STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G271	A. BUILDING _____ B. WING _____	08/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-ROLLINS GROUP HOME	297 BOB ROLLINS ROAD FOREST CITY, NC 28043

(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 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: implement written policies and procedures that prohibit mistreatment, neglect and abuse of clients (W149); ensure allegations of abuse were immediately reported to the administrator and to other officials in accordance with State law (W153); implement sufficient client protection measures after becoming aware of abuse allegations and after an investigation was in process (W155); ensure investigation results were reported to the administrator and to other officials in accordance with State law within 5 days of abuse allegations (W156); and show evidence of appropriate corrective action for verified allegations of abuse (W157). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated services of Client Protection to it's clients.	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 record/document review and interview, the facility failed to assure it's policies and	W 149		

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

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W 149	Continued From page 1 procedures that prohibit abuse and neglect were implemented to prevent the abuse of 3 of 6 clients residing in the group home (#2, #4 and #6). The findings are: Review of facility abuse/neglect investigations on 8/28/18 revealed one investigation started on 7/19/18 and ending on 8/6/18. The original scope of the investigation was to determine if staff A had physically or verbally abused clients in the group home and to assess if staff A had violated company cell phone policy. Continued review of the facility investigation revealed that additional allegations were added during the investigation due to statements during staff interviews. As a result, the total facility abuse/neglect/mistreatment investigation allegations included: (A) Staff A being verbally and physically abusive toward clients and violating client #2's privacy by leaving a bathroom door open while the client was showering; (B) Staff B failing to appropriately perform restrictive intervention guidelines while client #4 was having a behavior and (C), to determine if any staff members "violated company policy" by spraying client #6 with a water bottle in the face in attempt to wake the client up. A. Review of the facility investigation conclusions revealed that verbal abuse was substantiated for Staff A toward client #4, as well as failure to respect privacy for client #2 and "violating company policy" by spraying client #6 in the face with a water bottle to wake the client up. Interview with the facility operations manager (OM) on 8/28/18 revealed staff A was suspended from employment effective 7/19/18, and did not work again prior to termination from employment.	W 149		

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W 149	Continued From page 2 Review of the facility notifications related to staff A revealed both the 24 hour Health Care Personnel Registry (HCPR) and the 5 day HCPR reports were not completed until 8/9/18. Review of the Incident Response Improvement System (IRIS) report revealed it was first entered on 8/9/18 and indicated the department of social services and the client #4's guardian were notified on 8/9/18. Interview with the OM on 8/28/18 revealed the guardian was contacted on 7/19/18, but formal written evidence of this was not available. The OM also indicated the investigation was not completed within 5 working days because the investigator and administrative staff had not reached conclusions about all of the allegations. B. Review of the facility investigation staff interview summaries on 8/28/18 revealed a relative of a staff member was interviewed on 7/23/18 about an incident which occurred on 7/23/18 on the facility van in the morning prior to the clients being transported to the day program. The interview indicated that while parked in the facility driveway, the visitor overheard staff B say "No [client #4]" and "give me your hand" and then heard 3 "smacks" then heard someone crying and again heard "No [client #4]" and heard 2 "smacks". The visitor did indicate witnessing client #6 getting off the van crying, but otherwise did not visually witness anything related to what was overheard. Review of the interview summary for staff B revealed the staff member indicated that client #2, #4 and #6 were involved in a behavior on the van while in the parking lot on the morning of 7/23/18, which included clients #2 and #6 hitting	W 149		

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W 149	Continued From page 3	W 149		

client #4. Staff B indicated she intervened with Your Safe, I'm Safe approved restrictive interventions. Further review of the interview summary indicated staff B did admit she "popped" client # 4 on the hand while the van was on the way to the day program when the client had gotten out of her seat and was pulling on another client's clothes. Review of the investigation "Factual Findings" revealed staff B "failed to follow Your Safe I'm Safe intervention techniques by hitting client #4 on the hand one time". Further review of the investigation revealed staff B did receive corrective actions.

