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	34G143	A. BUILDING _____ B. WING _____	C 06/18/2018

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W 122	CLIENT PROTECTIONS CFR(s): 483.420 The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: The facility failed to: establish and implement written policies and procedures that prohibited the neglect of the clients (W149), conduct thorough investigations (W154) and results of investigations sent to the Health Care Personnel Registry (HCPR) as mandated (W156). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated Client Protections.	W 122		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility neglected to assure written policies and procedures were developed and implemented in order to prevent the potential for future elopements and client neglect. This affected 2 of 3 audit clients (#1 and #6). The findings are: 1. The facility did not have written policies and procedures in place to address client #1's elopements.	W 149		

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

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Review on 6/18/18, of the human rights committee minutes revealed the following incidents reports dated 5/31/18, 6/2/18 and 6/4/18, were all elopements for client #1. The facility did not develop and implement a behavior improvement plan to address this elopement behavior.

Review on 6/18/18 of client #1's record revealed an admission date of 4/20/18 and a moderate intellectual diagnosis.

Review of the three incident reports revealed the following as identified:

a. Review on 6/18/18 of an incident report dated 5/31/18 at 6:30pm revealed, "[Client #1] became defiant and would not listen to staff's Request to comply with house rules. [Client #1] walked out the side kitchen door and walked down the street 2 houses. Staff ran and caught up with [Client #1] and urged [Client #1] to come back to the house [Client #1] complied and came back."

b. Review on 6/18/18 of an incident report dated 6/2/18 at 6:30pm revealed, "[Client #1] refused to bathe. When asked a second time, he told staff no. Staff left his room. [Client #1] came to the front area dressed in clothing (Jacket, white sweats) and exited the door. He refused to return and headed in the direction of the store. 911 was contacted he was returned by the Durham Police with snacks (Coke & porkskins), At 7:30pm. He ate his snacks, continued to refuse a bath and made a second attempt to leave the building but he observed staff...."

c. Review on 6/18/18 of an incident report dated 6/4/18 at 3:30pm revealed, "[Client #1] left facility.

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Staff rode the neighborhood looking for client. Staff asked cashier at the store if they had seen client. They reported yes he was asking for cig., pork skins, & Coca-cola. Cashier report client left store after no one gave him cig. and went up the street. Staff rode the area of hwy 55 unable to locate client. 911 was contacted full description of client given and officer notified and dispatched to facility for picture of client and other identifying info.... Staff continued riding looking for client. Client was located at local convenience store and brought back to facility...checked for injury none noted...."

During an interview on 6/18/18 via telephone, the Durham Police records department identified an, "Incident/Investigation report for a Missing Person was made on 6/4/18 for [Client #1]" and there was no other information available. This information was also made available to the surveyors for review via fax from the Durham Police records department.

During an interview on 6/18/18, the administrator confirmed she was unaware client #1 had target behaviors which included leaving the facility amongst other unidentified behaviors of sexual overtures from his past placement. Further interview confirmed client #1 did not have a behavior plan to address his behaviors of elopement and sexual overtures. The facility did not have documented policies and procedures to address elopement(s). She further revealed this was the facility's first time having a runner and having sexual overtures. Additionally, she revealed 911 was to be called for elopements.

During observations in the home on 6/18/18, client #1 was calm and interacted well with staff

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and other clients. Client #1 eagerly and independently stuck his hand out first for a hand shake to greet both surveyors. Client #1 was with an one-on-one staff constantly throughout observations in the home on 6/18/18. There were no attempts of elopement noted during observations in the home. Additional observations in the home on 6/18/18, the staff to client interactions were positive and there were 3 staff on duty.

