Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	950013	A. BUILDING: _____ B. WING _____	C 11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
USPIRITUS-BROOKLAWN-PILOTS	2108 DAVID GRAVES DRIVE LOUISVILLE, KY 40218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E 460	902 KAR 20:320 7(4)(c)2 Section 7. Admin and Oper of a Level I or II (4) Direct-care staff for a Level I PRTF. (c) In order to assure that the residents are adequately supervised and are cared for in a safe and therapeutic manner, the direct-care staffing plan for a Level I PRTF shall meet the requirements established in this paragraph. 2. At least one (1) direct-care staff member shall be assigned to direct-care responsibilities for each three (3) residents during normal waking hours when residents are not in school. This requirement is not met as evidenced by: Based on interview, record review, and review of the facility policy, it was determined the facility failed to ensure that at least one (1) direct care staff member was assigned to each three (3) residents during normal waking hours when the residents were not in school. On Sunday, 07/17/2022 from approximately 8:00 AM to 2:00 PM, only two (2) staff were on duty to supervise and care for the nine (9) residents on census at the cottage. In interview on 08/01 at 7:17 PM, Shift Supervisor #1 said she made the decision without prior approval to keep Resident #1 in his/her bedroom for the first shift because she heard from night shift staff that Resident #1 had threatened some of the residents. However, there was no evidence that a staff member was assigned to stay at or near Resident #1's doorway	E 460	E 460 • All Residential Managers were retrained and reoriented to the policy and practice surrounding required ratios in the Level I PRTF Program. • This included what required ratios were during both sleeping and waking hours. o This included what procedures should be followed in order to meet the policy and practices (i.e., who should cover shifts where events [call off, vacation, etc.] that could potentially allow a risk of operating out of ratio, who should be contacted in such circumstances, etc.). o Residential Mangers will retrain all direct care staff working in a Level I PRTF on Level I PRTF staff ratios and who to call if they are present for a shift that is not meeting those requirements by December 16, 2022. • All Residential Managers were retrained and reoriented to the practice of keeping the monthly staffing schedules for their assigned cottage(s) up to date and accurate. o Residential Director and/or Assistant Residential Director will routinely spot check monthly schedules created by the Residential Managers to ensure they are being updated timely and accurately. • Maintaining required ratios and keeping schedules adequately updated have both been added as standing agenda items for discussion in the bi-monthly (twice a month) Residential Manager meeting. These items will continue to be agenda items and will be discussed at each meeting by the Residential Director and/or Assistant Residential Director to help ensure consistency, that expectations surrounding these items are being met, and to discuss any potential issues with said items. Continued on next page.	8/5/22 12/16/22 8/5/22 8/5/22 & ongoing

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

President & CEO | December 12, 2022

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E 460	Continued From page 1 to monitor the resident to ensure his/her well-being while he/she stayed alone for several hours in his/her room. The findings include: Review of the facility policy, titled Program Staffing, Policy Number: 6.01.02, Last Review, 05/28/2021, under Section B Direct Care Staffing Pattern, 1. It is recognized that youth needs may require an increased staff-to-youth ratio. Staffing will be increased when needs arise for special precautions/observations or at other times when increased acuity may be anticipated such has holidays, school breaks, etcetera. Continued review of the policy under Section C. Psychiatric Residential Treatment Facilities, the cottages maintain a staffing ratio of at least 1 staff per 3 kids during the waking hours and 1 staff per 9 kids during sleeping hours. Review of the Cottage's PRTF staff July 2022 Schedule, revealed on 07/17/2022 that two (2) staff (YCW #1 and Shift Supervisor #1) were scheduled from 8:00 AM -2:00 PM. At 2:00 PM, YCW #5 was scheduled to work from 2:00 PM-12:00 Midnight. Review of camera coverage footage from 8:30 AM to 2:00 PM, revealed only two (2) staff persons, YCW #1 and Shift Supervisor #1 were in the cottage working with the residents. An interview on 08/02/2022 at 1:15 PM with YCW #9 revealed there should be one (1) staff member on duty for every three (3) residents during waking hours. He stated on 07/17/2022, while Resident #1 was still on census, and the cottage had 9 residents, there should have been 3 staff	E 460	• A check box will be added to the Change of Shift form that will verify that adequate staffing to meet ratios is in place before the off going direct care shift exits the cottage. All employees working in Level I PRTF will be informed of this new requirement.	12/16/22

