

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

PRINTED: 04/30/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18G017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2020
NAME OF PROVIDER OR SUPPLIER OAKWOOD ICF/IID, UNIT 3			STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 000	<p>INITIAL COMMENTS</p> <p>A complaint investigation (KY31533) and a COVID-19 focused infection control survey was initiated on 04/13/2020 and concluded on 04/21/2020. The facility was found to be in compliance with 42 CFR 483.470 Physical Environment and has implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.</p> <p>The complaint was substantiated. Immediate Jeopardy was identified on 02/21/2020 at 42 CFR 483.410 Governing Body and Management (W0102) and 42 CFR 483.420 Client Protections (W0122). Standard level deficiencies were identified at W0104, W0127, and W0251.</p> <p>On 04/01/2020, at 2:38 AM, Direct Service Professional (DSP) #3 entered Client #1's bedroom, even though he was not assigned to supervise/care for the client. DSP #2 observed DSP #3 grab the client's face and ask the client, "What the fuck is your problem," and then slam the client's head into a wall. DSP #3 was also observed to grab Client #1's arm and pull the client down onto the bed.</p> <p>Further, on 04/02/2020, at 7:03 AM, DSP #10 turned off the lights in the living area of Client #2's home. Client #2 became upset, began flailing his/her arms and legs, and was screaming. DSP #9 and DSP #10 responded to the client's behavior with yelling, threats to leave the client alone, calling the client a "fat (inaudible)," and telling the client he was "done."</p>	W 000			

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.

PRINTED: 04/30/2020
FORM APPROVED
OMB NO. 0938-0391

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: NRTU11 Facility ID: 101090 If continuation sheet Page 2 of 26

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

PRINTED: 04/30/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18G017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2020
NAME OF PROVIDER OR SUPPLIER OAKWOOD ICF/IID, UNIT 3			STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 102	<p>Continued From page 2</p> <p>policies as necessary to provide for the health and safety of clients, and review and analyze the facility's processes and outcome data to reduce or eliminate the risk of harm to clients.</p> <p>Review of Client #1's medical records revealed on 03/09/2020, the facility moved the client from Unit 2 (another facility on the campus) to Unit 3. In addition, the facility moved Client #2 from Unit 2 to Unit 3 on 03/18/2020.</p> <p>Interview with the Facility Director for Unit 2 and Unit 3 on 04/12/2020 at 3:45 PM and 04/13/2020 at 10:40 AM and 2:15 PM, revealed there were approximately forty (40) clients in Unit 2. Further interview revealed the team evaluated who could move to Unit 3 to help decrease the census in Unit 2. Subsequently, Clients #1 and #2 were moved from Unit 2 to Unit 3. The Facility Director stated the facility had hoped that "spreading the clients out would decrease the number of peer-to-peer incidents" and clients would have a "different client/staffing mix." He also stated that the facility was monitoring clients and staff in Unit 3 in an effort to prevent client abuse.</p> <p>However, review of a Final Expanded Investigation revealed the facility substantiated that DSP (Direct Support Professional) #3 abused Client #1 on 04/01/2020. The investigation revealed on 04/01/2020 at approximately 2:40 AM, DSP #3 grabbed Client #3 by the face and slammed the client's head into a door. DSP #3 then proceeded to grab the client by the arm and jerk the client off the bed. The investigation revealed that these actions met the definition of physical abuse and the facility suspended DSP #3 on 04/01/2020 and terminated DSP #3 on 04/14/2020.</p>	W 102			

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

PRINTED: 04/30/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18G017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2020
NAME OF PROVIDER OR SUPPLIER OAKWOOD ICF/IID, UNIT 3			STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 102	Continued From page 3	W 102			
W 104	<p>Continued review of the facility's Final Expanded Investigations revealed the facility substantiated that DSP #9 and DSP #10 verbally abused Client #2 on 04/02/2020. The facility concluded that on 04/02/2020 at approximately 7:03 AM, DSP #9 and DSP #10, without question, spoke harshly and inappropriately to Client #2, which then led to the client becoming upset and displaying physical aggression and self-injurious behavior.</p> <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.</p> <p>This STANDARD is not met as evidenced by: Based on interview, record review, review of facility investigations, and review of the Governing Body policy, it was determined that the facility failed to ensure the Governing Body maintained the general policy and operating direction to prevent physical/verbal abuse of two (2) of two (2) sampled clients (Clients #1 and #2). Interviews with the Director, a member of the facility's governing body, revealed Clients #1 and #2 were relocated from one facility (Unit 2) within the campus (the campus is divided into four facilities/units) to Unit 3. According to the interview, this move was part of a reorganization to decrease the census in Unit 2 and to give the clients more room. In addition, the Former Director stated the facility had monitoring mechanisms in place to ensure clients were not abused. However, on 04/01/2020, Direct Support Professional (DSP) #3, a staff member not</p>	W 104			

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

PRINTED: 04/30/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18G017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2020
NAME OF PROVIDER OR SUPPLIER OAKWOOD ICF/IID, UNIT 3			STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 104	<p>Continued From page 4</p> <p>assigned to supervise or care for Client #1, entered the client's bathroom and physically abused the client (refer to W122 and W127).</p> <p>In addition, on 04/02/2020, at approximately 7:00 AM, DSP #9 and DSP #10 verbally abused Client #2 (refer to W122, W127, and W251).</p> <p>The findings include:</p> <p>Review of the facility's policy, Performance Improvement (PI) Council (Governing Body), dated 08/28/2019, revealed the PI council was the facility's Governing Body. The policy stated that the role of the PI Council was to exercise general policy and operating direction over the facility. According to the policy, the PI Council was responsible for ensuring the necessary environment was provided to ensure client health and safety.</p> <p>1. Review of Client #1's medical record revealed the facility transferred the client from Unit 2 to Unit 3 on 03/09/2020.</p> <p>Review of the facility's Final Expanded Investigative Report, dated 04/08/2020, revealed on 04/01/2020 at 2:40 AM, DSP #2 was assisting Client #1 from the shower when DSP #3 entered the client's bathroom. DSP #3 grabbed the client by the face, asked the client, "What the fuck is your problem?" and then proceeded to slam the client's head against the door. DSP #2 got between DSP #3 and the client and escorted the client into his/her bedroom. DSP #2 then turned away from the client to retrieve clothing and told DSP #3 that he needed to leave. However, DSP #3 went around DSP #2 and grabbed the arm of Client #1, jerked the client off the bed, and</p>	W 104			

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

PRINTED: 04/30/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18G017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2020
NAME OF PROVIDER OR SUPPLIER OAKWOOD ICF/IID, UNIT 3			STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 104	<p>Continued From page 5</p> <p>repeated to the client, "I asked you, what was your problem?" The facility substantiated that DSP #3 abused Client #1.</p> <p>2. Review of the medical record revealed Client #2 was transferred to the facility from Unit 2 on 03/18/2020, and was moved back to Unit 2 on 04/10/2020.</p> <p>A review of the facility's Final Expanded Investigation dated 04/09/2020 revealed the facility reviewed the video/audio footage of Client #2's home for 04/02/2020 at 7:00 AM. The facility's review determined that at 7:03 AM, the lights in the living area were turned off where Client #2 was seated. The client started yelling and was waving his/her arms and kicking his/her legs. At this time, DSP #9 could be heard loudly asking the client, "Do you want me to call a code green?" (call for help with a client who is having behaviors or has eloped) ... "You're a fat (inaudible)." DSP #9 then stated to the client loudly, "You're done, you understand?" DSP #9 then yelled at the client and stated, "You keep this up and we will leave, you understand me?" Per video footage, Client #2 was still seated on the couch. The audio then revealed DSP #10 said to the client, "Listen, you hit me again and we're going to have a problem." According to the facility's investigation, DSP #11, who was also present, did not intervene to protect the client, nor did he report the incident to his supervisor.</p> <p>Continued review of the facility's Final Expanded Investigation revealed the facility substantiated that Client #2 was verbally abused. The facility concluded that on 04/02/2020 at approximately 7:03 AM, DSP #9 and DSP #10, without question, spoke harshly and inappropriately to Client #2,</p>	W 104			

