STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	18G017	A. BUILDING ______ B. WING ______	C 08/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD ICF/IID, UNIT 3	2441 SOUTH HIGHWAY 27 SOMERSET, KY 42501

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W 000	INITIAL COMMENTS A complaint investigation (KY32185) and a COVID-19 focused infection control survey was initiated on 08/10/2020 and concluded on 08/11/2020. The complaint was unsubstantiated; however, standard level deficient practice was identified. 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.	W 000		
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on interview, review of video footage, record review, and review of the facility policy, it was determined the facility failed to ensure the Positive Behavior Support Plan (PBSP) was implemented for one (1) of four (4) clients (Client #1) in Home 113. The staff in home 113 failed to implement recommended interventions in the client's Positive Behavior Support Plan (PBSP) when Client #1 exhibited behaviors on 07/30/2020. Review of the video surveillance revealed Client #1 had yelled "bye-bye" to Direct Support Professional (DSP) #2, attempting to get the staff member to leave the home. The client's behavior continued to escalate and staff physically guided the client to the bathroom to	W 288		

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

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W 288	Continued From page 1	W 288		

take a shower, which was not a specific intervention on the client's PBSP or Crisis Intervention Plan.

The findings include:

Review of the facility policy, "Positive Behavior Supports," dated 03/07/2019, revealed the entire Positive Behavior Support process is one that respects the self-determination of the individual and seeks to maximize his/her change for choice, decision-making, goal-setting, and self-management. Review of the policy further revealed the staff are trained in the implementation of the client's plan and the plan is available in the client's Life Book for easy access and reference.

Observation of Client #1 on 07/30/2020 at 11:10 AM revealed the client in Resource Room D with one DSP present. The client was seated at a table and working on a computer. Client #1 immediately started telling the surveyor and Risk Manager Supervisor "bye-bye" upon entrance to the room. Interview with the Risk Manager Supervisor at this time revealed this is a behavior displayed by the client when he is not comfortable with someone or wants someone to go away. She stated this request is honored, whenever possible, as it has been seen to be a precursor to self-injurious behaviors (SIB) or physical aggression. The surveyor and the Supervisor both exited the room.

Review of the medical record revealed Client #1 was admitted to the facility on 12/12/2016 and had diagnoses of Autistic Disorder, Intermittent Explosive Disorder, Obesity, unspecified, Speech Disturbance, Severe Intellectual Disability, and

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W 288	Continued From page 2 Unspecified Disorder Psychological Development. Review of the Individual Plan Report, effective date 06/11/2020, revealed Client #1 required a level of supervision of one (1) to two (2) for all areas except when in the community, at which time the client required one (1) to one (1). The one (1) to two (2) ratio meant that the client could be assigned, along with another client, to one (1) staff member for supervision. The report also revealed the client target behaviors included physical aggression, SIB, excessive fluid consumption, eluding area of supervision, and pica (eating non-edible items)-like behaviors. Further review revealed the client did not have a scheduled shower/bath time and that he/she may choose whether to bathe in the morning or the evening. Review of the PBSP, dated 05/15/2020, revealed the precursor and behavioral signals exhibited by Client #1 for the behaviors listed in the Individual Plan Report. The plan revealed guidance on interventions to implement if the client tells a staff "bye-bye." The guidance revealed for the staff member to leave if able to do so and, if not, to try prompting the client by stating first to do this, and then offer access to something he wants. The guidance also stated if the behavior continued to escalate to call for assistance and switch out staff. Continued review of the PBSP revealed that when the client experienced heightened anxiety he would sweat profusely. The recommendation was to offer to wipe the client's face with a cool, moist washcloth, stating that this will cool him/her down and possibly de-escalate the behavior quicker. Further review revealed if the client continued to display behaviors then	W 288		

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W 288	Continued From page 3 provide prompting to engage in an alternative activity. Review of the Crisis Intervention Plan, dated 03/26/2020, revealed if Client #1 continues to engage in high intensity SIB, to alter his/her environment. The plan stated to rearrange personal items, stuffed animals, and furniture. This would initiate the client to immediately address this change and replace the items where he/she needs for them to be, therefore stopping the SIB. This activity may need to be cycled through multiple times to allow him/her to de-escalate. Review of the Daily Home Report, dated 07/30/2020, revealed DSP #3 was assigned to Client #1 and DSP #2 was assigned as a float. The float position relieves staff for breaks and meals. Review of the video, dated 07/30/2020, at approximately 6:30 PM-6:40 PM, revealed Client #1 yelling and saying "bye-bye" to DSP #2. The client opened the door to Home 113 and told DSP #2 "bye-bye" to try to get her to leave. The video revealed that DSPs #2, #3, and #4 were present in the living area and were trying to block the client from pushing DSP #2 out the door. One of the other clients was seated at one of the dining tables and was also yelling so it was difficult to hear what the staff were saying to Client #1. The video did reveal DSP #4 looking at Client #1 and pointing, with his arm, away from the front door area, as if trying to direct the client away. Continued review of the video revealed the client then dropped down onto his/her bottom and started to scoot toward DSP #2 in another effort to push her away. The video then revealed DSP	W 288		

