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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 000	INITIAL COMMENTS A complaint survey was completed on September 1, 2023 for intake #NC00206631. The complaint was substantiated. Deficiencies were cited. An immediate jeopardy was identified, however a Plan of Protection was developed to remove the immediate jeopardy to the clients in the facility.	W 000		
W 122	CLIENT PROTECTIONS CFR(s): 483.420(a) The facility must ensure the rights of all clients. Therefore the facility must This CONDITION is not met as evidenced by: Based on observation, record review and interview the facility failed to: notify legal guardians of significant incidents in a timely manner (W148), implement written policies and procedures that prohibit neglect of the clients (W149), thoroughly investigate allegations of neglect regarding improper supervision of clients (W154) and prevent additional possibilities for physical abuse (W156). 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 148	COMMUNICATION WITH CLIENTS, PARENTS & CFR(s): 483.420(c)(6) The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by:	W 148		

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

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W 148	Continued From page 1 Based on record review and interviews, the facility failed to ensure 1 of 3 audit clients (#4) guardian was notified of allegations of neglect in a timely manner. The finding is: Review on 8/31/23 of an internal investigation completed by the facility dated 8/1/23 revealed former staff B brought a loaded handgun to the facility on 7/31/23 when she reported to work. Former staff A told the Residential Manager (RM) that client #4 was outside playing with sticks and when he walked towards client #4, he pointed the gun at former staff A and told him to stand back. Former staff A told the RM, he assumed the gun was a toy that his parents gave him during the weekend home visit, so he walked over and removed the gun from client #4's hands. Former staff A told the RM when he handled the gun, he realized it was heavy and even then failed to recognize it was real gun. He stated he walked into the group home in the dining room and asked former staff B if she recognized it. Former staff B stated the gun was real, took the gun from former staff A and put it in her purse. Interview on 9/1/23 with client #4's legal guardian revealed she was never notified by management of the incident that occurred on 7/31/23 involving a staff person bringing a loaded firearm into the facility. Further interview revealed that former staff A contacted her by phone to inform her of the incident. Interview on 9/1/23 with the Program Manager revealed the facility could not provide any documentation that the legal guardian was notified of this incident on 7/31/23.	W 148		
W 149	STAFF TREATMENT OF CLIENTS	W 149		

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W 149	Continued From page 2 CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure written policies and procedures were implemented that prohibit neglect by maintaining appropriate supervision to meet client needs and maintaining client safety in the home. This affected 6 of 6 clients (#1, #2, #3, #4, #5 and #5). The findings are: A. Review on 8/31/23 of an internal investigation completed by the facility dated 8/1/23 revealed former staff B brought a loaded handgun to the facility on 7/31/23 when she reported to work. Former staff A told the Residential Manager (RM) that client #4 was outside playing with sticks and when he walked towards client #4, he pointed the gun at former staff A and told him to stand back. Former staff A told the RM, he assumed the gun was a toy that his parents gave him during the weekend home visit, so he walked over and removed the gun from client #4's hands. Former staff A told the RM when he handled the gun, he realized it was heavy and even then failed to recognize it was real gun. He stated he walked into the group home in the dining room and asked former staff B if she recognized it. Former staff B stated the gun was real, took the gun from former staff A and put it in her purse. Interview on 8/31/23 with former staff A revealed on 7/31/23 he worked second shift from 3:30pm-11pm. He stated former staff B was working, as well as, a newer male direct care staff. Further interview revealed he heard client	W 149		

