STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS Investigations #91528-I and #91590-I were completed on 6/18/20 to 7/1/20 and resulted in deficiencies written at W158, W159, W191, W214, and W249. On 6/24/20 at 11:45 a.m., Immediate Jeopardy (IJ) was determined based on the facilities failure to effectively integrate, monitor, and coordinate services to meet the client's needs and to provide behavioral intervention training to all staff. The facility developed a plan to remove the IJ, which included adjusting the alarm system, revising Client #1's behavior support plan, adding an additional staff in the morning hours, and staff training. On 7/1/20 at 11:40 a.m., the IJ was removed from the facility. During the investigations, a Focused Infection Control Survey was also completed and resulted in no deficiencies written.	W 000	On 07-01-20 Opportunity Living was removed from Immediate Jeopardy (IJ) as the following items were put in place: Alarm system in the home was adjusted, Client's BMP was revised, additional staff added to the morning shift and all staff that work in said house were trained on the client's BMP POC 9/12/20	
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 interviews and record reviews, the facility failed to comply with the Condition of Participation: Facility Staffing. The facility failed to effectively integrate, monitor, and coordinate services in order to meet client needs. Client #1 had three elopement attempts in May and six elopement attempts in June. On 6/2/20 and	W 158	W158 Facility Staffing Opportunity Living failed to ensure that specific staffing requirements were met POC: Opportunity living will ensure that adaquate staff is present in each home to meet client's needs This is accomplished by monitoring staffing daily for 2 months then monthly for 6 months Person(s) responsible: Direct Support supervisors, Compliance and Training Specialist and Director of Health Services Monitered by: Director of Residential Services or designee Date of Correction: Immediately	

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 158	Continued From page 1 6/20/20, Client #1 had actual elopements and the facility found him outside. The facility also failed to provide behavioral intervention training to all staff. Based on interviews and record reviews, the facility failed to effectively integrate, monitor, and coordinate services in order to meet client needs. See W159. Based on interviews and record reviews, the facility failed to provide behavioral intervention training to all employees. See W191. On 6/24/20 at 11:45 a.m., Immediate Jeopardy (IJ) was determined based on the facilities failure to effectively integrate, monitor, and coordinate services to meet the client's needs and to provide behavioral intervention training to all staff. The facility developed a plan to remove the IJ, which included adjusting the alarm system, revising Client #1's behavior support plan, adding an additional staff in the morning hours, and staff training. On 7/1/20 at 11:40 a.m., the IJ was removed from the facility.	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 interviews and record reviews, the Qualified Intellectual Disability Professional (QIDP) failed to effectively integrate, monitor, and coordinate services in order to meet client needs.	W 159		

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W 159	Continued From page 2 This affected 1 of 1 client (Client #1) reviewed during investigations # 91528-I and #91590-I. Findings follow: 1. Record review revealed the following: a. Client #1's Behavior Reports, indicated, Client #1 had three elopement attempts in May. In June, Client #1 had an elopement attempts on 6/5/20, 6/6/20, 6/10/20, two on 6/15/20, and two on 6/16/20. Client #1 had one Behavior Report for an actual elopement on 6/20/20. A Behavioral Report from 6/2/20 when Client #1 had an actual elopement is missing. b. Client #1's Data Summary indicated Client #1 had three elopement attempts in May and five elopement attempts from 6/1/20 to 6/19/20. c. Client #1's Communication Program dated 7/2/19 noted, "Anytime (Client #1) seems to want to go outside or attempts to leave the home unattended, take (Client #1) to the device and train him how to use it. Anytime he attempts or does exit the home a behavior report must be written." When interviewed on 6/19/20 at 10:25 a.m. the Director of Programming Services reported the facility addressed Client #1's elopement behavior in his communication plan. They keep track of his numbers by the behavior reports. She stated they document actual and attempts at elopement on a behavior report. The Director of Programming Services did not believe they needed a behavior support plan for elopement because it would contain the same thing as the communication program. She also believed they did not need to make any revisions or changes to	W 159	W159- QIDP Opportunity Living failed to have each client's active treatment integrated, coordinated and monitered by the QIDP Plan of Correction: Staff will be educated on the correct way to fill out behavior reports and specific client BMP(s) including when and how to fill out the behavior report. As the staff are being trained they will sign a training sheet to show they have been trained correctly. The Direct Support Supervisor (DSS), and the QIDP will review all behavior reports. Refresher training will continue for 6 months. Person Responsible: QIDP(s) Monitered by: Director of Residential Services or designee Date of Correction: Immediately	

