STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G139	A. BUILDING _____ B. WING _____	C 12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TANAGER PLACE	2309 C STREET SW CEDAR RAPIDS, IA 52404

(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 The investigation of incidents #86444-I, #87056-I, #87271-I, #87325-I, #87406-I were conducted 11/7/19 - 12/19/19. In addition to the investigations, the annual health facility survey was conducted. As a result of the investigations, the facility was determined to be in an Immediate Jeopardy (IJ) based on the facilities failure to protect clients from abuse from other clients, the Governing Body's failure to provide adequate oversight and direction, failure to ensure proper implementation of policies, failure to ensure facility staff demonstrated the skills to effectively manage client behaviors, and failure to ensure the Qualified Intellectual Disabilities Professional effectively and consistently monitored, coordinated, and integrated services and supports for identified client needs. The facility was notified of the IJ on 11/14/19 at approximately 1:44 p.m. The IJ was removed on 11/25/19 at approximately 11:35 p.m. Condition-level deficiencies were cited at W102, W122, and W158. Standard level deficiencies were cited at W104, W127, W149, W159, W193, and W289. A second IJ was determined based on the facilities failure to consistently implement policies and procedures which addressed the identification, reporting, investigating, and safeguarding of clients following allegations of abuse. The facility was notified of the IJ on 12/11/19 at 5:08 p.m. The IJ was removed on 12/18/19 at 3:30 p.m. Standard-level deficiencies were cited at W149, W153, W154, and W155.	W 000	See attached POC 3/31/2020	

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

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

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W 000	Continued From page 1 Additionally, a deficiency was cited at Iowa Code 481 IAC 50.7(3). As a result of the annual health facility survey, standard-level deficiencies were cited at W124, W125, W210, W226, W247, W262, W263, W322, W323, W336, W463, W440, and W475.	W 000		
W 102	GOVERNING BODY AND MANAGEMENT CFR(s): 483.410 The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to maintain minimal compliance with the Condition of Participation (CoP) - Governing Body and Management. The governing body failed to provide adequate operating direction after identification of an increase in peer-to-peer aggressions, failed to ensure consistent implementation of policies to prevent violence and abuse, and failed to ensure facility staff were able to effectively implement client plans to keep clients safe. The led to the determination of an Immediately Jeopardy. Cross reference W104: Based on interviews and record review, the governing body failed to provide general oversight of the facility to ensure the health and safety of all clients as evidenced by failure to ensure consistent implementation of policies and procedures, failed to provide direction to ensure client safety, and failed to take appropriate action to address an identified	W 102		

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W 102	Continued From page 2 increase in peer-to-peer aggression. Cross reference W122: Based on interviews and record review, the facility failed to provide all clients with a safe environment free of abuse from peers. The facility identified a significant increase with peer-to-peer aggressions but failed to incorporate effective interventions to keep clients safe. The facility failed to take measures to ensure clients were not at risk for further abuse from peers, failed to ensure the safety and security of all children in Terry Cottage, and failed to provide all clients in Terry Cottage the right to live in a safe environment. The facility failed to consistently follow policies regarding completing 24-hour follow-up after incidents of peer-to-peer aggression, identification of injuries, and proper completion of Critical Incident Reports.	W 102		
W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on interviews and record review, the governing body failed to provide general oversight of the facility to ensure the health and safety of all clients as evidenced by failure to ensure consistent implementation of policies and procedures, failed to provide direction to ensure client safety, and failed to take appropriate action to address an identified increase in peer-to-peer aggression. The governing body failed to ensure staff were able to effectively manage client behaviors through implementation of the client	W 104		

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W 104	Continued From page 3 Individual Support Plans. Cross reference W127: Based on observations, interviews and record reviews, the facility failed to ensure the development and implementation of adequate systems to identify and prevent client-to-client abuse and/or mistreatment. The facility failed to take appropriate action to ensure clients were provided a safe environment free from physical abuse from other clients. Cross reference W149: Based on interviews and record review, the facility failed to implement facility policies, as written, as evidenced by failure to complete 24-hour follow-up following incidents of peer-to-peer aggression, failure to identify injuries following incidents of peer-to-peer aggression, and failure to complete Critical Incident Reports (CIRs) per facility policy. Additionally, the facility failed to implement policies regarding abuse and mandatory reporting; as evidenced by, failure to consistently report all allegations of abuse immediately to the Administrator (or designee) and the appropriate state agency, failure to ensure nurses examinations were completed after allegations were reported, failure to complete the CIR in accordance with facility policies, and failure to consistently take action to ensure the safety of the child following allegations of abuse. Cross refernce W158: Based on observation, interviews, and record review, the Qualified Intellectual Disabilities Professional (QIDP) failed to update client Individual Program Plans (IPPs) to provide nterventions consistent with a cottage wide Consumer to Consumer Behavior Management Plan (BMP) that had been implemented in an effort to reduce the number of	W 104		

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W 104	Continued From page 4 peer-to-peer aggressions. The QIDP failed to change client IPP interventions after a noted increase of peer-to-peer aggression and failed to ensure all identfied supports were incorporated into client programs. The facility staff failed to demonstrate the skills and competencies to effectively manage inappropriate client behaviors.	W 104		
W 122	CLIENT PROTECTIONS CFR(s): 483.420 The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on interviews and record review, the facility failed to provide all clients with a safe environment free of abuse from peers. The facility identified a significant increase with peer-to-peer aggressions but failed to incorporate effective interventions to keep clients safe. The facility failed to ensure clients were not at risk for further abuse from peers, failed to ensure the safety and security of all children in Terry Cottage, and failed to provide all clients in Terry Cottage the right to live in a safe environment. The facility failed to consistently follow policies regarding completing 24-hour follow-up after incidents of peer-to-peer aggression, identification of injuries, and proper completion of Critical Incident Reports. This led to the determination of an Immediate Jeopardy. Cross reference W127: Based on observations, interviews and record reviews, the facility failed to ensure the development and implementation of adequate systems to identify and prevent client-to-client abuse and/or mistreatment. The	W 122		

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W 122	Continued From page 5 facility failed to take appropriate action to ensure clients were provided a safe environment free from physical abuse from other clients. Cross reference W149: Based on interviews and record review, the facility failed to implement facility policies, as written, as evidenced by failure to complete 24-hour follow-up following incidents of peer-to-peer aggression, failure to identify injuries following incidents of peer-to-peer aggression, and failure to complete Critical Incident Reports (CIRs) per facility policy. Additionally, the facility failed to implement policies regarding abuse and mandatory reporting; as evidenced by, failure to consistently report all allegations of abuse immediately to the Administrator (or designee) and the appropriate state agency, failure to ensure nurses examinations were completed after allegations were reported, failure to complete the CIR in accordance with facility policies, and failure to consistently take action to ensure the safety of the child following allegations of abuse.	W 122		
W 124	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(2) The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to inform the guardians of possible side	W 124		

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W 124	Continued From page 6 effects of behavior modifying medications. This affected 5 of 5 sample clients (Client #1, Client #3, Client #10, Client #14 and Client #16) and potentially all other clients residing at the facility (Clients #2, #4, #6, #7, #8, #9, #11, #13, #15 and #17). Findings follow: 1. Record review on 11/25/19 of the November 2019 Physician's Orders revealed Client #1 had prescribed behavior modifying medications of Buspar and Trazadone. A written informed consent, signed by the guardians and Human Rights Committee (HRC) in August and September of 2019, listed the two medications. The written consent contained no information regarding the possible side effects of the behavior modifying medication. When interviewed on 11/26/19 at 10:30 a.m. Qualified Intellectual Disabilities Professional (QIDP) A said she didn't know if the written consents included side effect information. She said the nursing department handled the consents. 2. Record review on 11/21/19 of the November 2019 Physician's Orders revealed Client #3 had prescribed behavior modifying medications of Paroxetine, Hydroxyzine, Divalproex, Risperidone and Lithium Carb. A written informed consent, signed by the guardian and HRC in July 2019, included the medications of Paroxetine, Hydroxyzine, Divalproex and Topiramate (which was discontinued by the time of the survey). Risperidone and Lithium Carb was not listed in the consent. The written informed consent contained no information regarding the possible side effects of the behavior modifying medications.	W 124		

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W 124	Continued From page 7 3. Record review on 11/21/19 of the November 2019 Physician's orders revealed Client #10 had prescribed behavior modifying medications of Concerta, Methylphenidate, Divalproex, Escitalopram and Quetiapine. A written informed consent signed by the guardian and HRC in April 2019 listed the medications of Concerta, Ritalin (Methylphenidate), Depakote (Divalproex), Seroquel (Quetiapine) and Clonidine. Escitalopram/Lexapro was not listed on the consent. The written informed consent contained no information regarding possible side effects of the behavior modifying medications. 4. Record review on 11/26/2019 of the November 2019 Physician's Orders for Client #14 revealed he had prescribed behavior modifying medication of Vyvanse, Clonidine and Geodon. A written informed consent signed by the guardian and HRC in July and August 2019 listed the same medications. The written informed consent contained no information regarding possible side effects. 5. Record review on 11/26/2019 of the November 2019 Physician's Orders for Client #16 revealed he had prescribed behavior modifying medication of Ativan, Propranolol, Lithium, Trazadone, Vistaril, Prozac, Trileptal and Prolixin. A written informed consent signed by the guardian and HRC in November 2019 listed the same medications. The written informed consent contained no information regarding possible side effects. When interviewed on 11/26/19 at 9:10 a.m. QIDP B stated guardians were not provided with written side effect information regarding the behavior	W 124		

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W 124	Continued From page 8 modifying medications. She said the facility used to send this information to the guardians, but no longer did. 6. When interviewed on 12/02/19 at 9:30 a.m. the Health Services Manager/Registered Nurse (HSM/RN) stated the psychiatrist or nursing staff called the guardian to obtain verbal consent before starting a new behavior modifying medication. During that conversation, the doctor or nursing staff would discuss the purpose of the medication with the guardian and potential side effects. The date of the verbal consent would be noted, but there was no documentation the possible side effects were discussed. The HSM/RN confirmed the facility did not include possible medication side effects in the written informed consent signed by the guardian and Human Rights Committee.	W 124		
W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observations, interview and record review, the facility failed to obtain guardian consent for all restrictive measures. This affected 3 of 5 sample clients (Client #3, Client #10, Client #16). Findings follow: 1. Observation at the Sinclair Cottage on 11/21/19 at 7:10 a.m. revealed Client #3 got clothing from a cupboard in the common area of the home.	W 125		

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W 125	Continued From page 9 The cupboard had been unlocked by staff. The supervisor present stated the clients had clothing and hygiene items locked in individual cupboards. The items were not accessible to the clients unless staff unlocked the cupboards. When asked if this restriction applied to all of the clients, the supervisor stated some of the clients were allowed to keep clothing in their rooms. Follow up observation on 11/25/19 at 3:20 p.m. revealed Client #3 had no clothing in his room, other than a coat. Record review on 11/24/19 revealed a written informed consent signed by Client #3's guardian and Human Rights Committee (HRC) in July 2019 listing several restrictive measures. The restricted access to clothing and hygiene items was not listed. When interviewed on 11/25/19 at 9:20 a.m. Qualified Intellectual Disabilities Professional (QIDP) A acknowledged the restricted access to clothing and hygiene items was not included in the written informed consent for Client #3. 2. Observation at Sinclair Cottage on 11/20/19 at approximately 4:40 p.m. revealed Client #3 received his afternoon medications, which included Risperidone. Record review on 11/21/19 revealed a psychiatry note dated 9/17/19, which noted medication changes. The psychiatrist recommended two new medications: Risperidone and Lithium Carb. The psychiatrist noted he had called Client #3's mother/guardian and obtained verbal permission to start the new medications. According to Client #3's Medication Administration Record (MAR), Client #3 began taking the Risperidone on	W 125		

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W 125	Continued From page 10 9/17/19 and Lithium Carb on 9/18/19. The most recent written informed consent in Client #3's chart, signed by the guardian and HRC, was dated July 2019 and did not include Risperidone or Lithium Carb. When interviewed on 11/25/19 at 9:20 a.m. QIDP A confirmed the facility had not yet obtained written informed consent from the guardians or HRC for the two new behavior modifying medications, which had been started two months prior. 3. Record review on 11/21/19 revealed Client #10 had prescribed behavior modifying medications of Concerta, Methylphenidate, Divalproex, Escitalopram and Quetiapine. A written informed consent signed by the guardian and HRC in April 2019 listed the medications of Concerta, Ritalin (Methylphenidate), Depakote (Divalproex), Seroquel (Quetiapine) and Clonidine. Escitalopram/Lexapro was not listed on the consent. A review of the Medication Administration Record (MAR) revealed Client #10 started taking Escitalopram/Lexapro on 6/18/19. QIDP B provided a current written informed consent, which included the Lexapro, signed by the guardian on 9/18/19, which was three months after Client #10 began taking the medication. When interviewed on 12/03/19 at 4:15 p.m., QIDP B said the facility had obtained verbal consent from the guardian for the Escitalopram/Lexapro, but had not obtained written guardian consent until 9/18/19. The QIDP B located a Authorization for Medication form, which showed Client #10's guardian had given verbal consent for Lexapro on 6/14/19, but the form was not signed by the guardian.	W 125		

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W 125	Continued From page 11 4. Record review on 11/26/2019 revealed an expired written informed consent for Client #16. The consent signed on 11/7/2018 covered the time period of 11/7/2018 to 11/6/2019. QIDP B provided a current written informed consent for the period 11/6/2019 to 11/5/2020. The guardian signed the current consent on 11/22/2019 (16 days after implementation) and the HRC representative signed on 11/25/2019 (19 days after implementation). Both consents authorized many restrictive measures including, but not limited to: physical escort, physical restraint and secure time out, reduction of privileges, non-exclusionary time out, personal items locked up and eight psychotropic medications. When interviewed on 11/26/2019 at 10:00 a.m. QIDP B reported she received verbal consent from the guardian before implementation of the new consent on 11/6/2019. When asked if she documented the verbal consent, she admitted she had not. QIDP B acknowledged the guardian and HRC provided written consent for the restrictions after the prior consent had expired.	W 125		
W 127	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(5) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure the development and implementation of adequate	W 127		

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W 127	Continued From page 12	W 127		

systems to identify and prevent client-to-client abuse and/or mistreatment. The facility failed to take appropriate action to ensure clients were provided a safe environment free from physical abuse from other clients. This affected 10 clients (Client #3, #5, #8, #10, #12, #13, #14, #15, #16, and #17) identified during the investigation of #86444-I and #87406-I and potentially 17 of 17 clients who resided at the facility. Findings follow:

Observations at Terry Cottage between 11/12/19 and 11/18/2019 revealed incidents of aggression between peers and other behavioral episodes. Examples included, but not limited to, the following:

a. On 11/14/19 at 6:25 a.m., Client #15 began running around Terry Cottage. He verbally challenged Client #14; staff redirected Client #15 and he aggressed toward the staff. Terry Cottage has three levels with stairs between each level; Client #14 and Client #15 ran around the cottage, from the first level to the third level, making inappropriate comments to peers and staff. Staff verbally redirected the clients. At 6:30 a.m., Client #14 thrust his pelvis on the couch in a sexualized manor and laughed. Client #15 thrust his pelvis against Client #14's leg; staff redirected Client #15. Staff then positioned themselves between the two clients and verbally prompted Client #15 multiple times to take a break in the vent room. At 6:40 a.m., Client #15 crawled up the steps from the second level of the cottage while holding onto staff's leg, and making cat noises; staff played along and said "Nice kitty." Client #15 continued to taunt Client #14 and yelled "Fuck you (Client #14)". Youth Service Worker (YSW) E held Client #14 back as he attempted to aggress toward Client #15. Client #14 then took YSW E's

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walkie-talkie and called "Back up to Unit #4"; YSW E retrieved the walkie-talkie and canceled the call for backup but several staff arrived at Terry Cottage. At 6:45 a.m. there were six staff in the cottage with five clients awake in the common areas, one staff was with Client #10 in his bedroom assisting him to get ready, Client #12 was in his bedroom asleep, and Client #16 was in his bedroom. Client #14 punched Client #13 in the left lower back before staff could separate the two. Client #15 pushed and hit staff, staff redirected him, and he continued to run around the cottage between the first and third level of the cottage, with Client #14 following him, and Client #15 began banging his head. Staff continued to verbally redirect the clients to finish their routines and get ready for school. Client #15 ran toward Client #13 and Client #13 pushed Client #15 causing Client #15 to fall back and hit his back on the staff desk. Client #15 began crying and went to his bedroom. A few minutes later, as the Surveyor walked by, Client #15 laughed as he thrust his hips in a sexualized manor against his mattress. Client #14 was by Client #15's bedroom, attempted to push staff out of his way as he was threatening and attempting to aggress at Client #15. Client #14 hit staff as the staff body positioned to block him. Client #15 then stood in his bedroom door, attempting to hit YSW K in the testicles; YSW K continued to block Client #15, asked him to stop, and prompted Client #15 to take his bath and get ready for school. Client #15 laughed. Client #14 continued to attempt to aggress toward Client #15 while verbally threatening him; staff continued to body position in front of him and redirected him to get ready for school. Client #14 began to hit YSW O; YSW O redirected Client #14 and when Client #14 continued, YSW O was placed in a physical hold

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W 127	Continued From page 14 for less than 30 seconds. Client #14 briefly went to his bedroom. Client #14 returned to the first level to obtain clothing from his locker and began to escalate by getting loud, verbally taunting, and attempting to instigate Client #16 who was sitting in a chair on the first level. Client #14 started to hit Client #16's arm and say "tag". Staff verbally redirected Client #14, and staff positioned themselves between the clients. Client #14 aggressed toward staff, tried to reach around staff hitting at Client #16 saying "tag", and laughing. Two staff continued to position themselves in front of Client #16 while redirecting Client #14 to go finish his morning routine. Client #14 left for school at 7:19 a.m. When the observation ended at 7:28 a.m., Client #12 remained in bed and Client #15 was in the bathroom taking a bath. b. Observation on 11/18/2019 at 4:35 p.m. revealed seven staff present in Terry Cottage. At approximately 5:20 p.m. while downstairs in the dining room, Client #15 began to yell and punched the wall. Shift Leader (SL) A redirected Client #15 and when Client #15 continued, she directed Client #15 take a break in the hallway. Client #15 took a brief break in the hallway and then returned to the dining room. At approximately 5:30 p.m., Client #15 began to make inappropriate comments and loudly whispered "pussy". SL A verbally redirected him stating the language was inappropriate; Client #15 laughed. Client #10 sat across the table from Client #15; both clients began to make various noises (passing gas), rude and inappropriate comments, and then would laugh. Staff reminded the clients the behavior was inappropriate and asked them to stop, but both continued. YSW G positioned herself at the table, standing between	W 127		

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the clients; the Clinical Supervisor was standing by the table. After a brief conversation, Client #15 began to make loud screeching noises, inappropriate comments, kissing gestures toward others, and then rubbed his foot on YSW G's leg. YSW G continued to redirect the clients and asked them to stop with no response. The Inpatient Clinical Supervisor (ICS) asked what they were supposed to be doing; Client #10 raised his fist at her. She asked why he wanted to hit someone and offered a high five instead. Client #10 and Client #15 continued to taunt each other; staff told Client #10 that Client #15 was trying to get him in trouble and redirected him to focus on the meal. Client #15 continued to mumble inappropriate language and comments and made inappropriate gestures to others. The ICS asked Client #15 what kind of yogurt he had, he did not respond and continued to make inappropriate comments and use foul language. As Client #10 cleared his dishes, he walked by Client #15 who attempted to grab him. YSW G positioned herself between the clients and again verbally redirected the clients. Client #15 reached over and pinched Client #10's forearm and Client #10 kicked Client #15 in the leg. The ICS reminded the boys of their boundaries. At 5:51p.m., Client #15 finished his meal and ran upstairs. At 5:55 p.m., Client #15 walked around the cottage and blew on several people's faces, including the Director of Inpatient Services (DIS), and thrust his hips in a sexualized manor on various items in the cottage, with minimal redirection. Client #15 continued with the same behavior while staff commented the behavior was inappropriate. At 6:29 p.m., Client #15 discovered his headphones were broken. As staff tried to assist Client #15 with his headphones, he told staff to "Shut the fuck up", punched staff, and

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W 127	Continued From page 16 punched himself. YSW G asked Client #15 to take a break, he responded by calling her "Fat ass and fat fuck", and continued to make inappropriate comments. YSW L then informed Client #15 he needed to calm down, and he had one minute to go take a break or he would be escorted to take a break. At 6:33 p.m., after YSW L told Client #15 she would escort him to take a break Client #15 crawled to the "Vent Room". At 6:34 p.m., Client #15 exited the room and immediately aggressed at YSW L. YSW G attempted to give him his headphones and he threw them at her. Record review on 11/7/19 revealed the facility peer-to-peer tracking spreadsheet which revealed 117 documented peer-to-peer aggressions between 8/1/19 and 11/7/19 in the facility; 105 of the incidents occurred in Terry Cottage and 12 incidents occurred in Sinclair Cottage. Examples included, but not limited to, the following: a. On 8/12/19 at 7:11 a.m. in Terry Cottage, Client #10 placed Client #14 in a chokehold and punched him the mouth before staff could intervene. Staff applied first aid to Client #14's lip. b. On 8/17/19 at 7:50 p.m. as Clients #5 and #14 returned from the playground Client #5 kicked Client #14 in the stomach, Client #14 then bit Client #5. Client #5 grabbed Client #14's arm and scratched him. The report indicated Client #5 had some bruising and swelling from the bite and Client #14 had scratches on his arm and stomach. c. On 8/24/19 at 7:15 a.m. in Terry Cottage Client #14 bit Client #10 on the bicep of the left arm. Client #14 reported slight pain and had the bite	W 127		

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W 127	Continued From page 17 washed. d. On 9/8/19 at 7:40 a.m. outside Terry Cottage Client #16 attacked Client #10 with a stick. Client #10 sustained a cut on his right hand. e. On 9/22/19 at 4:00 p.m. in Terry Cottage Clients #10 and #14 were involved in an altercation. Client #14 ended up with a scratch on the wrist and indicated it hurt to touch. f. On 9/25/19 at 7:29 p.m. in Terry Cottage, Client #14 entered the cottage escalated. The record indicated he "unprovoked" ran up to Client #13 and kicked him in the left eye. The kick left a mark and possible bruise. g. On 9/27/19 at 5:30 p.m. in Sinclair Cottage, Client #3 grabbed two metal serving spoons from the kitchen and tried to assault Client #8. Client #8 hid behind Client #1. Client #8 hit Client #1 with the metal spoons several times in the head. Client #1 was transported by ambulance to the emergency room (ER) and diagnosed with a concussion. h. On 9/28/19 at 7:30 a.m. in Terry Cottage, Client #16 became upset about staff expectations. The report indicated Client #16 yelled and screamed which escalated several peers (Client #5, Client #10, Client #12, and Client #14), who then assaulted him. The report indicated Client #12 initiated the aggression and then Client #5, Client #10, and Client #14 also began to hit and kick Client #16 in the face and the private area, Client #5 also hit him with her lanyard. Client #16 sustained a busted lip and stated he was sore. i. On 10/3/19 at 4:20 p.m. in Terry Cottage, Client	W 127		

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W 127	Continued From page 18 #12 punched Client #10 in the face (left eye) after the Client #10 hit staff. Client #10 ended up with a black eye and received ice treatment. j. On 10/4/19 at 6:45 p.m. in Terry Cottage, Client #16 agreed to leave group and calm down in his room. As he walked to his room, Client #12 slapped and punched Client #16 before staff could separate. k. On 10/5/19 at 7:40 a.m. in Terry Cottage, Client #12 punched Client #10 in the face after yelling and swearing at him. Client #10's bottom lip was swollen and bleeding. . l. On 10/17/19 at 8:00 p.m. in Terry Cottage, Client #12 tackled Client #15 to the ground to the point where the client could not breathe. Client #12 punched him in the nose causing it to bleed. Review of the facility policy "ICFID Peer To Peer Guidelines", undated, instructed "If a consumer has aggressed towards a peer(s) resulting in injury twice in a 30 day period, it must be reported to DIA. For the purposes of this reporting guideline, injury is described as significant and could include abrasion, cut, bite, or bruise lasting longer than 24 hours requiring a healing process. For the purposes of this reporting guideline, lingering pain, soreness, or red marks may not meet criteria for "injury"; these will be assessed on an individual basis and will continue to be monitored via the aforementioned process." When interviewed on 11/12/19 at approximately 8:45 a.m., Qualified intellectual Disabilities Professional (QIDP) B stated the facility had identified an increase in the amount of peer-to-peer aggressions in Terry Cottage. She explained they started social skills/boundary	W 127		

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group, staff were being more diligent about redirecting clients, and if the client continued then staff were having the client take a break. She said many of the peer-to-peers aggressions occurred after one client would invade the personal space of another or when the kids would start wrestling/playing around. QIDP B explained since Client #12 moved into the facility, his Interdisciplinary team (IDT) had continued to meet and tried to incorporate more structure. She said there had been several changes made to Client #12's IPP including adding interventions to address perseverating, secure time-out was added, and the facility was looking to get a one-on-one staff for Client #12. She explained the children being referred to the facility had more behavioral needs and they were working with the staff to ensure more consistency and routine.

When interviewed on 11/12/19 at 5:15 p.m., Client #16 said he didn't feel safe at Terry Cottage. He explained he didn't feel safe because other clients hit and kicked him.

When interviewed on 11/13/19 at approximately 10:00 a.m., Shift Leader (SL) D stated she did not believe the clients in Terry Cottage were safe recently. She indicated Client #16 used to aggress toward others, but since Client #12 was admitted to the facility, Client #16 frequently hid in his bedroom. She also said Client #11 used to spend a lot of time in his room, but since Client #12 arrived, he stayed in the common areas to protect staff. She stated a lot of the training took place "On the fly" and felt more pre-training (before staff were counted in ratio) needed to take place. She said staff who had worked at the facility for 3 to 4 months were considered "Veteran staff". She said as far as she knew,

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Terry and Sinclair Cottages were both supposed to have four staff on duty, but often they only were provided with three staff which was "Terribly difficult" to safely do. She acknowledged there had been some really difficult days in Terry Cottage when there were only three staff on shift. She reported some days the facility had only a few staff available respond to assistance calls. She estimated additional staff assistance was called in Terry Cottage at least every other day.

When interviewed on 11/13/19 at 10:30 a.m., Shift Lead (SL) B said she primarily worked at Sinclair Cottage, but sometimes covered at Terry Cottage. SL B stated back up staff were called to Terry Cottage when the clients had serious behaviors. When asked if she thought the clients at Terry Cottage were safe, SL B responded "yes and no". She said Terry Cottage had more behavioral issues and consistent staffing had been a problem. On a good day with no client behaviors, three staff was sufficient to staff the house, but at other times, the environment did not feel safe due to the number of client behaviors. SL B noted Terry Cottage had lost quite a few staff, so there was many newer staff who were still training.

When interviewed on 11/13/19 at 11:15 a.m., SL A said Client #12 had been aggressive toward Client #14 and she thought Client #14 was afraid of Client #12. She also recalled an incident when Client #12 tackled and choked Client #15. She thought Client #15 was also afraid of Client #12. SL confirmed awareness of the 9/28/19 incident when four peers (Clients #5, #10, #12 and #14) assaulted Client #16 as a group and caused injuries. She confirmed no investigation or review

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W 127	Continued From page 21 of the incident had been completed to her knowledge. She tried to ask staff what happened but had not received a good explanation. At that point, she instructed staff to make sure it did not happen again. SL A stated she thought all of the clients except Client #17 was afraid of Client #12 (other clients at Terry Cottage were Client #10, Client #11, Client #13, Client #14, Client #15 and Client #16). She also mentioned since Client #12 moved in on 9/23/19 many of the clients have been in tears due to being scared of his behavior. She said Client #12 would snap without warning. SL A said they tried to keep one or two staff near Client #12, even though one-on-one staff was not incorporated into Client #12's Individual Program Plan. SL A said this was difficult to do when there was only three staff at the cottage. She said they could call staff from other cottages for back up when needed. SL A also reported another incident, date unknown, when she observed YSW M in Client #12's face yelling and called Client #12 names while Client #12 was escalating. SL A said she did not report the incident to anyone. The surveyors instructed SL A to follow the facility policy, which instructed staff to report all allegations of abuse immediately to the Administrative Team. When interviewed on 11/13/19 at 1:55 p.m., YSW B said he primarily worked at Sinclair Cottage, but sometimes covered at Terry Cottage. YSW B stated Terry Cottage called for staff assistance at least once a day, up to multiple times per day. When asked if Terry Cottage provided a safe environment, YSW B said yes and no. He said Terry Cottage now had all boys and seemed to have more unsafe days. The boys often wrestled and roughhoused, but had gotten worse since Client #12 moved in. When one client escalated,	W 127		

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W 127	Continued From page 22 it seemed like they would all start to escalate. YSW B noted Client #14's behaviors had increased after Client #12 was admitted to the facility. YSW B said it could be "very scary" when the clients all escalated. He reported Client #11 would hide in the bathroom when the other clients escalated. YSW B said Client #16 started to spend a lot of time in his bedroom or the small family room, When interviewed on 11/13/19 at 2:45 p.m., SL C said she worked at Sinclair Cottage but covered a lot at Terry Cottage. When asked if Terry Cottage was a safe environment, SL C said only if there were four or more staff present. She said the past few weeks the facility typically had four staff on duty, but before there was three staff. SL C said when four staff worked, one staff stayed with Client #12 and the other three staff managed the other seven clients. SL C said Client #12 wasn't required to have a one-on-one staff per his program, but a staff person tried to stay close to him. When asked if she thought the other clients felt safe in Terry Cottage, SL C said no. She said clients were spending more time in their bedrooms. She said Client #15 told her multiple times he wanted to go to Sinclair Cottage because he felt safer there. She said Client #16 would go to his room and sometimes refused to come out and Client #16 had asked to go to Sinclair Cottage due to the noise level at Terry Cottage. SL C said Client #14 had also mentioned not feeling safe at Terry Cottage and asked to go to Sinclair Cottage. SL C said she told Qualified Intellectual Disabilities Professional (QIDP) B know the clients in Terry Cottage did not feel safe. She said some staff had left Terry Cottage due to the client behaviors and lack of support.	W 127		

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When interviewed on 11/13/19 at 4:05 p.m., YSW C stated she worked at Sinclair Cottage, but had responded to calls for staff assistance at Terry Cottage. She said Terry Cottage sometimes called for staff assistance several times per day. YSW C said she had heard Client #14 say he was not comfortable around Client #12.