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E 460	Continued From page 2 on duty. For example, he stated if two (2) staff members had to implement a physical hold, it was preferable to have a third staff monitor for any physical or emotional changes in the resident, and the third person would need to be available to address needs of the other residents in the cottage while the other 2 staff were implementing an Emergency Safety Intervention (ESI). Interview, on 09/13/2022 at 4:25 PM with the Vice President (VP) of Residential Services, revealed The Residential Manager was responsible for ensuring the appropriate staffing levels for the cottages, but the Division Director and Assistant Division Director may assist at times with ensuring the staff to resident ratio was met, by calling in staff or working the shift at the cottage themselves. Interview, on 08/18/2022 at 8:34 AM with the Residential Manager #1, revealed on 07/17/2022 the census at the cottage was nine (9) residents for the first shift, from 8:00 AM-2:30 PM. He stated the staff-to-resident ratio for the PRTF should have been one (1) staff member per three (3) residents. He stated on 07/17/2022, there should have been 3 staff members there for the day shift. He said he was responsible for making the staffing schedule, and if a scheduled staff person did not report to work, the staff present should have notified him, and he would have found someone to fill the void. He stated if he was unable to locate a staff person to report to the cottage, he would come and work the shift to ensure the staff to resident ratio was met. He stated he originally scheduled YCW #8 as the third staff person for the first shift on 07/17/2022, but forgot YCW #8 did not work on Sundays. Residential Manager #1 said he could have	E 460		

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E 460	Continued From page 3 gotten YCW #11, an as needed (PRN) staff person, to fill in if someone at the cottage had notified him that the staff-to-resident ratio was not met for the day shift. Residential Manager #1 stated the cottage should have had 3 staff on duty during the 1st shift, but he added that he thought Shift Supervisor#1 had the ability to monitor the residents on 07/17/2022 with one (1) additional staff member to assist her. Interview with Director of Training and Professional Development, on 11/01/2022 at 1:34 PM, revealed any number of residents in a cottage (PRTF), greater than six (6) required three (3) staff on duty to meet the 3:1 ratio of staff to residents. Continued interview on 10/24/2022 at 3:09 PM with The VP of Residential Services, revealed she would never be okay with the staff to resident ratio not being met at the PRTF cottages. She stated meeting the 3:1 ratio was the law. Shesaid the facility's number one job was to keep the residents safe. She said with inadequate staffing, anything could happen, and the residents needed constant supervision because they did not always make good choices. She stated on 07/17/2022 Shift Supervisor #1 did not notify her leadership that the cottage was short staffed, and since she was a longtime employee she should have known to contact Residential Manger #1, the Division Director, or Assistant Division Director to get a third staff member to come in and cover the shift with her and YCW #1. The VP of Residential Services said a third staff person would have been helpful in meeting Resident #1's needs on that day, as well as assisting other residents. She stated the staff on duty on 07/17/2022 did not follow the facility's staffing policy.	E 460		

