Exhibit 4
# Initial Comments

This report is a result of a second Credible Allegation Survey conducted at Rainier School - PAT E on 08/21/17, 08/22/17, 08/23/17, 08/24/17, 08/25/17 and 08/29/17. A sample of 10 Clients was selected from a total of 103 Clients. Three Expanded Sample Clients were added. Deficient practices were identified.

The survey was conducted by:
- Gerald Heilinger
- Patrice Perry
- Jim Tarr
- Sarah Tunnell
- Linda Davis

The surveyors are from:
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- Aging & Long Term Support Administration
- Residential Care Services, ICF/IID Survey and Certification Program
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# Condition

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, record review, and interview, the facility failed to meet the Condition of Participation for Governing Body. The Governing Body failed to ensure the facility met the Condition of Participation for Active Treatment at the Recertification Survey of 07/15/16, the Credible Allegation Survey of 09/23/16, and the Credible Allegation Survey of 08/29/17. This failure resulted in the facility's deficient practices going uncorrected for 13 months and the facility failed to develop a system in which corrected deficiencies remained in compliance, thereby ensuring Clients received the protections and services they needed.

Findings included:

1. During the Recertification Survey of 07/15/16, Active Treatment regulations were found to be out of compliance for W195, W196, W214, W227, W234, W237, W249, W250, W252, W255, and W261.

After the facility sent a letter alleging all deficiencies had been corrected, the Credible Allegation Survey of 09/23/16 found Active Treatment regulations continued to be out of compliance for W195, W196, W214, W234, W237, W249, W250, and W255. The facility gained compliance with regulations W227, W252, and W261.

The letter dated 07/07/17 requesting a survey visit stated that the facility believed they were in compliance with all the regulations and they had reviewed all Comprehensive Functional Assessments, Positive Behavior Support Plans, Ad-Hocs, and Individual Habilitation Plans for all clients to address all assessed needs.
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<th>ID TAG</th>
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During the Credible Allegation Survey of 08/29/17, Active Treatment regulations continued to be out of compliance for W195, W196, W214, W234, W237, and W249. Regulation W227 was corrected during the 09/23/16 Survey, however was found out of compliance on 08/29/17. In addition, new citations were written for W239, W259, and W260.

2. Through observation, record review, and interview, the Governing Body failed to ensure the facility met the Condition of Participation for Active Treatment. This failure affected ten of ten Sample Clients (Client #1, #2, #3, #4, #5, #7, #9, #10, and #11) and 3 Expanded Sample Clients (Clients #12, #13 and #14) at the facility, and had the potential to affect all Clients. See W104 for details.

3. Through observation, record review, and interview, the facility failed to ensure ten of ten Sample Clients (Clients #1, #2, #3, #4, #5, #7, #8, #9, #10 and #11) and three Expanded Sample Clients (Clients #12, #13 and #14) received aggressive training designed to meet their identified needs. See W195 for details.

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 Governing Body failed to ensure the facility met the Condition of Participation for
| [W 104] | Continued From page 3  
Active Treatment. This failure effected ten of ten Sample Clients (Clients #1, #2, #3, #4, #5, #7, #8, #9, #10, and #11) and 3 Expanded Sample Clients (Clients #12, #13 and #14) and had the potential to effect all Clients at the facility. The facility did not correct the following: ensure clients did not spend large portions of their day not involved in training activities, ensure all Clients had enough training objectives to fill their day, Individual Habilitation Plans (IHP) were current, Clients had consents for restrictions, needs identified in the Comprehensive Functional Assessments (CFA) received training, Positive Behavior Support Plans (PBS) had replacement behaviors, and training programs contained enough detail to ensure all staff implemented the program the same across all shifts. In addition, the facility failed to ensure the grounds were kept in safe repair. This failure prevented the Clients from having their identified needs met and training documented to increase their independence, resulted in restrictive practices without due process, and prevented Clients from living in an environment free of hazards.  
This is a repeat citation from the Recertification Survey of 07/15/16 and the Credible Allegation Survey of 09/23/16.  
Findings included:  
Environmental  
Observation on 08/21/17 at 9:45 AM of the sidewalk near the corner of 3rd Street and Heyns Street showed a metal covering in the sidewalk that had a piece of metal partially covering it. The metal cover over the metal opening in the sidewalk was slightly raised and had a jagged... | [W 104] |
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<th>(W 104) Continued From page 4</th>
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<td>edge. The facility had a warning cone near the site but nothing had been done to prevent staff, Clients, or visitors from being exposed to the jagged metal.</td>
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<td>Observation on 08/21/17 at 9:50 AM of the sidewalk, near the gymnasium and across the street from the swimming pool, had several pieces of plywood covering a section of the sidewalk. These pieces of plywood bent when people walked on them and caused the edges of the pieces of plywood to sink or rise thereby creating an uneven surface and a potential tripping hazard. The pieces of plywood appeared weathered and to have been in place for a while. On one occasion facility staff were seen to avoid walking on the plywood.</td>
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<td>During an interview on 08/25/17 at 9:00 AM Staff P. Developmental Disabilities Administrator 2, stated that he was not aware of the status of work orders for the two areas mentioned above.</td>
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<td>Failure to Correct Previous Citations</td>
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<td>1. During the Recertification Survey of 07/15/16, Active Treatment regulations were found to be out of compliance for W195, W196, W214, W227, W234, W237, W249, W250, W252, W255, and W261.</td>
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<td>After the facility sent a letter alleging all deficiencies had been corrected, the Credible Allegation Survey of 09/23/16 found Active Treatment regulations continued to be out of compliance for W195, W196, W214, W234, W237, W249, W250, and W255. The facility gained compliance with regulations W227, W252, and W261.</td>
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The letter dated 07/07/17 requesting a survey visit stated that the facility believed they were in compliance with all the regulations and they had reviewed all CFAs, PBSPs, Ad-Hocs, and IHPs for all clients to address all assessed needs.

During the Credible Allegation Survey of 08/29/17, Active Treatment regulations continued to be out of compliance for W195, W196, W214, W234, W237, and W249. Regulation W227 was corrected during the 09/23/16 Survey was found out of compliance on 08/29/17. In addition, new citations were written for W239, W259, and W260.

Through observation, record review and interview, the facility failed to ensure ten of ten Sample Clients (Clients #1, #2, #3, #4, #5, #7, #8, #9, #10 and #11) and three Expanded Sample Clients (Clients #12, #13 and #14) received aggressive training designed to meet their identified needs. See W195 for details.

W 111

The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights.

This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure accurate information was available to Adult Training Program (ATP) staff regarding one of ten Sample Clients' (Client #8) diet. This failure placed Client #8 at risk for choking if she ate while at ATP.
Findings included:

Review of Client #8's Individual Habilitation Plan dated 07/13/17 showed Client #8 was on a 3500 calorie ground texture diet. Review of Client #8's Monthly Person Responsible Review completed by an Adult Training Specialist, dated 08/01/17, showed Client #8 was on a 2200 calorie chopped texture diet.

During an interview on 08/25/17 at 8:56 AM, Staff C, Psychology Associate, Staff D, Attendant Counselor Manager, Staff E, Habilitation Plan Administrator, and Staff J, Adult Training Supervisor, stated that Client #8 was on a 3500 Calorie ground texture diet and the diet on the ATP Monthly Responsible Review was not correct.

483.420(a)(3) PROTECTION OF CLIENTS RIGHTS

The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.

This STANDARD is not met as evidenced by:

Based on observation, record review, and interview, the facility failed to have a consent for one of ten Sample Clients (Client #3) when her plan required she use a junior sized fork and spoon to restrict the amount of food with each bite. This failure resulted in the Client's rights
Continued From page 7
being restricted without due process.

This is a repeat citation from the Recertification Survey of 07/15/16 and Credible Allegation Survey of 09/23/16.

Findings included:

Observation at House on 08/21/17 at 11:36 AM showed Client #8 seated at a table eating with a junior size spoon.

Review of Client #8's Individual Habilitation Plan (IHP) dated 07/13/17 showed Client #8 was to use a junior size fork and spoon with reminders to eat slowly and take smaller bites. Client #8's Comprehensive Functional Assessment, signed 07/20/17, showed Client #8 was to use "adaptive silverware to decrease the amount of food she can put on a fork or spoon at one time." There was no consent for the use of the junior utensils to restrict bite size.

