PRINTED: 06/18/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI A. BUIL[		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		03G008	B. WING			R <b>05/08/2019</b>	
	PROVIDER OR SUPPLIER  DA DE LOS ANGELES	S		STREET ADDRESS, CITY, STATE, ZIP CODE 1402 EAST SOUTH MOUNTAIN AVENUE PHOENIX, AZ 85040		1 001	00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{W 000}	INITIÁL COMMEN	rs	{W 0	00}			
{W 102}	investigation survey resulting in Govern Client Protections a Conditions of Partic conducted on May had 36 clients and recent abuse invest deficiencies were c GOVERNING BOD CFR(s): 483.410  The facility must en	e complaint (AZ0053609) y dated February 8, 2019, ing Body and Management, and Health Care Services cipation not being met was 6 through 8, 2019. The facility the surveyors reviewed three tigations. The following ited. Y AND MANAGEMENT  sure that specific governing nent requirements are met.	{VV 1	02}			
	Based on the Cond Protections being n Body failed to exerce the facility to assure policy and appropria to provide client pro- allegation of abuse, of Governing Body MET.	is not met as evidenced by: dition of Participation of Client ot met and the Governing cise operating direction over e implementation of the abuse ate actions were taken in order of operation and safety during an the Condition of Participation and Management is NOT					
	Governing Body an W104 483.410(a)(1 reviews, staff interv documentation, and	dition of Participation: d Management ) Based on clinical record iews, review of facility I review of facility policies and ility failed to ensure that the					
ABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE		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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		• •		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		02000	B. WING			l	R
		03G008	D. WING			05/	08/2019
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
HACIEN	DA DE LOS ANGELES				402 EAST SOUTH MOUNTAIN AVENUE PHOENIX, AZ 85040		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO	BE	(X5) COMPLETION DATE
{W 102}	governing body exet the facility in regard three abuse investig implement their abuse investigation and fatwo allegations of a could result in further W122 483.420 Comprotections W149 483.420(d)(1 W154 483.420(d)(3 W155 483.420(d)(4 GOVERNING BOD CFR(s): 483.410(a)	pricised operating direction over s to two (#11 and #35) of gations. The facility failed to use policy by failing to prevent use during an abuse iled to thoroughly investigate buse. The deficient practice er client abuse.  dition of Participation: Client ) ) ) ) )	{W 10				
	Based on clinical review of facility door facility policies and to ensure that the goperating direction two (#11 and #35) of The facility failed to by failing to prevent an abuse investigate two allegerations.	s not met as evidenced by: ecord reviews, staff interviews, cumentation, and review of procedures, the facility failed overning body exercised over the facility in regards to of three abuse investigations. implement their abuse policy further potential abuse during ion and failed to thoroughly gations of abuse. The deficient t in further client abuse.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	(X:	3) DATE SURVEY COMPLETED
		03G008	B. WING			R <b>05/08/2019</b>
	PROVIDER OR SUPPLIER  DA DE LOS ANGELES	· ····		STREET ADDRESS, CITY, STATE, ZIP C 1402 EAST SOUTH MOUNTAIN AVE PHOENIX, AZ 85040		00/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		I SHOULD BE	
{W 104}	that the client had a intellectual disability member was the graphave a history of season and the client had a intellectual disability member was the graphave a history of season accupied that the classic for a couple hours or returned he was obsurbed in the commented "Upon caregiver noted a bruise on patient blood coming from noted purple bruise by 1 centimeters, rig centimeters by 2 canostril. Client denied the injuries him injuries. Notes was amount again"  Review of a witness dated April 22, 2019 (client #11) out of hwas telling me how for him to give her mentioned that he comment while laugus aying not to make client) didn't look at to her. When I took bruise on the right season in the rig	It's clinical record revealed a diagnosis of severe y and aphasia, a family uardian and client #11 did not elf-injury.  In treport dated April 22, 2019 ient had been out of the facility with family and when he eserved to have injuries of eview of the incident report a returning to the facility, bruise on patient's right cheek, is right upper arm, and some left nostril. Upon assessment, is on right cheek 3 centimeters the upper arm bruise 5.5 entimeters, and blood from left	{W 10	D4}		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
		03G008	B. WING		R <b>05/08/2019</b>	
	PROVIDER OR SUPPLIER  DA DE LOS ANGELES	<b>.</b>		STREET ADDRESS, CITY, STATE, ZIP CODE 1402 EAST SOUTH MOUNTAIN AVENUE PHOENIX, AZ 85040		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{W 104}	he had been crying room and lay in his sponge bath I also right arm and he waw was hurting."  Nurse's Notes date documented "Per in an attempt to enshave no alleged peto patient's bedside compliant"  A Nurse's Note date revealed that the fahad been on an out the facility. The Nurasked onsite off duoutside as they wer (Family member) seleave."  A Nurse's Note date documented "(Namofficer/staff #1) calle Per (name of CEO) patient."  Review of another was "Approximately 11:24 approached me and me. I asked (name talk about. (Name of bad.' Who did you my (family member to say he did not was member) house, it jets to see the second of the	He just wanted to go into his bed. While giving him a noticed a bigger bruise on his as complaining his right hand d April 23, 2019 at 12:40 a.m. abuse reporting protocol, and sure resident safety, as we repetrator, I did not allow family a Family became upset but bed April 23, 2019 at 1:10 a.m. amily member that the resident ting with previously returned to rese's Note documented "I by police officer to escort them be causing a disturbance. The at on the floor refusing to bed April 23, 2019 at 1:30 a.m. are of CEO (chief executive and advised of situation. In family was allowed to see	{W 10	04}		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		03G008	B. WING		0	R 5/08/2019
	PROVIDER OR SUPPLIER  DA DE LOS ANGELES	3		STREET ADDRESS, CITY, STATE, ZIP CODI 1402 EAST SOUTH MOUNTAIN AVENUI PHOENIX, AZ 85040		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE
{W 104}	said I don't know, y said my (family met told client care advertised to shut him up this true. (Name of you later"  Review of the facility 26, 2019 revealed we staff and the client's review of the facility evidence as to how allegation of abuse  An interview was conditionally abuse offices abuse of abus	client) said who do you think. I ou tell me. (Name of client) mber). (Name of client) also ocate that his (family member). I asked (name of client) was client) said 'Shhh I will talk to by's investigation dated April written statements from facility is family member. Further by's investigation revealed no the facility concluded that the did not occur.	{W 1	04}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		03G008	B. WING				R <b>08/2019</b>
	PROVIDER OR SUPPLIER  DA DE LOS ANGELES			STREET ADDRESS, CITY, STATE, ZIP CO 1402 EAST SOUTH MOUNTAIN AVEN PHOENIX, AZ 85040			0012010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD	BE	(X5) COMPLETION DATE