When interviewed on 11/13/19 at 5:05 p.m., YSW D said she did not think the clients at Terry Cottage felt safe. She explained the clients often asked to go to Sinclair Cottage. YSW D stated she did not think the clients were safe when Client #12 was present because he could be very aggressive and his behavior was unpredictable.

When interviewed on 11/14/19 at 7:20 a.m., Client #17 reported he did not feel safe at Terry Cottage. He said Client #12 had hit him several times, but stated he was not afraid of him because he would hit him back.

When interviewed on 11/14/19 at 7:40 a.m., YSW E said Client #15 had told him multiple times he did not feel safe. YSW E reported Client #11 also said he did not feel safe when Client #12 was present. YSW E stated the other clients were scared when Client #12 escalated toward staff. YSW E said he felt Terry Cottage was overall an unsafe environment and it was not feasible to keep everyone safe. YSW E expressed he believed the clients were being "re-traumatized" in the Terry Cottage environment. He said Client #12 would belittle the other clients. He said Client #14 seemed to be afraid of Client #12 off and on. YSW E reported he felt staff had not documented all the peer-to-peer aggressions because staff did not want to or know how to do the paperwork or

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they just considered the clients to be "roughhousing". He believed the clients safety had been compromised by a lack of staff assigned to Terry Cottage. He also acknowledged staff often gave the clients what they wanted despite bad behavior to avoid problems, which often contradicted their behavior plan.

When interviewed on 11/14/19 at 9:30 a.m., the Chief Operating Officer (COO), DIS, Inpatient Clinical Supervisor (ISC) and QIDP A acknowledged and discussed the increased rate of peer-to-peer aggressions. They identified Client #12 as the primary instigator of aggression, but acknowledged Client #10, Client #14, and Client #16 also had high rates of aggression toward their peers. They reported QIDP B had implemented a Cottage Behavior Management Plan (BMP) for all the clients who resided in Terry Cottage but were not aware if any other changes were made to Client #10, Client #14, or Client #16's IPP. The COO discussed the facility had clients with very challenging behaviors and the client referrals the facility had received had similar behavioral challenges.

When interviewed on 11/14/19 at 10:45 a.m., QIDP B explained on 10/2/19 the facility had implemented a Consumer to Consumer Behavior Management Plan (BMP), effective for all the clients who resided within Terry Cottage. She said the Consumer to Consumer BMP was implemented do to the increase in peer-to-peer aggressions occurring within Terry Cottage. QIDP B said she also discussed boundaries when she met with each of the clients individually. She confirmed no changes were made to the interventions in Client #10, Client #14, or Client #16's IPPs after each client displayed an increase

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W 127	Continued From page 25 in peer-to-peer aggression. She said no staff or client had reported to her they felt the environment was unsafe. Additional record review revealed the "Consumer to Consumer BMP", initiated 10/2/19, due to the frequency and intensity of the consumer-to-consumer aggressions occurring within the cottage. The document noted this plan was to be implemented when any Terry Cottage client engaged in boundary-breaking behaviors. These behaviors included posturing aggressively towards another peer, rough-housing playfully with another peer (wrestling, grabbing, shoulder-checking, etc), physically aggressing towards another peer (punching, kicking, biting, pushing, hitting, takedowns, pinching, choking, etc.); threatening to aggress or harm another peer, attempts to engage a peer in tag by "tagging" them; pulling, pushing, or encouraging a peer to enter a bedroom, bathroom, the vent room, or family room with them, and attempting to kiss, hug, or touch in a sexualized manner. The plan instructed staff to immediately redirect the behavior and if it continued, staff were to direct the client to take a break in an area of the cottage deemed safe and appropriate by staff. If the client did not stop and take a break, staff were instructed to physically guide/escort the client to an area designated for time away. If the client became actively combative during the escort, the plan instructed to follow the clients IPP addressing safety, offering a therapeutic hold if danger was imminent. The plan instructed time away lasted as long as necessary to ensure safety. When interviewed on 11/19/2019 at 3:00 p.m. YSW F stated she had been made aware of the	W 127		

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W 127	Continued From page 26 10/2/2019 Terry Cottage Consumer to Consumer BMP, but admitted many staff did not follow it all the time for various reasons. She explained if staff followed the Cottage BMP, in some cases it might have made behaviors worse. She also stated she felt many of the new staff had not been trained adequately. When interviewed on 11/21/19 at 8:15 a.m., QIDP B confirmed the Terry Cottage Consumer to Consumer BMP was to take precedence over the client IPPs for boundary violations. She confirmed staff were uncertain as to whether they should follow the client IPPs or the Terry Cottage Consumer to Consumer BMP therefore added this plan into each client's IPP within the last week. When interviewed on 11/27/19 at 8:45 a.m., YSW I said staff were trained to follow the client IPPs so most staff did not follow the Consumer to Consumer BMP. Review of facility policies revealed the "ICF/ID Special Treatment Procedures", last revised 5/30/19. The section titled "Harassment and Violence Toward Others" noted harassment and violence toward others would not be tolerated. The procedure instructed, "Children who experience interpersonal conflicts will be placed in separate treatment pods. Alternative intervention is to place the child on Shadow, in which a child who is harassing another child will have to remain at arm's length of staff. Should harassment or violence continue, a Special Care Review may be called in an interdisciplinary effort to problem-solve strategies/interventions to be attempted."	W 127		

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W 127	Continued From page 27 Further record review revealed a document titled "Tanager Place PMIC and ICF/ID Client and Consumer Rights", undated. The policy noted, "You have the right to be free form coercion, abuse, retaliation and neglect". The policy also noted, "Tanager Place staffs are responsible for respecting the personal dignity and positive social identify of clients, consumers and their families". When interviewed on 12/5/19 at 9:40 a.m., QIDP B confirmed the facility had not been following the procedure in its entirety regarding violence towards others. She said the IDT met several times to discuss Client #12's ongoing behaviors and aggression; QIDP B confirmed the facility had not called a Special Care Review after noting Client #10, Client #14, and Client #16 had an increase in aggression toward peers.	W 127		
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 interviews and record review, the facility failed to implement facility policies, as written, as evidenced by failure to complete 24-hour follow-up following incidents of peer-to-peer aggression, failure to identify injuries following incidents of peer-to-peer aggression, and failure to complete Critical Incident Reports (CIRs) per facility policy. Additionally, the facility failed to implement policies regarding abuse and mandatory reporting; as evidenced by, failure to consistently report all allegations of abuse	W 149		

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W 149	Continued From page 28 immediately to the Administrator (or designee) and the appropriate state agency, failure to ensure nurses examinations were completed after allegations were reported, failure to complete the CIR in accordance with facility policies, and failure to consistently take action to ensure the safety of the child following allegations of abuse. This affected 10 of 10 clients (Client #1, #3, #5, #10, #11, #12, #13, #14, #15, and #16) identified during the investigation of #86444-I, #87056-I, #87325-I, #87406-I, and 1 former client (Client #19). Findings follow: 1. Record review on 11/7/19 revealed the facility peer-to-peer tracking spreadsheet. Review of the spreadsheet revealed the facility failed to ensure 24-hour follow-up for potential injuries had occurred after incidents of peer-to-peer aggression. The facility failed to complete 24-hour follow-up on the following incidents of peer-to-peer aggression: a On 9/22/19, Client #10 scratched Client #14's left wrist. The facility failed to complete 24-hour follow-up. On 9/27/19, five days after the incident, follow-up was completed and noted a small red mark was still present on Client #14. b. On 9/8/19, Client #16 brought his right fist down onto Client #10's left shoulder causing a red mark and "what appears to be the formation of a bruise." The record lacked 24-hour follow-up but noted on 9/14/19, six days after the incident, "no visible mark, injury, or signs of discomfort observed. 24 hour follow up does not appear to have been completed." c. On 9/26/19, Client #16 bit Client #13 leaving a bite mark. The record lacked 24-hour follow-up.	W 149		

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W 149	Continued From page 29 On 9/30/19, four days after the incident, follow-up was completed and no injury was reported. d. On 9/21/19, Client #14 smacked Client #5's left wrist, leaving a red mark. 24-hour follow-up was not completed to determine in any injury occurred. On 9/30/19, nine days after the incident, follow-up was completed with no visible injury. e. On 9/25/19, Client #14 kicked Client #13 in the face resulting in a cut above the left eyebrow and some redness. Follow-up was completed two days after the incident, on 9/27/19, and noted no pain or injury. f. On 9/29/19, Client #12 hit Client #10 in the face. The facility failed to complete 24-hour follow-up on Client #10. On 10/6/19, seven days following the incident, Client #10 was assessed and noted his lip was swollen and there was a cut on the bottom lip. g. On 9/29/19, Client #10 bit Client #12 on his hand. The 24-hour follow-up noted Client #12 had a scratch on the left side of his neck and red marks on both sides of his neck. The follow-up lacked any information regarding if an injury occurred on Client #12's hand. Record review revealed the facility policy "ICFID Peer to Peer Reporting Guidelines", undated. The guidelines instructed, "Direct care staff working the following shift will complete the required 24 hour follow up of possible or sustained injury and document in the shift change over communication." Additionally, the guidelines instructed the QIDP would input the information into a spreadsheet during the next business day	W 149		

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W 149	Continued From page 30 and complete necessary follow up which would include ensuring 24-hour accident/injury follow-up was completed. 2. Continued record review of the facility peer-to-peer tracking spreadsheet revealed the facility failed to follow the policy regarding identification of an injury therefore failed to accurately reflect the number of injuries caused by the same aggressor. The peer-to-peer tracking spreadsheet revealed the following: a. On 9/6/19, Client #10 caused a scratch on the anterior side at the base of Client #13's neck. The 24-hour follow-up noted the scratch remained on Client #13's neck. The documented noted "N/A" for number of injuries by the aggressor. b. On 9/22/19, Client #10 scratched Client #14's left wrist. The facility failed to complete 24-hour follow-up but noted on 9/27/19 a small red mark was still present on Client #14. The number of injuries by aggressor noted "(Client #10) - NA due to amended reporting policy. Red mark present after 24 hours does not necessarily qualify. No lingering pain, no medical attention required." c. On 9/28/19, Client #10 scratched Client #14 on the right side of his neck. The 24-hour follow-up noted the scratch was still visible. The number of injuries by aggressor noted "(Client #10) - NA due to amended reporting policy. Red mark present after 24 hours does not necessarily qualify. No lingering pain, no medical attention required." d. On 9/28/19, Client #10 scratched Client #14's left arm. The 24-hour follow-up noted the scratch on Client #14 was still visible. The number of injuries by aggressor noted "(Client #10) - NA due	W 149		

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to amended reporting policy. Red mark present after 24 hours does not necessarily qualify. No lingering pain, no medical attention required."

e. On 9/28/19, Client #10 and Client #12 were roughhousing and began to choke one another; Client #12 obtained a scratch on his neck. The 24-hour follow-up revealed the scratch was still present. The number of injuries by aggressor noted "(Client #10) - NA due to amended reporting policy. Red mark present after 24 hours does not necessarily qualify. No first aid or medical attention required."

f. On 9/28/19, Client #12 attacked Client #16 by punching him in the face and kicking him. Client #10, Client #5, and Client #14 also started to hit Client #16 in the face and kick him in his private parts; Client #5 hit Client #16 in the face with her lanyard. The 24-hour follow-up noted Client #16's lip was no longer bleeding but was cut and red. The number of injuries by aggressor noted "(Client #12) - NA due to amended reporting policy. Following consult with (Director of Inpatient Services (DIS)) and (Qualified Intellectual Disabilities Professional (QIDP) B), this does not meet criteria as injury did not result in outside medication attention." The facility failed to include Client #5, Client #10, or Client #14 may have caused Client #16's cut lip.

g. On 9/29/19, Client #10 bit Client #12 on his hand. The 24-hour follow-up noted Client #12 had a scratch on the left side of his neck and red marks on both sides of his neck. The follow-up lacked any information regarding if an injury occurred on Client #12's hand. The number of injuries by aggressor noted "(Client #10) - NA due to amended reporting policy. Red mark present

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W 149	Continued From page 32 after 24 hours does not necessarily qualify. No first aid or medication attention required." h. On 9/29/19, Client #12 hit Client #10 in the face. 24-hour follow-up was not completed but noted on 10/6/19 Client #10 was assessed and his lip was swollen and there was a cut on the bottom lip. The injuries by aggressor noted "(Client #12) - NA due to amended reporting policy. Following consult with the (DIS) and (QIDP) B, this does not meet criteria as injury did not result in outside medication attention." i. On 10/3/19, Client #12 punched Client #10 in the face. The initial injury noted Client #10's entire face was swollen and had a red mark covering most of the left side of his face. The 24-hour follow-up noted Client #10 had bruising around his eye. The injuries by aggressor noted "(Client #12) - NA due to amended reporting policy. Following consult with the (DIS) and (QIDP B), this does not meet criteria as injury did not result in outside medical attention." j. On 10/5/19, Client #12 punched Client #10 in the face. The 24-hour follow-up revealed Client #10's lip was swollen and there was a cut on the bottom lip. The injuries by aggressor noted "(Client #12) - NA due to amended reporting policy. Following consult with the (DIS) and (QIDP B), this does not meet criteria as injury did not result in outside medical attention." k. On 10/6/19, Client #12 punched Client #13 on the left side of his mouth. The 24-hour follow-up noted Client #13 had a small cut which appeared to be healing. The injuries by aggressor noted "(Client #12) - NA. Consult re: this incident meeting criteria for possible self-report has been	W 149		

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W 149	Continued From page 33 completed by (QIDP B) to (DIS). Resulting injury is minor: (Client #12) continues to have significant adjustments and modifications to his programing to aid in stabilization. His IDT continues to meet regularly to explore his ongoing appropriateness for this program." l. On 10/13/19, Client #12 punched Client #13 in the mouth. The 24-hour follow-up noted Client #13 had a small cut on his bottom lip. The injuries by aggressor noted "(Client #12) - resulting injury is minor; (Client #12) continues to have significant adjustments and modifications to aid in stabilization. His IDT continues to meet regularly to explore his ongoing appropriateness for this program." m. On 10/28/19, Client #16 punched Client #15 in the face. The 24-hour follow-up noted Client #15 had a small scratch on the right side of his forearm. The number of injuries by aggressor noted "NA- due to amended reporting policy. Injury is not significant and did not result in outside medical attention needed." n. On 11/2/19, Client #12 punched Client #14 on the left eye. The 24-hour follow-up noted Client #14 had a bruise on his eye. The injuries by aggressor noted "A consumer to consumer narrative was not initially completed for this incident. However, an (Accident Injury Reporting Form (AI)) was. This was given to DIA on-site on 11/12/19. Determined peer involvement on 11/17/19. At this time, this would not have been reported per our interpretation of peer to peer policy. However, following our amendment on 11/13/19, this would now meet criteria to report." Review of the "ICFID Peer to Peer Reporting	W 149		

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Guidelines", undated, instructed the QIDP to input the peer-to-peer aggression onto the spreadsheet including the number of incidents the aggressor had initiated resulting in injury within a 30-day period. The guidelines included "For the purposes of this reporting guideline, injury is descried as significant and could include abrasion, cut, bite, or bruise lasting longer than 24 hours requiring a healing process. For the purposes of this reporting guideline, lingering pain, soreness, or red marks may not meet criteria for "injury"; these will be assessed on an individual basis and will continue to be monitored via the aforementioned process."

When interviewed on 11/12/19 at 10:30 a.m., Qualified Intellectual Disabilities Professional (QIDP) B stated from her understanding, the facility revised the policy regarding peer-to-peer aggression and how injury was defined to allow for the facility to determine if something would be considered an injury or not. She said cuts, bruises, abrasions, ect. were all examples of what an injury may be. QIDP B acknowledged the policy did not note outside medical attention was required to be considered an injury and acknowledged scratches and bruises, for example, would appear to be an injury.

When interviewed on 11/14/19 at 9:30 a.m., the Director of Inpatient Services (DIS) explained the facility assessed and determined injuries from peer-to-peer aggression on an individual basis. When asked about bruising by the eye and cut lips being an injury for example, the DIS stated it would depend on the severity of the bruise and again stated they assessed clients individually to determine if it was an injury. The DIS acknowledged the facility policy definition of an

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W 149	Continued From page 35 injury did not include the client would require outside medical treatment to be considered an injury. 3. Review of Critical Incident Reports (CIRs) revealed the following: a. A CIR, dated 9/27/19, was completed after Client #3 hit Client #1 multiple times in the head with metal serving spoons. The CIR noted Client #3 was in an escalated state, grabbed two metal serving spoons, and attempted to hit another client with them. The peer ran and hid behind Client #1. Client #3 attempted to hit the peer but hit Client #1 several times instead. The CIR failed to identify whom the assigned/responsible staff was and failed to include statements from all individuals involved or who witnessed the incident. b. A CIR, dated 9/29/19, was completed after Client #10 told Youth Services Worker (YSW) F Client #12 had touched his private area, and tried to kiss him. The CIR noted on 9/28/19, Client #12 returned from a day pass and gave Client #10 a hug. Client #10 kissed Client #12 on the cheek, and Client #12 had attempted to kiss Client #10 back when staff intervened. The CIR noted "Program manager reviewed incident with staff on shift." And noted an interview with YSW F regarding the allegation and YSW D was interviewed regarding the incident on 9/28/19. The CIR failed to identify if any additional staff or clients were interviewed to determine if anyone had witnessed the alleged incident reported by Client #10. c. A CIR, dated 9/30/19, was completed after Client #12 reported to staff Client #10 had	W 149		

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touched his private area. The CIR noted, "Narrative from staff on shift Monday, the date (Client #12) made this allegation." The narrative completed a statement from YSW F which included she was not present in the cottage when the situation occurred, she had been outside supervising other clients. YSW G and YSW J's names were listed but the CIR lacked any statements taken from them. The CIR failed to include statements from all staff who worked and failed to identify who the assigned/responsible staff was.

d. A CIR, dated 10/6/19, was completed after Client #14 alleged Client #12 attempted to touch his private area while in the family room. The CIR noted the Program Manager had followed-up with staff that worked but failed to identify who was interviewed, noting "Staff One" and "Staff Two". The CIR failed to identify who the assigned/responsible staff was.

e. A CIR, dated 11/22/19, was completed after Client #16 had aggressed toward Client #10 on 11/19/19 and 11/20/19. The CIR failed to identify the assigned/responsible staff and failed to include statements from anyone involved or witnessed the incidents.

Review of facility policies revealed "Risk Management", last revised 11/2019. The policy instructed the CIR was to be completed and submitted by the involved staff, statements and information was to be gathered from individuals involved or who witnessed the incident, and the CIR was to include the assigned/responsible staff.

Additional review revealed the "ICF/ID Special

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W 149	Continued From page 37 Treatment Procedures", last revised 5/30/12. The procedures instructed "Allegations of consumer mistreatment, neglect or abuse and injuries of unknown origin will be investigated immediately ...". When interviewed on 11/19/19 and 9:45 a.m., Qualified Intellectual Disabilities Professional (QIDP) A explained to complete a CIR, they would obtain some verbal statements from staff, take information from the completed Accident Injury Report, and sometimes staff would e-mail information regarding an incident. QIDP A acknowledged the facility had not been following the Risk Management policy, in its entirety, regarding proper completion of CIRs by failure to identify who was interviewed, not documenting who the assigned/responsible staff was, and not interviewing any additional staff or clients who may have witnessed an incident. When interviewed on 11/19/19 at 12:05 p.m., QIDP B explained several people completed CIRs as a collaborative effort. QIDP B explained the staff and/or Shift Lead normally initiated a CIR, the Program Manager was to complete all follow-up with staff; the QIDP would review the client plans, supervision, and follow-up with the clients involved, and the DIS would complete administrative review of the CIR once completed. QIDP B stated the staff who reported an incident was interviewed but not all staff who worked at the time was interviewed. QIDP B said the facility was able to take a verbal or written statement from staff for the CIR and said the DIS had instructed the former Program Manager to summarize staff statements in the CIR. QIDP B said the facility did not interview other clients who may have witnessed an incident but did follow-up	W 149		

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with all clients involved. QIDP B confirmed the facility had not followed the Risk Management policy, as written, regarding the completion of the CIR. She stated as a system, the facility needed to get everyone on the same page to ensure everyone completed the CIRs in the same manner.

4. The facility failed to consistently follow policies and procedures regarding reporting allegations of client abuse and neglect, completing internal investigations, ensuring separation between the victim and alleged perpetrator, and ensuring nursing assessments for injuries. Review of facility allegations of abuse, dated 4/26/19 - 12/12/19, revealed the following:

a. A CIR, dated 4/26/19, was initiated after former Client #19 reported to a staff, following an escalation, that another staff had taken her hand and bent it backwards "breaking her hand". Staff reported her hand was swollen and offered her ice. Staff noted, "Staff asked (Client #19) again what had happened and changed her story saying that staff broke her finger." On 4/17/19 Client #19 was taken to Urgent Care and it was determined her hand was bruise and not broken. The CIR lacked a statement from the alleged perpetrator, lacked a summary or Administrative review following the completion of the CIR, and lacked documentation the allegation was reported to the Department of Human Services (DHS).

b. A CIR was initiated on 6/7/19 after Qualified Intellectual Disabilities Professional (QIDP) A received an e-mail from Client #3's mother who reported Client #3 told her staff had placed him in a headlock, pushed him against the wall, and also made a comment referring to him as "Daffy

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shoulder by pushing her to the ground during an escalation. The CIR noted on 9/20/19, nursing assessed Client #19 again and noted she verbalized pain in her left should/arm, had a bruise on her left wrist presenting with minor swelling with a hardened area on palpation, and decreased range of motion. Client #19 informed the nurse she was telling school personnel and reporting the incident to the DHS. The CIR noted "Since (Client #19) did not make an allegation of abuse to us, and because she self-reported to us that she told school, this did not meet criteria for us to also report to DHS." The facility failed to ensure separation between the alleged perpetrator and Client #19. The CIR lacked any witness statements from the incident, and failed to provide a summary of the facility findings, noting the facility had not received any findings from the DHS investigation. The facility failed to report the allegation to the DIA until 9/20/19, two days after the allegation was made.

When interviewed on 12/10/19 at 1:45 p.m. the DIS said she was not sure why the allegation was not reported to the DIA until two days later.

f. A CIR, dated 10/14/19, was completed after Client #12 alleged a staff had pushed him, pushed him into a wall, hit him, and restrained him against a wall/corner during an escalation when Client #12 was being physically aggressive. The CIR lacked an assessment for injuries. The facility failed to separate the alleged perpetrator from Client #12. The facility informed Client #12's DHS
caseworker but failed to report the allegation to the DHS abuse intake.

g. A CIR, dated 10/18/19, after Client #12

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reported staff had sworn at him, flicked him off, and hit the back of his head the previous night while he was in an escalation. The CIR failed to note if any assessment was completed for potential injuries or marks and failed to include a summary of the facilities findings. The facility failed to separate the alleged perpetrator from Client #12. The facility notified Client #12's DHS caseworker but failed to report the allegation to the DHS abuse intake.

h. A CIR, dated 10/24/19, after Client #12 reported staff pushed him during an escort. The CIR noted Client #12 had no injuries. The facility failed to separate the alleged perpetrator from Client #12. The facility informed Client #12's DHS caseworker but failed to report the allegation to the DHS abuse intake.

i. A CIR, dated 10/24/19, after Client #12 reported staff had thrown him aggressively onto his bed but was unable to recall the time or day it occurred. Client #12 had no visible injuries. The CIR noted the facility reviewed the incident with one staff in the cottage but failed to interview or obtain statements from any other staff to attempt to determine if or when the alleged incident occurred. The CIR noted, "Because (Client #12) regularly engages in physical aggression (near-daily), narrowing down a potential day/time of the alleged incident is challenging." Additionally, the Administrative Review section noted, "At this time, there does not appear to be any evidence of wrong doing on staff's part ...". The facility notified the DHS caseworker but failed to report the allegation to the DHS abuse intake.

j. A CIR, dated 10/28/19, after Client #12 reported staff deliberately hurt him during an escort.

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W 149	Continued From page 42 Following the escalation while processing with staff, Client #12 continued to say staff had abused him and reported staff hit his face and broke his finger. Nursing assessed Client #12 on 10/29/19 and noted Client #12 reported soreness in his hand and there was some redness visible but had no swelling, bruising, or marks. Administrative review noted additional staff members, including the LP, witnessed the incident. The CIR included consult occurred with the staff involved in the alleged incident but failed to include any staff statements regarding the incident noting, " Program staff appropriately documented and reported (Client #12's) allegation to the QIDP. Staff reported that teaching and behavioral interventions were offered to (Client #12) appropriately and per his individualized program plan and MANDT training, to ensure the safety of others. Hand-on interventions were offered safely and appropriately. At this time, this alleged incident does not appear to have occurred." The CIR included a statement from the LP, who was present for a therapeutic hold. The facility failed to separate the alleged perpetrator from contact with Client #12. The facility reported the allegation to Client #12's DHS caseworker but failed to report the allegation to the DHS abuse intake. k. A CIR, dated 11/4/19, was initiated after staff reported during an escalation on 11/3/19 at approximately 8:30 a.m., another staff got within inches of Client #16's face, grabbed Client #16's clothing, and pushed Client #16 into the wall aggressively multiple times causing Client #16's head to hit the wall. Staff noted several of Client #16's acne sores opened and began to bleed, and Client #16 was very upset, crying, and sobbing. Staff reported the incident to Shift Lead	W 149		

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W 149	Continued From page 43 (SL) A, who provided Client #16 first aid, offered him an ice pack, and provided support to return to baseline. The CIR failed to include a completed nursing assessment for potential injuries following the incident. Staff and SL A failed to immediately report the incident to the Administrative team. The CIR noted staff e-mailed Qualified Intellectual Disabilities Professional (QIDP) B about the incident on 11/3/19 at 9:00 p.m., over 12 hours after the incident occurred. The Director of inpatient Services (DIS) and the Inpatient Clinical Supervisor (ICS) were notified of the allegation on 11/4/19 at approximately 1:00 p.m., over 24 hours after the incident occurred. The CIR noted QIDP B spoke to the staff that witnessed the incident and SL A but failed to include either statement on the CIR. The CIR lacked an interview from the alleged perpetrator and lacked a summary of the facility findings. I. When interviewed on 11/13/19 at 11:15 a.m., Shift Lead (SL) A reported one day, she could not recall the exact date, Youth Services Worker (YSW) M was in Client #12's face yelling and called Client #12 names while Client #12 was in an escalation. She said YSW M yelled at Client #12 "I'm sick of this shit" and called Client #12 an "idiot". She stated YSW M was in Client #12's face yelling at him, to the point Client #12 said YSW M was spitting on him. SL A said she told YSW M several times to back away but he did not. SL A said had not reported the incident to the Administrative team. The Surveyors instructed SL A to follow the facility policy and to report the allegation immediately. When interviewed on 11/14/19 at 9:30 a.m., the Director of Inpatient Services (DIS) reported she was not aware of the allegation and SL A had not	W 149		

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W 149	Continued From page 44 reported the incident. The DIS stated she would follow-up on the allegation. The record lacked a completed CIR into the allegation. When interviewed on 12/10/19 at 1:45 p.m., the DIS confirmed the facility had not completed a CIR for the allegation. She stated the facility had spoken to both SL A and YSW M about the alleged incident but did not feel the need to complete the investigation since YSW M's employment was terminated. Review of facility policies revealed the "Child Abuse and Mandatory Reporting", undated, instructed "Any staff person suspecting child abuse of a consumer may have occurred is required to make a report to their immediate supervisor and appropriate administrative staff. Make a report for internal investigation does not release the mandatory reporter from their mandated responsibility to make a report to the Department of Human Services, if the individual reporting "reasonably believes a child has suffered abuse."" The section titled Conducting a child abuse investigation" instructed investigative staff needed to gather sufficient information to enable them to determine if a situation warrants a referral to DHS and establish there is reason to believe abuse occurred. The policy noted child abuse investigations may include, but was not limited to: a nurse's examination of consumer injuries, statements from the alleged victim by having the victim either write or dictate specifics relating to the incident, statements from the alleged perpetrator, other staff/adults who were present, and from other clients if appropriate. It also included "Action to ensure the safety of the	W 149		

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child, either through limiting contact, placing the alleged perpetrator on leave status per operating procedures, or reassignment of the alleged perpetrator."

Additional review revealed guidelines for staff to refer to titled "Child Abuse Report", undated. The guidelines instructed "If a client makes a statement that indicates that they were abused or neglected" staff were not to ask leading questions but get the basic information of who and when. The guidelines then instructed staff to call and report the allegation to Linn County DHS and provided the phone number; if no answer, staff were to call the Iowa Child Abuse Hotline and provided the phone number. The paper continued to instruct staff to complete the Report of Suspected Child Abuse form, fax it to DHS, and send the completed form to the Director of Residential Services.

