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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| HACIENDA DE LOS ANGELES | 1402 EAST SOUTH MOUNTAIN AVENUE PHOENIX, AZ 85040 |

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| {W 000} | INITIAL COMMENTS<br><br>The follow-up to the complaint (AZ0053609) investigation survey dated February 8, 2019, resulting in Governing Body and Management, Client Protections and Health Care Services Conditions of Participation not being met was conducted on May 6 through 8, 2019. The facility had 36 clients and the surveyors reviewed three recent abuse investigations. The following deficiencies were cited. | {W 000} | | |
| {W 102} | GOVERNING BODY AND MANAGEMENT<br>CFR(s): 483.410<br><br>The facility must ensure that specific governing body and management requirements are met.<br><br>This CONDITION is not met as evidenced by:<br>Based on the Condition of Participation of Client Protections being not met and the Governing Body failed to exercise operating direction over the facility to assure implementation of the abuse policy and appropriate actions were taken in order to provide client protection and safety during an allegation of abuse, the Condition of Participation of Governing Body and Management is NOT MET.<br><br>Findings include:<br><br>W102 483.410 Condition of Participation: Governing Body and Management<br>W104 483.410(a)(1) Based on clinical record reviews, staff interviews, review of facility documentation, and review of facility policies and procedures, the facility failed to ensure that the | {W 102} | | |

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| {W 102} | Continued From page 1<br>governing body exercised operating direction over the facility in regards to two (#11 and #35) of three abuse investigations. The facility failed to implement their abuse policy by failing to prevent further potential abuse during an abuse investigation and failed to thoroughly investigate two allegations of abuse. The deficient practice could result in further client abuse.<br><br>W122 483.420 Condition of Participation: Client Protections<br>W149 483.420(d)(1)<br>W154 483.420(d)(3)<br>W155 483.420(d)(3)<br>W157 483.420(d)(4) | {W 102} | | |
| {W 104} | GOVERNING BODY<br>CFR(s): 483.410(a)(1)<br><br>The governing body must exercise general policy, budget, and operating direction over the facility.<br><br>This STANDARD is not met as evidenced by:<br>Based on clinical record reviews, staff interviews, review of facility documentation, and review of facility policies and procedures, the facility failed to ensure that the governing body exercised operating direction over the facility in regards to two (#11 and #35) of three abuse investigations. The facility failed to implement their abuse policy by failing to prevent further potential abuse during an abuse investigation and failed to thoroughly investigate two allegations of abuse. The deficient practice could result in further client abuse.<br><br>Findings include: | {W 104} | | |

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-Review of client #11's clinical record revealed that the client had a diagnosis of severe intellectual disability and aphasia, a family member was the guardian and client #11 did not have a history of self-injury.

Review of an incident report dated April 22, 2019 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 22, 2019 at 10:50 p.m. documented "Phoenix police department onsite. Officer...spoke with patient. Patient stated that he did the injuries himself. Officer took pictures of injuries. Nose was found actively bleeding small amount again..."

Review of a witness statement (CCA/Staff #164) dated April 22, 2019 documented "While getting (client #11) out of his (family member's) car, she was telling me how she had to give him money for him to give her water bottle back. She mentioned that he was opening it. She made a comment while laughing and looking at him saying not to make her get elder abuse. (Name of client) didn't look at her or want to say good bye to her. When I took him inside I noticed he has a bruise on the right side of his face by his mouth and his nose is bloody. His eyes also looked like

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he had been crying. He just wanted to go into his room and lay in his bed. While giving him a sponge bath I also noticed a bigger bruise on his right arm and he was complaining his right hand was hurting."

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 perpetrator, 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) approached me and said he would like to talk to me. I asked (name of client) what he wanted to talk about. (Name of client) stated 'She did me bad.' 'Who did you bad?' (Name of client) stated my (family member). (Name of client) proceeded to say he did not want to return back to his (family member) house, it just went too far. I asked (name of client) how did you sustain those

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bruises. (Name of client) said who do you think. I said I don't know, you tell me. (Name of client) said my (family member). (Name of client) also told client care advocate that his (family member) tried to shut him up. I asked (name of client) was this true. (Name of client) said 'Shhh I will talk to you later..."