Continued review of the investigation did not reveal staff B was suspended immediately following the allegation. Interview with the OM did indicate staff B continued to work with client's prior to the corrective actions, which were initiated on 8/9/18. Further review of the investigation, verified by interview with the OM on 8/28/18 confirmed no notifications were made to IRIS, HCPR or DSS regarding this abuse allegation. The investigation also did not include evidence the client's guardian was notified immediately following the allegation.

C. Review of the facility investigation interview summaries on 8/28/18 revealed staff B was first interviewed on 7/19/18 and indicated she had sprayed client #6 one time in the face with a spray bottle to attempt to wake the client. Staff B indicated she had been directed by staff C to do this as the way "to wake her up". Staff B indicated she had witnessed staff A and staff D spray client #6 in the face as well, to wake her up. The facility's summary of interview with client #6 completed on 7/19/18 revealed the client did indicate being sprayed in the face because she

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W 149	Continued From page 4	W 149		

was hard to wake up. The client indicated that staff C, E, D and B had all sprayed her with a water bottle. The facility interview summary with staff E on 7/20/18 indicated she had sprayed client #6 in the face to wake her up two times. The facility interview summary with staff C on 7/23/18 indicated she had sprayed client #6 in the face with water to wake her up 3 times.

The facility interview summary with the facility residential manager (RM) on 7/19/18 revealed that on 7/16, staff B stated to her that she had sprayed client #6 in the face to wake her up and the RM told staff B she could not do that. The interview summary indicated a house staff meeting occurred on 7/17/18 in which she told all staff to not use the spray bottle to wake up the client. Interview with the RM on 8/28/18 confirmed multiple staff had been using a spray bottle to wake up client #6 because she was hard to wake up at times. The RM indicated the first she became aware of this staff practice toward client #6 was on 7/16/18. She indicated she had not made administrative staff aware of this at that time, and indicated she told all staff not to use this practice on 7/17/18 during a house staff meeting. She also indicated that based on her knowledge of how long some staff had been working in the home, this practice had been going on for at least 6 months. Review of the documentation on 8/28/18 of the minutes for this meeting revealed this practice was covered and staff were told to no longer do it.

Continued review of the facility investigation, confirmed by interview with the OM on 8/28/18, did not reveal any immediate staff suspensions related to this mistreatment, and did not reveal that IRIS, HCPR, or DSS were notified as

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W 149	Continued From page 5	W 149		

required for this client mistreatment. The investigation did not include evidence the guardian was notified immediately. Interview with the OM on 8/28/18 revealed the RM did not receive corrective actions for not immediately reporting the staff mistreatment of client #6 to administrative staff. Staff A, B, and E all received corrective action, for what included "inappropriate redirection of clients". Interview with the OM on 8/28/18 revealed staff C ended employment with the facility at the end of July, 2018, prior to corrective actions being initiated.

The facility abuse and neglect policy and procedure titled "Protection from Abuse and Neglect", was reviewed on 8/28/18. The policy indicated that any incidents of abuse, neglect, humiliation or exploitation are to be reported to a supervisor and investigated immediately. The policy described abuse to include "the infliction of mental or physical pain or injury by other than accidental means". Humiliation was described as "demeaning or lowering a persons pride, self-respect or dignity". The policy also indicated that investigations should be completed within five business days and the OM is responsible for ensuring notifications to IRIS and DSS are completed and the HCPR 24 hour and 5 day reports are completed timely.

