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W 000	INITIAL COMMENTS Complaint Intake #: NC00153458	W 000		
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 ensure implementation of written policies and procedures that prohibit mistreatment, neglect or abuse of clients (W149); failed to ensure that all allegations of neglect and abuse were reported immediately to the administrator and to other officials in accordance with state law (W153); and failed to provide evidence that all alleged violations were thoroughly investigated (W154). 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 review of facility records and staff interviews, the facility failed to assure its policies and procedures prevented neglect, by not ensuring procedures to manage behaviors were followed for 1 of 3 sampled clients (#2). The	W 149		

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

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W 149	Continued From page 1 finding is: Review of the record for client #2 on 7/15/19 revealed a person centered plan (PCP) dated 10/24/18. The PCP indicated client #2 has diagnoses including schizoaffective disorder, seizure activity and osteoporosis. The PCP also indicated the client has a behavioral support plan (BSP) to address target behaviors which included hallucinations, self injurious behavior, property destruction, verbal aggression and physical aggression, and indicated client #2 will throw himself down on the floor or against a wall when upset. The PCP also indicated the client has a history of falling when getting up out of bed and has fallen numerous times in his bedroom. In response, the interdisciplinary team agreed to place a video monitor in the bedroom to be used at night. The PCP indicated client #2 requires monitoring due to a limited awareness of danger and a tendency to look down and not look where he is going. Further review of the record revealed a BSP dated 1/10/19 which included target behaviors of: self injurious behavior defined as scratching self, using a tool such as a clothes hanger to inflict wounds, biting his hands or arms, and banging hands on objects; property destruction defined as banging on walls and furniture, throwing objects, including furniture, and destroying window coverings and blinds: physical aggression defined as hitting, kicking, or in some way attempting to hurt others. The intervention plan for verbal or physical aggression and property destruction included instructions for staff to redirect client #2 to another activity, and keeping the environment low in excessive noise and activity, and if these measures did not work then direct the client to	W 149		

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another area until calm. Continued review of interventions indicated that if client #2 had not calmed with 60 minutes, staff should contact the house manager, qualified intellectual disabilities professional (QIDP), behavior analyst or the administrator on call.

Review of the facility's critical incidents on 7/15/19 revealed an Incident Response Improvement System (IRIS) document completed for a critical incident which occurred on 2/9/19. The IRIS contained documentation indicating client #2 was hospitalized on 2/9/19 with resulting findings of 3 fractured ribs on his right side, due to behavioral outburst and self injury while in the group home. Further review of the critical incident revealed an associated facility accident/incident report. The accident/incident report was completed on 2/9/19 with a time of incident indicated as 9:30 AM and location indicated as in the group home bedroom and bathroom. The description of the incident indicated that the client was having a behavior, hitting the wall and doors and bed with his fist causing old wounds to open up and bleed as well as self injurious behavior creating new wounds. The "notes or concerns from notifications" section of the report stated "called behavior specialist several times, no answer". The "description and treatment given" section of the report completed by the facility nurse on 2/10/19 indicated client #2 had scratches all over the right lower forearm and wrist and a bruise on the back of his right upper arm as well as a swollen neck. The description also indicated the hospital reported right side ribs 9, 10 and 11 were broken. The "additional research and/or follow up by the QIDP" section of the report indicated "medication changes were made recently and his interdisciplinary team

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continues to monitor his progress and will revise supports as needed".

Continued review of the critical incident report revealed written statements from direct care staff members F, G and H, as well as the nursing staff who was on call on 2/9/19. Interview with the QIDP on 7/16/19 who was on call on 2/9/19, revealed written statements from staff were obtained due to the seriousness of the injury. Review of the written statements revealed a statement from the third shift staff member (F) working on the night of 2/8/19. The statement indicated that on entering the home, client #2 could be heard yelling and hitting the wall in his bedroom. Further review of the statement revealed a description of "violent hallucinations". Staff member F indicated redirection was attempted, but "all attempts failed" and the behavior continued throughout the entire shift. Continued review of the statement indicated staff member F never saw the client fall and indicated the client "tore down the monitor in his room".