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W 149	Continued From page 3 #4 had returned from a home visit with his parents, so he went back to his bedroom to check on him. Former staff A stated client #4 was not in his bedroom so he went to the backyard and observed client #4 with something in his hand. Client #4 told him to stand back and he pointed a gun at him. Former staff A stated he thought the gun was a toy gun and he reached over and removed it from client #4's hands. He immediately realized the gun was heavy and was a real gun. He opened the chamber of the gun and observed there were bullets in the gun and that it appeared a bullet was lodged in the chamber. Former staff A stated he walked into the kitchen with the gun, once it was unloaded and asked former staff B about the gun. Former staff B confirmed the gun was hers, it was a real gun and was loaded with bullets. Former staff B took the gun, put it in her purse and walked outside, put the purse in the facility van and continued to finish the remainder of the shift. Former staff A stated he walked outside and found additional bullets on the ground in the backyard and gave them to former staff B. Continued interview on 8/31/23 with former staff A revealed he contacted the RM on 8/1/23 by phone and reported the incident involving the gun. Former staff A stated no one from management interviewed him about the gun for approximately 2 weeks, until he he went to the office in Raleigh and asked what management was going to do about the situation. At that time, the facility had not informed the guardian of the situation therefore he notified the guardian. Interview on 8/1/23 with former staff B revealed she was not scheduled to work on 7/31/23. She stated she was shopping and received a call	W 149		

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asking if she could work second shift. Former staff B stated she did not have transportation to work so she arranged for an Uber ride to the facility. Former staff B stated when she arrived at work, she left her purse on the desk in the staff office. Additional interview revealed she started cooking supper, cleaning and washing dishes. She stated she also checked on client #4 because he was alone outside playing with sticks. Additional interview revealed client #4 has elopement behaviors so she checked on him every 5-10 minutes by looking out the dining room door, which was open, to ensure he had not climbed the fence and eloped from the home. Former staff B stated former staff A came into the kitchen holding a gun and asked her if she recognized it. Former staff B stated she had forgotten that the loaded gun was in her purse when she was called into work. She stated she was uncertain whether client #4 had gone into her purse in the staff office and removed the gun or if someone else had gone into her purse.

Additional interview on 8/31/23 with former staff B stated on 7/31/23 when she retrieved the gun from former staff A, she left the facility for about 30 minutes and then returned to work the rest of her shift. Former staff B stated there was no further conversation about the gun with former staff A. She further stated she did not call management on 7/31/23 regarding the gun.

Interview on 8/31/23 with the RM revealed he became aware of the incident of former staff B bringing a loaded gun to work on 8/1/23 when former staff A contacted him. The RM stated he had talked with former staff A during the evening on 7/31/23 and he never reported the incident involving the gun to him. Further interview

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revealed during the conversation on 8/1/23 with former staff A, he told the RM the reason he reported the gun incident on 8/1/23 was that client #5 would probably tell the RM. The RM stated former staff B was contacted and told she was on administrative suspension and not to report to work until the investigation was concluded. Additional interview with the RM revealed he reported the gun incident to the Program Manager by phone on 8/1/23. The RM stated he walked around the group home on 8/1/23 to make certain there were no additional hazards to the clients in the home.

Interview on 8/31/23 with the qualified intellectual disabilities professional (QIDP) revealed he had been informed by the RM on 8/1/23 that former staff B had brought a loaded gun to work in her purse on 7/31/23. He started an internal investigation on 8/1/23. Former staff B was placed on administrative suspension and had not worked since 7/31/23. The QIDP further stated that during the investigation, he was told by former staff B that when she arrived to work on 7/31/23, she placed her purse on the living room couch. She had forgotten that gun was inside of her purse. Former staff B became aware that the gun was in her purse when former staff A brought the gun inside the home to show her. Former staff B confirmed the gun was loaded. She took the gun and placed it back in her purse and locked it in the cabinet in the staff office. She remained at the facility the entire shift. When asked if any additional training was provided to staff he stated the Program Manager had conducted some training on Behavior Support Plans and Policies and Procedures.

Interview on 8/31/23 with the Program Manager

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revealed she instructed the QIDP on 8/1/23 to start an internal investigation into the events that happened on 7/31/23 involving former staff B bringing a loaded gun to work. Further interview confirmed that former staff B was placed on administrative suspension and had not returned to work since 7/31/23. Additional interview confirmed an administrative decision had been made to terminate former staff B effective 8/31/23.