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E 855	Continued From page 4	E 855	E 855	
E 855	902 KAR 20:320 8(12)(e) Section 8. Resident Rights (12) A Level I or Level II PRTF shall prohibit all cruel and unusual disciplinary measures including the following: (e) Verbal abuse, ridicule, or humiliation; This requirement is not met as evidenced by: Based on interviews, review of video camera coverage provided by the facility, and policy review, it was determined the facility failed to protect one (1) or ten (10) sampled residents, Resident #1, from experiencing abuse through ridicule and humiliation. On 07/17/2022 Shift Supervisor #1 decided to make Resident #1 stay in his/her bedroom all day because she received report from night staff that the resident had been misbehaving. About one (1) hour before lunch, Resident #1 urinated on himself/herself. Resident #1 stuck his/her hand out of his/her bedroom door (which was the way the residents were instructed to make it known they needed staff assistance) and Shift Supervisor #1 brought dry clothes and a towel to the resident's bedroom door. Per camera footage review, and per interview with YCW #1, Shift Supervisor #1 waved Resident #1 out of his/her room, turned to the other residents who were making bookmarks in the milieu, and said, "See this is what big boys/girls do, they piss on themselves, and you really pissed on yourself." Interview with YCW #1 revealed two (2) of the residents making bookmarks heard Shift Supervisor #1's statement, and laughed.	E 855	• Jillian Parks and Amanda Whitlow did not return to work after the incident that occurred on 7/17/2022. Deborah Francis, Jillian Parks, and Amanda Whitlow (staff who were involved in the incident) were officially suspended on 7/20/2022. Employment of Deborah Francis and Jillian Parks was terminated 8/19/2022.	Suspension 7/20/22 Termination 8/19/22
			• Training on Client Rights and Responsibilities and Bellewood & Brooklawn Youth Rights. Training to be provided at new hire orientation and annually (by September 30th each year, set up to auto-assign staff through the Relias Learning Management System). Updated Youth Rights to be more specific in what types of abuse youth will be protected from, to include shame, ridicule, and humiliation (see attachment).	8/15/22 12/8/22
			• All existing staff were required to complete additional trainings by 9/2/22: *Appropriate Responses to Emergency Safety Situations*; *Speak Up for Client Safety*; and *Hand-Off Communication*. These trainings include information on how to safely and effectively interact with youth, especially during challenging or potentially unsafe situations. Further, specific steps are provided related to communicating and reporting any inappropriate, unsafe, or countertherapeutic behaviors exhibited by staff, especially those that do not show respect for human dignity, individuality, or cultural and personal beliefs, as well as any forms of abuse and neglect including verbal, mental, physical, and sexual abuse. Completion of and compliance with these additional trainings is recorded in each staff's training record via the Relias Learning Management System.	9/2/22
			• Daily reviews of all Emergency Safety Physical Interventions (ESPI) on business days and weekends/holidays if necessary and thrice-weekly reviews of resident grievances are conducted to determine, in addition to any safety concerns, whether any youth rights are violated. These include document and video reviews, when available. Any violations or concerns noted are documented, and the information is shared with the staff's supervisor for follow-up, which may	9/1/22

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E 855	Continued From page 5 The findings include: Review of the facility's policy, titled Youth (Resident) Rights, not dated, revealed youth in the residential program have the right to be treated with consideration and respect for their human dignity and individuality including cultural and personal values, and beliefs. In addition, the resident had the right to receive adequate and humane services that included protection from neglect, verbal, mental, physical, and sexual abuse. Review, of the facility policy titled Reporting of Abuse, Neglect, or Exploitation, Policy Number: CS-015, revealed any staff member who has reasonable cause to believe that an incident of abuse, neglect, or exploitation has occurred with a client is required to make a report as mandated in Kentucky Regluatory Statute (KRS) 620.030 and KRS 209.030. Staff is to notify a supervisor about the report. The supervisor is to provide consultation about reporting and notifications, as needed. Interview, on 07/20/2022 at 5:22 PM with YCW #1, revealed she reported to work on 07/17/2022 at about 8:15-8:19 AM. She said Shift Supervisor #1 reported to work before she did. She said Shift Supervisor #1 gave her an update on the residents. YCW #1 said Shift Supervisor #1 told her she was upset with Resident #1 because he/she had ruined her church day. She said Shift Supervisor #1 said she was going to hold (restrain) Resident #1, and she was going to make him/her throw up. Continued interview, on 07/20/2022 at 5:22 PM with YCW #1, revealed before lunch, Resident #1	E 855	Continued from page 5 • (cont.) include additional coaching, training, or disciplinary action. If there are safety issues noted, these will be addressed immediately. • Monthly Safe Crisis Management (SCM) Refreshers (1 hr) and annual Safe Crisis Management (SCM) recertification (4 hrs) provided to all cottage and clinical staff includes review of Youth Rights and how to sensitively and effectively work with youth, especially when addressing particularly challenging or sensitive issues; this will include emphasizing that shame, humiliation, and/or ridicule is countertherapeutic and is not an acceptable intervention tool. Completion of all refreshers and annual Safe Crisis Management (SCM) recertification is recorded in staff's training record via Relias Learning Management System.	9/1/22