Review of the written statement from direct care staff member H on 7/16/19, who worked on first shift on 2/9/19, revealed upon arrival to the group home, client #2 could be heard yelling and banging on the window in his bedroom. Further review of the statement revealed the client went to the kitchen to eat breakfast at 8:30 AM and began banging his fist on the table, throwing his plate to the floor and refusing to take medications. After being redirected to his room and staff checking on him every 10 minutes the client "finally came out of his room to get medications" and "staff noticed him bleeding on his hand and arm from repeatedly scratching himself". Staff then notified nursing staff and the

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home manager. Continued review of the statement indicated staff attempted to contact the behavioral specialist and there was no answer. The statement indicated behaviors continued throughout the whole shift and "staff took turns trying to calm and redirect but nothing helped". Descriptions of behaviors included throwing himself up against the wall and "banging on the wall so hard until another consumers pictures fell off the wall". Continued review of the statement revealed that at 2:30 PM "after hours of redirecting", staff went into the client's room and noticed his neck starting to swell and again contacted nursing and attempted to call the home manager again three times with no answer. The statement indicated the on call QIDP was contacted at that time, who "tried getting in touch with the home manager". Further review of the statement indicated nursing staff directed staff to take a picture of the client's neck and to "send the client out for x-rays".

Review of the written statement for direct care staff member G on 7/16/19, who also worked on 1st shift on 2/9/19 revealed client #2 continued behaviors throughout the entire shift. Behaviors were described as hitting the walls with his fists and yelling as well as "throwing his body into his room wall".

Review of the written statement of the on call nurse for 2/9/19 on 7/16/19 revealed she was called at 9:50 AM on 2/9/19 because the client had scratched himself during self injurious behavior and she advised first aide for those areas. The statement indicated she was told that the client had been having a behavior since 11:00 PM on 2/8/19 and behaviors were described as hitting walls and rolling around on the floor. The

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nurse's statement indicated she advised the group home staff to contact her again if they noticed swelling or bruising and to notify the home manager, behavioral specialist and the on-call QIDP of the behaviors. Further review of the statement indicated direct care staff called again at 2:50 PM to report swelling in the client's neck and the on-call MD was contacted and advised sending the client to the ER for x-rays due to osteoporosis diagnoses. The statement indicated the administrator and the on-call QIDP were notified of the decision to send the client to the emergency room. Review of the hospital report on 7/16/19 revealed the "impression" documentation by the medical doctor to indicate acute fractures of the right ninth through eleventh ribs, with extensive subcutaneous emphysema.

Review of the behavior support data sheets on 7/16/19 revealed an entry for 2/8/19 on first shift which indicated verbal aggression, banging fists, yelling and hallucinations. The descriptions of behaviors included client #2 threatening other individuals, banging his fists and "angry and violent". The time frame of the behaviors indicated "off and on all shift", and indicated no staff were notified of client #2's behaviors. Further review of the data sheets revealed an entry for 2/8/19 for third shift which indicated verbal aggression, yelling and slamming doors. The description of interventions indicated "redirection failed" and "all shift", and indicated no staff were notified during the shift. Continued review of the data sheets revealed an entry for 2/9/19 at 2:30 PM which described "swelling due to behavior" and indicated behaviors had occurred all shift and further indicated the client was observed throwing his body into the wall. The documentation on the data sheet also

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indicated the home manager and behavioral specialist were called with no answer and the home manager "called back later and was notified".

Interview with the third shift staff person (C) working on the night of 7/15/19 revealed she was not working on 2/8/19 or 2/9/19. Staff C indicated she was aware she could call nursing staff during the night if a client had an injury or was having a behavior and needed PRN medication, but indicated otherwise she did not have anyone else to call to assist with or provide guidance related to client behaviors.