During an interview on 08/25/17 at 8:58 AM, Staff C, Psychology Associate, Staff D, Attendant Counselor Manager, Staff E, Habilitation Plan Administrator, and Staff J, Adult Training Supervisor, stated that Client #8 uses a junior fork and spoon to take smaller bites because of a history of throwing up.

The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.
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This STANDARD is not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure a formal program for financial management was developed for one of ten Sample Clients (Client #3), despite identified needs for formal money management training. This failure prevented Client #3 from learning to manage his money.

Findings included:

- Observation at House on 08/22/17 at 7:46 AM showed Client #3 went to the Attendant Counselor Manager's (ACM) office to obtain money.

- Review of Client #3’s file showed a Comprehensive Functional Assessment dated 02/07/17 that identified Client #3 was in need of learning to identify the value of specific denominations of money (coins and bills), understand what items cost, and how much money should be received after a purchase. An Individual Habilitation Plan (IHP), dated 02/13/17, in the section labeled IHP Spending Plan, stated that Client #3 needed staff assistance to budget funds according to his wants and needs. Despite the above assessed needs the facility initiated the following training objective which stated “Given original verbal cue, [Client #3’s first name] will independently write the first two letters of his last name [Client #3’s first two letters of his last name], on the withdrawal ledger when requesting money ...” The IHP long range goal included identifying money denominations by 2017.

During an interview on 08/25/17 at 9:00 AM, Staff Q, ACM, stated this current plan was to sign his
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<td>W 126</td>
<td>Continued From page 9 name to receive money but there was not training to manage his money or learn to budget his money.</td>
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<td>W 159</td>
<td>483.430(a) QIDP</td>
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<td>Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure the Qualified Intellectual Disability Professional (QIDP) provided aggressive oversight of Clients' Individual Habilitation Plans (IHP) for ten of ten Sample Clients (Clients # 1, #2, #3, #4, #5, #7, #8, #9, #10 and #11) and three Expanded Sample Clients (Client #12, #13 and #14). The QIDP did not ensure accurate diet information was on file at the Adult Training Program, restrictive measures were implemented without due process, a financial management program was not written after being assessed as needed. Client needs were not identified and assessed, objectives were not developed for identified needs, teaching plans were not written clearly to allow staff to provide training on different shifts and in different environments. In addition, program data was not collected frequently enough to determine when skills had been learned, replacement behaviors were not identified for Clients exhibiting inappropriate behaviors, IHPs were not implemented as written, a Comprehensive Functional Assessment was not accurate, a completed IHP was not available for staff, and a program for use and storage for eyeglasses was not initiated for a Client that had broken his eyeglasses on two prior occasions. The failure to provide aggressive oversight from</td>
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<td>W 159</td>
<td>Continued From page 10 the QIDP prevented Clients from receiving training to meet their needs.</td>
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<td>Client #4</td>
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<td>Observations on 08/21/17, 08/22/17 and 08/23/17 showed Client #4 walked alone in the middle of the street on his way to and from work.</td>
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<td>Record review of the QIDP Review, dated 07/06/17, showed the writer had observed that Client #4 walked in the middle of the street several times and he had prompted him to move to the sidewalk. The QIDP stated in the review that he stayed in the area to ensure Client #4’s safety and to direct traffic away from Client #4 when he did not move to the sidewalk. Despite the QIDP witnessing the unsafe pedestrian skills of Client #4 several times, the QIDP did not recommend training for Client #4 to teach him how to safely walk around the facility grounds.</td>
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1. Through record review and interview the QIDP failed to ensure accurate information was available to Adult Training Program staff for one of ten Sample Clients (Client #8). See W111 for details.

2. Through observation, record review and interview the QIDP failed to ensure a consent was obtained for restrictive adaptive equipment for one of ten Sample Clients (Client #8) prior to using the equipment. See W125 for details.

3. Through observation, record review and interview the QIDP failed to ensure a formal money management program was developed for one of ten Sample Clients (Client #3). See W126 for details.
[W 159] Continued From page 11

4. Through observation, interview, and record review, the QIDP failed to ensure the facility provided a robust day filled with active treatment designed to train six of ten Sample Clients (Clients #1, #4, #7, #9, #10 and #11) and one Expanded Sample Client (Client #12) to become more independent and move to a less restrictive setting. See W196 for details.

5. Through observation, record review, and interview, the QIDP failed to identify the needs of three of ten Sample Clients (Clients #2, #3 and #9). See W214 for details.

6. Through observation, record review, and interview, the QIDP failed to ensure objectives for identified needs were written for four of ten Sample Clients (Client #4, #7, #9, and #11) and one Expanded Sample Clients (Client #14) to address an identified and assessed need. See W227 for details.

7. Through observation, record review, and interview, the QIDP failed to ensure three of ten Sample Clients (Clients #4, #5, and #9) and one Expanded Sample Client (Client #12) had teaching plans which contained enough detailed instructions for staff to train Clients consistently on their objectives across all shifts. See W234 for details.

8. Through record review and interview the QIDP failed to ensure data was recorded with adequate frequency to determine when the skill had been learned for one of ten Sample Clients (Client #2). See W237 for details.
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9. Through observation, record review, and interview, the QIDP failed to ensure four of ten Sample Clients (Clients #3, #7, #9, and #11) had replacement behaviors for their inappropriate behaviors. See W239 for details.

10. Through observation, record review, and interview, the QIDP failed to ensure the Individual Habilitation Program (IHP) was implemented as written for two of ten Sample Clients (Clients #2 and #4) and one Expanded Sample Client (Client #13). See W249 for details.

11. Through record review and interview the QIDP failed to ensure an accurate Comprehensive Functional Assessment was completed for one of ten Sample Clients (Client #2). See W 259 for details.

12. Through record review and interview the QIDP failed to ensure a completed IHP was available in the Clients' file for one Expanded Sample Client (Client #14). See W260 for details.

13. Through observation, record review, and interview, the QIDP failed to identify the need to teach one of ten Sample Clients (Client #3) how to use and care for prescription eyeglasses. See W436 for details.

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, record review, and
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interview, the facility failed to ensure ten of ten Sample Clients (Clients #1, #2, #3, #4, #5, #7, #8, #9, #10 and #11) and three Expanded Sample Clients (Clients #12, #13 and #14) received aggressive training designed to meet their identified needs. The facility did not provide clients with a robust day filled with training opportunities (they had large periods of time unengaged, idle or performing tasks they already knew how to do), did not identify needs that required assessment for development of training programs, did not write objectives for identified and assessed needs, did not provide clear directions for staff to implement training, did not ensure program data was collected frequently enough to determine when a skill was learned, did not ensure training for replacement behaviors was available to clients with inappropriate behaviors, did not ensure the Individual Habilitation Plan (IHP) was implemented as written. In addition, the facility did not provide accurate assessment information to staff and did not ensure a completed IHP was available in the Client's file. This failure prevented Clients from learning new skills to increase their independence and move to a less restrictive setting, and placed Clients at risk for harm when their IHP was not implemented as written.

1. Through observation, record review, and interview, the facility failed to ensure the Qualified Intellectual Disability Professional (QIDP) provided aggressive oversight of Clients' Individual Habilitation Plans (IHP) for ten of ten Sample Clients (Clients #1, #2, #3, #4, #5, #7, #8, #9, #10 and #11) and three Expanded Sample Clients (Client #12, #13 and #14). See W159 for details.
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<td>W 195</td>
<td>Continued From page 14</td>
<td>2. Through observation, record review and interview, the facility failed to ensure six of ten Sample Clients (Clients #1, #4, #7, #9, #10, and #11) and one Expanded Sample Client (Client #12) were actively engaged in training. See W196 for details.</td>
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<td>3. Through observation, interview, and record review, the facility failed to identify the needs of three of ten Sample Clients (Clients #2, #3 and #9) and one Expanded Sample Client (Client #14). See W214 for details.</td>
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<td>4. Through observation, record review, and interview, the facility failed to have objectives for four of ten Sample Clients (Client #4, #7, #9, and #11) and one Expanded Sample Clients (Client #14) to address an identified and assessed need. See W227 for details.</td>
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<td>5. Through observation, record review, and interview, the facility failed to ensure three of ten Sample Clients (Clients #4, #5, and #9) and one Expanded Sample Client (Client #12) had teaching plans which contained enough detailed instructions for staff to train Clients consistently on their objectives across all shifts. See W234 for details.</td>
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<td>6. Though record review and interview the facility failed to ensure data was recorded with adequate frequency to determine when the skill had been learned for one of ten Sample Clients (Client #2). See W237 for details.</td>
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<td>7. Through observation, record review, and interview, the facility failed to ensure four of ten Sample Clients (Clients #3, #7, #9, and #11) had replacement behaviors for their inappropriate</td>
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behaviors. See W239 for details.