The facility failed to suspend multiple staff members immediately following allegations of abuse and failed to report all allegations of abuse immediately to administration and to outside entities as required by state law and by the facility's policy and procedures. The facility also failed to assure adequate corrective action and failed to increase monitoring after incidents of abuse, therefore the facility was found to be

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W 149	Continued From page 6 neglectful.	W 149		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) 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. This STANDARD is not met as evidenced by: Based on facility record/document review and interviews, the facility failed to ensure two allegations of abuse were immediately reported to the administrator and to other officials in accordance with state law for 1 of 1 investigation reviewed. The findings are: Review of facility abuse/neglect investigations on 8/28/18 revealed one investigation started on 7/19/18 and ending on 8/6/18. The original scope of the investigation was to determine if staff A had physically or verbally abused clients in the group home and to assess if staff A had violated company cell phone policy. Continued review of the facility investigation revealed that additional allegations were added during the investigation due to statements during staff interviews. As a result, the total facility abuse/neglect/mistreatment investigation allegations included: (A) Staff A being verbally and physically abusive toward clients and violating client #2's privacy by leaving a bathroom door open while the client was showering; (B) Staff B failing to appropriately perform restrictive intervention guidelines while client #4 was having	W 153		

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W 153	Continued From page 7	W 153		

a behavior and (C) to determine if any staff members "violated company policy" by spraying client #6 with a water bottle in the face in attempt to wake the client up.

A. Review of the facility investigation conclusions revealed that verbal abuse was substantiated for Staff A toward client #4, as well as failure to respect privacy for client #2 and "violating company policy" by spraying client #6 in the face with a water bottle to wake the client up. Interview with the facility operations manager (OM) on 8/28/18 revealed staff A was suspended from employment effective 7/19/18, and did not work again prior to termination from employment.

Review of the facility notifications related to staff A revealed both the 24 hour Health Care Personnel Registry (HCPR) and the 5 day HCPR reports were not completed until 8/9/18. Review of the Incident Response Improvement System (IRIS) report revealed it was first entered on 8/9/18 and indicated the department of social services (DSS) and the client #4's guardian were notified on 8/9/18. Interview with the OM on 8/28/18 revealed the guardian was contacted on 7/19/18, but formal written evidence of this was not available.

B. Review of the facility investigation staff interview summaries on 8/28/18 revealed a relative of a staff member was interviewed on 7/23/18 about an incident which occurred on 7/23/18 on the facility van in the morning prior to the clients being transported to the day program. The interview indicated that while parked in the facility driveway, the visitor overheard staff B say "No [client #4]" and "give me your hand" and then heard 3 "smacks" then heard someone crying

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and again heard "No [client #4]" and heard 2 "smacks". The visitor did indicate witnessing client #6 getting off the van crying, but otherwise did not visually witness anything related to what was overheard.

Review of the interview summary for staff B revealed the staff member indicated that client #2, #4 and #6 were involved in a behavior on the van while in the parking lot on the morning of 7/23/18, which included client's #2 and #6 hitting client #4. Staff B indicated she intervened with Your Safe, I'm Safe approved restrictive interventions. Further review of the interview summary indicated staff B did admit she "popped" client # 4 on the hand while the van was on the way to the day program when the client had gotten out of her seat and was pulling on another client's clothes. Review of the investigation "Factual Findings" revealed staff B "failed to follow Your Safe I'm Safe intervention techniques by hitting client #4 on the hand one time".

Further review of the investigation revealed staff B did receive corrective actions. Continued review of the investigation, verified by interview with the OM on 8/28/18 confirmed no notifications were made at any time to IRIS, HCPR or DSS regarding this abuse allegation. The investigation also did not include evidence the client's guardian was notified immediately following the allegation.

C. Review of the facility investigation interview summaries on 8/28/18 revealed staff B was first interviewed on 7/19/18 and indicated she had sprayed client #6 one time in the face with a spray bottle to attempt to wake the client. Staff B indicated she had been directed by staff C to do this as the way "to wake her up". Staff B

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indicated she had witnessed staff A and and staff D spray client #6 in the face as well, to wake her up. The facility's summary of interview with client #6 completed on 7/19/18 revealed the client did indicate being sprayed in the face because she was hard to wake up. The client indicated that staff C, E, D and B had all sprayed her with a water bottle. The facility interview summary with staff E on 7/20/18 indicated she had sprayed client #6 in the face to wake her up two times. The facility interview summary with staff C on 7/23/18 indicated she had sprayed client #6 in the face with water to wake her up 3 times.