Review of the recommendations from the internal investigation dated 8/1/23 revealed: Staff to be reinserviced on the following: Reporting Procedures, polices and procedures, all client behavior support programs, client specifics, I'm safe and you're safe, documenting behaviors, nutritional needs and diets, medication administration, client Rights and reporting procedures and inservices on Abuse, Neglect and Exploitation. Further review of documentation provided by the facility revealed in their inservices since 7/31/23 there was only documentation staff had been inserviced on reporting procedures, behavior support programs and documentation of behaviors. No other documentation could be located to confirm any of these recommendations from 8/1/23 internal investigation had been implemented.

Additional interview on 8/1/23 with the Program Manager confirmed there was no additional documentation to confirm these recommendations had been completed to ensure clients in the home were protected from additional incidents of neglect. Additional interview with the program manager confirmed the local law enforcement agency was not informed.

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B. Review on 8/31/23 of a facility investigation dated 8/18/23 - 8/25/23 revealed allegations reported included: residents are being whooped by staff when they have behaviors. Interview with client #5 revealed former staff A punched him in the head area in 2021 because he was trying to steal food. Interview with staff G revealed, she had seen former staff A punch client #5 in the chest and sometimes he would take client #3 in the room and close the door and she would hear client #3 screaming and crying. Conclusion: the allegation of abuse and neglect against former staff A was substantiated.

Observations on 8/31/23 at approximately 9:00am revealed the state surveyor was in the home when former staff A knocked on the door. One of the clients opened the door. Former staff A walked into the facility where the clients were. The RM was in another room giving clients medication. The surveyor asked former staff A his name, in which he responded. The surveyor then informed him that he wasn't supposed to be in the home. Former staff A stated he needed to get his books from client #4. The surveyor informed the RM of former staff A being in the home however, he stated he was giving medications and would handle it later. The surveyor retrieved the books from client #4 and provided them to former staff A. He then left the home. At no time were the police or management staff notified about former staff A being on the premises.

Interview on 8/31/23 with the RM revealed former staff A had shown up to the facility on 3 occasions since the substantiated abuse allegation. The first time, he pulled up to the home as former staff A was leaving. He was uncertain if former staff A

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went into the home where the clients were. Former staff A showed up again on 8/30/23, accompanied by a police officer, stating he had left some belongings in the garage. The RM allowed former staff A and the officer entry through the garage however, he was not able to locate the items. Management had instructed to call a supervisor and the police if former staff A showed up at the facility. The RM confirmed he was aware that former staff A walked inside of the home where the clients were today however, he did not notify management or call the local police because he was giving medications.

Interview on 8/31/23 with the Program Manager revealed she was aware of the allegation of abuse against former staff A and participated in the investigation. She further confirmed former staff A was suspended during the investigation. Former staff A later submitted a resignation letter, which was accepted by the facility. The facility substantiated the abuse allegation on former staff A. The Program Manager confirmed that staff were to notify management; request the former staff to leave the premises and if he doesn't, then staff were to call the police. She further confirmed former staff A should not have been around the clients due to the substantiated abuse allegation.

C. Observations on 8/31/23 at 11:01am - 11:08am revealed client #3 was outside with staff E. Client #3 started running down the street in which the home was located. Staff E walked behind client #3 however, there was a significant gap between them. Client #3 reached the stop sign at the end of the street which was 0.4 miles away from the home. He then crossed the busy street and begun walking in the center of the 2

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lanes. Staff E was observed to jog/walk until she reached client #4. She then directed him back to the facility.

Review on 8/31/23 of client #3's Individual Support Plan (ISP) dated 2/10/23 revealed client #3 has diagnoses of traumatic brain injury, seizure disorder, type I diabetes, autism, severe I/DD, ADHD and disruptive mood dysregulation disorder. Client #3 has been aggressive, engages in destructive behavior and displays disruptive screaming, door slamming and banging on surfaces. He has broken items and attempts to runs from caregivers. Client #3's behavior support plan (BSP) dated 1/30/23 revealed client #3 lacks awareness of safety/danger.

