STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
DEVELOPMENTAL DISABILITIES ADMINISTRATION B32-25
Lakeland Village, S. 2320 Salnave Rd.
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RECEIVED
NOV 11 2015
Residential Care Services
ICF/IID Program

Loida Baniqued, Field Manager
ICF/IID Survey and Certification Program
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

Re: Credible allegation of compliance, recertification Survey 1/12/2015-1/27/2015, revisit 3/23/2015-3/27/2015

Dear Ms. Baniqued,

This letter constitutes the credible allegation of compliance for the Lakeland Village ICF/IID, as required by your letter of April 10, 2015. Submission of this credible allegation of compliance is not an admission that a deficiency existed or that one was cited correctly.

This credible allegation of compliance will address all the deficiencies cited under 42 CFR §483.410 (W102), Governing Body and Management, and 42 CFR §483.440 (W195), Active Treatment Services. The deficiencies cited under both of the conditions of participation have been corrected as of 11/06/15. By addressing the deficiencies found in each of the specific standards cited under each condition, I believe Lakeland Village ICF/IID is now in substantial compliance with the cited conditions of participation. The following summary describes for both conditions: (1) how and when the corrections were made, (2) the systems that are in place to maintain compliance, and (3) how the corrective action will be monitored to ensure the deficient practice does not recur.

(1) <u>How and when the corrections were made</u>

- For Resident #7, a new Positive Behavior Support Plan (PBSP) / Functional Assessment written on 4/7/15 (full approval by 6/15/15). This plan was revised on 10/20/15.
- By 6/17/15, 25 direct care staff were trained on Resident #7's new PBSP.
- Resident #7 diagnoses were updated per the DSM-5 on 6/9/15 by the Psychology Associate. He is now diagnosed with [redacted] in addition to his other diagnoses.

- Resident #7's Individual Habilitation Plan (IHP) meeting was convened by his QIDP on 5/27/15. The IHP included a comprehensive functional assessment, determination of needs, and supporting active treatment programs to meet those needs. Programs are reviewed by each responsible discipline and reported to the QIDP on the Monthly Progress Report. The QIDP reviews the programs at least quarterly and more often if indicated.
- ARNP Psychiatric Assessment of Resident #7 was completed 4/9/15 and is located in the Resident Unit Record.
- Resident #7's PBSP includes working with him to clean or exchange his bag after walks; offering him exchange items to replace items he already has in his bags (cigarette butts, gum, etc.); working with him to move to relaxation areas when agitated; encouraging daily supervised walks.
- All outdoor garbage cans were removed from the route Resident #7 normally walks.
- For Resident #1, his IDT met on 5/12/15 to discuss whether his isolation and lack of engagement in active treatment might be due to a significant physical decline over the past several years (he is [redacted] years old).
- Resident #1 subsequently received a PASSR Level 1 screening and Level II evaluation, and was transferred to the Lakeland Village nursing facility on [redacted]15.
- Resident #14's toileting positioning device (restraint) was discontinued by the physician on 3/25/2015.

(2) <u>The systems that are in place to maintain compliance</u>

- All ICF residents were reviewed for the presence of [redacted] or [redacted] like behavior. Three residents were identified (including Resident #7). All had current [redacted] Behavior Support Programs with appropriate assessments in place.
- 100% review and modification of all Individualized Active Treatment schedules for each resident who lives in the ICF to ensure they were individualized and specific to each resident.
- Management sent emails to all staff on 5/5/15/ and 8/5/15 regarding not dropping inappropriate items onto the ground, noting that disciplinary action could occur for violations.
- 333 direct care staff were trained in active treatment by H&W Independent Solutions by 6/3/15.
- 10 Attendant Counselor Managers received 8 hours of active treatment training H&W independent Solutions on 6/1/15
- In September 2015, peer mentors identified as "Trend Setters" were deployed to all cottages to teach, coach, and mentor peers related to active treatment implementation. Mentors were on cottages 7 days per week for the entire month from 7:00 a.m. to 7:00 p.m.

- The IDT's completed a 100% review of Individual Habilitation Plans for all residents who live in the Lakeland Village ICF to ensure active treatment prioritized needs were appropriately addressed based on resident need.
- ACM and Adult Programs staff use the Active Treatment Monitoring tool 2 times per week and providing feedback to staff related to observations.
- QIDP's monitor active treatment implementation through Quarterly Reviews.
- 80% completion of identification of replacement behaviors for those residents with Positive Behavior Support Plans.
- The IDT completed a 100% review for all residents who live in the Lakeland Village ICF and update of all individualized Active Treatment Schedules.
- Revised Monthly Program Recording form to include Individual Teaching Prescription and Plan of Action giving additional active treatment directions to staff.
- Primary Need auto populates into client records, including Client Profile, Monthly Program Recording Form and in the Annual Comprehensive Functional Assessment (IHP) and the Monthly Progress Report
- QIDPs complete quarterly reviews and determine program revisions based on client performance.
- Active Treatment Programs are reported at least quarterly and are reviewed for progress or lack thereof by the QIDP quarterly.
- Attendant Counselor Managers complete Active Treatment audits 2 times per week and Meal audits monthly to ensure Active Treatment compliance.
- Lakeland Village procedure 3.7 Therapeutic Interventions was updated on 4/27/2015 to include all residents living at Lakeland Village.

(3) **How the corrective action will be monitored to ensure the deficient practice does not recur.**

- Active Treatment Monitoring tool is reviewed by the DDA 2 weekly. Issues are addressed face to face by the DDA 2.
- Psychology Associates complete peer review prior to Human Rights Advisory Committee review of Positive Behavior Support Programs.
- Positive Behavior Support Programs with restrictive procedures are reviewed by Human Right Advisory Committee as presented. The committee meets monthly.
- Monthly Quality Assurance meeting reviews POC status report including review of all internal audit tools.
- Habilitation Plan Administrator IHP checklist created to review timeliness of assessments 5/12/2015.
- The Administration has informed all disciplines of required participation in the annual Individual Habilitation Plan.

- Administration will monitor participation in the Individual Habilitation Plan Meetings by reviewing a sample of IHP attendance signature sheets and reporting to the Superintendent or designee who takes corrective action as indicated.
- Occupational Therapy tracks residents using toilet positioning devices. Numbers were reduced from 9 individuals to 4 who currently use the device. The facility continues to evaluate through assessment the need for the remaining toilet positioning devices.
- Quarterly review for restraint reduction is completed by Occupational Therapy and Physical Therapy and recommendations are forwarded to the IDT for review for proposed reductions if indicated.

I look forward to your revisit.

Sincerely,

Anthony DiBartolo, Superintendent
Lakeland Village

CC:
Bill Moss, Assistant Secretary ALTSA
Candace Ghering, Director of RCS
Donna Cobb, Senior Counsel
Evelyn Perez, Assistant Secretary DDA
Donald Clintsman, Deputy Assistant Secretary DDA
Janet Adams, DDA Office Chief
Larita Paulsen, DDA QM Unit Manager

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G007	A. BUILDING _____ B. WING _____	R 03/27/2015

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{W 000}	INITIAL COMMENTS This report is a result of a Post Survey to an Annual Recertification Survey conducted at Lakeland Village on 3/23/15 through 3/27/15. The facility had repeat citations for: W100, W102 - Condition of Participation for Governing Body and Management, W104, W195 - Condition of Participation for Active Treatment, W196, W214, W240, W242, W250, and W460. New citations were written for W159, W189, W206, W226, W239, W246, and W436. The survey was conducted by: Gerald Heilinger, Kathy Heinz, Jim Tarr, and Carla Lundberg The survey team is from: Department of Social & Health Services Aging & Disability Services Administration Residential Care Services, ICF/IID Survey and Certification Program PO Box 45600, MS: 45600 Olympia, WA 98504 360-725-2405	{W 000}		
{W 100}	440.150(c) ICF SERVICES OTHER THAN IN INSTITUTIONS "Intermediate care facility services" may include services in an institution for the mentally retarded (hereafter referred to as intermediate care facilities for persons with mental retardation) or persons with related conditions if: (1) The primary purpose of the institution is to provide health or rehabilitative services for mentally retarded individuals or persons with	{W 100}		

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 100}	Continued From page 1 related conditions; (2) The institution meets the standards in Subpart E of Part 442 of this Chapter; and (3) The mentally retarded recipient for whom payment is requested is receiving active treatment as specified in §483.440. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility did not meet the Condition Of Participation of Active Treatment Services. Findings Include: The facility did not meet the Condition of Participation (COP) of Active Treatment Services. The facility did not assure Residents received continuous active treatment programs that included aggressive and consistent implementation of formal and informal training programs and supports. The facility failed to develop individual plans structured to promote consistent implementation of training programs to teach skills and increase independence. See W195. This is a repeat citation from the 1/27/15 Recertification Survey.	{W 100}		
{W 102}	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: Based on observation, interview and record	{W 102}		

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{W 102}	Continued From page 2 review, the facility did not meet the Condition Of Participation in Governing Body and Management by not exercising operating direction over the facility and by not meeting the requirements for the Conditions Of Participation of Active Treatment Services. This failure potentially affected all Residents served. See W104 and W195 This is a repeat citation from the 1/27/15 Recertification Survey.	{W 102}		
{W 104}	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to develop policies and procedures that addressed the use of toilet seat restraints for residents. Failure to develop policies and procedures regarding the use of toilet seat restraints resulted in residents being restrained on toilets without clear guidelines to staff. Findings include: Observation on 3/23/15 at Evergreen House revealed there was a toilet seat restraint attached to the toilet. Direct Care Staff revealed the restraint was for Resident #14. The facility Superintendent was unable to produce a specific policy for the use of toilet seat restraints for the residents residing in the ICF/IID. The facility terminated the use of the restraint for Resident #14 on 3/25/15. This is a repeat citation from the 1/27/15 Annual Recertification Survey.	{W 104}		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION	W 159		

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W 159	Continued From page 3 PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility did not ensure the Qualified Intellectual Disability Professional (QIDP) provided coordination of, monitoring of, and oversight of the active treatment programs to ensure two of thirteen Sample Residents (Resident #1 and Resident #7) received a consistently implemented active treatment program. Findings Include: See W196: Based on observation; interview and record review, the facility failed to develop and implement an active treatment program which aggressively and consistently addressed needed supports and services to meet behavior related and training needs for one of one Sample Residents (Resident #7) who ingested cigarette butts and chewed and swallowed used gum found on the ground. Further, the facility failed to develop and implement an active treatment program for one of one Sample Residents (Resident #1) who experienced a decline in health and who was observed to spend the majority of his time in his bed with the door closed or with a screen in front of the door resulting in isolation from others. See W206: Based on observation, interview and record review, the facility failed to ensure the interdisciplinary team included persons with expertise in functionally assessing skills, identifying needs, developing plans, training staff,	W 159		

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W 159	Continued From page 4 and monitoring and making changes to the individual plan for one of one Sample Residents (Resident #7) whose diagnosis included [redacted] and who consistently exhibited the behavior of [redacted] and [redacted] and [redacted] identified as a potential health hazard. See W214: Based on observation, interview and record review, the facility failed to functionally assess behavior which interfered with the provision of active treatment, including analysis of the potential causes and environmental and/or social conditions which elicited and/or sustained the behaviors, for one of one Sample Residents (Resident #7) whose diagnoses included [redacted] and who consistently exhibited the challenging and/or maladaptive behaviors. See W239: Based on observation, interview and record review, the facility failed to develop an active treatment program which included objectives to teach skills or replacement behaviors to address behaviors exhibited by one of one Sample Residents (Resident #7) whose diagnosis [redacted] and who consistently exhibited the behavior of [redacted] and [redacted] and [redacted] as well as other interfering behaviors. See W240: Based on observation, interview and record review, the facility failed to develop written instruction to staff about enhancing the safety of one of one Sample Residents (Resident #7) whose diagnosis included [redacted] by monitoring the contents of the purses he used to secrete [redacted] and [redacted] in order to ingest them at a later time. See W242: Based on observation, interview and record review, the facility failed to ensure the	W 159		

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W 159	Continued From page 5 Individual Program Plan for one of one Sample Residents (Resident #7) who routinely scraped [redacted] sidewalks and roadways and who routinely picked up [redacted] from the ground included teaching hand washing skills. See W246: Based on observation, interview and record review, the facility to ensure one of one Sample Residents (Resident #1) had a treatment plan which ensured he spent a major portion of his day out of bed and out of his bedroom.	W 159		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to develop and implement a training system which resulted in staff receiving competency-based training to respond to behaviors which interfered with the provision of active treatment services for one of one Sample Residents (Resident #7) whose diagnoses included [redacted] and who consistently exhibited the behavior of [redacted] and [redacted] and [redacted] as well as other challenging behaviors. Findings Include: Resident #7 was observed from 3:54 PM to 5:15 PM on 3/23/15. Resident #7 was observed to rummage through a purse taking out small cans of chewing tobacco which appeared to be empty and running his fingers around the bottom of the cans and putting his fingers in his mouth. Resident #7 was observed to use the fingernails	W 189		

