Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL029-128	A. BUILDING: ______ B. WING ______	03/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WORKSHOP OF DAVIDSON	275 MONROE ROAD LEXINGTON, NC 27292

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V 000	INITIAL COMMENTS A complaint survey was completed on March 5, 2020. The complaint (Intake #NC00161318) was substantiated. Deficiencies were cited. This facility is licensed for the following service categories: 10A NCAC 27G .2300 Adult Development and Vocational Programs for Individuals with Developmental Disabilities and 10A NCAC 27G .5400 Day Activity for Individuals of All Disability Groups. The incident referenced in this report occurred at the group home in which Deceased Client #1 (DC #1) from the Adult Development Vocational Program and Day Activity Program resided.	V 000		
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and	V 111		

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V 111	Continued From page 1 vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to complete an admission assessment prior to the delivery of services affecting 1 of 1 Deceased Client (DC #1). The findings are: Attempted review on 3/2/2020 of a record for DC #1 at the program revealed no documentation of an admission assessment, an admission date, presenting problems, strengths or needs, family information or social history, evaluations or assessments appropriate for DC #1's needs, no treatment plan, no strategies to address DC #1's presenting problem until a treatment plan could be established. Review on 2/25/2020 of DC #1's record, from the group home in which she resided, revealed: -An admission date of 10/3/2019 to the group home. -Diagnoses of Mild Intellectual Disability Disorder, Spina Bifida, Congenital Deafness, Somatic Symptom Disorder, Major Depressive Disorder, Dandy Walker Syndrome, Intraocular Lens Dislocation and Osteoporosis.	V 111		

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V 111	Continued From page 2 -Date of death on 2/21/2020 -An assessment dated 10/3/19 was completed in the group home. Interview on 3/2/2020 with the Executive Director revealed: -DC #1 did not receive billable services so no assessment was completed. -"She was a nonparticipant. She was paid only for her piece work."	V 111		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

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This Rule is not met as evidenced by:
Based on record reviews and staff interviews the facility failed to complete a treatment plan within 30 days of admission affecting 1 of 1 Deceased Client (DC #1). The findings are:

Attempted review on 3/2/2020 of a record for DC #1 at the program revealed no documentation DC #1's presenting problem, strengths or needs, provisional or admitting diagnosis, pertinent social, family or medical history, evaluations or assessments appropriate to DC #1's needs and no treatment plan or strategies to address DC #1's presenting problem.

Review on 2/25/2020 of DC #1's record from the group home revealed:
-An admission date of 10/3/2019 to the group home.
-Diagnoses of Mild Intellectual Disability Disorder, Spina Bifida, Congenital Deafness, Somatic Symptom Disorder, Major Depressive Disorder, Dandy Walker Syndrome, Intraocular Lens Dislocation and Osteoporosis.
-Date of death on 2/21/2020
-A treatment plan dated 8/7/19 noting "...engage in education and psychosocial opportunities daily, will increase participating in daily social and academic activities, reducing the frequency of somatic complaints, initiate at least one positive social interaction with peers each week and describe mood instability effects on personal family and/or social life"
-No goals related to DC #1's work/participation in the 2300 or 5400 programs.

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V 112	Continued From page 4 Interview on 3/2/2020 with the Executive Director revealed: -DC #1 did not receive billable services, so a treatment plan was not completed. -"She was a nonparticipant. She was paid only for her piece work."	V 112		
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable:	V 113		

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V 113	Continued From page 5 (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain a client record affecting 1 of 1 Deceased Client (DC #1). The findings are: Attempted review on 3/2/2020 of a record for DC #1 at the program revealed no documentation of an admission date, diagnoses, a client record number, a screening and assessment, emergency information, of a signed statement from the client or legally responsible person granting permission to seek emergency care, or services provided and progress towards outcomes. Interview on 3/2/2020 with the Executive Director revealed: -DC #1 did not receive billable services, so there was no record for DC #1. -"She was a nonparticipant. She was paid only for her piece work."	V 113		

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V 512	Continued From page 6	V 512		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the governing body failed to protect 1 of 1 Deceased Client (DC #1) from serious harm. The findings are: Review on 2/25/2020 of DC #1's record from the group home revealed: -An admission date of 10/3/2019 to the group home -Diagnoses of Mild Intellectual Disability Disorder, Spina Bifida, Congenital Deafness, Somatic	V 512		