8. Through observation, record review, and interview, the facility failed to ensure the Individual Habilitation Program (IHP) was implemented as written for two of ten Sample Clients (Clients #2 and #4) and one Expanded Sample Client (Client #13). See W249 for details.

9. Through record review and interview the facility failed to ensure an accurate Comprehensive Functional Assessment was completed for one of ten Sample Clients (Client #2). See W259 for details.

10. Through record review and interview the facility failed to ensure a completed IHP was available in the Clients' file for one Expanded Sample Client (Client #14). See W260 for details.

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, record review, and interview, the facility failed to ensure six of ten Sample Clients (Clients #1, #4, #7, #9, #10, and
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#11) and one Expanded Sample Client (Client #12) were actively engaged in treatment and training instead of sitting/standing around unengaged. This failure prevented Clients from learning skills and prevented them from having the opportunity to move to a less restrictive living setting as quickly as possible.

Findings included:

Client #1

Observation on 08/21/17 at 9:50 AM at Location. House showed Client #1 came out of his bedroom, sat briefly on the couch, went outside briefly, came into the house and drank a pop, and then left for the facility Canteen at 10:16 AM. (During this and all subsequent observations, Client #1 had a staff directly assigned to be with him.)

Observation on 08/21/17 at the Canteen showed Client #1 leaving at 10:34 AM. He returned to his house where he sat on the couch. The observation ended at 10:50 AM when he left the house. No training as outlined in his Individual Habilitation Plan (IHP) occurred during this time.

Observation on 08/21/17 at 1:50 PM at Location. House showed Client #1 in the living room watching television. At 1:55 PM he took garbage bags out of the waste cans on each side of the house. At 2:00 PM he ate a small container of yogurt. After getting hand sanitizer seven times, he went outside. He came into the house and went back outside a couple of times. At 2:45 PM he drank a pop. The observation ended at 3:15 PM. No training as outlined in his IHP occurred during this time.
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Observation on 08/22/17 at 9:08 AM at [redacted] House showed that Client #1 returned to the house. Client #1 spent time with staff, had a snack, and sat outside on a love-seat swing until the observation ended at 10:36 AM. No activity occurred while outside. No training as outlined in his IHP occurred during this time.

Observation on 08/22/17 at 1:46 PM at [redacted] House showed Client #1 walked outside and away from the house. At 2:00 PM he returned to the house. He spent time sitting or standing with staff, but there was no structured activity. At 2:55 PM he left the house with staff. No training as outlined in his IHP occurred during this time.

Observation on 08/23/17 at 9:33 AM at [redacted] House showed Client #1 walked back to the house. At 9:38 AM he left the house. He purchased a pop from a machine near the Administration Building and then returned to the house at 9:58 AM to drink it. He spent time watching TV or signing with staff until 10:30 AM when he left the house and went to the switchboard in the Administration Building. He went to the facility headquarters at 10:45 AM and then went back to his house at 11:05 AM. No training as outlined in his IHP occurred during this time.

Observation on 08/23/17 from 2:25 PM - 3:43 PM at [redacted] House showed he was standing around with staff. Staff had not engaged him in any learning activities as outlined in his IHP.

Record review on 08/24/17 of Client #1’s file showed an IHP, dated 11/08/16, with a training objective for washing his clothes, pointing to a
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$5.00 bill, scooping his own medication, taking a blank receipt to the cashier when getting petty cash money, and washing a dish (at his work program). In addition there were 5 objectives related to reducing his inappropriate behaviors and one objective which was designated as a positive replacement behavior for the inappropriate behaviors.

During an interview on 08/25/17 at approximately 10:00 AM Staff A, current Habilitation Plan Administrator (HPA), Staff K, Attendant Counselor Manager (ACM), Staff P, Developmental Disabilities Administrator (DDA) 2, and Staff G, prior HPA, stated that the IHP was accurate. They stated that staff should attempt to get Client #1 to go to work in the afternoon but it is left up to Client #1.

Client #4

Observation at Oakley Hall on 08/21/17 from 2:18 PM-2:55 PM showed Client #4 unfolded newspapers and placed them in a wooden frame independently, carried rolled newspapers to another room and removed single newspapers from a pile handed to him by Adult Training Program (ATP) staff. No training was observed during this 37 minute observation.

Observation of Client #4 on 08/22/17 at 8:52 AM showed he walked in the middle of the street on his way to work, appeared to nap while at work in Oakley Hall and performed tasks he was adept at. The observation ended at 10:56 AM and no training was observed during this two hour and four minute observation.

Observation at Oakley Hall on 08/22/17 from 1:35
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PM-2:42 PM showed Client #4 appeared to nap and completed tasks he was adept at. No training was observed during this one hour and seven minute observation.

Observation of Client #4 on 08/23/17 from 8:45 AM- 9:40 AM (when staff picked him up for an off campus trip) showed he walked in the middle of the street on his way to work, sat idle at Oakley Hall and completed tasks he was adept at. No training was observed during this 55 minute observation.

Review of Client #4’s file showed a Comprehensive Functional Assessment (CFA) dated 05/09/17 that identified numerous training needs. The IHP dated 05/09/17 identified two formal programs, participation in sensory activity and work at ATP. An IHP revision dated 03/01/17 (which appeared to be implemented after the IHP on 05/09/17) had additional training objectives of shaving his left cheek and mixing juice thoroughly.

During an interview on 08/25/17 at 11:10 AM, Staff O. ACM, stated that ATP was a combination of work and active treatment and was supplemented with informal training throughout the day.

Client #7

Observation of Client #7 on 08/21/17 at [time] House from 11:05 AM - 12:21 PM showed she sat in a wheelchair in the living room and then ate lunch. No training was observed during this time period.

Observation of Client #7 on 08/22/17 at [time]
Continued From page 20

House from 3:46 PM - 4:41 PM showed she sat on a rocking chair in the living room then moved to the dining room and looked out the window. Staff encouraged her to paint her nails, which elicited no response from her. She sat on the rocking chair and got a foot bath and then went on a golf cart ride. No training was observed during this time period.

Observation of Client #7 on 08/23/2017 at House from 8:34 AM - 9:34 AM showed she sat in her wheelchair in the dining room and looked out the window, and put labels on small plastic baskets with physical assistance. No training was observed during this time period.

Observation of Client #7 on 08/23/17 at House from 1:03 PM - 1:50 PM showed she sat with her feet in a foot bath, put on her socks and shoes, and moved herself in her wheelchair to the bedroom and bathroom. No training was observed during this time period.

Review on 08/24/17 of Client #7's files showed she had two training objectives for place setting and tooth brushing. Record review of Client #7's Active Treatment Schedule (ATS) dated 07/07/17 showed that Client #7 was supposed to work at AC VOC (Attendant Counselor Vocational) Oakley from Monday-Friday, she participated in "leisure/group activities on/off house" from 12:00 PM - 2:30 PM, she returned to AC VOC Oakley from 3:00 PM-3:30 PM, "leisure/group activities on/off house" from 4:00 PM-4:30 PM, "activities or personal preference" from 4:30 PM-5:00 PM, and "leisure/group activities on/off house" from 6:00 PM-7:30 PM.

During an interview on 08/25/17 at 11:00 AM,
Continued From page 21

Staff E, HPA and Staff B, ACM, stated that Client #7 had a third objective regarding money management to accept a receipt from a clerk. Staff stated the focus of Client #7’s active treatment was to interact appropriately with peers and staff.

Client #9

Observation of Client #9 on 08/21/17 at the Canteen from 10:16 AM - 10:41 AM showed he sat at a table with stacking blocks in front of him. A staff prompted him to stack and unstack the blocks. He did not respond and intermittently rocked forward and backward on his stationary chair, and then returned to his house for lunch. No training occurred during this period to help him learn new skills.

Observation of Client #9 on 08/21/17 at House from 1:46 PM - 2:22 PM showed he sat on a chair in the living room and dining room, ate a snack, went to the bathroom, and put his cup in the kitchen. No training occurred during this period to help him learn new skills.