Interview with the facility home manager on 7/16/19 revealed she was contacted by direct care staff on 2/9/19, but she could not recall at what time or what was discussed. Interview with the behavioral specialist on 7/16/19 indicated she never received a phone call from direct care staff on 2/9/19 and thought maybe they dialed the wrong number. Interview with the QIDP who was on-call on 2/9/19 revealed she was called by direct care staff on 2/9/19, but it was after medical and nursing staff had made the decision to send the client to the emergency room.

Further review of the record for client #2 on 7/16/19 revealed the BSP had not been updated since 1/10/19 and there was no evidence the interdisciplinary team had met to discuss the incident except for a psychiatric clinic visit on 2/12/19 attended by the QIDP. The documentation from the psychiatric clinic visit indicated the client was being seen at that time as a follow-up to a "significant behavior that occurred over the weekend where he broke three ribs". The only changes indicated were discontinuing

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W 149	Continued From page 7 Ambien 10mg at night, which was started on 2/7/19 and increasing Clozaril to 200mg twice a day. Interview with the QIDP on 2/16/19 confirmed the BSP was not followed as directed because managerial/clinical staff were not called timely or did not respond with assistance or interventions to help client #2 after engaging in dangerous behaviors which had been occurring for extended periods of time between 2/8/19 and 2/9/19. The QIDP also could not provide evidence all staff had been specifically trained related to contacting managerial or clinical staff as directed in client #2's BSP and could not provide evidence the interdisciplinary team had met to discuss necessary changes to the client's PCP/BSP to help ensure neglect of client #2 did not occur again.	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 review of facility records and interviews, the facility failed to ensure an injury of unknown source for 1 of 3 sampled clients (#3) was reported immediately to the administrator. The finding is: Review of incident reports for client #3,	W 153		

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conducted on 7/15/19, revealed an incident report dated 6/22/19. This report documented on 6/22/19 at 1:25 PM staff D noticed a large bruise on client #3's left hip area while assisting client #3 with a shower. Continued review of the 6/22/19 incident report revealed the nurse was notified of the bruise of unknown origin on 6/22/19 and an attempt was made to notify the qualified intellectual disabilities professional (QIDP) on 6/22/19 at 1:35 PM. Further review of the 6/22/19 incident report revealed the group home manager and the facility administrator were notified of the bruise on 6/24/19. Subsequent review of the 6/22/19 level II incident report for client #3 revealed client #3's guardians had arrived at the group home at 3:15 PM on 6/22/19 to take client #3 for a pre-planned outing at which time the guardians were made aware of the bruise on client #3's left hip. On-going review of the 6/22/19 incident report revealed documentation stating client #3's guardians had taken client #3 to the local emergency department for medical evaluation of the bruise to his left hip. Nursing notation included on the incident report was dated 6/24/19 and documented client #3 had a large, dark bruise which was two inches in width and four inches long on his left hip and spread to his lower left abdomen. Further review of facility records revealed a state IRIS report was initiated by the facility on 6/25/19.

Interview with the QIDP conducted on 7/16/19 revealed the injury of unknown source to client #3's left hip had been discovered by direct care staff while assisting client #3 with a shower on Saturday, 6/22/19. Continued interview with the QIDP revealed she became aware of the bruise of unknown source on client #3's left hip on Monday, 6/24/19, and further revealed the facility

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W 153	Continued From page 9 administrator was not notified of the injury until Monday, 6/24/19. Interview conducted with the facility administrator on 7/16/19 verified the administrator was not notified of the bruise of unknown origin on client #3's left hip which had been observed by direct care staff on 6/22/19 until 6/24/19. Therefore, the facility failed to report an injury of unknown source to the facility administrator for a period of two days after it was discovered, and failed to notify state officials for a period of three days after the injury was discovered.	W 153		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on review of facility records and interview, the facility failed to provide evidence an allegation of abuse was thoroughly investigated for 1 of 3 sampled clients (#3). The finding is: Review of incident reports for client #3, conducted on 7/15/19, revealed an incident report dated 6/22/19. This report documented on 6/22/19 at 1:25 PM staff D noticed a large bruise on client #3's left hip area while assisting client #3 with a shower. Continued review of the 6/22/19 incident report revealed the nurse was notified of the bruise of unknown origin on 6/22/19 and an attempt was made to notify the qualified intellectual disabilities professional (QIDP) on 6/22/19 at 1:35 PM. Further review of the 6/22/19 incident report revealed the group home manager	W 154		

