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LIFE, INC CHEROKEE TRAIL GROUP HOME	105 CHEROKEE TRAIL WILMINGTON, NC 28409

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W 000	INITIAL COMMENTS A complaint survey was completed on 1/28/2020. Deficiencies were cited as a result of the complaint survey for Intake #NC00159216. The complaint allegation regarding providing adequate supervision was substantiated.	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 clients were assisted with safeguarding their privacy during dressing (W130); implement written policies and procedures that prohibit neglect of clients (W149), ensure that direct care staff immediately reported all allegations of neglect to the administrator and other officials as required by policy (W153), and ensure that all allegations of neglect were thoroughly investigated by management staff (W154). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated services of client protections to its clients.	W 122		
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.	W 130		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 130	Continued From page 1 This STANDARD is not met as evidenced by: Based on observations, record review and interview the facility failed to provide privacy for 1 of 4 audit clients (#1) during his morning routine. The finding is: Staff did not provide for audit client #1's privacy during dressing. During observations in the facility on 1/28/20 at 5:55am staff F went to the hallway to redirect client #1 to his bedroom when she saw that he was wearing a shirt and an incontinence product. Staff F walked into client #1's bedroom to locate a pair of pants for him to wear. The bedroom door was open leaving him in full view. Staff F selected a pair of pants and began to dress client #1 while he was sitting on the bed. The door to the bedroom remained open while client #1 was being dressed. Staff F was the only staff working with 5 clients on third shift. At 5:55am, there were 3 clients awake (#1, #3 and #5). Review on 1/28/20 of client #1's individual program plan (IPP) dated 4/3/19 revealed he needs reminders to knock and has a limited awareness of privacy. Interview on 1/28/20 with the qualified intellectual disabilities professional (QIDP) revealed staff should assist client #1 with shutting doors when he is dressing due to his limited awareness of privacy.	W 130		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit	W 149		

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W 149	Continued From page 2 mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on observation, record review and interview the facility failed to assure it's policies and procedures that prohibit neglect were implemented to prevent the neglect of 3 of 4 audit clients (#1, #3 ,#5). The finding is: Staff failed to ensure client #3 was adequately supervised to prevent him from invading the privacy of clients #1 and #5. Observations on 1/27/20 in the facility from 3:40-6:00pm revealed there were sensors at both the front and back doors of the facility. There was also a sensor above client #3's bedroom door off from the living room. When the bedroom door was opened, a clicking noise could be heard. Observation on 1/27/20 of client #3's door revealed the batteries on the door alarm needed to be replaced. Once the residential manager (RM) replaced the batteries, the door alarm began to chime loud enough so the sound could be detected at the back of the facility. Interview on 1/27/20 with the RM revealed the batteries on the door alarm needed to be replaced. After the RM replaced the batteries, the door alarm began to chime loud enough so the sound could be detected at the back of the facility. Further interview revealed she checks the batteries every week to see if they need to be replaced. Subsequent interview revealed that she did not remember what date the door alarm for client #3 was last checked.	W 149		

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Interview on 1/27/20 with staff E revealed he felt there was an issue with not having sufficient staff to cover the areas of the facility which included: kitchen, living room, dining room and back hallway. Further interview revealed client #3 has a long history of making sexual advances towards his peers. Additional interview revealed he had witnessed a dozen incidents during the past year with client #3 targeting clients #1 and #5.

Additional interviews with staff E revealed client #3 took advantage of staff being busy in the laundry room and kitchen to approach other clients. Staff E stated client #3 was quick and in less than 5 minutes he could take clients by the hand, lead them to the bathroom and disrobe them. Staff E further stated if staff don't immediately see clients #1 and #5 they go looking for them in the bathroom, to make certain client #3 has not lead them into the bathroom areas of the facility.

Subsequent interview with staff E revealed he has been reporting these incidents to his manager. He stated less than a week ago he was busy assisting with dinner when he noticed client #1 was not in the common area of the facility and found him naked in the bathroom with client #3. Staff E stated he did not think that anything sexual took place.

Review on 1/27/20 of the staff communication log revealed an entry dated 1/18/20 which revealed staff found clients #1 and #3 in the bathroom together. Client #5 was naked.

Interview on 1/27/20 with the RM revealed she was aware of the entry on 1/18/20 and had talked with staff E about this incident, however she did

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not report it to the qualified intellectual disabilities professional (QIDP) .