Interview on 8/31/23 with the RM revealed staff E started working at the facility on yesterday (8/30/23). She had not received any client specific training regarding behaviors. He was planning to review target behaviors with her today but the clients ended up being out of school and another staff didn't show up for work, which left them short staffed. The RM stated "technically she shouldn't have been working with the clients because she hadn't been trained."

Interview on 8/31/23 with the QIDP revealed staff E should not have been responsible for supervising clients since she had not received training. Someone in management should be monitoring her closely and making sure she's familiar with the clients' treatment plans.

Review on 8/31/23 of the facility's policy on Protection from Abuse and Neglect (revised 5/12) defined Neglect as, "failure to provide care and

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services necessary to maintain the mental health, physical health and well-being of the client." Further review of this policy indicated failure to report incidents of abuse will result in disciplinary action.

During the survey it was confirmed the facility had failed to put substantive corrections in place to protect clients after a former employee brought a loaded gun to the facility, didn't protect clients when a former staff who abused clients showed up at the house, as well as, the fact 3 of 3 audit clients (#2, #3 and #4) behavior support programs were not consistently followed which put them at risk for elopements from the facility and being injured by cars in the neighborhood, the team on site substantiated an immediate jeopardy to the clients in the facility.

The facility developed the following plan to remove the jeopardy to the clients in the facility which included: "Initiate an investigation re: the events of elopement that took place on 8/31/23. All staff on 1st shift will be placed on administrative leave and statements /interviews started, present day by the Quality Assurance Manager. Train all staff on all three shifts on the weapon policy starting 8/31/23. Ensure completion of incident report on individual for [client #3]. QIDP will review all BSP's/BSG's and ISP's to ensure appropriateness starting 8/31/23. QIDP will train all staff on the behaviors and their antecedents starting 8/31/23. PM will train QIDP on internal policies related to staffing ratios, active treatment, reporting practices, completion of incident reports, abuse and neglect, and weapons policy. QIDP will train all staff on staffing ratio, monitoring and active treatment effective 8/31/23. Ensure a member of management (i.e.;

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W 149	Continued From page 11 Site Supervisors from another home) Area Supervisors, QIDP's and PM's) will be present on each waking shift to ensure appropriate monitoring of the home to assist in preventing abuse and neglect in all forms. Monitoring will take place until the Condition is lifted. A member of management (including AS, QP, and PM) will conduct daily monitoring in the home to ensure understanding and compliance of training. Monitoring will continue until Condition status is lifted. Completion of ICF daily calls, daily shift observations, and weekly site reviews by members of management (SS, AS, QP, PM) starting 8/31/23. Completion of weekly monitoring on resident safety by Operation Support Specialist. PM to train Clinical staff on resident safety, adhering to all ISP's, BSP's, expectations for active treatment, and reporting procedures." This plan was signed by the Executive Director on 8/31/23. After reviewing the above plan of protection dated 8/31/23, the team on site accepted the plan which removed the immediate jeopardy to the clients in the home effective 8/31/23.	W 149		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure an incident of neglect was thoroughly investigated and all sources of evidence were considered. This affected 1 of 6 clients (#4). The finding is: Review on 8/31/23 of an internal investigation	W 154		

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completed by the facility dated 8/1/23 revealed former staff B brought a loaded handgun to the facility on 7/31/23 when she reported to work. Former staff A told the residential manager (RM) that client #4 was outside playing with sticks and when he walked towards client #4, he pointed the gun at former staff A and told him to stand back. Former staff A told the RM, he assumed the gun was a toy that his parents gave him during the weekend home visit, so he walked over and removed the gun from client #4's hands. Former staff A told the RM when he handled the gun, he realized it was heavy and even then failed to recognize it was real gun. He stated he walked into the group home in the dining room and asked former staff B if she recognized it. Former staff B stated the gun was real, took the gun from former staff A and put it in her purse.

