

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/14/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04G007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/30/2025
NAME OF PROVIDER OR SUPPLIER SOUTHEAST ARKANSAS HUMAN DEVELOPMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTER CIRCLE WARREN, AR 71671		
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W 104	<p>GOVERNING BODY CFR(s): 483.410(a)(1)</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on interviews, record review, facility document review, and facility policy review, it was determined that the facility's Governing Body failed to monitor and revise operating policies ensuring direct care staff were notified of changes to behavioral support plans (BSP), failed to ensure direct care staff demonstrated knowledge and skills to perform a physical restraint and nursing staff demonstrated appropriate medical justification for a chemical restraint. Three Immediate Jeopardies were cited at W128, W193 and W249.</p> <p>The findings include:</p> <p>Refer to W128, W193, and W249 for additional information.</p> <p>During an interview conducted on 09/18/2025 at 2:57 PM, Quality Assurance Supervisor (QAS) #15 stated that the Quality Assurance Department did not have a system in place to ensure that changes to the IPP or BSP were effectively communicated to direct care staff, but verbalized that they would be glad to create one.</p> <p>During an interview on 09/22/2025 at 3:55 PM, the Administrator stated the Governing Body includes the Executive Staff, but indicated the Governing Body had not held regular meetings since COVID (Coronavirus disease 2019). The Administrator provided meeting minutes to two meetings held on 06/03/2025 and 06/25/2025.</p>	W 104			

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 104	Continued From page 1 A review of a facility policy titled Policy and Procedure Development and Review revised on 07/26/2021, indicated, "Policy development at the [Facility name] is the responsibility of the Superintendent with participation by staff at all levels, input from the individuals served, parents, volunteers, sister agencies of State government, the Board of Directors of DDS(Developmental Disability Services) and administrative chain of command. All policies and procedures are reviewed at least yearly ... 1.The Executive staff (formerly known as Service Area Directors) is a standing committee and has a core membership consisting of Superintendent, Institutional Business Manager, Residential Services Director, Nurse Manager, Quality Assurance Coordinator, Assistant Superintendent, Education and Instruction Coordinator, Maintenance Coordinator, and the following: DHS(Department of Human Services) Program Coordinator ...3. The Executive Staff meet on a regularly scheduled basis and maintain adequate records on the meetings. 4. The responsibility of the Executive Staff is to advise the Superintendent on needs for new policies, or revisions of existing policies, to prepare draft changes as recommended to obtain the view of those who may be affected by policies, and to assure that policies are consistent with goals, laws, and standards by which the center operates..."	W 104			
W 122	CLIENT PROTECTIONS CFR(s): 483.420(a) The facility must ensure the rights of all clients. Therefore the facility must This CONDITION is not met as evidenced by: Based on observations, interviews, and record review the facility failed to establish an effective	W 122			

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W 122	<p>Continued From page 2</p> <p>process, through implementation of written policies and procedures, to prevent abuse or maltreatment to clients, to ensure all staff were reporting abuse in a timely manner, failed to ensure residents were not subjected to psychological abuse and failed to provide psychological support to affected clients. (Cross Reference W127, W128, W149)</p> <p>The cumulative effect of these systemic problems resulted in the Condition of Participation, Client Protections being found as not met.</p> <p>(W127) Based on record reviews and interviews, the facility failed to provide psychological and/or immediate emotional support for 1 (Resident #2) of 2 residents (Resident #2 and Resident #4) sampled in a case mix who were subjected to a traumatic event and failed to ensure residents were free from abuse and neglect for 1 (Resident #1) of 3 (Resident #1, #2, and #3) case mix residents reviewed for abuse and neglect. Cited at an IJ level.</p> <p>(W128) Based on interviews, record review, facility document review, facility policy review, and camera footage, it was determined that the facility failed to ensure appropriate replacement behaviors were implemented prior to initiating a personal physical restraint and a medical justification for administering a chemical restraint to manage a behavior and inhibit movement for 1 (Resident 1) of 3 (Resident 1, Resident 2, and Resident 3) of 3 residents reviewed for restraints. Cited at an IJ level.</p> <p>(W149) Based on record observation, record review, and interview, the facility failed to ensure that one (Resident #1) of three sampled residents</p>	W 122			

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W 122	Continued From page 3 failed to implement their policy and procedure to provide a helmet as ordered to prevent staff abuse and neglect which resulted in sustained injuries and client demise.	W 122			
W 127	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(5) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide psychological and/or immediate emotional support for 1 (Resident #2) of 2 residents (Resident #2 and Resident #4) sampled in a case mix who were subjected to a traumatic event and failed to ensure residents were free from abuse and neglect for 1 (Resident #1) of 3 (Resident #1, #2, and #3) case mix residents reviewed for abuse and neglect. The findings are: Refer to W193 for review of camera footage. Refer to W193 and W128 written at an Immediate Jeopardy level for additional information. Review of Resident #2's Face Sheet revealed diagnoses of mild intellectual disability and unspecified mood disorder. Review of the face sheet indicated the facility admitted Resident #1 (R1) with diagnoses that included severe intellectual disability, autism spectrum disorder, seizure disorder, 9P Syndrome (neurological disorder) unspecified	W 127			

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W 127	<p>Continued From page 4</p> <p>disruptive, impulse control, and conduct disorder.</p> <p>Review of the social history intake dated 02/12/2025, revealed Resident #1 had a functional language age equivalent to 2 years. Behaviors exhibited included aggression (biting, scratching, pulling hair, kicking, or hit), property destruction (flip furniture if frustrated), self-injury (will hit self). Resident #1 current supervision level 1:1 and visual during sleeping hours. A 30-day review was scheduled for 03/18/2025.</p> <p>The Individual Program Plan (IPP) with an implementation date of 04/01/2025, revealed Resident #1 had a severely impaired intellectual functioning level, required one -on -one supervision level, had a targeted behavior of physical aggression, and required a hard-shell helmet as adaptive equipment.</p> <p>Review of a Behavior Report dated 09/07/2025 revealed Resident #1 had inappropriate behaviors including agitation and psychiatric symptoms. Resident #1 exhibited physical aggression, including hair-pulling. The report documented that the supervisor was called at 6:40 PM and the nurse was called at 6:41 PM.</p> <p>Review of a Restraint Reporting Form dated 09/07/2025 at 6:43PM revealed the Authorizing QIDP (Qualified Intellectual Disability Person)/Supervisor on duty was RCTS #3. The type of restraint was identified as personal and chemical. Reason for restraint was aggression toward staff. The personal restraint was documented at 6:43PM including escalating and agitated behavior. The release of restraint was documented at 6:56PM, including a reference that R1's behavior was beginning to calm. The</p>	W 127			

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W 127	<p>Continued From page 5</p> <p>chemical restraint was documented at 7:04PM, and the other box was marked with the word compliant written. RN #7 documented Geodon 20mg IM (an atypical antipsychotic used to treat schizophrenia and bipolar disorder) see nurses' notes. RCTS #3 documented the Administrator was notified at 7:11PM.</p> <p>Review of the debriefing form for the behavior report dated 09/07/2025 indicated Resident #1 received a personal and chemical restraint due to aggression directed towards staff and to prevent escalation again. In the "possible actions by staff to decrease future necessity of restraint" there was no documentation. In additional comments section there is documentation immediately after the chemical restraint medical took charge.</p> <p>Review of the EMS run report dated 09/07/2025 documented, "...R1 is pulseless and apneic, pupils are fixed and dilated. Facility staff reports that the patient became combative, attempting to bite other residents. Facility staff first attempted physical restraint which was ineffective, so Geodon was administered for chemical restraint. Facility staff have no idea at what point the pt (patient) stopped breathing and lost pulse. EMS continued CPR with chest compressions. AED pad had to be reapplied in the proper position as they were initially over the abdomen ..."</p> <p>Review of a Nursing Note dated 09/07/2025 at 7:03 PM revealed, "Arrived back to unit. Resident was still in personal restraint. Resident was laying on back and repositioned to the side. Pulse was checked and noted. Geodon 20mg was given IM in right gluteal @ (at) 19:04PM (7:04PM)." The nurse's note was signed by RN #7.</p>	W 127			

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W 127	<p>Continued From page 6</p> <p>Resident #2</p> <p>In an interview on 09/23/25 at 1:20 PM, Resident #2 was asked if they were present on 09/07/25 during the physical and chemical restraint for Resident #1, and responded "I was sitting on the couch with [C.N.A #10] and [Resident #1] had grabbed [C.N.A #5's] hair and tried to bite C.N.A. #5's neck. "I left and went outside to get help and saw [C.N.A #1] and C.N.A. #1 ran back to the house" Resident #2 reported being present for the physical restraint and the chemical restraint of Resident #1. Resident #2 remembered C.N.A #8 and C.N.A #10 being involved. Resident #2 stated that Resident #1 was lying face down, and when they repositioned Resident #1 onto their back, something was not right, and Resident #1 was not breathing. Resident #2 reported telling staff Resident #1 was not breathing and no one responded. Resident #2 indicated that staff were afraid to do CPR, and if (Resident #2's) arm had not been messed up, they would begin the compressions. Resident #2 reported what they remembered most was that "[Resident #1] was not moving, they (staff) did nothing, and they were wrong to keeping me here." Resident #2 also indicated that when Resident #1's parents came, Resident #2) had written them a letter saying how sorry (Resident #2) was for them and gave them a little toy that Resident #1 played with, and the parents said that they would place the toy in (Resident #1's) pocket during the funeral. Resident #2 indicated that (Resident #2) could not go anywhere, there was nothing to do. The TAs (teachers assistants) are now working on the units, and a lot of people are quitting.</p> <p>Resident #4 Resident #4 was unable to be interviewed.</p>	W 127			

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W 127	Continued From page 7 Certified Nursing Assistant #8 In an interview on 09/16/2025 at 6:21 PM, C.N.A #8 stated he was present on the day of the incident of 09/07/2025 involving Resident #1. C.N.A #8 stated being assigned to take Resident #2 to the hospital. However, C.N.A. #8 believed that C.N.A #10 was actually going to be the staff member to take Resident #2 to the hospital. C.N.A. #8 indicated that Resident #1 had been assigned to C.N.A #5, and C.N.A. #5 had requested the Resident #1 go to the shower. Resident #1, Resident 2, and C.N.A, #10 were sitting on the couch when Resident #1 grabbed C.N.A #5 hair, pulling her toward closer in an attempt to bite the neck and was restrained by myself and C.N.A #10. We held him down until someone could call for help and assist. Resident #1's chair fell backwards, and Resident #2 had gone to get help and came back to the unit. At first, Resident #1 was supine, C.N.A. #8 was holding the resident's arm as they rocked to the side. "I had one arm, and [C.N.A #10] had the other arm. No one at that time had [Resident #1's] legs." RCS #2 was trying to leave and told us to let Resident #1 go, but then Resident #1 ripped off C.N.A #10's shirt. RCS #4 and C.N.A #1 arrived and held Resident #1's legs, but before they arrived, the resident had gotten up and we took [the resident] back down on their face, we had the resident's arms and legs for maybe 7 minutes. They (RCTS #9) tried to apply a human body wrap, but it was too small. Two nurses came in with a shot, Resident #1 was lying prone and was breathing. I had the resident's left arm, and C.N.A #10 had the right arm, and their head. C.N.A #1 and RCS #4 secured the resident's legs. Resident #1 was released, turned over, and a pillow was placed under their head. RCS #4 was positioned at Resident #1's head. After the	W 127			

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W 127	<p>Continued From page 8</p> <p>shot we let go, and I did not assist in rolling Resident #1 over. Resident #1 had been restrained for 11 minutes. Once, I accidentally placed my elbow on Resident #1's back during the physical restraint and repositioned to correct it. In response to the question, were supervisors available, C.N.A.#8 responded, "Yes, they came in," but they were unsure of the time.</p> <p>In an additional interview on 9/24/25 at 11:00 AM, C.N.A #8 stated that Resident #2 was there but did not recall when the resident left.</p> <p>Certified Nursing Assistant #5 In an interview on 09/16/2025 at 7:26 PM, C.N.A #5, indicated being assigned to the unit as a floater, on 09/07/2025 at 6:25 PM and began working with Resident #1, who was a 1:1, and was familiar with the resident's behavior plan. RCS #2 spoke with C.N.A #8, regarding Resident #2 needing transportation to the hospital for an x-ray. C.N.A #5 proceeded to take Resident #1 to the shower, and Resident #1 grabbed C.N.A.#5's hair, pulling C.N.A.#5 closer in an attempt to bite C.N.A.#5's neck. C.N.A #10 and C.N.A #8 attempted to intervene at the same time. The chair Resident #1 was seated in went backwards while Resident #1 had a hold of C.N.A. #5's hair. Resident #1 released C.N.A. #5's hair, attempted to bite C.N.A #10 while ripping C.N.A. #10's shirt off. C.N.A #5 phoned the nurse's station. The crisis team arrived, composed of RCTS # 3 and RCS #4. C.N.A #5 recalled C.N.A #10, RCM#16, RD, RN#7, LPN #6 being involved. Resident #1 was moving and RN #7 administered a chemical restraint. LPN #6 stated Resident #1 was unresponsive and called EMS. C.N.A #5 was looking for the AED (automated external defibrillator) while C.N.A #10 began CPR, and</p>	W 127			

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W 127	<p>Continued From page 9</p> <p>EMS arrived. C.N.A #5 was asked if Resident #2 had been present during the physical and chemical restraint of Resident #1 and responded that Resident #2 had been present and seated next to C.N.A #10 before Resident #1 grabbed hair. C.N.A. #5 stated Resident #2 expressed concerns for C.N.A. #5 afterwards.</p> <p>Residential Care Supervisor (RCS) #2 In an interview on 09/11/2025 at 1:48 PM to 2:17 PM, in reference to Resident #2, the Residential Care Supervisor (RCS #2), verbalized after coming out of the restroom 09/07/2025 staff was observed to trying to verbally calm Resident #1 down. RCS #2 observed Certified Nursing Aide (C.N.A.) # 10, RCS #4, C.N.A #8, C.N.A #5, and C.N.A #1, in the vicinity trying to restrain R #1 after the resident grabbed C.N.A #10's hair. Resident #1 had torn C.N.A #10's shirt. C.N.A #10 was on Resident #1's arm, C.N.A #1, C.N.A #8, and RCS #4 were on the opposing arm. Resident #1 was lying supine. RCS #2 threw a towel on Resident #1's face, to keep the resident from hurting themselves or others. The staff then relocated, with C.N.A #10 holding Resident #1's left wrist, and C.N.A #8 holding the right wrist. Resident #1 continued to be uncontrollable, fighting and scratching, was supine on the floor, got up, and was then placed prone on the floor. RCS #2 stated that the decision was made to release R1, so they grabbed personal bag and left, due to shift being over.</p> <p>In an additional interview on 09/24/2025, at 10:41 AM, RCS#2 was asked if Resident #2 was in the residential home during the physical and chemical restraint, and stated that Resident #2 had been in the living room during the physical restraint, as the resident was waiting on C.N.A</p>	W 127			

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W 127	<p>Continued From page 10 #10 for transportation to the hospital, and that Resident #2 had remained there.</p> <p>Maltreatment Investigator During concurrent review of cameras review footage and interview on 09/10/2025 at 2:48 PM, the Maltreatment Investigator (MI) verbalized staff did not do the restraint correctly. The MI confirmed at 6:44:06 PM of video Certified Nursing Assistant (CNA) #8 was observed with right hand on R1's back, and then CNA #10 leans forward, placing their forearm on R1's back. The MI verbalized CNA #10 appears to be placing elbow in R1's back and shifting own weight onto R1's back. The MI was asked why R1 received an injection when the resident was not combative, the MI verbalized, "I can't answer that."</p> <p>Quality Assurance Coordinator During concurrent review of camera and interview on 09/10/2025 at 2:53 PM, the Quality Assurance Coordinator (QAC) verbalized the restraint being observed was incorrect due to R1 being on their stomach (prone). The QAC verbalized CNA #8's hold should have been on the shoulders or wrist, not on R1's back. The QAC reported the arm on the back can restrict a residents' breathing.</p> <p>Licensed Practical Nurse #6 In an interview on 09/11/2025 at 7:06 PM, LPN #6, stated that C.N.A #5 was notified by phone they were doing a MIPIR (Mark/Injuries/Potential Injury Report) on Resident #1, as the resident had bitten their tongue. The nurses asked the C.N.A #5 to send a text message to the APRN for a chemical restraint. When LPN #6 arrived, she redirected one resident to their room but did not redirect Resident #2. LPN #6 left and returned.</p>	W 127			

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W 127	<p>Continued From page 11</p> <p>After returning to the unit, RN #7 and staff rolled Resident #1 and administered an injection to the resident's right hip. There had been no pulse or response from a sternal rub. 911 was called, RN #7 began CPR, I ran for an AED, then EMS took over.</p> <p>In an additional interview on 9/24/25, at 11:30 AM, LPN #6 confirmed not redirecting Resident #2 or Resident #4 to their room.</p> <p>RN #7</p> <p>During an interview on 09/15/2025 at 2:40 PM, RN #7 reported receiving a call that R1 had a behavior and had bitten their own lip and was bleeding. RN #7 reported upon entering the unit, R1 was not in a restraint, was awake, and there was no blood. RN #7 verbalized R1 was on the floor, laying on back, looking like normal self. RN #7 reported there were two male staff standing around R1.</p> <p>RN #7 reported contacting PAPRN #21 to notify R1 was having a behavior but did not observe the behavior. RN #7 reported receiving orders for a chemical restraint from PAPRN #21. RN #7 reported going back to the mini clinic to obtain the chemical restraint. After obtaining the chemical restraint and returning to the unit, RN #7 stated R1 was still awake and laying on the floor. RN #7 reported checking R1's pulse and then gave the chemical restraint. RN #7 stated after administering the chemical restraint things went downhill, they performed a sternal rub and started CPR. RN #7 reported someone took over CPR and RN #7 left to get AED pads. RN #7 reported placing the AED pads on R1. ?When asked whether an assessment of Resident R1 was completed prior to administering the chemical</p>	W 127			

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W 127	<p>Continued From page 12</p> <p>restraint, RN #7 stated that R1 was visually observed but a full head-to-toe assessment was not performed. A pulse was checked in both the neck and arm, but respirations were not counted.</p> <p>When questioned about contacting PAPRN #21 without personally witnessing the behavior, RN #7 explained that PAPRN #21 is notified any time a behavior occurs. Regarding the facility's protocol for obtaining a chemical restraint, RN #7 stated that staff notify the PAPRN about the behavior, and if a medication order is received, it must be administered as ordered. When asked whether R1 was a danger to self or others at the time the chemical restraint was administered, RN #7 responded that R1 was not. When RN #7 was asked why the chemical restraint was administered when R1 was not a threat to self or others, RN #7 stated that once a doctor issues an order, the medication must be given as prescribed. RN #7 was asked if allowed to call PAPRN back and inform the resident was no longer having a behavior and RN #7 responded with "I am just doing what I am told to do and if we get an order, then we are required to give the medication."</p> <p>Registered Nurse Manager During an interview on 09/17/2025 at 1:35PM, the Registered Nurse Manager (RNM) reported working for the facility since 1998. The RNM reported nurses' responsibilities during a restraint are to monitor the resident by observing skin color, respirations, ensure the restraint is not too tight, and ensure the resident is properly placed on their back and not their stomach.</p> <p>The RNM reported that the resident's behavior needs to be out of control such as a danger to</p>	W 127			

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W 127	<p>Continued From page 13</p> <p>self or others prior to calling the PAPRN for a chemical restraint. The RNM reported that if a resident has calmed down and is no longer a threat to self or others, the nurse can contact PAPRN to notify the residents change of condition and inform a chemical restraint is no longer necessary.</p> <p>The RNM was asked, "What was R1's condition at the time the chemical restraint was administered?" RNM replied, "I don't know if R1 was unconscious or deceased, but I do know R1 was not having a behavior at that time."</p> <p>Administrator During an interview on 09/22/2025 at 4:22 PM, the Administrator stated unable to see a legal argument for abuse however, some staff were negligent in the incident occurring on 09/07/2025 with Resident #1.</p> <p>In an interview on 09/24/2025 at 2:03 PM, the Administrator stated the facility should have offered Resident #2 immediate support after observing the death during the restraint. The Administrator voiced intent to schedule the psychologist to meet with Resident #2 the following day.</p> <p>Policies The Policy titled Rights of Clients Served by The Facility (Facility 23) read in part " ... Individuals will be free from mental and physical abuse and free from physical and chemical restraints. Restraints can be temporarily ordered by a physician for medical purposes or to promote healing, applied in an emergency to prevent injury to the client and to others, as part of the Behavioral Support Plan or Health/Safety Plan.</p>	W 127			

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W 127	<p>Continued From page 14</p> <p>Emergency programmatic application of restraint requires authorization of a QIDP for continuation and extension ...As a resident you have the right to be: free from mental, physical, verbal and sexual abuse ...free from chemical and physical restraints except when authorized in writing by a physician for a specific and limited period of time, or by a QIDP only to protect you or others from injury ...Every resident has the right to:...privacy during treatment and care of personal needs. People not involved in the care of residents shall not be resident without the consent from the resident during examinations and treatment ..."</p> <p>The policy titled Prohibition of Harmful Acts (Facility 72) read in part "Each person served by [Facility Name] has the right to be free from treatment or conduct that is harmful to them physically or psychologically. [Facility name] strictly prohibits inappropriate treatment in any form or of any nature to individuals receiving services ...4. Compliance with this policy is the responsibility of all staff, consultants, volunteers at the facility or any other person as determined by the facility administrator. It is the responsibility of the facility administrator to ensure overall compliance with this policy and to take all necessary precautions to prevent the occurrence of harmful acts against residents of a facility (Persons outside the scope of this policy suspected of harmful acts against a person served at the facility will be report to the appropriate state protective agencies according to OLTC guidelines) ...Harmful Acts-Actions which include, but are not limited to inappropriate/harmful physical, verbal, psychological, sexual or neglectful acts, exploitation, misappropriation of property, and violation of the rights or dignity of individuals</p>	W 127			

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W 127	Continued From page 15 receiving services. Staff intervention-Staff members are expected to intervene immediately if they observe a client being subjected to a harmful act or suspect a client may be in danger of being subjected to a harmful act by a staff member, volunteer, parent/guardian, or contractor ...Do not leave a client alone with a person who is harming, attempting to harm or who you think may harm the client ...2.The facility administrator will ensure staff accused or suspected of committing harmful acts as defined in this policy leave the center campus and have no contact with any persons served at the facility until an investigation has been completed. Under no circumstance will the subject(s) of an investigation resume regular duties or assume new duties at the facility until investigative results are final. The facility administrator or designee may allow employees who are alleged to have committed harmful acts to be on the facility campus under the supervision of management staff during collection of written statements by the alleged perpetrator, while awaiting interview, and when being interviewed as part of an investigation ..."	W 127			
W 128	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(6) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints. This STANDARD is not met as evidenced by: Based on interviews, record review, facility document review, facility policy review, and camera footage, it was determined that the facility	W 128			

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W 128	<p>Continued From page 16</p> <p>failed to ensure appropriate replacement behaviors were implemented prior to initiating a personal physical restraint and a medical justification for administering a chemical restraint to manage a behavior and inhibit movement for 1 (Resident 1) of 3 (Resident 1, Resident 2, and Resident 3) of 3 residents reviewed for restraints.</p> <p>These findings have been determined to be Immediate Jeopardy as defined at 42 CFR §483.420(a)(6). The IJ began on 09/07/2025. The survey team provided the State Operations Manuel Appendix Q Immediate Jeopardy template to the Administrator on 09/23/2025 at 2:40 PM. The facility provided a plan of removal on 09/24/2025 at 11:25 AM and was approved on 09/24/2025 at 1:12 PM. The Plan of Removal noted all corrections were completed on 09/24/2025.</p> <p>Findings include:</p> <p>A review of the Face Sheet indicated the facility admitted Resident #1 (R1) with diagnoses that included severe intellectual disability, autism spectrum disorder, seizure disorder, 9P Syndrome (neurological disorder) unspecified disruptive, impulse control, and conduct disorder.</p> <p>Review of the Social History Intake, dated 02/12/2025, revealed Resident #1 had a functional language age equivalent to 2 years. Behaviors exhibited included aggression (biting, scratching, pulling hair, kicking, or hitting), property destruction (flip furniture if frustrated), self-injury (will hit self). Resident #1 ' s current supervision level was 1:1 (one on one supervision) and visual during sleeping hours. A 30-day review was scheduled for 03/18/2025.</p>	W 128			

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W 128	<p>Continued From page 17</p> <p>Review of the 30-day review by Clinical Psychologist (CP #20) dated 03/05/2025 revealed Resident #1 has a significant problem with biting and causing significant injury to those bitten. Resident #1 wears a helmet during the day to prevent resident from biting others. The review included current behavioral information, including a Behavioral Support Plan (BSP) which was in progress with the recommended target behavior of physical aggression. CP #20 recommended the IDT (Interdisciplinary Team) consider initiating a BSP with the target behavior of physical aggression.</p> <p>The Individual Program Plan (IPP) with an implementation date of 04/01/2025, revealed Resident #1 had severe intellectual functioning level, required one on one supervision level, had a targeted behavior of physical aggression, and required a hard-shell helmet as adaptive equipment.</p> <p>The Behavior Support Plan (BSP) with review date of 03/13/2025 and implementation date of 03/20/2025, revealed Resident #1 was a severe biter and had bitten own mother ' s thumb off and the side of a peer ' s face from the eyebrow to jaw. The BSP included, "as soon as client responds to an intervention, there is no need to proceed further." The BSP documented the first intervention is the use of the preventive restraint helmet, which included instruction that staff will follow the schedule set by the IDT (Interdisciplinary Team) and record when the helmet is taken off and put on using a specific form. The BSP included other interventions of positive reinforcement, redirection, separation to allow calming, resident choices, verbal</p>	W 128			