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W 288	Continued From page 4 #2 leaving the home. The client then got up and went outside the home and back in a couple of times, still yelling and upset. Another section of video, timed at approximately 6:45 PM, with a view down the hall toward Client #1's bedroom door, revealed DSP #2 guiding the client, with hands on, toward the bedroom door. The client appeared to resist the efforts of the DSP to guide him/her toward the room. The video revealed the client and DSP #2 entered the bedroom and then DSP #3 entered the bedroom door, followed by DSP #6. Within less than a minute, DSP #6 exited the door followed by DSP #3. Then both the client and DSP #2 exited the door and the client was still yelling and telling DSP #2 "bye." Interview with the Risk Manager Supervisor on 08/10/2020 at 2:40 PM, during the viewing of the video, revealed Client #1 did not have to get in the shower. She stated she thought there was some misunderstanding of the behavior plan and they were retraining the staff on the plan. Interview with DSP #3 on 08/10/2020 at 2:50 PM, revealed she had been employed at the facility for about one (1) month. She stated that on 07/30/2020 she observed DSP #2 guiding Client #1 toward the bathroom to try to get him/her to take a shower. She also stated that a shower helped the client to calm down. She further revealed that she had not witnessed this level of behavior from the client prior to this incident. Interview with DSP #2 on 08/10/2020 at 2:15 PM revealed she was familiar with Client #1 and his behavioral plan. She stated the client had been aggressive toward her since the start of the shift at 7:00 AM. She then stated that upon the client returning from the resource room, close to shift	W 288		

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change, he/she continued to be aggressive toward her. She stated she attempted to persuade the client to take a shower. A follow-up interview on 08/11/2020 at 9:07 AM, revealed she was trying to get the client into the shower to "keep him on a routine." She stated the client has different things he does throughout the day that is his/her routine. She explained that getting the client to take a shower was an effort to get him/her engaged in other activities and stop the aggressive behavior.

A post survey interview with the Shift Supervisor on 08/12/2020 at 7:40 AM, revealed DSP #3 had attempted to get Client #1 into the shower prior to DSP #2's attempt. She stated DSP #3 was new and DSP #2 had more experience with the client and was trying to help DSP #3. She further revealed that getting the client into the shower was the easiest way to de-escalate his/her behaviors.

Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 08/11/2020 at 9:30 AM, revealed he had worked with Client #1 for the past three (3) years. He stated he had viewed the video from 07/30/2020 and stated that it appeared the client was trying to get DSP #2 to leave the home. He then added that when this occurs the plan would be to switch out the staff if possible. The QIDP then stated that he had used the activity of a shower in the past with the client to change focus from the behavior. He explained that he would suggest a shower to the client when exhibiting behaviors and at times the client would follow the suggestion. The QIDP stated it did not appear as if the client was "going for" the shower suggestion, per the video, and stated other activity or task suggestions could have been tried.

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W 288	Continued From page 6 He added there was currently staff retraining occurring related to the PBSP for Client #1. Interview with the Behavior Analyst (BA) on 08/11/2020 at 9:50 AM, revealed she was aware of the PBSP for Client #1. She stated when the client was saying "bye-bye" to staff they might try to direct him to an incompatible activity, meaning an activity that would not allow the behavior to occur. She then added that if the client refused that suggestion staff should try another activity or task. She stated she had viewed the video from 07/30/2020 and stated DSP #2 should have left the home as the client was requesting. She stated that it appeared to end up as a power struggle. She also stated that a shower was not specifically an implementation on the behavior plan, but a suggestion of an activity. The client did not have to take a shower and the staff could have tried different activity suggestions and if refused, all those could have cycled back around to the shower. The BA then stated the staff in the facility had all been retrained on the PBSP for Client #1.	W 288		

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E 000	Initial Comments A COVID-19 focused Emergency Preparedness survey was initiated on 08/10/2020 and concluded on 08/11/2020. 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		

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I 000	Initial Comments A complaint investigation (KY32185) and a COVID-19 focused infection control survey was initiated on 08/10/2020 and concluded on 08/11/2020. The complaint was unsubstantiated and no deficient practice was identified.	I 000		

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