Interview on 1/27/20 with staff D revealed he could not keep up with the number of times that he has seen client #3 make sexual advances towards clients #1 and #5. Further interview revealed until December 2019 clients #1 and #5 shared a bedroom. Staff D stated that client #3's bedroom was nearby and he had been witnessed going into their bedroom and removing clients #1 and #5's clothing. He stated neither client was able to defend themselves. Staff D stated there were never any consequences for client #3's inappropriate behaviors.

Interview on 1/28/20 with staff F revealed she was overwhelmed trying to supervise 5 clients as the only staff on third shift from 11pm-7am. She stated on the morning of 1/28/20 around 5:15am, before the surveyors arrived at the facility, she was taking client #3 to the bathroom. She stated before she could follow client #3 to the hallway bathroom, she discovered 3 in the bathroom with client #5. She stated client #5 had his pants down and client #3 was looking at him.

Review on 1/27/20 of client #3's behavior support program (BSP) dated 5/27/19 revealed he has target behaviors of sexual misconduct, elopement, aggression and invading the personal space of others. The interventions included the use of a door alarm, constant supervision and removing him from the area when he displays this behavior.

Review on 1/27/20 of client #3's individual program plan (IPP) dated 8/1/19 revealed he functions in the severe range of intellectual

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disability and client #3 has a history of displaying inappropriate sexual behavior. Further review of the IPP revealed, "he has a history of displaying sexually inappropriate behavior targeting [clients #1, #5's names]. Staff should know the whereabouts of [client #3] at all times. Has an alarm on his door. Staff should respond to the alarm and remove him from the area when he displays this target behavior.

Additional interview on 1/28/20 with the QIDP revealed the team had not revised client #3's BSP to increase his level of supervision prior to 1/27/20.

Review on 1/28/20 of the facility policy 1204:13 (d) revealed Neglect is the failure to provide goods or services necessary to avoid physical harm, mental anguish or mental illness.

Subsequent interview on 1/27/20 with the QIDP revealed she was not aware of the communication log entry dated 1/18/20 about clients #1 and #3 being located in the bathroom together. When asked what constant supervision for client #3 required, she stated he was to be in staff's supervision at all times unless he was in his room and then he required 30 minute checks. She acknowledged the door alarm should be checked daily to ensure it is operational. Additional interview revealed client #3's bedroom had been relocated in December 2019 to give staff better visual supervision of him. Additional interview revealed the facility had increased client #3's level of supervision on 1/27/20 on second shift, when they were told by the surveyors that incidents of client #3 's inappropriate behavior had continued to occur. The QIDP also stated she was unaware of the incident that occurred on

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W 149	Continued From page 6 1/28/20 at 5:15am. Although the team had taken steps by moving client #3's bedroom and adding a door alarm to the bedroom door of client #3, the team failed to revise client #3's BSP, failed to add stricter staff supervision requirements and failed to provide adequate staffing to the facility to address client 3's behavioral needs.	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 record reviews and interviews the facility failed to assure the administrator was notified immediately of an incident. This affected 3 of 4 audit clients (#1, #3, #5). The finding is: Staff failed to notify the administrator of incidents of client #3's inappropriate behavior towards client #1 and #5 so these incidents could be thoroughly investigated. Interview on 1/27/20 with staff E revealed he felt there was an issue with not having sufficient staff to cover the areas of the facility which included: kitchen, living room, dining room and back hallway. Further interview revealed client #3 has a long history of making sexual advances towards his peers. Additional interview revealed he had	W 153		

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witnessed a dozen incidents during the past year with client #3 targeting clients #1 and #5.

Additional interviews with staff E revealed client #3 took advantage of staff being busy in the laundry room and kitchen to approach other clients. Staff E stated client #3 was quick and in less than 5 minutes he could take clients by the hand, lead them to the bathroom and disrobe them. Staff E further stated if staff don't immediately see clients #1 and #5 they go looking for them in the bathroom to make certain client #3 has not lead them into the bathroom areas of the facility.

Subsequent interview with staff E revealed he has been reporting these incidents to his manager. He stated less than a week ago he was busy assisting with dinner when he noticed client #1 was not in the common area of the facility and found him naked in the bathroom with client #3. Staff E stated he did not think that anything sexual took place.