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E 855	Continued From page 6 stuck his/her hand out of his/her door. YCW #1 said she went to the resident's door, and asked if he/she peed on himself/herself, and the resident said yes. She said Shift Supervisor #1 allowed the resident to come out of the room to go to the shower, and other cottage residents were sitting at the dining table making bookmarks. She said Resident #1 was trying to hide the front part of his/her body and his/her wet clothing from the residents, but Shift Supervisor #1 had Resident #1 turn to the residents at the dining table, and she said to the residents at the table, "This is what big boys/girls do, they piss on themselves," and then to Resident #1, "and you really pissed on yourself." YCW #1 stated a couple of the residents laughed when they heard Shift Supervisor #1's comments, but she (YCW #1) told them not to laugh. Review of the facility provided video coverage of the cottage on 07/17/2022, timestamp of 12:14 PM, revealed Shift Supervisor #1 obtained folded clothes and a folded towel. She then walked to Resident #1's door, and at 12:15.19 Resident #1 was seen at the doorway. Shift Supervisor #1 waved the resident out of his/her room with her hand, and the low part of the resident's shirt was a darker color like it was wet. There was no audio contained with the footage, but Shift Supervisor #1 was observed turning towards the residents at the dining table and said something to them. Resident #1 raised the towel up to his/her face area, and then he/she turned with Shift Supervisor #1 and walked toward the hallway where the shower was located. Interview, on 07/21/2022 at 5:40 PM with Resident #4, revealed, that (the other residents) saw that Resident #1 peed, and that he/she heard Shift Supervisor #1 say something like	E 855		

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E 855	Continued From page 7 Resident #1 was not a big boy/girl. Resident #4 said he/she really did not hear anything else. YCW #1 said she had concerns about Shift Supervisor #1's statement that she was going to put Resident #1 in a hold and make him/her throw up. She said she should have reported that to someone, and she felt really bad about that. YCW #1 said it was the first hold she had seen implemented, that it was all very shocking, and she really did not know who she should have contacted. However, she said, after the incident, she reported her concerns to the Director of Traning and Professional Development when he interviewed her for the facility's internal investigation of the incident. Interview, on 07/25/2022 at 4:53 PM with Shift Supervisor #1, revealed she denied telling the other residents in the cottage that Resident #1 had urinated on himself/herself. She said we do not call out residents for that because several residents had that problem. Shift Supervisor #1 said there was no bookmark making activity for the residents that day. However, the video camera coverage of the cottage milieu, revealed that on 07/17/2022 from 11:59 AM to 12:25.22 Shift Supervisor #1 was observed holding up long rectangular pieces of colored paper while she talked to the residents seated at the dining table. Markers and varied color paper strips were observed on the table. YCW #1 was seated at the table while the residents were drawing, coloring on the strips of paper. At 12:35.30. Resident #1 returned from the long hallway and walked to his/her room door. The resident paused outside the door and was looking at the other residents at the table. At 12:39.04, Shift Supervisor #1 walked down the	E 855		

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E 855	Continued From page 8 long hall, again, and Resident #1 followed her. At 12:39.58, Shift Supervisor #1 and Resident #1 returned to his/her bedroom door and the resident was holding a mop. Shift Supervisor #1 opened Resident #1's door and he/she entered his/her room carrying the mop, and the door closed. Interview, on 07/29/2022 at 2:49 PM with the Residential Manager #1 for Pilot's Cottage, revealed if a resident urinated on himself/herself, staff should have the resident take a shower and put on clean clothes, and then take his/her soiled clothing to the laundry room. Residential Manager #1 said staff should never talk down to a resident when he/she urinated on himself/herself because it could be due to a medical condition, or the resident may not have been able to control the situation. He stated the resdient should never be punished for urinating on himself/herself, and the staff person assisting the resident should never reveal the situation to his/her peers. Residential Manager #1 said that alone could trigger negative behavior on the part of the resident such as shouting or swinging at persons in the area. He said he knew Resident #1 well enough that such embarassement could have caused the resident to escalate if his/her peers laughed at him/her. Interview, on 07/24/2022 at 2:20 PM with Shift Supervisor #2, who worked Pilots' Cottage on 07/15/2022 and 07/16/2022, revealed it was not uncommon for residents to urinate on themselves. He stated staff should obtain clean clothes and get the resident in the shower as soon as possible. Shift Supervisor #2 said the situation should be handled discreetly because the resident would probably not want his/her peers to know it occurred. He said for staff to make the other residents in the milieu aware the resident had wet himself/herself was very	E 855		