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

PRINTED: 04/30/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18G017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2020
NAME OF PROVIDER OR SUPPLIER OAKWOOD ICF/IID, UNIT 3			STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 104	<p>Continued From page 6</p> <p>which then led to the client becoming upset and displaying physical aggression and self-injurious behavior.</p> <p>Interview with the Unit Administrator on 04/13/2020 at 3:15 PM, revealed the transfer of Clients #1 and #2 was done as part of a reorganization. He further stated he recommended Client #2 be returned to Unit #2, as the transfer was not successful and it was not good for the client.</p> <p>Interview with Qualified Intellectual Disability Professional (QIDP) #2 on 04/13/2020 at 1:45 PM, revealed she was assigned to Client #2 when the client was residing in Unit 3. She stated the client was transferred to Unit 3 in an attempt to give the clients more space and to decrease the population of clients in the homes. According to QIDP #2, Client #2 was moved back to Unit 2 on 04/10/2020. She stated she was informed that the client "needed" to move and she did not really know the reason when the transfer occurred.</p> <p>Interview with the Director on 04/12/2020 at 3:45 PM and on 04/13/2020 at 10:40 AM and 2:15 PM, revealed homes in Unit 3 were opened up, and Clients #1 and #2 were moved from Unit 2 to decrease the number of clients in Unit 2 and to give the clients more space. He stated Client #1 and all his/her housemates were moved as a whole, and Client #2 was chosen to move so the client could have a bigger open area outside the home. However, after the incident, the facility moved Client #2 back to Unit 2 because it "just didn't work out." When asked to elaborate, the Director stated the client was with a peer that he/she had not been with before. He stated that all staff had been recently reeducated regarding</p>	W 104			

PRINTED: 04/30/2020
FORM APPROVED
OMB NO. 0938-0391

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: NRTU11 Facility ID: 101090 If continuation sheet Page 8 of 26

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

PRINTED: 04/30/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18G017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2020
NAME OF PROVIDER OR SUPPLIER OAKWOOD ICF/IID, UNIT 3			STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 122	<p>Continued From page 8</p> <p>threatened Client #2 and called the client a "fat (inaudible)."</p> <p>Immediate Jeopardy was identified on 04/21/2020, was determined to exist on 04/01/2020, and is ongoing.</p> <p>The findings include:</p> <p>Review of the facility's Facility Risk Management Protocol, undated, revealed the facility must ensure all individuals served were free from abuse. Further review revealed the facility must proactively assure individuals are free from serious and immediate threat to their physical and psychological health and safety.</p> <p>1. Review of a Final Expanded Investigative Report revealed the facility substantiated that staff physically abused Client #1 on 04/01/2020. According to the investigation, Direct Support Professional (DSP) #3 was assigned to another home, but entered Client #1's home at approximately 2:30 AM on 04/01/2020. Shortly after DSP #3 entered the home, he followed DSP #2, who was assigned to supervise the client, into Client #1's room. Continued review of the Investigative Report revealed DSP #3 entered the client's bathroom, grabbed the client's face, and jerked the client's head into a door. The report revealed that DSP #2 got between the client and DSP #3, and escorted the client into the bedroom to assist the client with getting dressed. The report revealed a statement from DSP #2 that stated he had turned to get clothing for the client, and when he turned back around, he saw DSP #3 grab the client by the arm and jerk the client off the bed. DSP #2 grabbed DSP #3 by the arm and told him to leave. According to the report,</p>	W 122			

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

PRINTED: 04/30/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18G017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2020
NAME OF PROVIDER OR SUPPLIER OAKWOOD ICF/IID, UNIT 3			STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 122	<p>Continued From page 9</p> <p>this evidence led the facility to conclude that DSP #3's actions met the definition of physical abuse.</p> <p>2. Review of a Final Expanded Investigative Report revealed the facility substantiated that staff verbally abused Client #2 on 04/02/2020. The report revealed that DSP #9 and DSP #10 were coming on shift on 04/02/2020 and were assigned to the home where Client #2 resided. A third staff member, DSP #11, was also present in the home. The facility stated that video footage of Client #2's home for 04/02/2020 at 7:00 AM, revealed Client #2 was sitting on the living room couch in a recliner. At 7:03 AM, the lights in the living room were turned off and the client started yelling, waving his/her arms, and was kicking his/her legs. At this time, DSP #9 loudly asked the client, "Do you want me to call a code green (announcement made to request assistance with a client who is exhibiting behaviors)? DSP #9 then stated to Client #2, "You're a fat (inaudible)" and loudly stated, "You're done, you understand?" DSP #9 then yelled at the client and stated, "You keep this up and we will leave, you understand me?" Per video footage, Client #2 was still seated on the couch. The audio then revealed DSP #10 said to the client, "Listen, you hit me again and we're going to have a problem." Shortly after, the client got up from the couch and went toward the exit door. According to the Investigative Report, the client could be heard screaming and then the client was heard hitting or banging on something. Client #2 also exited the home and then re-entered the home with female staff several minutes later. Continued review of the Investigative Report revealed DSP #11 was present when the abuse took place but did not intervene to protect the client, nor did he report the incident to his supervisor. The facility</p>	W 122			

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

PRINTED: 04/30/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18G017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2020
NAME OF PROVIDER OR SUPPLIER OAKWOOD ICF/IID, UNIT 3			STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 122	Continued From page 10 concluded that on 04/02/2020 at approximately 7:03 AM, DSP #9 and DSP #10, without question, spoke harshly and inappropriately to Client #2 which then led to the client becoming upset and displaying physical aggression and self-injurious behavior.	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 observation, interview, record review, review of facility video/audio footage, review of facility investigations, and review of the facility's Risk Management Protocol, it was determined the facility failed to protect two (2) of two (2) sampled clients (Clients #1 and #2) from abuse. On 04/01/2020, Direct Support Professional (DSP) #3, who was not assigned to supervise the client, went into Client #1's bathroom, grabbed the client's face, and slammed the client's head into the wall/door. DSP #3 then grabbed the client's arm roughly and pulled the client down onto his/her bed. Client #1 was assessed to have cuts and bruising to the face after the incident. On 04/02/2020, at 10:50 AM staff completed an incident report that stated Client #2 had exhibited aggression toward staff, self-injurious behavior, and had caused property damage. However, when the facility reviewed the video/audio surveillance footage of the client's home on	W 127			

