STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G247	A. BUILDING _____ B. WING _____	C 06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINOAK GROUP HOME	**3175 BANK ROAD LINCOLNTON, NC 28092**

(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 June 7, 2024 for intake #NC00217541. The complaint allegation was substantiated and three conditions were cited. Additional deficiencies were cited.	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: The facility failed to implement written policies and procedures that prohibit mistreatment, neglect and abuse of a client (W149). The cumulative effect of these systemic practices resulted in the facility's failures to provide statutorily mandated services of client protections to its clients.	W 122		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure policies and procedures were implemented to prevent unintentional neglect due to escalating behaviors at the facility for 6 of 6 clients (#1, #2, #3, #4, #5 and #6). The findings are: Review on 6/6/24 of facility records revealed client #1 was transported to the hospital by EMS after client #2 pushed client #1 down to the floor. Client #1 was also hit on the head with an object. Further review revealed client #1 had an x-ray	W 149		

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

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W 149	Continued From page 1 done that determined he had a femur fracture, left broken hip, and inner thigh bruising. Continued review revealed it was unknown what caused the incident with both clients and what the facility was doing regarding the investigation process. Review on 6/6/24 of client #1's emergency department admission note dated 5/22/24 revealed that another client at the home pushed client #1 down and he landed on his left knee; in addition he was not wanting to bear weight. It was reported he normally ambulates without assistance. Further review revealed an x-ray was taken and the clinical impression was a subtrochanteric fracture and possible intertrochanteric fracture of the left proximal femur (closed fracture of left hip). There is no hip dislocation. Review on 6/6/24 of the facility's incident/accident reports from January 2024-June 2024 revealed the following: - 6/6/24 at 8:30am "2 staff on duty; Staff while in the kitchen heard yelling coming from [client #4's] room. Staff went to check and [client #4] was on the floor laying on his back engaged in a behavior." - 5/28/24 at 6:16pm "2 staff on duty; [client #5] told [client #4] to shut up and then they started fighting, slapping and biting at each other in the dining room." Further review revealed a note of concerns on the incident report per staff "very unsafe for the individuals served and only 2 staff on shift. The facility needs at least 3 to 4 staff on shift for this very reason. When staff is restraining a client, staff get tired and need to switch out, and have no one to switch out with to take over the restraint. No one to ensure others are ok and safe."	W 149		

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W 149	Continued From page 2 - 5/22/24 at 6:40pm: "2 staff on duty; [client #2] pushed [client #1] while staff was trying to redirect [client #2] to his room. Staff notified the nurse, QP, and HM; [client #1] was taken to the hospital by EMS due to not being able to bear weight." - 5/21/24 at 7:30am: "2 staff on duty; [client #4] became upset when staff asked him to clean his room, [client #4] began punching the walls, flipping on and off the lights, yelling, cussing, then charged at the staff. Staff implemented a restraint outside. Restraint implementation not effective at all, the more you try to calm [client #4] down the worse he gets." Further review revealed a note of concerns on the incident report per staff "If there is more than two staff here everyone should have helped with restraint that didn't happen." Continued reviewed revealed there was two nursing staff onsite. - 5/10/24 at 9:45am: "2 staff on duty; [client #5] was upset about coming to the day program. [Client #5] started banging head on van window punching and biting self." - 4/17/24 at 9:00am: "2 staff on duty plus behavior specialist (BS); [Client #6] walking up on staff then proceeded with pulling the fire alarm, punching the screen door, and running outside. Then choked a staff and grabbing at staff." - 4/16/24 at 9:00am: "2 staff on duty plus BS; [Client #6] tried to attack staff in living room. [Client #6] walked up on staff and tried to punch staff in the chest." - 3/5/24 at 1:45pm: "2 staff on duty; [Client #2] hit another client and was separated before leaving day program. [Client #2] got up and moved back to sit with individual he was just separated from while van was moving. [Client #2] fell in between the seats in front of [client #1] and]client #1] began smacking, punching, and hitting [client #2] with a lunchbox."	W 149		

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W 149	Continued From page 3 - 3/1/24 at 4:20pm: "2 staff on duty; [client #5] was fussing, cussing, and spitting at [client #4]. Staff tried to intervene, but [client #5] began punching and clawing at [client #4], tried to bite staff but got [client #4's] arm and bit him very badly." Further review revealed a note of concerns on the incident report by staff "Not enough staff on shift at a Behavioral home. This situation is very unsafe for two staff on shift and other roommates in the home. If house was staffed property situation could have been prevented." - 2/18/24 at 10:30am: "2 staff on duty; [Client #6] was sitting on the van when client #5 was having a behavior. [Client #5] punched [client #6] in the face and grabbed [client #6] around the neck." - 2/8/24 at 10:30am: "2 staff on duty; [Client #5] didn't want to get off the van. [Client #5] punched client #6 who was sitting beside him and grabbed [client #6's] neck." - 2/6/24 at 9:15am: "3 staff on duty; [Client #6] became upset because he wanted to call a friend early in the morning and that friend only wants [client #6] to call after 5pm. [Client #6] attacked staff and staff had to restrain him." - 1/16/24 at 7:45am: "2 staff on duty; [Client #4] told staff during breakfast that he wanted to see his girlfriend and staff redirected [client #4] letting him know to finish his breakfast. [Client #4] started banging on the walls, floors, throwing lamps, books, and chairs." A. Record review on 6/6/24 for client #1 revealed a behavior support plan (BSP) dated 5/1/23 with an objective that client #1's rate of target behaviors will decrease to two or less episodes per month for 6 consecutive months by 5/1/24. Further review revealed target behaviors of physical aggression, property destruction,	W 149		