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E 855	Continued From page 9 inappropriate. He said that was unacceptable, and he really had no words for that. Shift Supervisor #2 said he had never seen anything like that occur at least when he was on duty at the cottage. Interview, on 07/26/2022 at 4:20 PM with YCW# 30, revealed if she thought staff was being abusive toward a resident she would would immediately talk with that staff person, and then report the incident to a supervisor. She stated the residents were not in the facility to be abused. Interview, on 07/30/2022 at 2:54 PM with YCW #8, revealed abuse prevention was discussed every month at Town Hall meetings for the PRTF staff. Interview, on 07/28/2022 at 4:30 PM with Resident #1's Residential Therapist (#1), revealed it was not uncommon for PRTF youth to urinate on themselves. Residential Therapist #1 stated urinating on himself/herselft could have been a means to assert some type of control, but not necessarily a conscious act on his/her part. She said Shift Supervisor #1 should have handled the situation so that it did not become obvious to Resident #1's peers that he/she had urinated on himself/herself. Said staff must help the resident maintain his/her dignity, and should never be terse in their tone, or shame a youth in front of his/her for peers. The Therapist said we frequently enforce with staff that punitive treatment was never acceptable. She stated when dealing with the residents staff should never engage in punitive or abusive treatment. She said, put simply, that should neveroccur. Interview, on 08/22/2022 at 12:20 PM with the Division Director, revealed prior to the incidents of	E 855		

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E 855	Continued From page 10 07/17/2022, no one informed her of any issues with how Shift Supervisor #1 interacted with the Resident #1 or the other residents in the cottage. Interview, on 08/22/2022 at 10:15 AM with the Vice President (VP) of Residential Programming, revealed staff should never ridicule a youth in front of his/her peers. She stated all staff members should continually use language that would be helpful to the residents, and should promote postive relationshitps among residents and their peers. The VP of Residential Programming stated she was not alerted of this incident on 07/17/2022, but she said YCW #1 should have called the Residential Manager and reported her concerns, that is, what she saw and heard, and she knew YCW #1 would have had Residential Manager #1's phone number.	E 855		
E1085	902 KAR 20:320 10(3) Section 10. Quality Assurance (3) A Level I or Level II PRTF shall record all incidents or accidents that present a direct or immediate threat to the health, safety or security of any resident or staff member. Examples of incidents to be recorded include the following: physical violence, fighting, absence without leave, use or possession of drugs or alcohol, or inappropriate sexual behavior. The record shall be kept on file and retained at the facility and shall be made available for inspection by the licensure agency. This requirement is not met as evidenced by: Based on interview, record and policy review, it	E1085	E 1085 • Implemented CLT-007 Speak Up for Client Safety-Intervening and Escalating Safety Concerns policy (see attachment). This policy and procedure has been implemented to ensure staff know that they can and should intervene in any potentially dangerous situation. The policy and procedure also ensures that staff know who to talk to about concerns. • Vice President of Residential Programming notifies the Chief Executive Officer (CEO) immediately of any of the following situations: youth AWOL (Absent Without Leave), youth injury or illness requiring outside medical treatment, any allegations of youth being mistreated by a staff member, and any hospitalizations (psychiatric or medical). Vice President of Residential Programming and Chief Executive Officer speak at least weekly about routine happenings across both campuses. Continued on next page.	9/6/22 10/7/22

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USPIRITUS-BROOKLAWN-PILOTS	2108 DAVID GRAVES DRIVE LOUISVILLE, KY 40218

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E1085	Continued From page 11 was determined the facility failed to implement their Quality Assurance Program Processes to ensure the facility's administration remained fully aware of all incidents and any contributing factors that presented direct and immediate threats to the health, safety, and security of one (1) of ten (10) sampled Residents, Resident #1. On 07/17/2022 at 2:25 PM Shift Supervisor #1 and Youth Care Worker (YCW) #5 failed to implement a kneeling cradle hold in accordance with the facility's Physical Holding Policy. The staff members placed Resident #1 in a restraint (physical hold) but per YCW #1's report, the resident had not inflicted bodily injury on himself/herself, staff, or other residents. While restrained, Resident #1 vomited, became unresponsive, and Cardiopulmonary Resuscitation (CPR) was initiated by Shift Supervisor #1 and YCW #5. Emergency Medical Services (EMS) personnel was summoned to the cottage, took over CPR, and transferred the resident to a local Emergency Department (ED) where the resident passed away at 4:48 PM. Interview with YCW #1, who witnessed the resident's behavior just prior to the hold and the resident's response to the hold, revealed Shift Supervisor#1 and YCW #5 implemented the hold in Resident #1's bedroom out of camera view. She reported Shift Supervisor #1 pushed the resident so far forward during the hold that his/her nose almost touched the floor. While holding the resident she said she heard Shift Supervisor #1 tell Resident #1 to go ahead and vomit. Resident #1 vomited during the hold, began to cry, and subsequently became unconscious. Prior to 07/17/2022, record review and staff interviews revealed YCW #5 had secured Resident #1 in three (3) holds on 07/01/2022,	E1085	• Division Director for Residential (or Assistant Director as available) meets with the Residential Managers at least twice a month to review each youth's progress and provide guidance on staff needs. Division Director for Clinical (or Assistant Director for Clinical as available) meets with each therapist at least twice a month to review each youth's treatment progress and troubleshoot any barriers to success. Vice President of Residential Programming meets with Division Directors for Clinical and Residential for supervision and reviews treatment issues and supervisory issues related to staff, to provide consult and guidance on how to handle such situations. Vice President of Residential Programming then notifies the Chief Executive Officer of any potentially dangerous situations or other situations as appropriate.	11/1/22