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W 189	Continued From page 6 of his right hand to scrape a green substance, identified as green gum Resident #7 had scraped from the roadway, from inside the purse. He then used his tongue and teeth to remove the green substance from under his fingernails. Resident #7 refused the evening meal provided from the central kitchen. At no time during the observation were staff observed to attempt to teach any replacement behavior related to rummaging through the purse and eating gum which had been found on the ground. Resident #7 was observed at his day program from 10:37 AM on 11:03 on 3/25/15. Resident #7 was observed to kiss the back of Staff A ' s hand three times. He was also observed to attempt to touch Staff A ' s neck, although he was successfully redirected. When asked to wipe off his mouth, Resident #7 blew his nose on a washcloth and then required significant verbal and physical prompting to wash his hands. Resident #7 was observed to consistently say the words " chew, gum and walk. " While being escorted to his home from the day program, Resident #7 was observed to consistently ask Staff A for the gum she picked up off the ground in order to keep him from getting the gum. At no time during the observation was Staff A observed to attempt to teach any replacement behavior related to Resident #7 ' s hand kissing behavior or when Resident #7 attempted to touch her neck. Resident #7 was observed at his home from 11:03 AM to 12:03 PM on 3/25/15. Resident #7 was observed to refuse to wash his hands although he was in the kitchen area of the residence and prompted to do so. Resident #7 was observed to refuse the lunch meal. Resident #7 was observed to manipulate the objects in two purses and to blow mucus from his nose onto his	W 189		

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W 189	Continued From page 7 hands and lick his hands. Resident #7 was observed to kiss the back of the hand of a male staff. At no time during the observation were staff observed to attempt to teach any replacement behavior related to blowing mucus from his nose onto his hands and licking his hands, meal refusal or hand kissing. Resident #7 was observed from 7:41 AM to 8:45 AM on 3/26/15. Resident #7 was observed to pick up cigarette butts and used gum while on a walk with one-on-one staff on the facility grounds. During this observation, a " grounds worker " was observed to broadcast what she identified as ' weed and feed ' on the sidewalk and the ground in an area consistently used by Resident #7 for foraging cigarette butts and used gum. During this time period, Resident #7 was observed to refuse breakfast. At no time during the observation were staff observed to attempt to teach any replacement behavior related to picking up cigarette butts and used gum or meal refusal. Staff B was interviewed on 3/25/15 at 10:30 AM. Staff B explained that due to Resident #7 ' s history of aggression to self and others, the only strategy staff used was to verbally prompt him to not pick up cigarette butts and/or used gum. She confirmed Resident #7 ' s plan did not include instruction to staff about how they were to respond to Resident #7 ' s behaviors other than to encourage him to not eat cigarette butts and/or used gum. When asked if Resident #7 ' s plan included strategies to monitor the contents of the purses used by Resident #7 in order to lessen the likelihood of ingesting cigarette butts and used gum, Staff B said, " No, although we try to have him show us what he has, there is no system in place to go through the purses. " She said there were no strategies included in Resident #7 ' s	W 189		

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W 189	Continued From page 8 plan to help staff teach replacement behaviors. She said due to his mental health diagnoses, the only instruction given to the direct support staff was to redirect him when possible without upsetting him to the point where he would act out aggressively. She added, " We just try to keep him safe. " Staff B was again interviewed at 8:45 AM on 3/26/15. She confirmed the hand kissing behavior was not addressed in Resident #7 ' s plan. She confirmed the meal refusal behavior was not addressed in Resident #7 ' s plan. She also confirmed direct support staff had not received individual-specific training related to expected response to Resident #7 ' s behaviors which interfered with providing supports and services for him. The Qualified Intellectual Disabilities Professional (QIDP) and the Psychologist assigned to Resident #7 were interviewed on 3/26/15 at 11:45 AM with Resident #7 ' s records available for reference. When asked what staff were expected to do when Resident #7 picked up cigarette butts and/or used gum from the ground, roadway or sidewalks, the Psychologist said staff should redirect him. When asked if Resident #7 ' s plan addressed the hand-kissing behavior, the Psychologist said it was not viewed as a behavior that needed to be addressed. When asked if the behavior of meal refusal had been addressed, the Psychologist said the behavior had not been seen as frequent enough to address. When asked if the fingers in nose and blowing his nose in his hands and licking the mucus from his hands behavior was addressed in his plan, the Psychologist said it was not. When asked to show what replacement behaviors staff were supposed to teach when Resident #7 engaged in chewing and swallowing cigarette butts and/or	W 189		

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W 189	Continued From page 9 used gum, the Psychologist said the Behavior Support Plan addressed " positive strategies. " The Psychologist said she had not trained staff on what to do once Resident #7 was observed chewing on or swallowing cigarette butts or used gum. The Psychologist was not able to identify any replacement behaviors staff were expected to teach to Resident #7 when he exhibited aberrant or interfering behaviors. When asked if Resident #7 ' s plan addressed proactive strategies such as providing Resident #7 with gum prior to going on a walk as a possible method to reduce the frequency of putting used gum in his mouth, the Psychologist said, " Yes. " However, after looking at the plan, the Psychologist confirmed Resident #7 ' s plan did not include a strategy about assuring he had " new " gum available to chew.	W 189		
{W 195}	483.440 ACTIVE TREATMENT SERVICES The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop and implement systems that resulted in consistently implemented active treatment plans based on functionally assessed needs, ensured Residents had interdisciplinary teams with the right expertise, ensured Residents spent major portions of the day out of bed and their bedrooms, and taught and encourage Residents to control their daily activities. The lack of a consistently implemented system of programs and supports resulted in the Condition of	{W 195}		

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{W 195}	Continued From page 10 Participation of Active Treatment Services to be not met. Findings Include: See W196: Based on observation, interview and record review, the facility failed to develop and implement an active treatment program which aggressively and consistently addressed needed supports and services to meet behavior related and training needs for one of one Residents (Resident #7) who ingested cigarette butts and chewed and swallowed used gum found on the ground. Further, the facility failed to develop and implement an active treatment program for one of one Residents (Resident #1) in the sample who experienced a decline in health and who was observed to spend the majority of his time in his bed with the door closed or with a screen in front of the door resulting in isolation from others. See W206: Based on observation, interview and record review, the facility failed to ensure the interdisciplinary team included persons with expertise in functionally assessing skills, identifying needs, developing plans, training staff, and monitoring and making changes to the individual plan for one of one Residents (Resident #7) whose diagnosis included [redacted] and who consistently exhibited the behavior of [redacted] and [redacted] and [redacted] identified as a potential health hazard. See W214: Based on observation, interview and record review, the facility failed to functionally assess behavior which interfered with the provision of active treatment, including analysis of the potential causes and environmental and/or social conditions which elicited and/or sustained the behaviors, for one of one Residents (Resident #7) whose diagnoses included [redacted] and who consistently	{W 195}		

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{W 195}	Continued From page 11 exhibited the challenging and/or maladaptive behaviors. See W239: Based on observation, interview and record review, the facility failed to develop an active treatment program which included objectives to teach skills or replacement behaviors to address behaviors exhibited by one of one Residents (Resident #7) whose diagnosis included obsessive compulsive disorder and who consistently exhibited the behavior of [redacted] and [redacted] and [redacted] as well as other interfering behaviors. See W240: Based on observation, interview and record review, the facility failed to develop written instructions to staff about enhancing the safety of one of one Residents (Resident #7) whose diagnosis included [redacted] by monitoring the contents of the purses he used to conceal [redacted] and [redacted] in order to ingest them at a later time. See W242: Based on observation, interview and record review, the facility failed to assure the individual program plan for one of one Residents (Resident #7) who routinely scraped gum from sidewalks and roadways and who routinely picked up cigarette butts from the ground included teaching hand washing skills. See W246: Based on observation, interview and record review, the facility failed to ensure one of one Sample Residents (Resident #1) had a treatment plan which ensured he spent a major portion of his day out of bed and out of his bedroom. This is a repeat citation from the 1/27/15 Recertification Survey.	{W 195}		
{W 196}	483.440(a)(1) ACTIVE TREATMENT	{W 196}		

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{W 196}	Continued From page 12 Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop and implement an active treatment program which aggressively and consistently addressed needed supports and services to meet behavior related and training needs for one of one Sample Residents (Resident #7) who ingested cigarette butts and chewed and swallowed used gum found on the ground. Further, the facility failed to develop and implement an active treatment program for one of one Sample Residents (Resident #1) who experienced a decline in health and who was observed to spend the majority of time in his bed with the door closed or with a screen in front of the door resulting in isolation from others. Findings Include: Resident #7: Monday, 3/23/15: Resident #7 was first observed at his residence beginning at 3:54 PM on 3/23/15. He was seated in a chair in the " living area " of his home. He was dressed in jeans and a sweatshirt and wearing men ' s boots generally used for hiking or working. He was holding a woman ' s purse with	{W 196}		

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{W 196}	Continued From page 13 a[redacted]design. As he sat in the chair, he continually repeated the words " walk " and " chew. " Staff informed Resident #7 he could " go on a walk in a little while. " At 4:04 PM, Staff C prompted Resident #7 to put on his coat and his " vest " in order to go for a walk. As Resident #7 got his coat and prepared for the walk, Staff C explained Resident #7 walked on the roads around the facility campus and wore an orange vest to make him more visible to cars. Staff C said the boots worn by Resident #7 had a " code alert " imbedded in them to notify staff any time he attempted to leave the residence via the doors or the windows. Staff C explained Resident #7 was always one-on-one when outside the residence due to his behavior of [redacted] for [redacted] which had already been chewed and was generally stuck to the sidewalks or roadways, and rummaging through trash cans for objects of interest to him. Staff C explained Resident #7 carried a purse or some type of bag with him at all times in order to conceal the items found when walking around the campus. Staff C confirmed Resident #7 chewed on and swallowed the cigarette butts and the already chewed gum he found during his walks around campus. At 4:27 PM on 3/23/15, Resident #7 returned to his residence with Staff C. After removing the orange vest and his coat, Resident #7 sat in the chair referred to by staff as " [Name of Resident #7] ' s Chair. " Resident #7 was not prompted to wash his hands. At 4:29 PM, Resident #7 began rummaging through the[redacted]purse taking out small cans of chewing tobacco which appeared to be empty and running his fingers around the bottom of the cans and putting his fingers in his mouth. He also used the fingernails of his right hand to scrape a green substance	{W 196}		

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from inside the purse. He then used his tongue and teeth to remove the green substance from under his fingernails. Although Staff C and other direct support staff talked with him privately and encouraged him to give them the green substance and/or saying to him quietly, " that ' s yucky " or " that ' s not good, " no staff intervened and/or attempted to provide Resident #7 with an alternative to chewing and swallowing what was identified by Staff C as green gum that Resident #7 had scraped from the roadway on campus.