2. Staff neglected to follow the facility's third shift call-in-procedure and was sleeping during working hours.

Review on 6/18/18 of an incident report dated 5/23/18 at 5:00am revealed, "At or about 4:30 - 4:45 I heard what was believed to be a drawer closing shut coming from [Client #6's] room. I called for [Client #6] to come up front to sit in the day room with me. until I started baths. At 5:00am I started baths I went to get [Client #6] things for a shower out of her room. Upon entering her room I observed that she had taken out an out fit top and pants as well as socks, a bra and underwear. At this point I looked at [Client #6] to ask her to help put away the clothes she had taken out, this is when I noticed major injury to her right eye. I asked [Client #6] what happened to her eye she responded 'I fell out my bed.' ...[Client #6] was taken to the ER, cold compress was applied." Client #6 has diagnosis of moderate intellectual disabilities and diagnosed with Dementia, bilateral Glaucoma and bilateral Cataracts. This staff was noted to be the only staff working on this shift. As a result of this injury client #6 was seen in the emergency room, due to trauma to her eye.

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During observations of client #6's bedroom on 6/18/18 revealed the night stand has relocated away from her bed, next to the wall across from her bed. There was no furniture located next to her bed. Also a night light has been placed in her bedroom to provide for lighting during the night.

Review on 6/18/18 of the incident report interview with involved staff member (no date) revealed this staff was being investigated for "Neglect." Further review of this document revealed, "...From her own volunteered recollections and my questions, [staff's name] stated the following: Shortly after 3 AM she had fallen asleep in the day room. She was subsequently wakened at about 4:30 AM by what she took to be the sound of the closing of one of [Client #6's] chest drawers.... [Staff] further stated that she did not get a look at [Client #6's] face when she entered the day room, and that [Client #6] made no complaint about an injury. During this time, [staff] remained lying on the couch in the day room. According to [staff], they watched TV for a while during which time [staff] stated she again fell asleep and awoke at 5 AM; at which time she left the day room, and went to the bedroom area of the facility to wake other client...." Further review of this document concluded with recommendations:, "...recommend [staff's] employment be terminated...."

Review on 6/18/18 of the facility's third shift call-in-procedure dated 12/31/13 revealed, "Purpose: To ensure compliance of state requirements of having staff awake on site...This policy will provide a third party independence record of all facility participation to help ensure that staff is awake and alert between the hours of 11pm and 6a.m. Procedure: Staff must call in on

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W 149	Continued From page 5 the hour and make the following announcements: - I have looked in on all consumers, and all consumers in the facility are alive and well (you are required to check in on each consumer at least hourly.) - I am alert, and functioning, I do not require any assistance. - The facility is operating normally.... - Each staff call will be recorded. - Each staff should endeavor to call as close to on the hour as possible...." Review on 6/18/18 of staff's time sheet revealed 5/23/18 was the last date staff worked in the home and for the facility. This staff submitted her letter of resignation to the facility on 6/1/18. During an interview on 6/18/18, client #6 confirmed she fell out of her bed, when she injured her eye. She further stated her furniture has been moved around since her fall. During an interview on 6/18/18, the administrator confirmed these incidents did occur. Additional interview confirmed the staff should have been calling in and/or documenting per the third shift call-in-procedure, which she did not do. Further interview revealed when this staff was working there appeared to be a pattern of client injuries. During observations in the home on 6/18/18, the staff to client interactions were positive and staffing was appropriate 3 staff.	W 149		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated.	W 154		

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This STANDARD is not met as evidenced by:
Based on interview and document reviews the facility failed to conduct thorough investigations of all alleged violations this affected 1 of 1 newly admitted audit client (#1). The findings are:

Client #1's three elopements from the facility were not investigated.

1. Review on 6/18/18 revealed client #1 was admitted into the facility on 4/20/18 with a moderate intellectual diagnosis. Review on 6/18/18 of an incident report dated 5/31/18 at 6:30pm revealed, "[Client #1] became defiant and would not listen to staff's Request to comply with house rules. [Client #1] walked out the side kitchen door and walked down the street 2 houses. Staff ran and caught up with [Client #1] and urged [Client #1] to come back to the house [Client #1] complied and came back."