Continued record review revealed the policy "Risk Management", last revised 11/2019. The policy instructed a CIR was to be completed and submitted by staff involved, statements and information was to be obtained from others involved in or who witnessed an incident, and the required reporting actions were to be documented. The policy noted the administrative review was to identify possible causes of a problem and to determine approaches to minimize or eliminate the reoccurrence. Additionally, the policy section titled "Reporting Requirements" instructed staff were responsible for immediately notifying the Administrative Team in the event of child abuse by agency personnel. The policy noted the Compliance officer, or designee, was responsible for ensuring timely notification to the appropriate

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W 149	Continued From page 46 regulatory/consumer organization. When interviewed on 12/11/19 at approximately 11:00 a.m., QIDP B reported the facility completed two self-reports to the DIA on 12/10/19 and she was in the process of completing the CIR's for both allegations. QIDP B explained Client #14's mom reported Client #14 said staff broke his headphones, grabbed his arm, and held him against his will. She reported this occurred toward the end of last week or over the weekend. QIDP B said the second incident reported to DIA was after Client #15 reported during an escalation staff shoved and chucked him into the vent room. QIDP B confirmed neither allegation was reported to the DHS abuse intake and said the facility was still completing the internal investigation of the incidents. QIDP B explained not all allegations of abuse were reported to the DHS. She said the guidance used to determine if an allegation of abuse needed reported to the DHS included if there was a mark or an injury, if the client was scared, and if it was an escalation. When asked, QIDP B stated the facility had not separated the accused staff from contact with Client #14 or Client #15. QIDP B explained she was not aware after any allegation of client abuse or neglect, the accused staff should not have contact with the victim during the investigation. She stated the facility sometimes separated the accused staff but she said she was not sure of when or why to separate the accused staff from the victim. QIDP B confirmed the facility abuse policies and procedures were not followed consistently. When interviewed on 12/11/19 at 2:40 p.m., the Inpatient Clinical Supervisor (ICS) said she was not sure why the facility had not consistently reported allegations of abuse. She explained after	W 149		

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W 149	Continued From page 47 an allegation of abuse was made, the facility looked at various things to determine if a report needed to be filed with the DHS, which included if the child had been in a restraint, if the child felt safe, and if there was an injury. When asked, the ICS said the facility used the same, or similar, process to determine if the accused staff needed separated from the child. The ICS reviewed the above CIR's and the facility policies. The ICS explained the "Child Abuse Report" guidelines was not the policy and was outdated. The ICS confirmed she provided the Surveyor with the guidelines when the policy was requested and said the guidelines were posted around the campus for staff to use as a guide for when to report allegations of abuse to DHS. The ICS said, after her review of the CIRs, it did not seem like the facility policies were being followed then statedshe was not sure of the details since some of the allegations were made prior to her starting at the facility and also because she was still learning. When interviewed on 12/12/19 at 10:00 a.m., the Chief Operating Officer (COO) said per the Child Mandatory Reporter requirements, the facility was only required to report to DHS if they "reasonably believed" abuse had occurred. The COO stated the "Child Abuse Report" guidelines were outdated when the Surveyor attempted to discuss the differences between the facility policy and the guidelines for staff to follow. The DIS confirmed the "Child Abuse Report" guidelines were posted throughout the campus for staff to follow for allegations of abuse. The COO said the "Child Abuse and Mandatory Reporting" policy instructed nurses to complete an assessment of client injuries and explained if a client did not have an injury the nurse would not need to	W 149		

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W 149	Continued From page 48 complete an assessment. When asked how it was determined if a child had sustained an injury or not, the COO stated the staff were trained in basic first aid, know when they should call a nurse, and staff would report any injuries. The COO said the facility policy "Child Abuse and Mandatory Reporting" noted child abuse investigation "may include" but did not instruct every investigations would include the items listed. The COO continued to explain, the facility completed CIRs for all allegations of abuse, noted on the CIR "Program Staff 1, 2, etc." to identify staff interviewed, and reported all allegations to the DIA. The COO discussed with the population they work with at the facility, a client may make an allegation during an escalation then later rescind the allegation or other staff may have witnessed the incident and reported abuse did not occur, as some of the reasons the facility may not report to the DHS. The COO stated again the facility reported abuse when they reasonably believed abuse had occurred, per the Mandatory Reporter requirements. The COO did not respond when asked if the facility policy included when or why an allegation of abuse would not be reported to the DHS. The facilities failure to implement policies regarding reporting, investigating, and separating the alleged perpetrator from the victim following allegations of abuse led to a determination of Immediate Jeopardy. For additional information cross reference W153, W154, and W155.	W 149		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2)	W 153		

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W 153	Continued From page 49 The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to immediately report all allegations of client mistreatment and/or abuse to the Administrator, or designee, per facility policy and failed to consistently report all allegations of abuse to the appropriate state agency. This affected 2 of 2 clients (Client #12 and #16) involved in the investigation of ###, 2 clients added to the sample (Client #3 and #11) and 1 former client (Client #19). Findings follow: 1. When interviewed on 11/13/19 at 11:15 a.m., Shift Lead (SL) A reported one day, she could not recall the exact date, Youth Services Worker (YSW) M was in Client #12's face yelling and called Client #12 names while Client #12 was in an escalation. She said YSW M yelled at Client #12 "I'm sick of this shit" and called Client #12 an "idiot". She stated YSW M was in Client #12's face yelling at him, to the point Client #12 said YSW M was spitting on him. SL A said she did not report the incident to the Administrative team. The Surveyors instructed SL A to follow the facility policy and to report the allegation immediately. When interviewed on 11/14/19 at 9:30 a.m., the Director of Inpatient Services (DIS) reported she was not aware of the allegation and SL A had not reported the incident. The DIS stated she would follow-up on the allegation.	W 153		

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W 153	Continued From page 50 When interviewed on 12/3/19 at 3:00 p.m., SL A confirmed she failed to report the allegation to administration after instructed to do so by the Surveyors. Record review of facility allegations of abuse from 4/26/19 - 12/11/19 and the corresponding Critical Incident Reports (CIR) revealed the following: 2. A CIR, dated 4/26/19, was initiated after former Client #19 reported to a staff, following an escalation, that another staff had taken her hand and bent it backwards "breaking her hand". Staff reported her hand was swollen and offered her ice. Staff noted, "Staff asked (Client #19) again what had happened and changed her story saying that staff broke her finger." On 4/17/19, Client #19 was taken to Urgent Care and it was determined her hand was bruise and not broken. The CIR lacked documentation the allegation was reported to the Department of Human Services (DHS). 3. A CIR was initiated on 6/7/19 after Qualified Intellectual Disabilities Professional (QIDP) A received an e-mail from Client #3's mother who reported Client #3 told her staff had placed him in a headlock, pushed him against the wall, and also made a comment referring to him as "Daffy Duck". The CIR failed to include documentation regarding if the facility reported the allegation to the DHS. 4. A CIR was initiated on 8/9/19 after Client #3 reported to Shift Lead (SL) A that during a restraint the staff had raped him then immediately clarified and said the staff had assaulted him by pushing him into a wall and his breathing was	W 153		

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restricted. The CIR lacked documentation the allegation was reported to the DHS.

5. A CIR was initiated on 8/20/19 after staff reported they witnessed another staff hit Client #11 on the back of the head instead of using a bite release technique when Client #3 bit the staff on the stomach on 8/19/19. The facility staff failed to report the allegation to the Administrative Team until 8/21/19, the day after the incident occurred. The CIR failed to include if the allegation was reported to the Iowa Department of Inspections and Appeals (DIA).

6. A CIR, dated 9/21/19, after former Client #19 reported to the nurse, while being assessed on 9/18/19, staff had bent her hand back and caused her to scrape her elbow, and the staff hurt her left shoulder by pushing her to the ground during an escalation. The CIR noted on 9/20/19, nursing assessed Client #19 again and noted she verbalized pain in her left should/arm, had a bruise on her left wrist presenting with minor swelling with a hardened area on palpation, and decreased range of motion. Client #19 informed the nurse she was telling school personnel and reporting the incident to the DHS. The CIR noted "Since (Client #19) did not make an allegation of abuse to us, and because she self-reported to us that she told school, this did not meet criteria for us to also report to DHS." The facility failed to report the allegation to the DIA until 9/20/19, two days after the allegation was made.

7. A CIR, dated 10/14/19, was completed after Client #12 alleged a staff had pushed him, pushed him into a wall, hit him, and restrained him against a wall/corner during an escalation when Client #12 was being physically aggressive.

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W 153	Continued From page 52 The facility informed Client #12's DHS caseworker but failed to report the allegation to the DHS abuse intake. 8. A CIR, dated 10/18/19, after Client #12 reported staff had sworn at him, flicked him off, and hit the back of his head the previous night while he was in an escalation. The facility notified Client #12's DHS caseworker but failed to report the allegation to the DHS abuse intake. 9. A CIR, dated 10/24/19, after Client #12 reported staff pushed him during an escort. The CIR noted Client #12 had no injuries. The facility informed Client #12's DHS caseworker but failed to report the allegation to the DHS abuse intake. 10. A CIR, dated 10/24/19, after Client #12 reported staff had thrown him aggressively onto his bed but was unable to recall the time or day it occurred. Client #12 had no visible injuries. The CIR noted the facility reviewed the incident with one staff in the cottage but failed to interview or obtain statements from any other staff to attempt to determine if or when the alleged incident occurred. The CIR noted, "Because (Client #12) regularly engages in physical aggression (near-daily), narrowing down a potential day/time of the alleged incident is challenging." Additionally, the Administrative Review section noted, "At this time, there does not appear to be any evidence of wrong doing on staff's part ..." The facility notified the DHS caseworker but failed to report the allegation to the DHS abuse intake. 11. A CIR, dated 10/28/19, after Client #12 reported staff deliberately hurt him during an escort. Following the escalation while processing with staff, Client #12 continued to say staff had	W 153		

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abused him and reported staff hit his face and broke his finger. Nursing assessed Client #12 on 10/29/19 and noted Client #12 reported soreness in his hand and there was some redness visible but had no swelling, bruising, or marks. Administrative review noted additional staff members, including the LP, witnessed the incident. The CIR included consult occurred with the staff involved in the alleged incident but failed to include any staff statements regarding the incident noting, " Program staff appropriately documented and reported (Client #12's) allegation to the QIDP. Staff reported that teaching and behavioral interventions were offered to (Client #12) appropriately and per his individualized program plan and MANDT training, to ensure the safety of others. Hand-on interventions were offered safely and appropriately. At this time, this alleged incident does not appear to have occurred." The facility reported the allegation to Client #12's DHS caseworker but failed to report the allegation to the DHS abuse intake.

12. A CIR, dated 11/4/19, was initiated after staff reported during an escalation on 11/3/19 at approximately 8:30 a.m., another staff got within inches of Client #16's face, grabbed Client #16's clothing, and pushed Client #16 into the wall aggressively multiple times causing Client #16's head to hit the wall. Staff noted several of Client #16's acne sores opened and began to bleed, and Client #16 was very upset, crying, and sobbing. Staff reported the incident to Shift Lead (SL) A, who provided Client #16 first aid, offered him an ice pack, and provided support to return to baseline. Staff and SL A failed to immediately report the incident to the Administrative team. The CIR noted staff e-mailed Qualified Intellectual

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Disabilities Professional (QIDP) B about the incident on 11/3/19 at 9:00 p.m., over 12 hours after the incident occurred. The Director of inpatient Services (DIS) and the Inpatient Clinical Supervisor (ICS) were notified of the allegation on 11/4/19 at approximately 1:00 p.m., over 24 hours after the incident occurred.

Review of facility policy titled "Risk Management", last revised 11/19/19, instructed staff were to notify the Administrative Team immediately of any abuse by agency personnel. Additionally, the policy section titled "Reporting Requirements" instructed staff were responsible for immediately notifying the Administrative Team in the event of child abuse by agency personnel. The policy noted the Compliance officer, or designee, was responsible for ensuring timely notification to the appropriate regulatory/consumer organization.

Additional policy review revealed the "Standards Manual. Chapter 2a, Personnel Policies", undated. Section C "Child Abuse" instructed, "Children in treatment at Tanager Place have a right to a healthy environment. Children must feel safe and secure in a nurturing atmosphere for positive change to occur. ... Staff who suspect child abuse of a Tanager Place client/consumer, wherever the suspected abuse may have occurred, shall report the incident in accordance with Mandatory Reporter requirements. If abuse is suspected to have occurred by a Tanager Place employee, it should be reported immediately to Administration for further review."

Continued review revealed the "Therapeutic Living Environment Milieu Guidelines for Youth Care Staff" section titled "Child Abuse and Mandatory Reporting", undated, instructed every

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W 153	Continued From page 55 employee suspecting child abuse of a client was required to report to their immediate supervisor and the appropriate administrative staff. Additional review revealed guidelines hung up throughout the campus for staff to refer to titled "Child Abuse Report", undated. The guidelines instructed "If a client makes a statement that indicates that they were abused or neglected" staff were not to ask leading questions and get the basic information of who and when. The guidelines then instructed staff to call and report the allegation to Linn County DHS and provided the phone number; if no answer, staff were to call the Iowa Child Abuse Hotline and provided the phone number. The paper continued to instruct staff to complete the Report of Suspected Child Abuse form, fax it to DHS, and send the completed form to the Director of Residential Services. When interviewed on 12/11/19 at approximately 11:00 a.m., QIDP B explained not all allegations of abuse were reported to the DHS. She said the guidance used to determine if an allegation of abuse needed reported to the DHS included if there was a mark or an injury, if the client was scared, and if the allegation was during an escalation. When interviewed on 12/11/19 at 2:40 p.m., the Inpatient Clinical Supervisor (ICS) said she was not sure why the facility had not consistently reported allegations of abuse. She explained when an allegation of abuse was made the facility would look at various things to determine if a report needed to be filed with the DHS, which included if the child had been in a restraint, if the child felt safe, and if there was an injury. The ICS	W 153		

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W 153	Continued From page 56 reviewed the above CIR's and the facility policies. The ICS explained the "Child Abuse Report" guidelines was not the facility policy and was outdated. The ICS confirmed she provided the Surveyor with the guidelines when the policy was requested and the guidelines were hung up around the entire campus for staff to use as a guideline for when to report allegations of abuse to DHS. The ICS said after her review of the CIRs, it did not seem like the facility policies were being followed then stated she was not sure of all the details since some of the allegations were made prior to her starting at the facility and also because she was still learning. When interviewed on 12/12/19 at 10:00 a.m., the Chief Operating Officer (COO) said per the Child Mandatory Reporter requirements, the facility was only required to report to DHS if they "reasonably believed" abuse had occurred. The COO stated the "Child Abuse Report" guidelines were outdated when the Surveyor attempted to discuss the differences between the facility policy and the guidelines posted for staff to follow. The DIS confirmed the "Child Abuse Report" guidelines were posted throughout the campus for staff to follow for allegations of abuse. The COO stated the facility needed to do a better job of documenting on the CIR the reasons the facility did not reasonably believe abuse had occurred and therefore was not reported to the DHS.	W 153		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated.	W 154		

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W 154	Continued From page 57 This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to consistently complete thorough investigations, per facility policies. The facility failed to consistently obtain staff statements, failed to consistently identify who the assigned/responsible staff was, failed to consistently include an Administrative Review of the investigation, and failed to consistently note how the client would be safeguarded during the facility investigation and/or following the investigation. This affected #6 of #6 clients (Client #1, #3, #10, #12, #14, and #16) involved in the investigations of #, 1 client added (#11), and 1 former client (#19). Findings follow: Review of facility Critical Incident Reports from 11/7/19 - 12/11/19 revealed the following: a. A CIR, dated 4/26/19, was initiated after former Client #19 reported to a staff, following an escalation, that another staff had taken her hand and bent it backwards "breaking her hand". Staff reported her hand was swollen and offered her ice. Staff noted, "Staff asked (Client #19) again what had happened and changed her story saying that staff broke her finger." On 4/17/19, Client #19 was taken to Urgent Care and it was determined her hand was bruised and not broken. The CIR lacked a statement from the alleged perpetrator and lacked a summary or Administrative review following the completion of the CIR. b. A CIR was initiated on 8/9/19 after Client #3 reported to Shift Lead (SL) A that during a restraint the staff had raped him, he immediately clarified and said the staff had assaulted him by pushing him into a wall and his breathing was	W 154		

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W 154	Continued From page 58 restricted. The CIR lacked a summary of the facility findings. c. A CIR was initiated on 8/20/19 after staff reported they witnessed another staff hit Client #11 on the back of the head instead of using a bite release technique when Client #3 bit the staff on the stomach on 8/19/19. The CIR lacked a statement from the alleged perpetrator and lacked a summary of the facilities findings. d. A CIR, dated 9/21/19, after former Client #19 reported to the nurse, while being assessed on 9/18/19, staff had bent her hand back and caused her to scrape her elbow, and the staff hurt her left shoulder by pushing her to the ground during an escalation. The CIR noted on 9/20/19, nursing assessed Client #19 again and noted she verbalized pain in her left should/arm, had a bruise on her left wrist presenting with minor swelling with a hardened area on palpation, and decreased range of motion. Client #19 informed the nurse she was telling school personnel and reporting the incident to the DHS. The CIR lacked any witness statements from the incident and failed to provide a summary of the facility findings, noting the facility had not received any findings from the DHS investigation. The facility failed to ensure separation between the alleged perpetrator and Client #19. e. A CIR, dated 9/27/19, was completed after Client #3 hit Client #1 multiple times in the head with metal serving spoons. The CIR noted Client #3 was in an escalated state, grabbed two metal serving spoons, and attempted to hit another client with them. The peer ran and hid behind Client #1. Client #3 attempted to hit the peer but hit Client #1 several times instead. The CIR failed	W 154		

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W 154	Continued From page 59 to identify whom the assigned/responsible staff was and failed to include statements from all individuals involved or who witnessed the incident. f. A CIR, dated 9/29/19, was completed after Client #10 told Youth Services Worker (YSW) F Client #12 had touched his private area, and tried to kiss him. The CIR noted on 9/28/19, Client #12 returned from a day pass and gave Client #10 a hug. Client #10 kissed Client #12 on the cheek, and Client #12 had attempted to kiss Client #10 back when staff intervened. The CIR noted "Program manager reviewed incident with staff on shift." And noted an interview with YSW F regarding the allegation and YSW D was interviewed regarding the incident on 9/28/19. The CIR failed to identify if any additional staff or clients were interviewed to determine if anyone had witnessed the alleged incident reported by Client #10. g. A CIR, dated 9/30/19, was completed after Client #12 reported to staff Client #10 had touched his private area. The CIR noted, "Narrative from staff on shift Monday, the date (Client #12) made this allegation." The narrative completed a statement from YSW F which included she was not present in the cottage when the situation occurred, she had been outside supervising other clients. YSW G and YSW J's names were listed but the CIR lacked any statements taken from them. The CIR failed to include statements from all staff who worked and failed to identify who the assigned/responsible staff was. h. A CIR, dated 10/6/19, was completed after Client #14 alleged Client #12 attempted to touch	W 154		

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W 154	Continued From page 60 his private area while in the family room. The CIR noted the Program Manager had followed-up with staff that worked but failed to identify who was interviewed, noting "Staff One" and "Staff Two". The CIR failed to identify who the assigned/responsible staff was. i. A CIR, dated 10/18/19, after Client #12 reported staff had sworn at him, flicked him off, and hit the back of his head the previous night while he was in an escalation. The CIR failed to include a summary of the facilities findings and failed to note if staff was separated from Client #12 during the investigation. j. A CIR, dated 10/24/19, after Client #12 reported staff had thrown him aggressively onto his bed but was unable to recall the time or day it occurred. The CIR noted the facility reviewed the incident with one staff in the cottage but failed to interview or obtain statements from any other staff to attempt to determine if or when the alleged incident occurred. The CIR noted, "Because (Client #12) regularly engages in physical aggression (near-daily), narrowing down a potential day/time of the alleged incident is challenging." k. A CIR, dated 10/28/19, after Client #12 reported staff deliberately hurt him during an escort. Following the escalation while processing with staff, Client #12 continued to say staff had abused him and reported staff hit his face and broke his finger. The CIR included "Consultation occurred with the staff involved in the alleged incident" and noted "Program staff appropriately documented and reported (Client #12's) allegation to the QIDP. Staff reported that teaching and behavioral interventions were	W 154		

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W 154	Continued From page 61 offered to (Client #12) appropriately and per his individualized program plan and MANDT training, to ensure the safety of others. Hand-on interventions were offered safely and appropriately. At this time, this alleged incident does not appear to have occurred." The CIR included a statement from the LP, who was present for a therapeutic hold. The Administrative review noted additional staff witnessed the incident but the CIR failed to include statements from the staff who witnessed the incident. The facility failed to note how Client #12 was safeguarded following the allegation of abuse. l. A CIR, dated 11/4/19, was initiated after staff reported during an escalation on 11/3/19 at approximately 8:30 a.m., another staff got within inches of Client #16's face, grabbed Client #16's clothing, and pushed Client #16 into the wall aggressively multiple times causing Client #16's head to hit the wall. Staff noted several of Client #16's acne sores opened and began to bleed, and Client #16 was very upset, crying, and sobbing. Staff reported the incident to Shift Lead (SL) A, who provided Client #16 first aid, offered him an ice pack, and provided support to return to baseline. The CIR noted QIDP B spoke to the staff that witnessed the incident and SL A but failed to include either statement on the CIR. The CIR lacked an interview from the alleged perpetrator and lacked a summary of the facility findings. m. A CIR, dated 11/22/19, was completed after Client #16 had aggressed toward Client #10 on 11/19/19 and 11/20/19. The CIR failed to identify the assigned/responsible staff and failed to include statements from anyone involved or who witnessed the incidents.	W 154		

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W 154	Continued From page 62 n. When interviewed on 11/13/19 at 11:15 a.m., Shift Lead (SL) A reported one day, she could not recall the exact date, Youth Services Worker (YSW) M was in Client #12's face yelling and called Client #12 names while Client #12 was in an escalation. She said YSW M yelled at Client #12 "I'm sick of this shit" and called Client #12 an "idiot". She stated YSW M was in Client #12's face yelling at him, to the point Client #12 said YSW M was spitting on him. SL A said she told YSW M several times to back away but he did not. SL A said had not reported the incident to the Administrative team. The Surveyors instructed SL A to follow the facility policy and to report the allegation immediately. When interviewed on 11/14/19 at 9:30 a.m., the Director of Inpatient Services (DIS) reported she was not aware of the allegation and SL A had not reported the incident. The DIS stated she would follow-up on the allegation. The record lacked a completed CIR into the allegation. When interviewed on 12/10/19 at 1:45 p.m., the DIS confirmed the facility had not completed a CIR for the allegation. She stated the facility had spoken to both SL A and YSW M about the alleged incident but did not feel the need to complete the CIR since YSW M's employment was terminated. Review of facility policies revealed the "ICF/ID Special Treatment Procedures", last revised 5/30/12. The procedures instructed "Allegations of consumer mistreatment, neglect or abuse and injuries of unknown origin will be investigated	W 154		

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W 154	Continued From page 63 immediately ...". Continued review of facility policies revealed the "Child Abuse and Mandatory Reporting", undated. The section titled "Conducting a child abuse investigation" instructed investigative staff needed to gather sufficient information to enable them to determine if a situation warranted a referral to DHS and establish there was reason to believe abuse occurred. The policy noted child abuse investigations may include, but was not limited to a nurse's examination of consumer injuries, statements from the alleged victim by having the victim either write or dictate specifics relating to the incident; statements from the alleged perpetrator, other staff/adults who were present, and from other clients if appropriate. It also included "Action to ensure the safety of the child, either through limiting contact, placing the alleged perpetrator on leave status per operating procedures, or reassignment of the alleged perpetrator." Additional review revealed the policy "Risk Management", last revised 11/2019. The policy instructed a CIR was to be completed and submitted by staff involved, statements and information was to be obtained from others involved in or who witnessed an incident, and the required reporting actions were to be documented. The policy included the administrative review was to identify possible causes of a problem and to determine approaches to minimize or eliminate the reoccurrence. The policy noted the Compliance officer, or designee, was responsible for ensuring timely notification to the appropriate regulatory/consumer organization. When interviewed on 11/19/19 at 9:45 a.m.,	W 154		

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W 154	Continued From page 64 Qualified Intellectual Disabilities Professional (QIDP) A explained to complete a CIR, they would obtain some verbal statements from staff, take information from the completed Accident Injury Report, and sometimes staff would e-mail information regarding an incident. QIDP A acknowledged the facility had not been following the Risk Management policy, in its entirety, regarding proper completion of CIRs by failure to identify who was interviewed, not documenting who the assigned/responsible staff was, and not interviewing any additional staff or clients who may have witnessed an incident. When interviewed on 11/19/19 at 12:05 p.m., QIDP B explained several people completed CIRs as a collaborative effort. QIDP B explained the staff and/or Shift Lead normally initiated a CIR, the Program Manager was to complete all follow-up with staff; the QIDP would review the client plans, supervision, and follow-up with the clients involved, and the DIS would complete administrative review of the CIR once completed. QIDP B stated the staff who reported an incident was interviewed but not all staff who worked at the time was interviewed. QIDP B said the facility was able to take a verbal or written statement from staff for the CIR and said the DIS had instructed the former Program Manager to summarize staff statements in the CIR. QIDP B said the facility did not interview other clients who may have witnessed an incident but did follow-up with all clients involved. QIDP B confirmed the facility had not followed facility policies, as written, regarding the completion of the CIR. She stated as a system, the facility needed to get everyone on the same page to ensure everyone completed the CIRs in the same manner.	W 154		

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W 154	Continued From page 65 When interviewed on 12/11/19 at approximately 2:40 p.m., the Inpatient Clinical Supervisor (ICS) confirmed it did not seem like the facility policies were being followed then stated she was not sure of the details since some of the allegations were made prior to her starting at the facility and also because she was still learning. When interviewed on 12/12/19 at 10:00 a.m., the Chief Operating Officer (COO) said the policy "Child Abuse and Mandatory Reporting" noted child abuse investigation "may include" but did not instruct each item was completed for each allegation. The COO continued to explain, the facility completed CIRs for all allegations of abuse, noted on the CIR "Program Staff 1, 2, etc." to identify staff interviewed, reported all allegations to the DIA, and each CIR had an Administrative review completed of the incident.	W 154		
W 155	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must prevent further potential abuse while the investigation is in progress. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure separation between the alleged perpetrator and victim following all allegations of abuse. This affected 1 client (Client #12) involved in the investigation of # and 1 former client (Client #19). Finding follows Record review on 12/11/19 revealed the following facility allegations of abuse and the corresponding facility Critical Incident Reports (CIRs), dated 4/26/19 - 12/12/19:	W 155		

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W 155	Continued From page 66 a. A CIR, dated 9/21/19, after former Client #19 reported to the nurse, while being assessed on 9/18/19, staff had bent her hand back and caused her to scrape her elbow, and the staff hurt her left shoulder by pushing her to the ground during an escalation. The CIR noted on 9/20/19, nursing assessed Client #19 again and noted she verbalized pain in her left should/arm, had a bruise on her left wrist presenting with minor swelling with a hardened area on palpation, and decreased range of motion. Client #19 informed the nurse she was telling school personnel and reporting the incident to the DHS. The facility failed to ensure separation between the alleged perpetrator and Client #19. b. A CIR, dated 10/14/19, was completed after Client #12 alleged a staff had pushed him, pushed him into a wall, hit him, and restrained him against a wall/corner during an escalation when Client #12 was being physically aggressive. The facility failed to separate the alleged perpetrator from Client #12. c. A CIR, dated 10/18/19, after Client #12 reported staff had sworn at him, flicked him off, and hit the back of his head the previous night while he was in an escalation. The facility failed to separate the alleged perpetrator from Client #12. d. A CIR, dated 10/24/19, after Client #12 reported staff pushed him during an escort. The facility failed to separate the alleged perpetrator from Client #12. e. A CIR, dated 10/24/19, after Client #12 reported staff had thrown him aggressively onto his bed but was unable to recall the time or day it	W 155		

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W 155	Continued From page 67 occurred. Client #12 had no visible injuries. The CIR noted, "QIDP Consultation with staff involved in the alleged incident." The facility failed to separate the accused staff from Client #12 after the allegation was made. f. A CIR, dated 10/28/19, after Client #12 reported staff deliberately hurt him during an escort. Following the escalation while processing with staff, Client #12 continued to say staff had abused him and reported staff hit his face and broke his finger. Nursing assessed Client #12 on 10/29/19 and noted Client #12 reported soreness in his hand and there was some redness visible but had no swelling or bruising. The facility failed to separate the alleged perpetrator from contact with Client #12. Review of facility policies revealed the "Child Abuse and Mandatory Reporting" policy, undated. The policy noted child abuse investigations may include, but was not limited to " ... Action to ensure the safety of the child, either through limiting contact, placing the alleged perpetrator on leave status per operating procedures, or reassignment of the alleged perpetrator." When interviewed on 12/11/19 at approximately 11:00 a.m., QIDP B explained she was not aware after any allegation of client abuse or neglect, the accused staff should not have contact with the victim during the investigation. She stated the facility sometimes separated the accused staff but she said she was not sure of when or why to separate the accused staff from the victim. QIDP confirmed the facility abuse policies and procedures were not followed consistently. When interviewed on 12/11/19 at 2:40 p.m., the	W 155		

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W 155	Continued From page 68 Inpatient Clinical Supervisor (ICS) explained when an allegation of abuse was made, the facility looked at various things to determine if a report needed to be filed with the DHS, which included if the child had been in a restraint, if the child felt safe, and if there was an injury. When asked, the ICS said the facility used the same, or similar, process to determine if the accused staff needed separated from the child. The ICS reviewed the above CIR's and the facility policies. The ICS said after her review of the CIRs, it did not seem like the facility policies were being followed then stated she was not sure of the details since some of the allegations were made prior to her starting at the facility and also because she was still learning.	W 155		
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: Based on observation, interviews, and record review, the Qualified Intellectual Disabilities Professional (QIDP) failed to update client Individual Program Plans (IPPs) to provide nterventions consistent with a cottage wide Consumer to Consumer Behavior Management Plan (BMP) that had been implemented in an effort to reduce the number of peer-to-peer aggressions. The QIDP failed to change client IPP interventions after a noted increase of peer-to-peer aggression and failed to ensure all identfied supports were incorporated into client programs. The facility staff failed to demonstrate the skills and competencies to effectively manage	W 158		

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W 158	Continued From page 69 inappropriate client behaviors. This led to the determiniation of an Immediate Jeopardy. Cross reference W159: Based on interview and record review, the Qualified Intellectual Disabilities Professional (QIDP) failed to consistently coordinate, integrate, and monitor client services and supports; as evidenced by failure to incorporate a cottage wide Behavior Management Plan (BMP) into all client Individual Program Plans (IPPs), failure to change interventions in client IPPs after an identified increase in peer-to-peer aggression, and failure to ensure identified client supports were incorporated into the clients IPP. Cross reference W193: Based on observations, interviews and record reviews, facility staff failed to consistently demonstrate the skills and competencies necessary to manage inappropriate client behavior.	W 158		
W 159	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on interview and record review, the Qualified Intellectual Disabilities Professional (QIDP) failed to consistently coordinate, integrate, and monitor client services and supports; as evidenced by failure to incorporate a cottage wide Behavior Management Plan (BMP) into all client Individual Program Plans (IPPs), failure to change interventions in client IPPs after an identified increase in peer-to-peer aggression, and failure to ensure identified client supports	W 159		

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were incorporated into the clients IPP. This affected 4 of 4 sample clients (Client #10, #12, #14, and #16) identified during the investigation of #86444-I, 87056-I, #87325-I, #87406-I, and potentially all clients who resided in Terry Cottage. Findings follow:

1. Record review on 11/7/19 revealed the facility peer-to-peer tracking spreadsheet. The spreadsheet noted there were 105 incidents of peer-to-peer aggression in Terry Cottage from 8/1/19 - 11/7/19. Of the 105 incidents, 77 of the incidents were by four clients; Client #10, Client #12, Client #14, and Client #16. Client #10 aggressed at his peers 18 times, Client #12 had aggressed toward his peers 18 times, Client #14 aggressed at his peers 25 times, and Client #16 aggressed toward his peers 16 times.