At 4:31 PM, Resident #7 was asked if he wanted to eat dinner but said, " No, I don ' t want to eat. " Staff C replied, " Alright, you can eat later. Is that gum or plastic you are chewing on? " When Resident #7 did not reply, Staff C said, " Why don ' t you throw it away; it ' s wrong. " Resident #7 ignored the remark and continued to alternately scrape the green gum from the purse with his fingernails and put the substance in his mouth. He continued to rummage through the purse and take out objects including paper, empty chewing tobacco cans and other small pieces of material which were not readily identifiable and put them back into the purse. Although he was repeatedly offered the opportunity to eat the evening meal, Resident #7 consistently refused and continued to manipulate the objects in his purse and continued to scrape tiny pieces of the green gum with his fingernails and using his tongue and teeth, remove the green gum from under his fingernails to chew and swallow the gum. The observation was concluded at 5:15 PM. At no time during the observation were staff observed to offer Resident #7 a " new " piece of gum. At no time during the observation were staff observed to attempt to teach any replacement behavior related to rummaging through the purse

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and eating gum found on the ground. At no time during the observation were staff observed to prompt Resident #7 to wash his hands.
Tuesday, 3/24/15:
Resident #7 was observed at his residence beginning at 10:19 AM on 3/24/15. He was seated in " his chair. " In addition to the [redacted] purse Resident #7 was holding, there was another purse sitting on the small table next to Resident #7 ' s chair. This purse was [redacted] and a [redacted] attached to the front of the purse. When asked about the purse, Resident #7 grabbed the purse and clutched it to his chest.
During a clarification interview at 10:30 AM on 3/24/15, Staff B confirmed Resident #7 wore a " safety vest " while out with one-on-one staff as he walked around campus. According to the Home Manager, Resident #7 was so focused on finding gum and cigarette butts, he did not attend to environmental hazards such as on-coming traffic. Staff B confirmed the behaviors presented by Resident #7 were highly troubling and very difficult to manage. She explained there were procedures in place to have Resident #7 monitored by the nurse when he ingested cigarette butts. When asked what staff were supposed to do when Resident #7 attempted to pick up cigarette butts and put them in his mouth or in his purse, she said the instruction in Resident #7 ' s plan was to attempt to verbally distract him. When asked if that strategy worked, the Home Manager said " No, he knows where to find cigarette butts on campus and where to find gum and he basically does what he wants to do so he will not become aggressive. " Staff B explained that due to Resident #7 ' s history of aggression to self and others, no attempt beyond

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{W 196}	Continued From page 16 verbally prompting him to not pick up cigarette butts and/or used gum was done by staff. When asked if there were any strategies in place to provide Resident #7 with " new " gum to chew before going on walks, Staff B said " No, that ' s not included in his plan. " When told of the observation the previous day where Resident #7 continually scraped the green gum and placed it in his mouth, Staff B confirmed that was a typical behavior. She confirmed Resident #7 ' s plan did not include instruction to staff about how they were to respond to Resident #7 ' s behaviors other than to encourage him to not eat cigarette butts and/or used gum. When asked if Resident #7 ' s plan included strategies to monitor the contents of the purses to lessen the likelihood of ingesting cigarette butts and used gum, she said, " No, although we try to have him show us what he has, there is no system in place to go through the purses. " When asked if the team had considered ideas such as " trading " Resident #7 " new " gum for " used " gum, Staff B said there were no real strategies included in Resident #7 ' s plan to help staff teach replacement behaviors. When asked if there was any expectation by Resident #7 ' s team that he might learn new skills and change the foraging behavior, Staff B said due to his mental health diagnoses, the only instruction given to the direct support staff was to redirect him when possible without upsetting him to the point where he would act out aggressively. The Home Manager added, " We just try to keep him safe. " When asked about the purses Resident #7 had in his possession, Staff B said [redacted] purse was given to Resident #7 " yesterday " by a campus nurse. She said Resident #7 purchased the [redacted] purse at the on-campus store used by clients to purchase items donated to the	{W 196}		

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facility. When asked if the team for Resident #7 had discussed the function of the behavior of Resident #7 carrying purses rather than a backpack or the types of bags generally used by adult men, she said since Resident #7 purchased the purses himself, the use of the purses were viewed as a personal choice and " his right " to have them. When asked if she believed Resident #7 realized that carrying women ' s purses might appear to be stigmatizing and/or draw undue attention to himself, she said Resident #7 had carried women ' s purses for years and was not sure if Resident #7 actually preferred the purses or he purchased the purses because of their price and their availability at the donated goods store. When asked about the health risks associated with chewing on and swallowing cigarette butts and used gum, she said she constantly worried about that although, so far, Resident #7 was " pretty healthy. " She said Resident #7 had engaged in these behaviors " for years " and had not had serious illnesses. When asked to describe what efforts had been made to keep the campus free of cigarette butts and used gum, she referenced a recent email from the " administration " advising employees not to discard cigarette butts and gum on the grounds and outlined the penalty for doing so, including disciplinary action. She confirmed the residence where Resident #7 lived was located near an on-campus daycare center which served the children of people in the community, some of whom were not employees of the facility. She said she was not certain as to what actions, if any, had been taken to advise the parents and caregivers of the children served by the daycare center about the safety issues of discarding gum and cigarette butts on the grounds of the facility.
Wednesday, 3/25/15:

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{W 196}	Continued From page 18 Resident #7 was observed at his day program beginning at 10:37 AM on 3/25/15. He was seated in a chair holding the [redacted] purse, [redacted] purse and a black plastic garbage bag. At 10:39 AM, Resident #7 approached a female staff and took her hand and kissed the back of her hand. After replying, " Thank you " after Resident #7 kissed her hand, the direct care staff prompted him to get a washcloth and wipe his mouth. Resident #7 complied with the request to get a washcloth, but rather than wiping off his mouth, Resident #7 used the washcloth to blow his nose. Resident #7 complied with the staff ' s request to put the washcloth in the dirty clothes hamper but did not respond to the direct support staff ' s first verbal prompt to wash his hands. After multiple verbal and physical prompts to wash his hand, the direct support staff was successful in having Resident #7 wash his hands with soap and water. At 10:47 AM, Resident #7 made loud vocalizations using the words " chew " and " walk " over and over. The direct support staff responded to Resident #7 by saying things such as, " You are OK. You are safe. " The direct support staff encouraged Resident #7 to relax and prompted him to breathe deeply which he did one time. The direct support staff continually provided reassuring words to Resident #7 who approached her and again kissed the back of her hand two times to which she responded, " Thank You. " When Resident #7 attempted to touch the direct support staff ' s neck, she redirected him and he began saying the word " chew " over and over. The direct support staff reminded Resident #7 it was almost time to go home for lunch. At 10:58 AM, while exiting the day program area, Resident #7 saw a piece of already chewed gum on the ground in a flower bed near the exit. The	{W 196}		

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{W 196}	Continued From page 19 direct support staff noticed Resident #7 ' s reaction and picked up the gum before Resident #7 could reach it. Resident #7 began to repeat the words, [redacted] and " gum " but the direct support staff kept softly talking with him and successfully redirected Resident #7 back to his home. At 10:59 AM, as Resident #7 was taking off his vest and coat, the direct support staff confirmed she had successfully picked up the gum and kept Resident #7 from getting it. The direct support staff confirmed although she tried diligently to keep Resident #7 from picking up gum and cigarette butts, she was often unable to do so. When asked if the deep breathing was part of Resident #7 ' s plan, the direct support staff said, " No, but I ' ve found it works for him and helps him ' settle down ' . " When asked if Resident #7 ' s program included strategies to lessen the likelihood of him placing cigarette butts and/or used gum in his mouth, such as giving him gum prior to beginning the walk home, the direct support staff said, " No. " When asked about the hand-kissing behavior and the behavior of touching her neck, the direct support staff said she did not think the kissing behavior and/or the touching behavior was addressed in Resident #7 ' s individual plan and she was not certain of what her response to the behavior was supposed to be. Resident #7 was observed at his home from 11:03 AM to 12:03 PM. At 11:07 AM, Resident #7 was leaning on the kitchen counter. He walked to the kitchen cabinet and took out a glass. Staff D asked Resident #7 to wash his hands since he had not done so upon his arrival home. Resident #7 said, " No, " took the glass and walked back to " his chair. " Staff D asked Resident #7 if he wanted to help set the table for lunch but he declined. She asked Resident #7 where he got	{W 196}		

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{W 196}	Continued From page 20 his new [redacted] purse. Resident #7 responded with a word that was not clearly understandable and with help from other staff, she said, " Oh, the nurse brought it for you. " At 11:15 AM, Resident #7 began looking through the purses taking out objects including empty cans of chewing tobacco and pieces of paper. Resident #7 began touching the items in the purses and then licking his hands and fingers. Staff B brought him pictures of cats and Resident #7 smiled, looked at the cat pictures and placed the cat pictures in the [redacted] purse. At 11:44 AM, Resident #7 began making loud sounds generally associated with nose blowing. As he blew out air from his nose, mucus covered his right hand and fingers. He licked off the mucus on his right hand and fingers. Direct support staff, who were assisting other Residents with lunch, did not see and/or respond to the behavior. At 11:46 AM, as another Resident stood near Resident #7 ' s chair, Resident #7 began making very loud vocalizations. Staff ' s response to the vocalizations was to prompt the other Resident to move away from Resident #7 ' s chair. From 11:47 AM to 11:49 AM, Resident #7 sat in the chair with the little finger of his left hand alternating between his nostrils and his mouth. Staff, who were assisting other Residents served with lunch, did not respond to the behavior. At 11:50 AM, Staff B approached Resident #7 and asked him what was going to happen on Friday. Resident #7 responded by saying the word " pay " and during the conversation with Staff B, Resident #7 indicated he was going to buy " more purses. " During this observation, Resident #7 was asked multiple times if he wanted to eat lunch. Each time, Resident #7 declined saying, " No. " He was offered alternatives to the food which had come from the central kitchen, including peanut	{W 196}		

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{W 196}	Continued From page 21 butter and jelly and coffee, but he declined, A direct support staff explained Resident #7 did not like to eat at the same time as other Residents served and opined it was " too chaotic " during mealtime for Resident #7 to eat. At 11:51 AM, Resident #7 stood up and saying " I ' m sorry " walked toward a male direct support staff serving as the one-on-one staff for another Resident who was eating lunch and kissed the back of the staff member ' s hand. The staff member, who was a relatively new staff, did not respond to the hand kissing behavior other than to wipe off his hand after Resident #7 let go of him. The observation concluded at 12:03 PM. At the conclusion of the observation, Resident #7 was seated in the chair manipulating the objects in his purses. Although all other clients had finished lunch, Resident #7 had not eaten. At no time during the observation were staff observed to attempt to teach any replacement behavior related to rummaging through the purse, picking his nose and/or blowing his nose in his hands and licking the mucus. Thursday, 3/26/15: Resident #7 was observed in his home beginning at 7:41 AM on 3/26/15. He was seated in " his chair " holding his jacket repeating the words, " chew, walk and gum. " He was holding the [redacted] purse on top of his coat and the [redacted] purse was on the table next to the chair. At 7:43 AM, Staff D prompted Resident #7 to get his " grooming box. " From 7:43 AM to 8:00 AM, Staff D provided verbal and physical prompts for Resident #3 to brush his teeth and change his clothes. Throughout this time, Resident #7 could be heard saying the words " walk and chew "	{W 196}		

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{W 196}	Continued From page 22 repeatedly. Resident #7, accompanied by Staff D left the residence at 8:00 AM for a walk. The walk lasted from 8:00 AM to 8:18 AM. Although the surveyor followed from a distance throughout the entire walk, Resident #7 did not appear to be aware of the surveyor due to focusing on the ground. During the walk, Resident #7 was observed to pick up and/or scrape up objects which appeared to be gum, using his fingernails. As Resident #7 got close to the main road which ran in front of the facility, Staff D was able to successfully redirect Resident #7 back toward to interior of the campus. As Resident #7 and Staff D approached the sidewalk adjacent to the childcare center (next to the home where Resident #7 lived) a " grounds crew " worker was observed using a " spreader " which sprayed out pellets of what appeared to be fertilizer. The spreader broadcasted the pellets on the grass as well as on the sidewalk where Resident #7 and Staff D walked. The worker using the spreader identified the substance as " Weed and Feed " and confirmed it was the same product available and sold to the public. The worker said she had never been advised about safety concerns for using the chemical near areas where Residents served lived who were known to put objects found on the ground in their mouths. At 8:20 AM, Staff D confirmed Resident #7 picked up multiple objects on his walk, including used gum and cigarette butts. She confirmed she had to repeatedly redirect Resident #7 as he got close to the main road in front of the facility. She confirmed she had observed the worker using the broadcast spreader but had not considered the possibility that the chemical used which landed on	{W 196}		

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{W 196}	Continued From page 23 the sidewalk near the childcare center where there was gum stuck to the sidewalk might create even a greater hazard for Resident #7. She confirmed Resident #7 was not always able to distinguish between gum which had been stepped on and/or run over and flattened from bird droppings until he touched the object and felt the resistance as he attempted to scrape it up with his fingernails. When asked what she was supposed to do when Resident #7 picked up cigarette butts or scraped up gum from the ground, she said the only thing she could do was to encourage him not to take the material, but immediately added, " But he takes it anyway. " At 8:22 AM, Resident #7 returned to his home after walking, he took off his vest and his coat and sat in his chair. He began manipulating the objects in his two purses. At 8:26 AM, a direct support staff offered Resident #7 juice. He refused the juice but asked for water. The direct support staff got Resident #7 a glass of water and did not prompt Resident #7 to be involved in washing his hands and/or getting a drink of water for himself. Although Resident #7 was asked if he wished to eat breakfast, he consistently refused. At 8:36 AM, he was offered toast with peanut butter and honey. The observation was concluded at 8:45 AM. Resident #7 had not eaten the breakfast provided by the central kitchen or the toast with peanut butter made by the staff at the conclusion of the observation. Staff B was again interviewed at 8:45 AM on 3/26/15. She confirmed the hand kissing behavior was not addressed in Resident #7 ' s plan. She confirmed the meal refusal behavior was not addressed in Resident #7 ' s plan. She confirmed the meal refusal was a consistent	{W 196}		