The facility interview summary with the facility residential manager (RM) on 7/19/18 revealed that on 7/16/18, staff B stated to her that she had sprayed client #6 in the face to wake her up and the RM told Staff B she could not do that. The interview summary indicated a house staff meeting occurred on 7/17/18 in which she told all staff to not use the spray bottle to wake up the client. Interview with the RM on 8/28/18 confirmed multiple staff had been using a spray bottle to wake up client #6 because she was hard to wake up at times. The RM indicated the first she became aware of this staff practice toward client #6 was on 7/16/18. She indicated she had not made administrative staff aware of this at that time, and indicated she told all staff not to use this practice on 7/17/18 during a house staff meeting. She also indicated that based on her knowledge of how long some staff had been working in the home, this practice had been going on for at least 6 months.

Continued review of the facility investigation, confirmed by interview with the OM on 8/28/18, did not reveal that IRIS, HCPR, or DSS were

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W 153	Continued From page 10 notified at any time, as required for this client mistreatment. The investigation did not include evidence the guardian was notified immediately.	W 153		
W 155	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must prevent further potential abuse while the investigation is in progress. This STANDARD is not met as evidenced by: Based on review of facility records/documents and interviews, the facility failed to implement sufficient client ptotection measures immediately after becoming aware of abuse allegations and after an investigation was in progress for 1 of 1 investigation reviewed. Review of facility abuse/neglect investigations on 8/28/18 revealed one investigation started on 7/19/18 and ending on 8/6/18. The original scope of the investigation was to determine if staff A had physically or verbally abused clients in the group home and to assess if staff A had violated company cell phone policy. Continued review of the facility investigation revealed that additional allegations were added during the investigation due to statements during staff interview to include: (A) Staff B failing to appropriately perform restrictive intervention guidelines while client #4 was having a behavior and (B) to determine if any staff members "violated company policy" by spraying client #6 with a water bottle in the face in attempt to wake the client up. A. Review of the facility investigation staff interview summaries on 8/28/18 revealed a	W 155		

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relative of a staff member was interviewed on 7/23/18 about an incident which occurred on 7/23/18 on the facility van in the morning prior to the clients being transported to the day program. The interview indicated that while parked in the facility driveway, the visitor overheard staff B say "No [client #4]" and "give me your hand" and then heard 3 "smacks" then heard someone crying and again heard "No [client #4]" and heard 2 "smacks". The visitor did indicate witnessing client #6 getting off the van crying, but otherwise did not visually witness anything related to what was overheard.

Review of the interview summary for staff B revealed the staff member indicated that client #2, #4 and #6 were involved in a behavior on the van while in the parking lot on the morning of 7/23/18, which included client's #2 and #6 hitting client #4. Staff B indicated she intervened with Your Safe, I'm Safe approved restrictive interventions. Further review of the interview summary indicated staff B did admit she "popped" client # 4 on the hand while the van was on the way to the day program when the client had gotten out of her seat and was pulling on another client's clothes. Review of the investigation "Factual Findings" revealed staff B "failed to follow Your Safe I'm Safe intervention techniques by hitting client #4 on the hand one time", and as a result, the facility substantiated neglect.

Continued review of the investigation did not reveal staff B was suspended immediately following the allegation. Interview with the Operations Manager (OM) on 8/28/18 indicated staff B continued to work with client's prior to corrective actions, which were initiated on 8/9/18. The OM did not indicate any protective measures

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were implemented immediately following the discovery of this allegation on 7/23/18.