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W 149	Continued From page 4 stealing, toileting accidents, refusing hab activities, and tantrum. Review on 6/6/24 of client #1's psychology tracking record (December 2023 - May 2024) revealed the following total data collected from six consecutive months of occurrences for these target behaviors: - Physical aggression: 2 occurrences, missing data (12/23, 01/24, 03/24, 04/24) - Property destruction: 0 occurrences, missing data 12/23, 01/24, 03/24, 04/24, 05/24) - Stealing: 2/24 1 occurrence, missing data (12/23, 01/24, 03/24, 05/24) - Toileting accidents: 6 occurrences, missing data (02/24, 05/24) - Refusing hab activities: missing 6 months of data - Tantrum: 2 occurrences, missing data (12/23, 01/24, 02/24, 03/24, 04/24) - Total: 11 occurrences for 6 months review period B. Record review on 6/6/24 for client #2 revealed a BSP dated 6/1/24 with an objective that client #2's rates of target behaviors will decrease to five or less episodes per month for 6 consecutive months by 6/1/25. Further review revealed target behaviors of physical aggression, property destruction, self-injurious behavior (SIB), AWOL, and verbal outbursts. Review on 6/6/24 of client #2's psychology tracking record (December 2023 - May 2024) revealed total data collected from six consecutive months of occurrences for these target behaviors: - Physical aggression: 27 occurrences - Property destruction: 4 occurrences, missing data (12/23, 01/24, 02/24, 04/24)	W 149		

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W 149	Continued From page 5 - SIB: Missing 6 months of data - AWOL: Missing 6 months of data - Verbal Outbursts: 7 occurrences, missing data (02/24, 03/24, 04/24, 05/24) - Total: 38 occurrences for 6 months review period. C. Record review on 6/6/24 for client #3 revealed a BSP dated 7/1/21 with an objective that client #3's rate of target behaviors will decrease to two or less episode per month for 12 consecutive months by 7/1/22. Further review revealed target behaviors of physical aggression, verbal aggression, and obsessive behavior. Review on 6/6/24 of client #3's psychology tracking record (December 2023 - May 2024) revealed total data collected from six consecutive months of occurrences for these target behaviors: - Physical aggression: 0 occurrences, missing data(12/23, 01/24, 02/24, 04/24, 05/24) - Verbal Aggression: 0 occurrences, missing data(10/23, 11/23, 12/23, 02/24, 05/24) - Obsessive Behavior: 8 0 occurrences - Total: 8 occurrences for 6 months review period. D. Record review on 6/6/24 for client #4 revealed a BSP dated 11/15/23 with an objective that client #4 will learn to manage his daily routine, so that his rate of target behaviors will decrease to two or less episodes per month for 6 consecutive months by 11/1/24. Further review revealed target behaviors of physical aggression, tantrum, property destruction, verbal aggression, refusing to cooperate, AWOL, Inappropriate sexual behaviors, and Irrational V Statements. Review on 6/6/24 of client #4's psychology tracking record (February 2024 - May 2024)	W 149		

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revealed total data collected from 4 consecutive months of occurrences for these target behaviors:
- Physical aggression: 20 occurrences
- Tantrum: 16 occurrences, missing data (02/24)
- Property destruction: 16 occurrences
- Verbal aggression: 20 occurrences, missing data (04/24)
- Refusing to cooperate: missing 4 months of data
- AWOL: 6 occurrences
- Inappropriate sexual behaviors: missing 4 months of data
- Irrational V Statements: missing 4 months of data
- Total: 78 occurrences for 4 months review period.

E. Record Review on 6/6/24 for client #5 revealed a BSP dated 4/2/20 with an objective that by 5/1/21 client #5's rate of behavior disruptive to habilitation will decrease to zero episode per month for 6 consecutive months. Further review revealed target behaviors of physical aggression, verbal aggression, resistance, property destruction, SIB, and melt down/tantrum .

Review on 6/6/24 of client #5's psychology tracking record (December 2024 - May 2024) revealed total data collected from 6 consecutive months of occurrences for these target behaviors:
- Physical aggression: 11 occurrences, missing data (02/24)
- Verbal aggression: 24 occurrences
- Resistance: 6 occurrences, missing data (10/23, 11/23, 12/23, 01/24, 03/24, 04/24)
- Property destruction: 8 occurrences, missing data (10/23, 11/23, 02/24, 03/24)
- SIB: missing 6 months of data
- Melt down/tantrum: missing 6 months of data