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W 128	<p>Continued From page 18</p> <p>intervention, and separation from setting up to 30 minutes. The prevention and intervention portion documented, staff shall take immediate action to deflect or physically stop Resident #1 from engaging in self-injuries or aggressive behavior using the least restrictive method that is effective in managing behavioral needs. Staff remember their training in facility policies on how to manage behavioral emergencies.</p> <p>Refer to W193 for additional information.</p> <p>During the review of camera footage, staff did not attempt to verbally de-escalate or allow space for R1 after dislodging R1's hand from CNA #5 ' s hair. Staff are observed immediately attempting to place R1 into a personal restraint starting at 6:35 PM. Additional staff arrive to assist and R1 is observed in a personal restraint. At 6:39 PM, R1 is observed in a prone personal restraint until 6:52 PM when R1 is released. R1 lies in a prone position until 6:59 PM, when staff roll R1 onto back and place a pillow under R1 ' s head. R1 ' s last movement was observed at 6:59 PM. At 7:04 PM, RN #7 is observed administering a chemical restraint.</p> <p>A review of a Behavior Report, dated 09/07/2025, revealed Resident #1 had inappropriate behaviors including agitation and psychiatric symptoms. Resident #1 exhibited physical aggression, including hair-pulling. The report documented that the supervisor was called at 6:40 PM and the nurse was called at 6:41 PM.</p> <p>A review of a Restraint Reporting Form, dated 09/07/2025 at 6:43PM, revealed the Authorizing QIDP (Qualified Intellectual Disability Person)/Supervisor on duty was Residential Care</p>	W 128			

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W 128	<p>Continued From page 19</p> <p>Team Supervisor (RCTS) #3. The type of restraint was identified as personal and chemical. Reason for restraint was aggression toward staff. The personal restraint was documented at 6:43PM, including escalating and agitated behavior. The release of restraint was documented at 6:56PM, including a reference that R1 's behavior was beginning to calm. The chemical restraint was documented at 7:04PM, and the other box was marked with the word compliant written. RN (Registered Nurse) #7 documented Geodon 20mg (an atypical antipsychotic medication used to treat schizophrenia and bipolar disorder) IM see nurses' notes. RCTS #3 documented the Administrator was notified at 7:11PM.</p> <p>A review of the debriefing form for the behavior report dated 09/07/2025 indicated Resident #1 received a personal and chemical restraint due to aggression directed towards staff and to prevent escalation again. In the "possible actions by staff to decrease future necessity of restraint" there was no documentation. In the additional comments section documentation states, "immediately after the chemical restraint medical took charge."</p> <p>A review of the EMS (Emergency Medical Services) run report dated 09/07/2025 documented, "...R1 is pulseless and apneic, pupils are fixed and dilated. Facility staff reports that the patient became combative, attempting to bite other residents. Facility staff first attempted physical restraint which was ineffective, so Geodon was administered for chemical restraint. Facility staff have no idea at what point the (patient) stopped breathing and lost pulse. EMS continued CPR (Cardiopulmonary Resuscitation) with chest compressions. AED (Automated</p>	W 128			

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W 128	<p>Continued From page 20</p> <p>External Defibrillator) pad had to be reapplied in the proper position as they were initially over the abdomen ..."</p> <p>A review of text message 09/07/2025 at 6:48 PM, RN #7 sent to PAPER #21 indicated R1 was in a burrito (humane wrap) now and was being combative and aggressive and not calming down with redirection. A review of video footage indicates R1 was never placed in a humane wrap. PAPER #21 responded with an order for Geodon 20mg IM. (Geodon is an atypical antipsychotic medication, which is used to treat schizophrenia and bipolar disorder.)</p> <p>A review of physician's drug orders, dated 09/07/2025 at 6:48PM, revealed an order for Geodon 20mg (milligrams) IM (intramuscular) injection now.</p> <p>A review of September 2025 Medication Administration Record (MAR) revealed RN #7 documented Geodon 20mg was administered to R1 at 7:04PM.</p> <p>A review of a chemical restraint observation form dated 09/07/2025 at 7:04PM, documented R1 received Geodon 20mg and instructed the reader to see nurses ' notes. The form has starred information stating, "if any signs or symptoms of an adverse reaction are noted, vital signs are to be obtained, and the MD/Psychiatrist is to be notified immediately. If at any time the client is noted to be having respiratory distress, then 911 should be called immediately and the nurse is to remain with the client till the ambulance arrives."</p> <p>A review of a Nursing Note dated 09/07/2025 at 6:41 PM, revealed RN #7 documented, "Staff</p>	W 128			

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W 128	<p>Continued From page 21</p> <p>called the mini clinic to report a MIPIR being completed for resident biting tongue during a behavior. Upon arrival to unit resident being PR ' d (personal restraint). R1 bleeding from mouth observed. Psychiatric Advanced Practice Registered Nurse (PAPRN) #21 contacted @ (at) 18:48pm (6:48PM) and order given for Geodon 20mg IM. Left the unit to get chemical restraint." The nurse ' s note was signed by RN #7.</p> <p>A review of a Nursing Note dated 09/07/2025 at 7:03 PM revealed, "Arrived back to unit. Resident was still in personal restraint. Resident was laying on back and repositioned to the side. Pulse was checked and noted. Geodon 20mg was given IM in right gluteal @ (at) 19:04PM (7:04PM)." The nurse ' s note was signed by RN #7.</p> <p>A review of a Nursing Note dated 09/07/2025 at 7:05 PM documented, "Sternal rub done. Resident was unresponsive, noted to not be breathing. CPR started, AED obtained by [LPN #6]. AED applied, CPR continued. 911 had been called by [LPN #6]. CPR continued to ambulance crew arrived. Ambulance crew took over resident care at this time." The nurse ' s note was signed by RN #7.</p> <p>A review of a Nursing Note dated 09/07/2025 at 7:30 PM documented, "Resident was pronounced deceased by ambulance crew through [Medical Doctor #23] at 19:30pm (7:30PM). Registered Nurse Manager (RNM) notified. Administrator notified by RNM at 19:59 (7:59PM) mom notified per RNM." The nurse ' s note was signed by RN #7.</p> <p>A review of Case Note dated 09/07/2025 revealed the RNM notified R1 ' s mother of the resident's</p>	W 128			

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W 128	<p>Continued From page 22</p> <p>passing, and that the funeral home would be picking up the body and contacting the mother.</p> <p>Maltreatment Investigator During concurrent review of cameras review footage and interview on 09/10/2025 at 2:48 PM, the Maltreatment Investigator (MI) verbalized staff did not do the restraint correctly. The MI confirmed at 6:44:06 PM of video Certified Nursing Assistant (CNA) #8 was observed with right hand on R1 ' s back, and then CNA #10 leans forward, placing their forearm on R1 ' s back. The MI verbalized CNA #10 appears to be placing elbow in R1 ' s back and shifting own weight onto R1 ' s back. The MI was asked why R1 received an injection when the resident was not combative, the MI verbalized, "I can ' t answer that."</p> <p>Quality Assurance Coordinator During concurrent review of camera and interview on 09/10/2025 at 2:53 PM, the Quality Assurance Coordinator (QAC) verbalized the restraint being observed was incorrect due to R1 being on their stomach (prone). The QAC verbalized CNA #8 ' s hold should have been on the shoulders or wrist, not on R1 ' s back. The QAC reported the arm on the back can restrict a residents ' breathing.</p> <p>During a follow-up interview on 09/11/2025 at 11:07 AM, the QAC reported working at the facility for 23 years. The QAC confirmed being the CPI (Crisis Prevention Intervention) instructor and previous review of the video indicated the restraint was performed incorrectly. The QAC confirmed teaching protocols are for the residents ' back to be on the ground, and staff are to hold arms and legs, not their back. The QAC verbalized if the restraint is done incorrectly, then</p>	W 128			

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W 128	<p>Continued From page 23</p> <p>the staff should release and restart if another restraint is necessary.</p> <p>RCS #2 During an interview on 09/11/2025 at 1:48 PM, RCS #2 reported working at the facility since 2010. RCS #2 reported being the supervisor of unit 17. RCS #2 confirmed completion of CPI (Crisis Prevention Intervention) training.</p> <p>When asked about proper restraint procedures, RCS #2 stated that a resident should be on their back and not on their stomach. RCS #2 verbalized if a resident is restrained on their stomach, it could cause breathing difficulties. RCS #2 continued to state the appropriate hold positions include one person holding the head, one person holding each arm and one person holding the legs.</p> <p>CNA #1 During an interview on 09/11/2025 at 2:31 PM, CNA #1 reported working at the facility for approximately 5-6 months. CNA #1 reported completing Phase I training, which was described as covering the policies and procedures of the facility. CNA #1 also enrolled in a CNA course at the facility but did not pass the class. CNA #1 confirmed completion of CPI (Crisis Prevention Intervention) training.</p> <p>When asked about proper restraint procedures, CNA #1 stated that a resident should not be restrained in a prone (stomach-down) position. CNA #1 noted the resident's face should be visible, facing the staff, and the upper body should be elevated. CNA #1 indicated that restraining a resident in a prone position is prohibited because it may lead to choking on their</p>	W 128			

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W 128	<p>Continued From page 24</p> <p>tongue. CNA #1 confirmed that R1 was restrained in a prone (face-down) position for a period estimated at lasting 5 to 10 minutes.</p> <p>Residential Case Supervisor #4 During an interview on 09/11/2025 at 3:20 PM, Residential Case Supervisor (RCS) #4 reported working for the facility for nearly 6 years and holding a CNA license for approximately 3 years.</p> <p>Upon arrival in House 17 where R1 resides, RCS #4 reported observing R1 in a physical restraint on the ground, face-down. RCS #4 reported the restraint team needed assistance due to R1 ' s continued kicking, RCS #4 joined the restraint by securing R1 ' s legs. RCS #4 held the legs between the calf and ankle area while R1 remained prone with R1 ' s knees on the ground. No one at the time suggested repositioning R1. R1 remained in the prone position for approximately ten minutes after RCS #4 arrived. R1 continued to resist until CNA #5 asked if R1 was calm and ready to go to bed. R1 made a grunting sound, and shortly afterward, R1 appeared to calm down. The team then released R1 from the restraint.</p> <p>RCS #4 reported that after the resident was released, R1 remained lying on stomach with eyes closed. R1 made no further vocalizations but did move head slightly. RCS #4 reported checking for signs of life by placing a finger near nose to detect airflow and using two fingers on the left side of neck to check for a pulse, which was faint but present. RCS #4 believed a nurse also checked on R1 but could not recall which one.</p> <p>RCS #4 reported 5-10 minutes later a nurse</p>	W 128			

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W 128	<p>Continued From page 25</p> <p>returned to administer a chemical restraint. RCS #4 assisted in rolling R1 on side for the injection and then returned to supine (on back) position. LPN #6 expressed concern that R1 was not breathing. LPN #6 checked for breathing and a pulse. Upon confirming there was no pulse, RN #6 initiated CPR.</p> <p>RCS #4 verbalized staff should have turned R1 on back and the outcome may have been different.</p> <p>Residential Care Team Supervisor #3 During an interview on 09/11/2025 at 4:20 PM, Residential Care Team Supervisor (RCTS) #3 reported holding a CNA license since 2017 and having been employed at the facility since 2003, totaling nearly 23 years of service. RCTS #3 had worked in their current position for approximately 3-4 years. RCTS #3 identified that the proper position for a grounded physical restraint is for the residents to be on their back, with arms and legs secured.</p> <p>RCTS #3 remembered RN #7 checking R1 for breathing before administering the chemical restraint at approximately 7:04 PM. At that point, staff rolled R1 onto left side for the injection, which was administered into the resident 's right side. R1 was then rolled back onto back. The staff member noted that R1 showed no movement after being repositioned. RCTS #3 either looked at or touched R1 and then directed LPN #6 to check R1 's condition. When asked, RCTS #3 confirmed they had observed R1 in a restraint but could not recall the specifics of how R1 was being held. They were certain, however, that R1 was lying on his back when positioned for the chemical restraint.</p>	W 128			

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W 128	Continued From page 26 RCTS #3 did not observe any behavioral outbursts between the release of the physical restraint and the administration of the chemical restraint. RCTS #3 could not specify the duration between the two events. RCTS #3 assisted in rolling R1 for the injection but did not recall if R1 resisted being moved. RCTS #3 reported signing off on the monitoring form, after being informed that R1 had been released from the physical restraint. RCTS #3 confirmed being present for the chemical restraint and signed the documentation accordingly, though RCTS #3 expressed discomfort with doing so. RCTS #3 relied on CNA #5 for time tracking and reported that all notes were sent to the Administrator and that their own documentation was stored in their locker. RCTS #3 stated they did not witness the position R1 was in at the time of restraint release but confirmed that R1 was on the resident 's back during the chemical restraint. LPN #6 During an interview on 09/11/2025 at 5:10 PM, Licensed Practical Nurse (LPN) #6 reported working for the facility for 12 years, with the last 2 years as an LPN. LPN #6 previously worked as a direct care staff and then moved into a supervisor position before becoming a nurse. LPN #6 verbalized as an LPN, the primary responsibility upon receiving notification of a restraint is to respond immediately to the location of the incident. Upon arrival, the nurse is responsible for assessing the client involved in the restraint. This includes observing the client's physical condition, checking for signs of proper circulation, and ensuring the client's overall safety throughout the restraint process. In situations	W 128			

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W 128	<p>Continued From page 27</p> <p>where a restraint occurs on the ground, the expected and proper position for the client is supine (lying flat on the back) unless the client is seated upright. The supine position is preferred for safety and monitoring purposes.</p> <p>LPN #6 denied direct observation of R1 in a personal restraint. LPN #6 denied a supervisor being present during the alleged personal restraint. LPN #6 reported a resident must be a threat to self or others to receive a chemical restraint. LPN #6 denied R1 to be a threat to self or others and LPN #6 's presence in the unit was for the purpose of support as R1 was not an assigned patient.</p> <p>RN #7 During an interview on 09/15/2025 at 2:40 PM, RN #7 reported working for the facility for approximately 6 years. RN #7 reported working as an LPN prior to obtaining RN license. RN #7 verbalized duties did not change in current position when becoming an RN. RN #7 reported training received included CPR and CPI.</p> <p>RN #7 reported receiving a call that R1 had a behavior and had bitten their own lip and was bleeding. RN #7 reported upon entering the unit, R1 was not in a restraint, was awake, and there was no blood. RN #7 verbalized R1 was on the floor, laying on back, looking like normal self. RN #7 reported there were two male staff standing around R1.</p> <p>RN #7 reported contacting PAPER #21 to notify R1 was having a behavior but did not observe the behavior. RN #7 reported receiving orders for a chemical restraint from PAPER #21. RN #7 reported going back to the mini clinic to obtain the</p>	W 128			

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W 128	<p>Continued From page 28</p> <p>chemical restraint. After obtaining the chemical restraint and returning to the unit, RN #7 stated R1 was still awake and laying on the floor. RN #7 reported checking R1 ' s pulse and then gave the chemical restraint. RN #7 stated after administering the chemical restraint things went downhill, they performed a sternal rub and started CPR. RN #7 reported someone took over CPR and RN #7 left to get AED pads. RN #7 reported placing the AED pads on R1. When asked whether an assessment of Resident R1 was completed prior to administering the chemical restraint, RN #7 stated that R1 was visually observed but a full head-to-toe assessment was not performed. A pulse was checked in both the neck and arm, but respirations were not counted.</p> <p>When questioned about contacting PAPRN #21 without personally witnessing the behavior, RN #7 explained that PAPRN #21 is notified any time a behavior occurs. Regarding the facility ' s protocol for obtaining a chemical restraint, RN #7 stated that staff notify the PAPRN about the behavior , and if a medication order is received, it must be administered as ordered. When asked whether R1 was a danger to self or others at the time the chemical restraint was administered, RN #7 responded that R1 was not. When RN #7 was asked why the chemical restraint was administered when R1 was not a threat to self or others, RN #7 stated that once a doctor issues an order, the medication must be given as prescribed. RN #7 was asked if allowed to call PAPRN back and inform the resident was no longer having a behavior and RN #7 responded with "I am just doing what I am told to do and if we get an order, then we are required to give the medication."</p>	W 128			

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W 128	<p>Continued From page 29</p> <p>RCTS #9 During an interview on 09/16/2025 at 1:33 PM, RCTS #9 reported having worked at the facility for 13 years. RCTS # 9 confirmed receiving restraint training, CPR, and CPI. RCTS #9 stated there were behaviors from multiple residents on 09/07/2025. RCTS #9 reported that when residential services received a call requesting assistance in the unit, RCTS #3 and RCS #4 went to that unit and RCTS #9 went to other behaviors on campus. RCTS #9 reported bringing the humane wrap to the unit. RCTS #9 reported observing R1 personally restrained on stomach. RCTS #9 verbalized the proper way to restrain a resident is one their back and in a humane wrap on their side. RCTS #9 verbalized a supervisor is required to monitor all restraints and RCTS #3 was the supervisor for that unit.</p> <p>CNA #8 During an interview on 09/16/2025 at 6:21PM, CNA #8 reported having worked at the facility for approximately one year and confirmed that they had not yet completed the certified nursing assistant exam. CNA #8 confirmed that they assisted CNA #10 in trying to separate R1 from CNA #5 ' s hair. During the incident, CNA #8 and CNA #10 physically held R1 down until additional help arrived. CNA #8 reported that RCS #2 exited the office, at which point they attempted to release R1. However, R1 continued to roll side to side, kicked, and tore CNA #10 ' s shirt. R1 was then placed into a personal restraint.</p> <p>CNA #8 stated that R1 was lying on their stomach and that both they and CNA #10 were holding R1 ' s arms. CNA #1 and RCS #4 later arrived to assist with the restraint. CNA #8 acknowledged placing their right arm and elbow on R1 ' s back</p>	W 128			

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W 128	<p>Continued From page 30</p> <p>but stated this was solely to reposition themselves. CNA #8 recalled that after R1 was released from the restraint, the resident remained in the same position, with their buttocks up for the administration of a chemical restraint. CNA #8 confirmed that R1 had been physically restrained in a prone (stomach-down) position for approximately 10 to 11 minutes prior to receiving the injection.</p> <p>Registered Nurse Manager During an interview on 09/17/2025 at 1:35PM, the Registered Nurse Manager (RNM) reported working for the facility since 1998. The RNM reported nurses ' responsibilities during a restraint are to monitor the resident by observing skin color, respirations, ensure the restraint is not too tight, and ensure the resident is properly placed on their back and not their stomach.</p> <p>The RNM reported that the resident ' s behavior needs to be out of control such as a danger to self or others prior to calling the PAPRN for a chemical restraint. The RNM reported that if a resident has calmed down and is no longer a threat to self or others, the nurse can contact PAPRN to notify the residents change of condition and inform a chemical restraint is no longer necessary.</p> <p>The RNM was asked, "What was R1 ' s condition at the time the chemical restraint was administered?" RNM replied, "I don ' t know if R1 was unconscious or deceased, but I do know R1 was not having a behavior at that time."</p> <p>Assistant Administrator During an interview on 09/18/2025 at 10:28 AM, the Asst Admin (Assistant Administrator)</p>	W 128		

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W 128	<p>Continued From page 31</p> <p>verbalized RCTS #3 was the QIDP (Qualified Intellectual Disability Professional) designee on duty. The Asst Admin indicated the QIDP can approve restraints after regular business hours, weekends and holidays. The Asst Admin verbalized the QIDP is responsible for following the regulations and ensure compliance with the restraint and the restraint procedures. The Asst Admin verbalized there is a QIDP designee during evenings and weekends due to QIDPs travelling a long distance and the restraint would be over by the time one would arrive. The QIDP designees have more than a years ' experience and are upper-level residential supervisory staff.</p> <p>During a follow-up interview on 09/19/2025 at 10:27 AM, the Asst Admin (Assistant Administrator) verbalized the facility does not train staff to restrain residents on their stomach and when a nurse receives an order for a chemical restraint, it is not explicitly required by policy that the medication must be administered (if n ot required). Chemical restraints are treated the same as any other form of restraint under facility policy. According to the policy, once a client is deemed calm, all forms of restraint, physical or chemical, should be discontinued. Therefore, if the client appears calm and no longer presents a risk, the nurse is not obligated to administer the chemical restraint, even if an order was given. However, this discretion is not clearly outlined in the written policy. The Asst Admin reported R1 had not been combative for approximately 15 minutes when R1 received the chemical restraint. The Asst Admin reported R1 appeared to be unconscious and not combative when R1 received chemical restraint. The Asst Admin reported the initial restraint lasted approximately 7-8 minutes, then there was a skip in the video.</p>	W 128			

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W 128	<p>Continued From page 32</p> <p>When the video resumed, R1 was restrained on stomach approximately another 7-8 minutes.</p> <p>Maltreatment Administrator During an interview on 09/18/2025 at 3:28 PM, the Maltreatment Investigator (MI) reported working for the facility approximately 14 years. The MI reported being in the current position since 2019. The MI reported R1 was fighting in supine position in one portion of the video then the video skipped. When the footage resumed, R1 was in a prone position. The MI stated staff should not have placed R1 in a prone position personal restraint. The MI reported R1 should have been left alone after being released from CNA #5 's hair. The MI reported CNA #8 appeared to have placed arm on R1 's back a couple of times and CNA #8 should not have placed body weight on R1. The MI reported R1 appeared to be unconscious when staff rolled R1 into a prone position, had a bruise on right cheek, and R1 was discolored. The MI reported R1 did not move after being rolled onto back. The MI reported the nurses never checked on R1 until R1 received the chemical restraint. The MI reported it appeared R1 was not a threat to self or others and should not have received the chemical restraint. The MI reported R1 appeared to be unconscious at the time the chemical restraint was received. The MI reported after receiving the chemical restraint, R1 's arm was over face. LPN #6 moved R1 's arm and the arm flopped down. At that point, RN #7 realized R1 was not breathing and initiated CPR.</p> <p>Administrator During an interview on 09/19/2025 at 1:03 PM, the Administrator (Admin) reported working approximately 22 years in the Developmental</p>	W 128			

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W 128	Continued From page 33 Disability Service division with approximately 19 years being at this facility, the last 8.5 years in the Administrator role. The Administrator recalled review of camera footage revealed that during restraint, R1 was in the prone position, the restraint staff released R1 and stepped away. R1 laid prone for approximately 10 minutes. During that time, several staff physically assessed R1 and from their behavior they did not recognize that R1 was in distress. "In my initial review of camera footage, I was focused on making sure no one had intentionally committed harm or committed anything that was maltreatment." At one point, staff rolled R1 into a supine position and placed a pillow under R1 ' s head. The nurse reentered the frame and staff assisted in rolling R1 on side and, "you cannot see but I assume that is when the chemical was given." The Admin continued verbalizing that shortly thereafter, LPN #6 evaluated and from the reaction of staff they recognized R1 was in distress. The Admin stated staff moved to begin CPR and stopped reviewing the video. The Admin was asked if R1 was a danger to self or other when receiving the chemical restraint and the Admin stated, "with the caveat that I am not licensed, but based on my experience as Administrator, I would say R1 ' s behavior warranted an emergency intervention." The Admin stated the main concern was that R1 was restrained in an unsupported prone position for a significant amount of time. CPI, which is taught at this facility, is used for brief and temporary restraint. The Admin reported the details of R1 going from supine to prone are missing due to the video skipping. The Admin commented that staff did check to ensure R1 was breathing, and by staff ' s reaction, R1 was not in distress. The Admin verbalized R1 had lighting changes on skin, presumably indicating the	W 128			

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W 128	<p>Continued From page 34</p> <p>resident was breathing, but did not observe any large muscle movement.</p> <p>Psychiatric Advanced Practice Registered Nurse During a phone interview on 09/23/2025 at 12:56 PM. PAPRN #21 revealed receiving incorrect information from RN #7. PAPRN #21 verbalized being informed R1 was in a mechanical restraint. After speaking with Administration, PAPRN #21 was informed R1 was never in a mechanical restraint and was only placed into a personal restraint. PAPRN #21 indicated once a resident is no longer a threat to self or others, the nursing staff are not required to administer a chemical restraint as ordered but to call PAPRN #21 back and inform of the resident 's change in behavioral condition no longer requiring a chemical restraint. PAPRN #21 verbalized R1 should never have received the chemical restraint due to the length of time R1 had not been combative.</p> <p>Clinical Psychologist During an interview on 09/23/2025 at 1:33 PM, the Clinical Psychologist (CP) #20 stated being the person that reviews all behavior reports to track and trend resident behaviors. CP #20 indicated using behavior report information to assist in developing behavior support plans for residents. CP #20 reported reviewing R1 's behavior report for the incident on 09/07/2025. During CP #20 's review, the report did not indicate R1 was in a mechanical restraint only a personal restraint and receiving a chemical restraint. CP #20 stated previously speaking with PAPRN #21 and was informed R1 received a chemical restraint due to being a mechanical restraint. CP #20 stated immediately notifying the Assistant Administrator there was a discrepancy</p>	W 128			

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W 128	<p>Continued From page 35</p> <p>in the behavior report and what was reported to P APRN #21. CP #20 verbalized being a mandated reporter and felt the discrepancy should be reported to administration.</p> <p>Resident 2 During an interview on 09/29/2025 at 12:54 PM, Resident 2 (R2) reported being present on 09/07/2025 during the incident with R1. R2 verbalized when staff rolled R1 onto back after the release of the restraint, R2 informed staff R1 was not breathing. R2 indicated staff were afraid to do CPR.</p> <p>Policies Review of a policy titled, "Emergency Chemical Intervention," indicated the facility is committed to managing inappropriate behaviors and psychiatric symptoms that place the individual or others in danger using the least restrictive techniques. Emergency Chemical Intervention will not be used as a punishment, in lieu of programming or for staff convenience.</p> <p>It included the procedure:</p> <ol style="list-style-type: none"> 1. When an individual exhibits dangerous behaviors or their behavior indicates that dangerous behavior will soon follow, staff will contact the nurse on duty. <ol style="list-style-type: none"> a. The nurse will contact the Psych APRN, OR MD for further orders. 2. Staff working with the individual will note the use of Emergency Chemical Intervention on the Behavior Report Form and the Restraint Form. The nurse will document on the form her initial and the time given. 	W 128		