Observation of Client #9 on 08/22/17 at House from 1:38 PM - 3:36 PM showed he walked around the house, went to the Canteen where staff repeatedly prompted him to stack blocks, and to play the bells and tambourine. No training occurred during this period to help him learn new skills.

Observation of Client #9 on 08/22/17 at House from 4:49 PM - 6:08 PM showed he sat in a chair, got ready for dinner, and independently participated in the dining process. No training occurred during this period to help him learn new skills.
Continued From page 22 skills.

Observation of Client #9 on 08/23/17 from 9:38 AM - 11:08 AM showed he went to the Canteen twice, the exercise room for nine minutes, and returned to the house. He stacked blocks, threw a ball, and ate lunch. No training was observed during this time period.

Observation of Client #9 on 08/23/17 at House from 1:52 PM - 3:41 PM showed he sat in a chair, and went to the Canteen. He stacked blocks intermittently, sat idly, ate a snack, and staff attempted to get him to do chores. No training was observed during this time period.

Review on 08/24/17 of Client #9's file showed he had three training objectives related to putting his clothes away, an objective to brush his hair, and an objective to brush his teeth. Each of these would take a few minutes to complete each morning. Record review of Client #9's ATS dated 08/01/17 showed that he participated in non-descriptive "on/off house activities with staff" from 8:45 AM - 11:00 AM and "Leisure/group activities on/off house" from 1:00 PM - 5:00 PM and 6:00 PM - 7:00 PM.

During an interview on 08/25/17 at 9:56 AM, Staff M, ACM, and Staff N, HPA, stated that Client #9 was provided leisure and domestic activities so he does not seek water. When asked what the focus of Client #9's active treatment was, staff stated he was working on improving his communication, choice, and interacting with others. Staff stated he was not in a work program.

Client #10
Continued From page 23

Observation at House on 08/21/17 at 1:47 PM, showed Client #10 in her bedroom. Staff I, ACM, reported Client #10 was in her bedroom playing on her Wii video game. At 2:25 PM, a staff knocked on Client #10's bedroom door and asked her if she wanted to come to "happy hour." Client #10 remained in her bedroom. At 2:38 PM, a staff knocked and entered Client #10's bedroom but came back out a minute later. At 3:05 PM, Client #10 was still in her bedroom and the observation ended. No training was observed during this time.

Observation at House on 08/22/17 at 6:55 AM, showed Client #10 in her bedroom. At 7:16 AM, a staff knocked on Client #10's bedroom door and then entered her bedroom. The staff could be heard telling Client #10 that it was 7:15 AM. Staff entered her bedroom for very brief periods of time at 7:25 AM, 7:42 AM and 7:57 AM. At 7:58 AM, Client #10 came out of her bedroom and went into the bathroom. At 8:12 AM, a staff told the nurse that Client #10 was going on an outing that included lunch. At 8:14 AM, Client #10 was on the B side of the house with her purse. A staff told her to put away her purse, wash her hands and her breakfast was in the refrigerator. At 8:16 AM, Client #10 returned to the B side and sat in a chair at a table in the dining area. At 8:19 AM, the nurse asked Client #10 to sit in a chair by the medication cart, and Client #10 received her medication. At 8:24 AM, Client #10 told a staff she was going to get her breakfast. Client #10 went to the kitchen and took something out of the refrigerator and went to the A side dining area. A staff told Client #10 that she needed to eat in the B side dining area. At 8:27 AM, Client #10 went to the B side dining room.
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sat down at a table, ate her breakfast, and talked to a staff. The observation ended at 8:35 AM. No training was observed during this time.

Observation at [House] on [08/23/17] at 8:35 AM, showed Client #10 sat at a table in the B side dining room and ate breakfast. A staff sat next to her and told Client #10 to chop her food. At 8:39 AM, Client #10 finished her breakfast and a direct care staff told her to put her dishes away. Client #10 threw some items in the trash and took her dishes to the kitchen. At 8:40 AM, Staff I, ACM, told the surveyor that the entire house was going on an outing to Mud Mountain Dam and would not return until approximately 1:30 PM. At 8:45 AM, Client #10 went to her bedroom and a staff reminded her to take her cup off the table. Client #10 got the cup and took it to the kitchen and then returned to her bedroom. At 8:47 AM, Client #10 came out of her bedroom with scissors and paper and walked to the A side front room and talked to a staff. At 8:50 AM, Client #10 returned to her bedroom. A staff immediately knocked on the bedroom door and asked Client #10 if she wanted to help load the van. At 8:51 AM, Client #10 returned to the front room of the A side and stood by a table. A staff asked her if she wanted to help load the van but Client #10 remained at the table. At 8:56 AM, Client #10 and a staff cut paper with scissors. At 9:00 AM, Client #10 took a piece of paper to her bedroom and then returned to the front room and looked for a marker. At 9:06 AM, Client #10 walked around the house going from one side to the other. At 9:12 AM, Client #10 turned on the television in the A side living room. A staff handed her a hairbrush and Client #10 and the staff went to Client #10’s bedroom. At 9:22 AM, Client #10 returned to the A side front room.
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At 9:30 AM, Client #10 returned to her bedroom. At 9:36 AM, Client #10 got on the bus in preparation for the outing. No training was observed during this time.

Observation at [Redacted] House on 08/23/17 at 2:08 PM, showed Client #10 went into her bedroom. At 2:34 PM Staff I, ACM, told the surveyor that Client #10 was at the Canteen. At 2:37 PM, Client #10 was not observed at the Canteen and the surveyor returned to [Redacted] House at 2:48 PM. Client #10 was not in any common area of the house and her bedroom door was closed. At 3:04 PM, Staff I left [Redacted] House. At 3:09 PM, Staff I returned to [Redacted] House and went to Client #10's bedroom and verified Client #10 was in her bedroom and had not gone to the Canteen. At 3:24 PM, Staff I, ACM, knocked on Client #10's door and then opened the door and asked if she wanted juice. At 3:40 PM, Staff I brought a juice box and entered Client #10's bedroom and closed the door. The observation ended at 3:42 PM with Client #10 still in her bedroom. No training was observed during this time.

Review of Client #10's IHP, dated 09/06/16, and IHP Revision Form, dated 07/31/17, identified two formal objectives (washing her hands and making her bed). The IHP included a Service Care Plan which instructed direct care staff to involve Client #10 in an activity outside of her bedroom for 15 minutes daily.

Review of Client #10's ATS updated 08/11/17 showed leisure activities from 12:30 PM to 4:00 PM, 4:00 PM to 4:30 PM, 6:30 PM to 8:30 PM, and from 9:00 PM to 10:00 PM every day of the week.
During an interview on 08/25/17 at 10:05 AM with Staff C, Psychology Associate, Staff I, ACM, Staff A, HPA, and Staff P, DDA 2, stated that Client #10 was often sleepy as a side effect of the multiple medications she took to manage her seizures. They reported that, if pushed by staff to do active treatment, she would resist and might become physically aggressive. They stated that they are currently trying to get Client #10 to spend more time out of her room interacting and communicating with her peers. They wanted Client #10 to enjoy her day. They stated that Client #10 had a job at the Adult Training Program but rarely chose to attend.

Client #11

Observation of Client #11 on 08/21/17 at House from 2:24 PM - 3:10 PM showed she moved between the common area, living room, and dining room of the house. She laid on the couch five times, and moved to nearby chairs eight different times. No training was observed during this time period. (During this an all subsequent observations, Client #11 received protective supervision except when inside her bedroom.)

Observation of Client #11 on 08/22/17 at House from 3:42 PM - 4:46 PM showed she moved between the common areas and dining room of the house. She laid on the couch five times, moved to nearby chairs four times, went to the bathroom three times, and her bedroom two times. No training was observed during this time period.

Observation of Client #11 on 08/23/17 at
Continued From page 27

House from 8:33 AM - 8:58 AM showed she laid on the couch, was prompted to get her medication four times, and prompted to put her shoes on twice. No training was observed during this time period.

Observation of Client #11 on 08/23/17 at 1:16 PM - 1:34 PM showed she moved between the common area and kitchen, laid on the couch, went to her bedroom and bathroom. No training was observed during this time period.