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W 149	Continued From page 7 - Total: 49 occurrences for 6 month review period. F. Record Review on 6/6/24 for client #6 revealed a BSP dated 5/1/24 with an objective that client #6's rate of target behaviors will decrease to two or less episodes per month for six consecutive months by 5/1/25. Further review revealed target behaviors of physical aggression, AWOL, property destruction, SIB, and toileting accidents . Review on 6/6/24 of client #6's psychology tracking record (December 2024 - May 2024) revealed the total data collected from 6 consecutive months of occurrences for these target behaviors: - Physical aggression: 30 occurrences, missing data(12/23, 01/24) - SIB: 6 occurrences, missing data (12/23, 02/24, 03/24, 04/24) - AWOL: 16 occurrences - Property destruction: 40 occurrences - Toileting accidents: 7 occurrences (12/23, 02/24, 03/24) - Total: 99 occurrences for 6 months review period. Interview on 6/6/24 with Staff C revealed there are normally only two staff on second shift until around 7pm or 8pm, then only one staff to manage the facility until 7am in the morning. Staff C stated that he has been working double shifts since October of 2023 due to the facility not having enough staff and that there is a high turnover rate. Staff C stated that several behaviors occur on the second shift especially when there is a "small woman" on duty. Staff C confirmed that there was not another staff scheduled to work once Staff F gets off at 8pm on 6/6/24.	W 149		

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W 149	Continued From page 8 Further interview with Staff C revealed the home is "off the chain" and that the clients know they can overpower certain staff. Staff C stated that the clients have no respect for staff and don't like to do chores around the home. Staff C stated that he told the qualified intellectual disabilities professional (QIDP) that they needed more staff that are trained to manage the behaviors, stating "it is impossible to manage with just two staff". Staff C further revealed that he was told that they don't write enough incidents to show a need for more staff. Staff C stated that it was very difficult to document all the behaviors when trying to de-escalate continuous behaviors throughout the shift. Staff C revealed one day during second shift, two nurses were present at the facility conducting assessments and when the behaviors increased, both nurses stopped and left the facility, leaving two staff trying to restrain a client and the other clients were out of their line of sight. Staff C stated that he was tired and overworked, and that it was even difficult to get a 30 min break while on duty. Interview on 6/6/24 with Staff D revealed the facility has a very high turnover rate and that staff are afraid to work in this type of environment. Staff D stated "it's not right here; it's rough". Staff D stated that she is often tired from managing behaviors and implementing restraints, and there are no other staff to switch out with. Continued interview with Staff D revealed there is not enough staff to assist with the restraints and manage the other residents. Staff D stated that it is difficult to do duties around the home and run programs at times and that "with 2 staff, it is	W 149		

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impossible". Staff D stated this home "will never be right" and revealed that a while back there were 5 to 6 staff on first and second shift. However, a client got discharged and the agency dropped the staff ratio.

Staff D revealed that she noticed an increase in behaviors over 3 months ago due to too many new staff coming and leaving the facility. Staff D stated that new staff are afraid of the clients and would give into their demands. Staff D stated that she has complained several times to the home manager, and nothing has changed. Staff D revealed that she works from 7a-7p 6/6/24 and 6/7/24.

Interview on 6/6/24 with Staff F revealed she was scheduled to work from 7am until 8pm; there is only one staff overnight and the first shift enters at 7:00am. Staff F revealed that she hasn't worked at the facility that long and felt like they could use more help. Staff F stated that "some days are just bad". Staff revealed most behaviors happen before they leave for day program and when they return back to the facility from day program.

Interview on 6/6/24 with the home manager (HM) revealed there is usually one staff on third shift and two during first and second. The HM stated that he works mostly on the first shift with another staff and stays at times into second shift, 12 - 16 hours a day. The HM revealed the problem was with inconsistency and increased behaviors causes "a really horrible turnover rate due to the environment." The HM stated that he has complained numerous times to the previous QIDP and nothing changed.

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Further interview with the HM revealed, "not at all can this facility manage with only 2 staff on a shift." The HM stated that he has been attacked by a client and has had to implement restraints. The HM revealed that oftentimes staff have to interrupt med pass or bath time to assist with de-escalating a situation or implement a restraint, and that "sometimes there is not enough staff to do the restraint and keep a line of sight on the other clients".

The HM also stated that staff have called him for help on how to manage the clients. The HM stated "I can't work 24 hours" but tries to assist as much as he can. Further interview with the HM revealed he will be working from 6am - 8pm, leaving third shift staff working alone from 8pm - 7am.

Interview on 6/7/24 with the BS revealed that she is at the facility sometimes daily and has worked third and first shift as needed. The BS stated when there is not enough staff, she provides help when she can, and that "They really need the supports at the facility". The BS revealed the issue was a combination of not getting staff hired or having strong staff to manage the behaviors. The BS stated that there was an increase in behaviors due to staff turnover and lack of staff working on each shift and that "no way two staff could work that facility."

The BS also revealed that staff have complained to her about needing more staff and that they were exhausted. The BS revealed while staff are implementing a seated restraint, they would need three staff assisting and another staff to manage the other clients. The BS stated there is a high turnover rate and some staff are afraid to work

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with the clients. The BS revealed that she goes to the facility to do assessments with the clients after each reported incident. The BS stated that a client can get agitated over anything and then will want to hit someone. The BS stated that clients meet with the Psychiatrist quarterly and some clients every month depending on the increase in behaviors. The BS revealed that it can be sometimes difficult to manage her work due to supporting the staff at the facility. The BS stated that she also trains staff on how to manage the behaviors.