{W 104}	further stated that he family member was accused of hurting.  Another interview windependent consultable 2019 at 5:10 p.m. Seatility did not place visitations during the client's injury of unknown and the client's injury of unknown and the statement of Staff #521 stated the (staff #621) asked he member to set up a went out on another eiterated what she statement. Staff #52 written statement to was never question statements that the family member abut the family member abut the stated that it was his outing with his family about the bruise he the client stated "not Review of the facility which was updated May 6, 2019, did not statement was not stated that it was his outing with his family about the bruise he the client stated "not Review of the facility which was updated May 6, 2019, did not statement was not stated that it was his outing with his family about the bruise he the client stated "not Review of the facility which was updated May 6, 2019, did not statement was not statement."	an alleged assault. Staff #1 the was told that the client's is upset because she was the client.  was conducted with the altant (staff #619) on May 6, Staff #619 stated that the e any restrictions from family the facility's investigation of the known origin.  onducted with the staff 1) who wrote the April 23, 2019 on May 7, 2019 at 8:16 a.m. that the former administrator ther to call the client's family a meeting before the client family visit. Staff #521 e stated in her April 23, 2019 (21 stated that she gave her of the former administrator but the further regarding the e client made to her about his using him.  onducted with the client in his 19 at 9:52 a.m. The client is business what he did on the eity member. When questioned the sustained while on the outing, bobody hit me."  ty's Abuse and Neglect policy, at the time of the survey on out reveal that an alleged	{W 10				
	clients during an ab	have restricted access to buse investigation. Further y's Abuse and Neglect policy				:	:

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		03G008	B. WING			l .	08/2019
	PROVIDER OR SUPPLIER  DA DE LOS ANGELES			14	TREET ADDRESS, CITY, STATE, ZIP CODE 402 EAST SOUTH MOUNTAIN AVENUE HOENIX, AZ 85040		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{W 104}	conduct an abuse in	ce as to how the facility should	{W 10	04}			
	April 19, 2019 inclu seat (chair) with str seated positioning, tolerated. The ISP a ambulate with variodue to cognitive impincluded ambulation staff of 1-2 during pait.	dividual Support Plan) dated ded that client had cruiser aps for safety for mobility, school and transport as also included client was able to us levels of staff assistance pairments. Recommendations in as tolerable with staff and performance of transfers and					
	2019 revealed a ca walking the client in facility when the clie and proceeded to g documented "staff wanted" and redirect	dent Report dated April 21, regiver (staff #422) was his wheelchair throughout the ent unbuckled his safety belt et up and walk. The report was uncertain of what resident cted him back to his seat. Per lent "became upset and nd pull her hair"					
		f the Incident report revealed as reported to a registered ) on shift that day.					
	dated April 21, 2019 for (name of anothe (name of client) and walk when he took	statement from staff #422 documented "I was covering er caregiver) lunch. I had d he wanted to go outside for a off his seatbelt. I tried to strap ed to scratch my arms and					

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	:	03G008	B. WING			1	R <b>08/2019</b>
	PROVIDER OR SUPPLIER  DA DE L'OS ANGELES			14	TREET ADDRESS, CITY, STATE, ZIP CODE 402 EAST SOUTH MOUNTAIN AVENUE HOENIX, AZ 85040	, 00.	00.2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
{W 104}	attempt to bite." Per #422 and the client and another caregive the client in the character in the client in the character in the client in the character in the client back on his we combative toward set was redirected and without a problem  The IDT (Interdiscip dated April 22, 2019 relieving another caincident and the client change. Functional client has difficulty and "staff were not client), which cause On April 22, 2019 and Nursing (DON/staff the SA (State Agencambulating as he is caregivers for some in his wheelchair and Staff #53 further state only for transport art transported at the time the time in the facility's investiguated writter and #542. There was statement was obtain an interview with	r the documentation, staff came back inside the facility ver (staff # 542) helped buckle ir.  ent from staff #542 dated April led that she was in the was asked for help to put wheelchair "after he was being staff". It continued that client was sat back in his chair "  colinary Team) meeting note of included that staff #422 was aregiver at the time of the ent does not respond well to Analysis of Behavior revealed expressing his wants/desires able to understand (name of the domain of the ent does not respond well to Analysis of Behavior revealed expressing his wants/desires able to understand (name of the domain to become agitated"  to 9:30 a.m., the Director of #53) reported the incident to copy and stated that client was allowed to do but two the reason attempted to put him and restrain him with a seat belt. Interest the domain of the was not being	{W 1	04}			

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		03G008	B. WING			1	R 09/2040
NAME OF I	200 #050 00 00 00 00	033000	D. VI.IO.		TOUR ADDRESS OF A STATE TO SORE	05/	08/2019
	PROVIDER OR SUPPLIER DA DE LOS ANGELES			1	TREET ADDRESS, CITY, STATE, ZIP CODE 402 EAST SOUTH MOUNTAIN AVENUE PHOENIX, AZ 85040		
	0.114.44.03.4.07.4	TEMENT OF PERIODS					1
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{W 104}	•	ge 8 vestigated as an abuse	{W 10	04}			
	incident.	congaica ao an abase					
	May 7, 2019 at 9:33 client was sitting in pushed (transported hall by the facility er stated she was called the reception area, She said she did not staff #422 did not to client ended up on a client got up from halloor, staff #542 "freshe didn't know how In an interview with (staff #147) conduct a.m., she stated the reception area by the	aff #542 was conducted on 8 a.m. Staff #542 stated that his wheelchair and was being d) by staff #422 in the front htrance/reception lobby. She ed to help and when she got to client #35 was on the floor. So the see what happened and sell what happened or how the the floor. She stated that when its chair and ended up on the eaked out probably because we to deal with the client.  The Resident Care Manager ted on May 7, 2019 at 10:00 to incident happened by the main entrance door of the contribution.					
	the morning meetin #35 unbuckled the	e incident was discussed in g that on April 21, 2019, client seat belt on his wheelchair to put the client back into his eat belt back on.					
	In an interview with 7, 2019 at 11:11 a.m occurred at front lot client were coming back in the facility with chair and became of client and "someone called for staff #542 client was trying to g	staff #422 conducted on May n., she stated that the incident oby of the facility. She and the from outside and heading when the client got out of his combative. She stayed with the e else" or the front desk staff at to help. She stated that the get up from the chair and she ack in his wheelchair.					
	A phone interview w	rith the registered nurse					

	OF CORRECTION	IDENTIFICATION NUMBER:	1 ' '			COMPLETED	
		03G008	B. WING	ı		l .	R <b>08/2019</b>
	PROVIDER OR SUPPLIER  DA DE LOS ANGELES	3 '		1	TREET ADDRESS, CITY, STATE, ZIP CODE 402 EAST SOUTH MOUNTAIN AVENUE PHOENIX, AZ 85040	1 03/	0012019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	CTION SHOULD BE O THE APPROPRIATE	
{W 104}	12:10 p.m. Staff #2 nurse) on shift at the stated that staff #42 caregiver who wented told her that client was wheelchair and staft that the client then pulled.  This information was report which RN/stated April 21, 2019.  The facility has vide located at the fronted the incident occurred evidence that survest the front desk/ recewere reviewed.  An interview was consecurity Director/stated that staff #42 caregiver for lunched to deal with client #3 bases after the incident to deal with client #3 bases after the incident to deal with client #3 bases after the incident was re-trained to deal with client #3 bases after the incident #42 caregiver for lunched to deal with client #44 caregiver for lunched to deal with client #45 bases after the incident was re-trained to deal with client #45 bases after the incident #45 ba	conducted on May 7, 2019 at 1 was the RN (registered e time of the incident. She 22 was covering for another to lunch. She said staff #422 was trying to get up from his ff #422 bent over to ensure elelchair was locked. She said	{W 1	04}			

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			RIPLE CONSTRUCTION	COMPLETED		
			}		R	
		03G008	B. WING		05/08/2019	)
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HACIENI	DA DE LOS ANGELES	<b>3</b>		1402 EAST SOUTH MOUNTAIN AVENUE PHOENIX, AZ 85040		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLE	TION
{W 104}		=	{W 10	14}		
	during transport bed	cause client can ambulate.				