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E1085	Continued From page 12 07/08/2022, and 07/09/2022 The resident's Treatment Team met on 07/12/2022 and determined YCW #5 triggered Resident #1's negative behaviors and she should disinvolve herself of any future holds necessary for Resident #1. She was given that direction by Resident #1's Therapist and Residential Manager#1 prior to 07/17/2022. However, there was no evidence the Resident's Therapist revised Resident #1's Treatment and Plan/Behavior Support Plan(BSP) to include YCW #5 triggered the resident's behaviors. But, YCW #5 was the first staff member to secure Resident #1 in the hold on 07/17/2022. Interview with the Vice President (VP) of Residential Programming revealed prior to Resident #1's death, she was not aware the the Treatment Team had identified there was an issue with how YCW #5 affected Resident #1's behaviors. During the course of the investigation, the State Survey Agency (SSA) learned that on 07/09/2022 at 6:30 PM, YCW #5 prevented Resident #1 from leaving the timeout room hallway by blocking the exit door, thus creating a latched seclusion of the resident. On 07/17/2022 during the day shift from approximately 8:30 AM to 2:00 PM, Shift Supervisor #1 decided without prior approval from Resident #1's Residential Therapist, the Residential Manager or the resident's Psychiatrist, to keep Resident #1 in his/her bed for the day shift because she heard that he/she misbehaved on night shift. On 07/17/2022, while being kept in his/her room, Resident #1 urinated on himself/herself, and wet and soiled his/her clothing. Review of the facility's camera coverage of the cottage and interview with YCW #1, revealed Shift Supervisor #1 waved Resident #1 out of his/her room, and in	E1085		

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E1085	Continued From page 13 view of his/her peers (other residents) and ridiculed the resident by stating out loud so other residents heard the following: "This is what big boys/girls do, they piss on themselves," and then to Resident #1, "and you really pissed on yourself." Interview with YCW #1 revealed she did not think the hold was implemented per the facility's policy or per her recent training on Safe Crisis Management, and that she felt badly that she did not report Shift Supervisor #1's treatment of Resident #1 or the treatment of the resident during the hold. She stated she was new, it was the first hold she had witnessed, and she just did not know who she should have contacted to report what was going on. The findings include: Review of the facility's Quality Improvement Plan, Revised March 2022, revealed The Quality Improvement Plan establishes a structure that facilitates coordinated planning, measurement, assessment and improvement of organization processes and systems. By leading and promoting continuous learning and performance improvement throughout operations, the quality of care is optimized. The quality improvement program is intended to: improve safety, quality and client satisfaction in our care, treatment and services; create a culture of safety and quality; respond to changes in the external and internal environment to provide services that are responsive to client and community needs and delivered in a cost-efficient manner; ensure professional accountability for services and outcomes, and ensure compliance with the requirements of all state and federal stakeholders.	E1085		

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E1085	Continued From page 14 Interview on 07/20/2022 at 5:22 PM with YCW#1, revealed she had concerns about Shift Supervisor #1's statement, on the morning of 07/17/2022, that she was going to put Resident #1 in a hold and make him/her throw up. YCW #1 said she should have reported that to someone, and she felt really bad about that. YCW #1 said it was the first hold she had seen implemented, that it was all very shocking, and she really did not know who she should have contacted. However, she said after the incident, she was interviewed by the Director of Training and Professional Development and she reported her concerns to him. Interview, on 07/20/2022 at 10:40 AM with Residential Manager #1 revealed holds should not be implemented in a resident's bedroom because actions taken by the staff and the resident's status during the hold could not be documented on camera for later review. Residential Cottage Manager #1 said he would have moved the resident from the bedroom into the milieu. He said there were interventions such as a hook transport staff could have used to move the resident to a more public space with camera coverage. He stated he did not think the staff there on 07/17/2022 would have had difficulty transferring Resident #1. He said by doing so, the hold and the staff responses to the resident would have been documented for later review. Interview, on 07/29/2022 at 2:49 PM with Residential Manager #1, revealed a lot of residents had expressed in Treatment Team meetings they had issues with how Shift Supervisor #1 interacted with them. He said based on that information he decided to speak	E1085		