Continued record review revealed the following Individual Program Plans (IPPs) and updates made to client IPPs:

a. Client #10's IPP, last updated 11/7/19, to learn to manage his emotions safely and adaptively. The IPP addressed complying with authority figures decisions and following rules, to use coping skills instead of verbal aggression, to use coping skills instead of physical aggression, to use coping skills instead of self-harming. The IPP instructed when Client #10 exhibited physical aggression staff were to ask him to take a break, in the area of his choice, and give him one to two minutes to make a choice. If Client #10 continued the physical aggression, staff were to offer heavy work and/or proprioceptive interventions such as tug of war, a weighted blanked, wall push-ups, etc. If Client #10 continued to engage in physical aggression, and was a danger to himself or

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W 159	Continued From page 71 others, the IPP instructed staff to escort Client #10 to a safe place, away from triggers. If Client #10 became aggressive during the escort, staff was to offer a Mandt therapeutic physical hold. On 11/7/19, Client #10's IPP was updated to decrease the number of prompts for using a coping skills instead of verbal aggression, physical aggression, and self-harming. No intervention changes were made to the program. b. Client #12's IPP, last updated 10/29/19, to learn to manage his emotions safely and adaptively. The IPP addressed complying with authority figures and following rules, using a coping skill instead of verbal aggression, using a coping skill instead of physical aggression, and to use a coping skill instead of self-harming. The IPP instructed when Client #12 became physically aggressive, staff were to direct Client #12 to take a break in the location of his choice and give him one to two minutes to make a choice. If Client #12 continued, staff was to direct Client #12 to a specified area until he calmed. If Client #12 refused the break and continued to be aggressive, and presented a danger to himself or others, staff were to escort/guide Client #12 to a safe place, away from triggers, but were not to escort him to his bedroom noting Client #12 historically escalated when escorted to his bedroom. The IPP continued to instruct staff to use a Mandt therapeutic hold if he continued the aggression or became physically aggressive during the escort. Secure time-out was to be used if Client #12 was unable to deescalate during the Mandt therapeutic hold. On 10/7/19, Client #12's IPP was updated to reflect current medications. On 10/8/19, Client	W 159		

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W 159	Continued From page 72 #12's IPP was updated to include an objective and intervention for fixation and perseveration, as well as added using a firm voice into behavioral interventions. On 10/17/19, Client #12's IPP was updated to include the use of secure time-out. On 10/29/19, Client #12's IPP was updated to include escort preferences and guidelines for use. c. Client #14's IPP, last updated 8/20/19, to learn to manage his emotions safely and respectfully. The IPP addressed complying with authority figures and following rules, using a coping skill instead of verbal aggression, using a coping skill instead of physical aggression, using a coping skill instead of eloping, and to use a coping skill instead of becoming destructive. When Client #14 exhibited physical aggression, the IPP instructed staff to attempt to separate Client #14 from the peer he was having conflict with. Staff were to ask Client #14 to take a break in the location of his choice, giving him one to two minutes to make his choice; staff were to engage with him to promote regulation. If aggression continued and he presented a danger to himself or others, staff were to escort/guide Client #14 to a safe place away from triggers. If Client #14 continued to be physically aggressive, staff were to offer a Mandt therapeutic hold. Client #14's IPP, last updated 8/20/19, to display appropriate interactions with peers and adults. The IPP addressed displaying appropriate interactions with peers and displaying appropriate boundaries with peers and adults. The IPP noted Client #14 struggled with social relations and would get too close to people's boundaries, he struggled to understand how his behavior impacted others, and Client #14 often had disproportionate reactions to peers and could	W 159		

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become extremely reactive often lashing out physically. The IPP instructed when Client #14 exhibited inappropriate peer interactions, staff were to validate his feelings and identify the inappropriate behavior in a solution-focused manner. If he continued to exhibit inappropriate peer interactions, staff were to provide him with one to two coping skills in a quiet area. If Client #14 continued to engage in inappropriate interactions, staff were to disengage from Client #14 and praise his peers for ignoring his negative behaviors; staff were to resume contact with Client #14 immediately after he had choose to use coping skills and act in a socially expected manner. When Client #14 exhibited poor boundaries, staff were to immediately identify the poor boundary Client #14 was exhibiting and then use the opportunity to teach Client #14 how to demonstrate healthy boundaries. If Client #14 refused to practice and/or continued to exhibit poor boundaries, staff were to implement his IPP for following directions.

On 8/20/19, Client #14's IPP reinforcement procedures were updated and emotional outbursts was removed from the program.

d. Client #16's IPP, last updated 11/6/19, to learn to manage emotions and anxiety safety. The IPP addressed following rules and directions, using a coping skill instead of engaging in verbal aggression, to use a coping skill instead of becoming destructive, to use a coping skill instead of becoming aggressive. The IPP instructed when Client #16 was not following directions, engaged in verbal aggression, physical aggression, or destruction, staff were to use clear and direct phrasing to inform Client #16 what he needed to do, providing one to two options using

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W 159	Continued From page 74 a neutral voice. Staff were to ask Client #16 to take a break, in the area of his choosing, and give him one to two minutes to make a choice. The IPP continued to instruct, if Client #16 continued with aggression and presented a danger to himself or to others, staff were to escort/guide him to a safe place away from triggers. If he continued to be aggressive, staff were to provide Client #16 specific choices of where to take a break. If the aggression continued, staff were to remind Client #16 he needed to be in the designated area to ensure safety. Staff were to reduce the options for where Client #16 was able to take a break if the aggression continued. The IPP continued to instruct, if Client #16 exhibited physical aggression staff were to offer a Mandt restraint to keep everyone safe. The IPP included instructions for when Client #16 was breaking boundaries and/or inappropriate touching. The IPP instructed staff to remind Client #16 to resume appropriate behavior. If Client #16 refused, staff were to direct him to take a time away from the upsetting situation or people; staff were to give Client #16 time to make a safe/appropriate choice by giving him a time frame to process the direction and make a decision. If Client #16 refused, staff were to direct him to take a time away, in a location of his choice and where staff felt was appropriate. The IPP continued to instruct, if Client #16 exhibited verbal aggression staff were to implement his IPP that addressed verbal aggression. On 11/6/19, Client #16's IPP was updated to reflect his annual meeting and the IPP goal was to be continued; no intervention changes were made to his program.	W 159		

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W 159	Continued From page 75 When interviewed on 11/14/19 at approximately 10:45 a.m., QIDP B explained on 10/2/19 the facility had implemented a Consumer to Consumer Behavior Management Plan (BMP), effective for all the clients who resided within Terry Cottage. She said the Consumer to Consumer BMP was implemented do to the increase in peer-to-peer aggressions occurring within Terry Cottage. QIDP B said she also discussed boundaries when she met with each client individually. QIDP B confirmed there had not been any changes made to the interventions in Client #10, Client #14, or Client #16's IPPs after each client displayed an increase in peer-to-peer aggression. Additional record review revealed the Consumer to Consumer BMP, initiated 10/2/19, for all clients who resided in Terry Cottage. The plan noted it was put in place due to the frequency and intensity of the consumer-to-consumer aggressions occurring within Terry Cottage. The document noted this was to be used when any Terry Cottage client engaged in boundary-breaking behaviors including posturing aggressively towards another peer, rough-housing playfully with another peer (wrestling, grabbing, shoulder-checking, etc), physically aggressing towards another peer (punching, kicking, biting, pushing, hitting, takedowns, pinching, choking, etc.), threatening to aggress or harm another peer, attempts to engage a peer in tag by "tagging" them; pulling, pushing, or encouraging a peer to enter a bedroom, bathroom, the vent room, or family room with them, and attempting to kiss, hug, or touch in a sexualized manner. The plan instructed staff to immediately redirect the behavior and if it continued, staff were to direct the client to take a	W 159		

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W 159	Continued From page 76 break in an area of the cottage deemed safe and appropriate by staff. If the client did not stop and take a break, staff were to physically guide/escort the client to an area designated for time away. If the client became actively combative during the escort, the plan instructed staff to follow the clients IPP addressing safety, offering a therapeutic hold if danger was imminent. The plan instructed time away was to last as long as necessary to ensure safety. When interviewed on 11/19/19 at 3:00 p.m., YSW F reviewed the Consumer to Consumer BMP and stated she thought it was being implemented in Terry Cottage. YSW F confirmed client IPPs and the Consumer to Consumer BMP provided some different instructions such as the IPPs instructed to give the client a time frame to process and make a choice while the Consumer to Consumer BMP didn't. YSW F explained the Terry Cottage Consumer to Consumer BMP was implemented differently depending on what client was being addressed. She gave the example, staff knew Client #14 did not like to be touched and would physically aggress if staff put their hands on him, so staff would generally give him several redirects to take a break before staff would physically escort him. When interviewed on 11/20/19 at 11:50 a.m., YSW G said staff would follow the Terry Cottage Consumer to Consumer BMP depending on who the client was and what the client was doing. She explained Client #10, Client #14, and Client #15 would become more physically aggressive when staff had to put "hands-on" to intervene so staff would verbally redirect them several times prior to physically escorting. YSW G also explained the client IPPs normally instructed staff to provide the	W 159		

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W 159	Continued From page 77 client with a prompt and then give the client one to three minutes to make a choice, which was not what the Consumer to Consumer BMP instructed, it directed staff to immediately intervene if a client did not stop or refused to take a break. YSW G stated if a client was physically aggressing, staff normally would not wait one to three minutes for the client to decide where to take a break but instead would escort the client away. YSW G said the staff were trained to follow the client IPPs therefore the IPPs took precedence over the Consumer to Consumer BMP. When interviewed on 11/20/19 at 1:15 p.m., YSW H explained the Terry Cottage Consumer to Consumer BMP was implemented due to the overall behaviors occurring within Terry Cottage. YSW H stated the client IPPs overrode the Consumer to Consumer BMP; she stated she followed the client IPPs. YSW H gave the example Client #15 did not like to be touched so staff would try not to touch him, if possible, so staff followed his IPP and not the Consumer to Consumer BMP. When interviewed on 11/21/19 at 8:15 a.m., QIDP B explained the Terry Cottage Consumer to Consumer BMP took precedence over the client IPPs for boundary violations. She confirmed she failed to incorporate the Consumer to Consumer BMP into all Terry Cottage clients IPPs initially. QIDP B explained within the last week the Consumer to Consumer BMP was incorporated into all Terry Cottage client IPPs; she said part of the reason it was incorporated into the IPPs was due to staff uncertainty about whether to follow the client IPP or the Consumer to Consumer BMP.	W 159		

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W 159	Continued From page 78 2. Record review on 11/7/19 revealed facility self-reported incidents. The facility self-reported an incident on 9/30/19 after Client #10 reported to staff on 9/29/19 Client #12 had touched his private area. The facility completed an internal investigation into the allegation and instructed Client #10 and Client #12 were not to be podded together during the course of the internal investigation. QIDP B met with Client #10 and Client #12 individually, reviewed expectations for peer interactions, discussed age-appropriate sexual education, and teaching interventions to enhance the knowledge of appropriate social/relational skills. The facility also moved Client #10's bedroom to a different level of the cottage from Client #12. The facility completed another self-report on 10/1/19 after Client #12 alleged Client #10 had also touched his private area. The facility completed an internal investigation and instructed supervision was to continue to be heightened. QIDP B met with Client #10 and Client #12 individually, reviewed expectations for peer interactions, discussed age-appropriate sexual education, and teaching interventions to enhance the knowledge of appropriate social/relational skills. The facility also moved Client #10's bedroom to a different level of the cottage from Client #12. On 10/7/19, the facility made a third self-report after Client #14 reported Client #12 had touched his private area on 10/6/19. The facility completed an internal investigation into the alleged incident. The facility reviewed with staff Client #12's teaching interventions intended to redirect boundary invasions to be offered to Client #12 consistently and if boundary invasions with peers	W 159		

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continued, inappropriate sexualized boundaries persisted, or if Client #12 became aggressive staff were to implement his IPP for physical aggression. Staff were instructed to continue to closely monitor Client #12 for appropriate peer interactions. QIDP B met with Client #12 and reviewed age appropriate sexuality and socialization. Client #12's Interdisciplinary Team (IDT) met on 10/7/19 to discuss the severity and acuity of Client #12's challenging behaviors since his admit to the facility on 9/23/19. The internal investigation noted Client #12 had engaged in 12 incidents of peer-to-peer aggression and two allegations he had touched his peers inappropriately. The IDT discussed potential discharge if Client #12's behaviors continued at the same level of intensity.

On 11/2/19, the facility made a fourth self-report after staff observed Client #12 touching Client #14's exposed penis while watching a movie in the family room; Client #10 was also present in the family room. Staff immediately separated the clients. All clients remained separated throughout the remainder of the shift.

Record review on 12/10/2019 revealed a Critical Incident Report (CIR), dated 9/29/19. The report noted Client #14 told staff he did not feel safe around Client #12. He reported to staff Client #12 had tried to get him to go into the bathroom with him "to do inappropriate stuff". Staff noted they reassured Client #12 they would make sure he was safe and would keep a closer eye on everyone. QIDP B documented on the CIR but failed to note any changes to programming or supervision as a result.

When interviewed on 11/7/19 at approximately

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W 159	Continued From page 80 11:40 a.m., QIDP B explained the information the facility was provided prior to admitting Client #12 indicated his behaviors were a much lower severity than what Client #12 had been exhibiting since admit. She explained the facility was aware Client #12 had a history of being sexually abused but not acting out sexually toward others. She said Client #12's previous psychologist had provided some suggestions to use to work with Client #12 and the facility had incorporated some of these into Client #12's IPP. She explained not all of the suggestions were able to be incorporated due to Client #12 not exhibiting stability. Director of Inpatient Services (DIS) reported the facility had requested funding from the Managed Care Organization (MCO) for one-on-one staffing for Client #12, the MCO had approved the funding, but the facility had just received the contracts and still needed to review and sign the contract. During a follow-up interview on 11/12/19, QIDP B confirmed Client #12 needed to have a one-on-one staff due to the high and intense nature of his behaviors but the facility had not incorporated the one-on-one staff while waiting on contracts. QIDP B stated she could not recall the exact date Client #12's IDT determined one-on-one staff was needed for Client #12. When interviewed on 11/14/19 at 8:40 a.m., the Inpatient Clinical Supervisor explained she was still looking for documentation of when the IDT determined Client #12 needed to have a one-on-one staff. She showed the Surveyor an e-mail which noted funding was requested for a one-on-one staff for Client #12 on 10/16/19 and stated she was still looking for documentation of when the IDT determined Client #12 needed to have a one-on-one staff.	W 159		

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W 159	Continued From page 81 See W289 for additional information.	W 159		
W 193	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(3) Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, facility staff failed to consistently demonstrate the skills and competencies necessary to manage inappropriate client behavior. This affected 4 of 4 clients (Client #10, Client #14, Client #15) identified during the investigation of #86444- I and #87406-I, and potentially all clients who resided in Terry Cottage (Client #11, #12, #13, #17). Finding follows: Observations at Terry Cottage between 11/12/19 and 11/18/2019 revealed the following client behaviors and staff responses. Examples included, but are not limited to, the following: a. On 11/14/19 at 6:25 a.m., Client #15 began running around Terry Cottage. He verbally challenged Client #14; staff redirected Client #15 and he aggressed toward the staff. Terry Cottage has three levels with stairs between each level; Client #14 and Client #15 ran around the cottage, from the first level to the third level, making inappropriate comments to peers and staff. Staff verbally redirected the clients. At 6:30 a.m., Client #14 thrust his pelvis on the couch in a sexualized manor and laughed. Client #15 thrust his pelvis against Client #14's leg; staff redirected Client	W 193		

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W 193	Continued From page 82 #15. Staff then positioned themselves between the two clients and verbally prompted Client #15 multiple times to take a break in the vent room. At 6:40 a.m., Client #15 crawled up the steps from the second level of the cottage while holding onto staff's leg, and making cat noises; staff played along and said "Nice kitty." Client #15 continued to taunt Client #14 and yelled "Fuck you (Client #14)". Youth Service Worker (YSW) E held Client #14 back as he attempted to aggress toward Client #15. Client #14 then took YSW E's walkie-talkie and called "Back up to Unit #4"; YSW E retrieved the walkie-talkie and canceled the call for backup but several staff arrived at Terry Cottage. At 6:45 a.m. there were six staff in the cottage with five clients awake in the common areas, one staff was with Client #10 in his bedroom assisting him to get ready, Client #12 was in his bedroom asleep, and Client #16 was in his bedroom. Client #14 punched Client #13 in the left lower back before staff could separate the two. Client #15 pushed and hit staff, staff redirected him, and he continued to run around the cottage between the first and third level of the cottage, with Client #14 following him, and Client #15 began banging his head. Staff continued to verbally redirect the clients to finish their routines and get ready for school. Client #15 ran toward Client #13 and Client #13 pushed Client #15 causing Client #15 to fall back and hit his back on the staff desk. Client #15 began crying and went to his bedroom. A few minutes later, as the Surveyor walked by, Client #15 laughed as he thrust his hips in a sexualized manor against his mattress. Client #14 was by Client #15's bedroom, attempted to push staff out of his way as he was threatening and attempting to aggress at Client #15. Client #14 hit staff as the staff body positioned to block him. Client #15 then stood in	W 193		

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W 193	Continued From page 83 his bedroom door, attempting to hit YSW K in the testicles; YSW K continued to block Client #15, asked him to stop, and prompted Client #15 to take his bath and get ready for school. Client #15 laughed. Client #14 continued to attempt to aggress toward Client #15 while verbally threatening him; staff continued to body position in front of him and redirected him to get ready for school. Client #14 began to hit YSW O; YSW O redirected Client #14 and when Client #14 continued, YSW O was placed in a physical hold for less than 30 seconds. Client #14 briefly went to his bedroom. Client #14 returned to the first level to obtain clothing from his locker and began to escalate by getting loud, verbally taunting, and attempting to instigate Client #16 who was sitting in a chair on the first level. Client #14 started to hit Client #16's arm and say "tag". Staff verbally redirected Client #14, and staff positioned themselves between the clients. Client #14 aggressed toward staff, tried to reach around staff hitting at Client #16 saying "tag", and laughing. Two staff continued to position themselves in front of Client #16 while redirecting Client #14 to go finish his morning routine. Client #14 left for school at 7:19 a.m. When the observation ended at 7:28 a.m., Client #12 remained in bed and Client #15 was in the bathroom taking a bath. Facility staff continued to verbally prompt and redirect Client #14 and Client #15 but failed to implement the Consumer to Consumer Behavior Management Plan (BMP) or either clients Individual Program Plan (IPP) when the clients behavior continued. b. Observation on 11/18/2019 at 4:35 p.m. revealed seven staff present in Terry Cottage. At approximately 5:20 p.m. while downstairs in the dining room, Client #15 began to yell and	W 193		

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punched the wall. Shift Leader (SL) A redirected Client #15 and when Client #15 continued, she directed Client #15 take a break in the hallway. Client #15 took a brief break in the hallway and then returned to the dining room. At approximately 5:30 p.m., Client #15 began to make inappropriate comments and loudly whispered "pussy". SL A verbally redirected him stating the language was inappropriate; Client #15 laughed. Client #10 sat across the table from Client #15; both clients began to make various noises (passing gas), rude and inappropriate comments to each other and others in the dining room, and then would laugh. Staff reminded the clients the behavior was inappropriate and asked them to stop, but both continued. YSW G positioned herself at the table, standing between the clients; the Inpatient Clinical Supervisor (ICS) was also standing by the table. After a brief conversation, Client #15 began to make loud screeching noises, inappropriate comments, kissing gestures toward others, and then rubbed his foot on YSW G's leg. YSW G continued to redirect the clients and asked them to stop with no response. The ICS asked what they were supposed to be doing; Client #10 raised his fist at her. She asked why he wanted to hit someone and offered a high five instead. Client #10 and Client #15 continued to taunt each other; staff told Client #10 that Client #15 was trying to get him in trouble and redirected him to focus on the meal. Client #15 continued to mumble inappropriate language and comments and made inappropriate gestures to others. The ICS asked Client #15 what kind of yogurt he had, he did not respond and continued to make inappropriate comments and use foul language. As Client #10 cleared his dishes, he walked by Client #15 who attempted to grab him. YSW G positioned herself between the

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clients and again verbally redirected the clients. Client #15 reached over and pinched Client #10's forearm and Client #10 kicked Client #15 in the leg. The ICS reminded the boys of their boundaries. At 5:51p.m., Client #15 finished his meal and ran upstairs. At 5:55 p.m., Client #15 walked around the cottage and blew on several people's faces, including the Director of Inpatient Services (DIS), and thrust his hips in a sexualized manor on various items in the cottage, with minimal redirection. Client #15 continued the same behavior and staff commented the behavior was inappropriate. At 6:05 p.m. Client #16 had completed his routine/chores and was waiting to go on an outing to Wal-Mart. Client #15 brushed his teeth and was praised for doing his routine. Client #15 responded by threatening to hit staff as he walked from the first to the third level of the cottage. The ICS followed him but failed to redirect his behavior. At approximately 6:25 p.m., Client #14 approached Client #15 and made blowing noises at him. Client #15 threatened Client #14 and Client #14 did it again. Staff redirected both clients to take a break. At 6:29 p.m., Client #15 stood by the staff desk, playing with his earbuds when he broke them; Client #15 began to swear. YSW G offered to look at the earbuds and Client #15 began to name-calling, threatening, and swearing at her. YSW G verbally prompted Client #15 four times to take a break; he refused. YSW L then tells Client #15 he had one minute to go take a break or she would escort him to take a break. Client #15 continued to stand at the staff desk, softly calling staff names and then asked for help. YSW G attempts to look at the earbuds and Client #15 hit staff and hit himself. YSW L then told Client #15 she was going to escort him to take a break. YSW L began to escort Client #15 to his bedroom when

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he dropped to the floor and began to hit and kick. Client #15 then crawled to the "vent" room. Client #15 exited the vent room approximately 20 seconds later, YSWL began to thank Client #15 for taking a break when he aggressed toward her. YSW L escorted Client #15 back to the vent room and told him he needed to take a five minute break. SW G attempted to give him his headphones and he threw them at her. At approximately 6:40 p.m., Client #14 refused his chore to take out the trash. Staff reminded Client #14 he needed to complete his chores so he could go off grounds; Client #14 said he was staying back. Staff continued to talk with Client #14 about the outing, completing his routine, and gave him his money for the shopping trip. Client #16 said he would help take the garbage out so they could leave. YSW L told Client #16 no, she was only taking Client #14 to take the garbage out. As Client #16 attempted to help by picking up a bag and stepping out the cottage door, YSW L told Client #16 if he was not going to listen then he would not get to go off grounds to Wal-Mart. Client #16 stepped back into the cottage while Client #14 and YSW L took the garbage outside. When Client #14 and YSW L returned inside, Client #14 lightly hit Client #16 and Client #16 lightly hit him back. The ICS reminded both clients of boundaries. Client #14 then kicked at Client #16. At 6:55 p.m., they left for Walmart. Throughout the observation, staff continued to remind the clients of boundaries, identified inappropriate behaviors clients were exhibiting, verbally redirected inappropriate behaviors but failed to consistently implement Client #14, Client #15, and Client #16's IPP as written and failed to implement the Consumer to Consumer Behavior Management Plan (BMP) as written.

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W 193	Continued From page 87 Record review revealed the following Individual Program Plans (IPPs): a. Client #10's IPP, last updated 11/7/19, to learn to manage his emotions safely and adaptively. The IPP addressed complying with authority figures decisions and following rules, to use coping skills instead of verbal aggression, to use coping skills instead of physical aggression, to use coping skills instead of self-harming. The IPP instructed when Client #10 exhibited physical aggression staff were to ask him to take a break, in the area of his choice, and give him one to two minutes to make a choice. If Client #10 continued the physical aggression, staff were to offer heavy work and/or proprioceptive interventions such as tug of war, a weighted blanked, wall push-ups, etc. If Client #10 continued to engage in physical aggression, and was a danger to himself or others, the IPP instructed staff to escort Client #10 to a safe place, away from triggers. If Client #10 became aggressive during the escort, staff was to offer a Mandt therapeutic physical hold. b. Client #14's IPP, last updated 8/20/19, to learn to manage his emotions safely and respectfully. The IPP addressed complying with authority figures and following rules, using a coping skill instead of verbal aggression, using a coping skill instead of physical aggression, using a coping skill instead of eloping, and to use a coping skill instead of becoming destructive. When Client #14 exhibited physical aggression, the IPP instructed staff to attempt to separate Client #14 from the peer he was having conflict with. Staff were to ask Client #14 to take a break in the location of his choice, giving him one to two minutes to make his choice; staff were to engage with him to promote regulation. If aggression continued and	W 193		

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W 193	Continued From page 88 he presented a danger to himself or others, staff were to escort/guide Client #14 to a safe place away from triggers. If Client #14 continued to be physically aggressive, staff were to offer a Mandt therapeutic hold. c. Client #14's IPP, last updated 8/20/19, to display appropriate interactions with peers and adults. The IPP addressed displaying appropriate interactions with peers and displaying appropriate boundaries with peers and adults. The IPP noted Client #14 struggled with social relations and would get too close to people's boundaries, he struggled to understand how his behavior impacted others, and Client #14 often had disproportionate reactions to peers and could become extremely reactive often lashing out physically. The IPP instructed when Client #14 exhibited inappropriate peer interactions, staff were to validate his feelings and identify the inappropriate behavior in a solution-focused manner. If he continued to exhibit inappropriate peer interactions, staff were to provide him with one to two coping skills in a quiet area. If Client #14 continued to engage in inappropriate interactions, staff were to disengage from Client #14 and praise his peers for ignoring his negative behaviors; staff were to resume contact with Client #14 immediately after he had choose to use coping skills and act in a socially expected manner. When Client #14 exhibited poor boundaries, staff were to immediately identify the poor boundary Client #14 was exhibiting and then use the opportunity to teach Client #14 how to demonstrate healthy boundaries. If Client #14 refused to practice and/or continued to exhibit poor boundaries, staff were to implement his IPP for following directions.	W 193		

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W 193	Continued From page 89 d. Client #15's IPP, last updated 10/17/2019, to learn to display safe behaviors. The IPP addressed Client #15's behavior when not a safety concern. The procedure instructed staff should redirect, ensure he understand expectations, limit verbal contact and occasionally remind him he won't move onto the next activity until the current one is completed. The IPP addressed verbal aggression, sexualized language and sexualized gestures. The procedure instructed staff to firmly redirect Client #15 and ask him to stop the behavior while he was provided one minute to make a decision. If the behavior continued, the client needed to be directed to time away. The IPP addressed when the client failed to follow directions and began to yell or throw things for example staff needed to remind him of what he needed to be doing. Using clear expectations and direct phrasing staff were to provide him one to two options at most. Client #15 was to be given three to five minutes to process and make a decision. Staff were to offer one to two coping skills, if needed, and give one to two minutes to make a decision. If he client failed to make a good decision and the behavior continued staff were to direct him to time away. The IPP address physical aggression. The plan instructed staff to ask the client to take time away in a location of his choice while he was provided one to two minutes to make a decision. The client should be reminded of coping options. If danger was imminent, staff were to escort/guide the client to a safe place away from triggers and use physical restraint if necessary. The IPP addressed self-harm in the form of "head-banging" due a concussion on 9/1/2018. The plan instrcuted staff to firmly tell the client to "stop now". If the client continued to hit his head staff needed to physically intervene to keep him	W 193		

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W 193	Continued From page 90 safe which included a Mandt restraint. After self-harming, Client #15 was provided two coping skills and asked to process in time away. The IPP also noted Client #15 had a soft helmet he was to wear throughout the day. The IPP addressed self-harm in the form of biting his wrist/arms. The procedure called for staff to firmly tell Client #15 to "stop now". The procedure instructed staff to validate Client #15's feelings and provide an alternative activity. Client #15 was to be given one to three minutes to process and choose an activity. At this point if the client continued self-harm staff needed to physically intervene which included a Mandt restraint. e. Client #16's IPP, last updated 11/6/19, to learn to manage emotions and anxiety safety. The IPP addressed following rules and directions, using a coping skill instead of engaging in verbal aggression, to use a coping skill instead of becoming destructive, to use a coping skill instead of becoming aggressive. The IPP instructed when Client #16 was not following directions, engaged in verbal aggression, physical aggression, or destruction, staff were to use clear and direct phrasing to inform Client #16 what he needed to do, providing one to two options using a neutral voice. Staff were to ask Client #16 to take a break, in the area of his choosing, and give him one to two minutes to make a choice. The IPP continued to instruct, if Client #16 continued with aggression and presented a danger to himself or to others, staff were to escort/guide him to a safe place away from triggers. If he continued to be aggressive, staff were to provide Client #16 specific choices of where to take a break. If the aggression continued, staff were to remind Client #16 he needed to be in the designated area to ensure safety. Staff were to	W 193		

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reduce the options for where Client #16 was able to take a break if the aggression continued. The IPP continued to instruct, if Client #16 exhibited physical aggression staff were to offer a Mandt restraint to keep everyone safe.

The IPP included instructions for when Client #16 was breaking boundaries and/or inappropriate touching. The IPP instructed staff to remind Client #16 to resume appropriate behavior. If Client #16 refused, staff were to direct him to take a time away from the upsetting situation or people; staff were to give Client #16 time to make a safe/appropriate choice by giving him a time frame to process the direction and make a decision. If Client #16 refused, staff were to direct him to take a time away, in a location of his choice and where staff felt was appropriate. The IPP continued to instruct, if Client #16 exhibited verbal aggression staff were to implement his IPP that addressed verbal aggression.

Continued record review revealed a "Consumer to Consumer BMP" for Terry Cottage, initiated 10/2/19, due to the frequency and intensity of the consumer-to-consumer aggressions occurring within the cottage. The document noted this was to be used when any Terry Cottage consumer engaged in boundary-breaking behaviors including posturing aggressively towards another peer, rough-housing playfully with another peer (wrestling, grabbing, shoulder-checking, etc), physically aggressing towards another peer (punching, kicking, biting, pushing, hitting, takedowns, pinching, choking, etc.), threatening to aggress or harm another peer, attempts to engage a peer in tag by "tagging" them; pulling, pushing, or encouraging a peer to enter a bedroom, bathroom, the vent room, or family

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room with them, and attempting to kiss, hug, or touch in a sexualized manner. The plan instructed staff to immediately redirect the behavior and if it continued, staff directed the client to take a break in an area of the cottage deemed safe or appropriate by staff. If the client did not stop and take a break, staff were to physically guide/escort the client to an area designated for time away. If the client became actively combative during the escort, the plan instructed to follow the clients IPP addressing safety, offering a therapeutic hold if danger was imminent. The plan instructed time away lasted as long as necessary to ensure safety.