	#434) conducted or she stated that staff client #35, who can wheelchair and can #422 was covering went to lunch at tha unfastened his seat	with the unit leader (staff in May 8, 2019 at 11:40 a.m., if # 422 was new to the care of unbuckle his seat belt on his ambulate fast. She said staff for another caregiver who at time. She stated when client to belt, staff #411 was the only to staff #422 thought that apped in.				
		t revealed no evidence that terviews of possible witnesses				
	revealed the reasor because of the clier	f the facility's investigation of for the incident report was nt's "behavior". Under the Neglect or Exploitation (ANE) te "N/A"				
{W 122}	the facility conclude abuse occurred.	no evidence found as to how ed that in this incident, no	{W 12	2}		
	The facility must en protections requirer	sure that specific client ments are met.				
	Based on the facilit potential abuse duri	s not met as evidenced by: ty's failure to prevent further ing an alleged abuse to thoroughly investigate two				

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		03G008	B. WING _		i i	/08/2019	
	PROVIDER OR SUPPLIER  DA DE LOS ANGELES	S		STREET ADDRESS, CITY, STATE, ZIP CODE 1402 EAST SOUTH MOUNTAIN AVENUE PHOENIX, AZ 85040			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
{W 122}	allegations of abus corrective action do and the facility's fair policy; these system affected all clients. Participation of Client MET.  Findings include:  See W149-Based on clinical reand review of facility failed to impregarding two (#11 investigations. The potential abuse durinvestigation for on ensure that two (#10 of abuse were thor	e, failure to take appropriate uring an abuse investigation, ilure to implement their abuse matic failures potentially and resulted in the Condition of ent Protections to be NOT  ecord reviews, staff interviews, by policies and procedures, the element their abuse policy and #35) of three abuse facility failed to prevent further ring an alleged abuse the (#11) client and failed to 11 and #35) of three allegations oughly investigation. The ould result in further client	{W 123	2}		·	
	review of facility do facility policies and to ensure two (#11 investigations were deficient practice cabuse.  See W155-Based on clinical review of facility do facility policies and to prevent further pallegation of abuse	ecord reviews, staff interviews, ocumentation, and review of procedures, the facility failed and #35) of three abuse thoroughly investigated. The ould result in further client ecord review, staff interviews, ocumentation, and review of procedures, the facility failed extential abuse during an for one (#11) client. The ould result in further client					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		03G008	B. WING			R <b>05/08/2019</b>	
NAME OF I	PROVIDER OR SUPPLIER	03000	D. 11.110		TREET ADDRESS, CITY, STATE, ZIP CODE	05/	08/2019
	DA DE LOS ANGELES			14	402 EAST SOUTH MOUNTAIN AVENUE PHOENIX, AZ 85040		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{W 122}	abuse.  See W157- Based on clinical re interviews, the facilic corrective action was	cord review and staff ity failed to ensure appropriate as taken regarding a lack of a	{W 1	22}			
{W 149}	incident. STAFF TREATMEN CFR(s): 483.420(d) The facility must de policies and proced	(1) velop and implement written	{W 1	49}			
	This STANDARD is Based on clinical reand review of facility facility failed to implicate regarding two (#11 investigations. The potential abuse durinvestigation for one ensure that two (#1 of abuse were thorogenial as a secondary and the second	s not met as evidenced by: ecord reviews, staff interviews, y policies and procedures, the lement their abuse policy and #35) of three abuse facility failed to prevent further ing an alleged abuse e (#11) client and failed to 1 and #35) of three allegations bughly investigation. The buld result in further client					
	that the client had a intellectual disability member was the gu have a history of se	1's clinical record revealed diagnosis of severe and aphasia, a family lardian and client #11 did not lf-injury. nt report dated April 22, 2019					

NAME OF PROVIDER OR SUPPLIER HACIENDA DE LOS ANGELES  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  1402 EAST SOUTH MOUNTAIN AVENUE PHOENIX, AZ 85040	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILD	FIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  HACIENDA DE LOS ANGELES  STREET ADDRESS, CITY, STATE, ZIP CODE  1402 EAST SOUTH MOUNTAIN AVENUE			03G008	B. WING		P	
					1402 EAST SOUTH MOUNTAIN AVENUE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	( (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	DBE	(X5) COMPLETION DATE
Continued From page 13 revealed that the client had been out of the facility for a couple hours with family and when he returned he was observed to have injuries of unknown origin. Review of the incident report documented, "Upon returning to the facility, caregiver noted a bruise on patient's right cheek, a bruise on patient's right upper arm, and some blood coming from left nostril. Upon assessment, noted purple bruise on right cheek 3 centimeters by 1 centimeter, right upper arm bruise 5.5 centimeters by 2 centimeters, and blood from left nostril. Client denies any injury or fall."  Nurse's Notes dated April 23, 2019 at 12:40 a.m. documented "Per abuse reporting protocol, and in an attempt to ensure resident safety, as we have no alleged perpertarto, I did not allow family to patient's bedside. Family became upset but compliant"  A Nurse's Note dated April 23, 2019 at 1:10 a.m. revealed that the family member that the resident had been on an outing with previously returned to the facility. The Nurse's Note documented "I asked onsite off duty police officer to escort them outside as they were causing a disturbance. (Family member) sat on the floor refusing to leave."  A Nurse's Note dated April 23, 2019 at 1:30 a.m. documented "(Name of CEO) (chief executive officer/staff #1) called and advised of situation. Per (name of CEO) family was allowed to see patient."  Review of another witness statement from staff #521 dated April 23, 2019 documented "Approximately 11:45 a.m. (name of client)	{W 149}	revealed that the cl for a couple hours or returned he was ob unknown origin. Re documented, "Upor caregiver noted a ba bruise on patient's blood coming from noted purple bruise by 1 centimeter, rig centimeters by 2 cenostril. Client denie  Nurse's Notes date documented "Per in an attempt to enshave no alleged per to patient's bedside compliant"  A Nurse's Note date revealed that the fahad been on an out the facility. The Nurasked onsite off duroutside as they wer (Family member) saleave."  A Nurse's Note date documented "(Namofficer/staff #1) called Per (name of CEO) patient."	ient had been out of the facility with family and when he served to have injuries of view of the incident report in returning to the facility, ruise on patient's right cheek, is right upper arm, and some left nostril. Upon assessment, on right cheek 3 centimeters ht upper arm bruise 5.5 entimeters, and blood from left is any injury or fall."  If April 23, 2019 at 12:40 a.m. abuse reporting protocol, and sure resident safety, as we repetrator, I did not allow family in Family became upset but and April 23, 2019 at 1:10 a.m. mily member that the resident cing with previously returned to se's Note documented "I by police officer to escort them the causing a disturbance. The at on the floor refusing to the ed April 23, 2019 at 1:30 a.m. the of CEO (chief executive and advised of situation. I family was allowed to see witness statement from staff, 2019 documented	{W 14	19}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		03G008	B. WING			1	™ 08/2019	