Interview on 1/27/20 with staff D revealed he could not keep up with the number of times that he has seen client #3 make sexual advances towards clients #1 and #5. Further interview revealed until December 2019 clients #1 and #5 shared a bedroom. Staff D stated that client #3's bedroom was nearby and he had been witnessed to go into their bedroom and remove clients #1 and #5's clothing. He stated neither client was able to defend themselves. Staff D stated there were never any consequences for client #3's inappropriate behaviors. He stated he had reported these incidents to the residential manager.

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Interview on 1/28/20 with staff F revealed she was overwhelmed trying to supervise 5 clients as the only staff on third shift from 11pm-7am. She stated on the morning of 1/28/20 around 5:15am before the surveyors arrived at the facility, she was taking client #3 to the bathroom. She stated before she could follow client #3 that she discovered client #5 in the bathroom with client #3. She stated client #5 had his pants down and client #3 was looking at him.

Review on 1/27/20 of the staff communication log revealed on 1/18/20 revealed staff found clients #1 and #3 in the bathroom. together. Client #5 was naked.

Interview on 1/27/20 with the residential manager (RM) revealed she had been told of incidents of client #3's inappropriate behavior on 1/18/20 which was documented in the communication log. She stated she had not communicated this to the qualified intellectual disabilities professional (QIDP) to investigate. Further interview revealed she denied knowing of any additional incidents of client #3's inappropriate behavior towards clients #1 and #5. She however acknowledged staff F had communicated the incident that occurred on 1/28/20 at 5:15am involving clients #3 and #1 in the bathroom.

Interview on 1/28/20 with the QIDP revealed she had not been told of any incidents of client #3's inappropriate behavior towards clients #1 and #5, specifically she was unaware of the incident in the communication log on 1/18/20 involving clients #1 and #3. The QIDP also stated she had not been told of the incident on 1/28/20 at 5:15am involving client #5 and #3. Further interview revealed all staff have been trained to report any incidents of

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W 153	Continued From page 9 abuse, neglect or exploitation immediately to her so these incidents can be investigated.	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 consider all sources of evidence to thoroughly investigate allegations of neglect and exploitation involving 3 of 4 audit clients (#1, #3, #5) and a former client. The findings are: A. Management staff did not investigate allegations of exploitation by client #3 involving clients #1, #5. Interview on 1/27/20 with staff E revealed he felt there was an issue with not having sufficient staff to cover the areas of the facility which included: kitchen, living room, dining room and back hallway. Further interview revealed client #3 has a long history of making sexual advances towards his peers. Additional interview revealed he had witnessed a dozen incidents during the past year with client #3 targeting clients #1 and #5. Additional interviews with staff E revealed client #3 took advantage of staff being busy in the laundry room and kitchen to approach other clients. Staff E stated client #3 was quick and in less than 5 minutes he could take clients by the hand, lead them to the bathroom and disrobe them. Staff E further stated if staff don't	W 154		

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immediately see clients #1 and #5 they go looking for them in the bathroom, to make certain client #3 has not lead them into the bathroom areas of the facility.

Subsequent interview with staff E revealed he has been reporting these incidents to his manager. He stated less than a week ago he was busy assisting with dinner when he noticed client #1 was not in the common area of the facility and found him naked in the bathroom with client #3. Staff E stated he did not think that anything sexual took place.

Review on 1/27/20 of the staff communication log revealed an entry dated 1/18/20 which revealed staff found clients #1 and #3 in the bathroom. together. Client #5 was naked.

Interview on 1/27/20 with the residential manager (RM) revealed she was aware of the entry on 1/18/20 and had talked with staff E about this incident, however she did not report it to the qualified intellectual disabilities professional (QIDP).

Interview on 1/27/20 with the QIDP revealed these allegations were not investigated.