2. Review on 6/18/18 of an incident report dated 6/2/18 at 6:30pm revealed, "[Client #1] refused to bathe. When asked a second time, he told staff no. Staff left his room. [Client #1] came to the front area dressed in clothing (Jacket, white sweats) and exited the door. He refused to return and headed in the direction of the store. 911 was contacted he was returned by the Durham Police with snacks (Coke & porkskins), At 7:30pm. He ate his snacks, continued to refuse a bath and made a second attempt to leave the building but he observed staff...."

3. Review on 6/18/18 of an incident report dated 6/4/18 at 3:30pm revealed, "[Client #1] left facility. Staff rode the neighborhood looking for client. Staff asked cashier at the store if they had seen client. Staff asked cashier at the store if they had

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W 154	Continued From page 7 seen client. They reported yes he was asking for cig., pork skins, & Coca-cola. Cashier report client left store after no one gave him cig. and went up the street. Staff rode the area of hwy 55 unable to locate client. 911 was contacted full description of client given and officer notified and dispatched to facility for picture of client and other identifying info.... Staff continued riding looking for client. Client was located at local convenience store and brought back to facility...checked for injury none noted...." During an interview on 6/18/18, the administrator confirmed the facility had not conducted any investigations concerning client #1's elopements.	W 154		
W 156	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(4) The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to assure the results of an investigation was reported to the Health Care Personnel Registry (HCPR) within five working days of the incident as required by NC General Statute 131E-256. The finding is: An investigation and three elopements were not reported to the HCPR. a. Review on 6/18/18, of an investigation report with a start date of 5/23/18, revealed it was not submitted to the HCPR within five working days.	W 156		

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W 156	Continued From page 8 The five day investigation report has not been submitted as of 6/18/18 and no request for an extension had been submitted. b. Review on 6/18/18 of the human rights committee minutes revealed three separate incident reports of elopements for client #1 dated 5/31/18, 6/2/18 and 6/4/18, all were not reported to HCPR. During an interview on 6/18/18 via telephone, the Durham Police records department identified an, "Incident/Investigation report for a Missing Person was made on 6/4/18 for [Client #1]" and there was no other information available. This information was also made available to the surveyors for review via fax from the Durham Police records department. During an interview on 6/18/18, the administrator confirmed no information or a request for an extension has been submitted to the HCPR.	W 156		
W 158	FACILITY STAFFING CFR(s): 483.430 The facility must ensure that specific facility staffing requirements are met. This CONDITION is not met as evidenced by: The facility failed to: assure the qualified intellectual disabilities professional (QIDP) coordinated, integrated and monitored the programs for 1 of 1 audit clients in the home (W159) and facility did not provide sufficient direct care staff to manage and supervise clients (W186).	W 158		

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W 158	Continued From page 9 As a result the facility failed to provide statutorily mandated facility staffing requirements.	W 158		
W 159	QIDP CFR(s): 483.430(a) 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 interviews, record review and observations, the facility failed to assure the qualified intellectual disabilities professional (QIDP) developed an individual program plan (IPP) and behavior improvement plan (BIP) for 1 of 1 newly admitted audit clients (#1). The findings are: The QIDP did not develop client #1's IPP nor develop and implement a needed BIP to address target behaviors of elopement. Review on 6/18/18 of client #1's record revealed he was admitted into the facility on 4/20/18 with a moderate intellectual disabilities diagnosis. Further review did not reveal an IPP nor a BIP. Review on 6/18/18, of the human rights committee minutes revealed the following incident reports dated 5/31/18, 6/2/18 and 6/4/18, all three were elopements and there was no behavior plan to address this elopement behavior. a. Review on 6/18/18 of an incident report dated 5/31/18 at 6:30pm revealed, "[Client #1] became defiant and would not listen to staff's Request to comply with house rules. [Client #1] walked out the side kitchen door and walked down the street 2 houses. Staff ran and caught up with [Client #1]	W 159		

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and urged [Client #1] to come back to the house [Client #1] complied and came back."

b. Review on 6/18/18 of an incident report dated 6/2/18 at 6:30pm revealed, "[Client #1] refused to bathe. When asked a second time, he told staff no. Staff left his room. [Client #1] came to the front area dressed in clothing (Jacket, white sweats) and exited the door. He refused to return and headed in the direction of the store. 911 was contacted he was returned by the Durham Police with snacks (Coke & porkskins), At 7:30pm. He ate his snacks, continued to refuse a bath and made a second attempt to leave the building but he observed staff...."