Review of the facility's investigation dated April 26, 2019 revealed written statements from facility staff and the client's family member. Further review of the facility's investigation revealed no evidence as to how the facility concluded that the allegation of abuse did not occur.

An interview was conducted with the administrator (staff #620) on May 6, 2019 at 3:55 p.m.. Staff #620 stated that she was not the facility's abuse officer at the time of the incident. Staff #620 stated that from what she understood the facility could not prove that abuse occurred.

An interview was conducted with an independent consultant (staff #619) on May 6, 2019 at 4:00 p.m. Staff #619 stated that she did not want the client's family member to visit during the facility's investigation but the CEO (staff #1) was called, over ruled her decision and he allowed the family member to visit the client prior to the investigation being completed.

An interview was conducted with the CEO (staff #1) on May 6, 2019 at 4:50 p.m. Staff #1 stated that if the facility received an allegation of abuse that the alleged perpetrator would not be allowed in the facility pending the outcome of the investigation. Staff #1 stated that when he received the phone call from the facility he was just told that the resident had an injury and was

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| {W 104} | Continued From page 5<br>not made aware of an alleged assault. Staff #1 further stated that he was told that the client's family member was upset because she was accused of hurting the client.<br><br>Another interview was conducted with the independent consultant (staff #619) on May 6, 2019 at 5:10 p.m. Staff #619 stated that the facility did not place any restrictions from family visitations during the facility's investigation of the client's injury of unknown origin.<br><br>An interview was conducted with the staff member (staff #521) who wrote the April 23, 2019 witness statement on May 7, 2019 at 8:16 a.m. Staff #521 stated that the former administrator (staff #621) asked her to call the client's family member to set up a meeting before the client went out on another family visit. Staff #521 reiterated what she stated in her April 23, 2019 statement. Staff #521 stated that she gave her written statement to the former administrator but was never questioned further regarding the statements that the client made to her about his family member abusing him.<br><br>An interview was conducted with the client in his room on May 7, 2019 at 9:52 a.m. The client stated that it was his business what he did on the outing with his family member. When questioned about the bruise he sustained while on the outing, the client stated "nobody hit me."<br><br>Review of the facility's Abuse and Neglect policy, which was updated at the time of the survey on May 6, 2019, did not reveal that an alleged perpetrator should have restricted access to clients during an abuse investigation. Further review of the facility's Abuse and Neglect policy | {W 104} | | |

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| {W 104} | Continued From page 6<br>revealed no evidence as to how the facility should conduct an abuse investigation.<br><br>-Client #35 was admitted at the facility with diagnoses autistic disorder and moderate intellectual disability.<br><br>The client's ISP (Individual Support Plan) dated April 19, 2019 included that client had cruiser seat (chair) with straps for safety for mobility, seated positioning, school and transport as tolerated. The ISP also included client was able to ambulate with various levels of staff assistance due to cognitive impairments. Recommendations included ambulation as tolerable with staff and staff of 1-2 during performance of transfers and gait.<br><br>A review of the Incident Report dated April 21, 2019 revealed a caregiver (staff #422) was walking the client in his wheelchair throughout the facility when the client unbuckled his safety belt and proceeded to get up and walk. The report documented "staff was uncertain of what resident wanted" and redirected him back to his seat. Per the report, the resident "became upset and started to scratch and pull her hair"<br><br>Continued review of the Incident report revealed that this incident was reported to a registered nurse (RN/staff #21) on shift that day.<br><br>Review of a written statement from staff #422 dated April 21, 2019 documented "I was covering for (name of another caregiver) lunch. I had (name of client) and he wanted to go outside for a walk when he took off his seatbelt. I tried to strap him in and he started to scratch my arms and | {W 104} | | |

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attempt to bite." Per the documentation, staff #422 and the client came back inside the facility and another caregiver (staff # 542) helped buckle the client in the chair.