B. Review of the facility investigation interview summaries on 8/28/18 revealed staff B was first interviewed on 7/19/18 and indicated she had sprayed client #6 one time in the face with a spray bottle to attempt to wake the client. Staff B indicated she had been directed by staff C to do this as the way "to wake her up". Staff B indicated she had witnessed staff A and staff D spray client #6 in the face as well, to wake her up. The facility's summary of interview with client #6 completed on 7/19/18 revealed the client did indicate being sprayed in the face because she was hard to wake up. The client indicated that staff C, E, D and B had all sprayed her with a water bottle. The facility interview summary with staff E on 7/20/18 indicated she had sprayed client #6 in the face to wake her up two times. The facility interview summary with staff C on 7/23/18 indicated she had sprayed client #6 in the face with water to wake her up 3 times.

The facility interview summary with the facility residential manager (RM) on 7/19/18 revealed that on 7/16, staff B stated to her that she had sprayed client #6 in the face to wake her up and the RM told Staff B she could not do that. The interview summary indicated a house staff meeting occurred on 7/17/18 in which she told all staff to not use the spray bottle to wake up the client. Interview with the RM on 8/28/18 confirmed multiple staff had been using a spray bottle to wake up client #6 because she was hard to wake up at times. The RM indicated the first she became aware of this staff practice toward client client #6 was on 7/16/18. She indicated she had not made administrative staff aware of

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W 155	Continued From page 13 this at that time, and indicated she told all staff not to use this practice on 7/17/18 during a house staff meeting. She also indicated that based on her knowledge of how long some staff had been working in the home, this practice had been going on for at least 6 months. Continued review of the facility investigation, confirmed by interview with the OM on 8/28/18, did not reveal any immediate staff suspensions as a result of this mistreatment which was substantiated by the facility as "violating company policy". The OM did not indicate any protective measures were implemented immediately following the discovery of this allegation on 7/19/18.	W 155		
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 facility record/document review and interviews, the facility failed to ensure all investigation results were reported to the administrator or to other officials in accordance with State law within 5 days of abuse allegations for 1 of 1 investigation reviewed. The findings are: Review of facility abuse/neglect investigations on 8/28/18 revealed one investigation started on 7/19/18 and ending on 8/6/18. The original scope of the investigation was to determine if staff A had	W 156		

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physically or verbally abused clients in the group home and to assess if staff A had violated company cell phone policy. Continued review of the facility investigation revealed that additional allegations were added during the investigation due to statements during staff interviews. As a result, the total facility abuse/neglect/mistreatment investigation allegations included: (A) Staff A being verbally and physically abusive toward clients and violating client #2's privacy by leaving a bathroom door open while the client was showering; (B) Staff B failing to appropriately perform restrictive intervention guidelines while client #4 was having a behavior and (C) to determine if any staff members "violated company policy" by spraying client #6 with a water bottle in the face in attempt to wake the client up.

A. Review of the facility investigation conclusions revealed that verbal abuse was substantiated for Staff A toward client #4, as well as failure to respect privacy for client #2 and "violating company policy" by spraying client #6 in the face with a water bottle to wake the client up. Interview with the facility operations manager (OM) on 8/28/18 revealed staff A was suspended from employment effective 7/19/18, and did not work again prior to termination from employment.

Review of the facility notifications related to staff A revealed both the 24 hour Health Care Personnel Registry (HCPR) and the 5 day HCPR reports were not completed until 8/9/18. Review of the Incident Response Improvement System (IRIS) report revealed it was first entered on 8/9/18 and indicated the department of social services and the client #4's guardian were notified on 8/9/18. Interview with the OM on 8/28/18

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revealed the guardian was contacted on 7/19/18, but formal written evidence of this was not available.

B. Review of the facility investigation staff interview summaries on 8/28/18 revealed a relative of a staff member was interviewed on 7/23/18 about an incident which occurred on 7/23/18 on the facility van in the morning prior to the clients being transported to the day program. The interview indicated that while parked in the facility driveway, the visitor overheard staff B say "No [client #4]" and "give me your hand" and then heard 3 "smacks" then heard someone crying and again heard "No [client #4]" and heard 2 "smacks". The visitor did indicate witnessing client #6 getting off the van crying, but otherwise did not visually witness anything related to what was overheard.