Additional record review revealed a document titled "ICFID Team Meeting Agenda" dated 9/25/2019. The document revealed a section titled "Foundation rule of treatment review". The document reminded staff of many rules utilized within each cottage such as no foul language or swearing, no sexual comments or gestures allowed, no inappropriate or derogatory statements allowed, clients will not touch each other or staff, clients must maintain appropriate boundaries with peers (stay arm's length away at all times), no destruction of property and no play fighting. The agenda did not indicate how staff needed to respond to rule violations.

When interviewed on 11/12/19 at approximately 8:45 a.m., Qualified intellectual Disabilities Professional (QIDP) B stated the facility had identified an increase in the amount of peer-to-peer aggressions in Terry Cottage. She explained they started social skills/boundary group, staff were also being more diligent about redirecting clients, and if the client continued then staff were having the client take a break. She said

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W 193	Continued From page 93 many of the peer-to-peers aggressions occurred after one client would invade the personal space of another or when the kids would start wrestling/playing around. She explained the children referred to the facility had more behavioral needs and they were working with the staff to ensure more consistency and routine within the cottage. When interviewed on 11/14/19 at 7:40 a.m. YSW E reported staff often gave children what they wanted despite their behavior to avoid problems which often contradicted their IPPs. When interviewed on 11/14/19 at 10:45 a.m. QIDP B confirmed the facility had implemented a cottage wide "Consumer to Consumer BMP" for the clients who resided in Terry Cottage. She confirmed the procedures in the Consumer to Consumer BMP should have been used for every client in the house since it was implemented on 10/2/19. When interviewed on 11/19/2019 at 3:00 p.m. YSW F stated she was aware of the 10/2/19 Terry Cottage Consumer to Consumer BMP implemented in the cottage, but reported many staff did not follow it all the time for various reasons. She stated if staff followed the Consumer to Consumer BMP, it could have made the behaviors of certain clients escalate. She also stated she felt many of the new staff had not been trained adequately. When interviewed on 11/20/19 at 11:50 a.m., YSW G said staff would implement the Terry Cottage Consumer to Consumer BMP depending on who the client was and what the client was doing. She explained Client #10, Client #14, and	W 193		

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W 193	Continued From page 94 Client #15 would become more physically aggressive when staff had to put "hands-on" to intervene therefore staff would verbally redirect them several times prior to physically escorting. YSW G also explained the client IPPs normally instructed staff to provide the client with a prompt and then give the client one to three minutes to make a choice, which was not what the Consumer to Consumer BMP instructed; it directed staff to immediately intervene if a client did not stop or refused to take a break. YSW G stated if a client was physically aggressing, staff normally would not wait the one to three minutes for the client to decide where to take a break but instead would escort the client away. YSW G said the staff was trained to follow the client IPPs therefore the IPPs took precedence over the Consumer to Consumer BMP. When interviewed on 11/20/19 at 1:15 p.m., YSW H explained the Terry Cottage Consumer to Consumer BMP was implemented for the overall behaviors in Terry Cottage. YSW H stated the client IPPs overrode the Consumer to Consumer BMP; she stated she followed the client IPPs. YSW H gave the example Client #15 did not like to be touched so staff would try not to touch him, if possible, so staff followed his IPP and not the Consumer to Consumer BMP. During a follow-up interview on 11/21/19 at 8:15 a.m., QIDP B confirmed the Terry Cottage Consumer to Consumer BMP was to take precedence over the client IPPs for boundary violations. QIDP B stated all client IPPs were updated within the last week to include the Consumer to Consumer BMP instructions for boundary violations. She acknowledged staff had been confused as to whether they should	W 193		

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W 193	Continued From page 95 implement the client IPP's or the Consumer to Consumer BMP therefore to added the cottage BMP into each client's IPP. When interviewed on 11/27/19 at 8:45 a.m., YSW I said staff was trained to follow the client IPPs so most staff did not follow the Consumer to Consumer BMP put in place on 10/2/19.	W 193		
W 210	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3) Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. This STANDARD is not met as evidenced by: Based on interview and record reviews, the facility failed to complete assessments for clients within 30 days of admission. This affected 2 of 2 sample clients admitted within the past year (Client #1 and Client #10). Findings follow: 1. Record review on 11/25/19 revealed Client #1 was admitted to the facility on 5/21/19. Her Comprehensive Functional Assessment (CFA) was dated 6/28/19, which was 38 days after her admission date. Client #1's initial dietary assessment was completed on 7/29/19. Client #1's D & E (Diagnostic Evaluation) staff meeting dated 4/23/19 indicated the need for Speech, Occupational Therapy (OT) and Physical Therapy (PT) evaluations would be determined at the time of the 30-day Individual Habilitation Plan (IHP) meeting, held on 6/28/19. The team determined	W 210		

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W 210	Continued From page 96 at the IHP meeting that Speech and PT evaluations were not needed, but an OT evaluation was recommended. No OT evaluation could be located in Client #1's chart. In addition, no audiology/hearing exam could be located in Client #1's chart (See W323). When interviewed on 12/04/19 at 1:45 p.m., Qualified Intellectual Disabilities Professional (QIDP) A confirmed Client #1 did not have assessments completed within 30 days of her admission. 2. Record review on 11/21/19 revealed Client #10 was admitted to the facility on 12/07/18. His CFA was dated 12/07/18. Additional record review revealed no hearing assessment, nursing assessment or dietary assessment was completed within 30 days of admission (See W323 and W336). Client #10's 30-day staffing, dated 1/15/19, noted he had been referred for OT and Speech evaluations, but these were not located in Client #10's chart (See W322). When interviewed on 12/05/19 at 9:00 a.m., QIDP B confirmed Client #10's assessments had not been completed within 30 days of admission.	W 210		
W 226	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) Within 30 days after admission, the interdisciplinary team must prepare, for each client, an individual program plan. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the	W 226		

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W 226	Continued From page 97 facility failed to develop an Individual Habilitation Plan (IHP) within 30 days of admission. This affected 2 of 2 sample clients admitted to the facility in the past year (Client #1 and Client #10). Finding follows: 1. Record review on 11/25/19 revealed Client #1 was admitted to the facility on 5/21/19. Her 30-day Individual Habilitation Plan (IHP) team meeting was held on 6/28/19, which was 38 days after her admission date. When interviewed on 11/26/19 at 10:30 a.m. Qualified Intellectual Disabilities Professional (QIDP) A stated Client #1's 30-day IHP meeting was delayed in order to accommodate the guardian's schedule. QIDP A acknowledged the reason for the delay had not been documented. 2. Record review on 11/21/19 revealed Client #10 was admitted to the facility on 12/07/18. His 30-day IHP team meeting was held on 1/15/19, which was 39 days after the admission date. When interviewed on 11/26/19 at 9:10 a.m. QIDP B stated Client #10's 30-day IHP meeting was delayed because she took over as Client #10's QIDP and realized he needed to have his 30-day stafffing as soon as possible. It took some time to coordinate the meeting with other team members.	W 226		
W 247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility	W 247		

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failed to consistently encourage and promote client choice and opportunities for self-management and independence. This affected 5 of 5 sample clients (Client #1, Client #3, Client #10, Client #14 and Client #16) and 7 clients in addition to the sample (Clients #7, #8. #9, #11, #13, #14 and #15). Findings follow:

1. Observations at Sinclair Cottage on 11/20/19 from approximately 5:00 p.m. to 5:15 p.m. revealed Client#1, Client #3, Client #7, Client #8 and Client #9 eating dinner. Clients had been given either a spoon or fork to eat with and no knives. The menu was chicken fajitas on a large tortilla, rice and fresh fruit. There were no napkins in sight as the clients ate dinner.

2. Observation at Terry Cottage on 11/24/19 from approximately 5:05 p.m. to 5:20 p.m. revealed Client #10, Client #11, Client #13, Client #14, Client #15 and Client #16 eating dinner. There were only forks on the table. The menu was chicken patty sandwiches, French fries, corn and pudding or applesauce cups. No other utensils were provided. No napkins were in sight throughout the meal. At approximately 5:20 p.m., Client #11 used his forks and then his fingers to scoop up and eat the remaining ketchup on his plate. Client #11 then proceeded eat applesauce from a cup with a fork.

3. Observation at Sinclair Cottage on 11/21/19 at 6:30 a.m. revealed a staff person in the kitchen, serving Client #7's breakfast at the kitchen window as Client #7 stood on the dining room side of the window. The staff person measured Client #7's cereal and put it in the bowl, made a piece of toast and buttered it. Client #7 carried her breakfast items to the table and ate

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W 247	Continued From page 99 independently. 4. Observation at Sinclair Cottage on 11/21/19 at approximately 6:45 a.m. revealed Client #1 selected a container of yogurt for breakfast. Client #1 said she didn't like cold cereal for breakfast and would prefer hot cereal or eggs but those items were not available. The menu for breakfast was cold cereal, toast and fruit Monday through Friday. 5. Observation at Sinclair Cottage on 11/21/19 approximately 7:00 a.m. revealed Client #1 received her morning medications at the medication room half-door. Certified Medication Aide (CMA) A set up the medication in the medication room and handed them to Client #7 in a medication cup, with a glass of water. The CMA said nothing to Client #7 regarding the name or purpose of the medication. Client #1 did not participate in the medication pass in any way. Record review of Client #1's Comprehensive Functional Assessment (CFA), dated 6/28/19, included a Health Care section. According to the CFA, Client #1 had needs in the areas of naming her medication, naming the purpose of her medication, and indicating medication side effects. Setting up medication and indicating it was time to take her medication were listed as Not Applicable. 6. Observation at Sinclair Cottage at approximately 7:05 a.m. revealed Client #3 received his morning medications at the medication room half-door. CMA A set up the medication in the medication room and handed them to Client #7 in a medication cup, with a glass of water. The CMA said nothing to Client #3	W 247		

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regarding the name or purpose of the medication. Client #3 did not participate in the medication pass in any way.

Record review of Client #1's Comprehensive Functional Assessment (CFA), dated 12/10/18, included a Health Care section. According to the CFA, Client #3 had needs in the areas of naming his medication, naming the purpose of his medication, and indicating medication side effects. Setting up medication was listed as Not Applicable.

7. Observation at Terry Cottage on 11/20/19 at 6:10 a.m. revealed a staff person poured Client #11's cereal and milk for breakfast. At 6:30 a.m. a staff person poured cereal, milk and juice for Client #13. Neither client had any apparent physical disabilities and both ate independently.

8. Observation at Terry Cottage on 11/14/2019 at 7:20 a.m. revealed Youth Service Worker (YSW) B poured a bowl of cereal and milk for Client #16.

When interviewed on 12/3/2019 at 3:25 p.m. QIDP B confirmed staff should have allowed Client #16 the opportunity to pour his own milk and cereal. She also confirmed he was capable.

9. Observation at Terry Cottage on 11/18/2019 at 5:32 p.m. in the dining room revealed Shift Lead (SL) A brought drinks to the table for Client #14 and Client #15 after they had started the meal. At 5:34 p.m. SL A noticed the clients (#10, #14, #15) did not have napkins and provided them for them.

When interviewed on 12/3/2019 at 3:25 p.m. QIDP B confirmed clients should have been asked to get their own drinks and napkins before

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W 247	Continued From page 101 the meal. She also confirmed each client was capable. 10. Observation in Terry Cottage on 11/19/2019 at 5:00 p.m. in revealed Client #15 brought a stack of cups to the table for dinner. QIDP A then took the cups and distributed them to each client's place at the table. When interviewed on 12/3/2019 at 3:25 p.m. QIDP B confirmed staff should encourage the clients to set the table during meals as a learning opportunity. 11. Observation in Terry Cottage on 11/20/2019 at 6:27 a.m. revealed Youth Service Worker (YSW) C put Client #11's shoes on for him while he watched television. Continued observation at 7:09 a.m. revealed YSW D put Client #11's shoes on for him while he watched television. When interviewed on 12/03/19 at 3:25 p.m. QIDP B confirmed Client #11 had the ability to put on his own shoes. 12. Record review on 11/25/19 revealed Client #1 had a dietary evaluation dated 7/29/19. The dietician reviewed healthy eating habits with Client #1 and recommended one serving of the main dish at meals, increased physical activity and zero calorie water flavoring if available. When interviewed on 11/15/19 at 3:30 p.m. Client #1 said she had some zero calorie water flavoring in the past, but had used it up. Client #1 said she would need to purchase the water flavoring, because it was not provided by the facility. Client #1 indicated she didn't have the funds to purchase it.	W 247		

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W 247	Continued From page 102 When interviewed on 11/26/19 at 10:30 a.m. QIDP A said she didn't know anything about zero calorie water flavoring for Client #1. When interviewed on 12/04/19 at 12:00 p.m. and asked if the clients should be encouraged to be as independent as possible and involved with things such as medication administration, serving food, setting the table and putting on shoes, the Inpatient Clinical Supervisor said she would check into it. When interviewed on 12/04/19 at 1:45 p.m., QIDP A acknowledged staff should encourage the clients to be involved in activities of daily living and to be as independent as possible.	W 247		
W 262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to obtain consent from the Human Rights Committee for all restrictive measures. This affected 2 of 5 sample clients (Client #3 and Client #16). Findings follow: 1. Observation at the Sinclair Cottage on 11/21/19 at 7:10 a.m. revealed Client #3 got clothing from a cupboard in the common area of the home. The cupboard had been unlocked by staff. The	W 262		

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supervisor present stated the clients had clothing and hygiene items locked in individual cupboards. The items were not accessible to the clients unless staff unlocked the cupboards. When asked if this restriction applied to all of the clients, the supervisor stated some of the clients were allowed to keep clothing in their rooms. Follow up observation on 11/25/19 at 3:20 p.m. revealed Client #3 had no clothing in his room, other than a coat.

Record review on 11/24/19 revealed a written informed consent signed by Client #3's guardian and Human Rights Committee (HRC) in July 2019 listing several restrictive measures. The restricted access to clothing and hygiene items was not listed.

When interviewed on 11/25/19 at 9:20 a.m., Qualified Intellectual Disabilities Professional (QIDP) A acknowledged the restricted access to clothing and hygiene items were not included in the written informed consent for Client #3.

2. Observation at Sinclair Cottage on 11/20/19 at approximately 4:40 p.m. revealed Client #3 received his afternoon medications, which included Risperidone.

Record review on 11/21/19 revealed a psychiatry note dated 9/17/19, which recommended medication changes. The psychiatrist started two new medications: Risperidone and Lithium Carb. The psychiatrist noted he had called Client #3's mother/guardian and obtained verbal permission to start the new medications. According to Client #3's Medication Administration Record (MAR), Client #3 began taking the Risperidone on 9/17/19 and Lithium Carb on 9/18/19. The most

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W 262	Continued From page 104 recent written informed consent in Client #3's chart, signed by the guardians and HRC, was dated July 2019 and did not include Risperidone or Lithium Carb. When interviewed on 11/25/19 at 9:20 a.m. QIDP A confirmed the facility had not yet obtained written informed consent from the guardians or HRC for the two new behavior modifying medications, which had been started two months prior. 3. Record review on 11/26/2019 revealed an expired written informed consent for Client #16. The consent signed on 11/7/2018 covered the time period of 11/7/2018 to 11/6/2019. QIDP B provided a current written informed consent for the period 11/6/2019 to 11/5/2020. The guardian signed the current consent on 11/22/2019 (16 days after implementation) and the HRC representative signed on 11/25/2019 (19 days after implementation). Both consents authorized many restrictive measures such as but not limited to: physical escort, physical restraint and secure time out, reduction of privileges, non-exclusionary time out, personal items locked up and eight psychotropic medications. When interviewed on 11/26/2019 at 10:00 a.m., QIDP B confirmed the HRC failed to sign the current consent until 11/25/2019 (19 days after implementation).	W 262		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a	W 263		

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W 263	Continued From page 105 minor) or legal guardian. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility's Human Rights Committee (HRC) failed to ensure written guardian consent prior to implementation of all restrictive measures. This affected 3 of 5 sample clients (Client #3, Client #10 and Client #16). Findings follow: 1.Observation at the Sinclair Cottage on 11/21/19 at 7:10 a.m. revealed Client #3 got clothing from a cupboard in the common area of the home. The cupboard had been unlocked by staff. The supervisor present stated the clients had clothing and hygiene items locked in individual cupboards. The items were not accessible to the clients unless staff unlocked the cupboards. When asked if this restriction applied to all of the clients, the supervisor stated some of the clients were allowed to keep clothing in their rooms. Follow up observation on 11/25/19 at 3:20 p.m. revealed Client #3 had no clothing in his room, other than a coat. Record review on 11/24/19 revealed a written informed consent signed by Client #3's guardian and Human Rights Committee (HRC) in July 2019 listing several restrictive measures. The restricted access to clothing and hygiene items was not listed. When interviewed on 11/25/19 at 9:20 a.m. Qualified Intellectual Disabilities Professional (QIDP) A acknowledged the restricted access to clothing and hygiene items were not included in the written informed consent for Client #3 .	W 263		

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W 263	Continued From page 106 2. Observation on 11/20/19 at approximately 4:40 p.m. revealed Client #3 received his afternoon medications, which included Risperidone. Record review on 11/21/19 revealed a psychiatry note dated 9/17/19, which recommended medication changes. The psychiatrist started two new medications: Risperidone and Lithium Carb. The psychiatrist noted he had called Client #3's mother/guardian and obtained verbal permission to start the new medications. According to Client #3's Medication Administration Record (MAR), Client #3 began taking the Risperidone on 9/17/19 and Lithium Carb on 9/18/19. The most recent written informed consent in Client #3's chart, signed by the guardians and HRC, was dated July 2019 and did not include Risperidone or Lithium Carb. When interviewed on 11/25/19 at 9:20 a.m. QIDP A confirmed the facility had not yet obtained written informed consent from the guardians or HRC for the two new behavior modifying medications, which had been started two months prior. 3. Record review on 11/21/19 revealed Client #10 had prescribed behavior modifying medications of Concerta, Methylphenidate, Divalproex, Escitalopram and Quetiapine. A written informed consent signed by the guardian and HRC in April 2019 listed the medications of Concerta, Ritalin (Methylphenidate), Depakote (Divalproex), Seroquel (Quetiapine) and Clonidine. Escitalopram/Lexapro was not listed on the consent. A review of the Medication Administration Record (MAR) revealed Client #10 started taking Escitalopram/Lexapro on 6/18/19. A review of the Medication Administration Record	W 263		

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W 263	Continued From page 107 (MAR) revealed Client #10 started taking Escitalopram/Lexapro on 6/18/19. QIDP B later provided a current written informed consent, which included the Lexapro, signed by the guardian on 9/18/19, which was three months after Client #10 began taking the medication. An HRC representative signed the consent on 11/25/19. When interviewed on 12/03/19 at 4:15 p.m., QIDP B said the facility had obtained verbal consent from the guardian for the Escitalopram/Lexapro, but had not obtained written guardian consent until 9/18/19. QIDP B located a Authorization for Medication form, which showed Client #10's guardian had given verbal consent for Lexapro on 6/14/19, but the form was not signed by the guardian. 4. Record review on 11/26/2019 revealed an expired written informed consent for Client #16. The consent signed on 11/7/2018 covered the time period of 11/7/2018 to 11/6/2019. QIDP B provided a current written informed consent for the period 11/6/2019 to 11/5/2020. The guardian signed the current consent on 11/22/2019 (16 days after implementation) and the HRC representative signed on 11/25/2019 (19 days after implementation). Both consents authorized many restrictive measures such as but not limited to: physical escort, physical restraint and secure time out, reduction of privileges, non-exclusionary time out, personal items locked up and eight psychotropic medications. When interviewed on 11/26/2019 at 10:00 a.m., QIDP B acknowledged the guardian and HRC provided written consent for the restrictions after the prior consent had expired.	W 263		

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W 289	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(4) The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure all behavior management interventions were incorporated into client Individual Program Plans (IPPs). This affected 4 of 4 sample clients (Client #10, #12, #14, and #16) who resided in Terry Cottage and potentially all clients who resided in Terry Cottage (Client #11, #13, #15, and #17). Findings follow: Record review on 11/7/19 revealed the facility peer-to-peer tracking spreadsheet, dated 8/1/19 - 11/7/19. The spreadsheet revealed in Terry Cottage there were 105 incidents of peer-to-peer aggression between 8/1/19 - 11/7/19 in which four clients were the aggressors of 77 of the 105 incidents. Client #10 had aggressed his peers 18 times, Client #12 had aggressed his peers 18 times, Client #14 aggressed his peers 25 times, and Client #16 aggressed his peers 16 times. Additional record review revealed the following Individual Program Plans (IPPs): a. Client #10's IPP, last updated 11/7/19, to learn to manage his emotions safely and adaptively. The IPP addressed complying with authority figures decisions and following rules, to use	W 289		

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W 289	Continued From page 109 coping skills instead of verbal aggression, to use coping skills instead of physical aggression, to use coping skills instead of self-harming. The IPP instructed when Client #10 exhibited physical aggression staff were to ask Client #10 to take a break, in the area of his choice, and give him one to two minutes to make a choice. If Client #10 continued the physical aggression, staff were to offer heavy work and/or proprioceptive interventions such as tug of war, a weighted blanked, wall push-ups, etc. If Client #10 continued to engage in physical aggression and was a danger to himself or others, the IPP instructed staff to escort Client #10 to a safe place, away from triggers. If Client #10 became aggressive during the escort, staff was to offer a Mandt therapeutic physical hold. b. Client #12's IPP, last updated 10/29/19, to learn to manage his emotions safely and adaptively. The IPP addressed complying with authority figures and following rules, using a coping skills instead of verbal aggression, using a coping skill instead of physical aggression, and to use a coping skill instead of self-harming. The IPP instructed when Client #12 became physically aggressive, staff were to direct Client #12 to take a break in the location of his choice and give him one to two minutes to make a choice. If Client #12 continued, staff were to direct Client #12 to a specified area until he calmed. If Client #12 refused the break and continued to be aggressive, and presented a danger to his self or others, staff were to escort/guide Client #12 to a safe place, away from triggers, but was not to be escorted to his bedroom noting Client #12 historically escalated when escorted to his bedroom. The IPP continued to instruct staff to use a Mandt therapeutic hold if he continued the	W 289		

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aggression or became physically aggressive during the escort. Secure time-out was to be used if Client #12 was unable to deescalate during the Mandt therapeutic hold.

c. Client #14's IPP, last updated 8/20/19, to learn to manage his emotions safely and respectfully. The IPP addressed complying with authority figures and following rules, using a coping skill instead of verbal aggression, using a coping skill instead of physical aggression, using a coping skill instead of eloping, and to use a coping skill instead of becoming destructive. When Client #14 exhibited physical aggression, the IPP instructed staff to attempt to separate Client #14 from the peer he was having conflict with. Staff were to ask Client #14 to take a break in the location of his choice, giving him one to two minutes to make his choice; staff were to engage with him to promote regulation. If aggression continued and presented a danger to himself or others, staff were to escort/guide Client #14 to a safe place away from triggers. If Client #14 continued to be physically aggressive, staff were to offer a Mandt therapeutic hold.

d. Client #14's IPP, last updated 8/20/19, to display appropriate interactions with peers and adults. The IPP addressed displaying appropriate interactions with peers and displaying appropriate boundaries with peers and adults. The IPP noted Client #14 struggled with social relations and would get too close to people's boundaries, he struggled to understand how his behavior impacted others, and Client #14 often had disproportionate reactions to peers and could become extremely reactive often lashing out physically. The IPP instructed when Client #14 exhibited inappropriate peer interactions, staff

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were to validate his feelings and identify the inappropriate behavior in a solution-focused manner. If he continued to exhibit inappropriate peer interactions, staff were to provide him with one to two coping skills in a quiet area. If Client #14 continued to engage in inappropriate interactions, staff were to disengage from Client #14 and praise his peers for ignoring his negative behaviors and to resume contact with Client #14 immediately after he had choose to use coping skills and act in a socially expected manner. When Client #14 exhibited poor boundaries, staff were to immediately identify the poor boundary Client #14 was exhibiting and then use the opportunity to teach Client #14 how to demonstrate healthy boundaries. If Client #14 refused to practice and/or continued to exhibit poor boundaries, staff were to implement his IPP for following directions.

e. Client #16's IPP, last updated 11/6/19, to learn to manage emotions and anxiety safety. The IPP addressed following rules and directions, using a coping skill instead of engaging in verbal aggression, to use a coping skill instead of becoming destructive, to use a coping skill instead of becoming aggressive. The IPP instructed when Client #16 was not following directions, engaged in verbal aggression, physical aggression, or destruction, staff were to use clear and direct phrasing to inform Client #16 what he needed to do, providing one to two options using a neutral voice. Staff were to ask Client #16 to take a break, in the area of his choosing, and give him one to two minutes to make a choices. The IPP continued to instruct, if Client #16 continued with aggression and presented a danger to himself or to others, staff were to escort/guide him to a safe place away from triggers. If he

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continued to be aggressive, staff were to provide Client #16 specific choices of where take a break. If the aggression continued, staff were to remind Client #16 he needed to be in the designated area to ensure safety. Staff were to reduce the options for where Client #16 was able to take a break if the aggression continued. The IPP continued to instruct, if Client #16 exhibited physical aggression staff were to offer a Mandt restraint to keep everyone safe.

The IPP included instructions for when Client #16 was breaking boundaries and/or inappropriate touching. The IPP instructed staff to remind Client #16 to resume appropriate behavior. If Client #16 refused, staff were to direct him to take a time away from the upsetting situation or people; staff were to give Client #16 time to make a safe/appropriate choice by giving him a time frame to process the direction and make a decision. If Client #16 refused, staff were to direct him to take a time away, in a location of his choice and where staff felt was appropriate. The IPP continued to instruct, if Client #16 exhibited verbal aggression staff were to implement his IPP which addressed verbal aggression.

When interviewed on 11/12/19 at approximately 8:45 a.m., Qualified intellectual Disabilities Professional (QIDP) B stated the facility had identified an increase in the amount of peer-to-peer aggressions in Terry Cottage. She explained they started social skills/boundary group, staff were also being more diligent about redirecting clients, and if the client continued then staff were having the client take a break. She said many of the peer-to-peers aggressions occurred after one client would invade the personal space of another or when the kids would start

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wrestling/playing around. QIDP B explained since Client #12 moved into the facility, the Interdisciplinary team (IDT) had continued to meet and have tried to incorporate more structure. She said there had been several changes made to Client #12's IPP including adding interventions to address perseverating, secure time-out was added, and the facility was looking to get a one-on-one staff for Client #12. She explained the children being referred to the facility had more behavioral needs and they were working with the staff to ensure more consistency and routine.

When interviewed on 11/14/19 at approximately 9:30 a.m., the Director of Inpatient Services (DIS) and the Chief Operating Officer (COO) acknowledged an increase in the amount of peer-to-peer aggressions in Terry Cottage. Both discussed Client #12 was the factor for the increase but acknowledged Client #10, Client #14, and Client #16 had frequently engaged in peer-to-peer aggressions. The DIS and COO stated they knew a Cottage Behavior Management Plan (BMP) was put into place in Terry Cottage. The COO said these were the types of referrals/kids the facility was getting and the bigger issue was the facility was not receiving funding consistently for things such as one-on-one staffing.

Additional record review revealed program plan updates, which included:

a. On 11/7/19, Client #10's IPP was updated to decrease the number of prompts for using a coping skills instead of verbal aggression, physical aggression, and self-harming. No intervention changes were made to the program.