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

PRINTED: 04/30/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18G017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2020
NAME OF PROVIDER OR SUPPLIER OAKWOOD ICF/IID, UNIT 3			STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 127	<p>Continued From page 11</p> <p>04/02/2020 at approximately 1:30 PM, they discovered that DSP #9 and DSP #10 verbally abused Client #2 at approximately 7:30 AM that morning. The facility also determined that DSP #11 was present when the abuse occurred, but did not intervene to stop the abuse, and did not report the abuse as required by facility policy. Subsequently, Client #1 and other clients in the home were not protected from further potential abuse from DSP #9 and DSP #10 until 1:39 PM, approximately seven (7) hours after they verbally abused Client #2.</p> <p>The findings include:</p> <p>Review of the facility's policy, Facility Risk Management Protocol, undated, revealed the facility must have integrated systems to ensure all individuals served are free from abuse. According to the policy, the facility must proactively assure individuals are free from serious and immediate threat to their physical and psychological health and safety. The facility's policy defined physical abuse as any physical motion or action, by which bodily harm or trauma occurs, and includes but is not limited to hitting, slapping, pinching, punching, kicking, and burning. Physical abuse also included controlling behavior through corporal punishment as well as the use of any restrictive, intrusive procedure to control inappropriate behavior for purposes of punishment. The facility defined verbal abuse as any use of oral, written, or gestured language that was willful, which included disparaging and/or derogatory terms to individuals. Continued review of the facility's policy revealed the employees had the responsibility to immediately report to the Facility Director or designated representative and/or to other authorized officials</p>	W 127			

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

PRINTED: 04/30/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18G017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2020
NAME OF PROVIDER OR SUPPLIER OAKWOOD ICF/IID, UNIT 3			STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 127	<p>Continued From page 12</p> <p>of harm or potential for harm to adults and children, including, but not limited to all allegations of abuse.</p> <p>1. Observation of Client #1 on 04/13/2020 at 12:21 PM, revealed the client was sitting in the day room, wearing headphones, and working with Legos. Client #1 got up, came over to the surveyor (State Survey Agency Surveyor), and proceeded to greet her and Risk Manager #1 using sign language. The client had no visible injuries to his/her face.</p> <p>Review of Client #1's medical record revealed the facility admitted the client on 11/20/2003. The client had diagnoses of Severe Intellectual Disabilities, Cystic Fibrosis with Pulmonary Manifestations, Hyperosmality/Hyponatremia (sodium level in the blood that is higher than normal), and Unspecified Convulsions.</p> <p>Review of the Positive Behavior Support Plan (PBSP) for Client #1, dated reviewed 01/23/2020, revealed the client had occasions of nighttime accidents and should be encouraged to clean himself/herself when these occurred.</p> <p>Review of a facility Final Expanded Investigative Report, dated 04/08/2020, revealed on 04/01/2020 at 2:40 AM, DSP #2 was assisting Client #1 from the shower after an episode of urinary incontinence. The report stated DSP #3 entered the bathroom, grabbed the client by the face, and asked the client, "What the fuck is your problem?" DSP #3 then proceeded to slam the client's head against the door. DSP #2 stated he got between DSP #3 and the client, and escorted the client into the bedroom. Further review of the report revealed DSP #2 then turned away from</p>	W 127			

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

PRINTED: 04/30/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18G017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2020
NAME OF PROVIDER OR SUPPLIER OAKWOOD ICF/IID, UNIT 3			STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 127	<p>Continued From page 13</p> <p>the client to retrieve clothing and told DSP #3 that he needed to leave. The report revealed DSP #3 then went around DSP #2 and grabbed Client #1's arm, jerked the client off the bed, and repeated to the client, "I asked you, what was your problem?" According to the investigation, DSP #2 took the arm of DSP #3 and removed him from the client's bedroom. Review of the analysis and findings of the report revealed the facility substantiated that DSP #3 physically abused Client #1.</p> <p>Continued review of the facility's Final Expanded Investigative Report revealed a Registered Nurse (RN) assessed Client #1 for injury on 04/01/2020 at 2:52 AM. The RN documented that Client #1 had open areas that were approximately one-fourth inch in size to the upper mid-forehead and the tip of the nose, and discoloration to the left side of the nose. She further documented the client did not appear to be in any pain or distress.</p> <p>Review of the facility's video/audio surveillance footage of Client #1's home, dated 04/01/2020, revealed DSP #3 entered the home at 2:31 AM. The video then revealed at 2:38:48 AM, DSP #2 entered Client #1's room and at 2:38:58 AM, DSP #3 went into Client #1's room. Further review revealed at 2:40:09 AM, DSP #2 walked just outside Client #1's doorway and spoke with the two (2) other DSPs in the home, who got up from the living area and approached the client's bedroom door. Then at 2:41 AM, DSP #3 was observed leaving Client #1's room. Continued observation of the video/audio revealed at 2:41:33 AM, DSP #3 left the home with DSP #2 following. DSP #2 could be heard asking DSP #3 if he put his hands on the client like that all the time and if that made him feel big. DSP #3</p>	W 127			

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

PRINTED: 04/30/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18G017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2020
NAME OF PROVIDER OR SUPPLIER OAKWOOD ICF/IID, UNIT 3			STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 127	<p>Continued From page 14</p> <p>replied, "No," and then exited the home.</p> <p>Review of the Daily Supervisor Report, dated 03/31/2020, revealed for the second shift, DSP #2 was assigned to supervise three (3) clients, one of which was Client #1. DSP #3 was assigned as a "float" (staff member who relieved other staff for breaks and meals) staff member for another home, but was not assigned to supervise Client #1, nor any of the clients in the home where Client #1 resided.</p> <p>Interview with DSP #2 on 04/13/2020 at 4:15 PM, revealed he was assigned to supervise Client #1 on second shift starting on 03/31/2020. The DSP stated Client #1 had an incontinence episode and was in the shower. He stated he had gone into Client #1's bathroom to assist the client out of the shower when DSP #3 came into the client's bathroom. He stated DSP #3 grabbed the client and shoved the client's head against the door. He stated that at that point, he got between the client and DSP #3 and escorted the client into the bedroom. DSP #2 stated he turned to get clothing for the client and when he turned back around, he observed DSP #3 grab the client's arm and pull the client off the bed. Further interview revealed DSP #2 grabbed DSP #3 and removed him from the room. The DSP stated he then reported the incident to the Supervisor. DSP #2 stated he had never worked with DSP #3 and had only met him once before.</p> <p>Interview with DSP #12 on 04/14/2020 at 4:01 PM, revealed she was also assigned to Client #1's home on second shift on 03/31/2020 through 04/01/2020. She stated DSP #3 was not assigned to work in the home, but came to the home just before the incident. She stated they</p>	W 127			

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

PRINTED: 04/30/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18G017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2020
NAME OF PROVIDER OR SUPPLIER OAKWOOD ICF/IID, UNIT 3			STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 127	<p>Continued From page 15</p> <p>were seated in the living area of the home. According to DSP #12, when DSP #2 got up and went into Client #1's bedroom to check on the client, DSP #3 followed him. DSP #12 stated she then heard DSP #3 loudly say, "What the fuck are you doing?" She stated she went to see what was happening and discovered the client was still undressed from the shower. She stated she proceeded to assist the client to get dressed while DSP #2 and DSP #3 were outside the room, in the kitchen area, arguing. DSP #12 stated that she had not worked with DSP #3 before. She stated that she did not note any odd behavior prior to him going into the client's room that morning.</p> <p>Interview with the Supervisor on 04/14/2020 at 4:14 PM, revealed DSP #2 called him on 04/01/2020 and asked him to come to Client #1's home. He stated when he arrived DSP #2 reported the incident, and he had DSP #3 leave the facility.</p> <p>Interview with Risk Manager #1 on 04/14/2020 at 12:00 PM, revealed she interviewed DSP #3 as part of the facility's investigation. The Risk Manager stated DSP #3 told her that he went to Client #1's bathroom to assist DSP #2. According to the Risk Manager, DSP #3 told her that he grabbed and turned the client's face toward him to ask the client a question. However, according to the Risk Manager, DSP #3 denied the abuse allegations.</p> <p>Attempts to contact DSP #3 on 04/14/2020 at 1:00 PM and on 04/15/2020 at 4:40 PM, were unsuccessful.</p> <p>Interview with the facility's Human Resource</p>	W 127			