B. Management failed to consider all sources of evidence when investigating possible neglect of clients.

Review on 1/27/20 of an investigation dated 10/2/19 revealed an allegation was made to the facility nurse that a former client had not been fed and changed after having several seizures. Statements were taken from staff B and the reporting staff. The client involved in the

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W 154	Continued From page 11 allegations was nonverbal and was not able to interviewed. The allegations were not substantiated. Interview on 1/27/20 with staff B revealed the former client had multiple seizures in a very short time on 10/2/19 and was not alert. She stated she contacted the facility nurse who advised her to try to get him to consume Ensure when he was more alert. She stated she changed him and when he was more alert, she was able to give him 2 containers of Ensure. When asked if any of the clients had been interviewed, she stated she was uncertain. Interview on 1/27/20 with the qualified intellectual disabilities professional (QIDP) revealed there are two clients that are interviewable in the facility. When asked if they were in the facility on that date, she confirmed they were. When asked if clients #3 and #2 were interviewed, she stated, "No."	W 154		
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 observation, record review and interview the facility failed to provided sufficient direct care staff to manage and supervise clients	W 186		

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appropriately in the areas of dining, self help skills and behavioral intervention. This affected 3 of 4 audit clients (#1, #3 and #5). The finding is:

Staff failed to provide sufficient direct care staff to supervise client #3 as specified in his behavior support program (BSP).

Observations on 1/28/20 in the facility from 3:40-6:00pm revealed there were sensors at both the front and back doors of the facility. There was also a sensor above client #3's bedroom door off from the living room. When the bedroom door was opened, a clicking noise could be heard.

Interview on 1/27/20 with staff E revealed he felt there was an issue with not having sufficient staff to cover the areas of the facility which included: kitchen, living room, dining room and back hallway. Further interview revealed client #3 has a long history of making sexual advances towards his peers. Additional interview revealed he had witnessed a dozen incidents during the past year with client #3 targeting clients #1 and #5.

Additional interviews with staff E revealed client #3 took advantage of staff being busy in the laundry room and kitchen to approach other clients. Staff E stated client #3 was quick and in less than 5 minutes he could take clients by the hand, lead them to the bathroom and disrobe them. Staff E further stated if staff don't immediately see clients #1 and #5 they go looking for them in the bathroom, to make certain client #3 has not lead them into the bathroom areas of the facility.

Subsequent interview with staff E revealed he has been reporting these incidents to his manager.

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W 186	Continued From page 13	W 186		

He stated less than a week ago he was busy assisting with dinner when he noticed client #1 was not in the common area of the facility and found him naked in the bathroom with client #3. Staff E stated he did not think that anything sexual took place.

Review on 1/27/20 of the staff communication log revealed an entry dated 1/18/20 which revealed staff found clients #1 and #3 in the bathroom. together. Client #5 was naked.

Interview on 1/27/20 with the residential manager (RM) revealed she was aware of the entry on 1/18/20 and had talked with staff E about this incident, however she did not report it to the qualified intellectual disabilities professional (QIDP) .

Interview on 1/27/20 with staff D revealed he could not keep up with the number of times that he has seen client #3 make sexual advances towards clients #1 and #5. Further interview revealed until December 2019 clients #1 and #5 shared a bedroom. Staff D stated that client #3's bedroom was nearby and he had been witnessed to go into their bedroom and remove clients #1 and #5's clothing. He stated neither client was able to defend themselves. Staff D stated there were never any consequences for client #3's inappropriate behaviors.

Interview on 1/28/20 with staff F revealed she was overwhelmed trying to supervise 5 clients as the only staff on third shift from 11pm-7am. She stated on the morning of 1/28/20 around 5:15am before the surveyors arrived at the facility, she was taking client #3 to the bathroom. She stated before she could follow client #3 to the hallway

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W 186	Continued From page 14 bathroom, she discovered client #3 in the bathroom with client #5. She stated client #5 had his pants down and client #3 was looking at him. Review on 1/27/20 of client #3's behavior support program (BSP) dated 5/27/19 revealed he has target behaviors of sexual misconduct, elopement, aggression and invading the personal space of others. The interventions included the use of a door alarm, constant supervision and removing him from the area when he displays this behavior. Review on 1/27/20 of client #3's individual program plan (IPP) dated 8/1/19 revealed he functions in the severe range of intellectual disability and client #3 has a history of displaying inappropriate sexual behavior. Further review of the IPP revealed, "he has a history of displaying sexually inappropriate behavior targeting [clients #1, #5's names]. Staff should know the whereabouts of [client #3] at all times. He has an alarm on his door. Staff should respond to the alarm and remove him from the area when he displays this target behavior. Interview on 1/28/20 with the qualified intellectual disabilities professional (QIDP) revealed the home is currently understaffed and has vacancies on several shifts. Further interview revealed all staff have been trained on client #3's BSP. Additional interview revealed the team has not considered an increase in staffing.	W 186		
W 195	ACTIVE TREATMENT SERVICES CFR(s): 483.440 The facility must ensure that specific active treatment services requirements are met.	W 195		