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W 159	Continued From page 3 his plan as the last elopement Client #1 had was last July. When interviewed on 6/22/20 at 11:00 a.m. the Director of Programming Services reported Client #1 had an actual elopement on 6/20/20. She went to the home and had her eyes opened. She did not know until she filled a Behavioral Report out that she had to sign off on them. She decided they could not wait and needed to make some changes immediately. She stated they were writing a new behavior support plan tomorrow to address elopement. They are also getting approval to get another staff and changing the sound of the alarm. When interviewed on 6/24/20 at 11:45 a.m. the Director of Programming Services confirmed the facility failed to monitor and coordinate services to meet Client #1's needs. 2. Record review on 6/29/20 revealed the following: a. Client #1's behavioral data, indicated, Client #1 had an attempt at elopement on 6/26/20, 6/27/20, and 6/28/20. b. Client #1's behavioral report dated 6/28/20, indicated, he attempted an elopement. Behavioral Reports for 6/26/20 and 6/27/20 could not be located. c. Client #1's elopement program dated 6/23/20, indicated, "Any incidents of elopement must be reported to (the Director of Programming Services) or (Director of Nursing) immediately. A behavior report must also be completed."	W 159		

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W 159	Continued From page 4 When interviewed on 6/29/20 at 10:10 a.m. the Direct Support Supervisor (DSS) reported Client #1 had three attempts at elopement over the weekend, but she only had one behavior report. She did not know if they should write a behavior report for all attempts with the new program in place. When interviewed on 6/29/20 at 11:18 a.m. the Director of Programming Services confirmed the facility failed to write the Behavioral Reports for Client #1's attempts at elopement. She stated the Behavioral Reports are for her to monitor.	W 159		
W 191	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' behavioral needs. This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility failed to provide behavioral intervention training to all employees. This affected 1 of 1 client (Client #1) reviewed during investigations # 91528-I and #91590-I. Findings follow: 1. a. Record review revealed Client #1's Incident Report dated 6/2/20, indicated, "Staff went to check on (Client #1) to see if he was up or not for break when I found him outside. The door alarm was off from the last time he went outside. Staff that was working was (Direct Support Professional (DSP) A, DSP B, and DSP C)." When interviewed on 6/19/20 at 12:25 p.m. DSP B reported she arrived at work at 7:00 a.m. Client #1 was still asleep. He got up between 8:00 a.m.	W 191		

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W 191	Continued From page 5 and 8:30 a.m. Client #1 got dressed, ate breakfast, brushed his teeth, and he was given an option to stay in his bedroom and listen to music or go to the front of the house. He chose to stay in his bedroom. At approximately 8:45 a.m., his bedroom door alarm sounded and he started to head out the east door. Staff brought Client #1 back into the home. At approximately 9:30 a.m., the door alarm for the building sounded but not Client #1's bedroom alarm. DSP A turned off the building alarm. At approximately 10:05 a.m., the 15-minute timer sounded. DSP B went to check on Client #1 and found him outside the east door. She assisted Client #1 up off the ground and walked him around to the front of the building. They assume someone turned the alarm off. Facility staff did not know what to do after Client #1 eloped. The nurse came in and instructed them to contact the Director of Programming Services. The nurse also looked Client #1 over to ensure no injuries in case he fell. According to DSP B, Client #1 was in the front of the home around 9:30 a.m. She believed DSP A forgot to reset the alarm after they brought him back inside at 9:30 a.m. DSP B remembered Client #1 walked back towards his bedroom at approximately 9:47 a.m. Between 10:02 a.m. and 10:05 a.m., she found him outside. She believed he was out of sight for approximately 15 minutes. She thought his level of supervision was 15-minute checks, but she would have to ask the Qualified Intellectual Disability Professional (QIDP) or the Direct Support Supervisor (DSS). Since 6/2/20, they are to walk down the hall and keep him in sight to see where he is going. They watch the clients they are accountable for and wear a bracelet as a reminder. To stop Client #1 from leaving the building they block and redirect him, redirect him to the sensor room or his	W 191	W-191 Training Opportunity Living failed to provide behavioral intervening training to all employees POC: QIDP(s) will train all updated BMP(s) and document on training sheets. The QIDP(s) will observe and train on the BMP(s) as needed Direct support supervisors will be in the homes to check documentation and train where needed New Staff will be trained by the QIDP and/or the DSS on the BMP As client BMP's are updated staff will be trained on the changes and then will be monitered for 6 months. Person(s) responsible: QIDP, DSS Monitered by: Director of Residental Services or Designee Date of Correction: Immediately	