c. Review on 6/18/18 of an incident report dated 6/4/18 at 3:30pm revealed, "[Client #1] left facility. Staff rode the neighborhood looking for client. Staff asked cashier at the store if they had seen client. Staff asked cashier at the store if they had seen client. They reported yes he was asking for cig., pork skins, & Coca-cola. Cashier report client left store after no one gave him cig. and went up the street. Staff rode the area of hwy 55 unable to locate client. 911 was contacted full description of client given and officer notified and dispatched to facility for picture of client and other identifying info.... Staff continued riding looking for client. Client was located at local convenience store and brought back to facility...checked for injury none noted...."

During an interview on 6/18/18, the QIDP revealed he thought the facility had 90-days to complete the IPP. Additional interview confirmed the facility had not established a current 2018 IPP.

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W 159	Continued From page 11 During an interview on 6/18/18, the administrator confirmed the facility had not established a current 2018 IPP nor a BIP for client #1. During observations in the home on 6/18/18, client #1 was calm and interacted well with staff and other clients. Client #1 independently stuck his hand out first for a hand shake to greet both surveyors. Client #1 was with a constant one-on-one staff throughout observations in the home on 6/18/18. During observations in the home on 6/18/18, the staff to client interactions were positive and staffing was appropriate 3 staff.	W 159		
W 186	DIRECT CARE STAFF CFR(s): 483.430(d)(1-2) The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on record review, interview and observations the facility failed to assure sufficient staff to implement the individual program plan (IPP) and provide needed assistance to 3 of 3 audit client (#1, #3 and #6) residing in the home. The findings are: Sufficient staff were not available to meet the needs of the clients in home.	W 186		

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a. Review on 6/18/18 of an incident report dated 6/2/18 at 6:30pm revealed, "[Client #1] refused to bathe. When asked a second time, he told staff no. Staff left his room. [Client #1] came to the front area dressed in clothing (Jacket, white sweats) and exited the door. He refused to return and headed in the direction of the store. 911 was contacted he was returned by the Durham Police with snacks (Coke & porkskins), At 7:30pm. He ate his snacks, continued to refuse a bath and made a second attempt to leave the building but he observed staff...."

During interview on 6/18/18, the administrator revealed the staffing has been skeletal and 1 on 1 supervision was not put in place until this last elopement incident occurred.

During observations in the home on 6/18/18, client #1 was calm and interacted well with staff and other clients. Client #1 independently stuck his hand out first for a hand shake to greet both surveyors. Client #1 was with a constant one-on-one staff throughout observations in the home on 6/18/18.

During observations in the home on 6/18/18, the staff to client interactions were positive and staffing was appropriate 3 staff.

b. Review on 6/18/18 of an incident report dated 6/4/18 at 3:30pm revealed, "[Client #1] left facility. Staff rode the neighborhood looking for client. Staff asked cashier at the store if they had seen client. Staff asked cashier at the store if they had seen client. They reported yes he was asking for cig., pork skins, & Coca-cola. Cashier report client left store after no one gave him cig. and went up the street. Staff rode the area of hwy 55

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unable to locate client. 911 was contacted full description of client given and officer notified and dispatched to facility for picture of client and other identifying info.... Staff continued riding looking for client. Client was located at local convenience store and brought back to facility...checked for injury none noted...."

During interview on 6/18/18, the administrator revealed the staffing has been skeletal and 1 on 1 supervision was not put in place until this last elopement incident occurred.

During an interview on 6/18/18 via telephone, the Durham Police records department identified an, "Incident/investigation report for a Missing Person was made on 6/4/18 for [Client #1]" and there was no other information available. This information was also made available to the surveyors for review via fax from the Durham Police records department.