The written statement from staff #542 dated April 22, 2019 documented that she was in the dayroom when she was asked for help to put client back on his wheelchair "after he was being combative toward staff". It continued that client was redirected and was sat back in his chair without a problem..."

The IDT (Interdisciplinary Team) meeting note 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 restrain 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. There was no evidence that a statement was obtained from the RN (staff #21).

In an interview with the independent consultant on May 7, 2019 at 9:00 a.m., she stated that the

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| {W 104} | Continued From page 8<br>incident was not investigated as an abuse incident.<br><br>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 (transported) 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 "freaked out probably because she didn't know how to deal with the client"<br><br>In an interview with the Resident Care Manager (staff #147) conducted on May 7, 2019 at 10:00 a.m., she stated the incident happened by the reception area by the main entrance door of the facility. She said the incident was discussed in the morning meeting that on April 21, 2019, client #35 unbuckled the seat belt on his wheelchair and staff #422 tried to put the client back into his chair and put the seat belt back on.<br><br>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 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.<br><br>A phone interview with the registered nurse | {W 104} | | |

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| {W 104} | Continued From page 9<br>(RN/staff #21) was conducted on May 7, 2019 at 12:10 p.m. Staff #21 was the RN (registered nurse) on shift at the time of the incident. She stated that staff #422 was covering for another caregiver who went to lunch. She said staff #422 told her that client was trying to get up from his wheelchair and staff #422 bent over to ensure that the client's wheelchair was locked. She said the client then pulled staff #422's hair.<br><br>This information was not written in the incident report which RN/staff #21 that was completed on April 21, 2019.<br><br>The facility has video surveillance cameras located at the front lobby or reception area where the incident occurred. However, there was no evidence that surveillance videos of activities at the front desk/ reception area on April 21, 2019 were reviewed.<br><br>An interview was conducted with the facility Security Director/staff #392 on May 7, 2019 at 12:55 p.m. and said he was in charge during the period of April 21, 2019 and at the time no one requested to view the recording of the area of the lobby entrance where the incident occurred. He went on to add that the recordings are kept for 14 days and after that they are erased. At this time the time period is not available for viewing.<br><br>During an interview with the QIDP (staff #400) conducted on May 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 | {W 104} | | |

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| {W 104} | Continued From page 10<br>during transport because client can ambulate.<br><br>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 wheelchair and can ambulate fast. She said staff #422 was covering for another caregiver who went to lunch at that time. She stated when client unfastened his seat belt, staff #411 was the only caregiver with client so staff #422 thought that client had to be strapped in.<br><br>Review of the report revealed no evidence that facility conducted interviews of possible witnesses to the incident.<br><br>Continued review of the facility's investigation revealed the reason for the incident report was because of the client's "behavior". Under the Suspected Abuse, Neglect or Exploitation (ANE) was handwritten note "N/A"<br><br>Further, there was no evidence found as to how the facility concluded that in this incident, no abuse occurred. | {W 104} | | |
| {W 122} | CLIENT PROTECTIONS<br>CFR(s): 483.420<br><br>The facility must ensure that specific client protections requirements are met.<br><br>This CONDITION is not met as evidenced by:<br>Based on the facility's failure to prevent further potential abuse during an alleged abuse investigation, failure to thoroughly investigate two | {W 122} | | |