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

PRINTED: 04/30/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18G017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2020
NAME OF PROVIDER OR SUPPLIER OAKWOOD ICF/IID, UNIT 3			STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 127	<p>Continued From page 16</p> <p>Manager on 04/14/2020 at 1:55 PM, revealed DSP #3 was terminated on 04/14/2020 due to client abuse.</p> <p>2. Observation of Client #2 on 04/13/2020 at 12:30 PM, revealed the client had been moved to another facility within the campus. The client was dressed in street clothes and was ambulating in the day room of the home. The client approached the surveyor (State Survey Agency Surveyor) and Risk Manager #1, and was signing to go for a walk.</p> <p>Review of the medical record revealed Client #2 was admitted to the facility on 07/12/2004 and had diagnoses of Moderate Intellectual Disabilities, Developmental Disorders of Speech and Language, Conduct Disorder, Cardiomegaly, and Dysphagia.</p> <p>Review of Client #2's PBSP, revised 02/02/2020, revealed the client had target behaviors that included disruptive behavior, self-injurious behavior (hitting self on the head or banging head on hard surface), leaving the area of supervision, physical aggression, and property destruction.</p> <p>Review of an Incident Report dated 04/02/2020 at 10:50 AM, revealed DSP #10 completed an incident report that stated Client #2 exhibited aggression toward staff, self-injurious behavior, and had caused property damage.</p> <p>However, review of a facility Final Expanded Investigative Report dated 04/09/2020, revealed the facility reviewed the video/audio surveillance of Client #2's home on 04/02/2020, after the incident report was completed. During review of the video/audio surveillance, the facility</p>	W 127			

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

PRINTED: 04/30/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18G017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2020
NAME OF PROVIDER OR SUPPLIER OAKWOOD ICF/IID, UNIT 3			STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 127	<p>Continued From page 17</p> <p>discovered that DSP #9 and DSP #10 had verbally abused Client #2 at approximately 7:00 AM that morning. The report revealed that DSP #9 and DSP #10, without question, spoke harshly and inappropriately to Client #2, which led to the client becoming upset and displaying physical aggression and self-injurious behavior. According to the facility's investigation, the video footage also revealed that DSP #11 was present during the client abuse and did not intervene to protect the client, nor did he report the abuse. Subsequently, DSP #9 and DSP #10 continued to provide care to Client #2 and other clients in the home until 04/02/2020 at 1:39 PM.</p> <p>Review of the facility's video/audio surveillance footage for Client #2's home on 04/02/2020 revealed at 6:57 AM, DSP #9 entered the home. Client #2 was sitting on the couch, reclined, with his/her feet up. At 7:00 AM, DSP #10 was observed in the home. Further review revealed at 7:03 AM, the lights were turned off and Client #2 started flailing his/her arms and legs and screamed. DSP #9 stated to the client at 7:04 AM, "Not today (client's name)" and then yelled at the client, "Do you want me to call a code? You're a fat (inaudible)." Client #1 continued yelling while still seated in the recliner. DSP #9 told the client if he/she kept it up, they would leave the client alone. Then, DSP #10 stated to the client, "If you hit me again, we're going to have a problem."</p> <p>Continued review of the facility's video/audio revealed at 7:05 AM, Client #2 got up from the couch and went toward the exit door. At that point, DSP #9 yelled at the client, "Get to your room!" and "You are done!" The client continued to scream and began slapping himself/herself, sat</p>	W 127			

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

PRINTED: 04/30/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18G017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2020
NAME OF PROVIDER OR SUPPLIER OAKWOOD ICF/IID, UNIT 3			STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 127	<p>Continued From page 18</p> <p>on the floor, and started banging his/her head. The client continued to sit on the floor with self-injurious behavior and screaming. Then, at 7:08 AM, DSP #10 yelled at the client stating, "You kicked me!" DSP #9 asked DSP #10 if she should get someone "up here" because "you all" cannot risk getting hurt. At 7:09 AM, Client #2 exited the home and DSP #10 stated, "I'm going home!" The video then revealed Client #2 reentered the home at 7:15 AM with a female staff member. However, the client immediately exited the home again but returned at 7:17 AM with a female staff member and sat on the couch. Client #2 was no longer screaming at that time.</p> <p>Interview with DSP #9 on 04/15/2020 at 4:20 PM, revealed she and two (2) other staff members were assigned to supervise clients on 04/02/2020 in the home where Client #2 resided. She stated when she arrived at work Client #2 was up and seemed agitated. She stated DSP #10 turned off the lights in an effort to calm the client because the client did not want to go back to bed. DSP #9 stated when the lights were turned off the client started to kick and flail his/her arms and the "guys" tried to calm him/her down. According to DSP #9, Client #2 got up and headed to the exit door and the "guys" blocked the door. She stated she asked DSP #10 if he wanted her to call a code green, related to the client's behavior, but DSP #10 did not want to call a code. DSP #9 stated she had attended training regarding client abuse upon hire, about one month ago; however, she denied hearing staff make any abusive/inappropriate statements, and denied the comments she made on the facility's video/audio.</p> <p>An interview with DSP #10 was attempted on 04/15/2020 at 4:58 PM; however, the DSP ended</p>	W 127			

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

PRINTED: 04/30/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18G017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2020
NAME OF PROVIDER OR SUPPLIER OAKWOOD ICF/IID, UNIT 3			STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 127	<p>Continued From page 19</p> <p>the call after the surveyor (State Survey Agency Surveyor) identified herself and the reason for the call.</p> <p>An attempt to contact DSP #11 was made on 04/15/2020 at 4:36 PM, but there was no answer and no voice mail had been set up.</p> <p>Interview with Qualified Intellectual Disabilities Professional (QIDP) #2 on 04/13/2020 at 1:45 PM, revealed when she arrived at the facility on the morning of 04/02/2020, DSP #9 told her that Client #2 had hit his/her head on the wall. She stated she did not question the behavior because the client had displayed some behaviors recently because of activity limitations/restrictions due to COVID-19.</p> <p>Interview with Risk Manager #3 on 04/14/2020 at 1:05 PM, revealed he reviewed video surveillance footage of Client #2's home after the incident report was completed on 04/02/2020, and initiated an investigation at approximately 1:30 PM after the review. He stated the facility's video/audio surveillance was the most powerful evidence that Client #2 was abused. He stated DSP #9 could be heard screaming and cursing at the client and DSP #10 was heard to warn the client. Continued interview revealed all the staff involved (DSPs #9, #10, and #11) were fairly new, but all had received abuse training. The Risk Manager stated he thought that DSP #9 was upset that Client #2 was up because the client would usually sleep until noon. The Risk Manager confirmed that the staff were not removed from direct client care until 1:39 PM on 04/02/2020, after review of the video/audio.</p> <p>Interview with the Human Resources Manager on</p>	W 127			

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

PRINTED: 04/30/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18G017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2020
NAME OF PROVIDER OR SUPPLIER OAKWOOD ICF/IID, UNIT 3			STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 127	Continued From page 20 04/13/2020 at 1:00 PM, revealed DSP #10 quit on 04/05/2020 and has been marked a "no hire." DSP #9 and DSP #11 were both terminated on 04/09/2020 due to the incident involving Client #2 on 04/02/2020.	W 127			
W 251	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(3) Except for those facets of the individual program plan that must be implemented only by licensed personnel, each client's individual program plan must be implemented by all staff who work with the client, including professional, paraprofessional and nonprofessional staff. This STANDARD is not met as evidenced by: Based on observation, interview, record review, review of the facility's video surveillance footage, and review of the facility's policy, it was determined that the facility failed to ensure implementation of the Individual Program Plan (IPP) for one (1) of two (2) sampled clients (Client #2). Review of video footage, dated 04/02/2020, revealed Client #2 was displaying targeted behaviors included in the client's Positive Behavior Support Plan (PBSP), which is part of the client's IPP. Two (2) staff members, Direct Support Professionals (DSPs) #9 and #10, who were assigned to care for the client, failed to implement Client #2's PBSP and were verbally abusive to the client, which led to further escalation of the client's behaviors. The findings include: Review of the facility's policy, Positive Behavior	W 251			