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V 512	Continued From page 7 Symptom Disorder, Major Depressive Disorder, Dandy Walker Syndrome, Intraocular Lens Dislocation and Osteoporosis. -Date of death on 2/21/2020 -An assessment dated 10/3/19 for the group home, noting "...and in the PSR (Psycho-Social Rehabilitation Program), she will continue to learn how to cope with her depression and anxiety and increase her independent living skills to stabilize her mental health in the community." -A treatment plan dated 8/7/19 for the group home noting "will engage in education and psychosocial opportunities daily...", Attempted review on 2/25/2020 of the Contract Transportation Driver (CTD)'s record revealed: -No documentation of a record for the CTD Interview on 2/25/2020 with the Executive Director (ED) revealed: -The CTD was a contract worker with the facility -The facility had entered into an agreement for the contract agency to provide transportation to the clients. Review on 3/5/2020 of an Interlocal Agreement for the Procurement of Third-Party Transportation services, revealed: -The agreement was entered into on July 1, 2019 by a local county's Transportation Company and the Adult Development Vocational Program and Day Activity Program -The purpose of the agreement was to "allow the parties to purchase transportation services from a vender." Review on 2/26/2020 of the facility's Level III incident report, dated 2/21/2020, revealed: -"Shortly after 4pm, the office staff received a call from the Group Home Relief Supervisor in	V 512		

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V 512	Continued From page 8 Charge, [staff #1] stating that [DC #1] had fallen and hit her head. 911 had been called. The office staff went to the group home for back up assistance. Upon arrival at the group home, Emergency Medical Services and police were already on the scene. Cardiopulmonary Resuscitation (CPR) was being performed on [DC #1] and would continue to be performed for a lengthy amount of time. [The Executive Director] spoke with group home staff present (staff #1) to get statements as to what happened. [Staff #1] stated [DC #1] was on the driveway behind the transportation van and the bus driver was on the phone with 911 and doing CPR. [Staff #1] stated that she started to assist with CPR until the police arrived and then an officer took over. [Staff #1] called the office and reported the event. Staff witnessed lengthy CPR attempts and [DC #1] was bleeding from her face and head. There was a report of a piece of scalp in the driveway and staff saw a significant leg wound. After CPR was ceased, the officers' crime scene taped the area and did extensive photos and measurements. The Police interviewed the staff on duty and continued their investigation with the van driver at the police department. [DC #1]'s body was taken to [a local morgue] and the transportation van was picked up by [the van company] staff after the scene was released. It had been reported initially to staff (#1) by the van driver that [DC #1] had fallen down the steps of the van and hit her head. It was evident by the location of where [DC #1] lay, which was behind the van, and the extent of her leg injury that she had not merely fallen down the van steps. She was not located near the van door or the steps. Staff (#1) assumes that [DC #1] had decided to go to the mailbox instead of going straight inside when the accident occurred but cannot officially verify this. After leaving the police department, [the owner of the	V 512		

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transportation company] called [the ED] to review the situation. He stated that the van driver had let off 4 ladies and he thought he had seen all four ladies enter the residence, at which time he began to back the bus out of the driveway. He felt that he hit something (which he thought to be a trash can), so he pulled forward and could then see [DC #1] in his mirror. He exited the van and came to her to assist and called 911. [The owner of the transportation company] reported that a drug and alcohol screening of the driver would occur per their policy. [The Group Home Coordinator (the GHC)] had spoken with the Legal Guardian (of DC #1] about the accident before we were aware of the situation's outcome. After [DC #1]'s passing was verified by [the ED], we again spoke with [DC #1's Legal Guardian] to notify her of [DC #1]'s death. [The Legal Guardian] was in [a nearby state] with the family at this time and will return in a few days. She had been notified by an officer and [the GHC], of where [DC #1]'s body was taken in order to facilitate final arrangements. [The ED] left messages with [the Department of Social Services (DSS)] and [the Local Management Entity (LME)] on 2/21/2020 as well. [The ED] will follow up with DSS and the LME during business hours on Monday."