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W 128	<p>Continued From page 36</p> <p>3. Guardians will be notified of the use of Emergency Chemical Intervention by the nurse.</p> <p>4. The nurse will observe the client for any signs or symptoms of an adverse reaction to the Emergency Chemical Intervention at 15minutes after, 30minutes after, 1 hour after, and 4 hours after the Emergency Chemical Intervention. This is to be documented on the Emergency Chemical Intervention form.</p> <p>5. If any signs or symptoms of an adverse reaction are noted, vital signs are to be obtained, and the MD notified immediately. if at any time the client is noted to be having any respiratory distress then 911 should be called immediately, and the nurse is to remain with the client till the ambulance arrives.</p> <p>Review of a policy titled, "Use of Restraints," indicated the facility is committed to managing the dangerous behaviors of clients that place the safety of the client and/or others at risk by using the least restrictive interventions that are effective in managing the behavioral situation. While the elimination of dangerous behaviors is sought using positive behavior interventions and de-escalation techniques, it is acknowledged that clients may not always respond to these interventions and the dangerous behavior may escalate to an emergency situation in which physical and/or chemical restraint may be required to protect the safety of the client and/or others.</p> <p>Procedures provided included:</p>	W 128			

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W 128	Continued From page 37 1. Authorization a. The QIDP or Supervisor on Duty will ensure that the least restrictive interventions are used to effectively manage the behavioral situation. b. Personal Restraint i. Must be authorized by the QIDP or Supervisor on Duty ii. If staff is unable to call for authorization before the personal restraint is applied, staff will call the QIDP or Supervisor on Duty for authorization as soon as safely possible after the restraint is applied. c. Mechanical Restraint i. Must be authorized by the QIDP or Supervisor on Duty ii. If staff is unable to call for authorization before the mechanical restraint is applied, staff will call the QIDP or Supervisor on Duty for authorization as soon as safely possible after the restraint is applied. iii. The QIDP or Supervisor on Duty will notify the Superintendent/designee of the restraint use as soon as possible d. Preventive Restraint i. The client's Interdisciplinary Team ("IDT") determines if a preventive restraint (e.g., padded mittens) or restrictive clothing (e.g., a singlet body suit) is necessary to prevent or inhibit maladaptive behaviors (e.g., chronic skin picking; rectal digging and fecal smearing) that may place the client at greater risk of injury (e.g., infection due to reduced skin integrity). ii. Preventive Restraint is not used in an emergency situation; rather, it is used to prevent or inhibit maladaptive behaviors.	W 128			

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W 128	<p>Continued From page 38</p> <p>iii. The IDT will specify when the preventive restraint will be applied and when it will be removed. Times will be documented on a form specifically designed for the client and the device.</p> <p>iv. The use of Preventive Restraint will be documented in the client's Individual Program Plan.</p> <p>e. Chemical Restraint</p> <p>i. Must be ordered by the physician/psychiatric nurse practitioner</p> <p>ii. Nurse will administer as per doctor's/Psych APRN's order and authorization</p> <p>iii. Nurse will notify the Superintendent/designee as soon as possible</p> <p>2. Monitoring</p> <p>a. Personal Restraint</p> <p>i. Constant visual monitoring by staff is required while the client is in personal restraint</p> <p>b. Mechanical Restraint</p> <p>i. Constant visual monitoring by staff is required while the client is in mechanical restraint</p> <p>ii. The QIDP or Supervisor on Duty and a licensed nurse must assess the restraint incident face-to-face every 15 minutes to monitor the client for signs of distress and to ensure restraint integrity to optimize the safety of the client. Constant in-person monitoring of the restraint by the QIDP or Supervisor on Duty and a licensed nurse is preferred.</p> <p>c. Preventive Restraint</p> <p>i. Staff will monitor client for signs of distress and the integrity of the preventive restraint throughout the day as they go about their</p>	W 128			

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W 128	Continued From page 39 routine care of clients. This monitoring of the client and restraint integrity is to optimize the safety of the client. d. Chemical Restraint i. A licensed nurse will follow-up with the client per nursing guidelines. ii. NOTE: The licensed nurse must initial the Restraint Reporting Form when the chemical restraint was administered. The Policy titled Rights of Clients Served by The Facility (Facility 23) read in part " ... Individuals will be free from mental and physical abuse and free from physical and chemical restraints. Restraints can be temporarily ordered by a physician for medical purposes or to promote healing, applied in an emergency to prevent injury to the client and to others, as part of the Behavioral Support Plan or Health/Safety Plan. Emergency programmatic application of restraint requires authorization of a QIDP for continuation and extension ...As a resident you have the right to be: free from mental, physical, verbal and sexual abuse ...free from chemical and physical restraints except when authorized in writing by a physician for a specific and limited period of time, or by a QIDP only to protect you or others from injury ...Every resident has the right to:...privacy during treatment and care of personal needs. People not involved in the care of residents shall not be resident without the consent from the resident during examinations and treatment ..."	W 128			
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit	W 149			

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W 149	<p>Continued From page 40</p> <p>mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on record observation, record review, and interview, the facility failed to ensure that one (Resident #1) of three sampled residents failed to implement their policy and procedure to provide a helmet as ordered to prevent staff abuse and neglect which resulted in sustained injuries and client demise.</p> <p>The findings are:</p> <p>In an interview on 09/19/2025 at 10:27 AM, having reviewed camera video on the morning of 09/08/2025, the Assistant Administrator (Asst Admin) verbalized the following:</p> <p>The Asst Admin indicated not being informed of the 09/07/2025 incident until the morning of 09/08/2025, having just returned from vacation, from the Administrator.</p> <p>After reviewing the camera video, Asst Admin recalled that Resident #1 had been in a sofa chair with legs crossed, and the C.N.A #5 had picked up the client ' s shoes and blanket and bent down. Next to Resident #1, there was another staff member and Resident #2. Resident #2 had tapped the C.N.A #5on the leg with (the resident ' s foot, and then Resident #1 grabbed C. N.A. #5 ' shair toward the left side of face. C.N.A. #10, who was sitting next to Resident #1, jumped in to remove the client ' s grasp from the hair. As Resident 1 pulled C.N.A. #5 closer, the chair Resident #1 was seated in went backwards. Then C.N.A. #8 came to assist. RCS #2 came out of the restroom and appeared to be trying to speak to Resident 1 to calm them. RCS #4 and C.N.A. 1 came to assist from another residential home.</p>	W 149			

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W 149	<p>Continued From page 41</p> <p>Resident #1 was on their back kicking and a clump of C.N.A. #5 ' s hair that could be seen on the resident ' s leg in the video.</p> <p>The Asst Admin continued to state RCS #4 had Resident #1 ' s ankle area, C.N.A. #8 was on the resident ' s left side, C.N.A. #10 and C.N.A. #1 were on the resident ' s right side. There is a two-to-three-minute video outage. The video resumes and Resident #1 is lying prone. The resident ' s feet are kicking, and their back is arched. C.N.A. #8 and C.N.A. #10 are rubbing Resident #1 ' s back. I could not tell the exact location of the staff holding for a physical restraint before the outage and after as the video and the floor is dark, and all four staff members are African American and dark. I could not tell if anyone placed weight on Resident #1 ' s back.</p> <p>C.N.A. #1, #8, #10 and RCS #4 release Resident #1 and stand up. Resident#1 ' s left arm is bent at the elbow, RCS #4 stayed in the area, and C.N.A. #1 left.</p> <p>During the initial restraint, Registered Nurse (RN) #7 and Licensed Practical Nurse (LPN) #6 came in during the physical restraint. RN #7 is seen on the phone, and they both leave. When they came back, the Asst Admin reported being unable to tell if the physical restraint had ceased. C.N.A. #1 had reentered the unit and appeared to be assessing Resident #1 for breathing. RCS #4 touched Resident #1 to check for breathing. At some point Resident #1 had flipped over, and their head now was on a pillow. When RN #7 and LPN #6 came back in the residential home, Resident #1 appeared unconscious before receiving the chemical restraint. Resident #1 ' s</p>	W 149			

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W 149	<p>Continued From page 42</p> <p>eyes were closed, and legs were not kicking. LPN #6 had checked Resident #1 ' s mouth for air exchange and felt the right side of the resident ' s neck and a flurry of action began to do CPR. The Asst Admin recalled that at least ten people were present. The RCTS #3 had been in and out of the house, and RCS #2, the other supervisor had left and then came back.</p> <p>The Asst Admin reported Resident #1 had not been in the restraint for maybe eighteen minutes, physical restraint had been on for sixteen minutes. The gap where the video stopped, they had released Resident #1, and Resident #1 attacked another staff member. So, it must have been eight minutes on the resident ' s back, seven minutes on stomach, and a two-to-three-minute video gap.</p> <p>The Asst Admin was asked if the resident had worn a helmet and stated that Resident#1 had a hard helmet and a face guard, and it prevented biting. Resident#1 had bitten their mother and two staff members. One of the staff members had a broken thumb, and the bite was infected with an antibiotic resistant pathogen. The other staff member was still working, but on light duty from a bite that resulted in nerve damage. Resident #1 ' s helmet was a hard shell with a clear type of molding frame with an opening in the center part. The Asst Admin did not recall seeing the helmet in the video and was not aware as to whether the helmet was on, remembering that Resident #1 had previously been wearing the helmet, but the IDT had decided that the resident ' s behavior no longer required the helmet. After Resident #1 had bitten staff members on 07/02/2025, there was a special IDT (interdisciplinary team), completed on 7/3/2025. The Asst Admin stated</p>	W 149			

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W 149	<p>Continued From page 43</p> <p>that if Resident #1 had been wearing the helmet, the behavior would have still been there, but it would have prevented them from biting.</p> <p>The Asst Admin was asked how the direct care staff knew how to take care of the client and stated that it is called an IPP (Individual Program Plan), and it comes from residential services. The residents have a book in the unit, and it is in a simple format for the direct care staff and any floating staff. The book has color pictures with the level of care, and other information to include diet, adaptive equipment, behavioral plan and history, any triggers, as well as favorite activities. In other words, the IPP is in a shortened format for rapid review.</p> <p>When asked how changes are implemented for the care plan, the Asst Admin stated that if there is a change in behavior or physical condition, it is related to the direct care for changes in the treatment plan?" The Asst Admin stated that it is called a special IDT, and the narratives and recommendations are sent to the residential department for the supervisors to in-service the staff on programmatic changes. They will have each staff member in the residential home to read and then sign the in-service. There will be a signed in-service sheet, kept in the resident 's folder in the home and Quality Assurance keeps track of the training, and offered to provide the staff signed in-service (BSP) from the special IDT on 7/03/2025.</p> <p>In an interview with the Administrator on 09/19/2025 at 1:03PM, having reviewed camera video on the night of 09/07/2025, and considered, the Administrator verbalized being notified on 09/07/2025 at 7:11 PM by the Registered Nurse</p>	W 149			

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W 149	<p>Continued From page 44</p> <p>Manager (RNM) and the Residential Care Team Supervisor (RCTS) #3 of the incident involving Resident #1, as the administrator was on call. The Administrator observed C.N.A. #5 prompting Resident #1 by bending down. Resident #1 grabbed C.N.A. #5 ' s hair and then attempted to bite C.N.A. #5 on the neck. C.N.A. #5 placed a hand on Resident #1 to prevent it, while two staff restrained the resident in a [special] chair on a sofa. Resident #1 then placed both legs on C.N.A. #5 ' s hips pushing and kicking, pulled out the CNA ' s hair and moving backwards, causing the chair to fall back. Resident #1 had been restrained, and new staff came in the house. C.N.A. #1 was one of the additional staff. Resident #1 continued to attack [in a supine position]. There was an approximate video skip of two minutes. Resident #1 was now in a prone position when camera resumes. RCTS #9 brought in a humane body wrap, but it was never applied. Resident #1 was restrained in a prone position for about ten minutes and then staff stepped back. There were no concerns, no maltreatment observed with gestures of staff assessment. Staff rolled Resident #1 to the left, the resident was not in any distress and, the RN7 administered a chemical restraint. When CPR began, the Administrator reported they turned off the camera video. The Administrator was asked if able to provide the in-service of the IDT with the change to the BSP that had been signed by the staff members from the special IDT, dated 7/3/2025, to reinstate Resident #1 ' s helmet to prevent biting, as per policy.</p> <p>The Administrator provided the in-service which indicated two employees had read and signed the change to Resident #1 ' s IPP. None of the ten staff members involved in the physical or</p>	W 149			

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W 149	<p>Continued From page 45</p> <p>chemical restraint or had participated in Resident1 ' s care during the day of 09/07/2025 had signed the revision in reference to Resident #1 wearing a helmet to decrease biting.</p> <p>The Interdisciplinary Team (IDT) meeting dated 07/03/2025 signed by Health Program Coordinator (HPC) #13, Clinical Psychologist (CP) #20, Psychiatric Advanced Practice Registered Nurse (PAPRN) #21, Residential Director (RD), RN #12, and Resident ' s Mother vis telephone indicated the IDT had ordered that Resident #1 ' s helmet be applied due to continued behavior of biting.</p> <p>The policy Special Interdisciplinary Team Meetings read in part " ...Service providers may submit additions/changes or deletions of objectivities or other programmatic areas of an individual ' s IPP. The Case Manager will review the Objective Action Form and schedule a special Interdisciplinary Team meeting as necessary (change of medical condition, behavior, or other individual personal items). The case manager types up the case minutes, If the team determines that there is a recommendation/service objective behavioral objective, the Case Manager should ensure that this is included in the IDT sign-in-sheet. The recommendation /service objective should have a number continued from the current IPP with a service provider, implementation and completion date. The end date of this should be the ending date of the IPP. The Case Manager will place the addendum information on the individuals Monthly Plan Review for monthly monitoring. The Administrative Specialist will copy and distribute the addendum to the appropriate staff. The original addendum will be routed to the Records</p>	W 149			

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W 149	Continued From page 46 Room for placement in the individuals master record. " The Policy titled Rights of Clients Served by The Facility (Facility 23) read in part " ... Individuals will be free from mental and physical abuse and free from physical and chemical restraints. Restraints can be temporarily ordered by a physician for medical purposes or to promote healing, applied in an emergency to prevent injury to the client and to others, as part of the Behavioral Support Plan or Health/Safety Plan. Emergency programmatic application of restraint requires authorization of a QIDP for continuation and extension ...As a resident you have the right to be: free from mental, physical, verbal and sexual abuse ...free from chemical and physical restraints except when authorized in writing by a physician for a specific and limited period of time, or by a QIDP only to protect you or others from injury ...Every resident has the right to:...privacy during treatment and care of personal needs. People not involved in the care of residents shall not be resident without the consent from the resident during examinations and treatment ..."	W 149			
W 158	FACILITY STAFFING CFR(s): 483.430 The facility must ensure that specific facility staffing requirements are met. This CONDITION is not met as evidenced by: Based on observations, interviews, and record review the facility failed to ensure adequate qualified staff to ensure all clients are provided with appropriate interventions based on Individual Program Plans, and failed to ensure all staff were properly trained in chemical and physical restraint techniques and failed to supervise and prevent	W 158			

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W 158	Continued From page 47 the death of one resident during a restraint. (Cross Reference W186, W193) The cumulative effect of these systemic problems resulted in the Condition of Participation, Facility Staffing being found as not met. (W186) Based on record observations, interviews, and record reviews the facility failed to ensure there were sufficient staff present to respond to a behavioral event in accordance with the Individual Program Plan (IPP), to supervise and prevent death for one resident (Resident #1) sampled from case mix (Resident #1, #2, and #3) during a physical and chemical restraint. (W193) Based on interviews, record review, facility document review, facility policy review, and facility camera footage it was determined that the facility failed to demonstrate staff adequately administered interventions written in a behavior support plan to address inappropriate behaviors, and failed to administer physical and chemical restraints in accordance with the facilities training program, CPI nonviolent interventions for 1 (Resident #1) of 3 residents reviewed for physical and chemical restraint. This was cited at an IJ level.	W 158			
W 186	DIRECT CARE STAFF CFR(s): 483.430(d)(1-2) The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour	W 186			

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W 186	<p>Continued From page 48</p> <p>period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on record observations, interviews, and record reviews the facility failed to ensure there were sufficient staff present to respond to a behavioral event in accordance with the Individual Program Plan (IPP), to supervise and prevent death for one resident (Resident #1) sampled from case mix (Resident #1, #2, and #3) during a physical and chemical restraint.</p> <p>Findings include:</p> <p>Refer to W193 for additional information.</p> <p>A review of the face sheet indicated the facility admitted Resident #1 (R1) with diagnoses that included severe intellectual disability, autism spectrum disorder, seizure disorder, 9P Syndrome (neurological disorder) unspecified disruptive, impulse control, and conduct disorder.</p> <p>The Individual Program Plan (IPP) with an implementation date of 04/01/2025, revealed Resident #1 had a severely impaired intellectual functioning level, required one-on-one supervision, had a targeted behavior of physical aggression, and required a hard-shell helmet as adaptive equipment.</p> <p>The Behavior Support Plan (BSP) with a review date of 03/13/2025 and implementation date of 03/20/2025, revealed Resident #1 was a severe biter and had bitten the resident's own mother's thumb off and the side of a peer's face from the eyebrow to jaw. The BSP included, "as soon as client responds to an intervention, there is no need to proceed further." The BSP documented the first intervention is the use of the preventive</p>	W 186			

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W 186	<p>Continued From page 49</p> <p>restraint helmet, and included staff will follow the schedule set by the IDT (Interdisciplinary Team) and record when the helmet is taken off and put on using a specific form. The BSP included other interventions of positive reinforcement, redirection, separation to allow calming, resident choices, and verbal intervention. The prevention and intervention portion documented staff shall take immediate action to deflect or physically stop Resident #1 from engaging in self-injuries or aggressive behavior using the least restrictive method that is effective in managing behavioral needs. Staff remember their training in facility policies on how to manage behavioral emergencies.</p> <p>Review of facility's video footage indicated Residential Care Supervisor (RCS) #2 was initially present, clocked out and left the facility. Residential Care Team Supervisor (RCTS) # 3 was present for portions of the physical restraint and chemical restraint. RCS #4 was present and became involved in physical restraint. RCTS #9 brought in the humane wrap but left.</p> <p>During an interview on 09/11/2025 at 1:49 PM, RCS #2 indicated being present for a portion of the restraint but left due to the replacement staff being present. RCS #2 stated, "I should have stayed but my replacement was present and there were other supervisors present."</p> <p>During an interview on 09/11/2025 at 3:20 PM, Residential Case Supervisor (RCS) #4 reported that upon arrival in House 17 where R1 resides, RCS #4 reported observing R1 in a physical restraint on the ground, face-down. RCS #4 reported the restraint team needed assistance due to R1's continued kicking, RCS #4 joined the</p>	W 186			

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W 186	<p>Continued From page 50</p> <p>restraint by securing R1's legs. RCS #4 held the legs between the calf and ankle area while R1 remained prone with R1's knees on the ground. No one at the time suggested repositioning R1. R1 remained in the prone position for approximately ten minutes after RCS #4 arrived. R1 continued to resist until CNA #5 asked if R1 was calm and ready to go to bed. R1 made a grunting sound, and shortly afterward, R1 appeared to calm down. The team then released R1 from the restraint.</p> <p>During an interview on 09/11/2025 at 4:20 PM, Residential Care Team Supervisor (RCTS) #3 confirmed they had observed R1 in a restraint but could not recall the specifics of how R1 was being restrained. RCTS #3 reported being present for the chemical restraint.</p> <p>A review of the Restraint reporting form indicated RCTS #3 completed the form and documented being the supervisor on duty. RCTS #3 completed the Debriefing form indicating being the restraint incident leader.</p> <p>During an interview on 09/16/2025 at 1:33 PM, RCTS #9 stated there were multiple behaviors on 09/07/2025. RCTS #9 reported that when residential services received a call requesting assistance in the unit, RCTS #3 and RCS #4 went to that unit and RCTS #9 went to other behaviors on campus. RCTS #9 reported bringing the humane wrap to the unit. RCTS #9 reported observing R1 personally restrained on stomach.</p> <p>During an interview with the Administrator on 09/23/2025 at 9:22 AM, the surveyor asked for the process for the dissemination of information and/or programmatic changes and training in</p>	W 186			

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W 186	<p>Continued From page 51</p> <p>regard to the individual care plan for the direct care staff (C.N.A, RCS and floating staff) for Resident #1, specifically in relation to the wearing of the helmet to prevent biting. The Administrator stated that it should come from the case manager that initiated the IDT (Interdisciplinary Team), IPP or special IDT to meet a certain need. An administrative specialist will send out the BSP, which is a subdocument of the IPP and is written by the contracting psychologist. All the case managers will sit on the behavior support committee. There is no written policy, just an in-service. This becomes a funnel that goes to residential services, and the team shift supervisors and the residential care supervisors are responsible for ensuring that the direct staff are aware. It is the individual staff's responsibility to read and understand the BSP. The RCS (runs the house) and RCTS (runs the campus).</p> <p>The surveyor asked the Administrator how they determine the staffing needs in relation to acuity for direct care to meet the needs of the residents with changes to the IPP and BSP and how it is managed to ensure safety. The Administrator responded that this is two-prong processes; programmatically each case manager and IDT will assess the clients' needs based on history and current health care needs, and the second prong one of the licensed administrators will make decision based on the client's health and safety status for temporary adjustments and supervisory level. Due to the acuity of residents that have been admitted during the last two years, human resources that are currently available and the current staff in critical roles are providing direct support which takes them away from programmatic oversight responsibilities.</p>	W 186			

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W 193 W 193	Continued From page 52 STAFF TRAINING PROGRAM CFR(s): 483.430(e)(3) Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on interviews, record review, facility document review, facility policy review, and facility camera footage it was determined that the facility failed to demonstrate staff adequately administered interventions written in a behavior support plan to address inappropriate behaviors, and failed to administer physical and chemical restraints in accordance with the facility's training program, CPI nonviolent interventions for 1 (Resident #1) of 3 residents reviewed for physical and chemical restraint. These findings have been determined to be Immediate Jeopardy as defined at 42 CFR §483.420(a)(6). The IJ began on 09/07/2025. The survey team provided the State Operations Manuel Appendix Q Immediate Jeopardy template to the Administrator on 09/23/2025 at 2:40 PM. The facility provided a plan of removal on 09/24/2025 at 11:25 AM and was approved on 09/24/2025 at 1:12 PM. The Plan of Removal noted all corrections were completed on 09/24/2025. Findings include: A review of the Face Sheet indicated the facility admitted Resident #1 (R1) with diagnoses that included severe intellectual disability, autism spectrum disorder, seizure disorder, 9P Syndrome (neurological disorder) unspecified disruptive, impulse control, and conduct disorder.	W 193 W 193			

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W 193	<p>Continued From page 53</p> <p>Review of the social history intake dated 02/12/2025, revealed Resident #1 had a functional language age equivalent to 2 years. Behaviors exhibited included aggression (biting, scratching, pulling hair, kicking, or hit), property destruction (flip furniture if frustrated), self-injury (will hit self). Resident #1 current supervision level 1:1 and visual during sleeping hours. A 30-day review was scheduled for 03/18/2025.</p> <p>Review of the 30-day review by Clinical Psychologist (CP #20) dated 03/05/2025 revealed Resident #1 had a significant problem with biting and causing significant injury to those bitten. Resident #1 wore a helmet during the day to prevent the resident from biting others. The review included current behavioral information including a Behavioral Support Plan (BSP) which was in progress with the recommended target behavior of physical aggression. CP #20 recommended the IDT (Interdisciplinary Team) consider initiating a BSP with the target behavior of physical aggression.</p> <p>The Individual Program Plan (IPP) with an implementation date of 04/01/2025, revealed Resident #1 had a severely impaired intellectual functioning level, required one-on-one supervision, had a targeted behavior of physical aggression, and required a hard-shell helmet as adaptive equipment.</p> <p>The Behavior Support Plan (BSP) with a review date of 03/13/2025 and implementation date of 03/20/2025, revealed Resident #1 was a severe biter and had bitten the resident's own mother's thumb off and the side of a peer's face from the eyebrow to jaw. The BSP included, "as soon as</p>	W 193			

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W 193	<p>Continued From page 54</p> <p>client responds to an intervention, there is no need to proceed further." The BSP documented the first intervention is the use of the preventive restraint helmet, and included staff will follow the schedule set by the IDT (Interdisciplinary Team) and record when the helmet is taken off and put on using a specific form. The BSP included other interventions of positive reinforcement, redirection, separation to allow calming, resident choices, and verbal intervention. The prevention and intervention portion documented staff shall take immediate action to deflect or physically stop Resident #1 from engaging in self-injuries or aggressive behavior using the least restrictive method that is effective in managing behavioral needs. Staff remember their training in facility policies on how to manage behavioral emergencies.</p> <p>A review of the facility ' s camera footage dated 09/07/2025 indicated the following:</p> <p>Camera 2 labeled dayroom from 09/07/2025 at 6:35PM revealed Resident #1 sitting on the end of a couch with legs crossed and not wearing a helmet. The resident ' s helmet is observed lying on the end of a different couch in the room. Certified Nursing Assistant (CNA) #10 is observed sitting on another couch end approximately 3 feet from Resident #1. Resident #2 (R2) is observed sitting next to CNA #10 talking. CNA #5 walked in front of Resident #1 picked up a blanket and shoes from the floor before placing their right hand on Resident ' s right arm. R2 lifts left leg and attempted to kick toward CNA #5. Resident #1 lifts left arm and grabs CNA #5 ' s hair and pulls CNA #5 down toward self and attempts to bite CNA #5. CNA #10 stands up and attempts to get between CNA</p>	W 193			