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

PRINTED: 04/30/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18G017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2020
NAME OF PROVIDER OR SUPPLIER OAKWOOD ICF/IID, UNIT 3			STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 251	<p>Continued From page 21</p> <p>Support (PBS), dated 03/07/2019, revealed PBS is an approach to developing interventions for individuals who exhibit behaviors that impede community integration, and a value system that emphasizes the importance of supporting the individual's strengths, abilities, and desires.</p> <p>Review of the facility's policy, Positive Behavior Support Manual, dated 06/30/2017, revealed all staff who would be working with the client, or would reasonably be expected to know the procedures, are trained on the Behavior Guidelines and PBSPs prior to implementation.</p> <p>Observation of Client #2 on 04/13/2020 at 12:30 PM, revealed the client was up and ambulating in the day room of the home. The client approached the surveyor and Risk Manager #1 and was signing to go for a walk.</p> <p>Review of the medical record revealed the facility admitted Client #2 on 07/12/2004. Client #2 had diagnoses that included Moderate Intellectual Disabilities, Developmental Disorder of Speech and Language, Conduct Disorder, Cardiomegaly, and Dysphagia.</p> <p>Review of the PBSP for Client #2, revised 02/02/2020, revealed the client had challenging behaviors that included stating "No," banging his/her hand on hard surfaces, and scanning the environment for people or objects to hit/throw. The plan also stated the client displayed self-injurious behavior by hitting his/her head with his/her hand or banging his/her head on hard surfaces. Further review revealed Client #2 may leave a designated area or may display physical aggression or property destruction. The PBSP stated staff were instructed what to do if these</p>	W 251			

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

PRINTED: 04/30/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18G017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2020
NAME OF PROVIDER OR SUPPLIER OAKWOOD ICF/IID, UNIT 3			STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 251	<p>Continued From page 22</p> <p>behaviors were displayed. The plan stated if the client yelled "no" or raised his/her arms in a threatening manner, slammed doors or struck at objects, only one (1) staff person should speak with the client and staff should ask the client if he/she needed assistance. Further, if the client did not de-escalate, help the client change the subject, state something in a positive tone, i.e., "Let me see your smile." The PBSP also revealed environmental triggers to avoid with Client #2 included loud, crowded, and chaotic environments, which could trigger behaviors in the client.</p> <p>Review of Client #2's IPP, effective 03/14/2019, revealed the client's activity plan from 7:00 AM to 9:00 AM, was for the client to have breakfast, help to wipe down tables, make his/her bed, etc.</p> <p>Review of the facility's video surveillance footage for Client #2's home for 04/02/2020 revealed at 6:57 AM, Client #2 was sitting on the couch, reclined back with his/her feet up. At 7:00 AM, the client was looking around and following the staff in the room. At 7:03 AM, the lights were turned off and the client became upset as evidenced by his/her flailing of his/her arms and legs and some screams. The client remained seated on the couch/recliner. DSP #9 stated at 7:04 AM, "Not today (client's name)" and then yelled at Client #2, "Do you want me to call a code?...You're a fat (inaudible word)." The yelling continued while the client was still lying back in the recliner, and DSP #9 told the client if he/she kept it up they would leave him/her. Then, DSP #10 stated to the client, "If you hit me again, we're going to have a problem." The video then revealed at 7:05 AM, Client #2 got up off the couch and went toward the exit door to the home.</p>	W 251			

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

PRINTED: 04/30/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18G017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2020
NAME OF PROVIDER OR SUPPLIER OAKWOOD ICF/IID, UNIT 3			STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 251	<p>Continued From page 23</p> <p>At this point, DSP #9 was yelling at the client, "Get to your room!" and "You are done!" The client continued to scream and displayed escalated behaviors of slapping himself/herself, and then sat on the floor and started to bang his/her head.</p> <p>Continued observation of the video revealed it was unable to clearly determine whether the client was hitting his/her head on the floor or the wall. The client continued, on the floor, with self-injurious behavior and screaming until 7:08 AM when DSP #10 yelled at the client stating, "You kicked me!" At this point DSP #9 asked DSP #10, "Do you want me to get someone up here, cause you all can't risk getting hurt?" At 7:09 AM, Client #2 exited the home and DSP #10 stated, "I'm going home!" The video footage showed DSP #10 leaving the home behind the client. Then Client #2 reentered the home at 7:15 AM with a different female staff member accompanying him/her. However, the client immediately exited the home, did not return until 7:17 AM, and sat down on the couch. Client #2 was no longer screaming or flailing, or kicking.</p> <p>Review of a Final Expanded Investigative Report, dated 04/09/2020, revealed DSP #9 was trained on the PBSP for Client #2 on 02/28/2020 and DSP #10 was trained on the client's PBSP on 02/04/2020.</p> <p>Interview with DSP #9 on 04/15/2020 at 4:20 PM, revealed she and two (2) other staff members were assigned to the home where Client #2 resided on 04/02/2020. She stated when she arrived, Client #2 was up and seemed agitated. She stated DSP #10 turned the lights off in effort to calm the client because he/she did not want to</p>	W 251			

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

PRINTED: 04/30/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18G017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2020
NAME OF PROVIDER OR SUPPLIER OAKWOOD ICF/IID, UNIT 3			STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 251	<p>Continued From page 24</p> <p>go back to bed, even though the client was supposed to be up completing activities as part of his/her IPP. She then stated when the lights were turned off, the client started to kick and flail his/her arms and the guys tried to calm the client. She further stated the client then got up and headed to the door and the guys blocked the door. DSP #9 stated the facility had educated her regarding Client #2's IPP and PBSP prior to the client being moved to the home from another Unit within the facility. According to DSP #9, she believed they were following the client's PBSP.</p> <p>Interview with DSP #10 on 04/15/2020 at 4:58 PM, ended when the DSP hung up after the surveyor identified herself and the reason for the call.</p> <p>Interviews were conducted with DSP #8 on 04/13/2020 at 12:21 PM, and DSP #7 on 04/13/2020 at 12:30 PM regarding the client's PBSPs. DSP #8 stated the plan directs staff on how to care for the clients. DSP #7 stated staff would refer to the client's behavior plan for guidance on how to address behaviors.</p> <p>Interview with Qualified Intellectual Disability Professional (QIDP) #2 on 04/16/2020 at 10:56 AM, revealed staff were expected to implement clients' PBSPs and behaviors were monitored through a documentation system called "Care Tracker." She stated staff were required to document when behaviors occurred, the planned intervention that was used, and whether or not the intervention was successful. She further stated the system was monitored routinely and the information also assisted with the need for changes in plans. The QIDP then stated she did not review the video for the 04/02/2020 incident</p>	W 251			

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

PRINTED: 04/30/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18G017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2020
NAME OF PROVIDER OR SUPPLIER OAKWOOD ICF/IID, UNIT 3			STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 251	Continued From page 25 involving Client #2, but she did review the investigation and confirmed that the staff, DSP #9 and DSP #10, did not follow Client #2's PBSP.	W 251			