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W 195	Continued From page 15 This CONDITION is not met as evidenced by: The facility failed to assure: Staff failed to provide sufficient direct care staff to supervise client #3 as specified in his behavior support program (W186);.each client received a continuous active treatment program, which included aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services that was directed towards the acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible (W196); that supervision was provided consistently as indicated in 1 of 4 audit clients' individual program plan (W249), that data was collected as prescribed for client #3's behavior support program (W252) and the qualified intellectual disabilities professional (QIDP) revised as needed the behavior support program (BSP) as needed for 1 of 4 audit clients when it was determined it was not effective in addressing his behaviors (W257). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated active treatment services to the clients.	W 195		
W 196	ACTIVE TREATMENT CFR(s): 483.440(a)(1) Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this	W 196		

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W 196	Continued From page 16 subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the team failed to assure that a continuous aggressive active treatment program was implemented for 1 of 4 audit clients (#3) which provided consistent implementation of the individual program plan (IPP) and interventions in the facility, which promoted client function with as much independence as possible and prevented regression of acquired skills. The findings include: Staff failed to consistently implement client #3's behavior support program by failing to ensure his door sensor was working and he was consistently supervised. Cross reference W249.	W 196		
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.	W 249		

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This STANDARD is not met as evidenced by:
Based on observation, interviews and record review, the team failed to implement sufficient interventions to support the achievement of client #3's behavior support program (BSP). This affected 1 of 4 audit clients (#3). The finding is:

Staff failed to consistently implement client #3's behavior support program by failing to ensure his door sensor was working and that he was consistently supervised.

During observations at the facility on 1/27/20 from 3:30pm-6pm staff were noted to go in and out of client #3's bedroom which adjoined the living room. When staff opened client #3's bedroom door a clicking sound could faintly be detected from a sensor over his bedroom door. There were two direct care staff working with 5 clients.

Interview on 1/27/20 with the residential manager (RM) revealed she checks the batteries every week to see if they need to be replaced. She did not remember what date the door alarm for client #3 was last checked.

Interview on 1/27/20 with staff E revealed he felt there was an issue with not having sufficient staff to cover the areas of the facility which included: kitchen, living room, dining room and back hallway. Further interview revealed client #3 has a long history of making sexual advances towards his peers. Additional interview revealed he had witnessed a dozen incidents during the past year with client #3 targeting clients #1 and #5.

Additional interviews with staff E revealed client #3 took advantage of staff being busy in the laundry room and kitchen to approach other

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clients. Staff E stated client #3 was quick and in less than 5 minutes he could take clients by the hand, lead them to the bathroom and disrobe them. Staff E further stated if staff don't immediately see clients #1 and #5 they go looking for them in the bathroom, to make certain client #3 has not lead them into the bathroom areas of the facility.

Subsequent interview with staff E revealed he has been reporting these incidents to his manager. He stated less than a week ago he was busy assisting with dinner when he noticed client #1 was not in the common area of the facility and found him naked in the bathroom with client #3. Staff E stated he did not think that anything sexual took place.

Review on 1/27/20 of the staff communication log revealed an entry dated 1/18/20 which revealed staff found clients #1 and #3 in the bathroom together. Client #5 was naked.

Interview on 1/27/20 with staff D revealed he could not keep up with the number of times that he has seen client #3 make sexual advances towards clients #1 and #5. Further interview revealed until December 2019 clients #1 and #5 shared a bedroom. Staff D stated that client #3's bedroom was nearby and he had been witnessed to go into their bedroom and remove clients #1 and #5's clothing. He stated neither client was able to defend themselves. Staff D stated there were never any consequences for client #3's inappropriate behaviors.

Review on 1/27/20 of client #3's behavior support program (BSP) dated 5/27/19 revealed he has target behaviors of sexual misconduct,

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elopement, aggression and invading the personal space of others. The interventions included the use of a door alarm, constant supervision and removing him from the area when he displays this behavior.