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{W 196}	Continued From page 24 behavior and confirmed the team for Resident #7 had not asked that she and her residential staff record the food actually eaten by Resident #7. She confirmed there was no way to determine if Resident #7 actually ate a well-balanced diet since there was no record of what he ate. She said the team for Resident #7 considered not wanting to eat the food prepared by the central kitchen as a choice and " a right he had " to direct his own life. She said although sometimes Resident #7 would eat the food sent from the central kitchen, he rarely ate during the regularly scheduled mealtimes with other Residents served and opined it was the noise and the activity level, coupled with the ' control ' he had by selecting favored food such as fried eggs and peanut butter sandwiches, which reinforced the behavior of refusing to eat with other people served. When asked if the team for Resident #7 had assessed the function of the meal refusal behavior and provided instructions or strategies to staff to ensure Resident #7 received a well-balanced diet, she said although it had been discussed, she did not know of any strategies developed and consistently implemented, such as having him eat at different times, to address the meal refusal behavior. When asked what skills were direct support staff supposed to teach Resident #7 as a part of his active treatment program, she said his plan was about " reducing " the incidences of aggression by allowing him to go on walks in order to pick up cigarette butts, gum and other items of interest to him due to his mental health issues. According to Staff B there was no expectation of direct support staff to teach replacement behaviors since none were included in his plan. She confirmed that the role of the direct support staff had become one of keeping Resident #7 as safe as possible while they	{W 196}		

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{W 196}	Continued From page 25 accompanied him on walks where he foraged for cigarette butts, used gum and other items since the only strategy available to them was to verbally redirect him and/or to call for additional staff. Interview with The Qualified Intellectual Disabilities Professional and Psychologist: The Qualified Intellectual Disabilities Professional (QIDP) and the Psychologist assigned to Resident #7 were interviewed on 3/26/15 at 11:45 AM with Resident #7 ' s records available for reference. The QIDP confirmed he had been assigned to Resident #7 " for years. " The Psychologist confirmed she had been assigned to work with Resident #7 for approximately five years. Both the QIDP and the Psychologist said they spent time with him and observed Resident #7 frequently. Both confirmed they were aware of the challenging behaviors he presented. When asked if the PICA behavior was addressed in his plan, the QIDP quickly stated that no professional had ever given Resident #7 a diagnosis of PICA but rather, the ingesting of cigarette butts and already chewed gum stuck to the sidewalk or pavement was considered part of his [redacted] behaviors. When asked if the team for Resident #7 included a psychiatrist, the QIDP and the Psychologist confirmed the facility did not presently have a psychiatrist on staff and confirmed it had been approximately three years since the previous psychiatrist had left employment at Lakeland Village. The QIDP was asked to provide, for review, the last psychiatric evaluation since he was unable to locate it in the record during the interview. The QIDP and the Psychologist verified Resident #7 received [redacted] medications as well as medication for [redacted] The Psychologist	{W 196}		

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{W 196}	Continued From page 26 confirmed the [redacted] medication being used was [redacted] The Psychologist also confirmed Resident 7 received [redacted] on a regular basis due to back pain and arthritic pain. The Psychologist confirmed the assessment of the behaviors exhibited by Resident #7 was included in the Behavior Support Plan (BSP). When asked what staff were expected to do when Resident #7 picked up cigarette butts and/or used gum from the ground, roadway or sidewalks, the Psychologist said staff should redirect him. When told of the observation where he picked those items up even though staff had attempted to redirect him, the Psychologist said the plan called for staff to call for additional help if needed. The Psychologist was unable to provide a clear answer as to what purpose the additional staff served if there was no intent to interfere with the behavior of gathering cigarette butts and used gum and/or placing them in his mouth or his purse. The Psychologist said the behaviors were directly related to Resident #7 ' s diagnosis of [redacted] Neither the Psychologist nor the QIDP could identify actions taken by the facility to assure the facility grounds were reasonably free of cigarette butts and discarded gum, other than emails and memorandums sent to staff about possible disciplinary action if they were observed to discard those items on the campus. When asked if Resident #7 ' s plan addressed the hand-kissing behavior, the Psychologist said it was not viewed as a behavior that needed to be addressed. When told that Resident had attempted to kiss the surveyor ' s hand although she was a stranger to him, the QIDP indicated, " You entered his environment. " When asked if	{W 196}		

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{W 196}	Continued From page 27 the team had discussed the hand-kissing as a behavior which might possibly interfere with community-based activities, the QIDP asked, " Why should he have to change? " When asked if staff were provided instruction on how they were to respond when Resident #7 kissed their hands, the Psychologist explained it was just his way of greeting people and since various staff had different relationships with him it was not necessary to address the hand-kissing behavior. When asked if the team had discussed whether or not Resident #7 carrying women ' s purses was stigmatizing for him and/or placed him in a situation, particularly in community-based activities, where he might receive undue and perhaps unwanted reactions from others, the Psychologist responded by saying the purse carrying behavior was not a problem and it was the community who had to make accommodations to him rather than him having to change. The Psychologist went on to explain it was Resident ' s #7 ' s choice to purchase the women ' s purses and his " right " to carry them if he wanted to. When asked if Resident #7 had been assessed to understand that most men carried backpacks or satchels rather than women ' s purses, the Psychologist said, " He likes to wear women ' s clothing. " When asked to provide assessment data related to the statement of Resident #7 preferring to wear women ' s clothing, the Psychologist simply did not respond. The Psychologist was unable to provide assessment data which showed that carrying women ' s purses was, in actuality, a personal choice or simply based on the price and availability of the donated purses at the on-campus store.	{W 196}		

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{W 196}	Continued From page 28 When asked to show what replacement behaviors staff were supposed to teach when Resident #7 engaged in chewing and swallowing cigarette butts and/or used gum, the Psychologist said the Behavior Support Plan (BSP) addressed positive strategies. The Psychologist said she had not trained staff on what to do once Resident #7 was observed chewing on and/or swallowing cigarette butts and/or used gum. When asked if the behavior of meal refusal had been assessed and addressed, the Psychologist said the behavior had not been seen as frequent enough or important enough to address. The QIDP added that since Resident #7 was overweight, any weight loss would be desirable. When asked if the team had discussed whether or not Resident #7 received a nutritionally balanced diet since he often refused to eat the food prepared by the central kitchen, the Psychologist said it was "his right" to select alternatives. When asked if the fingers in nose and blowing his nose in his hands and licking the mucus from his hands behavior was addressed in his plan, the Psychologist said it was not. The Psychologist did not respond to the question of whether or not she had observed the behavior which staff confirmed was a typical behavior. The Psychologist and the QIDP explained the team for Resident #7 met frequently and discussed his challenging behaviors. The Psychologist explained Resident #7 experienced pain and received medication and opined that the [redacted] behaviors were related to pain.	{W 196}		

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{W 196}	Continued From page 29 When asked who was responsible for the overall management of Client #7 ' s complicated medication regimen, the Psychologist said the Advanced Practice Registered Nurse (APRN) was the prescriber in concert with the Neurologist. The QIDP explained the facility had recently hired a new physician who was currently getting to know the Residents served, including Resident #7. When asked if Resident #7 ' s plan addressed proactive strategies such as providing Resident #7 with gum prior to going on a walk as a possible method to reduce the frequency of putting used gum in his mouth, the Psychologist said, " Yes. " However, the Psychologist was unable to identify the part of Resident #7 ' s plan which provided instruction to staff and, after looking at the plan, confirmed Resident #7 ' s plan did not include a strategy about assuring he had " new " gum available to chew. The Psychologist was unable to identify the part of Resident #7 ' s plan which provided instruction to staff about what steps they were to take to examine the contents of Resident #7 ' s purses to remove those items which posed possible risks to him such as cigarette butts and used gum. The Psychologist said she thought it was in the plan but after looking at the plan confirmed there were no instructions to staff about what steps there were to take related to examining the contents of the purses used by Resident #7. The Psychologist confirmed she had not provided training to staff nor had she provided written instructions to staff about examining the contents of the Resident #7 ' s purses as a strategy to enhance his health and safety.	{W 196}		

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{W 196}	Continued From page 30 Record Review for Resident #7 was conducted at 6:00 PM on 3/26/15. His record included a BSP, dated 2/4/15, which included the following five objectives: " ...reduce aggression to 75% from the baseline for six consecutive months; ...reduce unsupported departures to 75% from the baseline for six consecutive months; ...reduce behavioral outbust [sic] to 75% from the baseline for six consecutive months; ...reduce obsessive/compulsive behaviors to 75% from the baseline for six consecutive months; and ...reduce stealing to 75% from the baseline for six consecutive months. " The " Description and Pertinent History " section of the BSP described a detailed history of this [redacted] year old man who, " ...has a long history of psychotic and compulsive behavior. A variety of [redacted] have been used over the years and he is currently on [redacted] which has been effective at controlling psychotic symptoms. Past symptoms included howling, digging in the dirt, rambling incoherently, etc. Compulsive behaviors include foraging for used gum (which he will scrape off the ground and put in his mouth) and cigarette butts; including a fixation on coffee and chewing tobacco. In recent years, [Resident #7] has been repeatedly changing clothing as well. At times, he changes clothing so frequently that he runs out of clean clothing and takes clothes belonging to others. Stealing behavior added as an objective to his BSP. " The BSP provided historic information related to [redacted] and [redacted] medications tried over the years and the efficacy of those medications. The " Justification " section of his BSP documented, " [Resident #7 ' s] aggressive behavior poses a serious threat to the safety of others. Additionally, it infringes on their right to	{W 196}		

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{W 196}	Continued From page 31 live and work in a place free from assault. Without intervention, his behavior would likely escalate, resulting in serious injury. ...Obsessive/compulsive behaviors pose a health and safety risk; items that [Resident #7] puts in his mouth could carry germs or disease and searching in garbage cans could result in serious injury or in illness/disease (e.g. broken glass, spoiled food, etc.). Such behaviors interfere with habilitative training efforts and when blocked can lead to aggressive outbursts. Tantrum behaviors interfere with habilitative training and have the potential to result in self-injury. This program utilizes positive supports to reduce the likelihood of challenging behaviors and the least restrictive strategies to deal with challenging behaviors that protect [Resident #7] and others. ...The current program utilizes positive supports and prevention strategies to minimize the potential for challenging behaviors. There are no restrictions or restraints used in this program. " The " Definition of Challenging Behaviors " section of the BSP provided the following definitions: " Aggression: Actual or attempted hitting, pushing, scratching, kicking or head butting, places hands around neck, choking and/or any other act which could be expected to cause damage to others if allowed to continue. Unsupported/Departures: Leaving or attempted to leave the cottage/training area unaccompanied by staff ...or attempting to leave unaccompanied by staff. Tantrum Behavior: Included in this definition are the following behaviors which may occur singly or in combination with each other: hitting or slapping himself, screaming, knocking over furniture, throwing objects not meant to be thrown, or breaking objects, hitting his hand on a wall or other hard object, or any behavior which	{W 196}		

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{W 196}	Continued From page 32 occurs with such intensity that injury or property destruction could be expected to occur if allowed to continued. Obsessive/Compulsive Behaviors: Placing, or attempting to place, an inedible or inappropriate item in his mouth, e.g. cigarette butt or used gum; digging through garbage cans; repetitive behaviors such as constantly changing clothes, turning lights off/on, repeated requests for chew after being told when he is next scheduled to receive it, etc.; and Stealing: Taking items that do not belong to him ... " The QIDP was again interviewed on 3/27/15 at 7:25 AM. The QIDP confirmed he was unable to locate the last psychiatric evaluation for Resident #7. The QIDP identified the Psychologist as the person on the team who was expected to have expertise in assessing Resident #7 ' s programmatic support needs and developing active treatment strategies related to his diagnosis of [redacted] since there was no Psychiatrist to assist the team in assessment of programmatic and environmental supports as well as medication management for Resident #7. The QIDP said after hearing about the survey observations, he understood why there might be concern about the lack of an aggressive treatment plan to address the observed behaviors such as meal refusal, licking mucus covered hands, lack of hand washing and the lack of a systemic approach to environmental sweeps to lessen Resident #7 ' s exposure to cigarette butts and used gum. The QIDP confirmed the team for Resident #7 was very aware that the behaviors he exhibited consistently posed risks for him. The QIDP was unable to identify efforts taken by the facility to seek help from consultants or experts in the field with experience in assessing needs, developing	{W 196}		

