STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16G042	A. BUILDING _____ B. WING _____	C 09/05/2024

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 #122799-I, #122817-I, and #122884-I resulted in a deficiency cited at W249. Investigation #122811-M resulted in a deficiency cited at W153. As a result of investigations #122803-I, #122805-M, #122815-I, #122891-I, and #123099-I no deficiencies were cited.	W 000	See Attached POC 10/3/24	
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) 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 reviews, the facility failed to ensure staff immediately reported all allegations of abuse, neglect, or mistreatment. This affected 1 of 1 client identified as a result of investigation #122811-M (Client #1). Findings follow: Record review on 8/21/24 of surveillance camera video for the right side living room at House 103 Cherry revealed at approximately 2:47 p.m. Staff D approached Client #1 as he sat in a chair. Staff D grabbed the front of his shirt with both hands and pulled him to the floor, which knocked over the chair. Client #1 could be seen on the floor grabbing at Staff D who stood near him. At 2:49 p.m., Staff A walked through living room while Client #1 laid on the ground. At 2:50 p.m., Client #1 tried hitting Staff D while still on the floor, then crawled into a brown recliner and sat on his	W 153		

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

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knees with stomach pressed to the back of the recliner. Client #1 grabbed the curtain off the window and pulled it down. At 2:55 p.m., Staff D pushed the brown chair forward from behind which made Client #1 fall to the floor. The brown recliner laid on top of him. At 2:58 p.m., Staff D placed one hand on top of the recliner and pushed it down while Client #1 was still underneath it. At 3:01 p.m., Staff D walked away from Client #1 into another room and Client #1 put part of the curtain into his mouth. Staff D returned and pulled the curtain from the other end while curtain still in Client #1's mouth. At 3:02 p.m., Client #1 was on the floor by a gray recliner where another peer was seated. Staff D pushed the blue chair against Client #1, which forced him up against the gray chair and pinned him. At 3:04 p.m., Client #1 crawled to another recliner in the living room and sat in it on his knees. Staff D pushed the recliner over, which caused the client to fall to the floor again with the recliner on top of him. At 3:05 p.m., the Treatment Program Manager (TPM) entered the living room and ended the incident. During the incident Staff B and Staff C can be seen in the living room; however, they did not attempt to intervene or immediately report the incident. Staff A could also be seen walking through the living room as the incident occurred, but failed to intervene or immediately report the incident.

Additional record review revealed Client #1, a 21 year old male, had diagnoses including: mild intellectual disability, depressive disorder, generalized anxiety disorder, insomnia, and intermittent explosive disorder. Client #1's behavior support program (BSP) included target behaviors of aggression (hitting, kicking, biting others, pushing, or any behavior that is meant to

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cause harm to others), destruction (throwing items, picking at walls, breaking items, tipping over furniture, or rendering an item unusable), self-injurious behaviors (SIB) (picking or tearing at sores or skin, scratching self, hitting self, or hitting head against an object), food stealing (taking or hiding food items not belonging to him), and explosive outbursts (uncontrolled verbal outbursts characterized by high pitched vocalizations, crying when not getting something he wants, screaming, verbal aggression, swearing, or threats about hurting or killing people or animals). If Client #1 engaged in aggression, destruction, SIB, or explosive outburst behavior, staff should attempt to block and clear the area to protect Client #1 and others as appropriate. If Client #1 engaged in food stealing staff should assist him to return the item to the kitchen or to the rightful owner. Client #1's BSP did not include the use of physical interventions.

Record review of the facility Abuse and Incident Management Policy, date 3/28/24, revealed the policy included unauthorized use of restrictive measures such as seclusion, time out, and unreasonable confinement as dependent adult abuse. Facility employees were mandatory abuse reporters and should immediately report all incidents of suspected abuse or neglect.

When interviewed on 8/21/24 at 10:07 a.m., Staff B confirmed she witnessed Staff A grab Client #1 by the front of his shirt and take him off the chair. She further confirmed she witnessed Staff A grab the back of recliner, lift, and watched as Client #1 fell onto the floor. Staff B confirmed she is a mandatory reporter and failed to intervene/immediately report the incident.