Interview on 6/7/24 with the QIDP revealed there has been an increase in behaviors at the facility. The QIDP stated the facility normally has one third shift and two staff on other shifts; however, the facility has struggled to keep staff on duty and hired. The QIDP revealed that there are not enough skilled staff to manage the type of behaviors at that facility. The QIDP stated that she has only been the QIDP for less than 2 months and was eased into the facility by the previous QIDP in order to get the clients familiar with her. The QIDP revealed there is a high turnover rate and that they are trying to hire more male staff for that facility.

Interview on 6/7/24 with the facility administrator revealed that there is a shortage of staff across the agency and that the agency has offered bonuses and higher pay to get people hired. The facility administrator stated that other staff from other facilities fill in as well. The facility administrator revealed she has increased the number of clinical staff at the facility to do assessments. She stated that it was not a requirement to have more than 3 staff on a shift; there can be up to three staff on first and second

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shift and one staff on third shift. The facility administrator stated that she was unaware that one staff was managing the home after 8pm on most days.

Review on 6/6/24 of the facility's daily staff schedule from March 2024 - May 2024 revealed several days between second and third shift where one staff would be left alone managing six clients from 8pm until 7am the next morning.

Review on 06/07/24 of the facility's NC/MH/IDD/SU Services Manual, updated 3/30/22, revealed policy 102.05 "Abuse, Neglect and Exploitation/" This policy defines neglect as the failure to provide services and supports necessary to protect a person from serious physical and/or psychological harm." Further review of the policy revealed unintentional neglect with harm is defined as "an act of carelessness, omission, accident or distraction that results in a substantiated allegation of neglect whereby there was harm to the person or significant risk for harm." Continued review of the facility's policy revealed the facility has zero tolerance for intentional neglect or unintentional neglect that results in harm or significant risk of harm.

Based on observations, interviews, and documentation review, the findings indicate that the team failed to re-evaluate the staff ratio due to an increase in aggressive behaviors at the facility. The team was neglectful in failing to revise the interventions, modify systems, safeguards, and implement adequate strategies in a timely manner in order to protect client #1 from his injury and to ensure client protections of all clients residing in the facility.

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	34G247	A. BUILDING _____ B. WING _____	C 06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINOAK GROUP HOME	3175 BANK ROAD LINCOLNTON, NC 28092

(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 158	Continued From page 13	W 158		
W 158	FACILITY STAFFING CFR(s): 483.430 The facility must ensure that specific facility staffing requirements are met. This CONDITION is not met as evidenced by: The facility failed to ensure sufficient direct care staff were available to manage and supervise the home in accordance with their individual program plans (W186). The cumulative effect of these systemic practices resulted in the facility's failures to provide statutorily mandated services of facility staffing requirements.	W 158		
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 observations, record reviews and interviews, the facility failed to ensure sufficient direct care staff were available to manage and supervise 5 of 6 clients in the home (#2, #3, #4, #5 and #6) in accordance with their individual program plans (IPP's). The findings are: Observations in the facility on 6/6/24 at 6:07pm revealed Staff C and Staff F to be on duty to supervise five clients (#2, #3, #4, #5 and #6). Further observation revealed client #6 quickly entered the surveyor's personal space, trying to	W 186		

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handshake and ask questions. Staff F intervened and redirected client # 6 to the kitchen to complete his chores. Continued observations at 6:22pm revealed client #6 once again entered the surveyors personal space very closely and Staff F intervened and redirected client #6 to the kitchen.

A. Record review on 6/6/24 for client #2 revealed a behavior support plan (BSP) dated 6/1/25 with an objective that client #2's rates of target behaviors will decrease to five or less episodes; per month for 6 consecutive months by 6/1/25. Further review revealed target behaviors of physical aggression, property destruction, SIB, AWOL, verbal outbursts. Continued review of the record revealed a behavioral Support plan data tracking form with a total of 38 occurrences for a 6 month review period.

B. Record review on 6/6/24 for client #3 revealed a BSP dated 7/1/21 with an objective for client #3's rate of target behaviors will decrease to two or less episode per month for 12 consecutive months by 7/1/22. Further review revealed target behaviors of physical aggression, verbal aggression, and obsessive behavior. Continued review of the record revealed a behavioral Support plan data tracking form with a total of 8 occurrences for a 6 month review period.

C. Record review on 6/6/24 for client #4 revealed a BSP dated 11/15/23 with an objective for client #4 will learn to manage his daily routine, so that his rate of target behaviors will decrease to two or less episodes per month for 6 consecutive months by 11/1/24. Further review revealed target behaviors of physical aggression, tantrum, property destruction, verbal aggression, refusing to cooperate, AWOL, Inappropriate sexual

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behaviors, and Irrational V Statements. Continued review of the record revealed a behavioral Support plan data tracking form with a total of 78 occurrences for a 4 month review period.

D. Record review on 6/6/24 for client #5 revealed a BSP dated 4/2/20 with an objective by 5/1/21 client #5's rate of behavior disruptive to habilitation will decrease to zero episode per month for 6 consecutive months. Further review revealed target behaviors of physical aggression, verbal aggression, resistance, property destruction, self-injurious behaviors, and melt down/tantrum . Continued review of the record revealed a behavioral Support plan data tracking form with a total of 49 occurrences for a 6 month review period.