Interview on 8/31/23 with former staff A revealed on 7/31/23 he worked second shift from 3:30pm-11pm. He stated former staff B was working, as well as, a newer male direct care staff. Further interview revealed he heard client #4 had returned from a home visit with his parents, so he went back to his bedroom to check on him. Former staff A stated client #4 was not in his bedroom so he went to the backyard and observed client #4 with something in his hand. Client #4 told him to stand back and he pointed a gun at him. Former staff A stated he thought the gun was a toy gun and he reached over and removed it from client #4's hands. He immediately realized the gun was heavy and was a real gun. He opened the chamber of the gun and observed there were bullets in the gun and that it appeared a bullet was lodged in the chamber. Former staff A stated he walked into the kitchen with the gun, once it was unloaded and

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asked former staff B about the gun. Former staff B confirmed the gun was hers, it was a real gun and was loaded with bullets. Former staff B took the gun, put it in her purse and walked outside, put the purse in the facility van and continued to finish the remainder of the shift. Former staff A stated he walked outside and found additional bullets on the ground in the backyard and gave them to former staff B.

Interview on 8/1/23 with former staff B revealed she was not scheduled to work on 7/31/23. She stated she was shopping and got a call that she needed to come to the facility to work on second shift. Former staff B stated she did not have transportation to work so she arranged for an Uber ride to the facility. Further interview former staff B stated when she arrived at work, she placed her purse on the desk in the office. She stated she was uncertain whether client #4 had gone into the staff office into her purse and removed the pistol or if someone else had gone into her purse.

Additional interview on 8/31/23 with former staff B stated on 7/31/23 when she retrieved the gun from former staff A, she left the facility for about 30 minutes and then returned to work the rest of her shift. Former staff B stated there was no further conversation about the gun with former staff A. She further stated she did not call management on 7/31/23 regarding the gun.

Interview on 8/31/23 with the qualified intellectual disabilities professional (QIDP) revealed he was told on 8/1/23 that he needed to start an internal investigation into the incident involving former staff B bringing a loaded gun in her purse to the home on 7/31/23. Further interview with the QIDP

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W 154	Continued From page 14 revealed former staff B had been placed on administrative suspension and had never returned to work after 7/31/23. The QIDP stated he was told by former staff B that she put her purse on the living room couch. Additional interview confirmed the QIDP did not further investigate the following discrepancies: where former staff B had stored her purse on 7/31/23, whether she had worked the entire shift with a loaded gun stored in the home or the facility van. There was also no further investigation how client #4 was unsupervised and got access to former staff B's purse.	W 154		
W 156	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(4) The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to report investigations of abuse and neglect to state and local officials within 5 working days of the incident as required by state law. The findings are: A. Review on 8/31/23 of an internal investigation completed by the facility dated 8/1/23 revealed former staff B brought a loaded handgun to the facility on 7/31/23 when she reported to work. Former staff A told the residential manager (RM) that client #4 was outside playing with sticks and when he walked towards client #4, he pointed the gun at former staff A and told him to stand back. Former staff A told the RM, he assumed the gun was a toy that his parents gave him during the weekend home visit, so he walked over and	W 156		

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removed the gun from client #4's hands. Former staff A told the RM when he handled the gun, he realized it was heavy and even then failed to recognize it was real gun. He stated he walked into the group home in the dining room and asked former staff B if she recognized it. Former staff B stated the gun was real, took the gun from former staff A and put it in her purse.

Interview on 8/31/23 with the Program Manager revealed she instructed the QIDP on 8/1/23 to start an internal investigation into the events that happened on 7/31/23 involving formed staff B bringing a loaded gun to work. Further interview confirmed that former staff B was placed on administrative suspension and had not returned to work since 7/31/23. Additional interview confirmed an administrative decision had been made to terminate former staff B effective 8/31/23. The Program Manager confirmed the facility did not notify the local authorities of this incident.

B. Review on 8/31/23 of a facility investigation dated 8/18/23 - 8/25/23 revealed allegations reported included: residents are being whooped by staff when they have behaviors. Interview with client #5 revealed former staff A punched him in the head area in 2021 because he was trying to steal food. Interview with staff G revealed, she had seen former staff A punch client #5 in the chest and sometimes he would take client #3 in the room and close the door and she would hear client #3 screaming and crying. Conclusion: the allegation of abuse and neglect against former staff A was substantiated.