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W 191	Continued From page 6 bedroom. DSP B stated Client #1 liked to rock in his chair, listen to music, and jump to get his mind off going outside. DSP B does not feel 15-minute checks are good enough. She stated he needed checked on sooner than that. She also stated Client #1 walked through the bathroom between his and Client #2's bedroom so his bedroom alarm will not sound. DSP B reported someone who did not care trained her. The QIDP had her sit down and read everything. DSP B stated Client #1 did have a communication program to push a button when he wanted to go outside. She stated if he elopes, she takes him to the button and tells him you did not tell us you wanted to go out. There is no communication button on the east door. Additional interview on 6/22/20 at 1:32 p.m. revealed DSP B reported they turn off Client #1's bedroom door alarm in the morning when they helped him get ready, while they went in and out of his bedroom. They also turned it off when they did his 15-minute checks. When interviewed on 6/19/20 at 12:15 p.m. DSP C reported DSP A and DSP B got ready for break time between 10:00 a.m. and 10:05 a.m. The 15-minute timer sounded and DSP B went back to check on Client #1. She found him right outside the door. When she walked inside, the door alarm was off. According to DSP C, an alarm sounded prior to that. She did not know who went into the office to reset the alarm. She stated it was either DSP A or DSP B. She believed they turned off the alarm on accident, instead of resetting it. Along with the door alarms, they had one timer for toileting and one timer for 15-minute visual checks. DSP C stated the door alarm was loud, but they had a busy	W 191		

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house. DSP C also noted they completed door alarm tests on the second shift and believed they needed to do a door alarm test on the first shift, as well. DSP C only knew of one other elopement attempt Client #1 had on 6/2/20. She did not know he had elopements. She stated the facility did not train her when she started working in House A. According to DSP C, they did not turn the door alarms off for any reason. She remembered DSP B had accountability of Client #1. They try to entertain Client #1 with music, take on golf carts rides, and bus rides.

When interviewed on 6/23/20 at 12:45 p.m. DSP A reported her and DSP B got ready for break time at approximately 9:30 a.m. DSP B went back to Client #1's room to see if he wanted break and found him outside. They did not hear an alarm. They did not reset the alarm when he went outside the time before. DSP A could not remember the time, but remembered when they looked at the 15-minute timer there was about 10 minutes left. According to DSP A, Client #1 usually went out the east door and they usually caught him before he went out. She could not remember who brought him in the time before he went out that day. They did not hear the bedroom alarm and the door alarm did not go off. DSP A never saw Client #1 go through his bathroom to Client #2's bedroom to avoid the door alarm before. DSP A did not know why he had a bedroom door alarm and she assumed it was because of his elopements. DSP A believed she was trained properly on programs although, she just did not know why he had the bedroom door alarm. Since the incident on 6/2/20, if Client #1 tried to go outside take him up front to listen to music. They also check on Client #1 every time the door alarm goes off. She stated his level of

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W 191	Continued From page 8 supervision is constant. He has documented 15-minute checks, but he needed constant supervision. DSP A also stated Client #1 had no safety skills outside and someone held onto his hands when walking outside. DSP A did not know who turned off the alarm or who had accountability for him on 6/2/20. b. Record review revealed Client #1's Incident Report dated 6/20/20, indicated, "(Client #1) was out by the road outside House A. B. I (walked) him back into House A. Staff acted like they didn't know he was outside." When interviewed on 6/23/20 at 9:45 a.m. DSP D reported he worked from 9:00 a.m. to 3:00 p.m. in House B on 6/20/20. He arrived at work between 8:45 a.m. and 8:50 a.m. When he pulled around the corner onto Westview, he saw Client #1 standing by the cars in the parking lot. DSP D pulled into House B parking lot across the street and ran over to get him. DSP D took Client #1 into House A and staff did not know he was outside. DSP D did not hear an alarm sounding and nobody came outside. DSP E sat at the dining room and said, "Oh, no alarm." when he walked in. DSP D assumed Client #1 got out the east doors. He remembered Client #1 had on a white t-shirt and blue shorts. Client #1 did not have anything on his feet. DSP D stated he worked in House A and knew about Client #1's elopements. When interviewed on 6/23/20 at 10:30 a.m. DSP E reported at a little before 9:00 a.m. Client #1 walked out of one of the doors. DSP D brought him back inside from the parking lot. She stated she was in the dining room by the front door. DSP E thought he must have gotten out the east	W 191		