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W 153	Continued From page 3 When interviewed on 8/22/24 at 9:00 a.m., Staff A confirmed she grabbed Client #1 by his shirt and removed him from the chair. She further confirmed they turned both chairs over while Client #1 sat in them. Staff A verified she was a mandatory reporter and confirmed Client #1's BSP did not authorize the use of any physical interventions. When interviewed on 8/20/24 at 3:03 p.m., TPM confirmed staff should have immediately reported the incident as possible abuse/mistreatment.	W 153		
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. This STANDARD is not met as evidenced by: Based on interviews and record reviews, facility staff failed to provide supervision as directed by the client's Behavior Support Plan (BSP) and the facility accountability policy. This affected 2 of 2 clients (Client #2 in investigation #122799-I and #122884-I, Client #5 in #122817-I). Findings follow: 1. Record review on 8/26/24 revealed the following:	W 249		

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a. Client #2's Incident Report dated 6/26/24 indicated at 7:50 a.m., Residential Treatment Supervisor (RTS) A discovered Client #2 at the glider outside the front door. The RTS A accompanied Client #2 back in the house. The accountable staff did not know Client #2 left the house. Review of the nursing assessment completed at 8:30 a.m. noted no signs of injury.

b. Client #2's Behavior Support Plan (BSP) dated 6/19/24 directed staff to provide Client #2 with five-minute visual checks in the home, one-on-one (1:1) supervision within one arm's-length when outside, and in a group of one. Behaviors to reduce include unsupervised leave, property destruction, disruptive behaviors, self-injurious behaviors, and aggressive behaviors toward others.

c. The facility's video footage of Client #2 dated 6/26/24 showed at 7:17 a.m. Client #2 walked out the front door unsupervised. He remained unsupervised in and around a foot from the glider for 33 minutes. At 7:50 a.m., RTS A discovered Client #2 and brought him back inside. The video showed Client #2 wearing a short-sleeved t-shirt, long pants, socks, and shoes during the incident.

d. The State Climatologist email dated 8/26/24 indicated on 6/26/24 between 7:00 a.m. and 8:00 a.m., partly cloudy weather conditions, the temperature at 70- and 72 degrees Fahrenheit, humidity 89%-95%, and winds at five to six miles per hour.

e. Client #2's Comprehensive Functional Assessment (CFA) dated 4/30/24 indicated Client #2 needed staff support to safely recognize and navigate situational, environmental, and stranger

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dangers.

f. Record review failed to reveal additional incidents of unsupervised leave within the past twelve months.

When interviewed on 8/26/24 at 11:35 a.m., Staff E confirmed she had accountability for Client #2 on 6/26/24 and failed to follow his level of supervision according to his BSP. She indicated she lost track of time.

2. Record review on 8/26/24 revealed Client #2's accountability sheet dated 6/26/24 indicated Staff F signed in to account for Client #2 at 6:00 a.m. but failed to sign out when he left the house at 7:15 a.m.

Additional record review revealed the facility's Accountability Policy dated 8/29/23 directed staff to sign into the responsibility and accountability for assigned individual(s). Staff must transfer accountability before leaving. Staff must sign out on the ISP data form (accountability sheet) with the time and their initials and hand it to the staff receiving account to sign in with their initials and time before leaving.

When interviewed on 8/27/24 at 8:30 a.m., Staff F confirmed on 6/26/24, he failed to complete the accountability transfer before he left Client #2.

When interviewed on 8/26/24 at 12:08 p.m., the Assistant Superintendent (AS) confirmed facility staff failed to follow Client #2's level of supervision as directed in his BSP and the facility accountability policy.