E. Record review on 6/6/24 for client #6 revealed a BSP dated 5/1/24 with an objective for client #6's rate of target behaviors will decrease to two or less episodes per month for six consecutive months by 5/1/25. Further review revealed target behaviors of physical aggression, AWOL, property destruction, self-injurious behaviors, and toileting accidents . Continued review of the record revealed a behavioral Support plan data tracking form with a total of 99 occurrences for a 6 month review period.

Review on 6/7/24 of facility's Restraint Implementation and Monitoring forms from January 2024- June 2024 revealed 6 times staff had to implement a restraint procedure due to aggressive behaviors, some requiring more than two staff to maintain level of supervision.

Review on 6/6/24 of the facility's Staff daily work

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schedule from March 2024 - May 2024 revealed several days between second and third shift where one staff would be left alone managing six clients from 8pm until 7am the next morning.

Interview on 6/16/24 with Staff C revealed there are normally only two staff on second shift until around 7pm or 8pm, then only one staff to manage the facility until 7am in the morning. Staff C stated that he has been working doubles since October of 2023 due to the facility not having enough staff and has a high turnover rate. Staff C stated that several behaviors occur on the second shift especially when there is a "small woman" on duty. Staff C confirmed that there was not another staff schedule to work once Staff F gets off at 8pm tonight.

Staff C also revealed the home is "off the chain" and that the clients know they can overpower certain staff. Staff C stated that the clients have no respect for staff and don't like to do chores around the facility. Staff C stated that he told the qualified intellectual disabilities professional (QIDP) that they needed more staff that are trained to manage the behaviors, "it is impossible to manage with just two staff". Staff C stated that he was told that they don't write enough incidents to show a need for more staff. Staff C stated that it was very difficult to document all the behaviors when trying to de-escalate continuous behaviors throughout the shift. Staff C revealed one day during second shift, two nurses were present at the facility conducting assessments and when the behaviors increased both nurses stopped and left the facility, leaving two staff trying to restraint a client and the other clients were out of their line of sight. Staff C stated that he was tired and overworked; difficulty getting a 30 min break while

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W 186	Continued From page 17 on duty. Interview on 6/6/24 with Staff D revealed the facility has a very high turnover rate and that staff are afraid to work in this type of environment. Staff D stated "it's not right here; it's rough". Staff D stated that she is oftentimes tired from managing behaviors and implementing restraints; and there is no other staff to switch out with. Staff D revealed there is not enough staff to assist with the restraints and manage the other residents. Staff D stated that it is difficult to do duties around the facility and run programs at times " with 2 staff, it is impossible". Staff D stated this home "will never be right" and revealed that a while back there were 5 to 6 staff on first and second shift; a client got discharge and the agency dropped the staff ratio. Staff D revealed that she noticed an increase in behaviors over 3 months ago due to too many new staff coming and leaving the facility. Staff D stated that new staff are afraid of the clients and would give into their demands. Staff D stated that she has complained several times to the home manager, and nothing has changed. Staff D revealed that she works from 7a-7p 6/6/24 and 6/7/24. Interview on 6/6/24 with Staff F revealed she was scheduled to work today from 7am until 8pm; there is only one staff overnight and the first shift enters at 7:00am. Staff F revealed that she hasn't worked at the facility that long and felt like they could use more help. Staff F stated that "some day or just bad". Staff revealed most behaviors happen before they leave for day program and when they return back to the facility from day program.	W 186		

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W 186	Continued From page 18 Observations in the facility on 6/7/24 at 8:45am revealed the HM and Staff D to be on duty to supervise five clients in the home (#2, #3, #4, #5 and #6). Further observation revealed the clients were getting showered and dressed to go to the day program. Interview on 6/6/24 with the home manager (HM) revealed there is usually one staff on third shift and two during first and second. The HM stated that he works mostly on the first shift with another staff and sometimes into the second shift; working 12 - 16 hours a day. The HM revealed the problem was with inconsistency and increased behaviors "it's a really horrible turnover rate due to the environment." HM stated that he has complained numerous times to the previous QIDP and nothing changed. The HM stated, "not at all can this facility manage with only 2 staff on a shift". The HM stated that he has been attacked by a client and have had to implement restraints. The HM revealed that oftentimes staff have to interrupt med pass or bath time to assist with de-escalating a situation or implement a restraint, "sometimes there is not enough staff to do the restraint and keep a line of sight on the other clients." The HM stated that staff have called him for help on how to manage the clients, and stated "I can't work 24hr's" but tries to assist as much as he can. Further interview on 6/7/24 review the HM will be working from 6am-8pm, leaving third shift staff working alone from 8pm-7am. The HM stated that the facility will have a new staff starting 6/7/24 on first shift from 7am-3pm. Interview on 6/7/24 with the behavior specialist (BS) revealed that she is at the facility sometimes	W 186		

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daily and has worked third and first shift as needed. The BS stated when there is not enough staff, she provides help when she can, and that "They really need the supports at the facility". The BS revealed the issue was a combination of not getting staff hired or having strong staff to manage the behaviors. The BS stated that there was an increase in behaviors due to staff turnover and lack of staff working on each shift and that "no way two staff could work that facility."