Review of the interview summary for staff B revealed the staff member indicated that client #2, #4 and #6 were involved in a behavior on the van while in the parking lot on the morning of 7/23/18, which included client's #2 and #6 hitting client #4. Staff B indicated she intervened with Your Safe, I'm Safe approved restrictive interventions. Further review of the interview summary indicated staff B did admit she "popped" client # 4 on the hand while the van was on the way to the day program when the client had gotten out of her seat and was pulling on another client's clothes.

Review of the investigation "Factual Findings" revealed staff B "failed to follow Your Safe I'm Safe intervention techniques by hitting client #4 on the hand one time". Further review of the investigation revealed staff B did receive

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corrective actions. Further review of the investigation, verified by interview with the OM on 8/28/18 confirmed no notifications were made to IRIS, HCPR or DSS at any time regarding this abuse allegation.

C. Review of the facility investigation interview summaries on 8/28/18 revealed staff B was first interviewed on 7/19/18 and indicated she had sprayed client #6 one time in the face with a spray bottle to attempt to wake the client. Staff B indicated she had been directed by staff C to do this as the way "to wake her up". Staff B indicated she had witnessed staff A and staff D spray client #6 in the face as well, to wake her up. The facility's summary of interview with client #6 completed on 7/19/18 revealed the client did indicate being sprayed in the face because she was hard to wake up. The client indicated that staff C, E, D and B had all sprayed her with a water bottle. The facility interview summary with staff E on 7/20/18 indicated she had sprayed client #6 in the face to wake her up two times. The facility interview summary with staff C on 7/23/18 indicated she had sprayed client #6 in the face with water to wake her up 3 times.

The facility interview summary with the facility residential manager (RM) on 7/19/18 revealed that on 7/16, staff B stated to her that she had sprayed client #6 in the face to wake her up and the RM told Staff B she could not do that. The interview summary indicated a house staff meeting occurred on 7/17/18 in which she told all staff to not use the spray bottle to wake up the client. Interview with the RM on 8/28/18 confirmed multiple staff had been using a spray bottle to wake up client #6 because she was hard to wake up at times. The RM indicated the first

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W 156	Continued From page 17 she became aware of this staff practice toward client client #6 was on 7/16/18. She indicated she had not made administrative staff aware of this at that time, and indicated she told all staff not to use this practice on 7/17/18 during a house staff meeting. She also indicated that based on her knowledge of how long some staff had been working in the home, this practice had been going on for at least 6 months. Review of the documentation on 8/28/18 of the minutes for this meeting revealed this practice was covered and staff were told to no longer do it. Continued review of the facility investigation, confirmed by interview with the OM on 8/28/18, did not reveal that IRIS, HCPR, or DSS were notified at any time as required for this client mistreatment. The investigation did not include evidence the guardian was notified immediately. Staff A, B, and E all received corrective action, for what included "inappropriate redirection of clients". Interview with the OM on 8/28/18 revealed staff C ended employment with the facility at the end of 7/18, prior to corrective actions being initiated. Interview with the facility OM on 8/28/18 indicated the investigation was not completed within 5 working days because the investigator and administrative staff had not reached conclusions about all of the allegations. The OM also indicated, administrative staff made the decision to combine the investigation of the new allegations discovered during the original investigation, so all allegations were a part of the same facility investigation.	W 156		
W 157	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(4)	W 157		

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W 157	Continued From page 18 If the alleged violation is verified, appropriate corrective action must be taken. This STANDARD is not met as evidenced by: Based on facility record/document review and interviews, the facility failed to show evidence of appropriate corrective action for 1 of 1 abuse investigation reviewed, including 1 of 3 verified allegations of abuse. The finding is: Review of facility abuse/neglect investigations on 8/28/18 revealed one investigation started on 7/19/18 and ending on 8/6/18. The original scope of the investigation was to determine if staff A had physically or verbally abused clients in the group home and to assess if staff A had violated company cell phone policy. Continued review of the facility investigation revealed that additional allegations were added during the investigation due to statements during staff interview to include: Staff B failing to appropriately perform restrictive intervention guidelines while client #4 was having a behavior and to determine if any staff members "violated company policy" by spraying client #6 with a water bottle in the face in attempt to wake the client up. Review of the facility investigation interview summaries on 8/28/18 revealed staff B was first interviewed on 7/19/18 and indicated she had sprayed client #6 one time in the face with a spray bottle to attempt to wake the client. Staff B indicated she had been directed by staff C to do this as the way "to wake her up". Staff B indicated she had witnessed staff A and and staff D spray client #6 in the face as well, to wake her up. The facility's summary of interview with client	W 157		