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and the facility administrator were notified of the bruise on 6/24/19. Subsequent review of the 6/22/19 level II incident report for client #3 revealed client #3's guardians had arrived at the group home at 3:15 PM on 6/22/19 to take client #3 for a pre-planned outing at which time the guardians were made aware of the bruise on client #3's left hip. On-going review of the 6/22/19 incident report revealed documentation stating client #3's guardians had taken client #3 to the local emergency department for medical evaluation of the bruise to his left hip. Nursing notation included on the incident report was dated 6/24/19 and documented client #3 had a large, dark bruise which was two inches in width and four inches long on his left hip and spread to his lower left abdomen. Further review of facility records revealed a state IRIS report was initiated by the facility on 6/25/19 which indicated the cause of the bruise on client #3's left hip was thought to be the result of a fall.

Review of the record for client #3, conducted on 7/16/19, revealed a nursing notation dated 6/24/19 documenting client #3 was assessed by the nurse and noted to have a large, dark bruise on his upper left hip that spread to the lower left abdomen which was two inches wide and four inches long. This nursing notation further documented that upon the nurses observation, client #3's belt was in the same area as the bruise and matches the bruising pattern.

Interviews conducted on 7/15/19 with staff A and staff B revealed client #3 frequently expresses concern that he might fall as part of his daily conversation, however, both staff A and staff B denied ever having observed client #3 to actually fall. Interviews conducted on 7/16/19 with staff C,

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staff D, and staff E verified client #3 often mentions his concerns about falling in his daily conversation, however, staff C, staff D, and staff E stated they had never observed client #3 to fall.

Interview with the QIDP conducted on 7/16/19 revealed the injury of unknown source to client #3's left hip had been discovered by direct care staff while assisting client #3 with a shower on Saturday, 6/22/19. Continued interview with the QIDP revealed she became aware of the bruise of unknown source on client #3's left hip on Monday, 6/24/19. Further interview with the QIDP revealed client #3's guardians had contacted the QIDP on 6/24/19 and expressed concern that the bruise on client #3's left hip may have been caused by rough handling by staff and further expressed concerns related to the demeanor of a direct care staff working at the group home on 6/22/19 when the guardians were made aware of client #3's bruise of unknown source.

Continued interview with the QIDP on 7/16/19 revealed on 6/25/19 a telephone interview was conducted with staff E who was not present in the home on 6/22/19 when the bruise was discovered. The QIDP stated she asked staff E to inquire of client #3 what had happened to cause the bruise on his hip, at which time client #3 stated he fell and indicated he fell against the bathroom door. Ongoing interview with the QIDP verified no further evidence was available to indicate a thorough investigation had been conducted by the facility related to the large bruise of unknown source on client #3's left hip, and further verified the concerns expressed by client #3's guardians related to the source of the bruise had not been addressed.

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W 191	Continued From page 12	W 191		
W 191	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' behavioral needs. This STANDARD is not met as evidenced by: Based on record/document review and staff interview, the facility failed to ensure staff were trained related to procedures for assuring client safety during behaviors for 1 of 3 sampled clients (#2). The finding is: Review of the record for client #2 on 7/15/19 revealed a person centered plan (PCP) dated 10/24/18. The PCP indicated client #2 has diagnoses including schizoaffective disorder, seizure activity and osteoporosis. The PCP also indicated the client has a behavioral support plan (BSP) to address target behaviors which included hallucinations, self injurious behavior, property destruction, verbal aggression and physical aggression, and indicated client #2 will throw himself down on the floor or against a wall when upset. The PCP also indicated the client has a history of falling when getting up out of bed and has fallen numerous times in his bedroom. In response, the interdisciplinary team agreed to place a video monitor in the bedroom to be used at night. The PCP indicated client #2 requires monitoring due to a limited awareness of danger and a tendency to look down and not look where he is going. Further review of the record revealed a BSP dated 1/10/19 which included target behaviors of: self injurious behavior defined as scratching self, using a tool such as a clothes hanger to inflict wounds, biting his hands or arms, and banging	W 191		