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W 289	Continued From page 114 b. On 10/7/19, Client #12's IPP was updated to reflect current medications. On 10/8/19, Client #12's IPP was updated to include an objective and intervention for fixation and perseveration, as well as added using a firm voice into behavioral interventions. On 10/17/19, Client #12's IPP was updated to include the use of secure time-out. On 10/29/19, Client #12's IPP was updated to include escort preferences and guidelines for use. c. On 8/20/19, Client #14's IPP reinforcement procedures were updated and emotional outbursts was removed from his program. d. On 11/6/19, Client #16's IPP was updated to reflect the annual meeting and the IPP goal was to be continued; no intervention changes were made to his program. Continued record review revealed "Consumer to Consumer BMP (Behavior Management Plan)", initiated 10/2/19. The plan noted it was put in place due to the frequency and intensity of the consumer-to-consumer aggressions occurring within Terry Cottage. The document noted this was to be used when any Terry Cottage client engaged in boundary-breaking behaviors including posturing aggressively towards another peer, rough-housing playfully with another peer (wrestling, grabbing, shoulder-checking, etc), physically aggressing towards another peer (punching, kicking, biting, pushing, hitting, takedowns, pinching, choking, etc.), threatening to aggress or harm another peer, attempts to engage a peer in tag by "tagging" them; pulling, pushing, or encouraging a peer to enter a bedroom, bathroom, the vent room, or family room with them, and attempting to kiss, hug, or	W 289		

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W 289	Continued From page 115 touch in a sexualized manner. The plan instructed staff to immediately redirect the behavior and if it continued, staff were to direct the client to take a break in an area of the cottage deemed safe and appropriate by staff. If the client did not stop and take a break, staff were to physically guide/escort the client to an area designated for time away. If the client became actively combative during the escort, the plan instructed staff to follow the clients IPP addressing safety, offering a therapeutic hold if danger was imminent. The plan instructed time away was to last as long as necessary to ensure safety. When interviewed on 11/14/19 at 7:40 a.m., Youth Services Worker (YSW) E stated he was not aware of any changes to Client #10, Client #14, or Client #16's IPP's. YSW E explained a Behavior Management Plan (BMP) was put into place for all the clients who resided in Terry Cottage do to an increase in peer-to-peer aggressions and the overall behaviors that had occurred within Terry Cottage. When interviewed on 11/14/19 at approximately 10:45 a.m., QIDP B explained the facility had implemented a Consumer to Consumer BMP, effective for all the clients who resided within Terry Cottage, on 10/2/19. She said the Consumer to Consumer BMP was implemented do to the increase in peer-to-peer aggressions occurring within Terry Cottage. QIDP B said she also discussed boundaries when she met with each of the clients individually. QIDP B confirmed there had not been any changes made to the interventions in Client #10, Client #14, or Client #16's IPPs after each client displayed an increase in peer-to-peer aggression.	W 289		

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W 289	Continued From page 116 When interviewed on 11/19/19 at 3:00 p.m., YSW F reviewed the Consumer to Consumer BMP and stated she thought it was being implemented in Terry Cottage. YSW F confirmed client IPPs and the Consumer to Consumer BMP had some different instructions, primarily the client IPPs generally gave the client a period of time, approximately one to three minutes, to process a prompt. YSW F explained she thought the Terry Cottage Consumer to Consumer BMP implementation was different depending on what client was being addressed. She gave the example, staff knew Client #14 did not like to be touched and would physically aggress if staff put their hands on him, so staff would generally give him several redirects to take a break before staff would physically escort him. When interviewed on 11/20/19 at 11:50 a.m., YSW G said staff would implement the Terry Cottage Consumer to Consumer BMP depending on who the client was and what the client was doing. She explained Client #10, Client #14, and Client #15 would become more physically aggressive when staff had to put "hands-on" to intervene therefore staff would verbally redirect them several times prior to physically escorting. YSW G also explained the client IPPs normally instructed staff to provide the client with a prompt and then give the client one to three minutes to make a choice, which was not what the Consumer to Consumer BMP instructed, it directed staff to immediately intervene if a client did not stop or refused to take a break. YSW G stated if a client was physically aggressing, staff normally would not wait the one to three minutes for the client to decide where to take a break but instead would escort the client away. YSW G said the staff were trained to follow the client IPPs	W 289		

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W 289	Continued From page 117 therefore the IPPs took precedence over the Consumer to Consumer BMP. When interviewed on 11/20/19 at 1:15 p.m., YSW H explained the Terry Cottage Consumer to Consumer BMP was implemented for the overall behaviors in Terry Cottage. YSW H stated the client IPPs overrode the Consumer to Consumer BMP; she stated she followed the client IPPs. YSW H gave the example Client #15 did not like to be touched so staff would try not to touch him, if possible, so staff followed his IPP and not the Consumer to Consumer BMP. When interviewed on 11/21/19 at 8:15 a.m., QIDP B confirmed the Terry Cottage Consumer to Consumer BMP was to take precedence over the client IPPs for boundary violations. She stated all client IPPs were updated within the last week to include the Consumer to Consumer BMP instructions for boundary violations. When interviewed on 11/27/19 at 8:45 a.m., YSW I said staff were trained to follow the client IPPs so most staff did not follow the Consumer to Consumer BMP put in place. Review of facility policies revealed the "ICF/ID Special Treatment Procedures", last revised 5/30/19. The section titled "Harassment and Violence Toward Others" noted harassment and violence toward others would not be tolerated. The procedure instructed, "Children who experience interpersonal conflicts will be placed in separate treatment pods. Alternative intervention is to place the child on Shadow, in which a child who is harassing another child will have to remain at arm's length of staff. Should harassment or violence continue, a Special Care	W 289		

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W 289	Continued From page 118 Review may be called in an interdisciplinary effort to problem-solve strategies/interventions to be attempted." When interviewed on 12/5/19 at 9:40 a.m., QIDP B confirmed the facility had not been following the procedure in its entirety regarding violence towards others.	W 289		
W 322	PHYSICIAN SERVICES CFR(s): 483.460(a)(3) The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility nursing department failed to follow up on assessments in the areas of Speech, Occupational Therapy (OT) and Physical Therapy (PT). This affected 4 of 5 sample clients. (Client #1, Client #3, Client #10, Client #16). Findings follow: 1. Record review on 11/25/19 revealed Client #1's D & E (Diagnostic Evaluation) staff meeting dated 4/23/19. According to the D & E the need for Speech, OT and PT evaluations would be determined at the time of the 30-day Individual Habilitation Plan (IHP) meeting, held on 6/28/19. The team determined at the IHP meeting that Speech and PT evaluations were not needed, but an OT evaluation was recommended. No OT evaluation could be located in Client #1's chart. When interviewed on 11/25/19 at 10:00 a.m., the Health Assistant (HA) confirmed an OT evaluation	W 322		

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had not yet been completed for Client #1. He stated there had been a conflict with the agency providing the OT services, so the evaluations were not done for a period of time. The HA acknowledged there were other providers in the area that also provided OT services.

2. Record review on 11/21/19 revealed Client #3's D & E staff meeting dated 5/21/18. According to the D & E, Client #3 had been referred for OT and PT evaluations and the Qualified Intellectual Disabilities Professional (QIDP) would request a Speech evaluation from the school system. Client #3 had an OT evaluation in his chart dated 11/01/18, with several additional follow-up visits to work on core strengthening. No evaluations for PT or Speech could be located in Client #3's chart.

When interviewed on 11/25/19 at 9:20 a.m. the Health Services Manager/Registered Nurse (HSM/RN) said she didn't know of any PT or Speech assessments for Client #3. She said the school might have completed a speech assessment, but it was not located in Client #3's chart.

When interviewed on 12/03/19 at 1:30 p.m., QIDP A said she was not Client #3's QIDP at the time of his D & E meeting in May 2018. She said she didn't know of a speech evaluation for Client #3.

3. Record review on 11/21/19 revealed Client #10's D & E dated 11/21/18 and 11/30/18. According to the D & E Client #10 had been referred for an OT evaluation, which would also determine whether Client #10 needed a PT evaluation. The D & E also noted Client #10 had been referred for a Speech evaluation. Client

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W 322	Continued From page 120 #10's 30-day IHP dated 1/15/19 noted Client #10 had been referred for a Speech evaluation and an OT evaluation. The IHP indicated Client #10 would be referred for a PT evaluation if recommended by the OT evaluation. Additional record review revealed no evaluations for OT, PT or Speech could be located in Client #10's chart. When interviewed on 11/25/19 at 9:40 a.m., QIDP B stated Client #10 was on a waiting list for an OT evaluation and it had not yet been completed. QIDP B said Client #10 received Speech services at school. 4. Record review on 11/25/2019 revealed Client #14's D & E staff meeting dated 5/21/2018. According to the D & E, Client #14 had been referred to Speech, OT, and PT for evaluations. Client #14 had an OT evaluation in his chart dated 12/6/2018 and this report did not make reference to whether Speech or PT assessments were needed. When interviewed on 11/25/2019 at 11:30 a.m., the HA confirmed Speech and PT evaluations had not been completed for Client #14. He stated if OT thought the client needed PT or Speech they would have documented it on their evaluation, but they did not so the facility did not pursue evaluations.	W 322		
W 323	PHYSICIAN SERVICES CFR(s): 483.460(a)(3)(i) The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.	W 323		

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W 323	Continued From page 121 This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to obtain vision and hearing evaluations at least annually. This affected 3 of 5 sample clients (Client #1, Client #3 and Client #10). Findings follow: 1. Record review on 11/25/19 revealed an audiology exam/hearing assessment could not be located in Client #1's chart. Client #1 was admitted to the facility on 5/21/19. The D & E (Diagnostic Evaluation) dated 4/23/19 listed Audiology under the Medical Section, but it was blank. Client #1's 30-day Individual Habilitation Plan (IHP) dated 6/28/19 had "pass whisper test" written next to Audiology. When interviewed on 11/26/19 at 8:45 a.m., the Health Assistant (HA) confirmed he was unable to locate a hearing evaluation for Client #1. 2. Record review on 11/25/19 revealed an audiology exam/hearing assessment could not be located in Client #3's chart. Client #3 was admitted to the facility on 6/11/18. The D & E report dated 6/21/19 noted "Audiology: 6/11/18", however the assessment was not located in Client #3's chart. Client #3's 30-day IHP dated 6/11/18 indicated he had passed his hearing exam on 6/11/18. When interviewed on 11/25/19 at 9:50 a.m., the Health Service Manager/Registered Nurse (HSM/RN) stated she was fairly new to the agency. She was unable to find any documentation of a hearing assessment for Client #3. 3. Record review on 11/25/19 revealed Client #3	W 323		

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had an eye exam with an eye doctor on 7/26/18. According to the exam report, Client #3 had astigmatism in his left eye. Glasses were prescribed, but optional. The report noted, "Recall in 1 year for Annual Eye Exam." Client #3's Health Report, dated 11/05/19, noted Client #3's last vision screening was done on 7/26/18 and no follow up appointment was necessary. No additional vision screening could be located in Client #3's chart.

When interviewed on 11/25/19 at 9:50 a.m., the HSM/RN stated Client #3's vision had likely been assessed at his annual physical, but would have been documented on the form used by the physician's office and was not part of the client's facility record. The HSM/RN obtained a copy of the physician's physical form on 11/25/19, which noted visual acuity was 20/20 in both eyes. Although Client #3's vision had apparently been assessed at his annual physical on 5/09/19, there was no follow up appointment with a professional eye doctor, as recommended by the eye doctor on 7/26/18.

3. Record review on 11/21/19 revealed Client #10's 30-day IHP meeting, dated 1/15/19, which noted "hearing test passed during admit nursing assessment". Client #10 had been admitted to the facility on 12/07/18. A review of nursing assessments revealed no information could be located regarding a hearing assessment for Client #10.

When interviewed on 11/26/19 at 10:00 a.m., the Health Assistant confirmed he could not locate any documentation regarding a hearing assessment.

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W 323	Continued From page 123 Additional record review on 12/03/19 revealed quarterly or annual nursing assessments were completed for Client #10 on 11/26/19, 9/17/19 and 6/17/19. Client #10 was admitted to the facility on 12/07/18. There were nursing notes dated 12/07/18, 12/11/18 and 12/14/18 noting Client #10 refused to come to the nursing office for a nursing assessment. There was no documentation of the nurse going to Client #10's cottage to attempt to assess him. There was no evidence a nursing assessment was done until 6/17/19, which was seven months after admission. When interviewed on 12/03/19 at 4:15 p.m., the Health Assistant acknowledged the first nursing assessment for Client #10 was completed seven months after his admission.	W 323		
W 336	NURSING SERVICES CFR(s): 483.460(c)(3)(iii) Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure quarterly nursing assessments were consistently completed. This affected 4 of 5 sample clients (Client #3, Client #10, Client #14 and Client #16). Findings follow: 1. Record review on 11/21/19 revealed an annual nursing assessment was completed for Client #3 on 7/01/19. No quarterly nursing assessment	W 336		

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W 336	Continued From page 124 since 7/01/19 could be located in Client #3's chart. When interviewed on 11/24/19 at 9:50 a.m., the Health Services Manager/Registered Nurse (HSM/RN) stated Client #3 had refused to come to the nursing office on 9/11/19 for his scheduled quarterly nursing assessment. The nursing office is located in a different building on the Tanager campus, which has several group homes and office buildings. The HSM/RN indicated no further attempts had been made to complete a quarterly nursing assessment with Client #3. She said she had not attempted to go to Client #3's group home/cottage to do the nursing assessment. Additional record review on 12/03/19 revealed a quarterly nursing assessment dated 3/28/19 was in Client #3's chart, but the quarterly assessment done prior to that was dated 9/11/18, six months earlier. During a follow-up interview on 12/03/19 at 11:05 a.m., the HSM/RN confirmed a quarterly nursing assessment for Client #3 was due in December 2018 and there was no documentation it had been done. 2. Record review on 12/03/19 revealed quarterly or annual nursing assessments were completed for Client #10 on 11/26/19, 9/17/19 and 6/17/19. Client #10 was admitted to the facility on 12/07/18. There were nursing notes on 12/07/18, 12/11/18 and 12/14/18 indicating that Client #10 refused to come to the nursing office for a nursing assessment. There was no documentation of the nurse going to Client #10's cottage to attempt to assess him. There was no evidence a nursing assessment was done until 6/17/19, which was	W 336		

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W 336	Continued From page 125 seven months after admission. 3. Record review on 12/03/19 revealed quarterly or annual nursing assessments were completed for Client #14 on 11/25/19, 8/23/19, 5/21/19 and 11/19/18. No nursing assessment was completed in the six month period between November 2018 and May 2019. 4. Record review on 12/03/19 revealed quarterly or annual nursing assessments were completed for Client #16 on 11/25/19, 8/29/19, 5/22/19 and 11/27/18. No nursing assessment was completed in the six month period between November 2018 and May 2019. When interviewed on 12/03/19 at 4:15 p.m., the Health Assistant confirmed the missing quarterly nursing assessments for Client #10, Client #14 and Client #16. He acknowledged the first nursing assessment for Client #10 was completed seven months after his admission.	W 336		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure quarterly (every 90 days) fire drills occurred on all shifts. This potentially affected all clients (Client #10-17) who resided in Terry Cottage. Findings follow: Record review on 11/19/19 revealed Terry Cottage fire drills, dated 10/2018 - 9/2019.	W 440		

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W 440	Continued From page 126 Review of the first shift drills revealed drills were completed on 10/13/18, 4/16/19, and 7/28/19. The record lacked a completed drill during the first quarter, January - March, of 2019. Review of the third shift fire drills revealed drills were completed in Terry Cottage on 12/29/18, 6/5/19, and 9/24/19. The record lacked any completed drills during the first quarter, January - March, of 2019. When interviewed on 11/19/19 at 10:10 a.m., the Facilities Manager explained he provided a schedule of when drills were to be completed each month in each cottage. He confirmed the fire drills were not completed on a quarterly basis in Terry Cottage on the first and third shift, per the schedule.	W 440		
W 463	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(4) The client's interdisciplinary team, including a qualified dietitian and physician must prescribe all modified and special diets. This STANDARD is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure a physician was included when determining special diets. This affected 4 of 4 sample clients with recommendations for special diets (Client #1, Client #3, Client #10 and Client #16) Finding follows: 1. Observation at Sinclair Cottage on 11/20/19 at 5:00 p.m. revealed Client #1 asked for a second serving of rice. Youth Service Worker (YSW) A	W 463		

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indicated to Client #1 she could not have a second serving of rice, due to her diet, but could have extra fruit. Client #1 asked repeatedly for more rice and complained about the serving sizes. She did not receive additional rice. When asked about dietary restrictions at approximately 5:00 p.m., YSW A stated some of the clients could have seconds, but it depended on their diet order.

Record review on 11/25/19 revealed dietary assessments completed by the dietician for Client #1, dated 7/29/19 and 8/23/19. The dietary assessments indicated Client #1 was overweight. The dietician recommended Client #1 have only one serving of the main dish at meals, but could have extra fruits and vegetables. No physician's order for Client #1's diet could be located in her chart. Client #1's 30-day Individual Habilitation Plan (IHP) was held on 6/28/19 and contained no information regarding Client #1's diet, other than to note Client #1 had been referred for a dietary evaluation.

When interviewed on 11/26/19 at 8:45 a.m., the Health Assistant (HA) stated staff followed the diet listed on each client's Cardex. He confirmed, to his knowledge, the physician had not ordered a special diet or any type of diet for Client #1.

When interviewed on 11/26/19 at 10:30 a.m., Qualified Intellectual Disabilities Professional (QIPD) A said Client #1's diet order had not been discussed at the 30-day team meeting. She said she didn't know about the diet orders, which were handled by the nursing department.

Review on 11/26/19 of Client #1's Medical Information Cardex listed her diet as "Regular",

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but below this was information from the dietician noting the main serving should be limited to one serving, with extra fruits and vegetables allowed.

2. Record review on 11/21/19 revealed Client #3 had a dietary assessment by a dietician, dated 3/14/19, in which the dietician recommended main dish and milk be limited to one serving per meal or snack. The dietary assessment indicated Client #3 was overweight. According to a dietary assessment, completed on 7/29/19, staff should encourage fruit intake and tastes of vegetables. A review of Client #3's Medical Information Cardex revealed Client #3's diet was listed as "Regular", but below there was information from the dietician noting the main dish and milk should be limited to one serving per meal/snack. No physician's order for Client #3's diet could be located in his chart. Client #3's annual IHP was held on 6/10/19 and contained no information regarding his diet, other than to note he had been referred to the dietician when admitted.

When interviewed on 11/24/19 at 9:50 a.m., the Health Services Manager/Registered Nurse (HSM/RN) confirmed the clients didn't have physician's orders for their diets. She said the staff followed the dietary recommendations by the dietician, which were listed on each client's Cardex.

3. Record review on 11/21/19 revealed Client #10's 30-day IHP, dated 1/15/19. According to the IHP, Client #10 would be referred for a dietary assessment. An initial dietary assessment with the dietician was dated 5/20/19. The dietician recommended milk and juice be limited to one serving per meal or snack and entrees be limited to one serving at meals, with additional fruits and

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	16G139	A. BUILDING _____ B. WING _____	C 12/19/2019

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vegetables if still hungry. Client #10's Medical Information Cardex listed his diet as Regular, with comments to encourage fruits and vegetables and to keep servings of milk and juice to one 8 ounce glass. Client #10's IHP, dated 6/05/19, referenced his dietary evaluation on 5/20/19. The IHP noted Client #10 was overweight, according to the dietary assessment. The IHP noted Client #10 should be encouraged to try different foods, take walks and participate in physical activity. According to the IHP, staff should encourage fruits and vegetables and keep servings of milk and juice to one 8 ounce glass. The IHP did not mention the dietary recommendation to limit entrees to one serving. Additional record review revealed current physician's orders did not include a diet order.

4. Observation at Terry Cottage on 11/18/19 at 5:19 p.m. revealed Client #16 asked for more French toast sticks. A staff person offered Client #16 a yogurt instead of the French toast sticks. Client #16 got a yogurt. Observation on 11/19/19 at 5:12 p.m. revealed Client #16 got a second serving of chicken with staff consent.

Record review on 11/25/19 revealed Client #16 had a dietary assessment completed by the dietician, dated 2/25/19. The dietary assessment indicated Client #16 was overweight. The dietician recommended Client #16 continue with single portions at meals and snacks with the exception of fruits and vegetables. The most recent dietary assessment, dated 8/23/19, recommended limiting serving size of milk/juice to 8 ounces per meal/snack and to encourage fruits, vegetables and whole grains for increased fiber. Client #16's Medical Information Cardex listed his diet as "Low fat/low cholesterol diet, increase

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W 463	Continued From page 130 fiber intake, limit high sugar food/drinks". The Cardex also noted "3/11/19 - Per Dietician: Encourage to choose fruits and vegetables when offered at meals and snacks. Single serving only of main dish and 8 oz. milk. Unlimited fruits and vegetables." Client #16's IHP, dated 5/13/19, noted "Calorie monitored diet recommended at this time." No physician's order for Client #16's special diet could be located in his chart. When interviewed on 12/03/19 at 1:45 p.m., the HSM/RN again confirmed the facility did not obtain physician's orders for special diets. She said the facility followed the recommendations of the dietician.	W 463		
W 475	MEAL SERVICES CFR(s): 483.480(b)(2)(iv) Food must be served with appropriate utensils. This STANDARD is not met as evidenced by: Based on observations, the facility failed to provide appropriate utensils at mealtimes. This potentially affected 7 of 7 clients who resided in the Sinclair Cottage during the annual survey (Client #1, Client #3, Client #4, Client #6, Client #7, Client #8 and Client #9) and 7 of 7 clients who resided in the Terry Cottage (Client #10, Client #11, Client #13, Client #14, Client #15, Client #16 and Client #17). Findings follow: 1. Observation at the Terry Cottage on 11/18/2019 at 5:09 p.m. revealed a group of clients at dinner. Client #16 had French toast sticks, hashbrowns, a sausage patty and two cups of yogurt. Client #14 had French toast sticks and hashbrowns. The clients ate the food	W 475		

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W 475	Continued From page 131 with their fingers without being offered silverware until 5:15 p.m. At 5:28 p.m., Client #15 started dinner and ate his sausage patty with fingers as no silverware was on the table. Observations over the next few days revealed Client #14, Client #15 and Client #16 all used silverware independently. When interviewed on 12/03/2019 at 3:25 p.m., Qualified Intellectual Disabilities Professional (QIDP) B confirmed all three clients should have been provided with appropriate silverware before the meal started. 2. Observation at Sinclair Cottage on 11/20/19 at 4:40 p.m. revealed Client #1 set the tables for dinner. The staff person assisting Client #1 gave her only spoons to set on the tables. After Client #1 placed four spoons on the tables, the staff person said they were out of spoons and handed Client #1 forks to put at the remaining three spots. Each client had either a fork or spoon, but not both. The menu for supper was chicken fajitas on a large tortilla shell, rice and fresh fruit. At 4:55 p.m. Client #8 was observed stabbing his entire tortilla shell with his fork and eating bites off of it. There were no knives to cut up the tortilla shells/fajitas. 3. Observation at Terry Cottage on 11/24/19 at approximately 5:00 p.m. revealed clients and staff at the dining room tables, setting up for dinner. There were only forks on the table. The menu was chicken patty sandwiches, French fries, corn, and pudding or applesauce cups. No other utensils were provided. At approximately 5:20 a.m. Client #11 used his fork and then his fingers to scoop up and eat the remaining ketchup from his plate. Client #11 proceeded to eat	W 475		

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W 475	Continued From page 132 applesauce from a cup with a fork. 4. Observation at Sinclair Cottage on 11/21/19 at 6:30 a.m. revealed a staff person serving breakfast to Client #7. The staff person buttered a piece of toast with the handle of a fork. When asked about it, the staff person said there were no butter knives in the house. 5. Observations at Sinclair Cottage on 11/24/19 at 3:20 p.m. revealed no butter knives could be located in the kitchen utensil drawer or the dishwasher. A staff person present said there were no butter knives in the house because the clients had fought with the knives in the past. She said there was one paring knife available clients could use with supervision. Record reviews on 11/21/19 and 11/25/19 revealed Client #1 and Client #3 both had butter knives listed as restricted in their written informed consents, signed by the guardians and Human Rights Committee. According to both of the written consents, butter knives should be stored in a locked drawer, but made available during appropriate times, such as lunch and dinner. The butter knives could be used with staff supervision. When interviewed on 12/04/19 at 12:00 p.m. and asked about whether clients should be provided with appropriate utensils, the Inpatient Clinical Supervisor said she would check into it. The Inpatient Clinical Supervisor did not provide any follow up information to the Surveyor.	W 475		

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C 146	50.7(3) Additional notification 481-50.7(10A,135C) Additional notification. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: 50.7(3) When there is an act that causes major injury to a resident or when a facility has knowledge of a pattern of acts committed by the same resident on another resident that results in any physical injury. For the purposes of this subrule, " pattern " means two or more times within a 30-day period. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure all patterns of peer-to-peer aggression (two or more incidents resulting in injury by the same aggressor in a 30-day period) were reported to the Iowa Department of Inspections and Appeals (DIA), as required. This affected 6 of 17 clients (Client #5, #10, #12, #13, #14, and #16). Findings follow: Record review on 11/7/19 revealed the facility Peer-to-Peer tracking spreadsheet, which included the date, clients involved, description of the incident, injury caused, follow-up, and the number of injuries cause by the aggressor within 30 days. Review of the spreadsheet revealed the following: a. On 8/24/19, Client #10 kicked Client #16 on the leg and shoved him into a cabinet. According to the 24-hour follow-up, Client #16 had a bruise on	C 146		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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C 146	Continued From page 1 the side of his stomach. b. On 9/6/19, Client #10 caused a scratch on the anterior side at the base of Client #13's neck. The 24-hour follow-up noted the scratch remained on Client #13's neck. The document noted "N/A" for number of injuries by the aggressor. c. On 9/22/19, Client #10 scratched Client #14's left wrist. The facility failed to complete 24-hour follow-up but noted on 9/27/19 a small red mark was still present on Client #14. The number of injuries by aggressor noted "(Client #10) - NA due to amended reporting policy. Red mark present after 24 hours does not necessarily qualify. No lingering pain, no medical attention required." d. On 9/28/19, Client #10 scratched Client #14 on the right side of his neck. The 24-hour follow-up noted the scratch was still visible. The number of injuries by aggressor noted "(Client #10) - NA due to amended reporting policy. Red mark present after 24 hours does not necessarily qualify. No lingering pain, no medical attention required." e. On 9/28/19, Client #10 scratched Client #14's left arm. The 24-hour follow-up noted the scratch on Client #14 was still visible. The number of injuries by aggressor noted "(Client #10) - NA due to amended reporting policy. Red mark present after 24 hours does not necessarily qualify. No lingering pain, no medical attention required." f. On 9/28/19, Client #10 and Client #12 were roughhousing and began to choke one another; Client #12 obtained a scratch on his neck. The 24-hour follow-up revealed the scratch was still present. The number of injuries by aggressor noted "(Client #10) - NA due to amended reporting policy. Red mark present after 24 hours	C 146		

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C 146	Continued From page 2 does not necessarily qualify. No first aid or medical attention required." g. On 9/29/19, Client #10 bit Client #12 on his hand. The 24-hour follow-up noted Client #12 had a scratch on the left side of his neck and red marks on both sides of his neck. The follow-up lacked any information regarding if an injury occurred on Client #12's hand. The number of injuries by aggressor noted "(Client #10) - NA due to amended reporting policy. Red mark present after 24 hours does not necessarily qualify. No first aid or medication attention required." The facility failed to report the incidents to the Iowa Department of Inspections and Appeals (DIA) after Client #10 aggressed toward his peers, resulting in injury, on 8/24/19, 9/6/19, 9/22/19, 9/28/19, 9/28/19, 9/28/19, and 9/29/19. h. On 9/8/19, Client #16 brought his right fist down onto Client #10's left shoulder causing a red mark and "what appears to be the formation of a bruise." The record lacked 24-hour follow-up but noted on 9/14/19 staff completed follow-up and noted "no visible mark, injury, or signs of discomfort observed. 24 hour follow up does not appear to have been completed." i. On 11/19/19, Client #16 hit Client #10 in the face. The 24-hour follow-up revealed Client #10 had a small circular bruise noted above the right eyebrow. The number of injuries by aggressor noted "(Client #16) - 1". j. On 11/20/19, Client #16 hit Client #10 in the face. The 24-hour follow-up noted "Initial injury was self-inflicted on 11/19, but still looked swollen, and scabbed over ..." The number of injuries by aggressor noted "(Client #16) - 2;	C 146		

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C 146	Continued From page 3 self-reported to DIA on 11/22/19 (within 24 hours of the QIDP being aware of follow up." The facility self-reported to the DIA on 11/22/19 after Client #16 had engaged in two incidents of peer-to-peer aggression with injury on 11/19/19 and 11/20/19. The facility failed to report the incidents within 24 hours. When interviewed on 11/25/19 at 11:35 p.m., Qualified Intellectual Disabilities Professional (QIDP) B stated staff had completed the Accident Injury Report for the peer-to-peer on 11/20/19 but explained the 24-hour follow-up was not reported to her until approximately 9:15 p.m. on 11/21/19 during a nightly huddle call. She explained the facility completed the self-report to DIA on 11/22/19 at approximately 8:00 p.m. QIDP B stated there was an issue with the facilities process used for tracking peer-to-peers therefore was not reported to the DIA within 24 hours. k. On 9/28/19, Client #12 attacked Client #16 by punching him in the face and kicking him. Client #10, Client #5, and Client #14 also started to hit Client #16 in the face and kick him in his private parts; Client #5 hit Client #16 in the face with her lanyard. The 24-hour follow-up noted Client #16's lip was no longer bleeding but was cut and red. The number of injuries by aggressor noted "(Client #12) - NA due to amended reporting policy. Following consult with (Director of Inpatient Services (DIS)) and (Qualified Intellectual Disabilities Professional (QIDP) B), this does not meet criteria as injury did not result in outside medication attention." There was no additional information regarding Client #5, #10, or #14 potentially causing the injury to Client #12's lip.	C 146		

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C 146	Continued From page 4 l. On 9/29/19, Client #12 hit Client #10 in the face. 24-hour follow-up was not completed but noted on 10/6/19 Client #10 was assessed and noted his lip was swollen and there was a cut on the bottom lip. The injuries by aggressor noted "(Client #12) - NA due to amended reporting policy. Following consult with the (DIS) and (QIDP) B, this does not meet criteria as injury did not result in outside medication attention." m. On 10/3/19, Client #12 punched Client #10 in the face. The initial injury noted Client #10's entire face was swollen and had a red mark covering most of the left side of his face. The 24-hour follow-up noted Client #10 had bruising around his eye. The injuries by aggressor noted "(Client #12) - NA due to amended reporting policy. Following consult with the (DIS) and (QIDP B), this does not meet criteria as injury did not result in outside medical attention." n. On 10/5/19, Client #12 punched Client #10 in the face. The 24-hour follow-up revealed Client #10's lip was swollen and there was a cut on the bottom lip. The injuries by aggressor noted "(Client #12) - NA due to amended reporting policy. Following consult with the (DIS) and (QIDP B), this does not meet criteria as injury did not result in outside medical attention." o. On 10/6/19, Client #12 punched Client #13 on the left side of his mouth. The 24-hour follow-up noted Client #13 had a small cut that appeared to be healing. The injuries by aggressor noted "(Client #12) - NA. Consult re: this incident meeting criteria for possible self-report has been completed by (QIDP B) to (DIS). Resulting injury is minor: (Client #12) continues to have significant adjustments and modifications to his programing to aid in stabilization. His IDT continues to meet	C 146		

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C 146	Continued From page 5 regularly to explore his ongoing appropriateness for this program." p. On 10/13/19, Client #12 punched Client #13 in the mouth. The 24-hour follow-up noted Client #13 had a small cut on his bottom lip. The injuries by aggressor noted "(Client #12) - resulting injury is minor; (Client #12) continues to have significant adjustments and modifications to aid in stabilization. His IDT continues to meet regularly to explore his ongoing appropriateness for this program." q. On 11/2/19, Client #12 punched Client #14 on the left eye. The 24-hour follow-up noted Client #14 had a bruise on his eye. The injuries by aggressor noted, "A consumer to consumer narrative was not initially completed for this incident. However, an (Accident Injury Report) was. This was given to DIA on-site on 11/12/19. Determined peer involvement on 11/17/19. At this time, this would not have been reported per our interpretation of peer to peer policy. However, following our amendment on 11/13/19, this would now meet criteria to report." The facility failed to report the incidents of peer-to-peer aggression resulting in injury by Client #12 on 9/28/19, 9/29/19, 10/3/19, 10/5/19, 10/6/19, 10/13/19, and 11/2/19 to the DIA, as required. Review of the facility policy "ICFID Peer To Peer Guidelines", undated, instructed "If a consumer has aggressed towards a peer(s) resulting in injury twice in a 30 day period, it must be reported to DIA. For the purposes of this reporting guideline, injury is described as significant and could include abrasion, cut, bite, or bruise lasting longer than 24 hours requiring a healing process.	C 146		

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C 146	Continued From page 6 For the purposes of this reporting guideline, lingering pain, soreness, or red marks may not meet criteria for "injury"; these will be assessed on an individual basis and will continue to be monitored via the aforementioned process." When interviewed on 11/12/19 at 10:30 a.m., Qualified Intellectual Disabilities Professional (QIDP) B stated from her understanding, the facility revised the policy regarding peer-to-peer aggression and how injury was defined to allow for the facility to determine if something would be considered an injury or not. She said cuts, bruises, abrasions, etc. were all examples of what an injury may be. QIDP B acknowledged the policy did not note outside medical attention was required to be considered an injury and acknowledged scratches and bruises, for example, would appear to be an injury. When interviewed on 11/14/19 at 9:30 a.m., the Director of Inpatient Services (DIS) confirmed the incidents were not reported to DIA. She explained the facility assessed and determined injuries from peer-to-peer aggression on an individual basis. When asked about bruising by the eye and cut lips being an injury, for example, the DIS stated it would depend on the severity of the bruise and again stated they asses individually to determine if it is an injury. The DIS acknowledged the facility policy definition of an injury did not include the client would require outside medical treatment to be considered an injury.	C 146		

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TANAGER PLACE INVESTIGATION AND ANNUAL SURVEY

TANAGER PLACE
YOUR CHILD : OUR FOCUS

Tanager Place CMS-2567

W000 – Initial Comments.