The BS also revealed that staff have complained to her about needing more staff and that they were exhausted. The BS revealed while staff are implementing a seated restraint, they would need three staff assisting and another staff to manage the other clients. The BS stated there is a high turnover rate and some staff are afraid to work with the clients. The BS revealed that she goes to the facility to do assessments with the clients after each reported incident. The BS stated that a client can get agitated over anything and then will want to hit someone. The BS stated that clients meet with the Psychiatrist quarterly and some clients every month depending on the increase in behaviors. The BS revealed that it can be sometimes difficult to manage her work due to supporting the staff at the facility. The BS stated that she also trains staff on how to manage the behaviors.

Interview on 6/7/24 with the qualified intellectual disabilities professional (QIDP) revealed there has been an increase in behaviors at the facility. The QIDP stated the facility normally has one third shift and two staff on other shifts; but the facility has struggled to keep staff on duty and hired. The QIDP revealed that there are not enough skilled staff to managed the type of

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W 186	Continued From page 20 behaviors at that facility. The QIDP stated that she has only been the QIDP for less than 2 months and was eased into the facility by the previous QIDP in order to get the clients familiar with her. The QIDP revealed there is a high turnover rate and that they are trying to hire more male staff for that facility. Based on observations, interviews, and documentation review, the findings indicate that the team failed to re-evaluate the staff ratio due to an increase in aggressive behaviors at the facility. The team also failed to revise interventions, modify systems, safeguards, and implement adequate strategies to prevent possible injury.	W 186		
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 document significant events, specifically accurately tracking the rates of target behaviors (W253); and ensure the behavior support plans were reviewed and revised as needed after completion of an objective (W255). The cumulative effect of these systemic practices resulted in the facility's failures to provide statutorily mandated active treatment services to its 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 21 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 observations, record reviews, and interviews, the facility failed to ensure for 6 of 6 audit clients #1, #2, #3, #4, #5 and #6) received continuous services in the area of program implementation. The finding is: Cross reference W249. The facility failed to ensure 6 of 6 audit clients (#2, #3, #6, #9, #14 and #15) received a continuous active treatment program consisting of needed interventions and services as identified in the individual program plan (IPP) in the areas of program implementation, leisure, opportunities for choice and self management, and transfer guidelines. Cross reference W253. The facility failed to ensure that data relative to accomplishment of programs were documented. This affected 6 of 6 audit clients (#1, #2, #3, #4, #5 and #6). Cross reference W255. The facility failed to ensure the behavior support plan (BSP) for 3 of 6 clients (#1,#3, and #5) was reviewed and revised as needed after completion of an objective.	W 196		
W 249	PROGRAM IMPLEMENTATION	W 249		

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W 249	Continued From page 22 CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure that a continuous active treatment program consisting of needed interventions in managing aggressive client behaviors for 6 of 6 clients (#1, #2, #3, #4, #5 and #6). The finding is: Interview on 6/16/24 with Staff C revealed there are normally only two staff on second shift until around 7 or 8pm, then only one staff left to manage the facility until 7am in the morning. Staff C stated that he has been working doubles since October of 2023 due to the facility not having enough staff and has a high turnover rate. Staff C stated that several behaviors occur on the second shift. Staff C stated that the clients have no respect for staff and don't like to do chores around the facility. Staff C stated that he told the qualified intellectual disabilities professional (QIDP) that they needed more staff that are trained to manage the behaviors, "it is impossible to manage with just two staff". Staff C stated that he was told that they don't write enough incidents to show a need for more staff. Staff C stated that it was very difficult to document all the behaviors	W 249		

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when trying to de-escalate continuous behaviors throughout the shift. Staff C revealed one day during second shift, two nurses were present at the facility conducting assessments and when the behaviors increased both nurses stopped and left the facility, leaving two staff trying to restraint a client and the other clients were out of their line of sight. Staff C stated that he was tired and overworked; difficulty getting a 30 min break while on duty.

Interview on 6/6/24 with Staff D revealed the facility has a very high turnover rate and that staff are afraid to work in this type of environment. Staff D stated "it's not right here; it's rough". Staff D stated that she is oftentimes tired from managing behaviors and implementing restraints; and there is no other staff to switch out with. Staff D revealed there is not enough staff to assist with the restraints and manage the other residents. Staff D stated that it is difficult to do duties around the facility and run programs at times " with 2 staff, it is impossible". Staff D stated that she has complained several times to the home manager, and nothing has changed.

Interview on 6/6/24 with the home manager (HM) revealed there is usually one staff on third shift and two during first and second. The HM stated that he works mostly on the first shift with another staff and stay sometimes into the second shift; 12-16 hours a day. The HM revealed the problem was with inconsistency and increased behaviors "it's a really horrible turnover rate due to the environment". HM stated that he has complained numerous times to the previous QIDP and nothing changed. The HM stated, "not at all can this facility manage with only 2 staff on a shift". The HM revealed that oftentimes staff have to

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break med pass or bath time to assist with de-escalating a situation or implement a restraint, "sometimes there is not enough staff to do the restraint and keep a line of sight on the other clients". HM stated that staff have called him for help on how to manage the clients "I can't work 24 hours" but tries to assist as much as he can.