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W 193	<p>Continued From page 55</p> <p>#5 and Resident #1. CNA #10 stands behind R1 on R1 ' s right side while CNA #8 attempts to remove R1 ' s hand from CNA #5 ' s hair. R1 kicks feet up into CNA #5 stomach area. While R1 was kicking CNA #5, CNA #10 has right arm around R1 ' s right arm, and R1 and their chair falls backwards. R1 rolls out of the chair onto back with legs in the air.</p> <p>At 6:36PM, Resident Care Supervisor (RCS) #2 walks out of office into the room and over to the resident. The RCS picks up blanket and attempts to place over R1 ' s face. R2 is standing by chair observing the incident. R1 continues to kick and grab at staff. CNA #5 attempts to grab R1 legs and is unsuccessful. On Camera 2 at 6:37PM, CNA #5 is observed removing phone from pocket and making a call. CNA #8, #10, and #2 continue to attempt to calm or restrain R1 from self-injury and R2 is standing in front of fallen chair while observing the incident. R2 turns around and walks out of the unit. At 6:38PM, R2 returns to unit with CNA #1.</p> <p>On Camera 1 at 6:38PM, CNA #10 bent over above R1, holding onto R1 wrist, and then released the hold. R1 continue to hit at CNA #10, and CNA #10 swats at R1 arms. A towel is thrown over R1 ' s face, and R1 pulls the towel off face. R1 lifts legs in a kicking manner while lying on back. CNA #10 grabs R1 ' s wrists and pushing the wrist forward R1 ' s right side and while pushing arms, lunges toward R1, lands on knees, and appears to be on top of R1. CNA #1 grabs R1 ' s legs and appears to turn R1.</p> <p>On Camera 2 at 6:38PM, CNA #5 sets chair in upright position and moves chair away from the incident area. R1 continues to move arms in a</p>	W 193			

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W 193	<p>Continued From page 56</p> <p>swinging manner, and unable to view CNA #10, #8, and #1 ' s positions.</p> <p>On Camera 2 at 6:39PM, R1 is rolled from back, to right side, to stomach. CNA #10 stands up and places right hand on R1 ' s back at the top toward shoulders. CNA #8 is on R1 ' s left side. CNA #1 had own left arm extended straight. RCS #2 places towel under R1 ' s head. R1 is lying on stomach and right side of face lying on towel. CNA #10 ' s left hand is on R1 ' s neck.</p> <p>There is a skip in time from 6:38PM to 6:39PM in Camera 1 footage. There is no observation of R1 rolling from back to stomach.</p> <p>On Camera 1 at 6:39PM, R1 is observed lying on stomach, right side of face lying on a towel, and left hand bent under left side of stomach in a personal restraint. RCS #2 and CNA #5 observed standing on the left side of R1. CNA #8 observed with right hand placed in the middle of R1 ' s back and observed left hand placed on R1 ' s back on the left side in the rib area. RCS #2 observed bending over talking to R1.</p> <p>Camera 1 had another skip in footage from 6:39:47PM to 6:40:31PM.</p> <p>On Camera 1 at 6:40PM, R1 observed lying on stomach and moving body in a bucking motion. CNA #10 observed on knees with one hand on R1 ' s back. CNA #8 observed on knees with right hand placed in the middle of R1 ' s back and left hand placed on R1 ' s back on the left side in the rib area. CNA #1 is unable to be seen.</p> <p>On Camera 1 at 6:41PM, staff observed continuing to restrain R1 in same position as</p>	W 193			

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W 193	<p>Continued From page 57</p> <p>6:40PM. CNA #10 observed with right hand placed on the middle of R1 ' s back. R1 moves body and CNA #10 observed repositioning right hand in the middle of R1 ' s back with pressure placed on R1 ' s back.</p> <p>Camera 1 had another skip in footage from 6:41:04PM to 6:42:08PM.</p> <p>On Camera 1 at 6:42PM, R1 observed lying on stomach. CNA #10 observed with right hand on R1 ' s head. CNA #1 observed with right hand on R1 ' s upper back towards shoulder. CNA #8 observed with left hand on R1 ' s left upper arm near elbow and right hand in the middle of R1 ' s back. Residential Care Treatment Supervisor (RCTS) #3 enters the unit. RCS #2 has purse on right shoulder and meets RCTS #3 and together they exit the unit. RCS #4 is seen entering the unit.</p> <p>On Camera 1 at 6:43PM, R1 observed continuing to move in a bucking manner. RCS #4 observed standing in front of R1 ' s head.</p> <p>Camera 1 has another skip in footage from 6:43:07 to 6:43:40PM.</p> <p>On Camera 1, footage returns at 6:43:40PM, and RCS #4 is observed bending down and holding R1 ' s legs. RCTS #9 enters the unit pulling a rolling cart. R2 observed walking to the middle of the unit then over by the incident area.</p> <p>On Camera 4 at 6:43PM, CNA #5 observed talking with RCS #4. RCS #4 was standing at the head of R1 looking down. RCS #4 observed stepping around CNA #8 to the area of R1 ' s legs. R2 observed standing by the open unit door.</p>	W 193			

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W 193	<p>Continued From page 58</p> <p>RCTS #9 enters the unit pulling a rolling cart. R2 shuts the unit door and walks to the middle of the unit. RCTS #9 placed the cart in the middle of the room and exited the unit.</p> <p>On Camera 1 at 6:44PM, CNA #8 's left arm observed extended, holding on R1 's upper left arm and right hand placed on R1 's middle back. CNA #8 observed shifting own body weight, leaning in and placed right elbow on R1 's middle back, and forearm placed onto R1 's left side of back. CNA#8 placed right hand on R1 's left upper arm. CNA #10 's right hand is placed on the left side of R1 's head. RCS #4 observed position of holding R1 's legs. RCS #2 returns to the unit and walks over to the incident area. RCS #2 observed bending over toward R1.</p> <p>On Camera 4 at 6:44PM, RCS #2 observed returning to unit and walks over toward R1, bends over for a moment then stands up. RCS #2 observed talking. RCTS #3 and RCTS #9 returned to the unit.</p> <p>On Camera 1 at 6:45PM, R1 observed moving right leg. CNA #8 observed shifting own body weight and moved knees closer to R1 while maintaining right arm on R1 's back and left hand on R1 's left upper arm. CNA #1 observed on knees with upper body bent toward R1. Unable to identify the location of CNA #1 's arms. CNA #1 observed moving in different positions on knees. CNA #1 observed on right knee and left knee bent up with foot on the floor. CNA #10 right hand on R1 's left side of lower face and neck. CNA #4 observed toward R1 's legs. RCTS #9 placed body wrap on the floor, walked to rolling cart picked up two items, placed the items in chair, picked wrap up off the floor, and placed in a chair.</p>	W 193			

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W 193	<p>Continued From page 59</p> <p>On Camera 4 at 6:45PM, RCS #2 and RCTS #9 observed standing together having conversation. R2, CNA #5, and RCTS #3 observed standing at the kitchen counter having a conversation. RCTS #3 observed walking into office and RCS #2 exits the unit. RCTS #9 placed body wrap on the floor, walked to rolling cart pick up to items, placed in chair, pick wrap up off the floor and place in a chair.</p> <p>Camera 1 had another footage skipped from 6:46:05PM to 6:47:06PM</p> <p>On Camera 4 at 6:46PM, RCTS #3 and CNA #5 observed standing at the kitchen counter. R2 observed standing by office observing the incident. R2 observed making gestures and pointing toward R1 with left arm then place left hand in pants pocket, then walked toward the kitchen.</p> <p>On Camera 1 at 6:47PM, R1 observed moving upper body and CNA #8 observed on knees and leaning forward on R1 with bodyweight. CNA #8 right arm is across R1 ' s back and CNA ' s left arm repositioned R1 ' s left arm. CNA #1 returns own body back to being on both knees and unable to identify the location of arms. CNA #10 observed with right hand on R1 ' s left side of head holding R1 ' s head. CNA #8 repositions self, removes right arm from R1 ' s back and placed right hand on R1 ' s back. Registered Nurse (RN) #7 entered the unit and walked to the kitchen counter where RCTS #3 was standing. R1 ' s observed moving body and head. CNA #8 observed leaning on right arm that is placed on R1 ' s lower back while CNA #8 ' s left hand holding onto R1 ' s left arm.</p>	W 193			

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W 193	<p>Continued From page 60</p> <p>On Camera 1 at 6:48PM, Licensed Practical Nurse (LPN) #6 walks to kitchen counter where RN #7 and RCTS #3 are standing, crossed arms, leaned onto kitchen counter, and turned head to observe the restraint. RN #7 observed looking at cell phone, then closing phone. R1 continues to move as if trying to roll. CNA #8 observed leaning onto R1 with right elbow and arm on the middle of R1 ' s back. CNA #8 leans down more and places left forearm on R1 ' s left arm and right forearm across R1 ' s upper back.</p> <p>On Camera 1 at 6:49PM, LPN #6, RN #7, and RCTS #3 exit the unit. R1 observed moving head around from side to side. CNA #8 leans onto R1 with right forearm and observed CNA #8 reposition R1 ' s left arm with left hand.</p> <p>Camera 1 had another footage skipped from 6:49:43PM to 6:50:39PM.</p> <p>On Camera 1 at 6:50PM, CNA #10 observed holding R1 ' s shoulders with both hands. CNA #1 observed supporting self with left hand on floor and unable to identified location of right arm. RCS #4 observed positioned toward R1 ' s legs. CNA #8 ' s left hand observed on R1 ' s left upper arm, unable to identify location of right arm. RCTS #9 returns to unit. R1 observed turning head, lying on right side of face to lying on left side of face.</p> <p>Camera 1 skipped footage from 6:51:06PM to 6:52:05PM.</p> <p>On Camera 1 at 6:52PM, staff release R1 from restraint. At 6:52:10PM, observed R1 ' s last movement. Observed R1 lying on stomach, shirt</p>	W 193			

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W 193	<p>Continued From page 61</p> <p>up around shoulders exposing back, left side of face on floor, left arm is to the side with hand toward left side of abdomen. Staff observed walking and standing in the unit. RCS #4 observed leaning against wall near R1. At 6:53PM, CNA #1 walked over to R1, bending over and placing hand on R1 's right side. At 6:57PM, R1 observed lying in same position, not moving.</p> <p>Camera 1 skipped from 6:57:44PM to 6:58:25PM</p> <p>On Camera 1 at 6:58PM, R1 's shirt had been pulled down to middle of back. RCTS #9, RCS #4, CNA #8, CNA and R2 were observed standing and facing R1. At 6:58:29PM, RCS #4 observed bending over and touching R1 on right side of neck. At</p> <p>At 6:59PM, RCS #4, CNA #1, CNA #8, and CNA #10 roll R1 onto back from stomach. RCS #4 placed a pillow under R1 's head. R2 was standing with staff observing the incident involving R1.</p> <p>At 7:00PM, another resident walked into day room by the kitchen counter and observed R1 lying on back and staff standing around R1. CNA #10 observed sitting on a chair facing R1.</p> <p>At 7:01PM, RTCS #3, RN #7, and LPN #6 return to the unit. CNA #8 sat down on a chair arm. LPN #6 observed talking with the other resident who entered the room by the kitchen counter.</p> <p>At 7:02PM, RCTS #3 observed standing on the right side of R1. CNA # 8 and #10 stand up and walk toward R1. RCTS #9 walk with R2 toward the front door.</p>	W 193			

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W 193	<p>Continued From page 62</p> <p>At 7:03PM, RCTS #3 observed bending over toward R1 then straighten up. LPN #6 observed standing facing R1. RCTS #3, CNA #8, and CNA #1 are observed rolling R1 onto left side. RN #7 walks to R1.</p> <p>At 7:04PM, R1 is on left side and staff are holding R1 on side for RN #7 to administer an injection. After the injection, R1 is rolled onto back with right arm laying across face. LPN #6 walks over and touches R1 ' s right elbow, and R1 ' s arm falls down to side. LPN #6 walks up toward R1 ' s head. CNA # 8 and CNA #10 observed in seated position on chair.</p> <p>At 7:05PM, LPN #6 reaches down and obtains pulse in R1 ' s right arm. CNA #8 and CNA #10 stand up, RN# 7 observed rubbing R1 ' s chest, walking over and placing items on couch, walking back over to R1, rubbing R1 ' s chest again, then starting Cardiopulmonary Resuscitation (CPR).</p> <p>At 7:06PM, RN #7 was doing compressions. CNA #10 relieves RN #7 and continues compressions. RN #7 got up and walked away. RCS #14 walked over to the right side of R1.</p> <p>At 7:07PM, RCS #4 and CNA #10 took turns doing compressions. CNA #1 standing by bedroom. LPN #6 observed making a phone call. CNA #1 steps over R1 and stands by feet observing staff doing CPR then walks away from the scene. RN #7 observed at the kitchen counter.</p> <p>Missing footage from 7:08:18PM to 7:08:34PM.</p> <p>At 7:08PM, RN #7 observed bending over toward</p>	W 193			

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W 193	<p>Continued From page 63</p> <p>R1 head but unable to identify actions being taken. CNA #10 and RCS #4 continue compressions.</p> <p>At 7:09PM, CNA #1 returns to scene. RN #7 observed bent over with what appears to be an ambu (artificial manual breathing unit) bag (type of device known as a bag valve mask, used to provide respiratory support to patients) on R1 ' s face. CNA #10 and RCS #4 continue compressions.</p> <p>At 7:10PM RN #7 observed on knees using Ambu bag on R1. (A bag valve mask, sometimes known by the proprietary name Ambu bag or generically as a manual resuscitator or "self-inflating bag", is a hand-held device commonly used to provide positive pressure ventilation to patients who are not breathing or not breathing adequately.) CNA #5 and CNA #8 observed walking around the living area and moving items as if looking something. CNA #10 and RCS #4 continue compressions.</p> <p>At 7:11PM, RN #7 observed on knees using Ambu bag on R1. CNA #10 and RCS #4 continue compressions. LPN #6 places an object on the floor between RN #7 and RCS #4. RCS #4 picks up the AED (automated external defibrillator) pads and hands them to RN #7. CNA #5 pushes a chair out of the area.</p> <p>At 7:12PM, CNA #8 walks over to R1 and gets on knees on R1 ' s left side. RN #7 opens AED pads and RCS #4 is holding Ambu bag on R1 ' s face. CNA #5 continues to move furniture out of the center of the room. The AED is observed on the floor between RN #7 and RCS #4.</p>	W 193			

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W 193	<p>Continued From page 64</p> <p>Missing footage from 7:12:27PM to 7:13:30PM</p> <p>At 7:13PM, compressions have stopped, and an AED pad is present on right chest area between chest and abdomen. RN #7 lifts right arm up in a backing away motion, RCS #4 has left hand on left hip, and right hand up in a backing away motion.</p> <p>Missing footage from 7:13:44PM to 7:14:03PM.</p> <p>At 7:14PM, EMS (Emergency Medical Services) is on scene with observation of a stretcher on the left side of R1. One EMS personnel checked R1 ' s eyes with a bright light. RD observed on camera walking over to scene and observing EMS and staff. RCTS #3 observed moving chair out of way and RD turns to walk away. CNA #10 observed standing by observing.</p> <p>At 7:15PM, CNA #10 places Ambu bag on R1. LPN #6 observed walking up to scene with cell phone in hand. RN #7 walking around the living unit. LPN #6 and RD turn and walked away from the scene. CNA #5 walks up between CNA #10 and RCS #4.</p> <p>At 7:16PM, CNA #8 walks out of room and steps over R1 and replaces RCS #4 in doing compressions. RCTS #3 walks over and stands next to CNA #8. RCS #8 removes sweatshirt. RCTS #3 walks away from scene. CPR continues with staff switching out.</p> <p>Between 7:22PM and 7:23PM, EMS observed placing a line R1 ' s left leg. RD and RN #7 observing and then RD walks away from the scene.</p>	W 193			

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W 193	<p>Continued From page 65</p> <p>At 7:25PM, RCS #4 stands up, and EMS takes over compressions. The AED pad is observed in different location than previously placed, now located higher on right side of chest.</p> <p>At 7:29PM, the RD observed sitting in chair. CNA #8 observed standing beside a chair observing the scene.</p> <p>At 7:30PM, compressions and rescue breathing are stopped. EMS is observed standing up from a kneeled position. The RD stands up from seated position in chair and walks over to R1.</p> <p>At 7:31PM, RNM observed walking on scene. CNA #10 is leaning back against the wall. RN #12 arrived on scene. CNA #8 continues to stand and observe the scene.</p> <p>At 7:35PM, EMS observed exiting the area.</p> <p>On 09/07/2025 at 6:35PM, CNA #5, CNA #10, and CNA #8 failed to ensure R1 had adaptive device (helmet) in place according to review of video footage.</p> <p>On 09/07/2025 at 6:35PM, R1 is observed attempting to bite CNA #5, per review of video footage by this surveyor</p> <p>A review of a Behavior Report dated 09/07/2025 revealed Resident #1 had inappropriate behaviors including agitation and psychiatric symptoms. Resident #1 exhibited physical aggression, including hair-pulling. The report documented the supervisor was called at 6:40 PM and the nurse was called at 6:41 PM.</p> <p>A review of a Restraint Reporting Form dated</p>	W 193			

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W 193	<p>Continued From page 66</p> <p>09/07/2025 at 6:43PM revealed the Authorizing QIDP (Qualified Intellectual Disability Person)/Supervisor on duty was RCTS #3. The type of restraint was identified as personal and chemical. Reason for restraint was aggression toward staff. The personal restraint was documented as initiated at 6:43PM including escalating and agitated behavior. The release of restraint was documented at 6:56PM, including a reference that R1 ' s behavior was beginning to calm. The chemical restraint was documented at 7:04PM, and the other box was marked with the word compliant written. RN #7 documented Geodon 20mg IM (an atypical antipsychotic used to treat schizophrenia and bipolar disorder) see nurses' notes. RCTS #3 documented the Administrator was notified at 7:11PM.</p> <p>A review of the debriefing form for the behavior report dated 09/07/2025 indicated Resident #1 received a personal and chemical restraint due to aggression directed towards staff and to prevent escalation again. In the "possible actions by staff to decrease future necessity of restraint" there was no documentation. In additional comments section there is documentation immediately after the chemical restraint medical took charge.</p> <p>A review of the EMS run report dated 09/07/2025 documented, " ...R1 is pulseless and apneic, pupils are fixed and dilated. Facility staff reports that the patient became combative, attempting to bite other residents. Facility staff first attempted physical restraint which was ineffective, so Geodon was administered for chemical restraint. Facility staff have no idea at what point the pt (patient) stopped breathing and lost pulse. EMS continued CPR with chest compressions. AED pad had to be reapplied in the proper position as</p>	W 193			

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W 193	<p>Continued From page 67 they were initially over the abdomen ..."</p> <p>A review of annual weight and height record dated 2025 indicated R1 was five feet eight- and one-half inches tall and weighed 206 pounds in the month of August.</p> <p>A review of text message 09/07/2025 at 6:48 PM, RN #7 sent to PAPRN #21 indicated R1 was in a burrito (humane wrap) now and was being combative and aggressive and not calming down with redirection. A review of video footage indicates R1 was never placed in a humane wrap. PAPRN #21 responded with Geodon 20mg IM.</p> <p>A review of R1 ' s physician ' s drug orders, dated 09/07/2025 at 6:48PM, revealed an order for Geodon 20mg (milligrams) IM (intramuscular) injection now.</p> <p>A review of R1 ' s September 2025 Medication Administration Record (MAR), RN #7 documented Geodon 20mg IM injection was administered at 7:04PM.</p> <p>A review of chemical restraint observation form dated 09/07/2025 at 7:04PM documented R1 received Geodon 20mg and instructed the reader to see nurses ' notes. The form has starred information stating, "if any signs or symptoms of an adverse reaction are noted, vital signs are to be obtained, and the MD/Psychiatrist is to be notified immediately. If at any time the client is noted to be having respiratory distress, then 911 should be called immediately and the nurse is to remain with the client till the ambulance arrives."</p> <p>A review of nursing note dated 09/07/2025 at 6:41 PM, revealed RN #7 documented, "Staff called</p>	W 193			

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W 193	<p>Continued From page 68</p> <p>the mini clinic to report a MIPIR being completed for resident biting tongue during a behavior. Upon arrival to unit resident being PR ' d (personal restraint). R1 bleeding from mouth observed. P APRN #21 contacted @ (at) 18:48pm (6:48PM) and order given for Geodon 20mg IM. Left the unit to get chemical restraint." The nurse ' s note was signed by RN #7.</p> <p>A review of nursing note dated 09/07/2025 at 7:03 PM revealed, "Arrived back to unit. Resident was still in personal restraint. Resident was laying on back and repositioned to the side. Pulse was checked and noted. Geodon 20mg was given IM in right gluteal @ 19:04PM (7:04PM). The nurse ' s note was signed by RN #7.</p> <p>A review of nursing note dated 09/07/2025 at 7:05 PM documented, "Sternal rub done. Resident was unresponsive, noted to not be breathing. CPR started, AED obtained by [LPN #6]. AED applied, CPR continued. 911 had been called by [LPN #6]. CPR continued to ambulance crew arrived. Ambulance crew took over resident care at this time." The nurse ' s note was signed by RN #7.</p> <p>A review of nursing note dated 09/07/2025 at 7:30 PM documented, "Resident was pronounced deceased by ambulance crew through [Medical Doctor #23] at 19:30pm (7:30PM). RNM notified. Administrator notified by RNM at 19:59 (7:59PM) mom notified per RNM." The nurse ' s note was signed by RN #7.</p> <p>A review of case note dated 09/07/2025 revealed the RNM notified R1 ' s mother of the resident ' s passing, and that funeral home would be picking up the body and contacting the mother.</p>	W 193			

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W 193	<p>Continued From page 69</p> <p>Maltreatment Investigator During concurrent review of camera footage and interview on 09/10/2025 at 2:48 PM the Maltreatment Investigator (MI) verbalized staff did not do the restraint correctly.</p> <p>The MI confirmed at 6:44:06 of video CNA #8 was observed with right hand on R1 ' s back and then CNA #10 leans forward placing forearm on R1 ' s back. The MI verbalized CNA # 10 appears to be placing elbow in R1 ' s back and shifting own weight onto R1 ' s back.</p> <p>Quality Assurance Coordinator During concurrent review of camera and interview on 09/10/2025 at 2:53 PM, the Quality Assurance Coordinator (QAC) verbalized the restraint being observed was incorrect due to R1 being on stomach (prone). The QAC verbalized CNA #8 the hold should have been on the shoulders or wrist, not on R1 ' s back. The QAC reported the arm on the back can restrict a residents ' breathing.</p> <p>During a followup interview on 09/11/2025 at 11:07 AM, the QAC reported working at the facility for 23 years. The QAC confirmed being the CPI instructor and previous review of the video indicated the restraint was performed incorrectly. The QAC confirmed teaching protocols are for the residents ' back to be on the ground, and staff are to hold arms and legs, not their back. The QAC verbalized if the restraint is done incorrectly, then the staff should release and restart if another restraint is necessary.</p> <p>RCS #2 During an interview on 09/11/2025 at 1:48 PM,</p>	W 193			

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W 193	<p>Continued From page 70</p> <p>RCS #2 reported working at the facility since 2010. RCS #2 reported being the supervisor of unit 17. RCS #2 confirmed completion of CPI (Crisis Prevention Intervention) training. When asked about proper restraint procedures, RCS #2 stated that a resident should be on their back and not on their stomach. RCS #2 verbalized if a resident is restrained on their stomach, it could cause breathing difficulties. RCS #2 continued to state the appropriate hold positions include one person holding the head, one person holding each arm and one person holding the legs.</p> <p>RCS #2 reported exiting the restroom and finding that R1 was agitated, and the room was in chaos. RCS#2 stated CNA #1, CNA #5, CNA #8, and CNA #10 were present, and R1 had torn CNA #10 's shirt. The staff were engaged in physically restraining R1 on the floor. RCS #2 reported CNA #10 was holding a wrist, CNA #8 and CNA #1 was holding the other wrist.</p> <p>RCS #2 confirmed placing a towel on R1 's face to prevent R1 from biting, that the towel fell on the floor, and was then placed under R1 's head due to banging. RCS #2 reported R1 was not calming down, so RCS #2 removed themselves from the situation, grabbed their purse, and exited the building. RCS #2 stated when leaving the building, RCS #2 passed the nursing staff entering.</p> <p>RCS #2 stated, "I should have never left that night."</p> <p>CNA #1 During an interview on 09/11/2025 at 2:31 PM, CNA #1 reported working at the facility for approximately 5-6 months. CNA #1 completed</p>	W 193			

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W 193	<p>Continued From page 71</p> <p>Phase I training, which was described as covering the policies and procedures of the facility. CNA #1 also enrolled in a CNA course at the facility but did not pass the class. CNA #1 confirmed completion of CPI (Crisis Prevention Intervention) training.</p> <p>When asked about proper restraint procedures, CNA #1 stated that a resident should not be restrained in a prone (stomach-down) position. CNA #1 noted the resident's face should be visible, facing the staff, and the upper body should be elevated. CNA #1 indicated that restraining a resident in a prone position is prohibited because it may lead to choking on their tongue.</p> <p>CNA #1 reported sitting outside House 19 while waiting for their cousin to finish work when Resident #2 (R2) exited the building and stated that assistance was needed in House 17, the house R1 resided in. CNA #1 proceeded to House 17 to assist. Upon entering House 17, CNA #1 observed CNA #10 and CNA #8 holding R1 on the ground and CNA #10 's shirt was torn. CNA #8 was positioned on R1 's left side. CNA #1 attempted to calm R1 verbally. R1 was observed sitting upright on the resident 's buttocks at one point but then grabbed CNA #10. CNA #1 intervened by grabbing one of R1 's right arm. A personal restraint wrap was requested but the incorrect size was initially provided. A chemical restraint (injection) was administered prior to the arrival of the correct wrap.</p> <p>CNA #1 confirmed that R1 was restrained in a prone (face-down) position for a period estimated at lasting 5 to 10 minutes. The following staff were involved; CNA #1 was holding R1 's right</p>	W 193			