No Plan of correction required.

W102 – The facility must ensure that specific governing body and management requirements are met

Failed to provide adequate operating direction after identification of an increase in P2P aggression; Failed to ensure consistent implementation of policies to prevent violence and abuse; failed to ensure facility staff was able to effectively implement client's plans

Immediate actions taken in response to the Immediate Jeopardy

- Operational Governing Body has placed a hold on admissions thru the month of November 2019
- Lower occupancy will be maintained to ensure stabilization and ample time to train and update staff regarding long term response needs.
- Beginning, 11/15/2019, additional Behavior Management training specific to the IDD population will be mandatory.
- Staffing on the unit will be limited to those trained on the following:
- Managing Challenging Behaviors Focused Learning
- Choice Making for People with I/DD
- QIDP will provide training to staff on unit regarding each client's IPP.
- A representative from the Operational Governing Body will be present on the unit during wake hours to observe interactions and ensure competencies of staff.
- Governing Body will evaluate the appropriateness of each client currently enrolled in Terry Cottage. Those residents whose behavior is incompatible with other resident's needs and rights will be transferred or discharged from the unit.
- To manage challenging behaviors and support healthy interactions with peers, clients within Terry Cottage will be placed in Pods based on specific supports that are needed to meet the client's needs. Supervisor will align client groupings effective immediately 11/15/19.

Additional actions:

- To ensure support over weekend shifts, a member of the IP Governing Body has been present throughout the day.
- DIS has mandated additional trainings specific to the IDD population.
    - Choice Making for People with I/DD

- Supporting Healthy Personal Relationships for People with I/DD
- Supporting Individuals with IDD During Emergencies

- Mandatory Reporter training will be required to be retaken by all inpatient staff. This is to be finalized upon receipt 02/14/2020 and will be required every 3 years per State of Iowa policy.
- All IP staff will revisit and receive additional training on abuse reporting procedures. This is to be reviewed, at minimum quarterly.
- All IP staff will revisit and receive additional training around holds. This is to be reviewed, at minimum quarterly.
- Policy to be developed around cottage procedures. Expectation is that any staff member who fails to follow through with procedures will receive disciplinary action in the form of Coaching and Counseling or PIP.
- Will utilize Blake Stephenson, BCBA to provide consultation and support. Initial meeting scheduled 11/17/19 and will continue to provide consultation weekly.
- Required documentation was reviewed and modified to ensure critical information is captured and reported upon.
- Guidelines to track peer to peer aggression were expanded and a tracking sheet developed to monitor episodes of peer to peer aggression throughout each client's admission.
- IP governing body remains actively engaged in weekly care reviews, all-staff meetings, nightly huddles, and evening rotation within the milieu.
  - Terry Cottage staff and Administration will continue evening Huddle Call with debriefing and follow-up to occur around critical incidents / Accidents / Injuries / Consumer to Consumer. The governing body updated current policies and procedures around Peer to peer aggression and Critical incident reporting.

Methods to monitor compliance: IP Governing body [DIS, Program Managers, and Cottage Coordinators] will monitor compliance with mandatory trainings, ensuring the competency of staff on shift according to their supervision assignments, at a minimum quarterly. IP Governing Body will review peer to peer tracking guidelines with trends addressed. DIS will review team meeting notes to ensure abuse procedures are reviewed, at a minimum quarterly.

Person[s] responsible: QIDPs [Kristin Moore and Avary Brinker], DIS [Michelle Allmandinger], ICFID Program Manager [Tiffany Bunting]

Date of correction: Immediate, upon receipt 02/14/2020

[redacted]

TANAGER PLACE
YOUR CHILD : OUR FOCUS

W104 – The governing body must exercise general policy, budget, and operating direction over the facility.

Failed to provide general oversight, failed to ensure consistent implementation of policies and procedures, failed to provide direction to ensure client safety, failed to take appropriate action to address an identified increase in peer-to peer aggression, failed to ensure staff effectively manage client behaviors

Immediate actions taken in response to the Immediate Jeopardy

- Operational Governing Body has placed a hold on admissions thru the month of November 2019
- Lower occupancy will be maintained to ensure stabilization and ample time to train and update staff regarding long term response needs.
- Beginning, 11/15/2019, additional Behavior Management training specific to the IDD population became mandatory.
- Staffing on the unit has been limited to those trained on the following. In the event that PMIC staff respond to a crisis situation, those staff trained on these required trainings and the clients IPP will provide direction for managing
    - Managing Challenging Behaviors Focused Learning
    - Choice Making for People with I/DD
- QIDP will provide training to staff on unit regarding each client's IPP.
- A representative from the IP Governing Body [DIS, Campus/Program Managers, QIDPs, and Cottage Coordinators] had been present on the unit during wake hours to observe interactions and ensure competencies of staff, to continue for 14 days post determination for first IJ.
- IP Governing Body [DIS, Campus/Program Managers, QIDPs, and Cottage Coordinators] did evaluate the appropriateness of each client currently enrolled in Terry Cottage. Those residents whose behavior is incompatible with other resident's needs and rights had been transferred or discharged from the unit.
- To manage challenging behaviors and support healthy interactions with peers, clients within Terry Cottage had been placed in Pods based on specific supports that are needed to meet the client's needs. Supervisor will align client groupings effective immediately 11/15/19.

Additional actions:

- To ensure support and enhance competencies over weekend shifts, a member of the IP Governing Body [DIS, Campus/Program Managers, QIDPs, and Cottage Coordinators'] has been present throughout the day, and had continued for minimum of 14 days post determination of 1st Immediate Jeopardy.

- DIS has mandated additional trainings specific to the IDD population.
  - Choice Making for People with I/DD
  - Supporting Healthy Personal Relationships for People with I/DD
  - Supporting Individuals with IDD During Emergencies
- Mandatory Reporter training will be required to be retaken by all inpatient staff. This is to be finalized upon receipt 02/14/2020
- All IP staff will revisit and receive additional training on abuse reporting procedures, and will be ongoing at minimum annually.
- All IP staff will revisit and receive additional training around holds, and will be ongoing at minimum annually.
- Policy had been enhanced around cottage procedures expectations. Any staff member who fails to follow through with procedures will receive disciplinary action in the form of Coaching and Counseling or Performance Improvement Plan.
- Did utilize Blake Stephenson, BCBA to provide consultation and support. Initial meeting scheduled 11/17/19 and to continue weekly.
- Required documentation was reviewed and modified to ensure critical information is captured and reported upon.
- Guidelines to track peer to peer aggression were expanded and a tracking sheet developed to monitor episodes of peer to peer aggression throughout each client's admission.
- IP governing body remains actively engaged in weekly care reviews, all-staff meetings, nightly huddles, and evening rotation within the milieu.
  - Terry Cottage staff and Administration will continue evening Huddle Call with debriefing and follow-up to occur around critical incidents / Accidents / Injuries / Consumer to Consumer. The governing body updated current policies and procedures around Peer to peer aggression and Critical incident reporting.

Methods to monitor compliance: IP Governing body [DIS, Program Managers, and Cottage Coordinators] will monitor compliance with mandatory trainings, ensuring the competency of staff on shift according to their supervision assignments, at a minimum quarterly. IP Governing Body will review peer to peer tracking guidelines with trends addressed. DIS will review team meeting notes to ensure abuse procedures are reviewed, at a minimum quarterly.

Person[s] responsible: QIDPs [Kristin Moore and Avary Brinker], DIS [Michelle Allmandinger], ICFID Program Manager [Tiffany Bunting]

Date of correction: Immediate, upon receipt 02/14/2020

[redacted]

TANAGER PLACE
YOUR CHILD : OUR FOCUS

W122: Client Protections – The facility must ensure that specific client protection requirements are met.

Failed to provide all clients with a safe environment free of abuse from peers.

Immediate actions taken in response to the Immediate Jeopardy

- Operational Governing Body has placed a hold on admissions through November 2019
- Lower occupancy has been maintained to ensure stabilization and ample time to train and update staff regarding long term response needs.
- Beginning, 11/15/2019, additional Behavior Management training specific to the IDD population became mandatory.
- Staffing on the unit has been limited to those trained on the following. In the event that PMIC staff respond to a crisis situation, those staff trained on these required trainings and the clients IPP will provide direction for managing
    - Managing Challenging Behaviors Focused Learning
    - Choice Making for People with I/DD
- QIDP will provide training to staff on unit regarding each client's IPP.
- A representative from the IP Governing Body [DIS, Campus/Program Managers, QIDPs, and Cottage Coordinators] had been present on the unit during wake hours to observe interactions and ensure competencies of staff, to continue for 14 days post determination for first IJ.
- IP Governing Body [DIS, Campus/Program Managers, QIDPs, and Cottage Coordinators] did evaluate the appropriateness of each client currently enrolled in Terry Cottage. Those residents whose behavior is incompatible with other resident's needs and rights had been transferred or discharged from the unit.
- To manage challenging behaviors and support healthy interactions with peers, clients within Terry Cottage had been placed in Pods based on specific supports that are needed to meet the client's needs. Supervisor will align client groupings effective immediately 11/15/19.

Additional actions:

- To ensure support and enhance competencies over weekend shifts, a member of the IP Governing Body [DIS, Campus/Program Managers, QIDPs, and Cottage Coordinators'] has been present throughout the day, and had continued for minimum of 14 days post determination of 1st Immediate Jeopardy.
- To ensure support over weekend shifts, a member of the IP Governing Body has been present throughout the day.

- DIS has mandated additional trainings specific to the IDD population.
  - Choice Making for People with I/DD
  - Supporting Healthy Personal Relationships for People with I/DD
  - Supporting Individuals with IDD During Emergencies
- Mandatory Reporter training will be required to be retaken by all inpatient staff. This is to be finalized upon receipt 02/14/2020
- All IP staff will revisit and receive additional training on abuse reporting procedures. At a minimum this will be reviewed quarterly in team meetings.
- All IP staff will revisit and receive additional training around holds.
- Policy to be developed around cottage procedures. Expectation is that any staff member who fails to follow through with procedures will receive disciplinary action in the form of Coaching and Counseling or PIP.
- Will utilize Blake Stephenson, BCBA to provide consultation and support. Initial meeting scheduled 11/17/19.
- Required documentation was reviewed and modified to ensure critical information is captured and reported upon.
- Guidelines to track peer to peer aggression were expanded and a tracking sheet developed to monitor episodes of peer to peer aggression throughout each client's admission.
- IP governing body remains actively engaged in weekly care reviews, all-staff meetings, nightly huddles, and evening rotation within the milieu.
  - Terry Cottage staff and Administration will continue evening Huddle Call with debriefing and follow-up to occur around critical incidents / Accidents / Injuries / Consumer to Consumer. The governing body updated current policies and procedures around Peer to peer aggression and Critical incident reporting.

Methods to monitor compliance: IP Governing body [DIS, Program Managers, and Cottage Coordinators] will monitor compliance with mandatory trainings, ensuring the competency of staff on shift according to their supervision assignments, at a minimum quarterly. IP Governing Body will review peer to peer tracking guidelines with trends addressed. DIS will review team meeting notes to ensure abuse procedures are reviewed, at a minimum quarterly.

Person[s] responsible: QIDP [Kristin Moore and Avary Brinker], DIS [Michelle Allmandinger, ICFID Program Manager [Tiffany Bunting]

Date of correction: Fully corrected immediately, upon receipt 02/14/2020

[redacted]

TANAGER PLACE
YOUR CHILD : OUR FOCUS

W124: Protection of Clients Rights – The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent [if the client is a minor], or legal guardian, of the clients medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.

Failed to inform the guardians of possible side effects of behavior modifying medications.

- Modifications were made to the BMP Informed consent to include notification of risks. This includes possible side effects, other complications from treatments [medical and drug therapy], unintended consequences of treatment, other behavioral or psychological ramifications arising from treatment.
- Nursing services initiates contact with parent/legal guardian [if a minor] to obtain informed consent for new behavior modifying medications. Drug information sheet is provided to parent/guardian [if a minor] to outline benefits, uses, side effects, and possible interactions.
- Once parental/guardian consent has been obtained, documentation of date and time of verbal consent will be collected on the Authorization for Medication. Follow-up for written consent will begin immediately.
- QIDP will follow-up with Human Rights Committee [HRC] to obtain verbal and written consent.
- No behavior modifying medication will be started without written consent from parent/legal guardian [if a minor] and member of HRC. In the event of an emergency [as determined by the treating physician], the facility may begin behavior modifying medications once verbal consent is obtained. This verbal consent will be authenticated in writing as soon as possible [not to exceed 30 days].

Methods to monitor compliance: Nursing services will forward complete form to QIDP. QIDP will verify consent contains verbal consent. Once written consent is obtained, this will be forwarded to Inpatient Administrative assistant for filing. IP Administrative assistant will review for completeness prior to filing. Health checklist has been created to help support this process. QIDP will monitor consent dates [obtained and expired] via the Behavior Modification informed consent. This Behavior Modification consent is to be reviewed, at a minimum monthly, during care reviews.

Person[s] responsible: Nursing services, and QIDP [Kristin Moore and Avary Brinker]

Date of correction: Implemented fully 01/01/2020

W125: Protection of Clients Rights – The facility must ensure the rights of all clients. Therefore the facility must allow and encourage individual clients to exercise their own rights as clients of the facility.

Failed to obtain guardian consent for all restrictive measures.

- Facility incorporates opportunities into daily life experiences that promote choice making and decision making by the client. Examples are as follows:
  - Kitchen is accessible and open during meal times. Clients are provided opportunity to choose what, where, and how to eat.
  - Clients have free choice in what to wear. Clothing may be stored in cubbies, free from locks or restrictive techniques.
  - Clients are encouraged to participate in the medication pass [examples of ways in which this is to be encouraged naming drug, purposes, dosage, times of day]
- Facility has ensured adequate supply of all utensils [tableware, utensils, and napkins] for each cottage. At a minimum this is one full set per client [unless designated as a restrictive technique by the parent/legal guardian and a member of the HRC].
- Facility has ensured access to clothing, toiletries, and other supplies as applicable to their Behavior Modification Program.
- Facility has provided training to certified med passers regarding ways in which they are to encourage client participation in the medication pass.
- QIDP initiates contact with the parent/legal guardian [if a minor] regarding all restrictive or intrusive techniques. This includes restraints, behavior modifying medications, restrictions on community access, contingent denial of any right, or restrictions of materials or locations in the home.
- Once consent is obtained from the parent/legal guardian [if a minor], QIDP will contact the Human Rights committee to ensure the written behavior management program does not violate the client's right.
- No restrictive or intrusive technique will be started without written consent from parent/legal guardian [if a minor] and member of HRC. In the event of an emergency, the facility may begin behavior modifying medications once verbal consent is obtained. This verbal consent will be authenticated in writing as soon as possible.
- The definition of restrictive or intrusive techniques [with examples of what it is and what it is not] is to be provided and reviewed with staff.

Methods to monitor compliance: IP governing body will periodically monitor meal times, med pass times, and general interactions of staff with clients to ensure staff encourage and promote client choice and self-management. Observation checklist

has been created to help support this process. QIDP will monitor consent dates [obtained and expired] via the Behavior Modification informed consent. This Behavior Modification consent is to be reviewed, at a minimum monthly, during care reviews.

Person[s] responsible: IP Governing Body [DIS, Program Manager, Cottage coordinators, QIDPs]

Date of correction: 03/31/2020

W127: Protection of Clients Rights – The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment.

The facility failed to take appropriate action to ensure clients were provided a safe environment free from physical abuse from other clients.

- Governing Body did evaluate the appropriateness of each client currently enrolled in Terry Cottage. Those residents whose behavior is incompatible with other resident's needs and rights will be transferred or discharged from the unit.
- To manage challenging behaviors and support healthy interactions with peers, clients within Terry Cottage will be placed in Pods based on specific supports that are needed to meet the client's needs. Supervisor will align client groupings effective immediately 11/15/19.
- Guidelines to track peer to peer aggression were expanded and a tracking sheet developed to monitor episodes of peer to peer aggression throughout each client's admission. Reviewed by QIDPs during team, at a minimum monthly and monitored quarterly by Quality Improvement department.
- IP governing body remains actively engaged in weekly care reviews, all-staff meetings, nightly huddles, and evening rotation within the milieu.
    - Terry Cottage staff and Administration will continue evening Huddle Call with debriefing and follow-up to occur around critical incidents / Accidents / Injuries / Consumer to Consumer. The governing body updated current policies and procedures around Peer to peer aggression and Critical incident reporting.
- If a consumer has aggressed towards a peer(s) resulting in injury twice in a 30 day period, it must be reported to DIA.
- All serious injury's must be reported to DIA
- QIDP will review IPPs and consult with BCBA, Blake Stephenson for any consumer that meets this criterion. Behavior Management plans will be adjusted accordingly to coordinate services and supports that are needed to meet the client's needs and prevent further incidents.

- Any consumer that meets this criterion over two consecutive months will be evaluated for appropriateness. Those residents whose behavior is incompatible with other resident's needs and rights will be transferred or discharged from the unit.

Methods to monitor compliance: QIDPs and IP Governing Body [DIS, Program Managers, and Cottage Coordinators] review prevalence of P2P during weekly care reviews and evening huddles. QI department monitors P2P for thresholds identified above, at a minimum quarterly.

Person[s] responsible: QIDPs [Kristin Moore and Avary Brinker]

Date of correction: Immediately upon receipt, 02/14/2020

W149: Staff treatment of clients – the facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, or abuse of the client.

Failed to complete 24-hour follow-up following incidents of peer-to-peer aggression, failure to identify injuries following incidents of peer to peer aggression, and failure to complete Critical Incident Reports [CIRs] per facility policy. Additionally, facility failed to implement policies regarding abuse and mandatory reporting.

Immediate actions taken in response to the Immediate Jeopardy

- Current policy around Child abuse and Mandatory Reporting had been provided to DIA as document given during their survey was obsolete and not a valid policy.
- Obsolete polices around Child Abuse and Mandatory reporting were removed and replaced with current organizational policies. All current policies are available to staff.
- Once an allegation of abuse has been alleged, the facility will take the following steps:
  - Administration is to be notified immediately of all allegations [required action step on CIR]
  - DIA notification is made [required action step on CIR]
  - Action is taken to ensure the safety of clients. Based on the nature, severity, and information provided regarding the allegation one of the following steps may be taken until the conclusion of the administrative review.
    - Staff immediately placed on Administrative Leave
    - Staff reassigned to a non-direct care role
    - Temporary reassignment of direct care work in another cottage
    - Temporary movement of client's cottage occupancy.

- Internal review and investigation of allegations will occur. As part of the internal investigation reports of suspected child abuse shall be made in accordance with Mandatory Reporter requirements.

- The administrative review of allegations and critical incidents now includes justifications regarding notifications and/or reporting to State entities.
- A policy for administrative leave pending conclusion of internal investigation and/or DHS had been be developed and implemented 12/12/2019.
- Policy on current Mandatory Reporting requirements and Administrative Leave was reviewed with staff prior to their next shift.
  - Email sent by end of day 12/12/2019 with policies attached.
  - Meeting occurred 12/12/2019 with shift leads, program managers, and QIDPs to ensure that IP Governing Body and staff know where to locate current Organizational Policies.
  - All staff did review and acknowledge receipt of policy prior to start of shift by end of day 12/16/2019
  - Expectations of immediate notification to administration will be reiterated with all staff.

Additional action taken:

- Direct care staff participates in ongoing trainings weekly [Tuesday or Thursday depending on schedule]. At a minimum, topics of policies and procedures around abuse reporting procedures will be reviewed quarterly.
- Child Abuse Report guidelines revised per State of Iowa DHS Mandatory Reporting guidelines for clarity purposes, and reviewed with staff.
- Documentation revised to assist with investigations of allegations. Specific documents created include client statement, witness statement, and summary of findings. Critical incident report template was updated and revised to include additional required elements.
- Reports to DHS [both founded and unfounded] are tracked and reviewed quarterly by the Executive team.
- Creation of self-report checklist developed on 12/16/2019 to ensure all allegations are thoroughly investigated and proper steps undertaken based on the nature of the allegation. Template created to support documentation of witness statements, client statements, and summary of findings.

Methods to monitor compliance: DIS and ICFID program manager will monitor for compliance of staff with all policies and procedures. DIS will continue to work closely with Executive team and IP Governing Body around policy development and periodic reviews with staff, at a minimum quarterly. ICFID Program Manager will complete

self-report checklist for each allegation and ensure that all requirements of investigations have occurred. DIS will monitor reporting of allegations to ensure reported within 24 hours of allegation and investigated thoroughly and the facility takes immediate actions to address circumstances where abuse, neglect or mistreatment has occurred.

Person[s] responsible: Director of Inpatient Services [Michelle Allmandinger] and ICFID Program Manager [Tiffany Bunting]

Date of Correction: Instated 12/12/2019; to be completed by end of day 12/16/2019

W153: Staff Treatment of Clients: all allegations of mistreatment, neglect, or abuse as well injuries of unknown source are reported immediately to Administrator or to other officials.

Facility failed to immediately report all allegations of client mistreatment and/or abuse to the administrator or designee, per facility policy and failed to consistently report all allegations of abuse to the appropriate state agency.

- Additional staff training was provided around Risk Management procedures, administrative leave, and child abuse reporting requirements on 12/13/2019. These documents were placed within the cottage binders and reviewed periodically in team meeting per policy review schedule.
- Direct care staff participates in ongoing trainings weekly [Tuesday or Thursday depending on schedule]. At a minimum, topics of policies and procedures around abuse reporting procedures will be reviewed quarterly
- Critical incident report tool was revised to include specific external notifications sent [DHS, DIA, Parent/Guardian, and Caseworker]
- Child Abuse Report guidelines revised per State of Iowa DHS Mandatory Reporting guidelines for clarity purposes, and reviewed with staff.
- Documentation revised to assist with investigations of allegations. Specific documents created include client statement, witness statement, and summary of findings. Critical incident report template was updated and revised to include additional required elements.
- Reports to DHS [both founded and unfounded] are tracked and reviewed quarterly by the Executive team.
- Creation of self-report checklist developed on 12/16/2019 to ensure all allegations are thoroughly investigated and proper steps undertaken based on the nature of the

allegation. Template created to support documentation of witness statements, client statements, and summary of findings.

Methods to monitor compliance: Self check list developed to monitor compliance with reporting procedures. This checklist is to be completed for each allegation. QIDPs will encourage open reporting and periodically check with each client around safety.

Person[s] responsible: ICFID program manager [Tiffany Bunting] monitors to ensure staff are reporting all allegations of abuse.

Date of correction: 12/16/2019

W154: Staff Treatment of Clients: The facility must have evidence that all alleged violations are thoroughly investigated

Facility failed to consistently obtain staff statements, failed to consistently identify who the assigned/responsible staff was, failed to consistently include an Administrative Review of the investigation, and failed to consistently note how the client would be safeguarded during the facility investigation and/or following the investigation.

- Direct care staff participates in ongoing trainings weekly [Tuesday or Thursday depending on schedule]. At a minimum, topics of policies and procedures around abuse reporting procedures will be reviewed quarterly
- Critical incident report tool was revised to include specific external notifications sent [DHS, DIA, Parent/Guardian, and Caseworker]
- Child Abuse Report guidelines revised per State of Iowa DHS Mandatory Reporting guidelines for clarity purposes, and reviewed with staff.
- Documentation revised to assist with investigations of allegations. Specific documents created include client statement, witness statement, and summary of findings. Critical incident report template was updated and revised to include additional required elements.
- Once an allegation of abuse has been alleged, the facility will take the following steps:
  - Immediately separate client and accused
  - Administration is to be notified immediately of all allegations.
  - Action is taken to ensure the safety of clients. Based on the nature, severity, and information provided regarding the allegation one of the following steps may be taken until the conclusion of the administrative review.
    - Staff immediately placed on Administrative Leave
    - Staff reassigned to a non-direct care role
    - Temporary reassignment of direct care work in another cottage
    - Temporary movement of client's cottage occupancy.

- Internal review and investigation of allegations will occur. As part of the internal investigation reports of suspected child abuse shall be made in accordance with Mandatory Reporter requirements.
    - DIA notification is made within 24 hours, or next business day for all major or physical injuries as well as all reports of abuse to DHS

- A policy for administrative leave pending conclusion of internal investigation and/or DHS had been developed and implemented 12/12/2019
- Reports to DHS [both founded and unfounded] are tracked and reviewed quarterly by the Executive team.
- Creation of self-report checklist developed on 12/16/2019 to ensure all allegations are thoroughly investigated and proper steps undertaken based on the nature of the allegation. Template created to support documentation of witness statements, client statements, and summary of findings.

Methods to monitor compliance: Self check list developed to monitor compliance with reporting procedures. This checklist is completed for each allegation.

Person[s] responsible: ICFID program manager [Tiffany Bunting] monitors to ensure staff are reporting all allegations of abuse.

Date of correction: 12/16/2019

W155: Staff Treatment of Clients: The facility must prevent further potential abuse while the investigation is in progress.

Facility failed to ensure separation between the alleged perpetrator and victim following all allegations of abuse.

- Once an allegation of abuse has been alleged, the facility will take the following steps:
    - Immediately separate client and accused
    - Administration is to be notified immediately of all allegations.
    - Action is taken to ensure the safety of clients. Based on the nature, severity, and information provided regarding the allegation one of the following steps may be taken until the conclusion of the administrative review.
        - Staff immediately placed on Administrative Leave
        - Staff reassigned to a non-direct care role
        - Temporary reassignment of direct care work in another cottage
        - Temporary movement of client's cottage occupancy.

- Internal review and investigation of allegations will occur. As part of the internal investigation reports of suspected child abuse shall be made in accordance with Mandatory Reporter requirements.
    - DIA notification is made within 24 hours, or next business day for all major or physical injuries as well as all reports of abuse to DHS

- A policy for administrative leave pending conclusion of internal investigation and/or DHS had been developed and implemented 12/12/2019
- Child Abuse reporting guideline updated per State of Iowa reporting requirements.
- Critical incident report was updated to include specific action items for immediate separation of client and accused as well as immediate notification to program manager.

Methods to monitor compliance: Self check list developed to monitor compliance with reporting procedures. CIR, statements, and checklist are completed for each allegation.

Person[s] responsible: ICFID program manager [Tiffany Bunting] investigates all allegations. DIS [Michelle Allmandinger] conducts quality review

Date of correction: Implemented fully 02/18/2020

W158: Facility Staffing – The facility must ensure that specific facility staffing requirements are met.

QIDP failed to update client IPPs to provide interventions consistent with BMP. QIDP failed to change client IPP interventions after a noted increase. Facility staff failed to demonstrate the skills and competencies to effectively manage inappropriate client behaviors.

Immediate actions taken in response to the Immediate Jeopardy

- Lower occupancy has been maintained to establish stabilization
- Mandatory trainings have been established. Staff will not be permitted to work on shift in Terry Cottage until which time they have completed trainings: Managing Challenging Behaviors Focused Learning and Choice Making for People with I/DD
- Experienced staff members on shift have been increased by coordinating scheduling with other cottages.
    - Assign experienced Shift Leader to 20 working hours in Terry Cottage.
    - Schedule at least one experienced leader in ICF/ID during second shift daily for next 14 days to guide, direct, and support direct care staff members. This will

include experienced shift leads, program coordinators, program managers, QIDPs and Inpatient Director.

- A representative from the operational Governing Body will be present on the unit during wake hours to observe interactions and ensure competencies of staff.

Additional Actions undertaken:

- QIDP developed a cottage wide BMP 10/02/2019
- Cottage Wide BMP was added to each client's IPP, effective 11/14/2019
- QIDP will review IPPs and consult with BCBA, Blake Stephenson for any client that has aggressed towards a peer(s) resulting in injury twice in a 30 day period, or caused a serious injury. Behavior Management plans [BMP] will be adjusted accordingly to coordinate services and supports that is needed to meet the client's needs and prevent further incidents.
- Any changes made to a client's BMP will be reviewed via email and questions to be followed up on in next scheduled weekly team to ensure effective implementation. QIDP will continue to monitor for effectiveness per the aforementioned criterion.
- Beginning, 11/15/2019, additional Behavior Management training specific to the IDD population will be mandatory.
- Staffing on the unit will be limited to those trained on the following:
    - Managing Challenging Behaviors Focused Learning
    - Choice Making for People with I/DD

Methods to monitor compliance: Clinical Supervisor, or designee and QIDP[s] will conduct ongoing case reviews of IPPs and incidents of peer to peer aggression. Each client will be reviewed in case review, at a minimum monthly.

Person[s] responsible: Clinical Supervisor, or designee [Holly Miller] and QIDPs [Kristin Moore and Avary Brinker]

Date of correction: Fully corrected immediately, upon receipt 02/14/2020

W159: QIDP – Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional.

Failed to consistently coordinate, integrate, and monitor client services and supports by failure to incorporate a cottage wide Behavior Management Plan [BMP] into all client Individual Program Plans [IPPs], failure to change client IPPs after an identified increase in P2P, and failure to ensure identified client supports.