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W 191	Continued From page 9 doors because he did not go past her out the front doors. According to DSP E, she heard the door alarm when DSP D brought Client #1 back inside. She stated Client #1 was out of his bedroom before he left, but she is not sure where she saw him. She thought she heard him in the sensory room. DSP A or DSP F had accountability for him. She was unsure where they were; she thought they were in the kitchen or in the back of the house. DSP E just started working in House A. She stated that at no time should they turn the door alarms off. She did not know of anyone that would turn the alarms off. According to DSP E, Client #1's room should not be next to the east door. She believes he was gone for seconds, it was hectic at that moment and he had just been up front in the sensory room. DSP E stated Client #1 was one-to-one supervision when actively seeking the door. She said there was a day recently when she brought him into the house. Client #1 waits until they are not paying attention. He is slow about it, but if elopes one time he will go again. When interviewed on 6/23/20 at 11:12 a.m. DSP F reported the overnight sat at the front of the house at the dining table. DSP F walked into the kitchen and talked to DSP A on the plans for the shift. A couple minutes prior DSP F took Client #1 to his bedroom to listen to music. Then DSP D brought him into the house. No alarm sounded. They checked the alarm when he came back in. They believe he went outside the same time the nurse went out the front door. According to DSP F, Client #1 was gone approximately three minutes. There is no reason they would turn his bedroom door alarm off. DSP F knew Client #1 went into other client bedrooms, but she was unaware that he would go through	W 191		

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his bathroom and into Client #2's bedroom. He had not attempted an elopement prior to the actual that day. If they see that he tries to elope, they have him stay in the living room. DSP D stated DSP A had Client #1's accountability. DSP D stated the facility trained her on programming. The only thing that has changed since 6/2/20 is the alarms. She stated he was a high level of supervision. They check him every 15 minutes, but this weekend he was constant one-to-one supervision. They usually let him walk down the hallway by himself. DSP D stated they need more staff if they have to follow him.

When interviewed on 6/23/20 at 12:45 p.m. DSP A reported between 8:50 a.m. and 8:55 a.m., her and DSP F waited on the 9:00 a.m. staff to arrive. They talked about the shift for the day. DSP E sat at the dining table. Client #1 just finished breakfast and was probably heading to his bedroom. They only follow him down the hallway if he is having a bad day. DSP A did not believe Client #1 had tried to elope prior to 8:50 a.m. DSP A watched the nurse leave and reset the door alarm. A few minutes later, DSP C brought Client #1 inside. DSP C told them Client #1 was out by the door. They checked the alarms and they worked. DSP A believed Client #1 went out of the east door at the same time the nurse went out of the front door. She witnessed the same thing happen later that day. The nurse left and they checked on Client #1, he was walking out of the door. They redirected him. DSP A did not know who had accountability for Client #1.

No current training for staff on Client #1's behavioral supports could be located.

When interviewed on 6/22/20 at 2:25 p.m. the

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W 191	Continued From page 11 Director of Programming Services confirmed the facility failed to train staff on behavioral supports for Client #1. 2. Record review on 6/29/20 revealed the following: a. Client #1's behavioral data, indicated, Client #1 had an attempt at elopement on 6/26/20, 6/27/20, and 6/28/20. b. Client #1's behavioral report dated 6/28/20, indicated, he attempted an elopement. Behavioral Reports for 6/26/20 and 6/27/20 could not be located. c. Client #1's elopement program dated 6/23/20, indicated, "Any incidents of elopement must be reported to (the Director of Programming Services) or (Director of Nursing) immediately. A behavior report must also be completed." When interviewed on 6/29/20 at 10:10 a.m. the Direct Support Supervisor (DSS) reported Client #1 had three attempts at elopement over the weekend, but she only had one behavior report. She did not know if they should write a behavior report for all attempts with the new program in place. When interviewed on 6/29/20 at 11:18 a.m. the Director of Programming Services confirmed the facility failed to write the Behavioral Reports for Client #1's attempts at elopement. She stated the Behavioral Reports are for her to monitor.	W 191		
W 214	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(iii)	W 214		