Review on 08/24/17 of Client #11’s file showed she had two training objectives to clean her room once a week and brush her teeth daily. Record review of Client #11’s ATS dated 06/13/17 showed that she participated in non-descriptive “on/off house activities with staff” from 10:00 AM-10:30 AM, "on house activities with staff" from 10:30-11:00 AM, "prefers to relax on the couch, listen to music in room" or "leisure/group activities on/off house" from 12:00 PM - 3:00 PM and 4:00 PM-4:30 PM, "activities of personal preference" from 4:30-5:00 PM, and "leisure/group activities on/off house" from 6:00 PM-7:30 PM.

During an interview on 08/25/17 at 11:00 AM, Staff E, HPA, and Staff B, ACM, stated that the focus of Client #11’s active treatment was safety, interaction with her environment, and helping around the house.

Client #12

Observation on 08/21/17 at 09:50 AM at the House showed he appeared to be asleep on the couch. At 10:57 AM staff asked him if he
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wanted to eat lunch and he got up and went into the dining room. No training activities occurred during this time.

Observation on 08/21/17 at 1:52 PM at [redacted] House showed he came into the house and went to the couch. Staff asked him to put away some clean dishes which he did independently. A short time later, staff gave him a small bag of chips and a pop which he ate while seated on a couch. At 2:05 PM he took his garbage to the kitchen and went to sit on a couch on the B side of the house. No staff were around. At 2:40 PM he looked at magazines. No staff were around. The observation ended at 3:15 PM with him seated on the couch with the TV on. No training activities as outlined in his Individual Habilitation Plan (IHP) occurred during this time.

Observation on 08/22/17 at [redacted] House at 9:00 AM showed he was lying down on a couch and appeared asleep. The TV was on. No staff were around. At 9:07 AM he was heard snoring. At 9:24 AM a staff brought him a small bag of chips and a pop. At 9:30 AM he went to the B side of the house and sat on a couch. No staff were with him. At 9:39 AM he returned to the A side and laid down on the couch. At 9:42 AM a staff had him help with washing windows. There did not appear to be any structured training occurring during this activity and Client #12 did not demonstrate thoroughness in washing windows, taking one or two swipes of his cloth on the spray the staff put on the window. They stopped washing windows at 9:49 AM. At 9:55 AM he had a snack of vegetables which he finished at 10:04 AM and then went to lie down on the couch. At 10:10 AM he walked to an apple tree not far from the house and picked a few
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apples and had some to eat after returning to the house at 10:16 AM. He finished eating the apples at 10:33 AM and went to lie down on a couch on the B side of the house at 10:39 AM. Lunch was served at 10:56 AM. No training activities as outlined in his IHP occurred during this time.

Observation on 08/22/17 at House at 1:48 PM showed he sat on the couch in the living room on A side of the house. At 1:58 PM he had a snack of pop and chips. At 2:06 PM, after finishing his snack, he went to the B side of the house and looked at some magazines. No staff were with him. The observation ended at 2:54 PM. He was still seated with the magazines. No training activities as outlined in his IHP occurred during this time.

Observation on 08/23/17 at House showed he was outside on the patio of the B side of the house by himself blowing bubbles. At 8:43 AM he came in, put the bubble container in his bedroom and went to the A side of the house. At 8:48 AM a staff asked him to help make pudding pops. At 8:50 AM he left the kitchen and stood in the dining room and looked out the window. At 8:51 AM, after throwing away the garbage from making the pudding, he laid down on the couch in the living room. At 8:58 AM a staff had him come into the dining room to do coloring. At 9:03 AM a staff read to him from a small book. At 9:16 AM the staff left. At 9:31 AM he left the house and got into a golf cart with staff and other clients. At 9:42 AM the golf cart was seen driving around at the facility and he was in the cart. At 10:00 AM the golf cart was seen driving past House without stopping, and he was still in the cart. At 10:20 AM the golf cart returned to the house and he came into the
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House. No training activities as outlined in his IHP occurred during this time.

Observation on 08/23/17 at 1:06 PM at [Redacted] House showed he sat on a couch on the B side living room. At 1:16 PM he sat on the couch on the A side of the house and had a snack of chips and pop. At 1:28 PM he took his garbage into the kitchen, laid down on a couch on the B side of the house and covered himself from head to toe with a blanket. At 1:55 PM he was heard snoring. At 2:18 PM he got up and went to the A side of the house and had a snack. No training activities as outlined in his IHP occurred during this time.

Observation on 08/24/17 at 8:10 AM at [Redacted] House showed he was at the dining room table and appeared to be finished with breakfast. At 8:16 AM he bussed his dishes to the kitchen and sat down on a couch in the living room. At 8:30 AM he laid down on the couch. At 8:35 AM he went to his room, got the bubble blowing items, and went outside to blow bubbles. No staff was with him. At 8:43 AM he went to the apple tree with staff and picked a few apples. They returned to the house 4 minutes later and he assisted in preparing the apples to eat, and he began to eat some at 8:52 AM. No training activities as outlined in his IHP occurred during this time.

Record review 08/24/17 of Client #12’s file showed an IHP, dated 01/12/17, that had objectives for washing his face and brushing his teeth. He also had four objectives related to reducing inappropriate behaviors and one objective that was designated as a replacement behavior.
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During an interview on 08/25/17 at approximately 9:00 AM Staff A, HPA, Staff K, ACM, Staff P, DDA 2, and Staff G, HPA, stated that the IHP was accurate. When told a summary of the above observations and the apparent lack of active treatment, they stated that Client #12 had very volatile, dangerous behavior and staff had to be careful not to do things that might provoke these behaviors. They stated that the IHP did not reflect a program related to staff needing to be very careful in how they interacted with Client #12 while still providing him the teaching and training he needed.

483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN

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 identify the needs of three of ten Sample Clients (Clients #2, #3 and #8) and one Expanded Sample Client (Client #14). The facility did not identify that Client #2 went into the community with a dirty face and arms and did not wear work clothes/boots to work in the Stone Room, Client #3 cut some of his hair off, Client #9 drank excessive amounts of water and Client #14 rummaged in the garbage can. This failure prevented the assessment of needs to develop training programs to teach the Clients needed skills.

This is a repeat citation of the Recertification Survey on 07/15/16 and the Credible Allegation Survey on 09/23/16.
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Findings included:

Client #2

Observation at Hurlbert Hall in the Stone Room on 08/23/17 at 9:57 AM showed Client #2 rubbed a black substance all over the disposable gloves he was wearing. At 10:04 AM and 10:30 AM staff were seen wiping off their arms with disposable wipes. At 10:45 AM staff wore protective covers over their shoes. Client #2 did not have coverings over his white sneakers as he was cued to spray the black substance out of a cement mixer with a hose. At 10:50 AM Client #2 left Hurlbert Hall with black smudges on his face, arms and shoes and returned to House. At 11:00 AM a staff stated to Client #2 that he (the Client) was going to the Coffee Shop for lunch. Client #2 was not cued to wash his face, hands or arms prior to leaving. The staff and Clients arrived at the Coffee Shop at 11:10 AM and Staff R verbally cued Client #2 to go wash his hands. At 11:13 AM Client #2 exited the bathroom with black smudges still on his face. At 11:16 AM staff commented "You still got a little dirt on your face from the Stone Room [Client #2 first name]." The staff did not cue him to clean it off.

Review of Client #2's file showed a Comprehensive Functional Assessment (CFA) dated 11/08/16 that identified Client #2 was dependent on verbal cues from staff for grooming needs. The Individual Habilitation Plan (IHP) dated 11/08/16 did not identify a training plan or instructions for Client #2 to have his hygiene needs met after finishing work in the Stone Room or use of work wear while working in a dirty environment, such as the Stone Room.
During an interview on 08/24/17 at 2:02 PM in the Stone Room a staff stated that Client #2 usually cleans up prior to leaving work and the lack of shoe coverings was an oversight.
During an interview on 08/25/17 at 11:50 AM, Staff O, Attendant Counselor Manager (ACM), stated that staff should have ensured Client #2 washed prior to leaving for the Coffee Shop.

Client #3

Review of Client #3's file showed Interdisciplinary Progress Notes dated 07/27/17 that stated Client #3 approached staff stating "look." Staff documentation showed that Client #3 was missing a 1 1/2 inch by 3-4 inch strip of hair from the top of his head and he stated that he cut it. There was no documentation of why he had cut a portion of his own hair.