	PROVIDER OR SUPPLIER  DA DE LOS ANGELES			STREET ADDRESS, CITY, STATE, ZIP CO 1402 EAST SOUTH MOUNTAIN AVEN PHOENIX, AZ 85040				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD	BE	(X5) COMPLETION DATE	
{W 149}	me. I asked (name talk about. (Name of bad.' 'Who did you my (family member to say he did not wa member) house, it is (name of client) how bruises. (Name of said I don't know, you said my (family mentold client care advotried to shut him up this true. (Name of you later"  Review of the facility review of the facility evidence as to how allegation of abuse  An interview was could allegate the facility pending investigation. Staff received the phone just told that the result not made aware of further stated that he family member was accused of hurting the Another interview windependent consulted.	of client) what he wanted to of client) stated 'She did me bad?' (Name of client) proceeded ant to return back to his (family ust went too far. I asked widid you sustain those client) said who do you think. I but tell me. (Name of client) also ocate that his (family member). I asked (name of client) was client) said 'Shhh I will talk to by's investigation dated April written statements from facility is family member. Further by's investigation revealed no the facility concluded that the did not occur.  I and the client of the stated with the CEO (staff at 4:50 p.m. Staff #1 stated believed an allegation of abuse petrator would not be allowed by the outcome of the stated that when he call from the facility he was saident had an injury and was an alleged assault. Staff #1 e was told that the client's upset because she was	{W 1	49}				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		03G008	B. WING				R <b>08/2019</b>
	PROVIDER OR SUPPLIER  DA DE LOS ANGELES	3		14	TREET ADDRESS, CITY, STATE, ZIP CODE 402 EAST SOUTH MOUNTAIN AVENUE HOENIX, AZ 85040	, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{W 149}	visitations during the client's injury of unknown and interview was comember (staff #521 witness statement of Staff #521 stated the asked her to call the up a meeting before another family visit, she stated in her Ap #521 stated that she to the former admir questioned further at the client made to habusing him.  Review of the facility which was updated May 6, 2019, did not perpetrator should be clients during an ab review of the facility revealed no evidence conduct an abuse in Further review of the policy which was upsurvey on May 6, 20 person(s) suspected visitors and vendors pending final outcomed and with the suspected, allegoneglect"	e facility's investigation of the known origin.  Inducted with the staff I) who wrote the April 23, 2019 on May 7, 2019 at 8:16 a.m. at the former administrator e client's family member to set the client went out on Staff #521 reiterated what oril 23, 2019 statement. Staff e gave her written statement histrator but was never regarding the statements that her about his family member  by's Abuse and Neglect policy, at the time of the survey on our reveal that an alleged have restricted access to buse investigation. Further by's Abuse and Neglect policy be as to how the facility should investigation.  The facility's Abuse and Neglect policy be as to how the facility should investigation.  The facility's Abuse and Neglect policy by the facility is Abuse and Neglec	{W 14	49}			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
				•			₹
		03G008	B. WING			05/	08/2019
	PROVIDER OR SUPPLIER  DA DE LOS ANGELES	<b>,</b>		1.	TREET ADDRESS, CITY, STATE, ZIP CODE 402 EAST SOUTH MOUNTAIN AVENUE PHOENIX, AZ 85040		
(X4) ID PREFIX TAG				ıx	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
{W 149}	intellectual disability A review of the Incic 2019, revealed a ca walking the client in facility when the clie and proceeded to g documented "staff v wanted" and redirect the report, the resid started to scratch and The Incident report was reported to a re  Continued review of the reason for the in the client's "behavio Abuse, Neglect or E handwritten note "N  Review of a written dated April 21, 2019 covering for anothe client wanted to go off his seatbelt. Staft him in and client staft attempted to bite he  The written stateme 22, 2019 document dayroom when she client back in his wh combative toward s was redirected and without a problem	dent Report dated April 21, aregiver (staff #422) was his wheelchair throughout the ent unbuckled his safety belt et up and walk. The report was uncertain of what resident cted him back to his seat. Per ent "became upset and not pull her hair" also included that the incident egistered nurse (RN/staff #21). If the Incident Report revealed incident report was because of or". Under the Suspected exploitation (ANE) was I/A" statement from staff #422 documented she was a caregiver for lunch when outside for a walk and he took if #422 wrote she tried to strap arted to scratch her arms and er.  Left from staff #542 dated April ed that she was in the was asked for help to put neelchair "after he was being taff". It continued that client was sat back in his chair	{W 1	49}			

NAME OF PROVIDER OR SUPPLIER  HACIENDA DE LOS ANGELES    SUMMARY STATEMENT OF DEFICIENCIES   HOPENIX, 2Z 85040	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	TIPLE CONSTRUCTION DING	COMPLETED		
NAME OF PROVIDER OR SUPPLIER  HACIENDA DE LOS ANGELES  (AUTOR PREFIX TAGE AND A CONTROLL TO THE PROCESSED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAGE  (SACH DESCISIONAL THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (W 149)  Continued From page 17  dated April 22, 2019 included that staff #422 was relieving another caregiver at the time of the incident and the client does not respond well to change. Functional Analysis of Behavior revealed client has difficulty expressing his wants/desires and "staff were not able to understand (name of client), which caused him to become agitated"  On April 22, 2019 at 9:30 a.m., the Director of Nursing (DON/staff #53) reported the incident to the SA (State Agency) and stated that client was ambulating as he is allowed to do but two caregivers for some reason attempted to put him in his wheelchair and restrained him with a seat belt. Staff #53 further stated that client uses the chair only for transport and he was not being transported at the time of the incident.  The facility's investigative report dated April 23, 2019 revealed written statements from staff #422 and #542.  An interview with staff #542 was conducted on May 7, 2019 at 9:33 a.m., Staff #542 stated that client was stitting in his wheelchair and was being pushed by staff #422 in the front hall by the facility entrance/reception lobby. She stated she was called to help and when she got to the reception area, client #35 was on the floor. She said she did not see what happened or how the client ended up on the floor, staff #542.			03G008	B. WING		į.	
PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  (W 149)  Continued From page 17  dated April 22, 2019 included that staff #422 was relieving another caregiver at the time of the incident and the client does not respond well to change. Functional Analysis of Behavior revealed client, which caused him to become agitated"  On April 22, 2019 at 9:30 a.m., the Director of Nursing (DON/Staff #53) reported the incident to the SA (State Agency) and stated that client was ambulating as he is allowed to do but two caregivers for some reason attempted to put him in his wheelchair and restrained him with a seat belt. Staff #53 truther stated that client uses the chair only for transport and he was not being transported at the time of the incident.  The facility's investigative report dated April 23, 2019 revealed written statements from staff #422 and #542.  An interview with staff #542 was conducted on May 7, 2019 at 9:33 a.m. Staff #542 stated that client was being pushed by staff #422 in the front hall by the facility entrance/reception lobby. She stated she was called to help and when she got to the reception area, client #35 was on the floor. She said she did not see what happened and staff #422 did not tell what happened or how the client ended up on the floor. She stated that when client ended up on the floor. She stated that when client got up from his chair and ended up on the floor, staff #542.					1402 EAST SOUTH MOUNTAIN AVENUE		
dated April 22, 2019 included that staff #422 was relieving another caregiver at the time of the incident and the client does not respond well to change. Functional Analysis of Behavior revealed client has difficulty expressing his wants/desires and "staff were not able to understand (name of client), which caused him to become agitated"  On April 22, 2019 at 9:30 a.m., the Director of Nursing (DON/staff #53) reported the incident to the SA (State Agency) and stated that client was ambulating as he is allowed to do but two caregivers for some reason attempted to put him in his wheelchair and restrained him with a seat belt. Staff #53 further stated that client uses the chair only for transport and he was not being transported at the time of the incident.  The facility's investigative report dated April 23, 2019 revealed written statements from staff #422 and #542.  An interview with staff #542 was conducted on May 7, 2019 at 9:33 a.m. Staff #542 stated that client was sitting in his wheelchair and was being pushed by staff #422 in the front hall by the facility entrance/reception lobby. She stated she was called to help and when she got to the reception area, client #35 was on the floor. She said she did not see what happened and staff #422 did not tell what happened or how the client ended up on the floor. She stated that when client got up from his chair and ended up on the floor, staff #542	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI	X (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
how to deal with the client"  In an interview with staff #422 conducted on May 7, 2019 at 11:11 a.m., she stated that the incident occurred at the front lobby of the facility. She and	{W 149}	dated April 22, 2019 relieving another caincident and the clie change. Functional client has difficulty and "staff were not client), which cause On April 22, 2019 a Nursing (DON/staff the SA (State Agenambulating as he is caregivers for some in his wheelchair arbelt. Staff #53 furth chair only for transptransported at the titted The facility's investing 2019 revealed writted and #542.  An interview with st May 7, 2019 at 9:33 client was sitting in pushed by staff #42 entrance/reception called to help and warea, client #35 was did not see what has tell what happened the floor. She stated his chair and ended "freaked out probath how to deal with the In an interview with 7, 2019 at 11:11 a.m.	en included that staff #422 was are giver at the time of the ent does not respond well to Analysis of Behavior revealed expressing his wants/desires able to understand (name of ed him to become agitated"  It 9:30 a.m., the Director of (#53) reported the incident to cy) and stated that client was allowed to do but two ereason attempted to put him and restrained him with a seat er stated that client uses the bort and he was not being time of the incident.  Igative report dated April 23, een statements from staff #422  aff #542 was conducted on a sa.m. Staff #542 stated that his wheelchair and was being the stated and staff #422 did not or how the client ended up on the floor. She said she appened and staff #422 did not or how the client got up from the up on the floor, staff #542 by because she didn't know the client"  staff #422 conducted on May in, she stated that the incident incident incident.		49}		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	COMPLETED	
		03G008	B. WING	· · · · · · · · · · · · · · · · · · ·	R 05/08/20	19
	PROVIDER OR SUPPLIER  DA DE LOS ANGELES	-		STREET ADDRESS, CITY, STATE, ZIP CODE 1402 EAST SOUTH MOUNTAIN AVENUE PHOENIX, AZ 85040		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	·	BE COMP	(X5) PLETION PATE
{W 149}	the client were comback in the facility were chair and became of client and "someonicalled for staff #542 client was trying to tried to strap him bath the comback of the c	ing from outside and heading when the client got out of his combative. She stayed with the e else" or the front desk staff to help. She stated that the get up from the chair and she ack in his wheelchair.  the report revealed no y conducted a thorough ude the following: ble witnesses to the incident at RN (staff #21) was not the incident; noce videos of activities at the n area on April 21, 2019; nation related to the incident ed out and concluded that in	{W 14	19}		
{W 154}	revision date of May Programmatic Abus abuse. The policy das occurring when a including restraint, i been approved as program Plan). STAFF TREATMEN CFR(s): 483.420(d) The facility must haviolations are thorough the standard on clinical results.	(3) ve evidence that all alleged	{W 15	54}		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		03G008	B. WING			R 05/08/2019	
	PROVIDER OR SUPPLIER  DA DE LOS ANGELES	<b>S</b>		1402 EA	ADDRESS, CITY, STATE, ZIP CODE ST SOUTH MOUNTAIN AVENUE IX, AZ 85040	1 001	0.2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD ROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{W 154}	facility policies and to ensure two (#11 investigations were deficient practice of abuse.  Findings include:  -Review of client #1 that the client had a intellectual disability member was the gu have a history of set.  Review of an incide revealed that the client had a intellectual disability member was the gu have a history of set.  Review of an incide revealed that the client a couple hours or returned he was obunknown origin. Redocumented "Upon caregiver noted a ba bruise on patient's blood coming from noted purple bruise by 1 centimeter, rig centimeters by 2 cenostril. Client denies  Review of another of #521 dated April 23 "Approximately 11:4 approached me and me. I asked (name talk about. (Name of bad.) "Who did you my (family member to say he did not was	procedures, the facility failed and #35) of three abuse thoroughly investigated. The buld result in further client a diagnosis of severe and aphasia, a family lardian and client #11 did not elf-injury.  Interport dated April 22, 2019 ient had been out of the facility with family and when he served to have injuries of view of the incident report returning to the facility, ruise on patient's right cheek, is right upper arm, and some left nostril. Upon assessment, on right cheek 3 centimeters the upper arm bruise 5.5 entimeters, and blood from left is any injury or fall."  witness statement from staff, 2019 documented 15 a.m. (name of client) disaid he would like to talk to of client) what he wanted to of client) stated 'She did me bad?' (Name of client) proceeded ant to return back to his (family)	{W 1	54}			
	member) house, it j	ust went too far. I asked w did you sustain those					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, , ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		03G008	B. WING				R <b>08/2019</b>
	PROVIDER OR SUPPLIER  DA DE LOS ANGELES	<b>3</b> - · · ·		14	TREET ADDRESS, CITY, STATE, ZIP CODE 402 EAST SOUTH MOUNTAIN AVENUE HOENIX, AZ 85040		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{W 154}	bruises. (Name of c said I don't know, y said my (family men told client care advo tried to shut him up	nge 20 client) said who do you think. I ou tell me. (Name of client) mber). (Name of client) also ocate that his (family member) o. I asked (name of client) was client) said 'Shhh I will talk to	{W 1	54}			
	26, 2019 revealed vertical staff and the client's the facility's investigation that the facility questing the stater regarding the incide facility's investigation.	ty's investigation dated April written statements from facility is family member. Review of gation revealed no evidence stioned the client further ments he made to staff #521 ent. Further review of the on revealed no evidence as to cluded that the allegation of r.					
	p.m Staff #620 sta facility's abuse offic Staff #620 stated th	producted with the #620) on May 6, 2019 at 3:55 ated that she was not the errat the time of the incident. The prove that abuse occurred.					