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W 214	Continued From page 12 The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to identify the specific developmental needs of clients in the Comprehensive Functional Assessment (CFA). This affected 1 of 1 client (Client #1) reviewed during investigations #91528-I and #91590-I. Finding follows: Record review revealed Client #1's CFA dated 6/20/19 failed to indicate Client #1 had a history of elopement. The CFA indicated Client #1 did not "(Run) away from designated area. (but will stray from areas when exploring environment)." When interviewed on 6/29/20 at 11:18 a.m. the Director of Programming Services confirmed the facility failed to identify elopement in Client #1's CFA.	W 214	W214 - CFA Individual progam Plan Opportunity Living failed to train staff on behavioral supports. POC: The QIDP will review and update the Comprehensive Functional Assessment (CFA) when significinat changes occur to a client's status. All CFA's will be reviewd for accuracy by September 15th, 2020 then annually thereafter Person(s) responsiblle: QIDP(s) Monitered by: Director of Residential Services or designee Date of Correction: September 12, 2020	
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.	W 249	The compliance and training specialist will evaluate and monitor the POC twice monthly to ensure accuracy and effeciveness of the POC	

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W 249	Continued From page 13 This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure clients received needed supports and services as outlined in the Individual Support Plan (ISP). This affected 1 of 1 client (Client #1) reviewed during investigations #91528-I and #91590-I. Findings follow: 1. Record review revealed Client #1's Incident Report dated 6/2/20, indicated, "Staff went to check on (Client #1) to see if he as up or not for break when I found him outside. The door alarm was off from the last time he went outside. Staff that was working was (Direct Support Professional (DSP) A, DSP B, and DSP C)." Additional record review revealed the following: a. The diagnosis of Client #1, age 22 at the time of the incident, included: Intellectual Disability, Cerebral Palsy, Retinopathy or Prematurity bilateral blindness, Moderate hearing loss (Left ear), and Stereotypic movement disorder. b. Client #1's annual evaluation dated 6/25/19, indicated, "Staff must be aware of where (Client #1) is at all times." According to website, wunderground.com, on 6/2/20 at 9:53 a.m. the temperature was 83 degrees Fahrenheit (F). When interviewed on 6/19/20 at 12:25 p.m. DSP B reported she arrived at work at 7:00 a.m. Client #1 was still asleep. He got up between 8:00 a.m. and 8:30 a.m. Client #1 got dressed, ate breakfast, brushed his teeth, and he was given an option to stay in his bedroom and listen to music or go to the front of the house. He chose to stay	W 249	W 249 Program implementation POC: Any client with behavioral issues that put themselves or others safety at risk will have appropriate programming to address safety issues. As client's programming is changed staff will be trained on the changes by the QIDP and/or DSS and monitered monthly for 6 months. Person(s) responsible QIDP(s), DSS Monitered by - Director of Residential Services or designee Date of Correction: immediately	

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in his bedroom. At approximately 8:45 a.m., his bedroom door alarm sounded and he started to head out the east door. Staff brought Client #1 back into the home. At approximately 9:30 a.m., the door alarm for the building sounded but not Client #1's bedroom alarm. DSP A turned off the building alarm. At approximately 10:05 a.m., the 15-minute timer sounded. DSP B went to check on Client #1 and found him outside the east door. She assisted Client #1 up off the ground and walked him around to the front of the building. They assume someone turned the alarm off. Facility staff did not know what to do after Client #1 eloped. The nurse came in and instructed them to contact the Director of Programming Services. The nurse also looked Client #1 over to ensure no injuries in case he fell. According to DSP B, Client #1 was in the front of the home around 9:30 a.m. She believed DSP A forgot to reset the alarm after they brought him back inside at 9:30 a.m. DSP B remembered Client #1 walked back towards his bedroom at approximately 9:47 a.m. Between 10:02 a.m. and 10:05 a.m., she found him outside. She believed he was out of sight for approximately 15 minutes. She thought his level of supervision was 15-minute checks, but she would have to ask the Qualified Intellectual Disability Professional (QIDP) or the Direct Support Supervisor (DSS). Since 6/2/20, they are to walk down the hall and keep him in sight to see where he is going. They watch the clients they are accountable for and wear a bracelet as a reminder. To stop Client #1 from leaving the building they block and redirect him, redirect him to the sensor room or his bedroom. DSP B stated Client #1 liked to rock in his chair, listen to music, and jump to get his mind off going outside. DSP B does not feel 15-minute checks are good enough. She stated