3. Record review on 8/29/24 revealed the

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following:
a. Client #5's IR dated 8/14/24 indicated RTS B found Staff G in a living room recliner with his eyes closed and head resting on his left hand while accountable for Client #5. RTS B stood before Staff G for three seconds, then called out his name. RTS B informed Staff G he could not sleep there. The nursing assessment noted no injury.

b. Client #5's BSP dated 8/2/24 directed staff to provide Client #5 with one-on-one (1:1) supervision within two arms-length between 8:00 a.m. and 8:00 p.m. because of PICA (eating inedible items) behaviors. Client #5 would move extremely fast and look for opportunities such as downtimes or staff looking away to engage in PICA. Identified signs include eyes darting, closely looking, scanning, and scoping. If attempted, staff should block and interrupt PICA behavior.

c. The facility's video footage dated 8/14/24 between 10:40 a.m. and 11:25 a.m. showed Staff G in the living room recliner on the left of Client #5. Staff G engaged in brief intermittent movements such as rocking in the recliner and heels on the ground, lifting his toes; movements faded to a stop. Occasionally, Staff G's head tilted to the left and rested on his left hand. At 11:07 a.m., Client #5 stood up, and Staff G verbally prompted her to sit; he rocked in the recliner and faded to a stop. Staff G remained still with his head resting on his left hand between 11:16 a.m. and 11:21 a.m. At 11:21 a.m., RTS B entered the room, stood before Staff G for three seconds, and then called his name. Staff G's body tensed as he looked up at RTS B. RTS B informed him he could not sleep at work.

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When interviewed on 8/29/24 at 12:40 p.m., RTS B recalled walking into the living room; he found Staff G in the recliner with his eyes closed and head resting on his left hand. He explained he stood before Staff G for a few seconds and waited for him to notice. When Staff G did not, he loudly called his name. When Staff G looked up, RTS B said he could not sleep at work.

When interviewed on 9/3/24 at 5:11 a.m., Staff G recalled he maintained focus on Client #5 between 10:40 a.m. and 11:21 a.m. because of her 1:1 supervision level. Staff G indicated because of how fast Client #5 could move when she stood up, staff should stand as well. When asked why he did not stand when Client #5 stood up, he stated she never stood up; she just rocked in her recliner. Staff G denied he was inattentive or dozing between 10:40 a.m. and 11:21 a.m.

When interviewed on 8/29/24 at 11:00 a.m., the AS confirmed Staff G failed to provide Client #5 with the level of supervision directed in her BSP.

4. Record review on 9/3/24 revealed the following:
a. Client #2's IR dated 8/18/24 indicated Staff H left early from her shift and failed to transfer accountability for Client #2 to another staff member. Client #2's level of supervision includes 1:1 supervision within two arms-length in a group of one. Nursing assessment completed at 6:26 a.m. noted Client #2 reported he fell and indicated pain from a raised area about golf ball size on the lower back of his head; the date, time, and cause unknown.

b. The facility's video footage dated 8/18/24 shows at 5:55 a.m. Staff H walked with Client #2

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to the living room. Client #2 sat in the recliner by the dining room entrance. Staff H walked from Client #2 to the living room entrance, stood there for a few minutes, walked to the staff office, and left the house. Staff failed to maintain the two arms-length of Client #2 for four minutes.

c. Client #2's accountability sheet dated 8/17/24 indicated Staff H signed out of accountability for Client #2 at 5:45 a.m. with no staff signed in at 5:45 a.m.

d. Client #2's BSP dated 6/26/24 directed staff to always provide Client #2 with 1:1 supervision within two arms-length and in a group of one.

e. Client #2's Supervision training sheet dated 6/26/24 directed staff to always provide Client #2 with 1:1 supervision within two arms-length and in a group of one. RTS C trained Staff H on Client #2's level of supervision on 8/17/24 at 10:30 p.m.

f. The facility's Accountability Policy dated 8/29/23 directed staff to sign out with their initials and time and hand the ISP data form to the staff receiving account to sign in with their initials and time before they could leave.

When interviewed on 9/3/24 at 1:30 p.m. Staff I recalled Staff H told her she needed to leave at 5:45 a.m. and asked who would sign into account for Client #2. Staff I explained they could not sign into account for Client #2 until additional first shift staff arrives and staff assignments come in.

When interviewed on 9/4/24 at 11:42 a.m., Staff H confirmed on 8/18/24, she failed to transfer accountability of Client #2 to another staff member before she left the shift early.