Interview on 6/7/24 with the Behavior Specialist (BS) revealed that she is at the facility sometimes daily and have worked on a third and first shift as needed. The BS stated when there is not enough staff, she provides help when she can, "They really need the supports at the facility." The BS stated that staff have complain to her about needing more staff and that they were exhausted. The BS revealed while staff are implementing a seated restraint, they would need three staff assisting and another staff to manage the other clients. The BS stated that a client can get agitated over anything and then want to hit someone. BS revealed that it can be sometimes difficult to manage her work duties due to supporting the staff at the facility.

A. Review on 6/6/24 of client #1's individual program plan (IPP) dated 7/25/23 revealed the following program goals: fold socks for storage, wash dishes after lunch, allows communication partner to walk away, giving others privacy, and return to classroom without incident.

B. Review on 6/6/24 of client #2's IPP dated 5/15/23 revealed the following program goals: brush teeth thoroughly, initiate bathing, respecting others personal space with FP assist, dust bedroom, visual task sequence-OSG, remain seated during training, and interaction with friends.

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W 249	Continued From page 25 C. Review on 6/6/24 of client #3's IPP dated 5/28/24 revealed the following program goals: assist with meal preparing lunch, count number by 5"s, and reduce disruptive behaviors. D. Review on 6/6/24 of client #4's IPP dated 5/10/23 revealed the following program goals: initiate bathing, complete activities in appropriate time, remains on task, work behaviors, and store food properly. E. Review on 6/6/24 of client #5's IPP dated 7/20/23 revealed the following program goals: tolerates wearing his glasses, sort dirty laundry, single digit subtraction, work behaviors, decrease behaviors disruptive to habitation, and places non-preferred hand in lap. F. Review on 6/6/24 of client #6's IPP dated 9/20/23 revealed the following program goals: assist with preparing breakfast, shave with electric razor, teeth brushing, remains in the work area, makes bed, and reduce disruptive behavior. Interview on 6/7/24 with the qualified intellectual disabilities professional (QIDP) revealed there has been an increase in behaviors at the facility. The QIDP stated the facility normally has one third shift and two staff on other shifts; but the facility has struggled to keep staff on duty and hired. The QIDP revealed that there are not enough skilled staff to manage the type of behaviors at that facility. The QIDP stated staff reported difficulties with completing the clients' daily progress data and communication log documentation due to not enough staff on each shift, trying to do chores around the home, and de-escalating clients' behaviors. She stated there	W 249		

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	34G247	A. BUILDING _____ B. WING _____	C 06/07/2024

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W 249	Continued From page 26 were days of missing documentation in the T-Log system. Interview on 6/7/24 with the facility administrator revealed that there is a shortage of staff across the agency and that the agency has offered bonuses and higher pay to get people hired. The facility administrator revealed that she was aware of the increase in behaviors at the facility and that she increased the number of clinical staff to go in and do assessments. Based on interviews and documentation review, the findings indicate that the team failed to re-evaluate the staff ratio due to an increase in aggressive behaviors at the facility. The team also failed to revise the interventions, modify systems, safeguards, and implement adequate strategies to decrease aggressive behaviors and increase client participation in active treatment.	W 249		
W 253	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(2) The facility must document significant events that are related to the client's individual program plan and assessments. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to document significant events, specifically accurately tracking the rates of target behaviors, affecting 6 of 6 clients (#1, #2, #3, #4, #5 and #6). The findings are: A. Record review on 6/6/24 for client #1 revealed a behavior support plan (BSP) dated 5/1/23 with an objective for client #1's rate of target behaviors to decrease to two or less episodes per month, for 6 consecutive months by 5/1/24. Further	W 253		

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W 253	Continued From page 27 review revealed target behaviors of physical aggression, property destruction, stealing, toileting accidents, refusing hab activities, and tantrums. Record review on 6/6/24 for client #1 revealed a psychology tracking record for the months October 2023 - May 2024. Further review revealed missing data for the following months and target behaviors: - Physical aggression: 11/23, 12/23, 01/24, 03/24, 04/24 - Property destruction: 11/23, 12/23, 01/24, 03/24, 04/24, 05/24 - Stealing: 10/23, 11/23, 12/23, 01/24, 03/24, 05/24 - Toileting accidents: 10/23, 02/24, 05/24 - Refusing hab activities: missing data from all reviewed months - Tantrum: 10/23, 11/23, 12/23, 01/24, 02/24, 03/24, 04/24 B. Record review on 6/6/24 for client #2 revealed a BSP dated 6/1/25 with an objective for client #2's rates of target behaviors to decrease to five or less episodes; per month for 6 consecutive months by 6/1/25. Further review revealed target behaviors of physical aggression, property destruction, self-injurious behavior (SIB), AWOL, verbal outbursts. Record review on 6/6/24 for client #2 revealed a psychology tracking record for the months November 2023- May 2024. Further review revealed missing data for the following months and target behaviors: - Property destruction: 12/23, 01/24, 02/24, 04/24 - SIB: missing data from all reviewed months - AWOL: 12/23, 01/24, 02/24, 03/24, 04/24, 05/24	W 253		