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W 249	Continued From page 15 he needed checked on sooner than that. She also stated Client #1 walked through the bathroom between his and Client #2's bedroom so his bedroom alarm will not sound. DSP B reported someone who did not care trained her. The QIDP had her sit down and read everything. DSP B stated Client #1 did have a communication program to push a button when he wanted to go outside. She stated if he elopes, she takes him to the button and tells him you did not tell us you wanted to go out. There is no communication button on the east door. When interviewed on 6/19/20 at 12:15 p.m. DSP C reported DSP A and DSP B got ready for break time between 10:00 a.m. and 10:05 a.m. The 15-minute timer sounded and DSP B went back to check on Client #1. She found him right outside the door. When she walked inside, the door alarm was off. According to DSP C, an alarm sounded prior to that. She did not know who went into the office to reset the alarm. She stated it was either DSP A or DSP B. She believed they turned off the alarm on accident, instead of resetting it. Along with the door alarms, they have one timer for toileting and one timer for 15-minute visual checks. DSP C stated the door alarm is loud, but they have a busy house. They do rely on the alarms right next to his room door alarm is loud, busy house, rely on the alarms but she believed his checks needed to be sooner. DSP C also believed they needed to do a door alarm test on the first shift, right now they are completed on the second shift. DSP C only knows of one other elopement attempt Client #1 had on 6/2/20. She did not know he had elopements. She stated the facility did not train her when she started working in House A. According to DSP C, they do not turn the door	W 249		

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W 249	Continued From page 16 alarms off for any reason. She remembered DSP B had accountability of Client #1. They try to entertain Client #1 with music, take on golf carts rides, and bus rides. When interviewed on 6/23/20 at 12:45 p.m. DSP A reported her and DSP B got ready for break time at approximately 9:30 a.m. DSP B went back to Client #1's room to see if he wanted break and found him outside. They did not hear an alarm. They did not reset the alarm when he went outside the time before. DSP A could not remember the time, but remembered when they looked at the 15-minute timer there was about 10 minutes left. According to DSP A, Client #1 usually goes out the east door and they usually catch him before he goes out. She could not remember who brought him in the time before he went out that day. They did not hear the bedroom alarm and the door alarm did not go off. DSP A has never seen Client #1 go through his bathroom to Client #2's bedroom to avoid the door alarm before. DSP A did not know why he had a bedroom door alarm and she assumed it was because of his elopements. DSP A believed she was trained properly on programs although, she just did not know why he had the bedroom door alarm. Since the incident on 6/2/20, if Client #1 tries to go outside take him up front to listen to music. They also check on Client #1 every time the door alarm goes off. She stated his level of supervision is constant. He has documented 15-minute checks, but he needs constant supervision. DSP A also stated Client #1 had no safety skills outside and someone held onto his hands when walking outside. DSP A did not know who turned off the alarm or who had accountability for him on 6/2/20.	W 249		