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{W 196}	Continued From page 33 programs, training staff and monitoring and changing programs to assure Resident #7 received a consistently implemented active treatment program. Resident #1: Observation on 3/23/15 at Evergreen Cottage at 1:25 PM revealed a direct care staff came out of Resident #1 ' s bedroom and put his wheelchair in the hallway. Resident #1 was lying down in his bed. Resident #1 was still in his bedroom at the end of the observation at 2:33 PM. Observation on 3/24/15 at Evergreen Cottage at 10:20 AM revealed Resident #1 was lying in bed in his bedroom and appeared to be asleep. Resident #1 was receiving nutrition [redacted] Interview with Staff E revealed the feeding process began at 6:00 PM in the evening and ended somewhere around 10:00 AM the next day. At 10:45 AM a direct care staff went into Resident #1 ' s bedroom and closed the door. At 11:00 AM the staff brought Resident #1, in a wheelchair, out of his bedroom and went into the bathroom. At 11:16 AM the staff pushed Resident #1 into the living room and put on a TV show for him to watch. Other Residents were preparing for or eating lunch. Resident #1, who can have " recreational eating " was not brought to the table. Observation on 3/24/15 at Evergreen Cottage at 2:12 PM revealed Resident #1 was in his bedroom with the bedroom door closed. At 3:15 PM a staff went into his bedroom to ask if he wanted to attend a People First meeting at the facility. Resident #1 did not go to the meeting and was still in his bedroom at the end of the observation at 3:25 PM. Observation on 3/24/15 at Evergreen Cottage at 4:50 PM revealed Resident #1 was in his	{W 196}		

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{W 196}	Continued From page 34 bedroom lying on his bed. He appeared to be watching TV. His bedroom door was open. Interview with Staff F revealed Resident #1 has had physical decline over the past several years. She state his plan calls for him to be turned every 2 hours and that he is to be out of bed for up to 3 hours, which can be done in any combination of time frames during the day. The observation ended at 5:25 PM with Resident #1 still in bed in his bedroom. Observation on 3/25/15 at Evergreen Cottage at 9:28 AM revealed Resident #1 was sitting in his wheelchair in his bedroom with the door open. He appeared to be watching TV. A short time later a direct care staff went into the room and as he left he shut the bedroom door. Review of Resident #1 ' s Active Treatment Schedule revealed his day was to start at 6:45 am with getting up, dressed and to participate in grooming activities. It included " PAT Day training at 9:15 - 10:30 " with suggested activities of " home living skills; laundry, making his bed, cooking, cleaning his room and other household chores etc. " These activities were also suggested from 1:15 - 2:30 PM. Interview with Staff G verified Resident #1 ' s day did not follow the Active Treatment Schedule in his green program book. The observation ended at 10:25 AM with Resident #1 still in his bedroom. Observation on 3/26/15 at Evergreen Cottage at 8:45 AM revealed Resident #1 was in his bedroom lying in bed and appeared to be asleep. The observation ended at 10:48 with Resident #1 still in his bed and appearing to be asleep. An interview was conducted on 3/26/15 at 2:45 PM with Staff H, the Psychologist (who had just taken over Resident #1 ' s case, and the Developmental Disabilities Administrator 1. Resident #1 ' s records were available. (The	{W 196}		

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{W 196}	Continued From page 35 QIDP was not available.) They verified that Resident #1 ' s IHP indicated social isolation was a primary concern. They verified the Active Treatment Schedule in his green program book was the current schedule for Resident #1. When the observations of Resident #1 were described to them, along with the Active Treatment Schedule and the primary concern being social isolation, they agreed that what had been observed was not following the active treatment schedule or meeting his primary need. They agreed that the active treatment plan needed to change in order to better meet Resident #1 ' s needs. This is a repeat citation from the 1/27/15 Recertification Survey.	{W 196}		
W 206	483.440(c)(1) INDIVIDUAL PROGRAM PLAN Each client must have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to: (i) Identifying the client's needs, as described by the comprehensive functional assessments required in paragraph (c)(3) of this section; and (ii) Designing programs that meet the client's needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the interdisciplinary team included persons with expertise in functionally assessing skills, identifying needs, developing plans, training staff, and monitoring and making changes to the individual plan for one of one Sample Residents (Resident #7) whose diagnoses included	W 206		

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W 206	Continued From page 36 [redacted] and who consistently exhibited the behavior of [redacted] and [redacted] and [redacted] Findings Include: Note: For greater detail regarding all observations, please see W196: Resident #7 was observed from 3:54 PM to 5:15 PM on 3/23/15. Resident #7 was observed to rummage through a [redacted] purse taking out small cans of chewing tobacco which appeared to be empty and running his fingers around the bottom of the cans and putting his fingers in his mouth. Resident #7 was observed to use the fingernails of his right hand to scrape a green substance, identified as green gum Resident #7 had scraped from the roadway on campus, from inside the purse. He then used his tongue and teeth to remove the green substance from under his fingernails. Resident #7 was observed to refuse the evening meal provided from the central kitchen. Resident #7 was observed at his day program from 10:37 AM on 11:03 on 3/25/15. Resident #7 was observed to kiss the back of Staff A ' s hand three times. He was also observed to attempt to touch her neck, although he was successfully redirected. When asked to wipe off his mouth, Resident #7 was observed to blow his nose on a washcloth and then require significant verbal and physical prompting to wash his hands with soap and water. Resident #7 was observed to consistently say the words " chew, gum and walk. " While being escorted to his home from the day program, Resident #7 was observed to consistently ask Staff A for the gum she had picked up off the ground in order to keep him from getting the gum. Resident #7 was observed at his home from 11:03 AM to 12:03 PM on 3/25/15. Resident #7	W 206		

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W 206	Continued From page 37 was observed to refuse to wash his hands although he was in the kitchen area of the residence and prompted to do so. Resident #7 was observed to refuse the lunch meal prepared by the central kitchen. Resident #7 was observed to manipulate the objects in two purses and to blow mucus from his nose onto his hands and lick his hands. Resident #7 was observed to kiss the back of the hand of male staff who did not respond to the behavior other than to wipe off his hand. Resident #7 was observed from 7:41 AM to 8:45 AM on 3/26/15. Resident #7 was observed to pick up cigarette butts and used gum while on a walk with one-on-one staff on the grounds of the facility. During this observation, a " grounds worker " was observed to broadcast what she identified as ' weed and feed ' on the sidewalk and the ground in an area consistently used by Resident #7 for foraging cigarette butts and used gum. Resident #7 was observed to refuse breakfast sent to the residence from the central kitchen. Staff B was interviewed on 3/25/15 at 10:30 AM. She explained that due to Resident #7 ' s history of aggression to self and others, no attempt beyond verbally prompting him to not pick up cigarette butts and/or used gum was done by staff. When asked if there were any strategies in place to provide Resident #7 with " new " gum to chew before going on walks, she said " No, that ' s not included in his plan. " When told of the observation the previous day where Resident #7 continually scraped the green gum from inside his purse and placed it in his mouth, she confirmed the behavior was " typical. " She confirmed Resident #7 ' s plan did not include instruction to staff about how they were to respond to his	W 206		

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W 206	Continued From page 38 behaviors other than to encourage him to not eat cigarette butts and/or used gum. When asked if Resident #7 ' s plan included strategies to monitor the contents of the purses used by Resident #7 to lessen the likelihood of ingesting cigarette butts and used gum, she said, " No, although we try to have him show us what he has, there is no system in place to go through the purses. " When asked if the team had considered ideas such as " trading " Resident #7 " new " gum for " used " gum, she said there were no strategies included in Resident #7 ' s plan to help staff teach replacement behaviors. When asked if there was an expectation by Resident #7 ' s team that he might learn new skills and change the foraging behavior, she said due to his mental health diagnoses, the only instruction given to direct support staff was to redirect him when possible without upsetting him to the point where he acted aggressively. Staff B added, " We just try to keep him safe. " Staff B was again interviewed at 8:45 AM on 3/26/15. She confirmed the hand kissing behavior was not addressed in Resident #7 ' s plan. She confirmed the meal refusal behavior was not addressed in Resident #7 ' s plan. She confirmed meal refusal was a consistent behavior and confirmed the team for Resident #7 had not asked direct care staff to record what food was eaten by Resident #7. The Qualified Intellectual Disabilities Professional (QIDP) and the Psychologist assigned to Resident #7 were interviewed on 3/26/15 at 11:45 AM with Resident #7 ' s records available for reference. The QIDP confirmed he had been assigned to Resident #7 " for years. " The Psychologist confirmed she had been assigned to work with Resident #7 for approximately five	W 206		

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W 206	Continued From page 39	W 206		

years. Both the QIDP and the Psychologist said they spent time with him and observed Resident #7 frequently. Both confirmed there were aware of the challenging behaviors he presented. When asked if the PICA behavior (eating inedible objects) was addressed in his plan, the QIDP explained that no " professional " had ever given Resident #7 a diagnosis of PICA but rather, the ingesting of cigarette butts and already chewed gum was considered part of his obsessive/compulsive behavior. When asked if the team for Resident #7 included a psychiatrist, the QIDP and the Psychologist confirmed the facility did not presently have a psychiatrist on staff and confirmed it had been approximately three years since the previous psychiatrist left Lakeland Village. The QIDP and the Psychologist verified Resident #7 received psychoactive medications as well as medication for seizures. The Psychologist confirmed the psychoactive medication being used was Risperidone. The Psychologist also confirmed Resident 7 received Oxycodone on a regular basis due to back pain and arthritic pain.

When asked what staff were expected to do when Resident #7 picked up cigarette butts and/or used gum from the ground, roadway or sidewalks, the Psychologist said staff should redirect him. The Psychologist said the behaviors were directly related to Resident #7 ' s diagnosis of Obsessive Compulsive Disorder (OCD). When asked to show what replacement behaviors staff were supposed to teach when Resident #7 engaged in chewing and swallowing cigarette butts and/or used gum, the Psychologist said the Behavior Support Plan (BSP) addressed " positive strategies. " The Psychologist said she had not trained staff on what to do once Resident

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W 206	Continued From page 40 #7 was observed chewing on or swallowing cigarette butts or used gum. Neither the Psychologist nor the QIDP could identify actions taken by the facility to assure the facility grounds were reasonably free of cigarette butts and discarded gum, other than emails and memorandums sent to staff about possible disciplinary action if they were observed to discard those items on the campus. When asked if the team had discussed whether or not Resident #7 carrying women ' s purses was stigmatizing for him and/or placed him in a situation where he might receive undesired reactions from others, the Psychologist responded by saying the purse carrying behavior was not a problem and it was the community who had to make accommodations to him, rather than him having to change. The Psychologist went on to explain it was Resident ' s #7 ' s choice to purchase the women ' s purses and his " right " to carry them if he wanted to. When asked if the behavior of meal refusal had been assessed and addressed, the Psychologist said the behavior had not been seen as frequent enough or important enough to address. When asked if Resident #7 ' s plan addressed the hand-kissing behavior, the Psychologist said it was not viewed as a behavior that needed to be addressed. When asked if the team had discussed the hand-kissing as a behavior which might interfere with community-based activities, the QIDP asked, " Why should he have to change? " When asked if staff were provided instruction as to the expected response when Resident #7 kissed their hands, the Psychologist explained it was just his way of greeting people and since various staff had different relationships	W 206		

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W 206	Continued From page 41 with him, it was not necessary to address the hand-kissing behavior. When asked if the fingers in nose and blowing his nose in his hands and licking the mucus from his hands behavior was addressed in his plan, the Psychologist said it was not. The Psychologist and the QIDP explained the team for Resident #7 met frequently and discussed his challenging behaviors. The Psychologist explained Resident #7 experienced pain and received medication and opined that the [redacted] behaviors were related to pain. When asked if Resident #7 ' s plan addressed proactive strategies such as providing Resident #7 with gum prior to going on a walk, the Psychologist said, " Yes. " However, after looking at the plan, the Psychologist confirmed Resident #7 ' s plan did not include a strategy about assuring he had " new " gum available to chew. The Psychologist was unable to identify the part of Resident #7 ' s plan which provided instruction to staff about what steps they were to take to examine the contents of Resident #7 ' s purses to remove those items which posed possible risks to him such as cigarette butts and used gum. The Psychologist said she thought it was in the plan but after looking at the plan confirmed there were no instructions to staff about what steps there were to take related to examining the contents of the purses used by Resident #7. The Psychologist confirmed she had not provided training to staff nor had she provided written instructions to staff about examining the contents of the Resident #7 ' s purses as a strategy to enhance his health and safety.	W 206		

