSP and indicated it was an oversight. B. The team failed to ensure medications to control inappropriate behaviors were used only as an integral part of the person centered plan (PCP) for 2 of 2 sampled clients (#1 and #2) residing in the Birch home. Examples include: 1. Review of the record for client #2 on 5/23/18 revealed a PCP dated 6/26/17. Review of the PCP revealed physician orders dated 5/18/18 for Zyprexa (anti-psychotic) 10mg daily at 9 PM and Trazedone (anti-depressive and sedative) 100mg daily at 9:00 PM. Continued review of the PCP revealed a BSP dated 8/17/17 which included target behaviors including self injurious behavior, aggression, spitting, crawling and Pica. Further review of the BSP revealed Zyprexa and Trazedone were not included as a part of the plan to control inappropriate behaviors. Interview with the QIDP on 5/23/18 confirmed	W 312	B. 1. By June 30, 2018, the BSP for Client #2 will be addended to include the use of Zyprexa and Trazadone as part of his plan. *Responsible Persons: Birch QIDP, Behavior Program Specialist, Summit Supervising Psychologist*	6/30/18

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W 312	Continued From page 16 Zyprexa and Trazedone were not included in the BSP. The QIDP indicated facility psychology staff were aware the behavioral medications needed to be added to the BSP, but did not plan on adding them until the next annual meeting to review the BSP. 2. Review of the record for client #1 on 5/23/18 revealed a PCP dated 1/24/18. Review of the PCP revealed physician orders dated 2/5/18 for Trazadone (antidepressant and sedative) 75 mg daily at 9:00PM. Continued review of the PCP revealed a BSP dated 9/27/17 which included target behaviors including self-injurious behaviors of striking head and face with fist, knee or object, dropping to the floor and striking head on floor, falling to floor on knees or bottom, and diving head first onto the floor. Further review of the BSP revealed Trazadone was not included as a part of the BSP plan to control inappropriate behaviors. Interview with the QIDP on 5/23/18 confirmed Trazadone was not included in the BSP. The QIDP indicated facility psychology staff were aware the behavioral medication needed to be added to the BSP, but did not plan on adding the medication until the next annual meeting to review the BSP.	W 312	2. By June 30, 2018, the BSP for Client #1 will be addended to include the use of Trazadone as part of her plan. *Responsible Persons: Birch QIDP, Behavior Program Specialist, Summit Senior Psychologist* **To address inclusion of the use of systematic interventions to manage inappropriate behavior into the clients' IPP for all residents:** Compliance to having the use of drugs for control of inappropriate behavior incorporated in their IPP will be monitored by the team at the time of the annual PCP, during Quarterly Drug Regimen reviews and annual BSP reviews. *Responsible Persons: Home QIDP, RN, and Psychology staff*	6/30/18
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by:	W 382	**W382** **To address all drugs and biologicals remaining locked until preparation and administration**	

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W 382	Continued From page 17 The facility failed to ensure all topicals with pharmacy labels were stored in a locked area except when being prepared for administration in the Cedar/Willow/Evergreen area as evidenced by observations and interviews. The finding is: Observations of the bathroom in the Evergreen area on 5/24/18 at 7:00 AM revealed topicals left on the counter including Clindamycin, Asorbate and E-Oil. Further observations, verified by the area director and the unit director, revealed the topicals to have pharmacy labels on them for one of the residents of Evergreen area. Continued observations of the bathroom revealed cabinets on the walls with no locking mechanism. Additional observations, substantiated by interviews with the area director and unit director, revealed the cabinets were for the residents of the Evergreen area and some to contain topicals having pharmacy labels. Additional interviews with the area director revealed it is the facility's policy and an area practice certain topicals could be left in an unlocked area and others had to be locked. Continued interview with the areas director, substantiated by observations in both Willow and Cedar areas revealed cabinets in the bathroom with no locking mechanism containing topicals with pharmacy labels for residents of those areas. As a result the facility has failed to ensure topicals have been stored in a locked area except for when being administered as required.	W 382	By June 15, 2018, the JIRDC Nursing Policy and Procedure #6.20 (Treatment Administration for Non-Nursing Staff) will be revised to state that "all treatments that have a pharmacy label, must be stored in a locked area (which is determined by the home and varies from home to home). Treatments must remain in a locked cabinet until administration; treatments must never be left unattended." Each home, including Evergreen, will identify locked storage as appropriate. By July 15, 2018, an in-service on the storage and security of medications and treatments will be provided for all nurses and non-nursing staff that are responsible for administration of treatments per Policy #6.20. This in-service will be documented on a Staff Development Training Roster. Monitoring will occur by the area Nurse Supervisor, QIDPs and TRII and/or TRIII. *Responsible Persons: Nurse Supervisors, QIDPs and Home Supervisors*	6/15/18 7/15/18