Review on 1/27/20 of client #3's individual program plan (IPP) dated 8/1/19 revealed he functions in the severe range of intellectual disability and client #3 has a history of displaying inappropriate sexual behavior. Further review of the IPP revealed, "he has a history of displaying sexually inappropriate behavior targeting [clients #1, #5's names]. Staff should know the whereabouts of [client #3] at all times. Has an alarm on his door. Staff should respond to the alarm and remove him from the area when he displays this target behavior."

Closer observation of the door sensor on 1/27/20 revealed the batteries in the sensor needed to be replaced. The residential manager replaced the batteries and when the door was opened, the sensor could be detected from the back of the facility.

Interview on 1/27/20 with the qualified intellectual disabilities professional (QIDP) revealed staff should be checking the batteries in the door sensor daily. Further interview revealed staff should consistently be aware of client #3's location as per his IPP and BSP. Additional interview confirmed client #3's supervision had previously required staff to check on client #3 every 30 minutes prior to 1/27/20 but that his supervision requirement had changed on 1/27/20 for staff to check on client #3's location every 15 minutes. She stated all staff had been inserviced on 1/27/20 of this change in supervision.

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W 249	Continued From page 20 Failure of the staff to closely monitor client #3 and provide consistent supervision to protect the other clients in the facility resulted in client #3's BSP not being implemented as written.	W 249		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure all data relative to objective criteria specified in the Individual Program Plan (IPP) was documented in measurable terms. This affected 1 of 4 audit clients (#3). The finding is: Client #3's objective data was not collected as indicated for his behavior support program (BSP). a) Review on 1/28/20 of the data for client #3's behavior support program revealed no available data for his target behaviors in the month of January 2020. Interview on 1/27/20 with staff E revealed he felt there was an issue with not having sufficient staff to cover the areas of the facility which included: kitchen, living room, dining room and back hallway. Further interview revealed client #3 has a long history of making sexual advances towards his peers. Additional interview revealed he had	W 252		

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witnessed a dozen incidents during the past year with client #3 targeting clients #1 and #5.

Additional interviews with staff E revealed client #3 took advantage of staff being busy in the laundry room and kitchen to approach other clients. Staff E stated client #3 was quick and in less than 5 minutes he could take clients by the hand, lead them to the bathroom and disrobe them. Staff E further stated if staff don't immediately see clients #1 and #5 they go looking for them in the bathroom to make certain client #3 has not lead them into the bathroom areas of the facility.

Subsequent interview with staff E revealed he has been reporting these incidents to his manager. He stated less than a week ago he was busy assisting with dinner when he noticed client #1 was not in the common area of the facility and found him naked in the bathroom with client #3. Staff E stated he did not think that anything sexual took place.

Review on 1/27/20 of the staff communication log revealed an entry dated 1/18/20 which revealed staff found clients #1 and #3 in the bathroom together. Client #5 was naked.

b) Interview on 1/28/20 with staff F revealed she was overwhelmed trying to supervise 5 clients as the only staff on third shift from 11pm-7am. She stated on the morning of 1/28/20 around 5:15am, before the surveyors arrived at the facility, she was taking client #3 to the bathroom. She stated before she could follow client #3, that she discovered client #5 in the bathroom with client #3. She stated client #5 had his pants down and client #3 was looking at him.

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W 252	Continued From page 22 Review on 1/28/20 revealed no documentation of this incident in client #3's behavioral data.	W 252		
W 257	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(iii) The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to revise 1 of 4 audit clients (#3) behavior support program (BSP) after episodes of sexually inappropriate behavior continued to occur. The finding is: The team failed to revise client #3's BSP after his bedroom was relocated and incidents of his sexually inappropriate behavior continued to occur. Review on 1/27/20 of client #3's BSP dated 5/27/19 revealed he has target behaviors of sexual misconduct, elopement, aggression and invading the personal space of others. The interventions included the use of a door alarm, constant supervision and removing him from the area when he displays this behavior. Review on 1/27/20 of client #3's individual program plan (IPP) dated 8/1/19 revealed he functions in the severe range of intellectual disability and client #3 has a history of displaying	W 257		

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inappropriate sexual behavior. Further review of the IPP revealed, "he has a history of displaying sexually inappropriate behavior targeting [clients #1, #5's names]. Staff should know the whereabouts of [client #3] at all times. He has an alarm on his door. Staff should respond to the alarm and remove him from the area when he displays this target behavior.