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W 206	Continued From page 42 When asked who was responsible for the overall management of Client #7 ' s medication regimen, the Psychologist said the Advanced Practice Registered Nurse was the prescriber in concert with the Neurologist. The QIDP explained the facility had recently hired a new physician who was currently getting to know the Residents served, including Resident #7. The QIDP was again interviewed on 3/27/15 at 7:25 AM. The QIDP confirmed he was unable to locate the last psychiatric evaluation for Resident #7. The QIDP identified the Psychologist as the person on the team who was expected to have expertise in assessing Resident #7 ' s programmatic support needs related to his diagnosis of [redacted] since there was no Psychiatrist to assist the team in assessment of programmatic and environmental supports as well as medication management for Resident #7. The QIDP said he understood why there was concern about the lack of an aggressive treatment plan to address the observed behaviors such as meal refusal, licking mucus covered hands, lack of hand washing and the lack of a systemic approach to environmental sweeps to lessen Resident #7 ' s exposure to cigarette butts and used gum. The QIDP confirmed the team for Resident #7 was aware the behaviors he exhibited consistently posed risks for him. The QIDP was unable to identify efforts taken by the facility to seek help from professionals with subject matter expertise in assessing needs, developing programs, training staff and monitoring and changing programs for people whose diagnosis include [redacted]	W 206		
{W 214}	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN	{W 214}		

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{W 214}	Continued From page 43 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 observation, interview and record review, the facility failed to ensure the interdisciplinary team included persons with expertise in functionally assessing skills, identifying needs, developing plans, training staff, and monitoring and making changes to the individual plan for one of one Sample Residents (Resident #7) whose diagnoses included [redacted] and who consistently exhibited the behavior of [redacted] and ingesting [redacted] Findings Include: Note: For greater detail regarding all observations, please see W196: Resident #7 was observed from 3:54 PM to 5:15 PM on 3/23/15. Resident #7 was observed to rummage through a [redacted] purse taking out small cans of chewing tobacco which appeared to be empty and running his fingers around the bottom of the cans and putting his fingers in his mouth. Resident #7 was observed to use the fingernails of his right hand to scrape a green substance, identified as green gum Resident #7 had scraped from the roadway on campus, from inside the purse. He then used his tongue and teeth to remove the green substance from under his fingernails. Resident #7 was observed to refuse the evening meal provided from the central kitchen. Resident #7 was observed at his day program from 10:37 AM on 11:03 on 3/25/15. Resident #7 was observed to kiss the back of Staff A ' s hand	{W 214}		

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{W 214}	Continued From page 44 three times. He was also observed to attempt to touch her neck, although he was successfully redirected. When asked to wipe off his mouth, Resident #7 was observed to blow his nose on a washcloth and then require significant verbal and physical prompting to wash his hands with soap and water. Resident #7 was observed to consistently say the words " chew, gum and walk. " While being escorted to his home from the day program, Resident #7 was observed to consistently ask Staff A for the gum she had picked up off the ground in order to keep him from getting the gum. Resident #7 was observed at his home from 11:03 AM to 12:03 PM on 3/25/15. Resident #7 was observed to refuse to wash his hands although he was in the kitchen area of the residence and prompted to do so. Resident #7 was observed to refuse the lunch meal prepared by the central kitchen. Resident #7 was observed to manipulate the objects in two purses and to blow mucus from his nose onto his hands and lick his hands. Resident #7 was observed to kiss the back of the hand of male staff who did not respond to the behavior other than to wipe off his hand. Resident #7 was observed from 7:41 AM to 8:45 AM on 3/26/15. Resident #7 was observed to pick up cigarette butts and used gum while on a walk with one-on-one staff on the grounds of the facility. During this observation, a " grounds worker " was observed to broadcast what she identified as ' weed and feed ' on the sidewalk and the ground in an area consistently used by Resident #7 for foraging cigarette butts and used gum. Resident #7 was observed to refuse breakfast sent to the residence from the central kitchen.	{W 214}		

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{W 214}	Continued From page 45 Staff B was interviewed on 3/25/15 at 10:30 AM. She explained that due to Resident #7 ' s history of aggression to self and others, no attempt beyond verbally prompting him to not pick up cigarette butts and/or used gum was done by staff. When asked if there were any strategies in place to provide Resident #7 with " new " gum to chew before going on walks, she said " No, that ' s not included in his plan. " When told of the observation the previous day where Resident #7 continually scraped the green gum from inside his purse and placed it in his mouth, she confirmed the behavior was " typical. " She confirmed Resident #7 ' s plan did not include instruction to staff about how they were to respond to his behaviors other than to encourage him to not eat cigarette butts and/or used gum. When asked if Resident #7 ' s plan included strategies to monitor the contents of the purses used by Resident #7 to lessen the likelihood of ingesting cigarette butts and used gum, she said, " No, although we try to have him show us what he has, there is no system in place to go through the purses. " When asked if the team had considered ideas such as " trading " Resident #7 " new " gum for " used " gum, she said there were no strategies included in Resident #7 ' s plan to help staff teach replacement behaviors. When asked if there was an expectation by Resident #7 ' s team that he might learn new skills and change the [redacted] behavior, she said due to his mental health diagnoses, the only instruction given to direct support staff was to redirect him when possible without upsetting him to the point where he acted aggressively. Staff B added, " We just try to keep him safe. " Staff B was again interviewed at 8:45 AM on 3/26/15. She confirmed the hand kissing behavior was not addressed in Resident #7 ' s	{W 214}		

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{W 214}	Continued From page 46 plan. She confirmed the meal refusal behavior was not addressed in Resident #7 ' s plan. She confirmed meal refusal was a consistent behavior and confirmed the team for Resident #7 had not asked direct care staff to record what food was eaten by Resident #7. The Qualified Intellectual Disabilities Professional (QIDP) and the Psychologist assigned to Resident #7 were interviewed on 3/26/15 at 11:45 AM with Resident #7 ' s records available for reference. The QIDP confirmed he had been assigned to Resident #7 " for years. " The Psychologist confirmed she had been assigned to work with Resident #7 for approximately five years. Both the QIDP and the Psychologist said they spent time with him and observed Resident #7 frequently. Both confirmed there were aware of the challenging behaviors he presented. When asked if the [redacted] behavior (eating inedible objects) was addressed in his plan, the QIDP explained that no " professional " had ever given Resident #7 a diagnosis of [redacted] but rather, the ingesting of cigarette butts and already chewed gum was considered part of his [redacted] behavior. When asked if the team for Resident #7 included a psychiatrist, the QIDP and the Psychologist confirmed the facility did not presently have a psychiatrist on staff and confirmed it had been approximately three years since the previous psychiatrist left Lakeland Village. The QIDP and the Psychologist verified Resident #7 received [redacted] medications as well as medication for [redacted] The Psychologist confirmed the psychoactive medication being used was [redacted] The Psychologist also confirmed Resident 7 received Oxycodone on a regular basis due to back pain and arthritic pain.	{W 214}		

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{W 214}	Continued From page 47 When asked what staff were expected to do when Resident #7 picked up cigarette butts and/or used gum from the ground, roadway or sidewalks, the Psychologist said staff should redirect him. The Psychologist said the behaviors were directly related to Resident #7 ' s diagnosis of [redacted] When asked to show what replacement behaviors staff were supposed to teach when Resident #7 engaged in chewing and swallowing cigarette butts and/or used gum, the Psychologist said the Behavior Support Plan (BSP) addressed " positive strategies: " The Psychologist said she had not trained staff on what to do once Resident #7 was observed chewing on or swallowing cigarette butts or used gum. Neither the Psychologist nor the QIDP could identify actions taken by the facility to assure the facility grounds were reasonably free of cigarette butts and discarded gum, other than emails and memorandums sent to staff about possible disciplinary action if they were observed to discard those items on the campus. When asked if the team had discussed whether or not Resident #7 carrying women ' s purses was stigmatizing for him and/or placed him in a situation where he might receive undesired reactions from others, the Psychologist responded by saying the purse carrying behavior was not a problem and it was the community who had to make accommodations to him, rather than him having to change. The Psychologist went on to explain it was Resident ' s #7 ' s choice to purchase the women ' s purses and his " right " to carry them if he wanted to. When asked if the behavior of meal refusal had	{W 214}		

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{W 214}	Continued From page 48	{W 214}		

been assessed and addressed, the Psychologist said the behavior had not been seen as frequent enough or important enough to address. When asked if Resident #7 ' s plan addressed the hand-kissing behavior, the Psychologist said it was not viewed as a behavior that needed to be addressed. When asked if the team had discussed the hand-kissing as a behavior which might interfere with community-based activities, the QIDP asked, " Why should he have to change? " When asked if staff were provided instruction as to the expected response when Resident #7 kissed their hands, the Psychologist explained it was just his way of greeting people and since various staff had different relationships with him, it was not necessary to address the hand-kissing behavior.

When asked if the fingers in nose and blowing his nose in his hands and licking the mucus from his hands behavior was addressed in his plan, the Psychologist said it was not. The Psychologist and the QIDP explained the team for Resident #7 met frequently and discussed his challenging behaviors. The Psychologist explained Resident #7 experienced pain and received medication and opined that the [redacted] were related to pain.

When asked if Resident #7 ' s plan addressed proactive strategies such as providing Resident #7 with gum prior to going on a walk, the Psychologist said, " Yes. " However, after looking at the plan, the Psychologist confirmed Resident #7 ' s plan did not include a strategy about assuring he had " new " gum available to chew. The Psychologist was unable to identify the part of Resident #7 ' s plan which provided instruction to staff about what steps they were to

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{W 214}	Continued From page 49 take to examine the contents of Resident #7 ' s purses to remove those items which posed possible risks to him such as cigarette butts and used gum. The Psychologist said she thought it was in the plan but after looking at the plan confirmed there were no instructions to staff about what steps there were to take related to examining the contents of the purses used by Resident #7. The Psychologist confirmed she had not provided training to staff nor had she provided written instructions to staff about examining the contents of the Resident #7 ' s purses as a strategy to enhance his health and safety. When asked who was responsible for the overall management of Client #7 ' s medication regimen, the Psychologist said the Advanced Practice Registered Nurse was the prescriber in concert with the Neurologist. The QIDP explained the facility had recently hired a new physician who was currently getting to know the Residents served, including Resident #7. The QIDP was again interviewed on 3/27/15 at 7:25 AM. The QIDP confirmed he was unable to locate the last psychiatric evaluation for Resident #7. The QIDP identified the Psychologist as the person on the team who was expected to have expertise in assessing Resident #7 ' s programmatic support needs related to his diagnosis of [redacted] since there was no Psychiatrist to assist the team in assessment of programmatic and environmental supports as well as medication management for Resident #7. The QIDP said he understood why there was concern about the lack of an aggressive treatment plan to address the observed behaviors	{W 214}		

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{W 214}	Continued From page 50 such as meal refusal, licking mucus covered hands, lack of hand washing and the lack of a systemic approach to environmental sweeps to lessen Resident #7 ' s exposure to cigarette butts and used gum. The QIDP confirmed the team for Resident #7 was aware the behaviors he exhibited consistently posed risks for him. The QIDP was unable to identify efforts taken by the facility to seek help from professionals with subject matter expertise in assessing needs, developing programs, training staff and monitoring and changing programs for people whose diagnosis include [redacted]	{W 214}		
W 226	483.440(c)(4) INDIVIDUAL PROGRAM PLAN 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 record review and interview, the facility failed to ensure one of one Sample Residents (Resident #3) had an Individual Habilitation Plan (IHP) developed within 30 days of being admitted to the facility. This failure prevented Resident #3 from having a comprehensive plan designed to help her develop the skills needed to move back into a less restrictive living setting. Findings include: Review on 3/26/15 of Resident #3 ' s record revealed she was admitted to the facility on [redacted]15, but there was no IHP in place for her. Interview on 3/26/15 with Staff I verified an IHP had not yet been developed. Interview on 3/26/15 with the QIDP revealed Resident #3 had originally been admitted to the facility on [redacted]15 for respite	W 226		