During an interview on 08/25/17 at 9:00 AM, Staff Q, ACM, stated that he likes to keep his hair short and Staff N, Habilitation Plan Administrator (HPA) stated that the note did not specify how the hair was cut, however it was clear to staff that Client #3 used his electric razor to cut his hair.

Review of the IHP dated 02/16/17 showed no preference for short hair or indication that Client #3 preferred to cut his own hair.

Client #9

Record review on 08/24/17 of Client #9's Positive Behavior Support Plan (PBS) signed 06/21/17 showed he had the behavior of inappropriate water drinking which was defined as drinking water out of the toilet. The identified function of...
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the behavior showed "[Client #9 first name] may be thirsty. He may have learned to satisfy his thirst inappropriately."

Review of Client #9's file on 08/24/17 showed no medical diagnosis or other investigation/assessment into excessive water drinking.

Record review on 08/24/17 of Client #9's 90 Day Healthcare Assessment dated 03/30/17 showed the following: "Chronic medical problems: [redacted] prior diagnosis of [redacted] history of inappropriate water consumption and possible primary polydipsia (abnormally great thirst as a symptom of disease (such as diabetes) or psychological disturbance). See full notes of [Staff BB]."

During an Interview on 08/25/17 at 9:56 AM, Staff M, ACM, and Staff N, HPA, stated that they did not know if Client #9's possible diagnosis of polydipsia had been looked into or other possible investigations/assessments into excessive water drinking. Staff identified the notes of Staff BB, Psychiatrist, in the files referred to in the 03/30/17 90 Day Healthcare Assessment, but could not find any other information regarding a possible polydipsia diagnosis nor any mention of polydipsia.

Client #14

Observation at [redacted] House on 08/21/17 at 11:11 AM showed Client #14 in the dining room with his hands in the garbage can.

Review of Client #14's file showed an Interdisciplinary Progress Note dated 08/20/17
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that stated Client #14 was trying to eat food from the garbage and staff attempted to redirect him which led to behaviors requiring a Behavior Response Team intervention. A PBSP dated 05/23/17 identified food seeking as a behavior to be decreased but it did not identify attempting to obtain food from the garbage as a concern.

During an interview on 08/29/17 at 9:02 AM, Staff F, Lead Psychologist, Staff H, Developmental Disability Administrator 1, and Staff C, Psychology Associate (not the assigned Associate for this Client), stated that rummaging in the garbage can would be considered an inappropriate behavior.

483.440(c)(4) INDIVIDUAL PROGRAM PLAN

The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.

This STANDARD is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to have objectives for four of ten Sample Clients (Client #4, #7, #9, and #11) and one Expanded Sample Clients (Client #14) to address an identified and assessed need. This failure prevented the Clients from having the opportunity to learn new skills and gain independence.

This is a repeat citation from the Recertification Survey of 07/15/16. The citation was found corrected during the 09/23/16 Survey, but the correction was not sustained.
W 227
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Findings included:

Client #7

Record review on 08/24/17 of Client #7’s Comprehensive Functional Assessment (CFA) dated 07/05/17 showed that "[Client #7 first name] needs to increase use of appropriate methods of communication to express wants/needs and choices instead of engaging in aggression or SIB. We will also offer her an opportunity to practice picture communication for basic items ..." The Individual Habilitation Plan (IHP) dated 06/27/17 showed that "to assist [Client #7 first name] with clearly communicating her wants and needs, a simple picture system will be trialed." There was not a communication objective in her IHP.

Observations of Client #7 at House on 08/21/17, 08/22/17, and 08/23/17 showed she did not use a picture communication system.

During an interview on 08/25/17 at 11:00 AM, Staff E, Habilitation Plan Administrator (HPA) and Staff B, Attendant Counselor Manager (ACM), stated that they had not implemented a picture communication system for Client #7.

Client #9

1. Observation on 08/21/17 at 10:40 AM showed Client #9 left the Canteen with his peers from House and a staff. Client #9 walked in front of his peers and staff, and walked on the street. Staff prompted him to use the sidewalk.

Observation on 08/22/17 at 2:20 PM showed Client #9 left the Canteen and walked home in
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the middle of the street. His assigned staff left
one minute before Client #9 with two Clients from
House due to staff shift change. A staff
assigned to another Client kept asking Client #9
to use the sidewalk. Eventually, he was escorted
home by Staff M, ACM.

Observation on 08/23/17 at 9:53 AM showed
Client #9 left the Canteen with peers from House
and one staff. Client #9 walked home in
the middle of the road. He was asked to use
the sidewalk and he complied.

Observation on 08/23/17 at 2:23 PM showed
Client #9 left House ahead of his peers
and staff who were going to the Canteen. Client
#9 walked towards the Canteen in the middle
of the street and did not use the sidewalk.

During an interview on 08/24/17 at 8:33 AM, Staff
U stated that one of Client #9's core needs was to
work on traffic safety.

Record review on 08/24/17 of Client #9's CFA
showed "he has little regard for cars/traffic and
walks down or at angles across parking lots and
roads on grounds ..." The IHP dated 06/22/17 did
not include objectives related to street safety.

2. Record review on 08/24/17 of Client #9's CFA
showed "[Client #9 first name] is spontaneous
with self-toiling, although he generally does not
complete the task appropriately. [Client #9 first
name] can use toilet paper to wipe but often
prefers to use clothing ...." The IHP dated
06/22/17 did not include objectives related to
toilet paper usage.

During an interview on 08/25/17 at 9:56 AM, Staff
### W 227

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M, ACM, and Staff N, HPA, stated that the Positive Behavior Support Plan (PBSP) addressed toilet paper usage and Client #9 self-toilets. Staff stated Client #9 does have a need for street safety skills.

Record review on 08/24/17 of Client #9's PBSP showed that it did not mention toilet paper usage.

Client #11

Record review on 08/24/17 of Client #11's CFA dated 06/09/17 showed needs in the areas of wearing weather appropriate clothing and pedestrian safety. The IHP dated 06/09/17 showed one of her core needs was "traffic safety." Client #11 did not have training objectives for wearing weather appropriate clothing or pedestrian safety.

During an interview on 08/25/17 at 11:00 AM, Staff E, HPA, and Staff B, ACM, stated that Client #11's needs are addressed informally although they are identified as core needs and agreed there weren't formal training objectives.

Client #4

Observation on 08/21/17 at 2:55 PM showed Client #4 left Hall and walked alone in the middle of 2nd Avenue, turned right on Heyns Street and continued to walk in the middle of the street.

Observation on 08/22/17 at 8:52 AM showed Client #4 walked alone down the middle of Heyns Street. At 8:56 AM a white ATP truck went around Client #4 and a golf cart stopped and asked if he wanted a ride. Neither cued Client #4 to move to
W 227

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the sidewalk. At 10:42 AM Client #4 walked alone in the middle of Heyns Street. Staff on a golf cart going the opposite way asked if he wanted a ride and the cart left when he did not respond. He was not cued to use the sidewalk.

Observation on 08/22/17 at 2:42 PM showed Client #4 walked alone in the middle of Heyns Street.

Observation at House on 08/23/17 at 8:45 AM showed a Direct Care Staff cued Client #4 "to walk on the sidewalks" prior to leaving for work. At 8:49 AM Client #4 walked alone in the middle of Heyns Street.

Review of Client #4's file showed a CFA dated 05/09/17 that identified Client #4 required staff supervision for safe pedestrian practices. The IHP dated 05/09/17 showed that Client #4 required assistance only when going to destinations beyond PAT E. Review of the Qualified Intellectual Disability Professional (QIDP) Review, dated 07/06/17, showed that the writer of the review had observed that Client #4 walked in the middle of the street several times and prompted him to move to the sidewalk. The QIDP stated in the review that he stayed in the area to ensure Client #4's safety and to direct traffic away from Client #4 when he did not move to the sidewalk. There was no training objective or teaching plan identified in the IHP for teaching Client #4 traffic safety.

During an interview on 08/25/17 at 11:10, Staff G, HPA, stated that the lack of pedestrian skills was an issue that should be addressed in the IHP with formal training objectives.
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Client #14

Observation at [redacted] House on 08/21/17 at approximately 11:05 AM showed a nurse instructed Client #14 to “wash hands more often” in relation to his eyes being red. At 11:11 AM Client #14 was seen with his hands in the garbage can while in the dining room. Staff R, Direct Care Staff, told Client #14 to wash his hands. Client #14 went into the kitchen, put soap on his right hand, rinsed his left hand and then left the kitchen. He did not wash his hands as staff had instructed.