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W 249	Continued From page 17 When interviewed on 6/19/20 at 1:00 p.m. the Direct Support Supervisor confirmed the facility failed to know Client #1's whereabouts at all times. She stated between Client #1's 15 minute checks staff have to know where he is. 2. Record review revealed Client #1's Incident Report dated 6/20/20, indicated, "(Client #1) was out by the road outside House A. B. I (walked) him back into House A. Staff acted like they didn't know he was outside." Additional record review revealed the following: a. The diagnosis of Client #1, age 22 at the time of the incident, included: Intellectual Disability, Cerebral Palsy, Retinopathy or Prematurity bilateral blindness, Moderate hearing loss (Left ear), and Stereotypic movement disorder. b. Client #1's annual evaluation dated 6/25/19, indicated, "Staff must be aware of where (Client #1) is at all times." According to website, wunderground.com, on 6/20/20 at 8:53 a.m. the temperature was 85 degrees Fahrenheit (F). When interviewed on 6/23/20 at 9:45 a.m. DSP D reported he worked from 9:00 a.m. to 3:00 p.m. in House B on 6/20/20. He arrived at work between 8:45 a.m. and 8:50 a.m. When he pulled around the corner onto Westview, he saw Client #1 standing by the cars in the parking lot. DSP D pulled into House B parking lot across the street and ran over to get him. DSP D took Client #1 into House A and staff did not know he was outside. DSP D did not hear an alarm sounding and nobody came outside. DSP E sat at the dining room and said oh no alarm when he	W 249		

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walked in. DSP D assumed Client #1 got out the east doors. He remembered Client #1 had on a white t-shirt and blue shorts. Client #1 did not have anything on his feet. DSP D stated he worked in House A and knew about Client #1's elopements.

When interviewed on 6/23/20 at 10:30 a.m. DSP E reported at a little before 9:00 a.m. Client #1 walked out of one of the doors. DSP D brought him back inside from the parking lot. She stated she was in the dining room by the front door. DSP E thought he must have gotten out the east doors because he did not go past her out the front doors. According to DSP E, she heard the door alarm when DSP D brought Client #1 back inside. She stated Client #1 was out of his bedroom before he left, but she is not sure where she saw him. She thought she heard him in the sensory room. DSP A or DSP F had accountability for him. She was unsure where they were; she thought they were in the kitchen or in the back of the house. DSP E just started working in House A. She stated that at no time should they turn the door alarms off. She did not know of anyone that would turn the alarms off. According to DSP E, Client #1's room should not be next to the east door. She believes he was gone for seconds, it was hectic at that moment and he had just been up front in the sensory room. DSP E stated Client #1 was one-to-one supervision when actively seeking the door. She said there was a day recently when she brought him into the house. Client #1 waits until they are not paying attention. He is slow about it, but if elopes one time he will go again.

When interviewed on 6/23/20 at 11:12 a.m. DSP F reported the overnight sat at the front of the

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house at the dining table. DSP F walked into the kitchen and talked to DSP A on the plans for the shift. A couple minutes prior DSP F took Client #1 to his bedroom to listen to music. Then DSP D brought him into the house. No alarm sounded. They checked the alarm when he came back in. They believe he went outside the same time the nurse went out the front door. According to DSP F, Client #1 was gone approximately three minutes. There is no reason they would turn his bedroom door alarm off. DSP F knew Client #1 went into other client bedrooms, but she was unaware that he would go through his bathroom and into Client #2's bedroom. He had not attempted an elopement prior to the actual that day. If they see that he tries to elope, they have him stay in the living room. DSP D stated DSP A had Client #1's accountability. DSP D stated the facility trained her on programming. The only thing that has changed since 6/2/20 is the alarms. She stated he was a high level of supervision. They check him every 15 minutes, but this weekend he was constant one-to-one supervision. They usually let him walk down the hallway by himself. DSP D stated they need more staff if they have to follow him.

When interviewed on 6/23/20 at 12:45 p.m. DSP A reported between 8:50 a.m. and 8:55 a.m., her and DSP F waited on the 9:00 a.m. staff to arrive. They talked about the shift for the day. DSP E sat at the dining table. Client #1 just finished breakfast and was probably heading to his bedroom. They only follow him down the hallway if he is having a bad day. DSP A did not believe Client #1 had tried to elope prior to 8:50 a.m. DSP A watched the nurse leave and reset the door alarm. A few minutes later, DSP C brought Client #1 inside. DSP C told them Client #1 was

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W 249	Continued From page 20 out by the door. They checked the alarms and they worked. DSP A believed Client #1 went out of the east door at the same time the nurse went out of the front door. She witnessed the same thing happen later that day. The nurse left and they checked on Client #1, he was walking out of the door. They redirected him. DSP A did not know who had accountability for Client #1. When interviewed on 6/24/20 at 11:45 a.m. the Director of Programming Services confirmed the facility failed to know Client #1's whereabouts at all times.	W 249		