Observations on 2/25/2020, at approximately 3:35pm, of the driveway outside of the group home where DC #1 resided, revealed:
-The facility was on the corner of street #1 and street #2
-The facility faced street #1
-The facility's driveway was on street #2
-The driveway was at a slight incline
-On the driveway were orange fluorescent paint markings
-One set of the markings was the outline of the

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V 512	Continued From page 10 transportation van -The second set of markings was where DC #1 was located -The transportation bus had pulled up the driveway -The markings of where DC #1 was located had her head and point of impact behind the passenger side of the transportation van -The facility's mailbox was located behind the transportation van's driver side Review on 2/28/2020 of a local police department's "determination of fault", dated 2/21/2020, revealed: -"On 2/21/2020, at 16:07 (4:07pm), vehicle number one (transportation van) was parked in the driveway of [the group home's address] unloading passengers. Unit number two (the pedestrian (DC #1)) had just gotten off of the bus and had walked behind vehicle number one. Vehicle number one backed up from its parked position and struck unit number two. The pedestrian sustained blunt force trauma injuries and expired on the scene. Vehicle number one came to rest facing north in the driveway. The pedestrian came to rest facing south in the driveway. The driver of vehicle number one contributed to the crash by improper backing." Review on 2/26/2020 of Additional Information Death Incident Report, dated 2/26/2020 and written by the ED revealed: -"On 2/21/2020, after [DC #1] had been pronounced [the ED] met with the group home residents to discuss the outcome ... it was explained to the residents that [DC #1] did not survive the accident...staff comforted the ladies during their grief. After the ladies had calmed down a bit, the ED asked if they had seen anything about the accident that they could share.	V 512		

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The residents did not share any concrete information ..."

Review on 2/26/2020 of an email from the owner of the transportation company to the ED, regarding "After Action Approach", revealed:
-There was no date on the email
-" ...After reviewing everything that we know about this tragic accident, we believe the driver could have avoided this entirely had he followed the policies in which he was trained. However, we are going to amend our current policies to make them even stronger and ensure compliance by retraining our workforce and performing on-area observations throughout the year. Our training: Client drop off: Current training states to make sure passengers are safely inside destination before leaving property. I think this is very clear and does not need to be changed. Although we are going to add this to our backing certification that will be explained below. Our current backing training reads as follows: Backing the vehicle can be very dangerous and should only be done when absolutely necessary. If you must back the vehicle, you should do the following: 1. If possible, get out of the vehicle to assess any hazards/obstacles 'GOAL=Get Out And Look! 2. Use an adult spotter to alert you to possible hazards 3. Before backing, check carefully in all directions, including the rear. As you can see, we have a backing policy that discourages backing but we will add to our current policy on backing and put more emphasis on NOT backing. Do not back unless you have no other safe choice. If you must back up, you are to back first into the area when you first arrive before dropping or picking up passengers so that once you have completed your assignment, you are pulling forward as the first action. We will continue with the GOAL policy, using an adult spotter when backing if

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available and passengers' safety: Make sure all passengers are safely inside destination before backing. Check carefully before backing check carefully in all directions including the rear, back no further than necessary, back slowly, move eyes, don't focus on an object, look, think and plan. Look high and low and scan for any potential hazards, a backing certificate will be created and implemented into our initial and annual training. I have attached a copy of this certification for your review. This certification will be administered through verbal training and through observation by a supervisor. The certification will be signed off and placed in the driver's file. These policy enhancements should eliminate a very high amount of backing conditions and make the conditions safer when we do still have to back. I will also be looking into the feasibility of installing back up cameras into our vehicles. This may take some time to find a system that is compatible with all of our vehicles that doesn't pose any other safety concern with how it is installed and monitored. I believe that if we heighten our awareness around these policies by retraining and certifying every driver, we will eliminate this from ever happening again. We began the retraining process with our driver 'safety stand down' meeting last night. We continue to pray for everyone involved. Our hearts are truly broken over this tragic event."

Interview on 2/25/2020 with client #2 revealed:
-Had ridden the transportation bus to the group home on 2/21/2020 along with DC #1, client #3 and client #4
-Once the bus pulled onto the driveway, all 4 clients got off.
-Client #2 went inside the house with client #3 and client #4
-Prior to walking into the group home, client #2

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had observed DC #1 walk behind the bus to "check the mail"
-"He (the CTD) backed up and did not see [DC #1]. I guess it must have been an accident. I usually check the mail, but that day I did not. I wait (until the bus leaves to check the mail) because it is safer that way."

Interview on 2/25/2020 with client #3 revealed:
-Was hearing impaired but could read lips
-On 2/21/2020, had ridden the transportation bus to the group home with DC #1, client #2 and client #4
-The transportation bus pulled into the driveway to let all 4 clients unload.
-Client #3 unlocked the facility's door and went inside along with client #2 and client #4.
-Did not see where DC #1 was when she got off the bus
-"She did not come inside with us. I think she went to check the mail."