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TWINBROOKS	189 FAIRMONT DRIVE MOCKSVILLE, NC 27028

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hands on objects; property destruction defined as banging on walls and furniture, throwing objects, including furniture, and destroying window coverings and blinds: physical aggression defined as hitting, kicking, or in some way attempting to hurt others. The intervention plan for verbal or physical aggression and property destruction included instructions for staff to redirect client #2 to another activity, and keeping the environment low in excessive noise and activity, and if these measures did not work then direct the client to another area until calm. Continued review of interventions indicated that if client #2 had not calmed with 60 minutes, staff should contact the house manager, qualified intellectual disabilities professional (QIDP), behavior analyst or the administrator on call.

Review of the facilities critical incidents on 7/15/19 revealed an Incident Response Improvement System (IRIS) document completed for a critical incident which occurred on 2/9/19. The IRIS contained documentation indicating client #2 was hospitalized on 2/9/19 with resulting findings of 3 fractured ribs on his right side, due to behavioral outburst and self injury while in the group home. Further review of the critical incident revealed an associated facility accident/incident report. The accident/incident report was completed on 2/9/19 with a time of incident indicated as 9:30 AM and location indicated as in the group home bedroom and bathroom. The description of the incident indicated that the client was having a behavior, hitting the wall and doors and bed with his fist causing old wounds to open up and bleed as well as self injurious behavior creating new wounds. The "notes or concerns from notifications" section of the report stated "called behavior specialist

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several times, no answer". The "description and treatment given" section of the report completed by the facility nurse on 2/10/19 indicated client #2 had scratches all over the right lower forearm and wrist and a bruise on the back of his right upper arm as well as a swollen neck. The description also indicated the hospital reported right side ribs 9, 10 and 11 were broken. The "additional research and/or follow up by the QIDP" section of the report indicated "medication changes were made recently and his interdisciplinary team continues to monitor his progress and will revise supports as needed".

Review of the behavior support data sheets on 7/16/19 revealed an entry for 2/8/19 on first shift which indicated verbal aggression, banging fists, yelling and hallucinations. The descriptions of behaviors included client #2 threatening other individuals, banging his fists and "angry and violent". The time frame of the behaviors indicated "off and on all shift, and indicated no staff were notified of client #2's behaviors. Further review of the data sheets revealed an entry for 2/8/19 for third shift which indicated verbal aggression, yelling and slamming doors. The description of interventions indicated "redirection failed" and "all shift", and indicated no staff were notified during the shift. Continued review of the data sheets revealed an entry for 2/9/19 at 2:30 PM which described "swelling due to behavior" and indicated behaviors had occurred all shift and indicated the client was observed throwing his body into the wall. The documentation on the data sheet also indicated the home manager and behavioral specialist were called with no answer and indicated the home manager "called back later and was notified".

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W 191	Continued From page 15 Interview with the third shift staff person (C) working on the night of 7/15/19 revealed she was not working on 2/8/19 or 2/9/19. Staff C indicated she was aware she could call nursing staff during the night if a client had an injury or was having a behavior and needed PRN medication, but indicated otherwise she did not have anyone else to call to assist with or provide guidance related to client behaviors. Interview with the facility home manager on 7/16/19 revealed she was contacted by direct care staff on 2/9/19, but she could not recall at what time or what was discussed. Interview with the behavioral specialist on 7/16/19 indicated she never received a phone call from direct care staff on 2/9/19 and thought maybe they dialed the wrong number. Interview with the QIDP who was on call on 2/9/19 revealed she was called by direct care staff on 2/9/19, but it was after medical and nursing staff had made the decision to send the client to the emergency room. Interview with the QIDP on 2/16/19 confirmed the BSP was not followed as directed because managerial/clinical staff were not called timely or did not respond with assistance or interventions to help client #2 after engaging in dangerous behaviors which had been occurring for extended periods of time between 2/8/19 and 2/9/19. The QIDP also could not provide evidence all staff had been specifically trained related to contacting managerial or clinical staff as directed in client #2's BSP.	W 191		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has	W 249		