Interview on 8/31/23 with the Program Manager revealed she was aware of the allegation of

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W 156	Continued From page 16 abuse against former staff A and participated in the investigation. She further confirmed former staff A was suspended during the investigation. Former staff A later submitted a resignation letter, which was accepted by the facility. The facility substantiated the abuse allegation on former staff A, however the local authorities were not notified.	W 156		
W 195	ACTIVE TREATMENT SERVICES CFR(s): 483.440 The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: The facility failed to assure: 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); assure 3 of 3 audit clients (#2, #3 and #4) received a continuous active treatment program consisting of supports and services in sufficient number to support the individual program plans (W249). 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	W 196		

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W 196	Continued From page 17 treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this 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 observation, interview and record review the facility failed to implement consistent strategies, supports and programs to ensure 3 of 6 audit clients (#2, #3 and #4) received active treatment services as described in their individual program plans (IPP) to ensure their behavior management needs were addressed. The finding is: Cross-refer to W249. The facility failed to ensure 3 of 3 audit clients received an active treatment program that was implemented and integrated across all settings.	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, record review and interview, the facility failed to ensure 3 of 6 clients (#2, #3 and #4) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Support Plan (ISP). The findings are:

A. Observations on 8/31/23 at 11:01am - 11:08am revealed client #3 was outside with staff E. Client #3 started running down the street in which the home was located. Staff E walked behind client #3 however, there was a significant gap between them. Client #3 reached the stop sign at the end of the street, which was 0.4 miles away from the home. He then crossed the busy street and begun walking in the center of the 2 lanes. Staff E was observed to jog/walk until she reached client #4. She then directed him back to the facility. Observations further revealed no active treatment was provided to client #3 between 9:00am - 11:08am. Client was observed to either sit on the couch with staff or walk around the home and/or outside during this time.

Review on 8/31/23 of client #3's ISP dated 2/10/23 revealed client #3 has diagnoses of traumatic brain injury, seizure disorder, type I diabetes, autism, severe I/DD, ADHD and disruptive mood dysregulation disorder. Client #3 has been aggressive, engages in destructive behavior and displays disruptive screaming, door slamming and banging on surfaces. He has broken items and attempts to runs from caregivers. He has priority needs identified in the areas of oral hygiene, medication administration, money management, privacy and laundry.

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W 249	Continued From page 19 Review on 8/31/23 of client #3's behavior support plan (BSP) dated 1/30/23 revealed client #3 lacks awareness of safety/danger. "[Client #3] requires close visual supervision during the day and safety precautions at night to ensure that he stays safe. Make sure you can see him and what he is doing. [Client #3] is still developing safety awareness and may wander during transition." Interview on 8/31/23 with the residential manager (RM) revealed staff E started working at the facility on yesterday (8/30/23). She had not received any client specific training regarding behaviors or the clients' ISP. He was planning to review target behaviors with her today but the clients ended up being out of school and another staff didn't show up for work, which left them short staffed. The RM stated "technically she shouldn't have been working with the clients because she hadn't been trained." Interview on 8/31/23 with the qualified intellectual disabilities professional (QIDP) revealed staff E should not have been responsible for supervising a client since she had not been trained. Someone in management should be monitoring her closely and making sure she's familiar with the clients behaviors and treatment plans. Interview on 8/31/23 with the program manager confirmed staff E should not have been working independently with clients since she had not been trained. She stated client #3 has a picture ring that should have been implemented. B. Review on 8/31/23 of an internal investigation completed by the facility dated 8/1/23 revealed former staff B brought a loaded handgun to the	W 249		

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facility on 7/31/23 when she reported to work. Former staff A told the RM that client #4 was outside playing with sticks and when he walked towards client #4, he pointed the gun at former staff A and told him to stand back. Former staff A told the RM, he assumed the gun was a toy that his parents gave him during the weekend home visit, so he walked over and removed the gun from client #4's hands. Former staff A told the RM when he handled the gun, he realized it was heavy and even then failed to recognize it was real gun. He stated he walked into the group home in the dining room and asked former staff B if she recognized it. Former staff B stated the gun was real, took the gun from former staff A and put it in her purse.