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| {W 122} | Continued From page 11<br>allegations of abuse, failure to take appropriate corrective action during an abuse investigation, and the facility's failure to implement their abuse policy; these systematic failures potentially affected all clients and resulted in the Condition of Participation of Client Protections to be NOT MET.<br><br>Findings include:<br><br>See W149-<br>Based on clinical record reviews, staff interviews, and review of facility policies and procedures, the facility failed to implement their abuse policy regarding two (#11 and #35) of three abuse investigations. The facility failed to prevent further potential abuse during an alleged abuse investigation for one (#11) client and failed to ensure that two (#11 and #35) of three allegations of abuse were thoroughly investigation. The deficient practice could result in further client abuse.<br><br>See W154-<br>Based on clinical record reviews, staff interviews, review of facility documentation, and review of facility policies and procedures, the facility failed to ensure two (#11 and #35) of three abuse investigations were thoroughly investigated. The deficient practice could result in further client abuse.<br><br>See W155-<br>Based on clinical record review, staff interviews, review of facility documentation, and review of facility policies and procedures, the facility failed to prevent further potential abuse during an allegation of abuse for one (#11) client. The deficient practice could result in further client | {W 122} | | |

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| {W 122} | Continued From page 12<br>abuse.<br><br>See W157-<br>Based on clinical record review and staff interviews, the facility failed to ensure appropriate corrective action was taken regarding a lack of a thorough investigation regarding a client (#35) incident. | {W 122} | | |
| {W 149} | STAFF TREATMENT OF CLIENTS<br>CFR(s): 483.420(d)(1)<br><br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.<br><br>This STANDARD is not met as evidenced by:<br>Based on clinical record reviews, staff interviews, and review of facility policies and procedures, the facility failed to implement their abuse policy regarding two (#11 and #35) of three abuse investigations. The facility failed to prevent further potential abuse during an alleged abuse investigation for one (#11) client and failed to ensure that two (#11 and #35) of three allegations of abuse were thoroughly investigation. The deficient practice could result in further client abuse.<br><br>Finding include:<br><br>-Review of client #11's clinical record revealed that the client had a diagnosis of severe intellectual disability and aphasia, a family member was the guardian and client #11 did not have a history of self-injury.<br><br>Review of an incident report dated April 22, 2019 | {W 149} | | |

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| {W 149} | Continued From page 13 | {W 149} | | |

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 perpetrator, 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) approached me and said he would like to talk to

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| {W 149} | Continued From page 14<br>me. I asked (name of client) what he wanted to talk about. (Name of client) stated 'She did me bad.' 'Who did you bad?' (Name of client) stated my (family member). (Name of client) proceeded to say he did not want to return back to his (family member) house, it just went too far. I asked (name of client) how did you sustain those bruises. (Name of client) said who do you think. I said I don't know, you tell me. (Name of client) said my (family member). (Name of client) also told client care advocate that his (family member) tried to shut him up. I asked (name of client) was this true. (Name of client) said 'Shhh I will talk to you later..."<br><br>Review of the facility's investigation dated April 26, 2019 revealed written statements from facility staff and the client's family member. Further review of the facility's investigation revealed no evidence as to how the facility concluded that the allegation of abuse did not occur.<br><br>An interview was conducted with the CEO (staff #1) on May 6, 2019 at 4:50 p.m. Staff #1 stated that if the facility received an allegation of abuse that the alleged perpetrator would not be allowed in the facility pending the outcome of the investigation. Staff #1 stated that when he received the phone call from the facility he was just told that the resident had an injury and was not made aware of an alleged assault. Staff #1 further stated that he was told that the client's family member was upset because she was accused of hurting the client.<br><br>Another interview was conducted with the independent consultant (staff #619) on May 6, 2019 at 5:10 p.m. Staff #619 stated that the facility did not place any restrictions from family | {W 149} | | |

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| {W 149} | Continued From page 15 | {W 149} | | |

visitations during the facility's investigation of the client's injury of unknown origin.

An interview was conducted with the staff member (staff #521) who wrote the April 23, 2019 witness statement on May 7, 2019 at 8:16 a.m. Staff #521 stated that the former administrator asked her to call the client's family member to set up a meeting before the client went out on another family visit. Staff #521 reiterated what she stated in her April 23, 2019 statement. Staff #521 stated that she gave her written statement to the former administrator but was never questioned further regarding the statements that the client made to her about his family member abusing him.