Review of Client #14’s file showed a Physician Order dated 08/21/17 with an order for antibiotic eye drops for conjunctivitis (an infection of the eye). The CFA dated 05/01/17 showed that Client #14 required verbal cues to wet hands, apply soap, lather soap, rinse hands, and to dry his hands. The IHP dated 05/23/17 did not include an objective related to handwashing.

During an interview on 08/25/17, Staff O, ACM, stated that Client #14 did not have a training program for handwashing.

483.440(c)(5)(i) INDIVIDUAL PROGRAM PLAN

{W 234}  

Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used. This STANDARD is not met as evidenced by:

Based on observation, record review, and interview, the facility failed to ensure three of ten Sample Clients (Clients #4, #5, and #9) and one Expanded Sample Client (Client #12) had teaching plans which contained enough detailed
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Instructions for staff to train Clients consistently on their objectives across all shifts. This failure resulted in Clients potentially receiving inconsistent training which could negatively impact their progression towards learning the skills.

This is a repeat citation from the Recertification Survey of 07/15/16 and the Credible Allegation Survey of 09/23/16.

Findings included:

Client #9

1. Observation on 08/22/17 at 5:45 PM showed Client #9 ate dinner with a weighted spoon held in his left hand.

Observation on 08/23/17 at 11:00 AM showed Client #9 ate lunch with a weighted spoon held in his left hand. His right hand was shaking more than his left during the meal.

Review on 08/24/17 of Client #9's file showed he had two training objectives related to putting his clothes away, an objective to brush his hair, and an objective to brush his teeth. These programs did not direct staff which hand Client #9 should use during the training.

During an interview on 08/25/17 at 9:56 AM, Staff M, Attendant Counselor Manager (ACM), and Staff N, Habilitation Plan Administrator (HPA), stated that they did not know which hand was dominant for Client #9. Staff agreed information about Client #9’s dominant hand was missing from the training description.
Continued From page 42

2. Record review of Client #9's Positive Behavior Support Plan (PBS/SP) signed 06/27/17 showed he had the behavior of inappropriate water drinking which was defined as drinking from the toilet. Client #9's replacement behavior was appropriate communication.

Record review of Client #9's Daily Behavior Summary for August 2017 showed staff marked the number of cues Client #9 needed to indicate appropriate communication "with 1-2 verbal cue from staff [Client #9 first name] will indicate his needs with a score of 2.5 or higher." There were no other instructions to indicate what cues staff should give Client #9, examples of how Client #9 should respond, when the program should be run, how it related to inappropriate water drinking, or how to communicate with Client #9 about the program.

During an interview on 08/29/17 at 10:00 AM, Staff F, Lead Psychologist, Staff C, not the assigned Psychology Associate for this Client, and Staff H, Developmental Disabilities Administrator 1, stated that the replacement communication plan was vague, especially since Client #11 uses two words.

Client #4

Observations at Hall on 08/21/17, 08/22/17 and 08/23/17 showed Client #4 worked on removing single sheets of newspaper from a pile of unfolded newspapers.

Record review of Client #4's program teaching plan showed an objective to remove single, ink stained soiled sheets. The program cue was "[Client #4 first name] please remove single, ink
## Continued From page 43

soiled sheets. The correction procedure for staff to use if the Client did not comply was "[Client #4 first name] let's get the newspaper from the cart ..."

During an interview on 08/29/17 at 9:55 AM, Staff X, Adult Training Supervisor, stated that the correction procedure was incorrect and was not updated when the prior objective had been met and the program was revised.

Client #5

Record review on 08/24/17 of Client #5's file showed written training programs for shaving his face, brushing his teeth, and cleaning his glasses. The program directed staff to mark a + for a correct response. The program did not provide a description of what the correct response would consist of or look like.

During an interview on 08/25/17 at approximately 10:35 AM Staff T, HPA, Staff Z, ACM, and Staff H, DDA 1, stated that there wasn't a description of what a correct response would consist of or look like.

Client #12

Record review on 08/24/17 of Client #12's file showed written training programs for brushing his teeth and washing his face. The program directed staff to mark a + for a correct response. The program did not provide a description of what the correct response would consist of or look like.

During an interview on 08/25/17 at 09:00 AM, Staff A, current HPA, Staff K, ACM, Staff P, DDA 2, and Staff G, prior HPA, stated that the
Continued From page 44

programs did not have a description of what the correct response would consist of or look like. They stated that they did not think it was necessary as it would be common sense.

483.440(c)(5)(iv) INDIVIDUAL PROGRAM PLAN

Each written training program designed to implement the objectives in the individual program plan must specify the type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives.

This STANDARD is not met as evidenced by:
Based on record review and interview the facility failed to ensure data was recorded with adequate frequency to determine when the skill had been learned for one of ten Sample Clients (Client #2). This failure prevented Client #2 from moving onto the next step of the objective as soon as he learned the skill.

This is a repeat citation of the Recertification Survey on 07/15/2016 and the Credible Allegation Survey on 09/23/16.

Findings included:

Record review of the Program Teaching Plan for Client #2 showed that the plan for placing a card on a board was to be taught daily with data being taken only twice a week. The criteria for moving to the next step of the objective was completing the task 6 out of 8 attempts. The entire month of July was documented as correctly performing the task and the Client moved to the next step. The month of August (up to August 22nd) had four attempts documented as completed correctly.
Continued From page 45

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\text{W 237}
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During an interview on 08/24/17 at 2:30 PM a staff stated that Client #2 was able to complete the task from the start of each of the objectives and if data was recorded daily when the plan was taught he would have completed the objective within the first 10 days of the month.

During an interview on 08/25/17 at 11:50 AM, Staff O. Attendant Counselor Manager, stated that Client #2 would have been progressed to the next step earlier if data had been taken more frequently.

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\text{W 239}
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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, record review, and interview, the facility failed to ensure four of ten Sample Clients (Clients #3, #7, #9, and #11) had replacement behaviors for their inappropriate behaviors. This failure resulted in the Clients having no alternative to get their needs met in a socially acceptable manner.

Findings included:

Client #3

Review of Client #3's file showed a Positive
Continued From page 46

Behavior Support Plan (PBS) dated 02/13/17 that identified Client #3 had separation anxiety related to family and may have agitation "until he learns to cope with it." No training program was identified within the PBS to teach Client #3 to manage his feelings related to family visits. Interdisciplinary Progress Notes dated 08/13/17 showed Client #3 returned from a home visit and was asked to leave his room for medication administration and he replied no and "gave me (staff) the middle finger". The note also indicates this is a "known behavior of being defiant after home visits."

During an interview on 08/25/17 at 9:00 AM, Staff N, Habilitation Plan Administrator (HPA), stated that Client #3 did exhibit behaviors after visits with family.

During an interview on 08/29/17 at 9:25 AM, Staff C, Psychology Associate (not the assigned Associate for Client #3), Staff H, Developmental Disability Administrator 1 (DDA1), and Staff F, Lead Psychologist, stated that there was not a transition plan for returning to the facility from a family visit.

Client #9

Observation on 08/21/17 at 1:56 PM showed Client #9 went to the restroom with a cup he got from the kitchen. Client #9 was observed going into the restroom two more times on 08/21/17 during the observation period without staff going with him.

Observation on 08/22/17 showed Client #9 went into the restroom five times between 1:55 PM-3:35 PM without staff going with him.
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<tr>
<th>W 239</th>
<th>Continued From page 47</th>
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<tbody>
<tr>
<td></td>
<td>Observation on 08/23/17 showed Client #9 went into the restroom seven times between 9:46 AM-10:30 AM and 2:00 PM-3:22 PM without staff going with him.</td>
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<td></td>
<td>Record review of Client #9’s PBSP signed 06/27/17 showed he had the behavior of inappropriate water drinking which was defined as drinking from the toilet. Client #9’s replacement behavior was appropriate communication which was not specifically defined for drinking from the toilet.</td>
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<td>During an interview on 08/29/17 at 10:00 AM, Staff F, Lead Psychologist, Staff C, not the assigned Psychology Associate for this Client, and Staff H, DDA1, stated that the replacement communication plan was vague, especially since Client #11 uses two words.</td>
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<td>Client #7</td>
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<td>Record review on 08/24/17 of Client #7’s PBSP expiring 06/27/18 showed she engaged in three inappropriate behaviors: self-injurious behavior, physical aggression toward peers, and physical aggression toward staff. Her replacement behavior objective was “When [Client #7 first name] shows signs of restless agitation, staff will give her 1 or more cues to participate in a preferred, positive activity.”</td>
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|       | Record review on 08/24/17 of Client #7’s Psychological Assessment dated 06/27/17 showed Client #7 engaged in the inappropriate behaviors due to “getting what she wants, escaping what she does not want, and
Continued From page 48

expressing pain.