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W 193	<p>Continued From page 72</p> <p>wrist, CNA #8 was holding R1 ' s left arm and top of shoulder, RCS #4 was holding R1 ' s legs, and CNA #10 was holding R1 ' s head. CNA #1 denied placing any body weight on R1 ' s back and did not recall anyone doing so.</p> <p>CNA #1 reported the decision to release the restraint was made collectively, with RCS #4 initialing the release. CNA #1 stated that all staff looked at each other then let go of R1. CNA #1 verbalized R1 did not move at the time of release. Later, R1 was turned onto back (supine) and a pillow placed under R1 ' s head. CNA #1 verbalized CNA #10 and CNA #8 checked on R1 and R1 was breathing. CNA #1 reported when the nurse arrived, R1 was rolled onto side and received the chemical restraint. Then another nurse entered and expressed concern that R1 did not appear to be breathing. A pulse check was performed by a nurse and CPR was initiated. CNA #1 ran to House 18 to retrieve the mouthpiece for the resuscitation bag and handed it to the nurse upon return. CNA #1 confirmed leaving the unit prior to EMS arrival. CNA #1 concluded the interview by stating, "We did everything right."</p> <p>RCS #4 During an interview on 09/11/2025 at 3:20 PM, RCS #4 reported working for the facility for nearly 6 years and has held a CNA license approximately 3 years. Upon hire, RCS #4 completed Phase I and CPI training.</p> <p>On September 7, 2025, during their scheduled 6:00 AM to 6:00 PM shift, RCS #4 was undergoing training in the Residential Services Office. During the shift, a call for assistance came from House 17, prompting them to respond along</p>	W 193			

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W 193	<p>Continued From page 73</p> <p>with RCTS #9. Upon arrival in House 17, they observed R1 in a physical restraint on the ground, face-down. Staff members CNA #1, CNA #8, and CNA #10 were actively restraining R1. One staff member was holding each arm near the elbow, and another was positioned at the head. RCS #4 could not recall which staff were on which side.</p> <p>RCS #4 reported the restraint team needed assistance due to R1 ' s continued kicking, RCS #4 joined the restraint by securing R1 ' s legs. RCS #4 held the legs between the calf and ankle area while R1 remained prone with R1 ' s knees on the ground. No one at the time suggested repositioning R1. R1 remained in the prone position for approximately ten minutes after RCS #4 arrived. R1 continued to resist until CNA #5 asked if R1 was calm and ready to go to bed. R1 made a grunting sound, and shortly afterward, R1 appeared to calm down. The team then released R1 from the restraint.</p> <p>RCS #4 reported that after release, R1 remained lying on stomach with eyes closed. R1 made no further vocalizations but did move head slightly. RCS #4 checked for signs of life by placing a finger near nose to detect airflow and using two fingers on the left side of neck to check for a pulse, which was faint but present. RCS #4 believed a nurse also checked on R1 but could not recall which one.</p> <p>RCS #4 reported 5-10 minutes later a nurse returned to administer a chemical restraint. RCS #4 assisted in rolling R1 on side for the injection and then returned to supine (on back) position. LPN #6 expressed concern that R1 was not breathing. LPN #6 checked for breathing and a pulse. Upon confirming there was no pulse, RN</p>	W 193			

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W 193	<p>Continued From page 74 #6 initiated CPR.</p> <p>RCS #4 verbalized RN #6 applied the AED on R1, RCS #4 and CNA #10 took turns performing chest compressions. At some point, RCS #4 took over the air bag. EMS arrived and staff continued compressions with EMS assistance until staff were told to stop. EMS instructed staff to stop CPR and R1 was pronounced dead at 7:04 PM.</p> <p>RCS #4 verbalized staff should have turned R 1 on back and the outcome may have been different.</p> <p>RCTS #3 During an interview on 09/11/2025 at 4:20 PM, RCTS #3 reported holding a CNA license since 2017 and has been employed at the facility since 2003, totaling nearly 23 years of service. RCTS #3 have worked in their current position for approximately 3-4 years. Over the past five years, RCTS #3 received training in maltreatment, physical and verbal abuse, and completed CPI (Crisis Prevention Intervention) training, though they noted they have not completed the advanced CPI course. They stated that during restraint situations, it is important to ensure the area is safe, and to confirm that neither the client nor staff are at risk of harm. RCTS #3 identified that the proper position for a grounded physical restraint is for the residents to be on their back, with arms and legs secured. Ideally, one staff member should be assigned to each limb, if staffing allows. They also acknowledged that they had not received detailed training on the exact staff positions during such restraints.</p> <p>On the day of the incident (09/07/2025), RCTS #3 confirmed that they were on campus and were</p>	W 193			

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W 193	Continued From page 75 initially under the pavilion dealing with another behavioral incident when they received notification that R1 was attempting to bite CNA #5. Upon responding to House 17, they observed that R1 was being physically restrained and exhibiting significant resistance and movement. Supervisors RCS #2 and RCS #4 were already present. RCTS #3 could not recall the specific restraint position or staff placements and noted that they were going back and forth between House 17 and other behaviors occurring elsewhere on campus at the time. RCTS #3 recalled entering House 17 again when a nurse indicated that a chemical restraint would be administered. RCTS #9 was also present and was reportedly attempting to retrieve the remaining parts of the humane wrap; however, due to time constraints, it was determined that the chemical restraint would arrive sooner than locating the correct wrap, so the wrap was not used. RCTS #3 stated that CNA #5 was assisting in tracking the restraint timeline and that they themselves were also documenting times on a personal paper. RCTS #3 remembered RN #7 checking R1 for breathing before administering the chemical restraint at approximately 7:04 PM. At that point, staff rolled R1 onto left side for the injection, which was administered into his right side. R1 was then rolled back onto back. The staff member noted that R1 showed no movement after being repositioned. RCTS #3 either looked at or touched R1 and then directed LPN #6 to check R1 's condition. LPN #6 then left to retrieve the AED. RCTS #3 reported stepping out to make phone calls to the RD, Administrator, and Residential Care Manager (RCM) #16. RCTS #3 accompanied LPN #6, who had called 911. The ambulance reportedly entered from the back of the campus. Upon	W 193			

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W 193	<p>Continued From page 76</p> <p>arrival, EMS personnel began CPR and utilized the AED. One of the EMS responders asked for the attending physician, and the RNM was in route. MD #23 officially pronounced R1 deceased at 7:30 PM, and CPR efforts were discontinued. When asked, RCTS #3 confirmed they had observed R1 in a restraint but could not recall the specifics of how R1 was being held. They were certain, however, that R1 was lying on his back when positioned for the chemical restraint. They did not observe any behavioral outbursts between the release of the physical restraint and the administration of the chemical restraint. RCTS #3 could not specify the duration between the two events. RCTS #3 assisted in rolling R1 for the injection but did not recall if R1 resisted being moved. Due to the presence of two supervisors and a nurse, RCTS #3 explained that they were moving in and out of the house to attend to other incidents on campus. RCTS #3 emphasized that because R1 was being attended to by supervisors and medical staff, they believed the situation was adequately managed. When asked about the number of nurses present, RCTS #3 stated they could not confirm the initial number but remembered that two nurses were involved by the time of the chemical restraint.</p> <p>When asked who was monitoring R1 ' s restraint, RCTS #3 assumed it was either RCS #2 or RCS #4, as both were supervisors present at the scene. RCTS #3 reported signing off on the monitoring form after being informed that R1 had been released from the physical restraint. RCTS #3 confirmed being present for the chemical restraint and signed the documentation accordingly, though RCTS #3 expressed discomfort with doing so. RCTS #3 relied on CNA #5 for time tracking and reported that all notes</p>	W 193			

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W 193	<p>Continued From page 77</p> <p>were sent to the Administrator and that their own documentation was stored in their locker. RCTS #3 stated they did not witness the position R1 was in at the time of restraint release but confirmed that R1 was on his back during the chemical restraint.</p> <p>Regarding training received since the incident, RCTS #3 confirmed participation in restraint training on September 11, 2025. They were instructed that individuals must never be restrained in a prone (stomach-down) position, and if such a position occurs, the restraint must be immediately stopped and restarted in a safe position. Staff were also instructed not to apply pressure to a client ' s head, to avoid using body weight during restraints, and to refrain from using the client ' s body for leverage when standing up. Supervisors were reminded to monitor the restraint process, ensure staff positioning is correct, and verify that no weight is placed on the client. Additionally, staff were instructed not to use the humane wrap if any part is missing and were reminded that either a supervisor or nurse must monitor all restraints. Supervisors should never leave during an active restraint.</p> <p>LPN #6 During an interview on 09/11/2025 at 5:10 PM, LPN #6 reported working for the facility for 12 years with the last 2 years as a LPN. LPN #6 previously worked as a direct care staff and then moved into a supervisor position before becoming a nurse. LPN #6 verbalized as an LPN, the primary responsibility upon receiving notification of a restraint is to respond immediately to the location of the incident. Upon arrival, the nurse is responsible for assessing the client involved in the restraint. This includes</p>	W 193			

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W 193	<p>Continued From page 78</p> <p>observing the client's physical condition, checking for signs of proper circulation, and ensuring the client's overall safety throughout the restraint process. In situations where a restraint occurs on the ground, the expected and proper position for the client is supine (lying flat on the back) unless the client is seated upright. The supine position is preferred for safety and monitoring purposes. Ideally, a proper personal restraint requires four to six staff members. This includes one staff member to maintain control of the head, two staff for the arms, two staff for the legs, and potentially one at the feet to ensure full support and safety. However, in circumstances where the full number of staff is not available, the team is expected to adapt and manage the situation with the staff present, doing the best possible to maintain control while prioritizing client safety.</p> <p>LPN #6 reported receiving a call from CNA #5 stating a MIPIR (minor injury/protective intervention report) was being completed for R1 due to possibly biting tongue. LPN #6 relayed the information to RN #7, as RN #7 was the primary nurse for R1 on that day. LPN #6 and RN #7 went to the unit of the incident. Upon arrival at the unit, LPN #6 started stopping and talking with another resident. LPN #6 reported RN #7 sent a text message to PAPRN #21 to notify of the situation. Both staff returned to the mini clinic to obtain the ordered chemical restraint. LPN #6 reported returning to the unit and observing R1 laying on back with staff surrounding. LPN #6 stated R1 was rolled onto left side and received the chemical restraint in the right hip. After the injection, R1 was returned to a supine position.</p> <p>LPN #6 reported assessing R1 's pulse and it was not detected. LPN #6 administered a sternal</p>	W 193			

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W 193	<p>Continued From page 79</p> <p>rub, and CPR was initiated by RN #6. LPN #7 voiced calling 911 and left to search for the AED. EMS returned a call and LPN #6 went outside to guide EMS to the proper location. LPN #6 denied direct observation of R1 in a personal restraint. LPN #6 denied a supervisor being present during the alleged personal restraint.</p> <p>LPN #6 reported a resident must be a threat to self or others to receive a chemical restraint. LPN #6 denied R1 to be a threat to self or others and LPN #6 ' s presence in the unit was for the purpose of support as R1 was not an assigned patient.</p> <p>RN#7 During an interview on 09/15/2025 at 2:40 PM, RN #7 reported working for the facility for approximately 6 years. RN #7 reported working as an LPN prior to obtaining RN license. RN #7 verbalized duties did not change in current position when becoming an RN. RN #7 reported training received included CPR and CPI.</p> <p>RN #7 reported receiving a call that R1 had a behavior and had bitten their own lip and was bleeding. RN #7 reported upon entering the unit, R1 was not in a restraint, was awake, and there was no blood. RN #7 verbalized R1 was on the floor, laying on back, looking like normal self. RN #7 reported there were two male staff standing around R1. RN #7 reported contacting PAPRN #21 to notify R1 was having a behavior but did not observe the behavior.</p> <p>RN #7 reported receiving orders for a chemical restraint from PAPRN #21. RN #7 reported going back to the mini clinic to obtain the chemical restraint. After obtaining the chemical restraint</p>	W 193			

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W 193	<p>Continued From page 80</p> <p>and returning to the unit, RN #7 stated R1 was still awake and laying on the floor. RN #7 reported checking R1 ' s pulse and then gave the chemical restraint. RN #7 stated after administering the chemical restraint things went downhill, they performed a sternal rub and started CPR. RN #7 reported someone took over CPR and RN #7 left to get AED pads. RN #7 reported placing the AED pads on R1.</p> <p>When asked whether an assessment of Resident R1 was completed prior to administering the chemical restraint, RN #7 stated that R1 was visually observed but a full head-to-toe assessment was not performed. A pulse was checked in both the neck and arm, but respirations were not counted.</p> <p>When questioned about contacting PAPER #21 without personally witnessing the behavior, RN #7 explained that PAPER #21 is notified any time a behavior occurs. Regarding the facility ' s protocol for obtaining a chemical restraint, RN #7 stated that staff notify the PAPER about the behavior , and if a medication order is received, it must be administered as ordered.</p> <p>When asked whether R1 was a danger to self or others, RN #7 responded that R1 was not. When RN #7 was asked why the chemical restraint was administered when R1 was not a threat to self or others, RN #7 stated that once a doctor issues an order, the medication must be given as prescribed. RN #7 was asked if allowed to call PAPER back and inform the resident was no longer having a behavior and RN #7 responded with "I am just doing what I am told to do and if we get an order, then we are required to give the medication."</p>	W 193			

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W 193	<p>Continued From page 81</p> <p>RCTS #9 During an interview on 09/16/2025 at 1:33 PM, RCTS #9 reported having worked at the facility for 13 years. RCTS # 9 confirmed receiving restraint training, CPR, and CPI.</p> <p>RCTS #9 stated there were multiple behaviors on 09/07/2025. RCTS #9 reported that when residential services received the call requesting assistance in the unit, RCTS #3 and RCS #4 went to that unit and RCTS #9 went to other behaviors on campus. RCTS #9 reported bringing the humane wrap to the unit. RCTS #9 reported observing R1 personally restrained on stomach.</p> <p>RCTS #9 verbalized the proper way to restrain a resident is one their back and in a humane wrap on their side. RCTS #9 verbalized a supervisor is required to monitor all restraints and RCTS #3 was the supervisor for that unit.</p> <p>CNA #8 During an interview on 09/16/2025 at 6:21PM, CNA #8 reported having worked at the facility for approximately one year and confirmed that they had not yet completed the certified nursing assistant exam. CNA #8 confirmed receiving basic training, CPI (Crisis Prevention Intervention) and CPR.</p> <p>CNA #8 explained that both they and CNA #10 were trying to determine which staff member would be responsible for transporting Resident #2 (R2) to the hospital. CNA #8 stated that CNA #5 was assigned as the one-on-one staff for Resident #1 (R1).</p> <p>CNA #8 admitted to being unaware that R1 was</p>	W 193			

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W 193	<p>Continued From page 82</p> <p>required to wear a helmet and noted that this was not the unit they typically worked on. They also mentioned the existence of a sign-off sheet in the office regarding R1 ' s helmet use.</p> <p>CNA #8 confirmed that they assisted CNA #10 in trying to separate R1 from CNA #5 ' s hair. During the incident, CNA #8 and CNA #10 physically held R1 down until additional help arrived. CNA #8 reported that RCS #2 exited the office, at which point they attempted to release R1. However, R1 continued to roll side to side, kicked, and tore CNA #10 ' s shirt. R1 was then placed into a personal restraint.</p> <p>CNA #8 stated that R1 was lying on their stomach and that both they and CNA #10 were holding R1 ' s arms. CNA #1 and RCS #4 later arrived to assist with the restraint. CNA #8 acknowledged placing their right arm and elbow on R1 ' s back but stated this was solely to reposition themselves.</p> <p>According to CNA #8, RCTS #9 brought an incorrectly sized body wrap. CNA #8 recalled that after R1 was released from the restraint, the resident remained in the same position, with their buttocks up for the administration of a chemical restraint. CNA #8 confirmed that R1 had been physically restrained in a prone (stomach-down) position for approximately 10 to 11 minutes prior to receiving the injection.</p> <p>CNA #5 During an interview on 09/16/2025 at 7:26PM, CNA #5 confirmed working at the facility for approximately three-and one-half years. CNA #5 reported not completing CNA classes and not being licensed. CNA #5 verbalized Unit 15 was</p>	W 193			

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W 193	<p>Continued From page 83</p> <p>their primary unit but had begun being floated into Unit 17 frequently to be one on one with R1. CNA #5 verbalized building a strong rapport with R1 and often used verbal prompts to help guide and support R1. CNA #5 reported overtime working with R1 on several occasions in the one-on-one capacity, CNA #5 became familiar with R1 ' s behavior and needs. CNA #5 reported being very confident in their ability to support R1 effectively. CNA #5 reported being familiar with R1 ' s behavior plan. CNA #5 continued to report the helmet was required if there was a risk of biting behavior. CNA #5 was aware that the helmet could be removed during meals, and it was authorized for R1 not to wear it, particularly when resident was calm and not exhibiting any aggressive behaviors.</p> <p>CNA #5 reported working with R1 during times with and without the helmet, depending on the circumstances at the time. If R1 was calm and engaged in an activity like using the iPad, R1 typically didn ' t have it on, and there was no immediate concern. CNA #5 stated on the day of the incident R1 ' s helmet was off, and R1 appeared content and focused. CNA #5 voiced, "At no point was I informed that R1 ' s helmet was required to be on continuously that day." CNA #1 reported if there had been a change in R1 ' s behavior protocol or helmet usage, the normal process would be for the supervisor to inform staff directly. We are required to sign a form acknowledging we ' ve read and understood any updates to a resident ' s plan. However, I did not receive any such notification regarding a change in R1 ' s helmet requirements that day. CNA #5 verbalized, "If I had known R1 was supposed to have the helmet on at all times, I would have made sure it was on. If R1 had the helmet on, it '</p>	W 193			

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W 193	<p>Continued From page 84</p> <p>s hard not to wonder if things might have gone differently had that information been communicated. That day was unlike anything I ever expected to happen." CNA #5 stated, "If R1 would have had the helmet on, R1 would not have been able to bite me."</p> <p>Regarding the day of incident, CNA #5 reported arriving at the unit around 6:25 PM and entered the office to receive shift update from previous shift. CNA #5 reported while receiving updates CNA #8 and CNA #10 entered. CNA #5 reported R1 was seated in a chair with legs tucked under self. CNA #5 reported speaking to R1 about taking a shower. R1 then grabbed CNA #5 's hair and pulled staff toward self. CNA #5 stated R1 was attempting to bite CNA #5 on the neck. CNA #8 and CNA #10 assisted in separating R1 from CNA #5.</p> <p>CNA #5 reported calling the supervisor at 6:40 PM and nursing staff at 6:41 PM. CNA #5 reported the crisis team arrived, including RCS #4, RCTS #3, a nurse and two other staff members but did know their names. CNA #5 verbalized during the incident CNA #5 was taking notes to remember the details of the incident. CNA #5 verbalized R1 was moving after the chemical restraint. CNA #5 stated LPN #6 observed R1 not breathing. CNA #5 stated CNA #10 was doing CPR and CNA #5 left the area to retrieve the AED. CNA #5 confirmed EMS arrived and took the situation over.</p> <p>CNA #5 could not recall R1 being on stomach but confirmed during a restraint the resident should be on their back. CNA #5 recalled R1 having an abrasion on the right side of face from moving and turning body constantly.</p>	W 193			

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W 193	<p>Continued From page 85</p> <p>Registered Nurse Manager During an interview on 09/17/2025 at 1:35PM, the Registered Nurse Manager (RNM) reported working for the facility since 1998. The RNM reported nurses ' responsibilities during a restraint are to monitor the resident by observing skin color respirations, ensure the restraint is not too tight, and ensure the resident is properly placed on their back and not their stomach.</p> <p>The RNM reported the resident ' s behavior needs to be out of control such as a danger to self or others prior to calling the PAPRN for a chemical restraint. The RNM reported that if a resident has calmed down and no longer a threat to self or others, the nurse can contact PAPRN to notify the residents change of condition and inform a chemical restraint is no longer necessary.</p> <p>The RNM was asked, "What was R1 ' s condition at the time the chemical restraint was administered?" RNM replied, "I don ' t know if R1 was unconscious or deceased, but I do know R1 was not having a behavior at that time."</p> <p>Maltreatment Investigator During an interview on 09/18/2025 at 3:28 PM, the Maltreatment Investigator (MI) reported working for the facility approximately 14 years. The MI reported being in the current position since 2019.</p> <p>The MI reported reviewing the video footage of the cameras inside the unit that recorded the incident on 09/07/2025. The MI verbalized the restraint was performed incorrectly and R1 should not have been restrained in a prone position. The</p>	W 193			

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W 193	<p>Continued From page 86</p> <p>MI reported R1 was fighting in supine position in one portion of the video then the video skipped and R1 was in a prone position and staff should not have placed R1 in a prone position personal restraint. The MI reported R1 should have been left alone after releasing CNA #5 ' s hair. The MI reported CNA #8 appeared to have placed arm on R1 ' s back a couple of times and not have put CNA #8 ' s body weight on R1.</p> <p>The MI reported R1 appeared to be unconscious when staff rolled R1 into a prone position, had a bruise on right cheek, and R1 was discolored. The MI reported R1 did not move after being rolled onto back. The MI reported the nurses never checked on R1 until R1 received the chemical restraint.</p> <p>The MI reported it appeared R1 was not a threat to self or others and should not have received the chemical restraint. The MI reported R1 appeared to be unconscious at the time the chemical restraint was received. The MI reported after receiving the chemical restraint, R1 ' s arm was over face. LPN #6 moved R1 ' s arm and the arm flopped down. At that point, RN #7 realized R1 was not breathing and initiated CPR.</p> <p>The MI verbalized four supervisors were present periodically during the incident. The MI reported two supervisors informed the MI they did not see R1 being restrained. The MI reported RCS #4 was involved in the restraint and did not correct R1 ' s position. MI reported that anyone who sees a personal restraint being performed incorrectly can instruct the team to adjust the restraint position and correcting a restraint is not limited to supervisors to enforce. The MI reported all staff have the opportunity to correct an incorrect</p>	W 193			

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W 193	<p>Continued From page 87</p> <p>restraint. The MI reported two other clients were present during the incident with one being present for the entirety of the incident.</p> <p>CNA #10</p> <p>During an interview on 09/19/2025 at 8:56 AM, CNA #10 reported working for the facility for approximately 8 years. CNA #10 confirmed having received CPR, CPI, and restraint training.</p> <p>CNA #10 reported working in Unit 13 and was floated to Unit 17 on 09/07/2025. CNA #10 reported knowing R1 was a bitter and had previously bitten two other staff members. CNA #10 stated R1 grabbed CNA #5 ' s hair and attempted to bite CNA #5 on the face or neck. CNA #10 confirmed assisting CNA #5 in removing R1 ' s hand from hair and the chair R1 was seated in fell backwards. CNA #10 stated R1 turned their aggression toward CNA #10 and attempted to bite that staff member and ripped their shirt. CNA #10 stated there were four staff trying to calm R1 down and placed R1 into a personal restraint. CNA #10 confirmed holding R1 ' s head to prevent injury to head due to R1 banging head on floor. CNA #10 stated one staff member was holding the ankles and the other two staff were holding R1 ' s shoulders.</p> <p>CNA #10 verbalized R1 was initially supine but flipped onto stomach and staff were unable to return R1 to a supine position. CNA #10 verbalized releasing R1 several times but R1 would attempt to bite staff. CNA #10 confirmed there were supervisors presenting monitoring R1 in the restraint.</p> <p>CNA #10 verbalized R1 ' s eyes were open at the time the chemical restraint was administered and</p>	W 193			

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W 193	<p>Continued From page 88</p> <p>that R1 was still in a personal restraint. CNA #10 stated after the injection CPR was initiated. CNA #10 stated providing rescue breaths for R1 when EMS arrived. CNA #10 confirmed that R1 had a bruise on check from hitting head on the floor. CNA #10 stated RN #7 and LPN #6 were the nurses present.</p> <p>Assistant Administrator During an interview on 09/19/2025 at 10:27 AM, the Assistant Administrator (Asst Admin) verbalized reviewing the facility 's camera footage of the incident on 09/07/2025. The Asst Admin provided a recall of camera review. R1 was seated on a component of a couch with legs crossed. CNA #5 approached R1, bent slightly forward to pick up R1 's shoes and a blanket. As CNA #5 leaned in R1 lunged toward CNA #5, grabbing hair and attempting to bite. CNA #10 jumped up from a seated position and moved to assist and approached R1 from behind. The chair tilted backwards as the struggle continued. CNA #8 assisted as well but cannot recall at what point. RCS #2 emerged and was speaking to R1. CNA #1 and RCS #4 entered the unit to assist. R1 was supine and actively kicking. On video, a clump of hair is observed on R1 's leg. The Asst Admin reported CNA #10 was on R1 's right side, CNA #8 on R1 's left, RCS #4 holding R1 's ankles. The Asst Admin stated CNA #1 was present but unable to determine location due to dark clothing blending.</p> <p>The Asst Admin verbalized there was a skip in footage and when footage resumes, R1 was prone (face-down). R1 's observed kicking legs, arching back, and moving head side to side. The Asst Admin reported that at some point staff suddenly released R1, staff stand up, and R1 was</p>	W 193			