Review of the facility's Abuse and Neglect policy, which was updated at the time of the survey on May 6, 2019, did not reveal that an alleged perpetrator should have restricted access to clients during an abuse investigation. Further review of the facility's Abuse and Neglect policy revealed no evidence as to how the facility should conduct an abuse investigation.

Further review of the facility's Abuse and Neglect policy which was updated again at the time of the survey on May 6, 2019 documented "...Any other person(s) suspected of abuse (including family, visitors and vendors) will have restricted access pending final outcome of investigation...The Administrator will ensure that staff fully cooperates with the organizations investigating the suspected, alleged or observed abuse or neglect..."

-Client #35 was admitted at the facility with

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| {W 149} | Continued From page 16<br>diagnoses autistic disorder and moderate intellectual disability.<br><br>A review of the Incident Report dated April 21, 2019, revealed a caregiver (staff #422) was walking the client in his wheelchair throughout the facility when the client unbuckled his safety belt and proceeded to get up and walk. The report documented "staff was uncertain of what resident wanted" and redirected him back to his seat. Per the report, the resident "became upset and started to scratch and pull her hair"<br><br>The Incident report also included that the incident was reported to a registered nurse (RN/staff #21).<br><br>Continued review of the Incident Report revealed the reason for the incident report was because of the client's "behavior". Under the Suspected Abuse, Neglect or Exploitation (ANE) was handwritten note "N/A"<br><br>Review of a written statement from staff #422 dated April 21, 2019 documented she was covering for another caregiver for lunch when client wanted to go outside for a walk and he took off his seatbelt. Staff #422 wrote she tried to strap him in and client started to scratch her arms and attempted to bite her.<br><br>The written statement from staff #542 dated April 22, 2019 documented that she was in the dayroom when she was asked for help to put client back in his wheelchair "after he was being combative toward staff". It continued that client was redirected and was sat back in his chair without a problem..."<br><br>The IDT (Interdisciplinary Team) meeting note | {W 149} | | |

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| {W 149} | Continued From page 17 | {W 149} | | |

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 "freaked out probably because she didn't know 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

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| {W 149} | Continued From page 18<br>the client were coming from 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.<br><br>However, review of the report revealed no evidence that facility conducted a thorough investigation to include the following:<br>-Interviews of possible witnesses to the incident and no evidence that RN (staff #21) was questioned regarding the incident;<br>-Review of surveillance videos of activities at the front desk/ reception area on April 21, 2019;<br>-Review of all information related to the incident<br>-How the facility ruled out and concluded that in this incident, no abuse occurred.<br><br>The facility's Abuse and Neglect Policy with revision date of May 6, 2019, it included Programmatic Abuse as one of the types of abuse. The policy defined Programmatic Abuse as occurring when an aversive technique, including restraint, is used on a client that has not been approved as part of a client's IPP (Individual Program Plan). | {W 149} | | |
| {W 154} | STAFF TREATMENT OF CLIENTS<br>CFR(s): 483.420(d)(3)<br><br>The facility must have evidence that all alleged violations are thoroughly investigated.<br><br>This STANDARD is not met as evidenced by:<br>Based on clinical record reviews, staff interviews, review of facility documentation, and review of | {W 154} | | |

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| {W 154} | Continued From page 19 | {W 154} | | |

facility policies and procedures, the facility failed to ensure two (#11 and #35) of three abuse investigations were thoroughly investigated. The deficient practice could result in further client abuse.

Findings include:

-Review of client #11's clinical record revealed that the client had a diagnosis of severe intellectual disability and aphasia, a family member was the guardian and client #11 did not have a history of self-injury.

Review of an incident report dated April 22, 2019 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."