Record review on 08/24/17 of Client #7's IHP dated 06/27/17 showed that she did not have a training objective to express pain, get what she wants, or escape what she does not want.

During an interview on 08/29/17 at 10:00 AM, Staff F, Lead Psychologist, Staff C, not the assigned Psychology Associate for this Client, and Staff H, DDA1, stated that the function of all Client #7's challenging behaviors was communication. Staff C attempted to explain the connection between engaging in preferred activities and the function of the behaviors, but agreed that Client #7 did not have a replacement behavior related to communication.

Client #11

Record review on 08/24/17 of Client #11's PBSP expiring 08/09/18 showed that she engaged in the inappropriate behaviors of self-injurious behavior (SIB), aggression, running away, agitation, and clothing perseverance. The replacement behavior objective was "Given verbal cues, [Client #11 first name] will engage in functional activities 8 times per day ..." The program was to be run when Client #11 was calm and was not correlated to her self-injurious behavior (SIB), aggression, running away, agitation, or clothing perseverance. During an interview on 08/29/17 at 10:00 AM, Staff F, Lead Psychologist, Staff C, not the assigned Psychology Associate for this Client, and Staff H, DDA1, stated that the function of all Client #11's challenging behaviors was the same: boredom. Staff C attempted to explain the connection between engaging in functional activities and the function of the behaviors. When
| (W 239) | Continued From page 49 asked how Client #11’s expectation of engaging in functional activities differed from other Clients living in an ICF/IID, Staff C stated Client #11 needed to engage in functional activities for her mental health. They did not understand providing an activity to Client #11 when she was calm, did not replace the need for Client #11 to engage in SIB, aggression, running away, agitation, and clothing perseveration. |
|         | W 239 |

(W 249) 483.440(d)(1) PROGRAM IMPLEMENTATION

As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure the Individual Habilitation Program (IHP) was implemented as written for two of ten Sample Clients (Clients #2 and #4) and one Expanded Sample Client (Client #13). Clients #2 and #13 were served foods that were not altered as required in the IHP and Client #4 did not have access to adaptive equipment at the Adult Training Program (ATP). This failure placed Clients at risk for choking.

This is a repeat citation of the Recertification Survey on 07/15/2016 and the Credible Allegation Survey on 09/23/16.
Findings included:

Client #2

Observation at House on 08/22/17 at 11:09 AM showed Client #2 cut sliced meat into approximately two inch pieces and ate it.

Observation at the Coffee Shop on 08/23/17 at 11:22 AM showed Client #2 was served a hamburger on a bun. The entire hamburger had been cut into approximately one inch pieces.

Review of Client #2's file showed an IHP dated 11/08/16 that identified a whole diet with chopped meat due to rapid chewing.

During an interview on 08/25/17 at 11:50 AM, Staff O, Attendant Counselor Manager (ACM) stated that the sliced meat should have been altered when served and the hamburger patty should have been chopped and placed on a whole bun, the entire hamburger including the bun should not have been chopped.

Client #13

Observation at House on 08/22/17 at 11:16 AM showed Client #13 ate spiral noodles that were approximately two inches long.

Review of Client #13's file showed an IHP dated 06/20/17 that identified his diet as ground. Record review of the facility Standard Operating Procedure 4.07 Appendix A, Diet Textures, dated 04/2015, showed a ground diet consisted of food pieces no larger than ¼ inch in diameter.
Continued From page 51

During an interview on 08/22/17 at 11:16 AM, Staff O, ACM, stated that Client #13 had a ground diet and the noodles did not need to be altered as they were "mushy."

During an interview on 08/25/17 at 11:00 AM, Staff O stated that the noodles should have been modified on the house by the server and the incorrect diet had been given to Client #13.

Client #4

Observation at [Redacted] House on 08/21/17 at 11:17 AM showed Client #4 ate lunch using a junior spoon.

Observation at Oakley Hall on 08/22/17 at 10:05 AM showed Client #4 ate pudding with a plastic, disposable spoon.

Review of Client #4's file showed an IHP dated 05/09/17 that stated Client #4 was to use junior size utensils to help reduce bite size.

During an interview on 08/24/17 at 1:50 PM, Staff Y stated that ATP had been provided disposable, plastic spoons not a junior size spoon for Client #4.

During an interview on 08/29/17 at 9:55 AM, Staff X, Adult Training Supervisor, stated that a junior spoon should have been used at ATP as written in the IHP.

Program Monitoring & Change

At least annually, the comprehensive functional assessment of each client must be reviewed by...
W 259  Continued From page 52  

the interdisciplinary team for relevancy and updated as needed.  

This STANDARD is not met as evidenced by:  
Based on record review and interview, the facility failed to ensure an accurate Comprehensive Functional Assessment (CFA) was completed for one of ten Sample Clients (Client #2). This failure prevented staff from knowing the current needs of the Client.  

Findings included:  

Review of Client #2's file showed a CFA dated 11/08/16 that had four sentences that were shaded on the photocopy and included statements indicating some information in the CFA was incorrect. The statements included: "I don't think he currently has a white board", "This should be updated to include current meds. Info can be found in my psych assessment", "This statement is outdated" and "This whole statement should be deleted. It is not current. Replace with the following."

During an interview on 08/25/17 at 11:50 AM, Staff O, Attendant Counselor Manager, stated that the draft was sent to various departments for amendments and then forwarded to the Habilitation Plan Administrator (HPA) for review and the final document was created by the HPA. When the HPA was questioned why the CFA dated 11/08/16 had not been updated, Staff G, HPA, stated that the CFA was due to be redone in November 2017 and he was waiting until then to complete it. He did not say why the CFA had not been updated on 11/08/16 prior to being placed in the Clients file.
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<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>D PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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<tr>
<td>W 260</td>
<td>Continued From page 53</td>
<td>483.440(f)(2) PROGRAM MONITORING &amp; CHANGE</td>
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<td>At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.</td>
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<td>This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure a completed Individual Habilitation Plan (IHP) was available in the Clients’ file for one Expanded Sample Client (Client #14). This failure prevented the Client from having knowledgeable staff attend to his training needs.</td>
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<td>Findings included: Review of Client #14’s file on 08/23/17 showed an IHP dated 05/23/17 with the word “Draft” handwritten on it. During an interview on 08/25/17 at 11:45 AM, Staff G, Habilitation Plan Administrator (HPA), when questioned why the draft version of the IHP was in the Clients’ file, initially stated that the IHP was misplaced. He left the room and when he returned he stated the final, correct version was sitting on his (the HPA’s) desk.</td>
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<td>W 436</td>
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<td>483.470(g)(2) SPACE AND EQUIPMENT</td>
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This STANDARD was not met as evidenced by:
Based on observation, record review, and interview, the facility failed to teach one of ten Sample Clients (Client #3) how to use and care for prescription eyeglasses. This failure placed Client #3 at risk for not utilizing a needed corrective vision aide.

Findings included:

Observations on 08/21/17 and 08/22/17 showed Client #3 was not wearing eyeglasses.

Observation on 08/23/17 at 3:00 PM showed Client #3 was wearing eyeglasses.

Review of Client #3’s file showed a Comprehensive Functional Assessment dated 02/07/17, which stated eyeglasses were ordered for multiple vision impairments on 01/15/15 and 05/2016 and he does not wear them. An Individual Habilitation Plan (IHP) dated 02/13/17 listed eyeglasses under adaptive equipment with a statement that he does not like to wear them. A plan for use and care of his eyeglasses was not found within the IHP.

During an interview on 08/25/17 at 9:00 AM, Staff Q, Attendant Counselor Manager, stated that Client #3 “broke” the last two pair of eyeglasses and the plan was for staff to observe how he did with the new pair prior to creating a program.