Interview on 2/25/2020 with client #4 revealed:
-Had ridden the transportation bus to the group home on 2/21/2020 along with DC #1, client #2 and client #3
-Stated client #3 was the first person off the bus.
-"She has a key to the house and lets us in".
-"[DC #1] got off the bus and I remember her checking the mail. She was behind the bus. I tried to tap her on the shoulder to tell her to get out of the driveway because the bus was coming behind her. She couldn't hear me."
-Stated staff #1 arrived at the facility, after DC #1 was injured, and told everyone to get into the group home.

Interview on 2/26/2020 with staff #1 revealed:
-Worked at the day program and at the facility once or twice a month

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THE WORKSHOP OF DAVIDSON	**275 MONROE ROAD LEXINGTON, NC 27292**

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V 512	Continued From page 14 -On the days she worked at the group home, her hours were Friday 4pm to 10pm, Saturday from 6am to 10pm and Sundays from 6am to 4pm. -On 2/21/2020, she had worked at the day program until about 3:45pm and then arrived at the group home on 2/21/2020 sometime after 4:00pm -"It takes me maybe 8 or 9 minutes to get to the facility from the day program. So, when I got to the group home, the [transportation bus] was there, the rest of the women were in the house, but [DC #1] was not. The driveway goes up hill and the bus was parked a little past halfway up and [DC #1] was laying behind the bus. [The CTD] was behind the bus, hovering over [DC #1] and was on the phone." -Had asked the CTD what's going on. -"He said [DC #1] fell and hit her head. He did not say how she fell. [DC #1] was located behind the bus laying on her back. She was more towards the passenger side. Her head was facing towards the end of the driveway and her feet were facing the tail of the bus. At that moment when I got out of the vehicle, I ran into the house to get something for her head. I came out and he told me to take over CPR (Cardiopulmonary Resuscitation). I checked for a pulse before I started CPR. She had a faint pulse. She opened her eyes and let out a deep breath. I thought that she was going to say something, but she didn't. There was blood running down the driveway and she had a gash, and a cut above her knee going down on her left leg." -The police arrived first and then the paramedics. -"[The CTD] kept saying she missed a step and then he said she was walking to the mailbox. It didn't make sense from where [DC #1] was laying that she missed a step. Her body was not by the steps of the bus at all. She was behind the bus. I asked to speak to the police officer and then I	V 512		

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gave a statement."

Interview on 2/28/2020 with a neighbor of the group home revealed:
-Had given a statement to the local police department on 2/21/2020.
-Had several large windows in the living room that faced the group home
-Had observed the transportation bus pull into the driveway on 2/21/2020 right before 4:00pm
-Had observed the clients exit the transportation bus
-Saw DC #1 walk behind the transportation bus
-Watched as the transportation bus backed down the driveway in a manner described as "sorta fast"
-Thought to herself the transportation bus was going to hit DC #1
-Watched as the transportation bus hit DC #1
-The CTD had walked behind the vehicle to aid DC #1 who was on the ground
-Observed as a woman with long braids in a sport utility vehicle pulled up to the group home.
-Several minutes later, the woman with the long braids started CPR and the driver of the transportation bus was on his phone
-A female officer arrived first and took over CPR
-Seconds later, more police officers and an ambulance arrived.
-"The next time I looked out the window, they had put a tarp over [DC #1], so I knew it was bad."

Interview on 2/26/2020 with the owner of the transportation company revealed:
-The bus had no back up cameras
-Had received a telephone call on 2/21/2020 from the CTD stating there had been an accident
-The CTD was still employed with the company, but had been suspended until the investigation was complete

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V 512	Continued From page 16 -"I was told there were 4 clients on the bus. They all exited and entered the facility. Apparently, [DC #1] did not go into the home and walked behind the bus to check the mailbox. She was in his blind spot." -At first, the CTD made statements DC #1 had fallen. -"Later, he admitted that he had backed into her in the driveway" Interview on 3/2/2020 with the CTD revealed: -Had been a bus driver for about 4 ½ years -Had been driving that route for 3 years -The policy for dropping clients off is to ensure they get into the facility unless they need physical assistance -None of the clients at the group home required physical assistance -Dropped off 4 clients on 2/21/2020 at 4:00pm -Thought all 4 of the clients went into the group home -Stated he was not aware one of the clients had gotten off the bus and walked behind it. -"She was in my blind spot and that is unfortunately when she got hit." -Had pulled the bus into the driveway so it would be closer to the facility's door -There were no back up cameras on the bus Further interview on 3/2/2020 with the CTD revealed: -Had been trained to make sure passengers were safely inside before leaving property. -Had been trained on the "GOAL=Get Out And Look!" policy -Had been trained to have a spotter when backing up if one was available -Was retrained in January 2020 on the backing up policy at his Agency -The interview failed to reveal why he did not use	V 512		