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W 193	<p>Continued From page 89</p> <p>lying on stomach. The Asst Admin reported LPN #6 and RN #7 entered the unit while R1 was still physically restrained. While in the unit, RN #7 is observed retrieving phone from pants pocket and appeared to be tapping on the phone. Both nurses then leave the unit. The Asst Admin stated CNA #1 appeared to touch R1 in a manner consistent with checking for breathing. Staff at some point flipped R1 over into supine position and placed a pillow under R1 ' s head and R1 ' s eye were closed. The Asst Admin reported RCS #4 placed hand on R1 ' s stomach area in a manner consistent with ensuring resident is breathing.</p> <p>The Asst Admin verbalized RN #7 returned with a syringe in hand and placed a hand on R1 ' s chest to ensure R1 was breathing. R1 was rolled onto left side and RN #7 administered the injection into right buttock/hip area then R1 was rolled back onto back. The Asst Admin verbalized LPN #6 walked up to R1 and placed right hand near R1 ' s mouth which was consistent with checking for breaths coming from the mouth. LPN #6 then touched the right side of R1 ' s neck again which is consistent with checking the pulse. LPN #6 stood up, appeared to say something to the group, then there was a flurry of action. Chest compressions were started but could not recall who initiated. The Asst Admin verbalized staff worked in a buddy system rotating doing compressions. The Asst Admin reported RN #6 placed AED pads on R1 and noted the left side patch was placed in a lower position. The Asst Admin verbalized two other residents were present during the restraint and there were 4 supervisors present at some point. The Asst Admin reported, the humane body wraps were brought by one supervisor, but they were the</p>	W 193			

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W 193	<p>Continued From page 90 wrong size.</p> <p>The Asst Admin verbalized the facility does not train staff to restrain residents on their stomach and when a nurse receives an order for a chemical restraint, it is not explicitly required by policy that the medication must be administered. Chemical restraints are treated the same as any other form of restraint under facility policy. According to the policy, once a client is deemed calm, all forms of restraint, physical or chemical, should be discontinued. Therefore, if the client appears calm and no longer presents a risk, the nurse is not obligated to administer the chemical restraint, even if an order was given. However, this discretion is not clearly outlined in the written policy.</p> <p>The Asst Admin reported R1 had not been combative for approximately 15 minutes when R1 received the chemical restraint. The Asst Admin reported R1 appeared to be unconscious and not combative when R1 received chemical restraint. The Asst Admin reported the initial restraint lasted approximately 7-8 minutes, then there was a skip in the video. When the video resumed, R1 was restrained on stomach approximately another 7-8 minutes.</p> <p>The Asst Admin reported RN #7 was currently on administrative leave due to CPR certification being expired. The Asst Admin verbalized RCST #3 was supervisor on duty, and their responsibilities included ensuring residents are not in distress during a restraint and will instruct staff release restraint if inappropriate. The Asst Admin verbalized R1 should have been placed in a humane wrap and would have preferred the nurse to have completed an assessment of the</p>	W 193			

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W 193	<p>Continued From page 91 resident after the release.</p> <p>Administrator During an interview on 09/19/2025 at 1:03 PM, the Administrator (Admin) reported working approximately 22 years in the Developmental Disability Service division with approximately 19 years being at this facility. The last 8.5 years as the Administrator role.</p> <p>The Admin voiced review of camera footage with the following information. The Admin observed CNA #5 prompting R1 to do something. Then CNA #5 bent down and R1 lashed out and grabbed CNA #5 's hair and attempted to bite. CNA #5 placed hand near R1 ' s in attempted to release R1 ' s grasp while two other staff rushed to assist from behind. Staff were not identified at the time, but they attempted to restrain R1 around the shoulders to get hand released from hair. R1 was seated in a chair and CNA #5 struggled to get released, R1 worked legs up and placed them on CNA #5 abdomen/hip area. Then R1 violently started pushing and tipped the chair over backwards. The two male staff continued to physically restrain R1 and at some point, additional staff were summoned for assistance. The Admin identified CNA #10 as initial staff and CNA #1 as additional staff summoned. R1 continued to resist and attack staff.</p> <p>The Admin reported at some point in the recording there is a 1-minute gap of footage and another point there is approximately 2-minute gap. During this time, R1 went from a supine to prone position. In the prone position, R1 continues to resist. At some point RCTS #9 brings in a humane wrap that was never applied. During the prone position, the restraint staff</p>	W 193			

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W 193	<p>Continued From page 92</p> <p>released R1 and stepped away. R1 laid prone for approximately 10 minutes. During that time. Several staff physically assessed him and from their behavior they did not recognize that R1 was in distress. "In my initial review of camera footage, I was focused on making sure no one had intentionally committed harm or committed anything that was maltreatment." At one point, staff rolled R1 into a supine position and placed a pillow under R1 ' s head. The nurse reentered the frame and staff assisted in rolling R1 on side and you cannot see but I assume that is when the chemical was given.</p> <p>The Admin continued verbalizing shortly thereafter, LPN #6 evaluated and from the reaction of staff they recognized R1 was in distress. The Admin stated staff moved to begin CPR and stopped reviewing the video.</p> <p>The Admin was asked if R1 was a danger to self or other when receiving the chemical restraint and the Admin stated, "with the caveat that I am not licensed, but based on my experience as Administrator, I would say R1 ' s behavior warranted an emergency intervention." The Admin stated the main concern was that R1 was restrained in an unsupported prone position for a significant amount of time. CPI which is taught at this facility, is used for brief and temporary restraint. The Admin reported the details of R1 going from supine to prone are missing due to the video skipping. The Admin commented that staff did check to ensure R1 was breathing and by staff ' s reaction R1 was not in distress. The Admin verbalized R1 had lighting changes on skin, presumably breathing, but did not observe any large muscle movement. The Admin reported CNA #5 and RN #7 were on administrative leave</p>	W 193			

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W 193	<p>Continued From page 93 due to CPR certification being expired.</p> <p>The Admin concluded the interview that there is no law in the state that prohibits prone restraint in an ICF (Intermediate Care Facility) and the facility does not have policies precluding a prone restraint. The Admin stated the nationally recognized training curriculum recognizes two types of prone restraints in their curriculum.</p> <p>Psychiatric Advanced Practice Registered Nurse During a phone interview on 09/23/2025 at 12:56 PM. PAPRN #21 revealed receiving incorrect information from RN #7. PAPRN #21 verbalized being informed R1 was in a mechanical restraint. After speaking with Administration, PAPRN #21 was informed R1 was never in a mechanical restraint and was only placed into a personal restraint. PAPRN #21 indicated once a resident is no longer a threat to self or others, the nursing staff are not required to administer a chemical restraint as ordered but to call PAPRN #21 back and inform of the resident ' s change in behavioral condition no longer requiring a chemical restraint. PAPRN #21 verbalized R1 should never have received the chemical restraint due to the length of time R1 had not been combative.</p> <p>Clinical Psychologist During an interview on 09/23/2025 at 1:33 PM, the Clinical Psychologist (CP) #20 stated being the person that reviews all behavior reports to track and trend resident behaviors. CP #20 indicated using behavior report information to assist in developing behavior support plans for residents. CP #20 reported reviewing R1 ' s behavior report for the incident on 09/07/2025. During CP #20 ' s review, the report did not</p>	W 193			

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W 193	<p>Continued From page 94</p> <p>indicate R1 was in a mechanical restraint only a personal restraint and receiving a chemical restraint. CP #20 stated previously speaking with PAPRN #21 and was informed R1 received a chemical restraint due to being a mechanical restraint. CP #20 stated immediately notifying the Assistant Administrator there was a discrepancy in the behavior report and what was reported to PAPRN #21. CP #20 verbalized being a mandated reporter and felt the discrepancy should be reported to administration.</p> <p>Resident #2 During an interview on 09/29/2025 at 12:54 PM, Resident 2 (R2) reported being present on 09/07/2025 during the incident with R1. R2 verbalized when staff rolled R1 onto back after the release of the restraint, R2 informed staff R1 was not breathing. R2 indicated staff were afraid to do CPR. R2 verbalized wanting to do CPR but was waiting to go to the hospital for an x-ray of arm and was physically unable to do CPR. R2 stated staff should have removed R2 from the situation.</p> <p>Review of training records revealed CNA #1 had completed Phase I training including CPI training on 04/25/2025. Review CPR certification indicated CNA #1 's had a current certification expiring in 04/2027.</p> <p>Review of training records revealed RCS #2 had completed Phase I training including CPI training on 10/01/2010. Review of CPR certification indicated RCS #2 had a current certification expiring in 10/2026.</p> <p>Review of training records revealed RCTS #3 had completed Phase I training including CPI training</p>	W 193			

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W 193	<p>Continued From page 95 on 10/04/2003. Review of CPR certification indicated RCTS #3 had a current certification expiring in 1/2026.</p> <p>Review of training records revealed RCS #4 had completed Phase I training including CPI training on 08/23/2019. Review of CPR certification indicated RCS #4 had a current certification expiring in 06/2026.</p> <p>Review of training records revealed CNA #5 had completed Phase I training including CPI training on 04/11/2023. Review of CPR certification indicated CNA #5 had an expired CPR certification which expired in 04/2025.</p> <p>Review of training records revealed LPN #6 had a current LPN license expiring 03/31/2026. Review of CPR certification indicated LPN #6 had a current certification expiring in 12/2025.</p> <p>Review of training records revealed RN #7 had a current RN license expiring 10/31/2026. RN #7 completed Phase I training including CPI training on 02/22/2019. Review of CPR certification indicated RN #7 had an expired CPR certification which expired on 03/08/2023.</p> <p>Review of training records revealed CNA #8 had completed Phase I training including CPI training on 12/20/2024. Review of CPR certification indicated CNA #8 had a current certification expiring in 11/2026.</p> <p>Review of training records revealed RCTS #9 had completed Phase I training including CPI training on 12/19/2014. Review of CPR certification indicated RCTS #9 had a current certification expiring in 03/2026.</p>	W 193			

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W 193	<p>Continued From page 96</p> <p>Review of training records revealed CNA #10 had completed CPI re-training on 02/22/2019. Review of CPR certification indicated CNA #10 had a current certification expiring in 07/2026.</p> <p>Crisis Prevention Intervention (CPI) Review of Crisis Prevention Intervention (CPI) documentation revealed that in an emergency, staff may have to temporarily hold a person in a supported prone, or face-down position, on the floor.</p> <p>Staff supporting the arms are instructed to apply the outside/inside principle by keeping the hand nearest the person on their wrist, the hand furthest from the person on their elbow, ensuring the person ' s elbow rests as close as possible to their body, with their wrist directly below their shoulder, so their shoulder is raised from the floor. Staff are to lie flat, placing their body on the outside of the person ' s elbow.</p> <p>The document revealed that when holding a person in an emergency floor hold in a supported prone position, staff may have to move the person into a supine position to maximize safety and minimize harm. It elaborated that staff are never to hold the person in an unsupported prone position.</p> <p>Job Descriptions Review of a Functional Job Description for the Certified Nursing Assistant revealed the Certified Nursing Assistant works under the general supervision of a Residential Care Supervisor/Residential Care Team Supervisor and is responsible for providing routine non-professional care of clients in a human</p>	W 193		

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W 193	<p>Continued From page 97</p> <p>development center, such as assistance. with hygiene, grooming, meals, toileting, and other activities of daily living. The Certified Nursing Assistant provides active treatment for the clients, ensures the health .and safety of the clients, and manages client inappropriate behaviors with approved management techniques and strategies.</p> <p>Review of a Functional Job Description for the Licensed Practical Nurse revealed the Licensed Practical Nurse is responsible for providing direct nursing care to patients in private homes, hospitals, clinics, and residential institutions. The functions include monitoring patient's condition by checking vital signs, measuring food and liquid intake and output, responding to call lights or patients' requests for assistance. and making rounds to observe patients. Provides direct care to patients...Documents and administers medications and treatments, changes in patient's condition or behavior, responses to care, and daily activities. Daily job duties include dealing with behaviors.</p> <p>Review of a Functional Job Description for the Registered Nurse revealed the Registered Nurse works under the general supervision of the Nursing Services Unit Manager and is responsible for evaluating and providing direct patient care. The Registered Nurse administers medications in compliance with OLTC and State board of nursing, provides nursing care and treatments... Contacts MD/APRN as needed for client orders. Provides nursing care during behaviors, contacts psychiatrist, and monitors client if in restraint.</p> <p>Review of a Functional Job Description for the</p>	W 193			

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W 193	Continued From page 98 Residential Care Supervisor/Expert revealed the Residential Care Supervisor works under the general supervision of the Residential Care Team Supervisor or Residential Care Manager and is responsible for analyzing, monitoring, mentoring, and evaluating the performance of Certified Nursing Assistants (CNAs) while directing the in-house operations of client care in a State operated facility. The Residential Care Supervisor supervises CNAs; mentors other RCS's and CNA staff; monitors performance of CNAs; provides guidance/instruction for staff regarding living unit operations and quality of client care; provides positive feedback on staff performance and constructive recommendations for improvement when weakness in CNA performance is identified; monitors and assesses the physical home environment and active treatment; assigns tasks to CNAs; conducts quarterly and as needed in-service and training for CNAs; verifies compliance with federal and state regulations and laws regarding operations of an ICF/IID, as well as compliance with agency/facility policy; addresses regulatory noncompliance issues with CNAs; addresses CNA noncompliance with client individual program plan (IPP) requirements; monitors client hygiene and grooming for compliance with quality standards; serves as Qualified Intellectual Disabilities Professional (QIDP)/designee; provides valuable input regarding client as member of the interdisciplinary team (IDT); monitors completed client related documentation for accuracy and quality improvement purposes; attends all mandatory training/in-services and applies knowledge/skills/information learned in performance of job duties. Review of a Functional Job Description for the	W 193			

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W 193	<p>Continued From page 99</p> <p>Residential Care Team Supervisor/Expert revealed the Residential Care Team Supervisor is responsible for overseeing the daily operations of a residential care facility, ensuring high-quality services and a safe, supportive environment for residents. This position provides leadership, supervision, and guidance to direct care staff while ensuring compliance with Arkansas state regulations and policies. The role requires strong leadership, problem-solving, and communication skills to effectively manage personnel, resolve resident concerns, and maintain operational efficiency. Responsibilities include to supervise, train, and evaluate direct care staff to ensure high standards of resident care and facility operations. Oversee the implementation of individualized care plans tailored to residents ' medical, social, and emotional needs. Monitor resident well-being and coordinate services with healthcare providers, therapists, and caseworkers. Respond to resident concerns, grievances, and emergency situations in a timely and effective manner. Ensure the facility operates in compliance with Arkansas health and safety regulations, Medicaid requirements, and agency policies. Conduct regular inspections and audits to maintain a clean, safe, and efficient living environment. Maintain accurate records, documentation, and reports related to resident care, staff performance, and incident management. Provide guidance and support in behavioral interventions, crisis management, and de-escalation techniques. Serve as the point of contact during emergencies, including medical incidents, behavioral issues, and facility-related concerns.</p> <p>Review of a Functional Job Description for the Nurse Manager revealed the Nurse Manager works under the general supervision of the</p>	W 193			

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W 193	Continued From page 100 Superintendent and is responsible for planning and directing the Nursing programs for SEAHDC. The Nurse Manager is a member of the Executive Staff and exercises a high level of judgement and broad authority to help manage the facility. Job Duties & Responsibilities include: Assists the Superintendent in the overall management of the facility; Represents the facility at special events; Plans and develops the strategic direction of the Nursing department; Directs the operations of the Nursing department; Exercises a high level of judgment; Cultivates relationships with community partners to provide services for residents; Ensures that programming offered meets the training needs of SEAHDC residents and is in compliance with state and federal regulations for active treatment in an ICF/IID; Conducts audits and inspections of the facility; Co-creates value along with other facility managers to ensure the facility provides high quality services to residents; Develops and implements facility and department policies, as well as nursing practices. Supervises personnel and activities in the Nursing department; Interviews and hires staff; Prepares functional job descriptions and PGCS packets; conducts performance evaluations; identifies training needs of staff supervised; counsels staff and administers discipline as needed; conducts monthly staff meetings; provides guidance to employees in relation to departmental issues. Coordinates and oversees the services provided by contractors including, but not limited to Speech Therapy, Physical Therapy, Occupational Therapy, Psychology, Psychiatry, & Dentistry. May conduct audits to ensure quality of service provision; Resolves conflicts between contractors and facility. Assists the Superintendent with administrative tasks. May represent the facility in	W 193			

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W 193	Continued From page 101 the absence of the Superintendent. May provide direct patient care within the RN scope of practice. Review of a Functional Job Description for the Residential Director revealed the Residential Director works under the general supervision of the OHS/DDS Superintendent HOC; Serves on the Executive Staff; Directs the 24-hour operation of living unit services within the human development center setting; performs administrative duties; may act on behalf of the Superintendent. Duties to be completed daily include: Organizes the 24-hour operations of Residential Services; monitors to ensure effectiveness of operations; coordinates activities with other Service Areas; reviews, approves and monitors Living Unit programs; develops and interprets policy and procedures; analyzes service area needs and recommends purchases/expenditures; monitors expenditures through review of supply usage, condition of equipment, and recurring needs; determines staffing levels for the Living Units; approves any changes in the Living Units, individual moves, staff changes; ensures the security of the individuals served; investigates and responds to complaints; establishes and monitors appropriate record keeping procedures, both in the . office and the units; approves special events/outings and holiday programs. Directly supervises Residential Services Manager, Residential Care Shift Managers, Residential Operations Managers, and Administrative Specialist II and III; indirectly supervises other staff through monitoring, making rounds, etc; Cultivates subordinate supervisors to give them the skills necessary to lead employs and ensure compliance with policies, practices, and program;	W 193			

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W 193	<p>Continued From page 102</p> <p>interviews and selects applicants; approves hiring recommendations of other supervisors; allocates resources and sets work priorities; evaluates employee performance; plans and participates in the training of employees; provides guidance regarding programming, daily operations and other aspects of work; assists employees with problems/concerns; takes disciplinary actions, non-disciplinary actions and provides written observations to employees as needed; conducts staff meetings.</p> <p>Policies</p> <p>Review of a policy titled, "Emergency Chemical Intervention," indicated the facility is committed to managing inappropriate behaviors and psychiatric symptoms that place the individual or others in danger using the least restrictive techniques. Emergency Chemical Intervention will not be used as a punishment, in lieu of programming or for staff convenience.</p> <p>It included the procedure:</p> <ol style="list-style-type: none"> 1. When an individual exhibits dangerous behaviors or their behavior indicates that dangerous behavior will soon follow, staff will contact the nurse on duty. <ol style="list-style-type: none"> a. The nurse will contact the Psych APRN, OR MD for further orders. 2. Staff working with the individual will note the use of Emergency Chemical Intervention on the Behavior Report Form and the Restraint Form. The nurse will document on the form her initial and the time given. 3. Guardians will be notified of the use of 	W 193			

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W 193	<p>Continued From page 103</p> <p>Emergency Chemical Intervention by the nurse.</p> <p>4. The nurse will observe the client for any signs or symptoms of an adverse reaction to the Emergency Chemical Intervention at 15minutes after, 30minutes after, 1 hour after, and 4 hours after the Emergency Chemical Intervention. This is to be documented on the Emergency Chemical Intervention form.</p> <p>5. If any signs or symptoms of an adverse reaction are noted, vital signs are to be obtained, and the MD notified immediately. if at any time the client is noted to be having any respiratory distress then 911 should be called immediately, and the nurse is to remain with the client till the ambulance arrives.</p> <p>Review of a policy titled, "Use of Restraints," indicated the facility is committed to managing the dangerous behaviors of clients that place the safety of the client and/or others at risk by using the least restrictive interventions that are effective in managing the behavioral situation. While the elimination of dangerous behaviors is sought using positive behavior interventions and de-escalation techniques, it is acknowledged that clients may not always respond to these interventions and the dangerous behavior may escalate to an emergency situation in which physical and/or chemical restraint may be required to protect the safety of the client and/or others.</p> <p>Procedures provided included: 1. Authorization a. The QIDP or Supervisor on Duty will ensure that the least restrictive interventions are used</p>	W 193			

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W 193	<p>Continued From page 104 to effectively manage the behavioral situation .</p> <p>b. Personal Restraint i. Must be authorized by the QIDP or Supervisor on Duty ii. If staff is unable to call for authorization before the personal restraint is applied, staff will call the QIDP or Supervisor on Duty for authorization as soon as safely possible after the restraint is applied.</p> <p>c. Mechanical Restraint i. Must be authorized by the QIDP or Supervisor on Duty ii. If staff is unable to call for authorization before the mechanical restraint is applied, staff will call the QIDP or Supervisor on Duty for authorization as soon as safely possible after the restraint is applied. iii. The QIDP or Supervisor on Duty will notify the Superintendent/designee of the restraint use as soon as possible</p> <p>d. Preventive Restraint i. The client's Interdisciplinary Team ("IDT") determines if a preventive restraint (e.g., padded mittens) or restrictive clothing (e.g., a singlet body suit) is necessary to prevent or inhibit maladaptive behaviors (e.g., chronic skin picking; rectal digging and fecal smearing) that may place the client at greater risk of injury (e.g., infection due to reduced skin integrity). ii. Preventive Restraint is not used in an emergency situation; rather, it is used to prevent or inhibit maladaptive behaviors. iii. The IDT will specify when the preventive restraint will be applied and when it will be removed. Times will be documented on a form</p>	W 193			

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W 193	<p>Continued From page 105 specifically designed for the client and the device.</p> <p>iv. The use of Preventive Restraint will be documented in the client's Individual Program Plan.</p> <p>e. Chemical Restraint</p> <p>i. Must be ordered by the physician/psychiatric nurse practitioner</p> <p>ii. Nurse will administer as per doctor's/Psych APRN's order and authorization</p> <p>iii. Nurse will notify the Superintendent/designee as soon as possible</p> <p>2. Monitoring</p> <p>a. Personal Restraint</p> <p>i. Constant visual monitoring by staff is required while the client is in personal restraint</p> <p>b. Mechanical Restraint</p> <p>i. Constant visual monitoring by staff is required while the client is in mechanical restraint</p> <p>ii. The QIDP or Supervisor on Duty and a licensed nurse must assess the restraint incident face-to-face every 15 minutes to monitor the client for signs of distress and to ensure restraint integrity to optimize the safety of the client. Constant in-person monitoring of the restraint by the QIDP or Supervisor on Duty and a licensed nurse is preferred.</p> <p>c. Preventive Restraint</p> <p>i. Staff will monitor client for signs of distress and the integrity of the preventive restraint throughout the day as they go about their routine care of clients. This monitoring of the client and restraint integrity is to optimize the safety of the client.</p>	W 193			

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W 193	<p>Continued From page 106</p> <p>d. Chemical Restraint</p> <p>i. A licensed nurse will follow-up with the client per nursing guidelines.</p> <p>ii. NOTE: The licensed nurse must initial the Restraint Reporting Form when the chemical restraint was administered.</p> <p>The Policy titled Rights of Clients Served by The Facility (Facility 23) read in part " ... Individuals will be free from mental and physical abuse and free from physical and chemical restraints. Restraints can be temporarily ordered by a physician for medical purposes or to promote healing, applied in an emergency to prevent injury to the client and to others, as part of the Behavioral Support Plan or Health/Safety Plan. Emergency programmatic application of restraint requires authorization of a QIDP for continuation and extension ...As a resident you have the right to be: free from mental, physical, verbal and sexual abuse ...free from chemical and physical restraints except when authorized in writing by a physician for a specific and limited period of time, or by a QIDP only to protect you or others from injury ...Every resident has the right to:...privacy during treatment and care of personal needs. People not involved in the care of residents shall not be resident without the consent from the resident during examinations and treatment ..."</p> <p>Standards of Practice</p> <p>Review of "Standards of Practice: Seclusion and Restraint," revised February 2022 per the American Psychiatric Nurses Association, revealed, "When an individual is physically restrained, immediate action is required to mitigate positional risks: prone restraint requires monitoring for the risk of positional asphyxiation."</p>	W 193			

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W 195	<p>ACTIVE TREATMENT SERVICES CFR(s): 483.440</p> <p>The facility must ensure that specific active treatment services requirements are met.</p> <p>This CONDITION is not met as evidenced by: Based on observations, interviews and record review, the facility failed to establish and follow an effective process to ensure all clients receive the services determined necessary based on the Individual Program Plans and failed to have an established, effective process to notify staff of changes to the IDT. (Cross Reference W249).</p> <p>The cumulative effect of these systemic problems resulted in the Condition of Participation, Active Treatment Services being found as not met.</p>	W 195			
W 249	<p>PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1)</p> <p>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</p>	W 249			

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W 249	<p>Continued From page 108</p> <p>interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>This STANDARD is not met as evidenced by: Based on interviews, record review, facility document review, facility policy review, and camera footage review, it was determined that the facility failed to implement the Individual Program Plan (IPP) including Behavior Support Plan (BSP) by placing adaptive equipment on resident to prevent biting and failed to ensure direct care staff were informed of changes to BSP for 1 (Resident #1) of 3 residents reviewed for implementation of IPP including BSP.</p> <p>These findings have been determined to be Immediate Jeopardy as defined at 42 CFR §483.420(a)(6). The IJ began on 09/07/2025. The survey team provided the State Operations Manuel Appendix Q Immediate Jeopardy template to the Administrator on 09/23/2025 at 2:40 PM. The facility provided a plan of removal on 09/24/2025 at 11:25 AM and was approved on 09/24/2025 at 1:12 PM. The Plan of Removal noted all corrections were completed on 09/24/2025.</p> <p>Findings include:</p> <p>A review of the Face Sheet indicated the facility admitted Resident #1 with diagnoses that included severe intellectual disability, autism spectrum disorder, seizure disorder, 9P Syndrome (neurological disorder) unspecified disruptive, impulse control, and conduct disorder.</p>	W 249			

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W 249	Continued From page 109 Review of the social history intake dated 02/12/2025, revealed Resident #1 had functional language age equivalent to 2 years. Behaviors exhibited included aggression (biting, scratching, pulling hair, kicking, or hit), property destruction (flip furniture if frustrated), self-injury (will hit self). Resident #1 ' s current supervision level 1:1 and visual during sleeping hours. A 30-day review was scheduled for 03/18/2025. Review of the 30-day review by Clinical Psychologist (CP #20) dated 03/05/2025 revealed Resident #1 had a significant problem with biting and causing significant injury to those bitten. Resident #1 wore a helmet during the day to prevent resident from biting others. The review included current behavioral information, including a Behavioral Support Plan (BSP) which was in progress with the recommended target behavior of physical aggression. CP #20 recommended the IDT (Interdisciplinary Team) consider initiating a BSP with the target behavior of physical aggression. The Behavior Support Plan (BSP) with review date of 03/13/2025 and implementation date of 03/20/2025, revealed Resident #1 was a severe biter and had bitten the resident ' s own mother ' s thumb off and the side of a peer ' s face from the eyebrow to jaw. The BSP included, "as soon as client responds to an intervention, there is no need to proceed further." The BSP documented the first intervention is the use of the preventive restraint helmet which included staff will follow the schedule set by the IDT (Interdisciplinary Team) and record when the helmet is taken off and put on using a specific form. The BSP included other interventions of positive reinforcement,	W 249			