(X5) DATE

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 101090	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 04/21/2020
NAME OF PROVIDER OR SUPPLIER OAKWOOD ICF/IID, UNIT 3		STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
I 001	<p>Continued From page 1</p> <p>to decrease the census in Unit 2 and to give the clients more room. In addition, the Former Director stated the facility had monitoring mechanisms in place to ensure clients were not abused. However, on 04/01/2020, Direct Support Professional (DSP) #3, a staff member not assigned to supervise or care for Client #1, entered the client's bathroom and physically abused the client.</p> <p>In addition, on 04/02/2020, at approximately 7:00 AM, DSP #9 and DSP #10 verbally abused Client #2.</p> <p>The findings include:</p> <p>Review of the facility's policy, Performance Improvement (PI) Council (Governing Body), dated 08/28/2019, revealed the PI council was the facility's Governing Body. The policy stated that the role of the PI Council was to exercise general policy and operating direction over the facility. According to the policy, the PI Council was responsible for ensuring the necessary environment was provided to ensure client health and safety.</p> <p>1. Review of Client #1's medical record revealed the facility transferred the client from Unit 2 to Unit 3 on 03/09/2020.</p> <p>Review of the facility's Final Expanded Investigative Report, dated 04/08/2020, revealed on 04/01/2020 at 2:40 AM, DSP #2 was assisting Client #1 from the shower when DSP #3 entered the client's bathroom. DSP #3 grabbed the client by the face, asked the client, "What the fuck is your problem?" and then proceeded to slam the client's head against the door. DSP #2 got between DSP #3 and the client and escorted the</p>	I 001			

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 101090	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 04/21/2020
NAME OF PROVIDER OR SUPPLIER OAKWOOD ICF/IID, UNIT 3		STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
I 001	<p>Continued From page 2</p> <p>client into his/her bedroom. DSP #2 then turned away from the client to retrieve clothing and told DSP #3 that he needed to leave. However, DSP #3 went around DSP #2 and grabbed the arm of Client #1, jerked the client off the bed, and repeated to the client, "I asked you, what was your problem?" The facility substantiated that DSP #3 abused Client #1.</p> <p>2. Review of the medical record revealed Client #2 was transferred to the facility from Unit 2 on 03/18/2020, and was moved back to Unit 2 on 04/10/2020.</p> <p>A review of the facility's Final Expanded Investigation dated 04/09/2020 revealed the facility reviewed the video/audio footage of Client #2's home for 04/02/2020 at 7:00 AM. The facility's review determined that at 7:03 AM, the lights in the living area were turned off where Client #2 was seated. The client started yelling and was waving his/her arms and kicking his/her legs. At this time, DSP #9 could be heard loudly asking the client, "Do you want me to call a code green?" (call for help with a client who is having behaviors or has eloped) ... "You're a fat (inaudible)." DSP #9 then stated to the client loudly, "You're done, you understand?" DSP #9 then yelled at the client and stated, "You keep this up and we will leave, you understand me?" Per video footage, Client #2 was still seated on the couch. The audio then revealed DSP #10 said to the client, "Listen, you hit me again and we're going to have a problem." According to the facility's investigation, DSP #11, who was also present, did not intervene to protect the client, nor did he report the incident to his supervisor.</p> <p>Continued review of the facility's Final Expanded Investigation revealed the facility substantiated</p>	I 001			

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 101090	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/21/2020
NAME OF PROVIDER OR SUPPLIER OAKWOOD ICF/IID, UNIT 3		STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 001	<p>Continued From page 3</p> <p>that Client #2 was verbally abused. The facility concluded that on 04/02/2020 at approximately 7:03 AM, DSP #9 and DSP #10, without question, spoke harshly and inappropriately to Client #2, which then led to the client becoming upset and displaying physical aggression and self-injurious behavior.</p> <p>Interview with the Unit Administrator on 04/13/2020 at 3:15 PM, revealed the transfer of Clients #1 and #2 was done as part of a reorganization. He further stated he recommended Client #2 be returned to Unit #2, as the transfer was not successful and it was not good for the client.</p> <p>Interview with Qualified Intellectual Disability Professional (QIDP) #2 on 04/13/2020 at 1:45 PM, revealed she was assigned to Client #2 when the client was residing in Unit 3. She stated the client was transferred to Unit 3 in an attempt to give the clients more space and to decrease the population of clients in the homes. According to QIDP #2, Client #2 was moved back to Unit 2 on 04/10/2020. She stated she was informed that the client "needed" to move and she did not really know the reason when the transfer occurred.</p> <p>Interview with the Director on 04/12/2020 at 3:45 PM and on 04/13/2020 at 10:40 AM and 2:15 PM, revealed homes in Unit 3 were opened up, and Clients #1 and #2 were moved from Unit 2 to decrease the number of clients in Unit 2 and to give the clients more space. He stated Client #1 and all his/her housemates were moved as a whole, and Client #2 was chosen to move so the client could have a bigger open area outside the home. However, after the incident, the facility moved Client #2 back to Unit 2 because it "just didn't work out." When asked to elaborate, the</p>	I 001		

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 101090	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/21/2020
NAME OF PROVIDER OR SUPPLIER OAKWOOD ICF/IID, UNIT 3		STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 001	Continued From page 4 Director stated the client was with a peer that he/she had not been with before. He stated that all staff had been recently reeducated regarding the facility's abuse policy and had recently received Compassionate Care Training. The Director stated administrative staff had also been monitoring the homes, where Client #1 and Client #2 resided, on a continuous basis in an effort to ensure abuse did not occur. He also stated that reviewing the video/audio surveillance after an incident report, related to client aggression, was a new intervention implemented to monitor staff/client interactions. The Director stated that due to this intervention, the facility determined that Client #2 was abused. However, the Director acknowledged the actions taken had not prevented client abuse. According to the Director, the incident with Client #1 was "blatant abuse." He stated DSP #3 was a long-term employee with no history of issues and "I don't know what changed."	I 001		
I 012	902 KAR 20:086-3(6) Section 3. Administration and Operation (6) Patient rights. Patient rights shall be provided for pursuant to KRS 216.510 to 216.525.	I 012		

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 101090	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 04/21/2020
NAME OF PROVIDER OR SUPPLIER OAKWOOD ICF/IID, UNIT 3		STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
1012	<p>Continued From page 5</p> <p>This requirement is not met as evidenced by: Based on observation, interview, record review, review of facility video/audio footage, review of facility investigations, and review of the facility's Risk Management Protocol, it was determined the facility failed to protect two (2) of two (2) sampled clients (Clients #1 and #2) from abuse. On 04/01/2020, Direct Support Professional (DSP) #3, who was not assigned to supervise the client, went into Client #1's bathroom, grabbed the client's face, and slammed the client's head into the wall/door. DSP #3 then grabbed the client's arm roughly and pulled the client down onto his/her bed. Client #1 was assessed to have cuts and bruising to the face after the incident.</p> <p>On 04/02/2020, at 10:50 AM staff completed an incident report that stated Client #2 had exhibited aggression toward staff, self-injurious behavior, and had caused property damage. However, when the facility reviewed the video/audio surveillance footage of the client's home on 04/02/2020 at approximately 1:30 PM, they discovered that DSP #9 and DSP #10 verbally abused Client #2 at approximately 7:30 AM that morning. The facility also determined that DSP #11 was present when the abuse occurred, but did not intervene to stop the abuse, and did not report the abuse as required by facility policy. Subsequently, Client #1 and other clients in the home were not protected from further potential abuse from DSP #9 and DSP #10 until 1:39 PM, approximately seven (7) hours after they verbally abused Client #2.</p> <p>The findings include:</p> <p>Review of the facility's policy, Facility Risk Management Protocol, undated, revealed the</p>	1012			