	member (staff #521 witness statement of Staff #521 stated the asked her to call the up a meeting before another family visit, she stated in her Ap #521 stated that she to the former admin questioned further r	onducted with the staff  ) who wrote the April 23, 2019 on May 7, 2019 at 8:16 a.m. eat the former administrator e client's family member to set e the client went out on Staff #521 reiterated what oril 23, 2019 statement. Staff e gave her written statement eistrator but was never regarding the statements that her about his family member					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		03G008	B. WING				R <b>08/2019</b>
	PROVIDER OR SUPPLIER  DA DE LOS ANGELES			140	REET ADDRESS, CITY, STATE, ZIP CODE D2 EAST SOUTH MOUNTAIN AVENUE IOENIX, AZ 85040	1 00/	00/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{W 154}	Continued From particles Review of the facility which was updated May 6, 2019, reveal facility should condition for the review of the policy which was upsurvey on May 6, 20 Administrator will end cooperates with the the suspected, allegated reglect"  -Client #35 was addiagnoses autistic of intellectual disability. The client's ISP (Inc. April 19, 2019 inclused (chair) with streseated positioning, tolerated. The ISP a ambulate with variodue to cognitive imparts.	ge 21  by's Abuse and Neglect policy, at the time of the survey on aled no evidence as to how the act an abuse investigation.  be facility's Abuse and Neglect odated again at the time of the 19 documented "The insure that staff fully erganizations investigating ged or observed abuse or mitted at the facility with disorder and moderate of the 19 documented "  dividual Support Plan) dated ded that client had cruiser aps for safety for mobility, school and transport as also included client was able to us levels of staff assistance pairments. Recommendations	{W 1				
	staff of 1-2 during p gait.  A review of the Incide 2019 revealed a call walking the client in facility when the client and proceeded to g documented "staff wanted" and redirect	dent Report dated April 21, regiver (staff #422) was his wheelchair throughout the ent unbuckled his safety belt et up and walk. The report was uncertain of what resident cted him back to his seat. Per ent "became upset and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		03G008	B. WING		R <b>05/08/2019</b>	
	PROVIDER OR SUPPLIER  DA DE LOS ANGELES			STREET ADDRESS, CITY, STATE, ZIP CODE 1402 EAST SOUTH MOUNTAIN AVENUE PHOENIX, AZ 85040		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
{W 154}	Continued From pa	ge 22	{W 15	54}		
		f the Incident report revealed as reported to a registered ) on shift that day.				
	dated April 21, 2019 for (name of another (name of client) and walk when he took him in and he started attempt to bite." Per #422 and the client and another careginate client in his characteristics.					
	22, 2019 document dayroom when she client back in his wh combative toward s	ent from staff #542 dated Apriled that she was in the was asked for help to put neelchair "after he was being taff". It continued that client was sat back in his chair				
	dated April 22, 2019 relieving another ca incident and the clie change. Functional client has difficulty and "staff were not	olinary Team) meeting note included that staff #422 was aregiver at the time of the ent does not respond well to Analysis of Behavior revealed expressing his wants/desires able to understand (name of d him to become agitated"				
	Nursing (DON/staff the SA (State Agend ambulating as he is caregivers for some	t 9:30 a.m., the Director of #53) reported the incident to cy) and stated that client was allowed to do but two reason attempted to put him d restrain him with a seat belt.				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ' '	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		03G008	B. WING		05	R /08/2019	
	PROVIDER OR SUPPLIER  DA DE LOS ANGELES			STREET ADDRESS, CITY, STATE, ZIP CODE 1402 EAST SOUTH MOUNTAIN AVENUE PHOENIX, AZ 85040			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETION DATE	
{W 154}	only for transport at transported at the till an interview with on May 7, 2019 at 9 incident was not invincident.  An interview with st May 7, 2019 at 9:33 client was sitting in pushed by staff #42 entrance/reception called to help and varea, client #35 was did not see what hat tell what happened the floor. She state his chair and ended "freaked out probat how to deal with the In an interview with 7, 2019 at 11:11 a.r occurred at front localient were coming back into the facility chair and became owith the client and desk staff called for that the client was that the client was that the client was that the client was that the client written and #542.	ated that client uses the chair and he was not being time of the incident.  the independent consultant 0:00 a.m., she stated that the restigated as an abuse  aff #542 was conducted on 8 a.m. Staff #542 stated that his wheelchair and was being 12 in the front hall by the facility lobby. She stated she was when she got to the reception is on the floor. She said she appened and staff #422 did not or how the client ended up on that when client got up from it up on the floor, staff #542 bly because she didn't know	{W 1	54}			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	TPLE CONSTRUCTION  NG	COMPLETED		
		03G008	B. WING		R <b>05/08/2019</b>	
NAME OF F	PROVIDER OR SUPPLIER	033000	J: 77	STREET ADDRESS, CITY, STATE, ZIP CODE	1 05/	08/2019
HACIEN	DA DE LOS ANGELES			1402 EAST SOUTH MOUNTAIN AVENUE PHOENIX, AZ 85040		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	) BE	(X5) COMPLETION DATE
{W 154}	evidence that facility possible witnesses evidence that RN (s regarding the incidence that RN (so regarding the incidence that RN (so regarding the incidence that RN (so regarding the incidence of activities a area on April 21, 20 area on A	y conducted interviews of to the incident and no staff #21) was questioned ent.  evidence that surveillance at the front desk/ reception 19 were reviewed.  If the facility's investigation in for the incident report was int's "behavior". Under the Neglect or Exploitation (ANE) te "N/A"  no evidence found as to how ad that in this incident, no  IT OF CLIENTS (3)	{W 15	4}		
		gnosis of severe intellectual				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		03G008	B. WING				08/2019
	PROVIDER OR SUPPLIER  DA DE LOS ANGELES			STREET ADDRESS, CITY, STATE, ZIP C 1402 EAST SOUTH MOUNTAIN AVE PHOENIX, AZ 85040			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG		I SHOULD E	BE	(X5) COMPLETION DATE
{W 155}	guardian and client self-injury.  Review of an incide revealed that the cli for a couple hours verturned he was obunknown origin. Redocumented "Upon caregiver noted a babruise on patient's blood coming from noted purple bruise by 1 centimeter, rig centimeters by 2 cenostril. Client denies.  Nurse's Notes date documented "Phoe Officerspoke with did the injuries hims injuries. Nose was amount again"  Review of a witness 2019 documented "of his (family membhow she had to give her water bottle bac opening it. She mad and looking at him selder abuse. (Name want to say good by inside I noticed he hof his face by his members also looked.)	ent report dated April 22, 2019 ient had been out of the facility with family and when he served to have injuries of view of the incident report returning to the facility, ruise on patient's right cheek, s right upper arm, and some left nostril. Upon assessment, on right cheek 3 centimeters ht upper arm bruise 5.5 entimeters, and blood from left is any injury or fall."  Id April 22, 2019 at 10:50 p.m. nix police department onsite. patient. Patient stated that he self. Officer took pictures of found actively bleeding small is statement dated April 22, "While getting (client #11) out be self. Officer took pictures of found actively bleeding small is statement dated April 22, "While getting (client #11) out be him money for him to give be him money for him to give can be a comment while laughing saying not to make her get a of client) didn't look at her or ye to her. When I took him has a bruise on the right side outh and his nose is bloody. It is determined that he had been crying. He	{W 15	55}			
		to his room and lay in his bed. sponge bath I also noticed a					

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:					COMPLETED		
		03G008	B. WING		<del></del>	ı	R 0 <b>8/2019</b>