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W 249	<p>Continued From page 110</p> <p>redirection, separation to allow calming, resident choices, and verbal intervention. The prevention and intervention portion documented, staff shall take immediate action to deflect or physically stop Resident #1 from engaging in self-injuries or aggressive behavior using the least restrictive method that is effective in managing behavioral needs. Staff shall remember their training in facility policies on how to manage behavioral emergencies.</p> <p>The Individual Program Plan (IPP) annual review meeting was held on 03/18/2025 and implemented on 04/01/2025.</p> <p>The Individual Program Plan (IPP) with an implementation date of ?04/01/2025?, revealed Resident #1 had severely impaired intellectual functioning level (limitations on intelligence, learning, adaptive behavior and everyday abilities), required one on one supervision level, targeted behavior of physical aggression, and required a hard-shell helmet as adaptive equipment.</p> <p>A review of IDT meetings notes revealed on 04/03/2025 a special IDT meeting was held to discuss a schedule to lessen the time Resident #1 wears hard-shell helmet. It was determined the first step would be for Resident #1 to not wear the helmet at meals and snack times, in addition to not wearing a helmet during sleeping times and bathing. CP #20 had the paperwork to account for the time the helmet was taken off and when it was placed back on. Stall will document the times and plan to lessen the time in helmet at next BSP meeting.</p> <p>A review of IDT meeting notes, dated 04/18/2025,</p>	W 249			

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W 249	<p>Continued From page 111</p> <p>revealed a special IDT meeting was held to discuss the possibility of placing Resident #1 on enhanced supervision while awake and with the helmet off. This would include lessen supervision level to visual supervisor while in room and times when wearing helmet. Resident #1 will have 30-minute safety checks.</p> <p>A review of a behavior report dated 05/01/2025 revealed Resident #1 had agitation that included pushing and screaming. Staff documented helmet was placed on resident and removed when resident went to sleep.</p> <p>A review of a behavior report dated 05/10/2025 revealed Resident #1 had inappropriate behaviors that included agitation, a tantrum, and attempted property damage. Resident #1 exhibited physical aggression, including attempted biting, hitting/slapping, and pushing/pulling. Resident #1 was redirected, received verbal intervention, and graduated guidance.</p> <p>A review of a behavior report dated 05/11/2025 revealed Resident #1 had inappropriate behavior including agitation and stealing snacks. Resident #1 exhibited physical aggression in the form of pushing/pulling. Resident #1 was redirected and received verbal intervention.</p> <p>A review of a behavior report dated 05/12/2025 revealed Resident #1 had inappropriate behavior, including agitation, a tantrum, and attempted own property damage. Resident #1 exhibited physical aggression in the form of pushing/pulling. Resident #1 was redirected, received verbal intervention, and graduated guidance.</p> <p>A review of a behavior report dated 05/30/2025</p>	W 249			

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W 249	<p>Continued From page 112</p> <p>revealed Resident #1 had inappropriate behavior including agitation and a tantrum. Resident #1 exhibited physical aggression in the form of choking self with helmet. Resident #1 was taking own helmet off and attempted to bite staff. Resident #1 was redirected with verbal intervention and medical services were contacted.</p> <p>A review of nursing notes for Resident #1 revealed no documentation for 05/30/2025.</p> <p>A review of a behavior report dated 05/31/2025 revealed Resident #1 had inappropriate behavior including agitation, a tantrum, and property damage of another client. Resident #1 exhibited physical aggression in the form of pushing/pulling. Resident #1 was redirected and received verbal intervention and graduated guidance. The supervisor was requested for assistance, and medical services were contacted. The Superintendent/Designee was informed of the aggression toward peers.</p> <p>A review of nursing notes revealed no documentation for 05/31/2025 on Resident #1.</p> <p>A review of a behavior report dated 06/10/2025 revealed Resident #1 had inappropriate behaviors including agitation and tantrum. Resident #1 exhibited physical aggression including biting, hitting/slapping, pushing/pulling, and scratching. Resident received redirection including restitution, verbal intervention, and graduated guidance. The supervisor was requested for assistance. Medical services were contacted due to fall in bedroom.</p> <p>A review of nursing notes dated 06/10/2025 at 7:18PM indicated a nurse completed a skin audit</p>	W 249			

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W 249	<p>Continued From page 113 and fall evaluation.</p> <p>A review of a behavior report dated 06/14/2025 revealed Resident #1 exhibited inappropriate behavior including a tantrum. Resident #1 had physical aggression including pulling a chair from another resident. Resident received redirection including verbal intervention.</p> <p>A review of a behavior report dated 06/24/2025 revealed Resident #1 exhibited inappropriate behavior including a tantrum. Resident #1 did not exhibit any physical aggression and received redirection with verbal intervention.</p> <p>A review of a behavior report dated 06/25/2025 revealed Resident #1 had inappropriate behaviors, including agitation and a tantrum. Resident #1 had physical aggression including attempted biting and hitting staffing. Resident #1 was redirected with verbal intervention and graduated guidance. The crisis team and medical services were contacted. The Superintendent/Designee was informed of the aggression toward peers.</p> <p>A review of IDT meeting notes dated 06/26/2025 a special IDT meeting was held to discuss the possibility of discontinuing the preventative restraint of wearing helmet. All team members present discussed Resident #1 not needing the helmet due to behaviors of biting or spitting not having been reported. It was agreed Resident #1 will no longer have the helmet used as a preventative restraint.</p> <p>A review of a behavior report dated 07/02/2025 revealed Resident #1 had inappropriate behaviors including agitation. Resident #1 exhibited physical</p>	W 249			

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W 249	<p>Continued From page 114</p> <p>aggression including biting, hitting/slapping, kicking, pushing/pulling, and scratching Resident Care Supervisor (RSC) #18. Resident #1 was redirected with verbal intervention and graduated guidance. Medical services were contacted.</p> <p>A review of IDT meeting notes dated 07/03/2025 indicated a special IDT meeting was held to discuss Resident #1 ' s needs to resume wearing the preventative restraint helmet. The notes indicated Resident #1 had an incident the day prior to the meeting which indicated Resident # 1 needed the helmet to ensure the safety of Resident #1, peers, and staff. Parameters were set by CP #20 including staff documenting the time the helmet was placed on and off using a specific form, Resident #1 will not wear helmet while eating, sleeping, and bathing. The helmet will be removed after an additional 15 minutes after the lunch meal.</p> <p>The preventive restraint log implemented on 07/03/2025 documented, "Instructions: Resident #1 will wear the helmet except for eating bathing and sleeping. It will be left off an additional 15 minutes after meals and snacks. Staff will document the placement and removal of Resident #1 ' s helmet on this form and turn it into residential services when the form is completed."</p> <p>A review of the preventive restraint log dated 07/03/2025, revealed there was no documentation 07/05/2025 through 07/18/2025, 07/20/2025 through 07/23/2025, or 07/24/25 through 09/06/2025. On 09/07/2025 Resident #1 had the helmet in place from 8:50 AM till 11:30 AM, with no further documentation of the helmet being on the rest of the day.</p>	W 249			

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W 249	<p>Continued From page 115</p> <p>A review of a behavior report dated 07/04/2025 revealed Resident #1 had inappropriate behaviors including agitation and attempted property damage. Resident #1 had physical aggression including attempted biting and kicking. Resident #1 received redirection and graduated guidance. Medical services were contacted. Resident #1 received a personal restraint at 5:20 PM and a chemical restraint at 6:07 PM.</p> <p>A review of the debriefing form for a behavior report dated 07/04/2025 indicated Resident #1 received a physical and chemical restraint due to attempts to bite staff and agitation. Possible actions by staff to decrease further necessity of restraint documented, "Continue to follow Resident #1 BSP with consistency."</p> <p>A review of nursing notes dated 07/04/2025 indicated Resident #1 had a behavior and was attempting to bite staff and hitting staff. Psychiatric Advanced Practice Registered Nurse (PAPRN) #21 was notified at 5:33 PM and provided an order for chemical restraint. The chemical restraint was administered at 6:07 PM.</p> <p>A review of a behavior report dated 07/05/2025 revealed Resident #1 had inappropriate behaviors including agitation and property damage. Resident #1 had physical aggression including attempted pushing/pulling. Resident #1 was redirected with verbal intervention.</p> <p>A review of a behavior report dated 07/13/2025 revealed Resident #1 had inappropriate behavior including agitation and a tantrum. Resident #1 had physical aggression including biting, hitting/slapping, and pushing/pulling. Resident #1 was redirected with restitution, verbal</p>	W 249			

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W 249	<p>Continued From page 116 intervention, and graduated guidance.</p> <p>A review of a behavior report dated 07/24/2025 revealed Resident #1 had inappropriate behaviors including nonperformance and pestering others. Resident #1 had physical aggression including head butting. Resident #1 was redirected with graduated guidance.</p> <p>A review of a behavior report dated 07/27/2025 revealed Resident #1 had inappropriate behaviors including tantrum, agitation, and smearing. Resident #1 had physical aggression including biting, hair pulling, head butting, hitting/slapping, and kicking. Resident #1 was redirected with verbal intervention and graduated guidance. The staff suggested separation to allow calming and separation from activity. The supervisor and the crisis team were requested for assistance.</p> <p>A review of a behavior report dated 08/09/2025 revealed Resident #1 had inappropriate behavior including agitation and stealing peer ' s property. Resident #1 had physical aggression including hitting/slapping, kicking, and scratching. Resident #1 was redirected with verbal intervention.</p> <p>A review of a behavior report dated 08/11/2025 revealed Resident #1 had inappropriate behaviors including a tantrum and property damage. Resident #1 exhibited physical aggression by knocking things down. Resident #1 was redirected with verbal intervention. The crisis team was requested.</p> <p>A review of a behavior report dated 08/14/2025 revealed Resident #1 had inappropriate behaviors including agitation and property damage. Resident #1 had physical aggression including</p>	W 249			

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W 249	<p>Continued From page 117</p> <p>biting, hitting/slapping, kicking, and pushing/pulling. Resident #1 was redirected with verbal intervention.</p> <p>A review of a behavior report dated 08/16/2025 at 6:40AM revealed Resident #1 had inappropriate behaviors including property damage, a tantrum, and agitation. Resident #1 exhibited physical aggression including biting. Resident #1 was redirected with verbal intervention. The supervisor was requested for assistance.</p> <p>A review of a behavior report dated 08/16/2025 at 2:48PM revealed Resident #1 had inappropriate behaviors including agitation. Resident #1 exhibited physical aggression including attempted biting and pushing/pulling. Resident #1 was redirected with verbal intervention and graduated guidance.</p> <p>A review of a behavior report dated 08/26/2025 at 5:35PM revealed Resident #1 had inappropriate behaviors including agitation and tantrum. Resident #1 exhibited physical aggression including biting, hair-pulling, hitting/slapping, and scratching. Staff attempted redirection with verbal intervention and graduated guidance. Resident #1 received a chemical restraint at 6:06 PM</p> <p>A review of the debriefing form for a behavior report dated 08/26/2025 indicated Resident #1 received a chemical restraint due to attacking staff by biting right thumb, pulling hair out, tantrum and agitation. Possible actions by staff to decrease further necessity of restraint documented, "Continue to follow Resident #1 BSP with consistency."</p> <p>A review of a behavior report dated 09/03/2025</p>	W 249			

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W 249	<p>Continued From page 118</p> <p>revealed Resident #1 had inappropriate behaviors including agitation and property damage. Resident #1 exhibited physical aggression including pushing/pulling staff. Resident #1 was redirected with verbal intervention.</p> <p>A review of a behavior report dated 09/07/2025 revealed Resident #1 had inappropriate behaviors including agitation and psychiatric symptoms. Resident #1 exhibited physical aggression including hair-pulling. Report documented supervisor was called at 6:40 PM and nurse was called at 6:41 PM.</p> <p>A review of the restraint reporting form dated 09/07/2025 at 6:43PM, documented Resident #1 was in a personal restraint at 6:43 PM and was released at 6:58 PM. Resident #1 received a chemical restraint at 7:04 PM.</p> <p>A review of the debriefing form for behavior report dated 09/07/2025 indicated Resident #1 received a personal and chemical restraint due to aggression to staff and to prevent escalation again. In the "possible actions by staff to decrease future necessity of restraint" there was no documentation. In additional comments section there is documentation immediately after the chemical restraint medical took charge.</p> <p>A review of Resident #1 ' s unit book located in the unit 17 office, revealed a face sheet, an in-service dated 04/10/2025 labeled IDT in-service training which did not have any staff signatures, 04/03/2025 IDT meeting with notes, IPP dated 04/01/2025, BSP with implementation date 03/20/25, an undated BSP in-service revealed only two staff signatures, habilitation objectives with completion date 03/31/2026, an</p>	W 249			

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W 249	<p>Continued From page 119</p> <p>individual 24-hour schedule, admission intake meeting sign in sheet, suicide risk assessment, social history intake, IDT meeting held on 02/13/2025, human rights committee consent for restriction form dated 02/13/2025, previous facility face sheet, previous facility medical information face sheet, and previous facility, IPP.</p> <p>A review of facility camera footage from 09/07/2025 at 6:35PM revealed Resident #1 sitting on the end of a couch with legs crossed and not wearing a helmet. The helmet is observed lying on the end of a different couch in the room.</p> <p>During an interview on 09/16/2025 at 7:26PM, the Certified Nursing Assistant (CNA) #5 confirmed supervisors inform direct care staff when there is a change to a BSP. CNA #5 confirmed Resident #1 was previously required to always wear helmet but thought it had been changed to no longer required to have on except when attempting to bite others. CNA #5 confirmed not being made aware Resident #1's BSP had changed, requiring Resident #1 to always wear helmet except meals and sleeping. CNA #5 verbalized Resident #1 was one on one supervision due to recently biting a staff member. CNA #5 confirmed Resident #1 had a dressing on buttocks and Resident required frequent monitoring to prevent Resident #1 from picking at the dressing. CNA #5 confirmed Resident #1 was not wearing helmet on 09/07/2025 when CNA #5 came on shift. CNA #5 stated, "If I had known he was to wear a helmet, I think that would have changed everything and Resident #1 would not have tried to bite me."</p> <p>During an interview on 09/17/2025 at 1:35PM,</p>	W 249			

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W 249	<p>Continued From page 120</p> <p>Registered Nurse Manager (RNM) verbalized Resident #1 had a helmet with a face shield to be worn as part of the BSP due to biting.</p> <p>During an interview on 09/18/2025 at 10:16AM, the Health Program Coordinator (HPC) #13 confirmed being responsible for Resident #1 health programming. HPC #13 confirmed being responsible for setting objectives for residents during IDT meetings and IPP meetings. HPC #13 stated being the liaison between the facility and the guardians. HPC #13 states being responsible for leading IDT meetings and ensuring residents are receiving the necessary services to better assist in becoming as independent as possible. HPC #13 confirmed IPP and BSP changes which occur during IDT meetings are sent in a memo to residential services and department heads via email.</p> <p>During an interview conducted on 09/18/2025 at 2:57 PM, Quality Assurance Supervisor (QAS) #15 stated that the Quality Assurance Department did not have a system in place to ensure that changes to the IPP or BSP were effectively communicated to direct care staff, but verbalized that they would be glad to create one.</p> <p>During an interview on 09/18/2025 at 3:28PM, the Maltreatment Investigator (MI) confirmed direct care staff are informed of changes through their supervisor when an IPP or BSP is created or changed. The MI verbalized each resident has a designated book in the unit containing the relevant information and staff are expected to review it prior to working with the residents.</p> <p>During an interview on 09/19/2025 at 9:49AM, the Residential Director (RD) confirmed residential</p>	W 249			

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W 249	<p>Continued From page 121</p> <p>services are responsible for ensuring staff are informed of changes to residents ' IPP and BSPs. The RD stated the changes are sent to residential services office via email, residential services make a copy of the updated BSP, and the Residential Care Team Supervisors (RCTS) take copies to Residential Care Supervisors (RCS) in the unit. The RCSs educate direct staff when staff arrive at work in the unit. A copy of the updated BSP is placed in the resident ' s unit book with in-service training sheets to be signed off when reviewed. The RD verbalized having the responsibility for verifying completion of in-services by RCTS and RCS by conducting unit visits and ensuring documentation is accurate and up to date.</p> <p>During an interview on 09/19/2025 at 10:27AM, the Assistant Administrator (Asst Admin) verbalized the completed IPP is sent to residential services. The supervisors ' in-service staff on the IPP information and place the IPP in the resident ' s unit book. Asst Admin stated the IPP is in a simple format for staff who float from different units can review quickly. The IPP format has pictures and colors for easy reference and the IPP will identify if the resident has a BSP. Asst Admin verbalized changes in BSP are sent to residential services to in-service staff. Asst Admin stated resident care supervisors provide the in-service to direct care staff on the program changes. Asst Admin stated the in-service sheets are sent from residential services to quality assurance to track the training was received by staff. The Assist Admin verbalized the Residential Director is responsible for ensuring direct care staff are in-serviced by residential care supervisors. The Asst Admin reported the facility has one staff member off work due to R1 biting</p>	W 249			

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W 249	<p>Continued From page 122</p> <p>thumb and fracturing it. Asst Admin stated the employee is currently on antibiotics and may end up losing the thumb. Asst Admin reported a second employee is on light duty due R1 biting employee's hand causing nerve damage.</p> <p>During an interview on 09/19/2025 at 1:03PM, the Administrator (Admin) verbalized resident information is given through an in-service with direct care staff from the residential supervisors. The Admin verbalized there are times when the information is given through other staff depending on the circumstances. The Admin confirmed residential supervisors receive the information and in-service direct care staff. The Admin confirmed direct care staff are expected to read residents ' BSP as part of their job responsibilities. The Admin confirmed IPP ' s and BSP ' s are located in each unit the resident resides in. The Admin confirmed Resident #1 was not wearing the helmet with face shield per the BSP on 09/07/2025 at the time of incident.</p> <p>During an interview on 09/19/2025 at 2:37PM, the Administrator verbalized the facility did not have the training in-service sign in sheets for BSP changes for direct care staff on Resident #1.</p> <p>During an interview on 09/23/2025 at 12:56 PM, the PAPRN #21 confirmed Resident #1 is to wear a helmet with face shield except during meals, snack times, and while sleeping. PAPRN #21 verbalized the face shield was a very pertinent part of the Resident plan due to being a threat to harm others. PAPRN #21 verbalized being informed Resident #1 did not have their helmet on during the behavior incident that occurred on 09/07/2025. PAPRN #21 verbalized Resident #1 had a history of biting, including biting their</p>	W 249			

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W 249	<p>Continued From page 123 mother ' s thumb off.</p> <p>During an interview on 09/23/2025 at 1:33 PM, the CP #20 confirmed writing the BSP for Resident #1 and tracking behaviors by reviewing the behavior reports. CP #20 confirmed creating the preventive restraint form for Resident #1. CP #20 verbalized completing training with residential services supervisors and habilitation supervisors on the changes of BSPs for residents, and that supervisors will training the direct care staff. CP #20 confirmed that extra training is completed when needed. CP #20 verbalized BSPs are not for emergency use but for behavior support. CP #20 stated training for emergency situations is completed by the staff development department. CP #20 stated staff are required to use the least restrictive interventions prior to any type of physical or chemical restraint. CP #20 confirmed Resident #1 had a history of aggression and biting, which required Resident #1 to wear a helmet for protection of self, staff, and peers.</p> <p>During an interview on 09/23/2025 at 2:17PM, HPC #13 confirmed the preventive restraint logs are sent to HPC for review then sent to the master file room. HPC #13 confirmed receiving preventive restraint logs on occasion but not as often as would have liked.</p> <p>Review of a policy titled, "Implementation of the Individual Program Plan (IPP)," revealed, "The Individual Program Plan (IPP) will be drafted, approved, finalized, and placed in the Master File within 30 days of the Interdisciplinary Team Meeting. Each Case Manager/Qualified Intellectual Disabilities Professional (QIDP) will prepare the IPP for the clients in their respective caseloads.</p>	W 249			

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W 249	Continued From page 124 The Procedure included: 1. The Case Manager/QIDP will draft, print and distribute the initial rough draft and data sheets to the service areas for review/edits within three (3) days of the staffing date. 2. The Case Manager/QIDP will type and submit the rough draft IPP to a peer Case Manager/QIDP for quality review and oversight. 3. The Case Manager/QIDP peer will review, make recommendations if indicated, and submit the rough draft back to the original Case Manager/QIDP. 4. The Case Manager/QIDP will then forward the rough draft to a Registered Nurse (RN) who will review the medical objectives, medications list, lab dates, vision exam, and dental exam objectives. Once the RN has reviewed and ensured the accuracy/appropriateness of the orders and objectives, the RN will route the rough draft to the Assistant Superintendent for an additional layer of quality review. 5. The Assistant Superintendent/QIDP will review and document the need for any recommendations, corrections, or clarifications with the IPP. 6. The Assistant Superintendent/QIDP will return the rough draft to the Case Manager for revision(s) and distribution following any revision(s). 7. The Case Manager will make the necessary corrections/clarifications and route to the Administrative Specialist II in Program Services	W 249			

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W 249	<p>Continued From page 125 for processing and distribution.</p> <p>8. The Case Manager ensures that the final IPP is distributed by the Administrative Specialist II and sent to the Master File within thirty (30) days of the Annual Review/30 Day Review meeting. If the 30th day falls on a weekend/holiday, the IPP should be completed the last business day before the 30th day. The 30-calendar day deadline will be strictly adhered to so he Case Manager should allow themselves time in case of emergency due to sickness, holidays, etc. that might occur.</p> <p>9. The IPP will be copied and sent to each service area as needed. An implementation notice will be attached to each copy. The notice form has a bottom section that is to be detached and routed back to the Records Room with original, deleted materials from the service providers' files.</p> <p>10. Service Providers of each service area will implement the objectives by the implementation dates specified.</p> <p>11. Case Managers will make on-site visits to the living units and classrooms to observe objectives being implemented. Case Managers will write a summary of the visits and will write an On-Site Monitoring on each individual.</p> <p>The policy Special Interdisciplinary Team Meetings" read in part " ...Service providers may submit additions/changes or deletions of objectivities or other programmatic areas of an individual ' s IPP. The Case Manager will review the Objective Action Form and schedule a special Interdisciplinary Team meeting as necessary (change of medical condition, behavior, or other individual personal items). The case manager</p>	W 249			

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W 249	Continued From page 126 types up the case minutes, If the team determines that there is a recommendation/service objective behavioral objective, the Case Manager should ensure that this is included in the IDT sign-in-sheet. The recommendation /service objective should have a number continued from the current IPP with a service provider, implementation and completion date. The end date of this should be the ending date of the IPP. The Case Manager will place the addendum information on the individuals Monthly Plan Review for monthly monitoring. The Administrative Specialist will copy and distribute the addendum to the appropriate staff. The original addendum will be routed to the Records Room for placement in the individuals master record."	W 249			
W 266	CLIENT BEHAVIOR & FACILITY PRACTICES CFR(s): 483.450 The facility must ensure that specific client behavior and facility practices requirements are met. This CONDITION is not met as evidenced by: Based on record review and interview, the facility failed to establish an effective process through written policies and procedures to prevent implement the use of chemical and physical restraint in an appropriate and safe manner. (Refer to W0280, W284). The cumulative effect of these systemic problems resulted in the Condition of Participation, Client Behavior and Facility Practices being found as not met.	W 266			

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W 266	Continued From page 127	W 266			
	(W280) Based on interviews, record review, facility document review, facility policy review, and camera footage, it was determined the facility failed to ensure that the use of a physical restraint was properly implemented with standards of practice and facility training protocols for one (Resident #1) of three sampled residents (Resident #1, #2, and #3) who were reviewed for physical restraints.				
	(W284) Based on interviews, record review, facility document review, facility policy review, and camera footage review, it was determined the facility failed to ensure the QIDP (Qualified Intellectual Disability Professional) or QIDP designee was present during behavioral event to supervise and monitor a physical and chemical restraint and prevent death for one (Resident #1) of 3 (Resident #1, #2, #3) sampled residents reviewed for physical and chemical restraints.				
W 280	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(1)(iv)(B)	W 280			
	Procedures that govern the management of inappropriate client behavior must address the use of physical restraints. This STANDARD is not met as evidenced by: Based on interviews, record review, facility document review, facility policy review, and camera footage, it was determined the facility failed to ensure that the use of a physical restraint was properly implemented with standards of practice and facility training protocols for one (Resident #1) of three sampled residents (Resident #1, #2, and #3) who were reviewed for physical restraints.				