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 101090	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/21/2020
NAME OF PROVIDER OR SUPPLIER OAKWOOD ICF/IID, UNIT 3		STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 012	<p>Continued From page 6</p> <p>facility must have integrated systems to ensure all individuals served are free from abuse. According to the policy, the facility must proactively assure individuals are free from serious and immediate threat to their physical and psychological health and safety. The facility's policy defined physical abuse as any physical motion or action, by which bodily harm or trauma occurs, and includes but is not limited to hitting, slapping, pinching, punching, kicking, and burning. Physical abuse also included controlling behavior through corporal punishment as well as the use of any restrictive, intrusive procedure to control inappropriate behavior for purposes of punishment. The facility defined verbal abuse as any use of oral, written, or gestured language that was willful, which included disparaging and/or derogatory terms to individuals. Continued review of the facility's policy revealed the employees had the responsibility to immediately report to the Facility Director or designated representative and/or to other authorized officials of harm or potential for harm to adults and children, including, but not limited to all allegations of abuse.</p> <p>1. Observation of Client #1 on 04/13/2020 at 12:21 PM, revealed the client was sitting in the day room, wearing headphones, and working with Legos. Client #1 got up, came over to the surveyor (State Survey Agency Surveyor), and proceeded to greet her and Risk Manager #1 using sign language. The client had no visible injuries to his/her face.</p> <p>Review of Client #1's medical record revealed the facility admitted the client on 11/20/2003. The client had diagnoses of Severe Intellectual Disabilities, Cystic Fibrosis with Pulmonary Manifestations, Hyperosmality/Hypermnatremia</p>	I 012		

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 101090	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/21/2020
NAME OF PROVIDER OR SUPPLIER OAKWOOD ICF/MID, UNIT 3		STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 012	<p>Continued From page 7</p> <p>(sodium level in the blood that is higher than normal), and Unspecified Convulsions.</p> <p>Review of the Positive Behavior Support Plan (PBSP) for Client #1, dated reviewed 01/23/2020, revealed the client had occasions of nighttime accidents and should be encouraged to clean himself/herself when these occurred.</p> <p>Review of a facility Final Expanded Investigative Report, dated 04/08/2020, revealed on 04/01/2020 at 2:40 AM, DSP #2 was assisting Client #1 from the shower after an episode of urinary incontinence. The report stated DSP #3 entered the bathroom, grabbed the client by the face, and asked the client, "What the fuck is your problem?" DSP #3 then proceeded to slam the client's head against the door. DSP #2 stated he got between DSP #3 and the client, and escorted the client into the bedroom. Further review of the report revealed DSP #2 then turned away from the client to retrieve clothing and told DSP #3 that he needed to leave. The report revealed DSP #3 then went around DSP #2 and grabbed Client #1's arm, jerked the client off the bed, and repeated to the client, "I asked you, what was your problem?" According to the investigation, DSP #2 took the arm of DSP #3 and removed him from the client's bedroom. Review of the analysis and findings of the report revealed the facility substantiated that DSP #3 physically abused Client #1.</p> <p>Continued review of the facility's Final Expanded Investigative Report revealed a Registered Nurse (RN) assessed Client #1 for injury on 04/01/2020 at 2:52 AM. The RN documented that Client #1 had open areas that were approximately one-fourth inch in size to the upper mid-forehead and the tip of the nose, and discoloration to the</p>	I 012		

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 101090	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/21/2020
NAME OF PROVIDER OR SUPPLIER OAKWOOD ICF/IID, UNIT 3		STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 012	<p>Continued From page 8</p> <p>left side of the nose. She further documented the client did not appear to be in any pain or distress.</p> <p>Review of the facility's video/audio surveillance footage of Client #1's home, dated 04/01/2020, revealed DSP #3 entered the home at 2:31 AM. The video then revealed at 2:38:48 AM, DSP #2 entered Client #1's room and at 2:38:58 AM, DSP #3 went into Client #1's room. Further review revealed at 2:40:09 AM, DSP #2 walked just outside Client #1's doorway and spoke with the two (2) other DSPs in the home, who got up from the living area and approached the client's bedroom door. Then at 2:41 AM, DSP #3 was observed leaving Client #1's room. Continued observation of the video/audio revealed at 2:41:33 AM, DSP #3 left the home with DSP #2 following. DSP #2 could be heard asking DSP #3 if he put his hands on the client like that all the time and if that made him feel big. DSP #3 replied, "No," and then exited the home.</p> <p>Review of the Daily Supervisor Report, dated 03/31/2020, revealed for the second shift, DSP #2 was assigned to supervise three (3) clients, one of which was Client #1. DSP #3 was assigned as a "float" (staff member who relieved other staff for breaks and meals) staff member for another home, but was not assigned to supervise Client #1, nor any of the clients in the home where Client #1 resided.</p> <p>Interview with DSP #2 on 04/13/2020 at 4:15 PM, revealed he was assigned to supervise Client #1 on second shift starting on 03/31/2020. The DSP stated Client #1 had an incontinence episode and was in the shower. He stated he had gone into Client #1's bathroom to assist the client out of the shower when DSP #3 came into the client's bathroom. He stated DSP #3 grabbed the client</p>	I 012		

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 101090	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/21/2020
NAME OF PROVIDER OR SUPPLIER OAKWOOD ICF/IID, UNIT 3		STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 012	<p>Continued From page 9</p> <p>and shoved the client's head against the door. He stated that at that point, he got between the client and DSP #3 and escorted the client into the bedroom. DSP #2 stated he turned to get clothing for the client and when he turned back around, he observed DSP #3 grab the client's arm and pull the client off the bed. Further interview revealed DSP #2 grabbed DSP #3 and removed him from the room. The DSP stated he then reported the incident to the Supervisor. DSP #2 stated he had never worked with DSP #3 and had only met him once before.</p> <p>Interview with DSP #12 on 04/14/2020 at 4:01 PM, revealed she was also assigned to Client #1's home on second shift on 03/31/2020 through 04/01/2020. She stated DSP #3 was not assigned to work in the home, but came to the home just before the incident. She stated they were seated in the living area of the home. According to DSP #12, when DSP #2 got up and went into Client #1's bedroom to check on the client, DSP #3 followed him. DSP #12 stated she then heard DSP #3 loudly say, "What the fuck are you doing?" She stated she went to see what was happening and discovered the client was still undressed from the shower. She stated she proceeded to assist the client to get dressed while DSP #2 and DSP #3 were outside the room, in the kitchen area, arguing. DSP #12 stated that she had not worked with DSP #3 before. She stated that she did not note any odd behavior prior to him going into the client's room that morning.</p> <p>Interview with the Supervisor on 04/14/2020 at 4:14 PM, revealed DSP #2 called him on 04/01/2020 and asked him to come to Client #1's home. He stated when he arrived DSP #2 reported the incident, and he had DSP #3 leave</p>	I 012		