Review of another witness statement from staff #521 dated April 23, 2019 documented "Approximately 11:45 a.m. (name of client) approached me and said he would like to talk to me. I asked (name of client) what he wanted to talk about. (Name of client) stated 'She did me bad.' 'Who did you bad?' (Name of client) stated my (family member). (Name of client) proceeded to say he did not want to return back to his (family member) house, it just went too far. I asked (name of client) how did you sustain those

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| {W 154} | Continued From page 20<br>bruises. (Name of client) said who do you think. I said I don't know, you tell me. (Name of client) said my (family member). (Name of client) also told client care advocate that his (family member) tried to shut him up. I asked (name of client) was this true. (Name of client) said 'Shhh I will talk to you later..."<br><br>Review of the facility's investigation dated April 26, 2019 revealed written statements from facility staff and the client's family member. Review of the facility's investigation revealed no evidence that the facility questioned the client further regarding the statements he made to staff #521 regarding the incident. Further review of the facility's investigation revealed no evidence as to how the facility concluded that the allegation of abuse did not occur.<br><br>An interview was conducted with the administrator (staff #620) on May 6, 2019 at 3:55 p.m.. Staff #620 stated that she was not the facility's abuse officer at the time of the incident. Staff #620 stated that from what she understood the facility could not prove that abuse occurred.<br><br>An interview was conducted with the staff member (staff #521) who wrote the April 23, 2019 witness statement on May 7, 2019 at 8:16 a.m. Staff #521 stated that the former administrator asked her to call the client's family member to set up a meeting before the client went out on another family visit. Staff #521 reiterated what she stated in her April 23, 2019 statement. Staff #521 stated that she gave her written statement to the former administrator but was never questioned further regarding the statements that the client made to her about his family member abusing him. | {W 154} | | |

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| {W 154} | Continued From page 21 | {W 154} | | |

Review of the facility's Abuse and Neglect policy, which was updated at the time of the survey on May 6, 2019, revealed no evidence as to how the facility should conduct an abuse investigation.

Further review of the facility's Abuse and Neglect policy which was updated again at the time of the survey on May 6, 2019 documented "...The Administrator will ensure that staff fully cooperates with the organizations investigating the suspected, alleged or observed abuse or neglect..."

-Client #35 was admitted at the facility with diagnoses autistic disorder and moderate intellectual disability.

The client's ISP (Individual Support Plan) dated April 19, 2019 included that client had cruiser seat (chair) with straps for safety for mobility, seated positioning, school and transport as tolerated. The ISP also included client was able to ambulate with various levels of staff assistance due to cognitive impairments. Recommendations included ambulation as tolerable with staff and staff of 1-2 during performance of transfers and gait.

A review of the Incident Report dated April 21, 2019 revealed a caregiver (staff #422) was walking the client in his wheelchair throughout the facility when the client unbuckled his safety belt and proceeded to get up and walk. The report documented "staff was uncertain of what resident wanted" and redirected him back to his seat. Per the report, the resident "became upset and started to scratch and pull her hair"

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Continued review of the Incident report revealed that this incident was reported to a registered nurse (RN/staff #21) on shift that day.

Review of a written statement from staff #422 dated April 21, 2019 documented "I was covering for (name of another caregiver) lunch. I had (name of client) and he wanted to go outside for a walk when he took off his seatbelt. I tried to strap him in and he started to scratch my arms and attempt to bite." Per the documentation, staff #422 and the client came back inside the facility and another caregiver (staff # 542) helped buckle the client in his chair.

The written statement from staff #542 dated April 22, 2019 documented that she was in the dayroom when she was asked for help to put client back in his wheelchair "after he was being combative toward staff". It continued that client was redirected and was sat back in his chair without a problem.."

The IDT (Interdisciplinary Team) meeting note 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 restrain him with a seat belt.