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W 249	Continued From page 16 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 facility record/document review and interview, the facility failed to ensure sufficient interventions were implemented to assure that objectives listed in the person centered plan (PCP) were implemented as prescribed relative to behavior management for 1 of 3 sampled clients (#2). The finding is: Review of the record for client #2 on 7/15/19 revealed a person centered plan (PCP) dated 10/24/18. The PCP indicated client #2 has diagnoses including schizoaffective disorder, seizure activity and osteoporosis. The PCP also indicated the client has a behavioral support plan (BSP) to address target behaviors which included hallucinations, self injurious behavior, property destruction, verbal aggression and physical aggression, and further indicated client #2 will throw himself down on the floor or against a wall when upset. The PCP additionally indicated the client has a history of falling when getting up out of bed and has fallen numerous times in his bedroom. In response the interdisciplinary team agreed to place a video monitor in the bedroom to be used at night. The PCP indicated client #2 requires monitoring due to a limited awareness of danger and a tendency to look down and not look where he is going.	W 249		

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Further review of the record revealed a BSP dated 1/10/19 which included target behaviors of: self injurious behavior defined as scratching self, using a tool such as a clothes hanger to inflict wounds, biting his hands or arms, and banging hands on objects; property destruction defined as banging on walls and furniture, throwing objects, including furniture, and destroying window coverings and blinds: physical aggression defined as hitting, kicking, or in some way attempting to hurt others. The intervention plan for verbal or physical aggression and property destruction included instructions for staff to redirect client #2 to another activity, and keeping the environment low in excessive noise and activity, and if these measures did not work then direct the client to another area until calm. Continued review of interventions indicated that if client #2 had not calmed with 60 minutes, staff should contact the house manager, qualified intellectual disabilities professional (QIDP), behavior analyst or the administrator on call.

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indicated that the client was having a behavior, hitting the wall and doors and bed with his fist causing old wounds to open up and bleed as well as self injurious behavior creating new wounds. The "notes or concerns from notifications" section of the report stated "called behavior specialist several times, no answer". The "description and treatment given" section of the report completed by the facility nurse on 2/10/19 indicated client #2 had scratches all over the right lower forearm and wrist and a bruise on the back of his right upper arm as well as a swollen neck. The description also indicated the hospital reported right side ribs 9, 10 and 11 were broken. The "additional research and/or follow up by the QIDP" section of the report indicated "medication changes were made recently and his interdisciplinary team continues to monitor his progress and will revise supports as needed".

Continued review of the critical incident report revealed written statements from direct care staff members F, G and H, as well as the nursing staff who was on call on 2/9/19. Interview with the QIDP on 7/16/19 who was on call on 2/9/19, revealed written statements from staff were obtained due to the seriousness of the injury. Review of the written statements revealed a statement from the third shift staff member (F) working on the night of 2/8/19. The statement indicated that on entering the home, client #2 could be heard yelling and hitting the wall in his bedroom. Further review of the statement revealed a description of "violent hallucinations". Staff member F indicated redirection was attempted, but "all attempts failed" and the behavior continued throughout the entire shift. Continued review of the statement indicated staff member F never saw the client fall and indicated

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the client "tore down the monitor in his room".