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his training when he backed up the bus on 2/21/2020

Interview on 2/25/2020 with the GHC revealed:
-Received a telephone call on 2/21/2020 from staff #1 at 4:07pm that DC #1 had fallen and hit her head.
-"I was told she was in and out of consciousness. Our plan was to get her to the emergency room. When we pulled up (to the group home), they were doing CPR on her. It looked like an impact and not a fall. She was behind the transportation bus."

Interview on 2/25/2020 with the ED revealed:
-An incident involving DC #1 and the transportation bus occurred on 2/21/2020 in the group home's driveway
-Was at the office when the GHC received a telephone call from staff #1
-It was reported DC #1 had fallen off the transportation bus and hit her head.
-"When I arrived at the facility, the police and ambulance were already there and the clients (#2, #3 and #4) were already in the house."
-DC #1 was lying on the driveway behind the transportation bus.
-"You could tell it was a hard impact and that she had not just fallen."

Follow up interview on 2/28/2020 with the ED revealed:
-"The only one that knows what happened on 2/21/2020 was [the CTD]. That's the long and short of it. Normally the staff is there before 4pm to monitor the clients getting off the bus. So, from this day forward, the group home staff need to be there by 3:45pm to monitor the clients' safety."

Review on 3/5/2020 of the facility's Plan of

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Protection, dated 3/5/2020 and written by the ED, revealed:
-"What will you immediately do to correct the above rule violation in order to protect clients from further risk or additional harm? Effective upon implementation of a new policy/training (3/3/2020) van loading and unloading policy was implemented in a formal policy. This information was put into place orally on 2/24/2020. This policy states that the group home staff will be in place to visually monitor the loading and unloading of all vans. Staff will arrive before van drop of (3:45pm) and will remain at the group home in the morning until vans have completed pickups. No activities such as checking the mail, collecting garbage cans and etc. will occur while vans are present in the driveway. Staff will remain in visual monitoring location to supervise and prompt as necessary while trash/mail occurs. At the workshop, a new traffic pattern has been developed that ensures vans are not pulling in or backing up. This plan was developed in conjunction with [the transportation agency."
-Describe your plans to make sure the above happens. Staff have been trained in the policy and have signed the acknowledgement of the responsibilities. Supervisory staff will do random drop in checks to ensure staff is in place at all locations. [The van company] not comes into the side lot and instead of pulling up to the overhand and then backing out, they go around in a circle and go back out with no backing. Workshop staff are in place in am/pm at each area to ensure riders get from the vehicles to the building. The van drivers have undergone additional training by their van provider company and have re-instituted a no backing certification protocol. No further pulling in and out at the ladies' group home has occurred by [the van company]. Workshop policy van loading and unloading contains information

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for the new drop off and pick up procedures and what staff responsibilities are. A new schedule showing which staff is assigned where was implemented at this week's staff meeting and staff have reviewed the policy by the ED. The ED gave time for questions, answered questions and staff signed confirmation of responsibility of understanding."

Deceased Client #1 (DC #1) had diagnoses of Mild Intellectual Disability Disorder, Spina Bifida, Congenital Deafness, Somatic Symptom Disorder, Major Depressive Disorder, Dandy Walker Syndrome, Intraocular Lens Dislocation and Osteoporosis. The facility elected to subcontract out the transportation service for the facility clients to a transportation agency. That agency had protocol in place which outlined specific loading and unloading protocol. DC #1, client #2, client #3 and client #4 rode the transportation bus on 2/21/2020 from the facility to the group home. They arrived at the group home at 3:55pm. The CTD pulled into the driveway and the clients exited. Clients #2, #3 and #4 went into the facility. DC #1, who was deaf, walked behind the bus to check the mail. The CTD backed out of the driveway failing to follow protocol which resulted in the death of a client. This deficiency constitutes a Type A1 rule violation for failure to protect from harm and must be corrected within 23 days. An administrative penalty of $6,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.