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| {W 154} | Continued From page 23<br>Staff #53 further stated that client uses the chair only for transport and he was not being transported at the time of the incident.<br><br>In an interview with the independent consultant on May 7, 2019 at 9:00 a.m., she stated that the incident was not investigated as an abuse incident.<br><br>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 "freaked out probably because she didn't know how to deal with the client"<br><br>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 outside and heading back into the facility when the client got out of his chair and became combative. She stayed with 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.<br><br>The facility's investigative report dated April 23, 2019 revealed written statements from staff #422 and #542.<br><br>However, review of the report revealed no | {W 154} | | |

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| {W 154} | Continued From page 24<br>evidence that facility conducted interviews of possible witnesses to the incident and no evidence that RN (staff #21) was questioned regarding the incident.<br><br>There was also no evidence that surveillance videos of activities at the front desk/ reception area on April 21, 2019 were reviewed.<br><br>Continued review of the facility's investigation revealed the reason for the incident report was because of the client's "behavior". Under the Suspected Abuse, Neglect or Exploitation (ANE) was handwritten note "N/A"<br><br>Further, there was no evidence found as to how the facility concluded that in this incident, no abuse occurred. | {W 154} | | |
| {W 155} | STAFF TREATMENT OF CLIENTS<br>CFR(s): 483.420(d)(3)<br><br>The facility must prevent further potential abuse while the investigation is in progress.<br><br>This STANDARD is not met as evidenced by:<br>Based on clinical record review, staff interviews, review of facility documentation, and review of facility policies and procedures, the facility failed to prevent further potential abuse during an allegation of abuse for one (#11) client. The deficient practice could result in further client abuse.<br><br>Findings include:<br><br>Review of client #11's clinical record revealed that the client had a diagnosis of severe intellectual | {W 155} | | |

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disability and aphasia, a family member was the guardian and client #11 did not have a history of self-injury.

Review of an incident report dated April 22, 2019 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 22, 2019 at 10:50 p.m. documented "Phoenix police department onsite. Officer...spoke with patient. Patient stated that he did the injuries himself. Officer took pictures of injuries. Nose was found actively bleeding small amount again..."

Review of a witness statement dated April 22, 2019 documented "While getting (client #11) out of his (family member's) car, she was telling me how she had to give him money for him to give her water bottle back. She mentioned that he was opening it. She made a comment while laughing and looking at him saying not to make her get elder abuse. (Name of client) didn't look at her or want to say good bye to her. When I took him inside I noticed he has a bruise on the right side of his face by his mouth and his nose is bloody. His eyes also looked like he had been crying. He just wanted to go into his room and lay in his bed. While giving him a sponge bath I also noticed a

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bigger bruise on his right arm and he was complaining his right hand was hurting."

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 perpetrator, 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) approached me and said he would like to talk to me. I asked (name of client) what he wanted to talk about. (Name of client) stated 'She did me bad.' 'Who did you bad?' (Name of client) stated my (family member). (Name of client) proceeded to say he did not want to return back to his (family member) house, it just went too far. I asked (name of client) how did you sustain those bruises. (Name of client) said who do you think. I said I don't know, you tell me. (Name of client) said my (family member). (Name of client) also

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| {W 155} | Continued From page 27<br>told client care advocate that his (family member) tried to shut him up. I asked (name of client) was this true. (Name of client) said 'Shhh I will talk to you later..."<br><br>An interview was conducted with an independent consultant (staff #619) on May 6, 2019 at 4:00 p.m. Staff #619 stated that she did not want the client's family member to visit during the facility's investigation but the CEO (staff #1) was called and he allowed the family member to visit the client prior to the investigation being completed.<br><br>An interview was conducted with the CEO (staff #1) on May 6, 2019 at 4:50 p.m. Staff #1 stated that if the facility received an allegation of abuse that the alleged perpetrator would not be allowed in the facility pending the outcome of the investigation. Staff #1 stated that when he received the phone call from the facility he was just told that the resident had an injury and was not made aware of an alleged assault. Staff #1 further stated that he was told that the client's family member was upset because she was accused of hurting the client.<br><br>An interview was conducted with the administrator (staff #620) on May 6, 2019 at 3:55 p.m.. Staff #620 stated that she was not the facility's abuse officer at the time of the incident. Staff #620 stated that she was aware of the incident and from what she understood the facility could not prove that abuse occurred.<br><br>Another interview was conducted with the independent consultant (staff #619) on May 6, 2019 at 5:10 p.m. Staff #619 stated that the facility did not place any restrictions from family visitations during the facility's investigation of the | {W 155} | | |