	PROVIDER OR SUPPLIER  DA DE LOS ANGELES		•	1	STREET ADDRESS, CITY, STATE, ZIP CODE 402 EAST SOUTH MOUNTAIN AVENUE PHOENIX, AZ 85040		
(X4) ID PREFIX TAG			ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
{W 155}	bigger bruise on his complaining his right.  Nurse's Notes date documented "Per in an attempt to enshave no alleged per to patient's bedside compliant"  A Nurse's Note date revealed that the far had been on an out the facility. The Nur asked onsite off duroutside as they wer (Family member) saleave."  A Nurse's Note date documented "(Namofficer/staff #1) called Per (name of CEO) patient."  Review of another was "Seview of another was "Seview of another was "Seview of another was "Seview of another was "Approximately 11:4" approached me anome. I asked (name talk about. (Name of bad.' "Who did you my (family member to say he did not was member) house, it judges. (Name of client) houses. (Name of call I don't know, you said I don't know, you sai	a right arm and he was not hand was hurting."  d April 23, 2019 at 12:40 a.m. abuse reporting protocol, and sure resident safety, as we repetrator, I did not allow family. Family became upset but  ed April 23, 2019 at 1:10 a.m. mily member that the resident ting with previously returned to se's Note documented "I by police officer to escort them e causing a disturbance. at on the floor refusing to  ed April 23, 2019 at 1:30 a.m. e of CEO (chief executive ed and advised of situation. family was allowed to see	{W 1	55}			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED R		
	03G008				05	05/08/2019		
NAME OF PROVIDER OR SUPPLIER  HACIENDA DE LOS ANGELES				STREET ADDRESS, CITY, STATE, ZIP CODE 1402 EAST SOUTH MOUNTAIN AVENUE PHOENIX, AZ 85040				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE		
{W 155}	told client care advertied to shut him up this true. (Name of you later"  An interview was consultant (staff #6 p.m. Staff #619 star client's family mem investigation but the and he allowed the client prior to the in.  An interview was consultant if the facility received the phone just told that the resultant the resultant was accused of hurting.  An interview was consultant family member was accused of hurting.  An interview was consultant family member was accused of hurting.  An interview was consultant family member was accused of hurting.  An interview was consultant family member was accused of hurting. Staff #620 stated the incident and from which was accused to the provent family member to staff p.m Staff #620 stated the incident and from which was accused to the provent family stated the provent fam	cate that his (family member). I asked (name of client) was client) said 'Shhh I will talk to onducted with an independent 19) on May 6, 2019 at 4:00 ted that she did not want the ber to visit during the facility's a CEO (staff #1) was called family member to visit the vestigation being completed. Onducted with the CEO (staff at 4:50 p.m. Staff #1 stated ceived an allegation of abuse petrator would not be allowed by the outcome of the #1 stated that when he call from the facility he was saident had an injury and was an alleged assault. Staff #1 he was told that the client's a upset because she was the client.  Onducted with the #620) on May 6, 2019 at 3:55 ated that she was not the err at the time of the incident. The was aware of the what she understood the facility	{W 1	55}				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION UNG	COMPLETED	
	03G008		B. WING		R 05/08/2019	
NAME OF PROVIDER OR SUPPLIER  HACIENDA DE LOS ANGELES			-	STREET ADDRESS, CITY, STATE, ZIP CODE 1402 EAST SOUTH MOUNTAIN AVENUE PHOENIX, AZ 85040		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		LD BE COMPLÉTION	
{W 155}	client's injury of unk Review of the facilit dated April 19, 2019 alleged perpetrator to clients during an Review of the facilit which was updated "Any other person (including family, vis restricted access per investigation" STAFF TRAINING I CFR(s): 483.430(e) The facility must pre initial and continuing employee to perfor efficiently, and come This STANDARD is Based clinical recoreview of facility doe facility failed to ensu care for one client (staff member. This to result in neglect as	y's Abuse and Neglect policy of did not reveal that an should have restricted access abuse investigation.  y's Abuse and Neglect policy on May 6, 2019 documented of suspected of abuse sitors and vendors) will have ending final outcome of PROGRAM (1)  byide each employee with g training that enables the m his or her duties effectively,	{W 18	55}		
	facility.  Findings include:					
	diagnoses autistic o intellectual disability					
	The client's ISP (Inc	dividual Support Plan) dated				

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		03G008	B. WING			尺 08/2019
	PROVIDER OR SUPPLIER  DA DE LOS ANGELES	-		STREET ADDRESS, CITY, STATE, ZIP CODE 1402 EAST SOUTH MOUNTAIN AVENUE PHOENIX, AZ 85040	1 00%	0012010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	) BE	(X5) COMPLETION DATE
W 189	seat (chair) with straseated positioning, tolerated. The ISP a ambulate with variodue to cognitive impincluded ambulation staff of 1-2 during pincluded are walking the client in facility when the client in facility when the client and proceeded to gincumented "staff of wanted" and redirect the report, the residuant and redirect the report, the residuant and the started to scratch and started to scratch and another care of client) and walk when he took of him in and he started attempt to bite." Per #422 and the client and another caregives the client in the chair the written statemed 22, 2019 document dayroom when she client back in his whombative toward significant statemed to scratch and another caregives the client back in his whombative toward significant statemed to scratch and another caregives the client back in his whombative toward significant statemed to scratch and scratch and statemed to scratch and statemed to scratch and statemed to scratch and scratch an	ded that client had cruiser aps for safety for mobility, school and transport as also included client was able to us levels of staff assistance pairments. Recommendations in as tolerable with staff and erformance of transfers and dent Report dated April 21, regiver (staff #422) was his wheelchair throughout the ent unbuckled his safety belt et up and walk. The report was uncertain of what resident eted him back to his seat. Per ent "became upset and indicated him back to his seat. Per ent "became upset and indicated him back to his seat. Per ent "became upset and indicated him back to his seat. Per ent "became upset and indicated him back to his seat. Per ent "became upset and indicated him back to his seat. Per ent "became upset and indicated him back to he was covering er caregiver) lunch. I had the wanted to go outside for a off his seatbelt. I tried to straped to scratch my arms and in the documentation, staff came back inside the facility ver (staff # 542) helped buckle in.  The trom staff #542 dated April ent from staff #543 dated April ent from staff #544 dated April ent from staff #545 dated April ent from staff #545 dated April ent from staff #545 dated A	W 1			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
03G008		B. WING			R <b>08/2019</b>		
	PROVIDER OR SUPPLIER  DA DE LOS ANGELES	S		STREET ADDRESS, CITY, STATE, ZIP CODE 1402 EAST SOUTH MOUNTAIN AVENUE PHOENIX, AZ 85040			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			JLD BE	(X5) COMPLETION DATE		
W 189	dated April 22, 2019 relieving another caincident and the clie change. Functional client has difficulty and "staff were not client), which cause The facility's investi 2019 documented if #542 "was uncertain when he unbuckled During an interview (RN/staff #20) conda.m., she stated client and required two stambulates because bump on things or allowed to ambulate needed when he within the bus.  An interview with st May 7, 2019 at 9:33 client was sitting in pushed by staff #42 entrance/reception called to help and varea, client #35 was did not see what hat tell what happened the floor. She state his chair and ended "freaked out probathow to deal with the	polinary Team) meeting note included that staff #422 was are giver at the time of the ent does not respond well to Analysis of Behavior revealed expressing his wants/desires able to understand (name of ed him to become agitated" igative report dated April 23, findings that staff #422 and n of what resident wanted it his safety belt.  I with a registered nurse ducted on May 7, 2019 at 8:17 ent #35 ambulates on his own eaff with him when he he walks fast and can easily the wall. She stated client is and uses the wheelchair as ants to and/or during transport aff #542 was conducted on a.m. Staff #542 stated that his wheelchair and was being 22 in the front hall by the facility lobby. She stated she was when she got to the reception is on the floor. She said she appened and staff #422 did not or how the client ended up on that when client got up from the got up on the floor, staff #542 by because she didn't know	W 1	89			