Review on 1/28/20 of his behavioral data for January 2020 revealed no incidents of target behaviors.

Review on 1/27/20 of the staff communication log revealed an entry dated 1/18/20 which revealed staff found clients #1 and #3 in the bathroom. together. Client #5 was naked.

Interview on 1/27/20 with staff E revealed he felt there was an issue with not having sufficient staff to cover the areas of the facility which included: kitchen, living room, dining room and back hallway. Further interview revealed client #3 has a long history of making sexual advances towards his peers. Additional interview revealed he had witnessed a dozen incidents during the past year with client #3 targeting clients #1 and #5.

Additional interviews with staff E revealed client #3 took advantage of staff being busy in the laundry room and kitchen to approach other clients. Staff E stated client #3 was quick and in less than 5 minutes he could take clients by the hand, lead them to the bathroom and disrobe them. Staff E further stated if staff don't immediately see clients #1 and #5 they go looking for them in the bathroom, to make certain client #3 has not lead them into the bathroom areas of the facility.

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Subsequent interview with staff E revealed he has been reporting these incidents to his manager. He stated less than a week ago he was busy assisting with dinner when he noticed client #1 was not in the common area of the facility and found him naked in the bathroom with client #3. Staff E stated he did not think that anything sexual took place.

Interview on 1/27/20 with staff D revealed he could not keep up with the number of times that he has seen client #3 make sexual advances towards clients #1 and #5. Further interview revealed until December 2019 clients #1 and #5 shared a bedroom. Staff D stated that client #3's bedroom was nearby and he had been witnessed to go into their bedroom and remove clients #1 and #5's clothing. He stated neither client was able to defend themselves. Staff D stated there were never any consequences for client #3's inappropriate behaviors.

Interview on 1/28/20 with staff F revealed she was overwhelmed trying to supervise 5 clients as the only staff on third shift from 11pm-7am. She stated on the morning of 1/28/20 around 5:15am before the surveyors arrived at the facility, she was taking client #3 to the bathroom. She stated before she could follow client #3 to the hallway bathroom, she discovered client #3 in the bathroom with client #5. She stated client #5 had his pants down and client #3 was looking at him.

Interview on 1/27/20 with the qualified intellectual disabilities professional (QIDP) revealed she was not aware of the communication log entry dated 1/18/20 about clients #1 and #3 being located in the bathroom together. When asked what

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W 257	Continued From page 25 constant supervision for client #3 required, she stated he was to be in staff's supervision at all times unless he was in his room and then he required 30 minute checks. She acknowledged the door alarm should be checked daily to ensure it is operational. Additional interview revealed client #3's bedroom had been relocated in December 2019 to give staff better visual supervision of him. Subsequent interview revealed the facility had increased client #3's level of supervision on 1/27/20 on second shift when they were told by the surveyors that incidents of client #3 's inappropriate behavior had continued to occur. The QIDP also stated she was unaware of the incident that occurred on 1/28/20 at 5:15am. Subsequent interview revealed the team had not revised client #3's BSP to increase his level of supervision prior to 1/27/20. The interdisciplinary team did not consider revising client #3's BSP after he continued to exhibit episodes of inappropriate sexual behavior targeting clients #1 and #5. This failure to revise client #3's BSP resulted in the facility's failure to consistently provide active treatment to client #3.	W 257		
W 361	PHARMACY SERVICES CFR(s): 483.460(i) The facility must provide or make arrangements for the provision of routine and emergency drugs and biologicals to its clients. Drugs and biologicals may be obtained from community or contract pharmacists or the facility may maintain a licensed pharmacy.	W 361		

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This STANDARD is not met as evidenced by:
Based on record review and confirmed by interviews with staff the facility failed to obtain Lactulose for 1 of 4 audit clients (#1) from an alternate pharmacy in a timely manner after this medication had been prescribed by his physician. The finding is:

Management staff failed to make arrangements to obtain Lactulose as prescribed by client #1's physician.

During medication pass observations on 1/28/20 at 7:45am staff A asked client #1 to come to the medication room. Staff A went over audit client #1's medications and stated that he was out of Lactulose. Staff A stated that the medication had been ordered but client #1 had missed several doses. Further interview confirmed the facility Nurse had been contacted but the medication had not been delivered as of 1/28/20 at 7:45am.