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| {W 155} | Continued From page 28<br>client's injury of unknown origin.<br><br>Review of the facility's Abuse and Neglect policy dated April 19, 2019, did not reveal that an alleged perpetrator should have restricted access to clients during an abuse investigation.<br><br>Review of the facility's Abuse and Neglect policy which was updated on May 6, 2019 documented "...Any other person(s) suspected of abuse (including family, visitors and vendors) will have restricted access pending final outcome of investigation..." | {W 155} | | |
| W 189 | STAFF TRAINING PROGRAM<br>CFR(s): 483.430(e)(1)<br><br>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.<br><br>This STANDARD is not met as evidenced by:<br>Based clinical record review, staff interviews, review of facility documentation and policies, the facility failed to ensure one staff was trained to care for one client (#35) while relieving another staff member. This deficient practice has potential to result in neglect and harm of all clients in the facility.<br><br>Findings include:<br><br>Client #35 was admitted at the facility with diagnoses autistic disorder and moderate intellectual disability.<br><br>The client's ISP (Individual Support Plan) dated | W 189 | | |

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April 19, 2019 included that client had cruiser seat (chair) with straps for safety for mobility, seated positioning, school and transport as tolerated. The ISP also included client was able to ambulate with various levels of staff assistance due to cognitive impairments. Recommendations included ambulation as tolerable with staff and staff of 1-2 during performance of transfers and gait.

A review of the Incident Report dated April 21, 2019 revealed a caregiver (staff #422) was walking the client in his wheelchair throughout the facility when the client unbuckled his safety belt and proceeded to get up and walk. The report documented "staff was uncertain of what resident wanted" and redirected him back to his seat. Per the report, the resident "became upset and started to scratch and pull her hair"

Review of a written statement from staff #422 dated April 21, 2019 documented "I was covering for (name of another caregiver) lunch. I had (name of client) and he wanted to go outside for a walk when he took off his seatbelt. I tried to strap him in and he started to scratch my arms and attempt to bite." Per the documentation, staff #422 and the client came back inside the facility and another caregiver (staff # 542) helped buckle the client in the chair.

The written statement from staff #542 dated April 22, 2019 documented that she was in the dayroom when she was asked for help to put client back in his wheelchair "after he was being combative toward staff". It continued that client was redirected and was sat back in his chair without a problem..."

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| W 189 | Continued From page 30<br>The IDT (Interdisciplinary Team) meeting note 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"<br><br>The facility's investigative report dated April 23, 2019 documented findings that staff #422 and #542 "was uncertain of what resident wanted when he unbuckled his safety belt.<br><br>During an interview with a registered nurse (RN/staff #20) conducted on May 7, 2019 at 8:17 a.m., she stated client #35 ambulates on his own and required two staff with him when he ambulates because he walks fast and can easily bump on things or the wall. She stated client is allowed to ambulate and uses the wheelchair as needed when he wants to and/or during transport in the bus.<br><br>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 "freaked out probably because she didn't know how to deal with the client"<br><br>In an interview with the Resident Care Manager | W 189 | | |

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(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 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.

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

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| W 189 | Continued From page 32<br>wheelchair and can ambulate fast. She said staff #422 was covering for another caregiver who went to lunch at that time. She stated when a caregiver cover for another caregiver and the relieving caregiver doesn't know what kind of care or supervision to provide to a client, the day program book and the client's ISP are always available. She also stated that there's always a life skills trainer and unit leader on shift to answer question from caregivers related to provision of client care according to the active treatment program and the ISP. However, she stated at the time of the incident, staff #422 "would have not had the opportunity to grab the book". She stated when client #35 unfastened his seatbelt, staff #422 thought that client had to be strapped in the wheelchair. | W 189 | | |