Interview on 8/1/23 with former staff B revealed she was not scheduled to work on 7/31/23. She stated she was shopping and received a call asking if she could work second shift. Former staff B stated she did not have transportation to work so she arranged for an Uber ride to the facility. Former staff B stated when she arrived at work, she left her purse on the desk in the staff office. Additional interview revealed she started cooking supper, cleaning and washing dishes. She stated she also checked on client #4 because he was alone outside playing with sticks. Additional interview revealed client #4 has elopement behaviors so she checked on him every 5-10 minutes by looking out the dining room door, which was open, to ensure he had not climbed the fence and eloped from the home. Former staff B stated former staff A came into the kitchen holding a gun and asked her if she recognized it. Former staff B stated she had forgotten that the loaded gun was in her purse when she was called into work. She stated she

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was uncertain whether client #4 had gone into her purse in the staff office and removed the gun or if someone else had gone into her purse.

Review on 8/31/23 of client #4's ISP dated 3/30/23 revealed he has a BSP to address the inappropriate behaviors of Property Destruction, Non-compliance, Elopement, physical aggression and self-injurious behavior (SIB).

Review of client #4's BSP revealed this program incorporates the use of door chimes, window alarms and psychotropic medications. The interventions to prevent client #4's target behaviors include: Always know his whereabouts at all times, At least every 15 minutes keep him engaged in tasks through habilitation goals, leisure activities, chores within the home, provide self soothing objects (rocking chair, weighted blanket, music, swing and walks), Make daily tasks organized and predictable and plan and slowly introduce changes in his routine.

Interview on 8/31/23 with the QIDP revealed it is imperative to know of client #4's location at all times because he has eloped from the home previously. Further interview revealed leaving client #4 in the backyard for periods of time on 7/31/23 while staff were not visually supervising him was not consistent with his BSP.

C. During observations at the home on 8/31/23 at 10:30am, as the surveyor was leaving the home, client #2 ran from staff E and attempted to get into the back of the surveyor's trunk. Staff E talked with client #2 and attempted to physically remove him from the surveyor's car trunk however, he would not comply. Staff E asked the surveyor how she should convince client #2 to get

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out of her trunk. Client #2 then climbed out of the surveyor's car and ran back up the hill near the front porch followed by staff E.

During observations of the home on 8/31/23 from 8:30am-10:30am, the three front windows were noted to be covered with sheets of plywood so there was no visible light coming into the living room with the exception of an overhead light that was missing 1 of 3 lightbulbs. There were holes on the walls of the living room and dining room. There was no television and very few personal belongings out in the dining room and living room.

Immediate interview on 8/31/23 with staff C indicated that clients #2, #3 and #4 have broken several windows and have punched holes in many of the walls. Staff C stated these damages have been reported to the RM.

Review on 8/31/23 of client #2's BSP dated 3/20/23 revealed he is non-verbal and has several target behaviors which include: elopement, physical aggression, property destruction and non-compliance. The strategies to prevent target behaviors include: Every 15 minutes keep client #2 engaged in tasks through habilitative goals, leisure activities and chores within the home. Provide self soothing objects such as: a rocking chair, weighted blanket, music and walks. Always know his whereabouts at all times.

Interview on 8/31/23 with the QIDP revealed staff E is a new employee who has not been trained on client #2's IPP and BSP and should have not been responsible for providing direct supervision for him, particularly outside.

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W 249	Continued From page 23 During this time, clients were either just sitting on the couch or walking around the home/outside. Staff were just sitting on the couch or walking outside in the yard with the clients. There were no attempts made by staff to engage the clients in active treatment programming. The lack of active treatment including following client behavior plans resulted in the the condition of active treatment being out of compliance.	W 249		