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#6 completed on 7/19/18 revealed the client did indicate being sprayed in the face because she was hard to wake up. The client indicated that staff C, E, D and B had all sprayed her with a water bottle. The facility interview summary with staff E on 7/20/18 indicated she had sprayed client #6 in the face to wake her up two times. The facility interview summary with staff C on 7/23/18 indicated she had sprayed client #6 in the face with water to wake her up 3 times.

The facility interview summary with the facility residential manager (RM) on 7/19/18 revealed that on 7/16, staff B stated to her that she had sprayed client #6 in the face to wake her up and the RM told Staff B she could not do that. The interview summary indicated a house staff meeting occurred on 7/17/18 in which she told all staff to not use the spray bottle to wake up the client. Interview with the RM on 8/28/18 confirmed multiple staff had been using a spray bottle to wake up client #6 because she was hard to wake up at times. The RM indicated the first she became aware of this staff practice toward client #6 was on 7/16/18. She indicated she had not made administrative staff aware of this at that time, and indicated she told all staff not to use this practice on 7/17/18 during a house staff meeting. She also indicated that based on her knowledge of how long some staff had been working in the home, this practice had been going on for at least 6 months.

Interview with the Operations Manager (OM) on 8/28/18 revealed the RM did not receive corrective actions for not immediately reporting the staff mistreatment of client #6 to administrative staff. Staff A, B, and E all received corrective action, for what included "inappropriate

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W 157	Continued From page 20 redirection of clients". Interview with the OM on 8/28/18 revealed staff C ended employment with the facility at the end of 7/18, prior to corrective actions being initiated.	W 157		
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 interview, the facility failed to provide interventions in sufficient number and frequency to support the achievement of a medication administration objective identified in the individual support plan (ISP) for 1 of 3 sampled clients (#6). The finding is: Observation conducted on 8/28/18 at 6:50 AM revealed client #6 entered the medication administration area, sanitized her hands, retrieved her medication bin from a shelf in the medication closet and received medications including: Propranolol 10 mg., Calcium 600 mg.-two tablets, Omeprazole 20 mg., Naltrexone 50 mg.- two capsules, Citalopram 20 mg., Lamotrigine 25 mg., Bentyl 20 mg., Cogentin 1 mg., Colace 100 mg., Haldol 10 mg., Vitamin D3 1000 units and Lotrisone cream applied topically.	W 249		

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W 249	Continued From page 21 Continued observation during the administration of client #6's medications revealed staff poured water and punched medications from the medication delivery cards without prompting client #6 to participate. Staff was further observed to prompt client #6 to state the name and side effects of the Colace, however, when client #6 did not respond no information was provided to client #6 regarding the name, purpose or side effects of medications administered. Review of the ISP for client #6 dated 1/23/18 was conducted on 8/22/18. The ISP contained an objective for client #6 to take the prescribed medication with 75% independence for 3 consecutive months utilizing the following steps: 1. Sanitize hands 2. Identify medication bin 3. Repeat name of medication 4. Name one side effect 5. Push medication into cup. Interview conducted on 8/28/18 with the Clinical Supervisor (acting qualified intellectual disabilities professional) revealed staff should provide client #6 with teaching and verbal prompts to identify the names and side effects of the prescribed medication as well as prompts to participate in pushing the medications from the delivery card into the medicine cup.	W 249		