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W 226	Continued From page 51 care and that the projected stay was for approximately 2 weeks. The QIDP revealed the facility had not started to develop an IHP because it did not anticipate Resident #3 would be at the facility past 30 days. Interview on 3/26/15 with the Superintendent verified the facility was receiving Federal money for Resident #3 ' s stay at the facility.	W 226		
W 239	483.440(c)(5)(vi) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop an active treatment program which included objectives to teach skills or replacement behaviors to address behaviors exhibited by two of two Sample Residents (Residents #5 and #7) who consistently exhibited behaviors which interfered with the provision of active treatment. Findings Include: 1. Resident #7 was observed from 3:54 PM to 5:15 PM on 3/23/15. Resident #7 was observed to rummage through a [redacted] purse taking out small cans of chewing tobacco which appeared to be empty and running his fingers around the bottom of the cans and putting his fingers in his mouth. Resident #7 was observed to use the fingernails of his right hand to scrape a green substance, identified as green gum	W 239		

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W 239	Continued From page 52 Resident #7 had scraped from the roadway, from inside the purse. He then used his tongue and teeth to remove the green substance from under his fingernails. Resident #7 refused the evening meal provided from the central kitchen. At no time during the observation were staff observed to attempt to teach any replacement behavior related to rummaging through the purse and eating gum found on the ground. Resident #7 was observed at his day program from 10:37 AM on 11:03 on 3/25/15. Resident #7 was observed to kiss the back of Staff A ' s staff members hand three times. He was also observed to attempt to touch her neck, although he was successfully redirected. When asked to wipe off his mouth, Resident #7 blew his nose on a washcloth and then required significant verbal and physical prompting to wash his hands. Resident #7 was observed to consistently say the words " chew, gum and walk. " While being escorted to his home from the day program, Resident #7 was observed to consistently ask Staff A for the gum she had picked up off the ground in order to keep him from getting the gum. At no time during the observation was Staff A observed to attempt to teach any replacement behavior related to Resident #7 ' s hand kissing behavior or when Resident #7 attempted to touch her neck. Resident #7 was observed at his home from 11:03 AM to 12:03 PM on 3/25/15. Resident #7 was observed to refuse to wash his hands although he was in the kitchen area of the residence and prompted to do so. Resident #7 was observed to refuse the lunch meal. Resident #7 was observed to manipulate the objects in two purses and to blow mucus from his nose onto his hands and lick his hands. Resident #7 was	W 239		

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W 239	Continued From page 53 observed to kiss the back of the hand of a male staff. At no time during the observation were staff observed to attempt to teach any replacement behavior related to blowing mucus from his nose onto his hands and licking his hands, meal refusal or hand kissing. Resident #7 was observed from 7:41 AM to 8:45 AM on 3/26/15. Resident #7 was observed to pick up cigarette butts and used gum while on a walk with one-on-one staff on the facility grounds. During this observation, a " grounds worker " was observed to broadcast what she identified as ' weed and feed ' on the sidewalk and the ground in an area consistently used by Resident #7 for foraging cigarette butts and used gum. During this time period, Resident #7 was observed to refuse breakfast. At no time during the observation were staff observed to attempt to teach any replacement behavior related to picking up cigarette butts and used gum or meal refusal. Staff B was interviewed on 3/25/15 at 10:30 AM. She explained that due to Resident #7 ' s history of aggression to self and others, no attempt beyond verbally prompting him to not pick up cigarette butts and/or used gum was done by staff. When asked if there were any strategies in place to provide Resident #7 with " new " gum to chew before going on walks, she said " No, that ' s not included in his plan. " When told of the observation the previous day where Resident #7 continually scraped the green gum and placed it in his mouth, she confirmed that was a typical behavior. She confirmed Resident #7 ' s plan did not include instruction to staff about how they were to respond to Resident #7 ' s behaviors other than to encourage him to not eat cigarette butts and/or used gum. When asked if Resident #7 ' s plan included strategies to monitor the	W 239		

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W 239	Continued From page 54 contents of the purses used by Resident #7 to lessen the likelihood of ingesting cigarette butts and used gum, she said, " No, although we try to have him show us what he has, there is no system in place to go through the purses. " When asked if the team had considered ideas such as " trading " Resident #7 " new " gum for " used " gum, Staff B said there were no strategies included in Resident #7 ' s plan to help staff teach replacement behaviors. When asked if there was any expectation that Resident #7 might learn new skills and change the foraging behavior, she said due to his mental health diagnoses, the only instruction given to the direct support staff was to redirect him when possible without upsetting him to the point where he would act out aggressively. Staff B added, " We just try to keep him safe. " Staff B was again interviewed at 8:45 AM on 3/26/15. She confirmed the hand kissing behavior was not addressed in Resident #7 ' s plan. She confirmed the meal refusal behavior was not addressed in Resident #7 ' s plan. The Qualified Intellectual Disabilities Professional (QIDP) and the Psychologist assigned to Resident #7 were interviewed on 3/26/15 at 11:45 AM with Resident #7 ' s records available for reference. The QIDP and the Psychologist confirmed they had worked with Resident #7 for five years or longer. When asked if the [redacted] behavior (ingesting inedible objects) was addressed in his plan, the QIDP quickly stated that no professional had ever given Resident #7 a diagnosis of [redacted] but rather, the ingesting of cigarette butts and already chewed gum stuck to the sidewalk or pavement was considered part of his [redacted] When asked what staff were expected to do	W 239		

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W 239	Continued From page 55 when Resident #7 picked up cigarette butts and/or used gum from the ground, roadway or sidewalks, the Psychologist said staff should redirect him. When asked if Resident #7 ' s plan addressed the hand-kissing behavior, the Psychologist said it was not viewed as a behavior that needed to be addressed. When asked if the behavior of meal refusal had been assessed and addressed, the Psychologist said the behavior had not been seen as frequent enough or important enough to address. When asked if the fingers in nose and blowing his nose in his hands and licking the mucus from his hands behavior was addressed in his plan, the Psychologist said it was not. When asked to show what replacement behaviors staff were supposed to teach when Resident #7 engaged in chewing and swallowing cigarette butts and/or used gum, the Psychologist said the Behavior Support Plan addressed " positive strategies. " The Psychologist said she had not trained staff on what to do once Resident #7 was observed chewing on or swallowing cigarette butts or used gum. The Psychologist was not able to identify any replacement behaviors staff were expected to teach to Resident #7 when he exhibited aberrant or interfering behaviors. When asked if Resident #7 ' s plan addressed proactive strategies such as providing Resident #7 with gum prior to going on a walk as a possible method to reduce the frequency of putting used gum in his mouth, the Psychologist said, " Yes. " However, after looking at the plan, the Psychologist confirmed Resident #7 ' s plan did not include a strategy about assuring he had " new " gum available to chew.	W 239		

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W 239	Continued From page 56 The QIDP was again interviewed on 3/27/15 at 7:25 AM. The QIDP said he understood why there was concern about the lack of an aggressive treatment plan to address the observed behaviors such as meal refusal, licking mucus covered hands, lack of hand washing and the lack of a systemic approach to environmental sweeps to lessen Resident #7 ' s exposure to cigarette butts and used gum. The QIDP confirmed the team for Resident #7 was aware the behaviors he exhibited consistently placed him at risk. 2. Resident #5 Observation on 3/23/15 at Bigfoot House at 3:50 PM revealed Resident #5 was walking through the kitchen area. At one point, he stopped walking and pressed his body (face forward) into the wall in the dining room. He held his body against the wall for a few minutes. During the annual recertification survey in January 2015, Resident #5 was observed pressing up against a light post located on a sidewalk. The behavior drew immediate, negative attention to Resident #5, but it did not appear to be self-injurious. Interview with Staff K on 3/25/15, about the behavior of wall rubbing revealed, Resident #5 pressed up against walls all the time. Staff K said, "That's what he does. It is just his behavior". Staff K stated he also pressed his body against the light posts when he went to and from work. Interview on 3/25/15 with the Psychologist, assigned to Resident #5, about the behavior of "rubbing on the walls" revealed she viewed the behavior as self- injurious and said it included grinding his knuckles into the wall. The Psychologist further revealed she was unclear why she had not seen any data collection sheets from staff tracking the self-injurious behavior. On 3/25/15 the State Surveyor and the	W 239		

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W 239	Continued From page 57 psychologist assigned to Resident #5 reviewed the data collection sheets for Resident #5 at Bigfoot House. There was no data collected by staff. Interview with Staff J in the presence of the Psychologist about the lack of data revealed direct care staff did not view the behavior of "wall rubbing" as self- injurious so they were not recording instances of the behavior. Review on 3/25/15 of the Behavior Support Plan dated 5/22/14 For Resident #5 revealed the behavior of rubbing against walls was considered a "distressed behavior" and the IDT decided it was a "means of communication" and was not necessarily a precursor to self-injurious behavior. The Interdisciplinary Team had determined it was not necessary to address the behavior of rubbing on walls in a formal program at this time.	W 239		
{W 240}	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop written instructions to staff about how to implement specific aspects of two of 13 Sample Residents (Residents #1 and #7) habilitation plan. Resident #7 ' s plan did not include instructions for monitoring the contents of the purses he used to conceal cigarette butts and used gum in order to ingest them at a later time. Resident #1 ' s habilitation plan did not include instructions to staff on how to decrease his social isolation once his physical condition had deteriorated. Findings include:	{W 240}		

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{W 240}	Continued From page 58 1. Resident #7 was observed from 3:54 PM to 5:15 PM on 3/23/15. Resident #7 was observed at his day program from 10:37 AM on 11:03 on 3/25/15. Resident #7 was observed at his home from 11:03 AM to 12:03 PM on 3/25/15. Resident #7 was observed at his home and on a walk on facility grounds from 7:41 AM to 8:45 AM on 3/26/15. Resident #7 was observed to consistently focus on finding gum and/or cigarette butts. During one observation, Resident #7 was observed scraping a green substance out of a purse he used. The staff identified the substance as used gum Resident #7 had found on the ground. Resident #7 put the used gum into his mouth. (See W196 for detailed description of all observations of Resident #7) Staff B was interviewed on 3/25/15 at 10:30 AM. She confirmed Resident #7 often hid cigarette butts and used gum in the purses he carried. When told of the observation where Resident #7 continually scraped green gum from a purse and placed it in his mouth, she confirmed that was a typical behavior. She confirmed Resident #7 ' s plan did not include instruction to staff about how they were to respond to Resident #7 ' s behaviors other than to encourage him to not eat cigarette butts and/or used gum. When asked if Resident #7 ' s plan included written instruction to staff on how they were to monitor the contents of the purses used by Resident #7 to lessen the likelihood of ingesting cigarette butts and used gum, she said, " No, although we try to have him show us what he has, there is no system in place to go through the purses. " The Qualified Intellectual Disabilities Professional (QIDP) and the Psychologist assigned to Resident #7 were interviewed on 3/26/15 at 11:45 AM with Resident #7 ' s records available for reference. The Psychologist confirmed there	{W 240}		

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{W 240}	Continued From page 59 were no written instructions to staff about what steps they were to take related to examining the contents of the purses used by Resident #7 to secrete cigarette butts and used gum as well as other objects which possibly posed a risk to his health and safety. Record Review for Resident #7 was conducted at 6:00 PM on 3/26/15. His record included a Behavior Support Plan (BSP), dated 2/4/15. The BSP did not include written instructions to staff about monitoring the contents of the purses used by Resident #7 to secrete cigarette butts and/or used gum. Resident #7 ' s record included an Individual Habilitation Plan (IHP), dated 5/28/14. The IHP did not include written instructions to staff about monitoring the contents of the purses used by Resident #7 to secrete cigarette butts and/or used gum. 2. Resident #1 was observed on 3/23/15 from 1:25 PM - 2:33PM; on 3/24/15 from 10:20 AM - 11:16 AM, from 2:12 PM - 3:25 PM, and from 4:50 PM - 5:25 PM; on 3/25/15 from 9:28 AM - 10:25 AM; and on 3/26/15 from 8:45 AM - 10:48 AM. During the majority of these times Resident #1 was in his bedroom alone. Review on 3/26/15 of Resident #1 ' s habilitation plan revealed his primary need was social isolation. The directions to staff in the habilitation plan included instructions which appeared to be related to someone with more independent physical abilities than Resident #1 had displayed during the observations. Interview on 3/25/15 with Staff G verified the instructions in Resident #1 ' s plan no longer fit his abilities and they did not have instructions on how to decrease Resident #1 ' s social isolation. This is a repeat citation from the 1/27/15	{W 240}		

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{W 240}	Continued From page 60 Recertification Survey.	{W 240}		
{W 242}	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the individual program plan for one of one Sample Residents (Resident #7) who routinely scraped gum from sidewalks and roadways and who routinely picked up cigarette butts from the ground included teaching skills associated with hand washing. Findings Include: Note: See W196 for detailed description of all observations of Resident #7. Resident #7 was first observed at his residence beginning at 3:54 PM on 3/23/15. He was seated in a chair in the " living area " of his home. At 4:04 PM, Staff C prompted Resident #7 to put on his coat in order to go for a walk. Staff C explained Resident #7 was always one-on-one when outside the residence due to his behavior of [redacted] for [redacted] which had already been chewed which was generally stuck to the sidewalks or roadways, and rummaging through trash cans for objects of interest to him. He explained Resident #7 carried a purse or some type of bag with him at all times in order to	{W 242}		