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 101090	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/21/2020
NAME OF PROVIDER OR SUPPLIER OAKWOOD ICF/IID, UNIT 3		STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 012	<p>Continued From page 10</p> <p>the facility.</p> <p>Interview with Risk Manager #1 on 04/14/2020 at 12:00 PM, revealed she interviewed DSP #3 as part of the facility's investigation. The Risk Manager stated DSP #3 told her that he went to Client #1's bathroom to assist DSP #2. According to the Risk Manager, DSP #3 told her that he grabbed and turned the client's face toward him to ask the client a question. However, according to the Risk Manager, DSP #3 denied the abuse allegations.</p> <p>Attempts to contact DSP #3 on 04/14/2020 at 1:00 PM and on 04/15/2020 at 4:40 PM, were unsuccessful.</p> <p>Interview with the facility's Human Resource Manager on 04/14/2020 at 1:55 PM, revealed DSP #3 was terminated on 04/14/2020 due to client abuse.</p> <p>2. Observation of Client #2 on 04/13/2020 at 12:30 PM, revealed the client had been moved to another facility within the campus. The client was dressed in street clothes and was ambulating in the day room of the home. The client approached the surveyor (State Survey Agency Surveyor) and Risk Manager #1, and was signing to go for a walk.</p> <p>Review of the medical record revealed Client #2 was admitted to the facility on 07/12/2004 and had diagnoses of Moderate Intellectual Disabilities, Developmental Disorders of Speech and Language, Conduct Disorder, Cardiomegaly, and Dysphagia.</p> <p>Review of Client #2's PBSP, revised 02/02/2020, revealed the client had target behaviors that</p>	I 012		

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 101090	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/21/2020
NAME OF PROVIDER OR SUPPLIER OAKWOOD ICF/IID, UNIT 3		STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 012	<p>Continued From page 11</p> <p>included disruptive behavior, self-injurious behavior (hitting self on the head or banging head on hard surface), leaving the area of supervision, physical aggression, and property destruction.</p> <p>Review of an Incident Report dated 04/02/2020 at 10:50 AM, revealed DSP #10 completed an incident report that stated Client #2 exhibited aggression toward staff, self-injurious behavior, and had caused property damage.</p> <p>However, review of a facility Final Expanded Investigative Report dated 04/09/2020, revealed the facility reviewed the video/audio surveillance of Client #2's home on 04/02/2020, after the incident report was completed. During review of the video/audio surveillance, the facility discovered that DSP #9 and DSP #10 had verbally abused Client #2 at approximately 7:00 AM that morning. The report revealed that DSP #9 and DSP #10, without question, spoke harshly and inappropriately to Client #2, which led to the client becoming upset and displaying physical aggression and self-injurious behavior. According to the facility's investigation, the video footage also revealed that DSP #11 was present during the client abuse and did not intervene to protect the client, nor did he report the abuse. Subsequently, DSP #9 and DSP #10 continued to provide care to Client #2 and other clients in the home until 04/02/2020 at 1:39 PM.</p> <p>Review of the facility's video/audio surveillance footage for Client #2's home on 04/02/2020 revealed at 6:57 AM, DSP #9 entered the home. Client #2 was sitting on the couch, reclined, with his/her feet up. At 7:00 AM, DSP #10 was observed in the home. Further review revealed at 7:03 AM, the lights were turned off and Client #2 started flailing his/her arms and legs and</p>	I 012		

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 101090	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 04/21/2020
NAME OF PROVIDER OR SUPPLIER OAKWOOD ICF/IID, UNIT 3		STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
I 012	<p>Continued From page 12</p> <p>screamed. DSP #9 stated to the client at 7:04 AM, "Not today (client's name)" and then yelled at the client, "Do you want me to call a code? You're a fat (inaudible)." Client #1 continued yelling while still seated in the recliner. DSP #9 told the client if he/she kept it up, they would leave the client alone. Then, DSP #10 stated to the client, "If you hit me again, we're going to have a problem."</p> <p>Continued review of the facility's video/audio revealed at 7:05 AM, Client #2 got up from the couch and went toward the exit door. At that point, DSP #9 yelled at the client, "Get to your room!" and "You are done!" The client continued to scream and began slapping himself/herself, sat on the floor, and started banging his/her head. The client continued to sit on the floor with self-injurious behavior and screaming. Then, at 7:08 AM, DSP #10 yelled at the client stating, "You kicked me!" DSP #9 asked DSP #10 if she should get someone "up here" because "you all" cannot risk getting hurt. At 7:09 AM, Client #2 exited the home and DSP #10 stated, "I'm going home!" The video then revealed Client #2 reentered the home at 7:15 AM with a female staff member. However, the client immediately exited the home again but returned at 7:17 AM with a female staff member and sat on the couch. Client #2 was no longer screaming at that time.</p> <p>Interview with DSP #9 on 04/15/2020 at 4:20 PM, revealed she and two (2) other staff members were assigned to supervise clients on 04/02/2020 in the home where Client #2 resided. She stated when she arrived at work Client #2 was up and seemed agitated. She stated DSP #10 turned off the lights in an effort to calm the client because the client did not want to go back to bed. DSP #9 stated when the lights were turned off the client</p>	I 012			

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 101090	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/21/2020
NAME OF PROVIDER OR SUPPLIER OAKWOOD ICF/IID, UNIT 3		STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 012	<p>Continued From page 13</p> <p>started to kick and flail his/her arms and the "guys" tried to calm him/her down. According to DSP #9, Client #2 got up and headed to the exit door and the "guys" blocked the door. She stated she asked DSP #10 if he wanted her to call a code green, related to the client's behavior, but DSP #10 did not want to call a code. DSP #9 stated she had attended training regarding client abuse upon hire, about one month ago; however, she denied hearing staff make any abusive/inappropriate statements, and denied the comments she made on the facility's video/audio.</p> <p>An interview with DSP #10 was attempted on 04/15/2020 at 4:58 PM; however, the DSP ended the call after the surveyor (State Survey Agency Surveyor) identified herself and the reason for the call.</p> <p>An attempt to contact DSP #11 was made on 04/15/2020 at 4:36 PM, but there was no answer and no voice mail had been set up.</p> <p>Interview with Qualified Intellectual Disabilities Professional (QIDP) #2 on 04/13/2020 at 1:45 PM, revealed when she arrived at the facility on the morning of 04/02/2020, DSP #9 told her that Client #2 had hit his/her head on the wall. She stated she did not question the behavior because the client had displayed some behaviors recently because of activity limitations/restrictions due to COVID-19.</p> <p>Interview with Risk Manager #3 on 04/14/2020 at 1:05 PM, revealed he reviewed video surveillance footage of Client #2's home after the incident report was completed on 04/02/2020, and initiated an investigation at approximately 1:30 PM after the review. He stated the facility's video/audio surveillance was the most powerful</p>	I 012		

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 101090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/21/2020
NAME OF PROVIDER OR SUPPLIER OAKWOOD ICF/IID, UNIT 3		STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 012	<p>Continued From page 14</p> <p>evidence that Client #2 was abused. He stated DSP #9 could be heard screaming and cursing at the client and DSP #10 was heard to warn the client. Continued interview revealed all the staff involved (DSPs #9, #10, and #11) were fairly new, but all had received abuse training. The Risk Manager stated he thought that DSP #9 was upset that Client #2 was up because the client would usually sleep until noon. The Risk Manager confirmed that the staff were not removed from direct client care until 1:39 PM on 04/02/2020, after review of the video/audio.</p> <p>Interview with the Human Resources Manager on 04/13/2020 at 1:00 PM, revealed DSP #10 quit on 04/05/2020 and has been marked a "no hire." DSP #9 and DSP #11 were both terminated on 04/09/2020 due to the incident involving Client #2 on 04/02/2020.</p>	I 012		

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

PRINTED: 04/30/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 18G017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2020
NAME OF PROVIDER OR SUPPLIER OAKWOOD ICF/IID, UNIT 3			STREET ADDRESS, CITY, STATE, ZIP CODE 2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 000	Initial Comments A COVID-19 focused Emergency Preparedness survey was initiated on 04/13/2020 and concluded on 04/21/2020. The facility was found to be in compliance with 42 CFR 483.475 Emergency Preparedness related to E0024. No deficient practice was identified.	E 000			

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.