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W 280	Continued From page 128 The findings are: Refer to W193 and W249 for additional information. A review of the Face Sheet indicated the facility admitted Resident #1 (R1) with diagnoses that included severe intellectual disability, autism spectrum disorder, seizure disorder, 9P Syndrome (neurological disorder) unspecified disruptive, impulse control, and conduct disorder. The Individual Program Plan (IPP) with an implementation date of 04/01/2025, revealed Resident #1 had severe intellectual functioning level, required one on one supervision level, had a targeted behavior of physical aggression, and required a hard-shell helmet as adaptive equipment which was addressed by a behavior support plan (BSP). The Behavior Support Plan (BSP) with review date of 03/13/2025 and implementation date of 03/20/2025, revealed Resident #1 was a severe biter and had bitten own mother's thumb off and the side of a peer's face from the eyebrow to jaw. The BSP included, "as soon as client responds to an intervention, there is no need to proceed further." The BSP documented the first intervention is the use of the preventive restraint helmet, which included instruction that staff will follow the schedule set by the IDT (Interdisciplinary Team) and record when the helmet is taken off and put on using a specific form. The BSP included other interventions of positive reinforcement, redirection, separation to allow calming, resident choices, verbal intervention, and separation from setting up to 30	W 280			

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W 280	<p>Continued From page 129</p> <p>minutes. The prevention and intervention portion documented, staff shall take immediate action to deflect or physically stop Resident #1 from engaging in self-injuries or aggressive behavior using the least restrictive method that is effective in managing behavioral needs. Staff remember their training in facility policies on how to manage behavioral emergencies.</p> <p>During the review of camera footage, staff did not attempt to verbally de-escalate or allow space for R1 after dislodging R1's hand from Certified Nursing Assistant (CNA) #5's hair. Staff are observed immediately attempting to place R1 into a personal restraint starting at 6:35 PM. Additional staff arrive to assist and R1 is observed in a personal restraint. At 6:39 PM, R1 is observed in a prone personal restraint until 6:52 PM when R1 is released. R1 lies in a prone position until 6:59 PM, when staff roll R1 onto back and place a pillow under R1's head. R1's last movement was observed at 6:59 PM. At 7:04 PM, RN #7 is observed administering a chemical restraint.</p> <p>A review of a Behavior Report, dated 09/07/2025, revealed Resident #1 had inappropriate behaviors including agitation and psychiatric symptoms. Resident #1 exhibited physical aggression, including hair-pulling. The report documented that the supervisor was called at 6:40 PM and the nurse was called at 6:41 PM.</p> <p>A review of a Restraint Reporting Form, dated 09/07/2025 at 6:43PM, revealed the Authorizing QIDP (Qualified Intellectual Disability Person)/Supervisor on duty was Residential Care Team Supervisor (RCTS) #3. The type of restraint was identified as personal and chemical. Reason</p>	W 280			

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W 280	<p>Continued From page 130</p> <p>for restraint was aggression toward staff. The personal restraint was documented at 6:43PM, including escalating and agitated behavior. The release of restraint was documented at 6:56PM, including a reference that R1's behavior was beginning to calm. The chemical restraint was documented at 7:04PM, and the other box was marked with the word compliant written. RN (Registered Nurse) #7 documented Geodon 20mg (an atypical antipsychotic medication used to treat schizophrenia and bipolar disorder) IM see nurses' notes. RCTS #3 documented the Administrator was notified at 7:11PM.</p> <p>A review of the debriefing form for the behavior report dated 09/07/2025 indicated Resident #1 received a personal and chemical restraint due to aggression directed towards staff and to prevent escalation again. In the "possible actions by staff to decrease future necessity of restraint" there was no documentation. In the additional comments section documentation states, "immediately after the chemical restraint medical took charge." ??</p> <p>Staff Interviews:</p> <p>Maltreatment Investigator During concurrent review of cameras review footage and interview on 09/10/2025 at 2:48 PM, the Maltreatment Investigator (MI) verbalized staff did not do the restraint correctly. The MI confirmed at 6:44:06 PM of video Certified Nursing Assistant (CNA) #8 was observed with right hand on R1's back, and then CNA #10 leans forward, placing their forearm on R1's back. The MI verbalized CNA #10 appears to be placing elbow in R1's back and shifting own weight onto R1's back. The MI was asked why R1 received</p>	W 280			

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W 280	<p>Continued From page 131</p> <p>an injection when the resident was not combative, the MI verbalized, "I can't answer that." ?</p> <p>Quality Assurance Coordinator During concurrent review of camera and interview on 09/10/2025 at 2:53 PM, the Quality Assurance Coordinator (QAC) verbalized the restraint being observed was incorrect due to R1 being on their stomach (prone). The QAC verbalized CNA #8's hold should have been on the shoulders or wrist, not on R1's back. The QAC reported the arm on the back can restrict a residents' breathing.</p> <p>During a follow-up interview on 09/11/2025 at 11:07 AM, the QAC reported working at the facility for 23 years. The QAC confirmed being the CPI (Crisis Prevention Intervention) instructor and previous review of the video indicated the restraint was performed incorrectly. The QAC confirmed teaching protocols are for the residents' back to be on the ground, and staff are to hold arms and legs, not their back. The QAC verbalized if the restraint is done incorrectly, then the staff should release and restart if another restraint is necessary. ?</p> <p>CNA #5 During an interview on 09/11/2025 at 2:31 PM, CNA #5 reported working for the facility for approximately 5-6 months. When asked about proper restraint procedures, CNA #1 stated that a resident should not be restrained in a prone (stomach-down) position. CNA #1 noted the resident's face should be visible, facing the staff, and the upper body should be elevated. CNA #1 indicated that restraining a resident in a prone position is prohibited because it may lead to choking on their tongue. CNA #1 confirmed that R1 was restrained in a prone (face-down) position</p>	W 280			

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W 280	<p>Continued From page 132 for a period estimated at lasting 5 to 10 minutes.</p> <p>Residential Case Supervisor #4 During an interview on 09/11/2025 at 3:20 PM, Residential Case Supervisor (RCS) #4 reported working for the facility for nearly 6 years and holding a CNA license for approximately 3 years.</p> <p>Upon arrival in House 17 where R1 resides, RCS #4 reported observing R1 in a physical restraint on the ground, face-down. RCS #4 reported the restraint team needed assistance due to R1's continued kicking, RCS #4 joined the restraint by securing R1's legs. RCS #4 held the legs between the calf and ankle area while R1 remained prone with R1's knees on the ground. No one at the time suggested repositioning R1. R1 remained in the prone position for approximately ten minutes after RCS #4 arrived. R1 continued to resist until CNA #5 asked if R1 was calm and ready to go to bed. R1 made a grunting sound, and shortly afterward, R1 appeared to calm down. The team then released R1 from the restraint.?</p> <p>RCS #4 reported that after the resident was released, R1 remained lying on stomach with eyes closed. R1 made no further vocalizations but did move head slightly. RCS #4 reported checking for signs of life by placing a finger near nose to detect airflow and using two fingers on the left side of neck to check for a pulse, which was faint but present. RCS #4 believed a nurse also checked on R1 but could not recall which one. '</p> <p>RCTS #9 During an interview on 09/16/2025 at 1:33 PM, RCTS #9 reported having worked at the facility</p>	W 280			

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W 280	<p>Continued From page 133</p> <p>for 13 years. RCTS # 9 confirmed receiving restraint training, CPR, and CPI. RCTS #9 stated there were behaviors from multiple residents on 09/07/2025. RCTS #9 reported that when residential services received a call requesting assistance in the unit, RCTS #3 and RCS #4 went to that unit and RCTS #9 went to other behaviors on campus. RCTS #9 reported bringing the humane wrap to the unit. RCTS #9 reported observing R1 personally restrained on stomach. RCTS #9 verbalized the proper way to restrain a resident is one their back and in a humane wrap on their side. RCTS #9 verbalized a supervisor is required to monitor all restraints and RCTS #3 was the supervisor for that unit.</p> <p>CNA #8</p> <p>During an interview on 09/16/2025 at 6:21PM, CNA #8 reported having worked at the facility for approximately one year and confirmed that they had not yet completed the certified nursing assistant exam. CNA #8 confirmed that they assisted CNA #10 in trying to separate R1 from CNA #5's hair. During the incident, CNA #8 and CNA #10 physically held R1 down until additional help arrived. CNA #8 reported that RCS #2 exited the office, at which point they attempted to release R1. However, R1 continued to roll side to side, kicked, and tore CNA #10's shirt. R1 was then placed into a personal restraint.</p> <p>CNA #8 stated that R1 was lying on their stomach and that both they and CNA #10 were holding R1's arms. CNA #1 and RCS #4 later arrived to assist with the restraint. CNA #8 acknowledged placing their right arm and elbow on R1's back but stated this was solely to reposition themselves.?CNA #8 recalled that after R1 was released from the restraint, the resident remained</p>	W 280			

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W 280	<p>Continued From page 134</p> <p>in the same position, with their buttocks up for the administration of a chemical restraint. CNA #8 confirmed that R1 had been physically restrained in a prone (stomach-down) position for approximately 10 to 11 minutes prior to receiving the injection.</p> <p>Registered Nurse Manager During an interview on 09/17/2025 at 1:35PM, the Registered Nurse Manager (RNM) reported working for the facility since 1998. The RNM reported nurses' responsibilities during a restraint are to monitor the residents by observing skin color, respirations, ensure the restraint is not too tight, and ensure the resident is properly placed on their back and not their stomach.</p> <p>Assistant Administrator During an interview on 09/19/2025 at 10:27 AM, the Asst Admin (Assistant Administrator) verbalized the facility does not train staff to restrain residents on their stomach and when a nurse receives an order for a chemical restraint, it is not explicitly required by policy that the medication must be administered (if not required). Chemical restraints are treated the same as any other form of restraint under facility policy. According to the policy, once a client is deemed calm, all forms of restraint, physical or chemical, should be discontinued. Therefore, if the client appears calm and no longer presents a risk, the nurse is not obligated to administer the chemical restraint, even if an order was given. However, this discretion is not clearly outlined in the written policy. The Asst Admin reported R1 had not been combative for approximately 15 minutes when R1 received chemical restraint. The Asst Admin reported R1 appeared to be unconscious and not combative when R1 received chemical restraint.</p>	W 280			

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W 280	<p>Continued From page 135</p> <p>The Asst Admin reported the initial restraint lasted approximately 7-8 minutes, then there was a skip in the video. When the video resumed, R1 was restrained on stomach approximately another 7-8 minutes.</p> <p>Maltreatment Administrator During an interview on 09/18/2025 at 3:28 PM, the Maltreatment Investigator (MI) reported working for the facility approximately 14 years. The MI reported being in the current position since 2019. The MI reported R1 was fighting in supine position in one portion of the video then the video skipped. When the footage resumed, R1 was in a prone position. The MI stated staff should not have placed R1 in a prone position personal restraint. The MI reported R1 should have been left alone after being released from CNA #5's hair. The MI reported CNA #8 appeared to have placed arm on R1's back a couple of times and CNA #8 should not have placed body weight on R1. The MI reported R1 appeared to be unconscious when staff rolled R1 into a prone position, had a bruise on right cheek, and R1 was discolored. The MI reported R1 did not move after being rolled onto back. The MI reported the nurses never checked on R1 until R1 received the chemical restraint. The MI reported it appeared R1 was not a threat to self or others and should not have received the chemical restraint. The MI reported R1 appeared to be unconscious at the time the chemical restraint was received. The MI reported after receiving the chemical restraint, R1's arm was over face. LPN #6 moved R1's arm and the arm flopped down. At that point, RN #7 realized R1 was not breathing and initiated CPR.</p> <p>Administrator</p>	W 280		

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W 280	<p>Continued From page 136</p> <p>During an interview on 09/19/2025 at 1:03 PM, the Administrator (Admin) reported working approximately 22 years in the Developmental Disability Service division with approximately 19 years being at this facility, the last 8.5 years in the Administrator role. The Administrator recalled review of camera footage revealed that during restraint, R1 was in the prone position, the restraint staff released R1 and stepped away. R1 laid prone for approximately 10 minutes. The Admin stated the main concern was that R1 was restrained in an unsupported prone position for a significant amount of time. CPI, which is taught at this facility, is used for brief and temporary restraint. The Admin reported the details of R1 going from supine to prone are missing due to the video skipping. The Admin commented that staff did check to ensure R1 was breathing, and by staff's reaction, R1 was not in distress. ?The Admin verbalized R1 had lighting changes on skin, presumably indicating the resident was breathing, but did not observe any large muscle movement.</p> <p>Policies The Policy titled Rights of Clients Served by The Facility (Facility 23) read in part " ... Individuals will be free from mental and physical abuse and free from physical and chemical restraints. Restraints can be temporarily ordered by a physician for medical purposes or to promote healing, applied in an emergency to prevent injury to the client and to others, as part of the Behavioral Support Plan or Health/Safety Plan. Emergency programmatic application of restraint requires authorization of a QIDP for continuation and extension ...As a resident you have the right to be: free from mental, physical, verbal and sexual abuse ...free from chemical and physical</p>	W 280			

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W 280	<p>Continued From page 137</p> <p>restraints except when authorized in writing by a physician for a specific and limited period of time, or by a QIDP only to protect you or others from injury ...Every resident has the right to:...privacy during treatment and care of personal needs. People not involved in the care of residents shall not be resident without the consent from the resident during examinations and treatment ..."</p> <p>Review of a policy titled, "Use of Restraints," indicated the facility is committed to managing the dangerous behaviors of clients that place the safety of the client and/or others at risk by using the least restrictive interventions that are effective in managing the behavioral situation. While the elimination of dangerous behaviors is sought using positive behavior interventions and de-escalation techniques, it is acknowledged that clients may not always respond to these interventions and the dangerous behavior may escalate to an emergency situation in which physical and/or chemical restraint may be required to protect the safety of the client and/or others.</p> <p>Procedures provided included:</p> <p>1. Authorization a. The QIDP or Supervisor on Duty will ensure that the least restrictive interventions are used to effectively manage the behavioral situation .</p> <p>b. Personal Restraint i. Must be authorized by the QIDP or Supervisor on Duty ii. If staff is unable to call for authorization before the personal restraint is applied, staff will call the QIDP or Supervisor on Duty for authorization as soon as safely possible</p>	W 280			

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W 280	<p>Continued From page 138 after the restraint is applied.</p> <p>c. Mechanical Restraint</p> <p>i. Must be authorized by the QIDP or Supervisor on Duty</p> <p>ii. If staff is unable to call for authorization before the mechanical restraint is applied, staff will call the QIDP or Supervisor on Duty for authorization as soon as safely possible after the restraint is applied.</p> <p>iii. The QIDP or Supervisor on Duty will notify the Superintendent/designee of the restraint use as soon as possible</p> <p>d. Preventive Restraint</p> <p>i. The client's Interdisciplinary Team ("IDT") determines if a preventive restraint (e.g., padded mittens) or restrictive clothing (e.g., a singlet body suit) is necessary to prevent or inhibit maladaptive behaviors (e.g., chronic skin picking; rectal digging and fecal smearing) that may place the client at greater risk of injury (e.g., infection due to reduced skin integrity).</p> <p>ii. Preventive Restraint is not used in an emergency situation; rather, it is used to prevent or inhibit maladaptive behaviors.</p> <p>iii. The IDT will specify when the preventive restraint will be applied and when it will be removed. Times will be documented on a form specifically designed for the client and the device.</p> <p>iv. The use of Preventive Restraint will be documented in the client's Individual Program Plan.</p> <p>e. Chemical Restraint</p> <p>i. Must be ordered by the physician/psychiatric nurse practitioner</p>	W 280			

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W 280	<p>Continued From page 139</p> <p>ii. Nurse will administer as per doctor's/Psych APRN's order and authorization</p> <p>iii. Nurse will notify the Superintendent/designee as soon as possible</p> <p>2. Monitoring</p> <p>a. Personal Restraint</p> <p>i. Constant visual monitoring by staff is required while the client is in personal restraint</p> <p>b. Mechanical Restraint</p> <p>i. Constant visual monitoring by staff is required while the client is in mechanical restraint</p> <p>ii. The QIDP or Supervisor on Duty and a licensed nurse must assess the restraint incident face-to-face every 15 minutes to monitor the client for signs of distress and to ensure restraint integrity to optimize the safety of the client. Constant in-person monitoring of the restraint by the QIDP or Supervisor on Duty and a licensed nurse is preferred.</p> <p>c. Preventive Restraint</p> <p>i. Staff will monitor client for signs of distress and the integrity of the preventive restraint throughout the day as they go about their routine care of clients. This monitoring of the client and restraint integrity is to optimize the safety of the client.</p> <p>d. Chemical Restraint</p> <p>i. A licensed nurse will follow-up with the client per nursing guidelines.</p> <p>ii. NOTE: The licensed nurse must initial the Restraint Reporting Form when the chemical restraint was administered.</p> <p>Standards of Practice</p>	W 280			

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W 284	<p>Review of "Standards of Practice: Seclusion and Restraint," revised February 2022 per the American Psychiatric Nurses Association, revealed, "When an individual is physically restrained, immediate action is required to mitigate positional risks: prone restraint requires monitoring for the risk of positional asphyxiation."</p> <p>MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(1)(iv)(F)</p> <p>Procedures that govern the management of inappropriate client behavior must address a mechanism for monitoring and controlling the use of interventions.</p> <p>This STANDARD is not met as evidenced by: Based on interviews, record review, facility document review, facility policy review, and camera footage review, it was determined the facility failed to ensure the QIDP (Qualified Intellectual Disability Professional) or QIDP designee was present during behavioral event to supervise and monitor a physical and chemical restraint and prevent death for one (Resident #1) of 3 (Resident #1, #2, #3) sampled residents reviewed for physical and chemical restraints.</p> <p>Findings include:</p> <p>Refer to W193 for additional information.</p> <p>A review of the face sheet indicated the facility admitted Resident #1 (R1) with diagnoses that included severe intellectual disability, autism spectrum disorder, seizure disorder, 9P Syndrome (neurological disorder) unspecified disruptive, impulse control, and conduct disorder.</p>	W 284			

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W 284	<p>Continued From page 141</p> <p>The Individual Program Plan (IPP) with an implementation date of 04/01/2025, revealed Resident #1 had a severely impaired intellectual functioning level, required one-on-one supervision, had a targeted behavior of physical aggression, and required a hard-shell helmet as adaptive equipment.</p> <p>The Behavior Support Plan (BSP) with a review date of 03/13/2025 and implementation date of 03/20/2025, revealed Resident #1 was a severe biter and had bitten the resident's own mother's thumb off and the side of a peer's face from the eyebrow to jaw. The BSP included, "as soon as client responds to an intervention, there is no need to proceed further." The BSP documented the first intervention is the use of the preventive restraint helmet, and included staff will follow the schedule set by the IDT (Interdisciplinary Team) and record when the helmet is taken off and put on using a specific form. The BSP included other interventions of positive reinforcement, redirection, separation to allow calming, resident choices, and verbal intervention. The prevention and intervention portion documented staff shall take immediate action to deflect or physically stop Resident #1 from engaging in self-injuries or aggressive behavior using the least restrictive method that is effective in managing behavioral needs. Staff remember their training in facility policies on how to manage behavioral emergencies.</p> <p>Review of facility's video footage indicated Residential Care Supervisor (RCS) #2 was initially present, clocked out and left the facility. Residential Care Team Supervisor (RCTS) # 3 was present for portions of the physical restraint and chemical restraint. RCS #4 was present and</p>	W 284			

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W 284	<p>Continued From page 142</p> <p>became involved in physical restraint. RCTS #9 brought in the humane wrap but left.</p> <p>During an interview on 09/11/2025 at 1:49 PM, RCS #2 indicated being present for a portion of the restraint but left due to the replacement staff being present. RCS #2 stated, "I should have stayed but my replacement was present and there were other supervisors present."</p> <p>During an interview on 09/11/2025 at 3:20 PM, Residential Care Supervisor (RCS) #4 reported that upon arrival in House 17 where R1 resides, RCS #4 reported observing R1 in a physical restraint on the ground, face-down. RCS #4 reported the restraint team needed assistance due to R1's continued kicking, RCS #4 joined the restraint by securing R1's legs. RCS #4 held the legs between the calf and ankle area while R1 remained prone with R1's knees on the ground. No one at the time suggested repositioning R1. R1 remained in the prone position for approximately ten minutes after RCS #4 arrived. R1 continued to resist until CNA #5 asked if R1 was calm and ready to go to bed. R1 made a grunting sound, and shortly afterward, R1 appeared to calm down. The team then released R1 from the restraint.</p> <p>During an interview on 09/11/2025 at 4:20 PM, Residential Care Team Supervisor (RCTS) #3 confirmed they had observed R1 in a restraint but could not recall the specifics of how R1 was being held.</p> <p>A review of the Restraint reporting form indicated RCTS #3 completed the form and documented being the Authorizing QIDP/supervisor on duty. RCTS #3 completed the Debriefing form indicating being the restraint incident leader.</p>	W 284			

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W 284	<p>Continued From page 143</p> <p>During an interview on 09/16/2025 at 11:58 AM, the Assistant Administrator (Asst Admin) stated RCTS #3 was the QIDP designee for the behavior event that occurred on 09/07/2025 with R1. Asst Admin stated the QIDP is responsible for authorizing emergency applications of restraints and provide extended times if required.</p> <p>During an interview on 09/16/2025 at 1:33 PM, RCTS #9 stated there were multiple behaviors on 09/07/2025. RCTS #9 reported that when residential services received a call requesting assistance in the unit, RCTS #3 and RCS #4 went to that unit and RCTS #9 went to other behaviors on campus. RCTS #9 reported bringing the humane wrap to the unit. RCTS #9 reported observing R1 personally restrained on stomach.</p> <p>During an interview on 09/19/2025 at 1:03 PM, the Administrator stated the QIDP designees are the supervisors on duty. The Administrator verbalized the facility ideally has six (6) RCTS who act as QIDP designee. The Administrator stated the true QIDPs are responsible for programming, organizing and leading the IDT.</p> <p>During an interview with the Administrator on 09/23/2025 at 9:22 AM, the surveyor asked for the process for the dissemination of information and/or programmatic changes and training in regard to the individual care plan for the direct care staff (C.N.A, RCS and floating staff) for Resident #1, specifically in relation to the wearing of the helmet to prevent biting. The Administrator stated that it should come from the case manager that initiated the IDT (Interdisciplinary Team), IPP or special IDT to meet a certain need. An administrative specialist will send out the BSP,</p>	W 284			

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W 284	<p>Continued From page 144</p> <p>which is a subdocument of the IPP and is written by the contracting psychologist. All the case managers will sit on the behavior support committee. There is no written policy, just an in-service. This becomes a funnel that goes to residential services, and the team shift supervisors and the residential care supervisors are responsible for ensuring that the direct staff are aware. It is the individual staff's responsibility to read and understand the BSP. The RCS (runs the house) and RCTS (runs the campus).</p> <p>The surveyor asked the Administrator how they determine the staffing needs in relation to acuity for direct care to meet the needs of the residents with changes to the IPP and BSP and how it is managed to ensure safety. The Administrator responded that this is two-prong processes; programmatically each case manager and IDT will assess the clients' needs based on history and current health care needs, and the second prong one of the licensed administrators will make decision based on the client's health and safety status for temporary adjustments and supervisory level. Due to the acuity of residents that have been admitted during the last two years, human resources that are currently available and the current staff in critical roles are providing direct support which takes them away from programmatic oversight responsibilities.</p> <p>Review of a Functional Job Description for the Residential Care Team Supervisor/Expert revealed the Residential Care Team Supervisor is responsible for overseeing the daily operations of a residential care facility, ensuring high-quality services and a safe, supportive environment for residents. This position provides leadership, supervision, and guidance to direct care staff</p>	W 284			

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W 284	<p>Continued From page 145</p> <p>while ensuring compliance with Arkansas state regulations and policies. The role requires strong leadership, problem-solving, and communication skills to effectively manage personnel, resolve resident concerns, and maintain operational efficiency. Responsibilities include to supervise, train, and evaluate direct care staff to ensure high standards of resident care and facility operations. Oversee the implementation of individualized care plans tailored to residents ' medical, social, and emotional needs. Monitor resident well-being and coordinate services with healthcare providers, therapists, and caseworkers. Respond to resident concerns, grievances, and emergency situations in a timely and effective manner. Ensure the facility operates in compliance with Arkansas health and safety regulations, Medicaid requirements, and agency policies. Conduct regular inspections and audits to maintain a clean, safe, and efficient living environment. Maintain accurate records, documentation, and reports related to resident care, staff performance, and incident management. Provide guidance and support in behavioral interventions, crisis management, and de-escalation techniques. Serve as the point of contact during emergencies, including medical incidents, behavioral issues, and facility-related concerns.</p> <p>Policies The Policy titled Rights of Clients Served by The Facility (Facility 23) read in part "... Individuals will be free from mental and physical abuse and free from physical and chemical restraints. Restraints can be temporarily ordered by a physician for medical purposes or to promote healing, applied in an emergency to prevent injury to the client and to others, as part of the Behavioral Support Plan</p>	W 284			

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W 284	<p>Continued From page 146</p> <p>or Health/Safety Plan. Emergency programmatic application of restraint requires authorization of a QIDP for continuation and extension ...As a resident you have the right to be: free from mental, physical, verbal and sexual abuse ...free from chemical and physical restraints except when authorized in writing by a physician for a specific and limited period of time, or by a QIDP only to protect you or others from injury ...Every resident has the right to:...privacy during treatment and care of personal needs. People not involved in the care of residents shall not be resident without the consent from the resident during examinations and treatment ..."</p> <p>Review of a policy titled, "Use of Restraints," indicated the facility is committed to managing the dangerous behaviors of clients that place the safety of the client and/or others?at risk by using the least restrictive interventions that are effective in managing the behavioral situation. While the elimination of dangerous behaviors is sought using positive behavior interventions and de-escalation techniques, it is acknowledged that clients may not always respond to these interventions and the dangerous behavior may escalate to an emergency situation in which physical and/or chemical restraint may be required to protect the safety of the client and/or others ... Procedures provided included: ... b. Personal Restraint i. Must be authorized by the QIDP or Supervisor on Duty ii. If staff is unable to call for authorization before the personal restraint is applied, staff will call the QIDP or Supervisor on Duty for authorization as soon as safely possible after the restraint is applied ... 2. Monitoring a. Personal Restraint i. Constant visual monitoring by staff is required while the client is in personal restraint ...</p>	W 284			

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W 284	Continued From page 147 Standards of Practice Review of "Standards of Practice: Seclusion and Restraint," revised February 2022 per the American Psychiatric Nurses Association, revealed, "When an individual is physically restrained, immediate action is required to mitigate positional risks: prone restraint requires monitoring for the risk of positional asphyxiation."	W 284		