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{W 242}	Continued From page 61 secrete the items found when walking around the campus. At 4:27 PM on 3/23/15, Resident #7 returned to his residence with Staff C. After removing his coat, Resident #7 sat in the chair referred to by staff as " [Name of Resident #7] ' s Chair. " Resident #7 was not prompted to wash his hands. At 4:29 PM, Resident #7 began rummaging through the [redacted] purse taking out small cans of chewing tobacco which appeared to be empty and running his fingers around the bottom of the cans and putting his fingers in his mouth. He also used the fingernails of his right hand to scrape a green substance from inside the purse. He then used his tongue and teeth to remove the green substance from under his fingernails. Although Staff C and other direct support staff talked with him privately encouraging him to give them the green substance and/or saying to him quietly, " that ' s yucky " or " that ' s not good, " no staff intervened and/or attempted to provide Resident #7 with an alternative to chewing and swallowing what was identified by Staff C as green gum Resident #7 had scraped from the roadway on campus. At 4:31 PM on 3/23/15, Resident #7 was asked " ...Is that gum or plastic you are chewing on? " When Resident #7 did not reply, Staff C said, " Why don ' t you throw it away, it ' s wrong. " Resident #7 ignored the remark and continued to alternately scrape the green gum from the purse with his fingernails and put the substance in his mouth. He continued to rummage through the purse and take out objects including paper, empty chewing tobacco cans and other small pieces of material which were not readily identifiable and put them back into the purse. Resident #7 continued to manipulate the objects in his purse and continued to scrape tiny	{W 242}		

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{W 242}	Continued From page 62 pieces of the green gum with his fingernails and using his tongue and teeth, remove the green gum from under his fingernails to chew and swallow the gum. The observation was concluded at 5:15 PM. At no time during the observation were staff observed to prompt Resident #7 to wash his hands. Resident #7 was observed at his day program beginning at 10:37 AM on 3/25/15. At approximately 10:40 AM, the direct support staff prompted Resident #7 to get a washcloth and wipe his mouth. Resident #7 complied with the request to get a washcloth, but rather than wiping off his mouth, Resident #7 used the washcloth to blow his nose. Resident #7 complied with the staff ' s request to put the washcloth in the dirty clothes hamper but did not respond to the direct support staff ' s first verbal prompt to wash his hands. Only after multiple verbal and physical prompts to wash his hand, the direct support staff was successful in having Resident #7 wash his hands with soap and water. Resident #7 was observed at his home from 11:03 AM to 12:03 PM. At approximately 11:09 AM, Staff D asked Resident #7 to wash his hands since he had not done so upon his arrival home. Resident #7 said, " No " and took a glass from the kitchen cabinet and walked back to " his chair. " At 11:15 AM, Resident #7 began looking through the purses taking out objects including empty cans of chewing tobacco and pieces of paper. Resident #7 began touching the items in the purses and then licking his hands and fingers. At 11:44 AM, Resident #7 began making loud sounds generally associated with nose blowing. As he blew out air from his nose, mucus covered his right hand and fingers. He licked off his right hand and fingers. Direct support staff, who were assisting other Residents with lunch, did not see	{W 242}		

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{W 242}	Continued From page 63 and/or respond to the behavior. From 11:47 AM to 11:49 AM, Resident #7 sat in the chair with the little finger of his left hand alternating between his nostrils and his mouth. Staff, who were assisting other Residents served with lunch, did not respond to the behavior. The observation concluded at 12:03 PM. At the conclusion of the observation, Resident #7 was seated in the chair manipulating the objects in his purses. At no time during the observation were staff observed to prompt Resident #7 to wash his hands other than the one verbal prompt which he refused when he arrived at his residence. Resident #7 was observed in his home beginning at 7:41 AM on 3/26/15. From 8:00 AM to 8:18 AM, Resident #7, accompanied by Staff D, walked around the campus. During the walk, Resident #7 was observed to pick up and/or scrape up objects which appeared to be gum, using his fingernails. At 8:20 AM, Staff D confirmed Resident #7 picked up multiple objects on his walk, including used gum and cigarette butts. She confirmed Resident #7 was not always able to distinguish between gum, which had been flattened, or bird droppings until he touched the object and felt the resistance as he attempted to scrape it up with his fingernails. At 8:22 AM, as Resident #7 returned to his home after walking, he sat in his chair and began manipulating the objects in his two purses. At no time during the observation, after he returned from walking on campus and picking up cigarette butts and scraping up gum, were staff observed to prompt Resident #7 to wash his hands. Record Review for Resident #7 was conducted at 6:00 PM on 3/26/15. His record included an Individual Habilitation Plan (IHP), dated 5/28/14. The IHP did not include an objective related to hand washing and/or teaching hygiene skills	{W 242}		

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{W 242}	Continued From page 64 related to cleanliness of his hands in relationship to the behaviors of picking up cigarette butts and gum chewed by others. The Qualified Intellectual Disabilities Professional assigned to Resident #7 was interviewed on 3/27/15 at 7:25 AM. The QIDP confirmed the team for Resident #7 had not identified learning and consistently performing hand washing as a prioritized need and had therefore not created a learning objective related to hand washing for Resident #7. This is a repeat citation from the 1/27/15 Recertification Survey.	{W 242}		
W 246	483.404(c)(6)(v) INDIVIDUAL PROGRAM PLAN The individual program plan must provide that clients who have multiple disabling conditions spend a major portion of each waking day out of bed and outside the bedroom area, moving about by various methods and devices whenever possible. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure one of one Sample Residents (Resident #1) spent a majority of his day out of bed and his bedroom. Resident #1 had experienced physical decline and spent most of his day in his bed. This failure put Resident #1 of further decline in skills and exacerbated his social isolation. Findings include: See W196 for a detailed description of the observations related to Resident #1. Resident #1 was observed on 3/23/15 from 1:25 PM - 2:33PM; on 3/24/15 from 10:20 AM - 11:16	W 246		

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W 246	Continued From page 65 AM, from 2:12 PM - 3:25 PM, and from 4:50 PM - 5:25 PM; on 3/25/15 from 9:28 AM - 10:25 AM; and on 3/26/15 from 8:45 AM - 10:48 AM. During the majority of these times Resident #1 was in his bed in his bedroom alone. Review on 3/26/15 of Resident #1 ' s habilitation plan revealed his primary need was social isolation. The directions to staff in the habilitation plan included instructions which appeared to be related to someone with more independent physical abilities than Resident #1 had displayed during the observations. Interview on 3/25/15 with Staff G verified the instructions in Resident #1 ' s plan no longer fit his abilities and they did not have instructions on how to decrease Resident #1 ' s social isolation.	W 246		
{W 250}	483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure one of one Sample Residents (Resident #1) had an Active Treatment Schedule which accurately directed staff on how to interact with him throughout his day. Resident #1 had experienced physical decline in the past several years, yet his Active Treatment Schedule seemed better related to a time when he had greater physical abilities. This failure prevented staff from being given instructions on how to best provide active treatment for Resident #1.	{W 250}		

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{W 250}	Continued From page 66 Findings include: See W196 for a detailed description of the observations related to Resident #1. Resident #1 was observed on 3/23/15 from 1:25 PM - 2:33PM; on 3/24/15 from 10:20 AM - 11:16 AM, from 2:12 PM - 3:25 PM, and from 4:50 PM - 5:25 PM; on 3/25/15 from 9:28 AM - 10:25 AM; and on 3/26/15 from 8:45 AM - 10:48 AM. During the majority of these times Resident #1 was in his bed in his bedroom alone. Sometimes the TV was on, but Resident #1 was not observed to be involved in any other social activities. Review on 3/25/15 of Resident #1 ' s Active Treatment Schedule revealed his day was to start at 6:45 AM with dressing, grooming, and toileting activities. This was to be followed by breakfast at 7:30 AM and then Pat Day Training at 9:15 AM. Lunch was to start around 11:15 AM and then Pat Day Training again at 1:15 PM. A " variety of gross and fine motor training opportunities " was to occur from 3-5 PM, followed by supper at 5:30 PM. The Active Treatment Schedule concluded the day with leisure activities, grooming and bathing from 6:30 - 11:00 PM. Interview on 3/25/15 with Staff G revealed Resident #1 was [redacted] years old and had experienced a significant physical decline in the past several years. Resident #1 was unable to stand by himself anymore, could participate in some grooming activities to a limited extent, and was fairly much confined to his bed. He revealed Resident #1 was turned every two hours and was out of bed for up to three hours per day. He verified that the Active Treatment Schedule located in the green program book did not accurately reflect Resident #1 ' s day. This is a repeat citation from the 1/27/15 Recertification Survey.	{W 250}		

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W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to develop and implement a system to ensure a helmet was clean and well maintained and to track the purchase of a new helmet used by one of one Expanded Sample Residents (Resident #14) who wore a [redacted] due to [redacted] Findings Include: Resident #14 was observed resting in a recliner at her residence at 1:56 PM on 3/25/15. The [redacted] worn by Resident #14 to protect her [redacted] when she experienced [redacted] was sitting on a table near her. The pink vinyl cushioning material on the inside of the [redacted] was torn in multiple places. There was a substance of unknown origin on the plastic [redacted] attached to the [redacted] There was what appeared to be dirt and debris on the inside of the [redacted] particularly near the top of the [redacted] When asked about the condition of the [redacted] Staff L said she accompanied Resident #14 to Spokane approximately two months ago to be fitted for a new [redacted] Staff L said she did not know why the new [redacted] had not been received and was not sure who was responsible for tracking the purchase of a new [redacted] When asked if there was a cleaning schedule for the [redacted] Staff L said she was not sure but did not	W 436		

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W 436	Continued From page 68 think so. Staff L said sometimes staff put the [redacted] in the machine used to sanitize the dishes and run it " through a cycle. " The Physical Therapist was interviewed at 8:20 AM on 3/27/15. The Physical Therapist confirmed Resident #14 was fitted for a new [redacted] on 1/6/15 in Spokane. According to the Physical Therapist, the vendor reported faxing a form required to process the [redacted] for payment to the facility ' s Advanced Practice Registered Nurse (APRN) two times but received no response. The Physical Therapist reported the APRN denied receiving either fax. The Physical Therapist confirmed that until questions about the new [redacted] were asked during the survey, he was unaware that the process for Resident #14 to receive a new [redacted] had stalled.	W 436		
{W 460}	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop and implement a system to record food eaten by one of one Sample Residents (Resident #7) in the sample who frequently refused to eat the meals prepared and sent to his residence by the central kitchen. Findings Include: Resident #7 was observed at his residence from 3:54 PM to 5:15 PM on 3/23/15. Although Resident #7 was offered multiple opportunities to eat the evening meal sent to the residence from	{W 460}		

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{W 460}	Continued From page 69 the central kitchen, he refused. Resident #7 was observed at his home from 11:03 AM to 12:03 PM on 3/24/15. Although Resident #7 was offered multiple opportunities to eat the midday meal sent to the residence from the central kitchen, he refused. Resident #7 was observed in his home beginning at 7:41 AM to 8:45 AM on 3/26/15. Although Resident #7 was offered multiple opportunities to eat the breakfast sent to the residence from the central kitchen, he refused. Staff B was interviewed at 8:45 AM on 3/26/15. She verified the meal refusal behavior was not addressed in Resident #7 ' s plan. She verified the meal refusal was a consistent behavior and confirmed the team for Resident #7 had not requested residential staff to record the food actually eaten by Resident #7. She verified there was no way to determine if Resident #7 received a well-balanced diet since there was no record of what he ate. The Qualified Intellectual Disabilities Professional (QIDP) and the Psychologist assigned to Resident #7 were interviewed on 3/26/15 at 11:45 AM with Resident #7 ' s records available for reference. When asked if the behavior of meal refusal was assessed and addressed, the Psychologist said the behavior had not been seen as frequent enough or important enough to address. The QIDP said since Resident #7 was overweight, any weight loss would be desirable. When asked if the team discussed whether or not Resident #7 received a nutritionally balanced diet since he often refused to eat the food prepared by the central kitchen, the Psychologist said it was " his right " to select alternatives. This is a repeat citation from the 1/27/15 Recertification Survey.	{W 460}		

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