- QIDP developed a cottage wide BMP 10/02/2019
- Cottage Wide BMP was added to each client's IPP, effective 11/14/2019
- QIDP will review IPPs and consult with BCBA, Blake Stephenson for any client that has aggressed towards a peer(s) resulting in injury twice in a 30 day period, or caused a serious injury.
- Behavior Management plans [BMP] will be adjusted accordingly to coordinate services and supports that is needed to meet the client's needs and prevent further incidents.
- Cottage Wide BMP was added to each client's IPP, effective 11/14/2019. This was incorporated into each client's IPP to eliminate confusion on which interventions to utilize.
- Cottage wide BMP will be utilized within each client's IPP as needed based on prevalence and severity of P2P aggression.
- QIDP will send notification of any changes made to a client's IPP will via email and questions to be followed up on in next scheduled weekly team to ensure effective implementation.
- QIDP will provide training to staff, as requested, regarding each client's IPP when amendments are made
- QIDP will continue to monitor for effectiveness per the aforementioned criterion.

Methods to monitor compliance: Clinical Supervisor, or designee and QIDP[s] will conduct file reviews, at least quarterly per Accreditation requirements, ensuring BMPS are incorporated and all IPPs are up to date.

Person[s] responsible: Clinical Supervisor, or designee [Holly Miller] and QIDPs [Kristin Moore and Avary Brinker]

Date of correction: no later than 3/31/2020 [Q2 for Fiscal Year]

W193: Training Program: Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the appropriate behavior of clients.

Facility failed to consistently demonstrate the skills and competencies necessary to manage inappropriate client behavior.

- Beginning, 11/15/2019, additional Behavior Management training specific to the IDD population had become mandatory, and will be retrained yearly and documented within their personal file.
- Staffing on the unit will be limited to those trained on the following:
    - Managing Challenging Behaviors Focused Learning
    - Choice Making for People with I/DD
- As a result of the increase of intensity and frequency of P2P aggression, QIDP developed a cottage wide BMP 10/02/2019
- Cottage Wide BMP was added to each client's IPP, effective 11/14/2019. This was incorporated into each client's IPP to eliminate confusion on which interventions to utilize.
- Cottage wide BMP will be utilized within each client's IPP as needed based on prevalence and severity of P2P aggression.
- QIDP will provide training to staff, as requested, regarding each client's IPP when amendments are made

Methods to monitor compliance: Clinical Supervisor, or designee, and QIDP[s] will conduct file reviews, at least quarterly per Accreditation requirements, ensuring BMPS are incorporated and all IPPs are up to date. Ongoing case review of each client is to occur with review of P2P aggressions

Person[s] responsible: Clinical Supervisor, or designee [Holly Miller] and QIDPs [Kristin Moore and Avary Brinker]

Date of correction: no later than 3/31/2019 [Q2 for Fiscal Year]

W210: Individual program plan – within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission

Facility failed to complete assessments for clients within 30 days of admission.

- Comprehensive functional assessment [CFA] is completed prior to admission by client's parent or legal guardian. If this is not completed or returned prior to admission it will be done during the admit process.
- The CFA guides recommendations for OT, PT, Speech, hearing, and dietary evaluations.
- All recommendations are to be scheduled within the first 30 days.

- Post evaluation, nursing will document occurrence of OT, PT, Speech, hearing and dietary evaluations.
- All documentation received by the evaluating office will be filed in the clients paper chart.
- Care review summary sheet has been created for each client to monitor specific client needs, including preventative and medical needs of the clients. This is to be reviewed, at minimum monthly.

Methods to monitor compliance: QIDPs reviews the CFA for completeness on the day of admit. If not done prior to admit, QIDPs will work with families to complete day of admit. Nursing services will attend care reviews, at a minimum once per month, to review preventative and general medical care needs of ICFID clients. Care review summary sheet has been created for each client to monitor specific client needs and will be reviewed at minimum monthly.

Person[s] responsible: QIDPs [Kristin Moore and Avary Brinker], nursing services

Date of correction: 03/31/2020

W226: Individual Program Plan – Within 30 days after admission, the interdisciplinary team must prepare, for each client, and individual program plan.

Facility failed to develop an Individual Habilitation Plan [IHP] within 30 days of admission.

- Each client will have an individual program plan identifying the client's needs, as described by the CFA.
- If a need is identified in the CFA, the appropriate professional associated with that need will conduct an initial evaluation to support development of the IPP.
- QIDP will coordinate with those professionals around development of the IPP.
- If delays arise outside of the QIDPs control, documentation will be entered into the clients chart as to reasoning why and attempts made to coordinate with those professionals. Attempts will be made via phone, email, and in person as appropriate. All attempts made will be documented in the client record.
- At a minimum, the QIDP and parent/guardian will participate in the CFA and development of IPP.
- At a minimum, the QIDP will ensure IPP done within 30 days of admit [IPP appt. scheduled 25 days post admit to assist in the process]
- At a minimum, the QIDP will complete the CFA annually

Methods to monitor compliance: QIDPs will review the CFA for completeness on the day of admit. If not done prior to admit, QIDPs will work with families to complete day of admit. QIDPs will schedule IPP appointment to occur within 25 days of admit to ensure done within 30 days of admit. Care review summary sheet has been created for each client to monitor specific client needs and timeline of completion.

Person[s] responsible: QIDPs [Kristin Moore and Avary Brinker]

Date of correction: 03/31/2020

W247: Individual Program Plan – Individual program plan must include opportunities for client choice and self-management.

Failed to consistently encourage and promote client choice and opportunities for self-management and independence.

- Facility incorporates opportunities into daily life experiences that promote choice making and decision making by the client [unless designated as a restrictive technique by the parent/legal guardian and a member of the HRC]. Examples are as follows:
  - Kitchen is accessible and open during meal times. Clients are provided opportunity to choose what, where, and how to eat.
  - Clients have free choice in what to wear. Clothing may be stored in cubbies, free from locks or restrictive techniques.
  - Clients are encouraged to participate in the medication pass [examples of ways in which this is to be encouraged naming drug, purposes, dosage, times of day]
- Facility has ensured adequate supply of all utensils [tableware, utensils, and napkins] for each cottage. At a minimum this is one full set per client [unless designated as a restrictive technique by the parent/legal guardian and a member of the HRC].
- Facility has provided training, and will continue to provide training, to staff regarding restrictive and intrusive techniques. This training is to take place upon hire and will periodically be reviewed, at least twice annually. Will be providing a list of examples as to what is and what is not restrictive or intrusive.
- Facility has provided training to certified med passers regarding ways in which they are to encourage client participation in the medication pass.

Methods to monitor compliance: IP governing body [DIS, Program Managers, and Cottage Coordinators] will periodically monitor meal times, med pass times, and general interactions of staff with clients to ensure staff encourage and promote client choice and self-management, at a minimum monthly. Observation checklist has been created to help support this process.

[redacted]

TANAGER PLACE
YOUR CHILD : OUR FOCUS

Person[s] responsible: IP Governing Body [DIS, Program Manager, Cottage coordinators]

Date of correction: 03/31/2020

W262: Program Monitoring and Change – The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.

Failed to obtain consent from the Human Rights Committee for all restrictive measures.

- QIDP initiates contact with the parent/legal guardian [if a minor] regarding all restrictive or intrusive techniques. This includes restraints, behavior modifying medications, restrictions on community access, contingent denial of any right, or restrictions of materials or locations in the home.
- Once consent is obtained from the parent/legal guardian [if a minor], QIDP will contact the Human Rights committee to ensure the written behavior management program does not violate the client's right.
- No restrictive or intrusive technique will be started without written consent from parent/legal guardian [if a minor] and member of HRC. In the event of an emergency, the facility may begin behavior modifying medications once verbal consent is obtained. This verbal consent will be authenticated in writing as soon as possible, within 30 days.
- The definition of restrictive or intrusive techniques [with examples of what it is and what it is not] is to be provided and reviewed with staff, in conjunction with ongoing trainings.

Methods to monitor compliance: Administrative Assistant will review consent before filing in client's paper chart to ensure written consent. QIDP will monitor consent dates [obtained and expired] via the Behavior Modification informed consent, to be reviewed during care reviews monthly.

Person[s] responsible: QIDPs [Kristin Moore and Avary Brinker], ICFID program manager [Tiffany Bunting]

Date of correction: Written consent practices fully implemented 01/01/2020. Definition of restrictive or intrusive techniques 03/31/2020.

W263: Program monitoring and change – the committee should insure that these programs are conducted only with the written informed consent of the client, parents [if the client is a minor] or legal guardian.

Failed to ensure written guardian consent prior to implementation of all restrictive measures.

- QIDP initiates contact with the parent/legal guardian [if a minor] regarding all restrictive or intrusive techniques. This includes restraints, behavior modifying medications, restrictions on community access, contingent denial of any right, or restrictions of materials or locations in the home.
- Once consent is obtained from the parent/legal guardian [if a minor], QIDP will contact the Human Rights committee to ensure the written behavior management program does not violate the client's right.
- No restrictive or intrusive technique will be started without written consent from parent/legal guardian [if a minor] and member of HRC. In the event of an emergency, the facility may begin behavior modifying medications once verbal consent is obtained. This verbal consent will be authenticated in writing as soon as possible, but not longer than 30 days.
- HRC will review that written consent was obtained.
- The definition of restrictive or intrusive techniques [with examples of what it is and what it is not] is to be provided and reviewed with staff.

Methods to monitor compliance: Administrative Assistance will review consent before filing in client's paper chart to ensure written consent. QIDP will monitor consent dates [obtained and expired] via the Behavior Modification informed consent, to be reviewed during care reviews monthly.

Person[s] responsible: QIDPs [Kristin Moore and Avary Brinker], ICFID program manager [Tiffany Bunting]

Date of correction: Written consent practices fully implemented 01/01/2020. Definition of restrictive or intrusive techniques is to be implemented on or before 03/31/2020.

W289: Management of Inappropriate client behavior – use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan.

Failed to ensure all behavior management interventions were incorporated into the client's individual program plan.

- Beginning, 11/15/2019, additional Behavior Management training specific to the IDD population became mandatory.
- Staffing on the unit is limited to those trained on the following:
    - Managing Challenging Behaviors Focused Learning
    - Choice Making for People with I/DD
- As a result of the increase of intensity and frequency of P2P aggression, QIDP developed a cottage wide BMP 10/02/2019
- Cottage Wide BMP was added to each client's IPP, effective 11/14/2019. This was incorporated into each client's IPP to eliminate confusion on which interventions to utilize.
- Cottage wide BMP will be utilized within each client's IPP as needed based on prevalence and severity of P2P aggression.
- QIDP will provide training to staff on unit regarding each client's IPP as requested.
- QIDP will send notification of any changes made to a client's IPP will via email and questions to be followed up on in next scheduled weekly team to ensure effective implementation.
- QIDP will provide training to staff, as requested, regarding each client's IPP when amendments are made
- QIDP will continue to monitor for effectiveness per the P2P guideline criterion.

Methods to monitor compliance: QI department and program managers will monitor compliance with required training, at a minimum quarterly. IP governing body will periodically monitor general interactions of staff with clients to ensure staff are utilizing client's IPP and receive prompt feedback, at a minimum monthly. Observation checklist has been created to help support this process.

Person[s] responsible: QI specialist, IP Governing Body [DIS, Program Manager, Cottage coordinators, QIDPs]

Date of correction: 03/31/2020

W322: Physician Services – The facility must provide or obtain preventative and general medical care.

Facility nursing department failed to follow up on assessments in the areas of Speech, Occupational Therapy [OT], and Physical Therapy [PT].

- The CFA guides recommendations for OT, PT, Speech, hearing, and dietary evaluations.
- All recommendations are to be scheduled within the first 30 days.
- In the event that the facility encounters delays with the evaluating office, alternate providers in the area that provide the needed service will be contacted
- Post evaluation, nursing will document occurrence of OT, PT, Speech, hearing and dietary evaluations.
- All documentation received by the evaluating office will be filed in the clients paper chart.
- Care review summary sheet has been created for each client to monitor specific client needs, including preventative and medical needs of the clients. This is to be reviewed, at minimum monthly.

Methods to monitor compliance: Nursing services will attend care reviews, at a minimum once per month, to review preventative and general medical care of ICFID clients. QIDPs, ICFID Program Manager, and nursing services will review medical needs of clients at this time.

Person[s] responsible: Nursing services [or designee]

Date of correction: 03/31/2020

W323: Physician Services – The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.

Facility failed to obtain vision and hearing evaluations at least annually.

- Clients will be scheduled for a vision and hearing evaluation as recommended by the CFA and/or at a minimum annually.
- Post evaluation, nursing will document occurrence of evaluation
- All documentation received by the evaluating office will be filed in the clients paper chart.
- Any recommendations for ongoing follow-up will be scheduled accordingly with the applicable professional, at minimum annually.

Methods to monitor compliance: Medical ICFID checklist has been created. This includes the date of last evaluation and any recommendations for ongoing follow-up. This is reviewed during care review meeting, at least monthly.

Person[s] responsible: Nursing services, ICFID program manager [Tiffany Bunting]

Date of correction: 03/31/2020

W336: Nursing Services – must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on the client need.

Failed to ensure quarterly nursing assessment.

- Clients receive an annual medical examination with a physician.
- Licensed nurses will conduct a review of the client's health status the remaining three quarters. This means a visual review of the body as well as an examination/assessment of body systems.
- Documentation of this health visit will be entered into the client's medical record and tracked ongoing via the Medical ICFID checklist and care review
- In the event the nursing assessment is delayed, all attempts made to complete assessment will be documented in the client's record.

Methods to monitor compliance: Medical ICFID care review/checklist has been created. This includes the date of last evaluation and any recommendations. This document and nursing needs are to be reviewed during monthly care reviews.

Person[s] responsible: Nursing services

Date of correction: 03/31/2020

W440: Evacuation Drills – The facility must hold evacuation drills at least quarterly for each shift of personnel.

Failed to ensure quarterly fire drills occurred on all shifts.

- Evacuation drills are to occur each shift, at least quarterly.

- Clients will participate when on campus.
- Shift times are broken out by awake and sleeping hours.
- ICFID Program Manager in collaboration with DIS and Facilities manager will develop and identify schedule of drills.
- Documentation of drills will be maintained in fire drills logs.

Methods to monitor compliance: Schedule of evacuation drills will be developed to monitor quarterly compliance. This will be reviewed during team meetings, at minimum quarterly.

Person[s] responsible: ICFID Program Manager [Tiffany Bunting] in collaboration with DIS [Michelle Allmandinger] and Facilities.

Date of correction: 03/31/2020

W463: Food and Nutrition Services – client's interdisciplinary team, including a qualified dietitian and physician must prescribe all modified and special diets.

Facility failed to ensure a physician was included when determining special diets.

- Qualified dietitian provides dietary recommendations monthly, or as needed based on clients individual needs
- Any recommendations are to be reviewed by a physician
- Physician is to approve/prescribe all modifications or special diets.
- Approval will be documented within the client's medical record.
- No changes are to be made to a client's diet without physician approval.
- All modifications or special diets are entered on a client's IPP and reviewed in care team as needed.

Methods to monitor compliance: File reviews will be done quarterly per accreditation, to check for physician approval. Dietary modifications/special diets will be added to nursing checklist and reviewed at minimum monthly during care review.

Person[s] responsible: ICFID program manager [Tiffany Bunting], nursing services

Date of correction: Fully implemented 03/31/2020

W475: Meal Services – Food must be served with appropriate utensils.

Facility failed to provide appropriate utensils at mealtimes.

- Facility incorporates opportunities into daily life experiences that promote choice making and decision making by the client At a minimum this is one full set per client [unless designated as a restrictive technique by the parent/legal guardian and a member of the HRC]. Examples are as follows:
  - Kitchen is accessible and open during meal times. Clients are provided opportunity to choose what, where, and how to eat.
  - Clients have free choice in what to wear. Clothing may be stored in cubbies, free from locks or restrictive techniques.
  - Clients are encouraged to participate in the medication pass [examples of ways in which this is to be encouraged naming drug, purposes, dosage, times of day]
- Facility has ensured adequate supply of all utensils [tableware, utensils, and napkins] for each cottage. At a minimum this is one full set per client [unless designated as a restrictive technique by the parent/legal guardian and a member of the HRC].
- Facility has provided training to staff regarding restrictive and intrusive techniques in conjunction with ongoing trainings. Will be providing a list of examples as to what is and what is not restrictive or intrusive.
- Facility has provided training to certified med passers regarding ways in which they are to encourage client participation in the medication pass.

Methods to monitor compliance: IP governing body [DIS, Campus/Program Manager, QIDPs, and Cottage Coordinators] will periodically monitor meal times, med pass times, and general interactions of staff with clients to ensure staff encourage and promote client choice and self-management. Observation checklist has been created to help support this process. This is to occur at a minimum, monthly.

Person[s] responsible: IP Governing Body [DIS, Program Manager, Cottage coordinators, QIDPs]

Date of correction: 03/31/2020

[redacted]

TANAGER PLACE
YOUR CHILD : OUR FOCUS

OST 2567

C146: 50.7 Additional notifications. The director or director designee shall be notified within 24 hours, or the next business day, by the most expeditious means available. 50.7(3) - When there is an act that causes major injury to a resident or when a facility has knowledge of a pattern of acts committed by the same resident on another resident that results in any physical injury.

- Once there is an act that causes major injury to a resident or when a facility has knowledge of a pattern of acts committed by the same resident on another resident that results in any physical injury:
  - Administration is to be notified immediately of all incidents
  - DIA notification is made within 24 hours, or the next business day
  - Internal review will occur. As part of the internal investigation reports of suspected child abuse shall be made in accordance with Mandatory Reporter requirements.
- The administrative review of allegations and critical incidents will include justifications regarding notifications and/or reporting to State entities.
- Policy on current Mandatory Reporting requirements and Administrative Leave is to be reviewed with staff prior to their next shift.
  - Email sent by end of day 12/12/2019 with policies attached.
  - Meeting to occur 12/12/2019 with shift leads, program managers, and QIDPs to ensure that IP Governing Body and staff know where to locate current Organizational Policies.
  - All staff are to review and acknowledge receipt of policy prior to start of shift by end of day 12/16/2019
  - Expectations of immediate notification to administration will be reiterated with all staff.

Additional action taken:

- Direct care staff participates in ongoing trainings weekly [Tuesday or Thursday depending on schedule]. Topics vary depending upon needs. Reporting procedures and guidelines are to be covered during these trainings.
- Child Abuse Report guidelines revised per State of Iowa DHS Mandatory Reporting guidelines for clarity purposes, and reviewed with staff.
- Documentation revised to assist with investigations of allegations. Specific documents created include client statement, witness statement, summary of findings, and critical incident report template.

- Creation of self-report checklist developed on 12/16/2019 to ensure all allegations are thoroughly investigated and proper steps undertaken based on the nature of the allegation. Template created to support documentation of witness statements, client statements, and summary of findings.

  Methods to monitor compliance: Self check list developed to monitor compliance with reporting procedures, to be completed with each allegation.

  Person[s] responsible: ICFID program manager [Tiffany Bunting] investigates all allegations. DIS [Michelle Allmandinger] conducts quality review

  Date of correction: Fully corrected immediately, upon receipt 02/14/2020

[redacted]

TANAGER PLACE
YOUR CHILD : OUR FOCUS

Class I and Class II Citation

W149: Staff treatment of clients – the facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, or abuse of the client.

Failed to complete 24-hour follow-up following incidents of peer-to-peer aggression, failure to identify injuries following incidents of peer to peer aggression, and failure to complete Critical Incident Reports [CIRs] per facility policy. Additionally, facility failed to implement policies regarding abuse and mandatory reporting.

Immediate actions taken in response to the Immediate Jeopardy

- Current policy around Child abuse and Mandatory Reporting had been provided to DIA as document given during their survey was obsolete and not a valid policy.
- Obsolete polices around Child Abuse and Mandatory reporting were removed and replaced with current organizational policies. All current policies are available to staff.
- Once an allegation of abuse has been alleged, the facility will take the following steps:
  - Administration is to be notified immediately of all allegations [required action step on CIR]
  - DIA notification is made [required action step on CIR]
  - Action is taken to ensure the safety of clients. Based on the nature, severity, and information provided regarding the allegation one of the following steps may be taken until the conclusion of the administrative review.
    - Staff immediately placed on Administrative Leave
    - Staff reassigned to a non-direct care role
    - Temporary reassignment of direct care work in another cottage
    - Temporary movement of client's cottage occupancy.
  - Internal review and investigation of allegations will occur. As part of the internal investigation reports of suspected child abuse shall be made in accordance with Mandatory Reporter requirements.
- The administrative review of allegations and critical incidents now includes justifications regarding notifications and/or reporting to State entities.
- A policy for administrative leave pending conclusion of internal investigation and/or DHS had been be developed and implemented 12/12/2019.
- Policy on current Mandatory Reporting requirements and Administrative Leave was reviewed with staff prior to their next shift.
  - Email sent by end of day 12/12/2019 with policies attached.
  - Meeting occurred 12/12/2019 with shift leads, program managers, and QIDPs to ensure that IP Governing Body and staff know where to locate current Organizational Policies.
  - All staff did review and acknowledge receipt of policy prior to start of shift by end of day 12/16/2019

- Expectations of immediate notification to administration will be reiterated with all staff.

Additional action taken:

- Direct care staff participates in ongoing trainings weekly [Tuesday or Thursday depending on schedule]. At a minimum, topics of policies and procedures around abuse reporting procedures will be reviewed quarterly.
- Child Abuse Report guidelines revised per State of Iowa DHS Mandatory Reporting guidelines for clarity purposes, and reviewed with staff.
- Documentation revised to assist with investigations of allegations. Specific documents created include client statement, witness statement, and summary of findings. Critical incident report template was updated and revised to include additional required elements.
- Reports to DHS [both founded and unfounded] are tracked and reviewed quarterly by the Executive team.
- Creation of self-report checklist developed on 12/16/2019 to ensure all allegations are thoroughly investigated and proper steps undertaken based on the nature of the allegation. Template created to support documentation of witness statements, client statements, and summary of findings.

Methods to monitor compliance: DIS and ICFID program manager will monitor for compliance of staff with all policies and procedures. DIS will continue to work closely with Executive team and IP Governing Body around policy development and periodic reviews with staff, at a minimum quarterly. ICFID Program Manager will complete self-report checklist for each allegation and ensure that all requirements of investigations have occurred. DIS will monitor reporting of allegations to ensure reported within 24 hours of allegation and investigated thoroughly and the facility takes immediate actions to address circumstances where abuse, neglect or mistreatment has occurred.

Person[s] responsible: Director of Inpatient Services [Michelle Allmandinger] and ICFID Program Manager [Tiffany Bunting]

Date of Correction: Instated 12/12/2019; to be completed by end of day 12/16/2019

[redacted]

TANAGER PLACE
YOUR CHILD : OUR FOCUS

W158: Facility Staffing – The facility must ensure that specific facility staffing requirements are met.

QIDP failed to update client IPPs to provide interventions consistent with BMP. QIDP failed to change client IPP interventions after a noted increase. Facility staff failed to demonstrate the skills and competencies to effectively manage inappropriate client behaviors.

Immediate actions taken in response to the Immediate Jeopardy

- Lower occupancy has been maintained to establish stabilization
- Mandatory trainings have been established. Staff will not be permitted to work on shift in Terry Cottage until which time they have completed trainings: Managing Challenging Behaviors Focused Learning and Choice Making for People with I/DD
- Experienced staff members on shift have been increased by coordinating scheduling with other cottages.
  - Assign experienced Shift Leader to 20 working hours in Terry Cottage.
  - Schedule at least one experienced leader in ICF/ID during second shift daily for next 14 days to guide, direct, and support direct care staff members. This will include experienced shift leads, program coordinators, program managers, QIDPs and Inpatient Director.
  - A representative from the operational Governing Body will be present on the unit during wake hours to observe interactions and ensure competencies of staff.

Additional Actions undertaken:

- QIDP developed a cottage wide BMP 10/02/2019
- Cottage Wide BMP was added to each client's IPP, effective 11/14/2019
- QIDP will review IPPs and consult with BCBA, Blake Stephenson for any client that has aggressed towards a peer(s) resulting in injury twice in a 30 day period, or caused a serious injury. Behavior Management plans [BMP] will be adjusted accordingly to coordinate services and supports that is needed to meet the client's needs and prevent further incidents.
- Any changes made to a client's BMP will be reviewed via email and questions to be followed up on in next scheduled weekly team to ensure effective implementation. QIDP will continue to monitor for effectiveness per the aforementioned criterion.
- Beginning, 11/15/2019, additional Behavior Management training specific to the IDD population will be mandatory.
- Staffing on the unit will be limited to those trained on the following:
  - Managing Challenging Behaviors Focused Learning
  - Choice Making for People with I/DD

Methods to monitor compliance: Clinical Supervisor, or designee and QIDP[s] will conduct ongoing case reviews of IPPs and incidents of peer to peer aggression. Each client will be reviewed in case review, at a minimum monthly.

Person[s] responsible: Clinical Supervisor, or designee [Holly Miller] and QIDPs [Kristin Moore and Avary Brinker]

Date of correction: Fully corrected immediately, upon receipt 02/14/2020

W122: Client Protections – The facility must ensure that specific client protection requirements are met.

Failed to provide all clients with a safe environment free of abuse from peers.

Immediate actions taken in response to the Immediate Jeopardy

- Operational Governing Body has placed a hold on admissions through November 2019
- Lower occupancy has been maintained to ensure stabilization and ample time to train and update staff regarding long term response needs.
- Beginning, 11/15/2019, additional Behavior Management training specific to the IDD population became mandatory.
- Staffing on the unit has been limited to those trained on the following. In the event that PMIC staff respond to a crisis situation, those staff trained on these required trainings and the clients IPP will provide direction for managing
    - Managing Challenging Behaviors Focused Learning
    - Choice Making for People with I/DD
- QIDP will provide training to staff on unit regarding each client's IPP.
- A representative from the IP Governing Body [DIS, Campus/Program Managers, QIDPs, and Cottage Coordinators] had been present on the unit during wake hours to observe interactions and ensure competencies of staff, to continue for 14 days post determination for first IJ.
- IP Governing Body [DIS, Campus/Program Managers, QIDPs, and Cottage Coordinators] did evaluate the appropriateness of each client currently enrolled in Terry Cottage. Those residents whose behavior is incompatible with other resident's needs and rights had been transferred or discharged from the unit.
- To manage challenging behaviors and support healthy interactions with peers, clients within Terry Cottage had been placed in Pods based on specific supports that are needed to meet the client's needs. Supervisor will align client groupings effective immediately 11/15/19.

Additional actions:

- To ensure support and enhance competencies over weekend shifts, a member of the IP Governing Body [DIS, Campus/Program Managers, QIDPs, and Cottage Coordinators'] has been present throughout the day, and had continued for minimum of 14 days post determination of 1st Immediate Jeopardy.
- To ensure support over weekend shifts, a member of the IP Governing Body has been present throughout the day.
- DIS has mandated additional trainings specific to the IDD population.
    - Choice Making for People with I/DD
    - Supporting Healthy Personal Relationships for People with I/DD
    - Supporting Individuals with IDD During Emergencies
- Mandatory Reporter training will be required to be retaken by all inpatient staff. This is to be finalized upon receipt 02/14/2020
- All IP staff will revisit and receive additional training on abuse reporting procedures. At a minimum this will be reviewed quarterly in team meetings.
- All IP staff will revisit and receive additional training around holds.
- Policy to be developed around cottage procedures. Expectation is that any staff member who fails to follow through with procedures will receive disciplinary action in the form of Coaching and Counseling or PIP.
- Will utilize Blake Stephenson, BCBA to provide consultation and support. Initial meeting scheduled 11/17/19.
- Required documentation was reviewed and modified to ensure critical information is captured and reported upon.
- Guidelines to track peer to peer aggression were expanded and a tracking sheet developed to monitor episodes of peer to peer aggression throughout each client's admission.
- IP governing body remains actively engaged in weekly care reviews, all-staff meetings, nightly huddles, and evening rotation within the milieu.
    - Terry Cottage staff and Administration will continue evening Huddle Call with debriefing and follow-up to occur around critical incidents / Accidents / Injuries / Consumer to Consumer. The governing body updated current policies and procedures around Peer to peer aggression and Critical incident reporting.

Methods to monitor compliance: IP Governing body [DIS, Program Managers, and Cottage Coordinators] will monitor compliance with mandatory trainings, ensuring the competency of staff on shift according to their supervision assignments, at a minimum quarterly. IP Governing Body will review peer to peer tracking guidelines with trends

addressed. DIS will review team meeting notes to ensure abuse procedures are reviewed, at a minimum quarterly.

Person[s] responsible: QIDP [Kristin Moore and Avary Brinker], DIS [Michelle Allmandinger, ICFID Program Manager [Tiffany Bunting]

Date of correction: Fully corrected immediately, upon receipt 02/14/2020

50.7(3): When there is an act that causes major injury to a resident or when a facility has knowledge of a pattern of acts committed by the same resident on another resident that results in any physical injury.

- Once there is an act that causes major injury to a resident or when a facility has knowledge of a pattern of acts committed by the same resident on another resident that results in any physical injury:
  - Administration is to be notified immediately of all incidents
  - DIA notification is made within 24 hours, or the next business day
  - Internal review will occur. As part of the internal investigation reports of suspected child abuse shall be made in accordance with Mandatory Reporter requirements.
- The administrative review of allegations and critical incidents will include justifications regarding notifications and/or reporting to State entities.
- Policy on current Mandatory Reporting requirements and Administrative Leave is to be reviewed with staff prior to their next shift.
  - Email sent by end of day 12/12/2019 with policies attached.
  - Meeting to occur 12/12/2019 with shift leads, program managers, and QIDPs to ensure that IP Governing Body and staff know where to locate current Organizational Policies.
  - All staff are to review and acknowledge receipt of policy prior to start of shift by end of day 12/16/2019
  - Expectations of immediate notification to administration will be reiterated with all staff.

Additional action taken:

- Direct care staff participates in ongoing trainings weekly [Tuesday or Thursday depending on schedule]. Topics vary depending upon needs. Reporting procedures and guidelines are to be covered during these trainings.
- Child Abuse Report guidelines revised per State of Iowa DHS Mandatory Reporting guidelines for clarity purposes, and reviewed with staff.

- Documentation revised to assist with investigations of allegations. Specific documents created include client statement, witness statement, summary of findings, and critical incident report template.
- Creation of self-report checklist developed on 12/16/2019 to ensure all allegations are thoroughly investigated and proper steps undertaken based on the nature of the allegation. Template created to support documentation of witness statements, client statements, and summary of findings.

Methods to monitor compliance: Self check list developed to monitor compliance with reporting procedures, to be completed with each allegation.

Person[s] responsible: ICFID program manager [Tiffany Bunting] investigates all allegations. DIS [Michelle Allmandinger] conducts quality review

Date of correction: Fully corrected immediately, upon receipt 02/14/2020