Review on 1/28/20 of audit client #1's physician orders dated 12/18/19 revealed, "Lactulose 10grams/15 ml. Give 2 tablespoons (30 ml) twice daily.

Review on 1/28/20 of the the medication administration record (MAR) for client #1 revealed he had missed the following doses:

1/26/20: 8am and 8pm
1/27/20: 8am and 8pm
1/28/20: 8am

Review on 1/28/20 of client #1's nursing evaluation dated 2/13/29 revealed he had diagnoses of Cerebral Palsy, Profound Intellectual Disability, History of Seizure Disorder,

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 361	Continued From page 27 History of Asthma, Osteoporosis, Chronic Constipation and Mood Disorder. Interview on 1/28/20 with the facility Nurse via phone revealed she had been made aware that client #1's Lactulose had been ordered but was not aware that staff had not received his medication as of 1/28/20. Further interview with the facility Nurse confirmed the facility did not have a back up pharmacy in the event a medication is prescribed by the physician and cannot be obtained by the contract pharmacy.	W 361		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on record review and interview, the system for drug administration failed to assure all drugs and supplements were administered in compliance with physician's orders for 2 of 4 audit clients (#1, #4). The findings are: A. During medication pass observations on 1/28/20 at 7:45am staff A asked client #1 to come to the medication room. Staff A went over audit client #1's medications and stated that he was out of Lactulose. Staff A stated that the medication had been ordered but that client #1 had missed several doses. Further interview confirmed the facility Nurse had been contacted but the medication had not been delivered as of 1/28/20 at 7:45am.	W 368		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G310	A. BUILDING _____ B. WING _____	01/28/2020

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W 368	Continued From page 28	W 368		

Review on 1/28/20 of audit client #1's physician orders dated 12/18/19 revealed, "Lactulose 10grams/15 ml. Give 2 tablespoons (30 ml) twice daily.

Review on 1/28/20 of the medication administration record (MAR) for client #1 revealed he had missed the following doses:

1/26/20: 8am and 8pm
1/27/20: 8am and 8pm
1/28/20: 8am

Review on 1/28/20 of client #1's nursing evaluation dated 2/13/29 revealed he had diagnoses of Cerebral Palsy, Profound Intellectual Disability, History of Seizure Disorder, History of Asthma, Osteoporosis, Chronic Constipation and Mood Disorder.

Interview on 1/28/20 with the facility Nurse via phone revealed she had been made aware that client #1's Lactulose had been ordered but was not aware that staff had not received his medication as of 1/28/20.

B. Client #4's prescribed diet which included receiving a dietary supplement was not followed.

During observations of breakfast on 1/28/20 at 8:00am revealed client #4 assisted himself in serving cereal, two muffins, juice and milk. He was not offered a dietary supplement.

Review on 1/28/20 of client #4's nutrition evaluation dated 9/2019 revealed he receives a regular diet with supplemental Boost to assist with weight maintenance twice daily. Further review of his nutrition evaluation revealed he has

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W 368	Continued From page 29 a desired weight range of 150-180 pounds and that he is 73 inches in height. His current weight was listed as 138 pounds. Review on 1/28/20 of his physician orders dated 12/18/19 revealed client #4 was prescribed a regular diet with seconds and food cut into bite sized pieces. Provide Ensure or Boost as a supplement twice daily. Interview on 1/28/20 with the qualified intellectual disabilities professional (QIDP) revealed client #4's diet order is current and should be followed.	W 368		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and interviews with staff, the staff failed to carry out fire drills at least quarterly on each shift. This affected all clients in the facility. The finding is: Staff failed to vary the times of fire drills specifically on third shift. Review on 1/27/20 of the fire drills completed during the year on third shift revealed the following: 8/31/19: 6:45am 9/10/19: 6:52am 12/13/19: 6:42am Interview on 1/28/20 with the residential manager	W 440		

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W 440	Continued From page 30 (RM) revealed the clients awake around 5:30am. Further interview revealed these fire drills are the only drills conducted on third shift during the past year. Interview on 1/27/20 with the qualified intellectual disabilities professional (QIDP) revealed fire drills have been conducted in the mornings between third shift and first shift to ensure all clients could be safely evacuated from the facility. Additional interview revealed one direct staff is scheduled to work from 11pm until 7am.	W 440		