Review of the written statement from direct care staff member H on 7/16/19, who worked on first shift on 2/9/19, revealed upon arrival to the group home, client #2 could be heard yelling and banging on the window in his bedroom. Further review of the statement revealed the client went to the kitchen to eat breakfast at 8:30 AM and began banging his fist on the table, throwing his plate to the floor and refusing to take medications. After being redirected to his room and staff staff checking on him every 10 minutes the client "finally came out of his room to get medications" and "staff noticed him bleeding on his hand and arm from repeatedly scratching himself". Staff then notified nursing staff and the home manager. Continued review of the statement indicated staff attempted to contact the behavioral specialist and there was no answer. The statement indicated behaviors continued throughout the whole shift and "staff took turns trying to calm and redirect but nothing helped". Descriptions of behaviors included throwing himself up against the wall and "banging on the wall so hard until another consumers pictures fell off the wall". Continued review of the statement revealed that at 2:30 PM "after hours of redirecting", staff went into the client's room and noticed his neck starting to swell and again contacted nursing and attempted calling the home manager again three times with no answer. The statement indicated the on call QIDP was contacted at that time, who "tried getting in touch with the home manager". Further review of the statement indicated nursing staff directed staff to take a picture of the client's neck and to "send the client out for x-rays".

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Review of the written statement for direct care staff member G on 7/16/19, who also worked on 1st shift on 2/9/19 revealed client #2 continued behaviors throughout the entire shift. Behaviors were described as hitting the walls with his fists and yelling as well as "throwing his body into his room wall".

Review of the written statement of the on call nurse for 2/9/19 on 7/16/19 revealed she was called at 9:50 AM on 2/9/19 because the client had scratched himself during self injurious behavior and she advised first aide for those areas. The statement indicated she was told that the client had been having a behavior since 11:00 PM on 2/8/19 and behaviors were described as hitting walls and rolling around on the floor. The nurse statement indicated she advised the group home staff to contact her again if they noticed swelling or bruising and to notify the home manager, behavioral specialist and the on-call QIDP of the behaviors. Further review of the statement indicated direct care staff called again at 2:50 PM to report swelling in the client's neck and the on-call MD was contacted and advised sending the client to the ER for x-rays due to osteoporosis diagnoses. The statement indicated the administrator and the on call QIDP were notified of the decision to send the client to the emergency room. Review of the hospital report on 7/16/19 revealed the "impression" documentation by the medical doctor to indicate acute fractures of the right ninth through eleventh ribs, with extensive subcutaneous emphysema.

Review of the behavior support data sheets on 7/16/19 revealed an entry for 2/8/19 on first shift which indicated verbal aggression, banging fists, yelling and hallucinations. The descriptions of

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behaviors included client #2 threatening other individuals, banging his fists and "angry and violent". The time frame of the behaviors indicated "off and on all shift, and indicated no staff were notified of client #2's behaviors. Further review of the data sheets revealed an entry for 2/8/19 for third shift which indicated verbal aggression, yelling and slamming doors. The description of interventions indicated "redirection failed" and "all shift", and indicated no staff were notified during the shift. Continued review of the data sheets revealed an entry for 2/9/19 at 2:30 PM which described "swelling due to behavior" and indicated behaviors had occurred all shift and indicated the client was observed throwing his body into the wall. The documentation on the data sheet also indicated the home manager and behavioral specialist were called with no answer and indicated the home manager "called back later and was notified".

Interview with the third shift staff person (C) working on the night of 7/15/19 revealed she was not working on 2/8/19 or 2/9/19. Staff C indicated she was aware she could call nursing staff during the night if a client had an injury or was having a behavior and needed PRN medication, but indicated otherwise she did not have anyone else to call to assist with or provide guidance related to client behaviors.

Interview with the facility home manager on 7/16/19 revealed she was contacted by direct care staff on 2/9/19, but she could not recall at what time or what was discussed. Interview with the behavioral specialist on 7/16/19 indicated she never received a phone call from direct care staff on 2/9/19 and thought maybe they dialed the wrong number. Interview with the QIDP who was

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W 249	Continued From page 22 on call on 2/9/19 revealed she was called by direct care staff on 2/9/19, but it was after medical and nursing staff had made the decision to send the client to the emergency room. Interview with the QIDP on 2/16/19 confirmed the BSP was not followed as directed because managerial/clinical staff were not called timely or did not respond with assistance or interventions to help client #2 after engaging in dangerous behaviors which had been occurring for extended periods of time between 2/8/19 and 2/9/19.	W 249		