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W 249	Continued From page 9 When interviewed on 9/3/24 at 12:05 p.m., the AS confirmed overnight shift starts at 10:00 p.m. and ends at 6:00 a.m. Regardless of time, staff could not leave until they transfer accountability to the individuals assigned to them. Staff failed to follow the accountability transfer policy as directed in the Accountability policy and Client #2's supervision level as directed in his BSP.	W 249		

Woodward Resource Center (WRC)
Standard Level Plan of Correction for DIA Investigation #122799-I, #122811-M, #122817-I, and #122884-I

Tag W-153 – Staff Treatment of Clients– CFR(s): 483.420(d)(2): 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.

DIA found the facility failed to ensure staff immediately reported all allegations of abuse, neglect, or mistreatment.

Individual response

Contract RTW D was relieved of his/her services to WRC on 8/1/24.

RTW C was informed WRC no longer needed his/her services on 8/16/24.

RTW B will be given discipline and retrained when he/she returns from medical leave.

RTW A will be given discipline and retrained by 10/3/24.

All staff regularly assigned to Client 1, including RTW A, B, and C were retrained on WRC's Abuse and Incident Management Policy including that allegations of abuse shall be reported timely. All employees volunteers and contractors shall take immediate steps to ensure that an individual involved in an incident receives needed appropriate treatment and protection from further harm. Staff were trained from 8/2/24 to 8/5/24.

Responsible: Assistant Superintendent of Habilitation Services
Date completed: 10/3/2024, with the exception of RTW B, if he/she has not returned from medical leave

Systemic response

All staff with regular contact with Client's were retrained on WRC's Abuse and Incident Management Policy including that allegations of abuse shall be reported timely. All employees volunteers and contractors shall take immediate steps to ensure that an individual involved in an incident receives needed appropriate treatment and protection from further harm. Staff were trained from 8/2/24 to 8/16/24.

WRC will continue to provide annual Abuse and Incident Management training to all staff. This includes training on immediately reporting allegations of abuse, neglect, mistreatment, and exploitation.

Responsible: Superintendent
Date completed: 10/3/2024, and on-going

Tag 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.

DIA found the facility staff failed to provide supervision as directed by the clients Behavior Support Plan (BSP) and the facility accountability policy.

Individual response

RTW E was retrained on WRC's Accountability Policy on 6/26/24.

RTW F was retrained on WRC's Accountability Policy on 6/26/24.

RTW E was given discipline on 7/31/24.

All staff regularly assigned to Client 2 were retrained on WRC's Accountability Policy from 6/26/24 to 7/2/24.

RTW G was retrained on Client 5's Behavior Support Plan (BSP) on 9/6/24.

RTW G was retrained on WRC's Accountability Policy on 9/6/24.

RTW G was retrained on WRC's Level of Supervision Policy on 9/6/24.

RTW G was given discipline on 9/20/24.

RTW H was retrained on WRC's Accountability Policy on 9/1/24.

RTW H was retrained on WRC's Level of Supervision Policy on 9/1/24.

RTW H was retrained on Client 2's Behavior Support Plan (BSP) on 9/1/24.

RTW H was given discipline on 9/19/24.

All staff regularly assigned to Client 2 were retrained on WRC's Accountability Policy from 8/28/24 to 9/3/24.

All staff regularly assigned to Client 2 were retrained on WRC's Level of Supervision Policy from 8/28/24 to 9/3/24.

All staff regularly assigned to Client 2 were retrained on Client 2's Behavior Support Plan (BSP) from 8/28/24 to 9/3/24.

All staff regularly assigned to Client 2 were retrained on Client 2's JSP Mobility Plan from 9/18/24 to 9/20/24.

Responsible: Assistant Superintendent of Habilitation Services

Date completed: 10/3/2024

Systemic response

All staff with regular contact with Client's were retrained on WRC's Accountability Policy from 9/9/24 to 9/19/24.

All staff with regular contact with Client's were retrained on WRC's Levels of Supervision Policy from 9/9/24 to 9/19/24.

WRC will continue to provide annual Accountability and Levels of Supervision training to all staff.

An Active Treatment Observation Checklist was developed on 9/12/24 and implemented on 9/19/24. Active Treatment Observations will be completed weekly by the RTS, TPM, TPA, and Assistant Superintendent of Habilitation Services.

Responsible: Superintendent
Date completed: 10/3/2024, and on-going