During an interview on 6/18/18, the administrator confirmed these incidents did occur. The staffing for the facility had been skeletal and the facility has not been staffed like it should have. She further stated she was unaware client #1 had prior behaviors of which included leaving the facility amongst other unidentified behaviors from his past placement. She stated, "I am not prepared to deal with a runner or one with sexual overtures." Further interview revealed there are to be two staff on all shifts and it has not been.

During observations in the home on 6/18/18, client #1 was calm and interacted well with staff and other clients. Client #1 independently stuck his hand out first for a hand shake to greet both surveyors. Client #1 was with a constant

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	34G143	A. BUILDING _____ B. WING _____	C 06/18/2018

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one-on-one staff throughout observations in the home on 6/18/18.

During observations in the home on 6/18/18, the staff to client interactions were positive and staffing was appropriate 3 staff.

c. Review on 6/18/18 of an incident report dated 4/27/18 at 5:00am revealed, "After undressing [Client #3] for a shower staff turned around to get [Client #3's] soap from her bathroom bin. Hearing the shower running [Client #3] proceeded to enter the shower alone. [Client #3] tripped over the entrance to the shower causing her to fall before staff could catch her. Client #3 is blind and her intellectual diagnosis is profound. This staff was noted to be the only staff working on this shift. As a result of this injury client #3 was seen in the emergency room, due to injury to her arm/shoulder.

Review on 6/18/18 of staff's time schedule revealed 5/23/18 was the last date staff worked in the home and for the facility. This staff submitted her letter of resignation to the facility on 6/1/18.

During observations in the home on 6/18/18, the staff to client interactions were positive and staffing was appropriate 3 staff.

d. Review on 6/18/18 of client #6's incident report dated 5/23/18 at 5:00am revealed, "At or about 4:30 - 4:45 I heard what was believed to be a drawer closing shut coming from [Client #6's] room. I called for [Client #6] to come up front to sit in the day room with me. until I started baths. At 5:00am I started baths I went to get [Client #6] things for a shower out of her room. Upon entering her room I observed that she had taken

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out an out fit top and pants as well as socks, a bra and underwear. At this point I looked at [Client #6] to ask her to help put away the clothes she had taken out, this is when I noticed major injury to her right eye. I asked [Client #6] what happened to her eye she responded 'I fell out my bed.' ...[Client #6] was taken to the ER, cold compress was applied." Client #6's functioning level is moderate and has been diagnosed with Dementia, bilateral Glaucoma and bilateral Cataracts. This staff was noted to be the only staff working on this shift. As a result of this injury client #6 was seen in the emergency room, due to trauma to her eye.

Review on 6/18/18 of the incident report interview with involved staff member (no date) revealed, "...From her own volunteered recollections and my questions, [staff's name] stated the following: Shortly after 3 AM she had fallen asleep in the day room. She was subsequently wakened at about 4:30 AM by what she took to be the sound of the closing of one of [Client #6's] chest drawers.... [Staff] further stated that she did not get a look at [Client #6's] face when she entered the day room, and that [Client #6] made no complaint about an injury. During this time, [staff] remained lying on the couch in the day room. According to [staff], they watched TV for a while during which time [staff] stated she again fell asleep and awoke at 5 AM; at which time she left the day room, and went to the bedroom area of the facility to wake other client...."

Review on 6/18/18 of the facility's third shift call-in-procedure dated 12/31/13 revealed, "Purpose: To ensure compliance of state requirements of having staff awake on site...This policy will provide a third party independence

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W 186	Continued From page 16 record of all facility participation to help ensure that staff is awake and alert between the hours of 11pm and 6a.m. Procedure: Staff must call in on the hour and make the following announcements: - I have looked in on all consumers, and all consumers in the facility are alive and well (you are required to check in on each consumer at least hourly.) - I am alert, and functioning, I do not require any assistance. - The facility is operating normally.... - Each staff call will be recorded. - Each staff should endeavor to call as close to on the hour as possible...." Review on 6/18/18 of staff's time schedule revealed 5/23/18 was the last date staff worked in the home and for the facility. This staff submitted her letter of resignation to the facility on 6/1/18. During an interview on 6/18/18, the administrator confirmed these incidents did occur. The staffing has been skeletal and there shifts and it has not been. Further interview confirmed the staff should not have been sleeping and should have been calling in and/or documenting per the third shift call-in-procedure, which she did not do. Additional interview confirmed there are to be two staff on all shifts. During observations in the home on 6/18/18, the staff to client interactions were positive and staffing was appropriate 3 staff.	W 186		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.	W 189		