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W 253	Continued From page 28 - Verbal outbursts: 02/24, 03/24, 04/24, 05/24 C. Record review on 6/6/24 for client #3 revealed a BSP dated 7/1/21 with an objective for client #3's rate of target behaviors will decrease to two or less episode per month for 12 consecutive months by 7/1/22. Further review revealed target behaviors of physical aggression, verbal aggression, and obsessive behavior. Record review on 6/6/24 for client #3 revealed a psychology tracking record for the months October 2023- May 2024. Further review revealed missing data for the following months and target behaviors: - Physical aggression: 10/23, 11/23, 12/23, 01/24, 02/24, 04/24, 05/24 - Verbal aggression: 10/23, 11/23, 12/23, 02/24, 05/24 D. Record review on 6/6/24 for client #4 revealed a BSP dated 11/15/23 with an objective for client #4 will learn to manage his daily routine, so that his rate of target behaviors will decrease to two or less episodes per month for 6 consecutive months by 11/1/24. Further review revealed target behaviors of physical aggression, tantrum, property destruction, verbal aggression, refusing to cooperate, AWOL, Inappropriate sexual behaviors, and Irrational V Statements. Record review on 6/6/24 for client #4 revealed a psychology tracking record for the months February 2024- May 2024. Further review revealed missing data for the following months and target behaviors: - Tantrum: 02/24 - Verbal aggression: 04/24 - Refusing to cooperate: missing data from all	W 253		

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reviewed months
- Inappropriate sexual behaviors: missing data from all reviewed months
- Irrational V Statements: missing data from all reviewed months

E. Record review on 6/6/24 for client #5 revealed a BSP dated 4/2/20 with an objective by 5/1/21 client #5's rate of behavior disruptive to habilitation will decrease to zero episode per month for 6 consecutive months. Further review revealed target behaviors of physical aggression, verbal aggression, resistance, property destruction, self-injurious behaviors, and melt down/tantrum .

Record review on 6/6/24 for client #5 revealed a psychology tracking record for the months October 2023- May 2024. Further review revealed missing data for the following months and target behaviors:
- Physical aggression: 02/24
- Resistance: 10/23, 11/23, 12/23, 01/24, 03/24, 04/24
- Property destruction: 10/23, 11/23, 02/24, 03/24
- SIB: missing data from all reviewed months
- Melt down/tantrum: missing data from all reviewed months

F. Record review on 6/6/24 for client #6 revealed a BSP dated 5/1/24 with an objective for client #6's rate of target behaviors will decrease to two or less episodes per month for six consecutive months by 5/1/25. Further review revealed target behaviors of physical aggression, AWOL, property destruction, self-injurious behaviors, and toileting accidents .

Record review on 6/6/24 for client #6 revealed a

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W 253	Continued From page 30 psychology tracking record for the months October 2023- May 2024. Further review revealed missing data for the following months and target behaviors: - Physical aggression: 11/23, 12/23, 01/24 - SIB: 10/23, 12/23, 02/24, 03/24, 04/24 - AWOL: 10/23, 11/23 - Toileting accidents: 10/23, 12/23, 02/24, 03/24 Interview on 6/7/24 with the home manager (HM) revealed that staff are having difficulties with completing documentation due to the lack of staff at the facility and increased behaviors. The HM stated that the staff do meet monthly to discuss completing documentation daily for each client. Interview on 6/7/24 with the behavior specialist (BS) revealed that it the facility staff's responsibility to collect data of each target behavior throughout the shift and document it into the agency's computer system daily, or they can document on the behavior data form located at the facility. The BS stated that she reviews the data and determine interventions. Interview on 6/7/24 with the qualified intellectual disabilities professional (QIDP) revealed there has been an increase in behaviors at the facility. The QIDP stated staff are not documenting daily as required and she has met with the staff during the facility meetings to discuss documentation requirements.	W 253		
W 255	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(i) The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including,	W 255		

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but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan.
This STANDARD is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure the behavior support plan (BSP) for 3 of 6 clients (#1, #3 and #5) was reviewed and revised as needed after completion of an objective. The findings are:

A. Review on 6/6/24 of client #1's clinical record revealed a BSP dated 5/1/23 with an objective for client #1's rate of target behaviors will decrease to two or less episodes per month, for 6 consecutive months by 5/1/24. Further review revealed target behaviors of physical aggression, property destruction, stealing, toileting accidents, refusing hab activities, and tantrums. No current BSP could be located.

Interview on 6/7/24 with the qualified intellectual disabilities professional (QIDP) confirmed the most current BSP for client #1's has been completed.

B. Review on 6/6/24 of client #3's clinical record revealed a BSP dated 7/1/21 with an objective for client #3's rate of target behaviors will decrease to two or less episode per month for 12 consecutive months by 7/1/22. Further review revealed target behaviors of physical aggression, verbal aggression, and obsessive behavior. No current BSP could be located.

Interview on 6/7/24 with the QIDP confirmed the most current BSP for client #3 has been completed.

C. Review on 6/6/24 of client #5's clinical record

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W 255	Continued From page 32 revealed a BSP dated 4/2/20 with an objective by 5/1/21 client #5's rate of behavior disruptive to habilitation will decrease to zero episode per month for 6 consecutive months. Further review revealed target behaviors of physical aggression, verbal aggression, resistance, property destruction, self-injurious behaviors, and melt down/tantrum . No current BSP could be located. Interview on 6/7/24 with the QIDP confirmed the most current BSP for client #5 has been completed.	W 255		