MAME OF PROVIDER OR SUPPLIER  HACIENDA DE LOS ANGELES  SUMMANY STATEMENT OF DEFICIENCIES  (FACH DEFICIENCY MUST BE PRECEDED BY FULL TAO  CONTINUED FROM USS TEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  W 189  Continued From page 31  (staff #147) conducted on May 7, 2019 at 10:00  a.m., she stated that staff #422 was new to the care of client #35 and may not know the client very well. She stated client #35 is able to buckle and unbuckle the seat belt on his wheelchair, and he does, staff is expected to redirect the client especially when there are safety concerns.  In an interview with staff #422 conducted on May 7, 2019 at 11:11 a.m., she stated that the incident occurred at front lobby of the facility. She and the client were coming from the outside and heading back in the facility when the client got out of his chair and became combative. She stated with the client and "someone else" or the front desk staff called for staff #542 to help. She stated that the toilent was trying to get up from the chair and she tried to strap him back in his wheelchair. She stated that she took care of client #35 only once or twice since she started at the facility and she did not know at that time that the client can ambulate and was allowed to do so. She stated she just wanted the client to be safe so she tried to strap him back in his wheelchair.  During an interview with the QIDP (staff #400) conducted on December 7, 2019 at 1:24 p.m., she stated that #35. She stated to "cover their bases after the incident" all staff and caregivers were re-trained to ensure that the seatbelt for the wheelchair of client #35 was latched on only during transport because client can ambulate.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED  R 05/08/2019	
HACIENDA DE LOS ANGELES  ### HACIENDA DE LOS	03G008			B. WING			
PRÉFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  W 189  Continued From page 31 (staff #147) conducted on May 7, 2019 at 10:00 a.m., she stated that staff #422 was new to the care of client #35 is able to buckle and unbuckle the seat belt on his wheelchair, and he does, staff is expected to redirect the client especially when there are are safety concerns.  In an interview with staff #422 conducted on May 7, 2019 at 11:11 a.m., she stated that the incident occurred at front lobby of the facility. She and the client were coming from the outside and heading back in the facility when the client got out of his chair and became combative. She stayed with the client and "someone else" or the front desk staff called for staff #542 to help. She stated that the client was trying to get up from the chair and she tried to strap him back in his wheelchair. She stated that she took care of client #35 only once or twice since she started at the facility and she did not know at that time that the client can ambulate and was allowed to do so. She stated she just wanted the client became an ambulate and was allowed to do so. She stated to strap him back in his wheelchair.  During an interview with the QIDP (staff #400) conducted on December 7, 2019 at 1:24 p.m., she stated that staff #422 covered for another caregiver for lunch and staff #422 was not trained to deal with client #35. She stated to 'cover their bases after the incident," all staff and caregivers were re-trained to ensure that the seatbelt for the wheelchair of client #35 was latched on only during transport because client can ambulate.					1402 EAST SOUTH MOUNTAIN AVENU	E	
(staff #147) conducted on May 7, 2019 at 10:00 a.m., she stated that staff #422 was new to the care of client #35 and may not know the client very well. She stated client #35 is able to buckle and unbuckle the seat belt on his wheelchair; and he does, staff is expected to redirect the client especially when there are safety concerns.  In an interview with staff #422 conducted on May 7, 2019 at 11:11 a.m., she stated that the incident occurred at front lobby of the facility. She and the client were coming from the outside and heading back in the facility when the client got out of his chair and became combative. She stayed with the client and "someone else" or the front desk staff called for staff #542 to help. She stated that the client was trying to get up from the chair and she tried to strap him back in his wheelchair. She stated that she took care of client #35 only once or twice since she started at the facility and she did not know at that time that the client can ambulate and was allowed to do so. She stated she just wanted the client to be safe so she tried to strap him back in his wheelchair.  During an interview with the QIDP (staff #400) conducted on December 7, 2019 at 1:24 p.m., she stated that staff #422 accvered for another caregiver for lunch and staff #422 careful for another caregiver for lunch and staff #42 careful for another caregiver for lunch and staff #42 careful for another caregiver for lunch and staff #42 careful for cover their bases after the incident" all staff and caregivers were re-trained to ensure that the seatbelt for the wheelchair of client #35 was latched on only during transport because client can ambulate.	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI	X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP	IOULD BE	COMPLETION
During an interview with the unit leader (staff #434) conducted on May 8, 2019 at 11:40 a.m., she stated that staff # 422 was new to the care of client #35, who can unbuckle his seat belt on his	W 189	(staff #147) conduct a.m., she stated that care of client #35 at very well. She state and unbuckle the she does, staff is expespecially when the In an interview with 7, 2019 at 11:11 a.m occurred at front lost client were coming back in the facility with the composition of the conduction of the conduction of the conducted on th	ted on May 7, 2019 at 10:00 at staff #422 was new to the nd may not know the client d client #35 is able to buckle eat belt on his wheelchair; and bected to redirect the client are are safety concerns.  staff #422 conducted on May n., she stated that the incident oby of the facility. She and the from the outside and heading when the client got out of his combative. She stayed with the else" or the front desk staff to help. She stated that the get up from the chair and she ack in his wheelchair. She care of client #35 only once started at the facility and she time that the client can allowed to do so. She stated client to be safe so she tried in his wheelchair.  with the QIDP (staff #400) mber 7, 2019 at 1:24 p.m., f #422 covered for another and staff #422 was not trained 35. She stated to "cover their dent" all staff and caregivers nsure that the seatbelt for the #35 was latched on only cause client can ambulate.  with the unit leader (staff May 8, 2019 at 11:40 a.m., f #422 was new to the care of	W 1	89		

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		03G008	B. WING		ſ	R / <b>08/2019</b>	
	PROVIDER OR SUPPLIER  DA DE LOS ANGELES			STREET ADDRESS, CITY, STATE, ZIP CODE 1402 EAST SOUTH MOUNTAIN AVENUE PHOENIX, AZ 85040			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE COMPLETIC		
W 189	#422 was covering went to lunch at that caregiver cover for relieving caregiver or supervision to program book and available. She also life skills trainer and question from caregulation care according program and the IS time of the incident, had the opportunity when client #35 unf	ge 32 ambulate fast. She said staff for another caregiver who at time. She stated when a another caregiver and the doesn't know what kind of care ovide to a client, the day the client's ISP are always stated that there's always a d unit leader on shift to answer givers related to provision of the active treatment P. However, she stated at the the staff #422 "would have not to grab the book". She stated fastened his seatbelt, staff lient had to be strapped in the	W	189			