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This STANDARD is not met as evidenced by:
Based on interviews, document review and observations, the facility failed to assure staff were sufficiently trained to perform their duties effectively and efficiently. This affected 2 of 3 audit clients (#1 and #3). The findings are:

1. Staff were not trained to work with client #1's elopement behaviors.

Review on 6/18/18 of client #1's incident reports dated 5/31/18, 6/2/18 and 6/4/18 revealed three elopements from the facility.

Review on 6/18/18 of client #1's record revealed he was admitted into the facility on 4/20/18. Further review of client #1's record did not reveal an individual program plan nor a behavior plan to address the elopement behavior.

During an interview on 6/18/18, the administrator confirmed the facility did not have a policy to address elopement, this was the first time the facility had a client with elopement behaviors and 911 would be called when client #1 elopes. Further interview confirmed the elopement behaviors were not part of a behavior plan and a behavior plan is needed to address his behaviors. Additionally, the psychologist has been on vacation; therefore no behavior plan has been established to address any of his behavioral needs.

During observations in the home on 6/18/18, client #1 was calm and interacted well with staff and other clients. Client #1 independently stuck his hand out first for a hand shake to greet both

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surveyors. Client #1 was with a constant one-on-one staff throughout observations in the home on 6/18/18.

During observations in the home on 6/18/18, the staff to client interactions were positive and staffing was appropriate 3 staff.

2. Staff were not adequately trained to work with blind and visually impaired clients.

Review on 6/18/18, of an internal investigation report dated 4/27/18 for client #3, revealed the following: "On April 27, 2018 in the process of preparation of the resident for bath time, a fall in the shower occurred. Resident, [Client #3] had been undressed and the shower was running. The attendant staff was present and was collecting and moving items. i.e. Soap, from the bathroom bin to begin the clients shower. The resident moved to step into shower alone without waiting of for or before she could be given assistance. She is very familiar with the facility, however, she then stumbled (she is legally blind) and tripped over the raised entrance. Staff attempted but was unable to prevent the fall which happened quickly. The resident was assisted to her feet. This was reported by staff who was attending and was the witness to this occurrence." This fall resulted in a fracture to client's right shoulder.

Review on 6/18/18 of staff's time schedule revealed 5/23/18 was the last date staff worked in the home and for the facility. This staff submitted her letter of resignation to the facility on 6/1/18.

During observations in the home on 6/18/18, staff worked with client #3 without any problems noted.

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W 189	Continued From page 19 Staff interview on 6/18/18, revealed they have worked at the facility for a long period of time and had not received any training from this facility on working with blind and visually impaired clients. During an interview on 6/18/18, with the qualified intellectual disabilities professional (QIDP) confirmed he was not aware of any facility training provided to staff concerning working with blind and visually impaired clients. During observations in the home on 6/18/18, staff worked with client #3 without any problems noted. During observations in the home on 6/18/18, the staff to client interactions were positive and staffing was appropriate 3 staff.	W 189		
W 226	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) Within 30 days after admission, the interdisciplinary team must prepare, for each client, an individual program plan. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to assure the interdisciplinary team prepared an individual program plan (IPP) within 30 days after admission into the facility for 1 of 1 newly admitted audit client (#1). The finding is: Client #1's individual program plan (IPP) was not developed within 30 days after admission. Review on 6/18/18 of client #1's record revealed	W 226		

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W 226	Continued From page 20 he was admitted into the facility on 4/20/18. Further review did not reveal an established and implemented IPP as of 6/18/18. During an interview on 6/18/18, the qualified intellectual disabilities professional (QIDP) confirmed client #1's IPP had not been developed within 30 days of his admission.	W 226		