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E1085	Continued From page 15	E1085		

with her about it. He stated Shift Supervisor #1 had been overbearing with the residents when it came to spirituality. He stated he told Shift Supervisor #1 staff members were not there to raise the residents, but to treat them using therapeutic interventions

Continued interview, on 08/18/2022 at 8:34 AM with the Residential Manager #1, revealed on 07/17/2022 the census at the cottage was nine (9) residents for the first shift, from 8:00 AM-2:30 PM. He stated the staff-to-resident ratio for the PRTF should have been one (1) staff member per three (3) residents. He said he was responsible for developing monthly staffing schedules, and if staff did not report to work, the staff on duty should have notified him and he would have found someone work in order comply with the facility's staffing policy, and to provide the necessary resources to ensure a safe resident environment.

Interview, on 08/10/2022 at 12;26 PM with Resident #1's Therapist (Residential Therapist #1), revealed during the Treatment Team Meeting on 07/12/2022, the team identified that Resident #1 would demonstrate unsafe behavior when YCW #5 was on duty at the cottage. She did not understand why the incident even happened. She stated per the hold reports, it seemed the resident was seeking the holds as a form of comfort. She stated on 07/12/2022, she directed YCW #5 to disinvolve herself with any situations of physical management as it pertained to Resident #1. She stated YCW #5 was supposed to keep her distance from the resident. She said she was unsure if reassignment of YCW #5 had been considered.

Interview, on 08/22/2022 at 12:20 PM with the

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E1085	Continued From page 16 Division Director, revealed Residential Manager #1 informed her of the conversation he had with YCW #5 about Resident #1 seeking her out for attention which ultimately ended in physical holding, and that he directed YCW #5 to not become involved in any of Resident #1 holds after the Treatment Team meeting that occurred on 07/12/2022. The Division Director stated Residential Manager #1 told her he directed YCW #5 to let other staff implement the holding of Resident #1, if that became necessary. In terms of monitoring the cottage, The Division Director said she made scheduled rounds and visited the cottages when opportunities arose, but she did not revealed how frequently she made the rounds. The Division Director said she had not identified any concerns with how Shift Supervisor #1 treated Resident #1 during his/her stay at the facility. Interview, on 08/22/2022 at 10:00 AM, with the Director of Training and Professional Development, revealed Resident #1's Residential Therapist and/or Residential Manager #1 did not contact him regarding their identified concerns with YCW #5's approach with Resident #1, and the recent series of holds she implemented prior to the final hold on 07/17/2022. He said he was not asked nor was he directed to increase monitoring of YCW #5, and/or provide her with additional education on physical holding and other Safe Crisis Management (SCM) strategies. The Director of Training and Professional Development stated if management identified there was not a therapeutic relationship between Resident #1 and YCW #5, then they should have gotten to the bottom of what was causing the issue. Interview, on 08/05/2022 at 11:10 AM with	E1085		

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E1085	Continued From page 17 Resident#1's psychiatrist, revealed it concerned him that Resident #1's door remained closed on 07/17/2022, without staff frequently assessing the resident's well-being. He stated the actions taken by the staff showed a lack of understanding of 7-year-old behavior. He stated with Resident #1's known intellectual disability isolating him/her from the other youth without frequent staff contact would be hard for him/her to conceptualize. He stated why would anyone want to punish the resident knowing he/she would not understand why that was occurring. In addition, Resident #1's psychiatrist stated one of Resident#1's past traumatic experiences was he/she had been locked in a room. Further, Resident #1's psychiatrist stated nonphysical management of a resident's behavior should always be the first-line intervention. He stated in lieu of holds, staff should try verbal interventions such verbal de-escalation, or ask the resident to go to the timeout room to process their anger or other issues they had. He said physical intervention should only be used if the resident became a threat to himself/herself or others. Review of the Coroner's Report, dated 07/18/2022, and signed by the Deputy Coroner, revealed the decedent underwent an autopsy on 07/18/2022. Remarks after the autopsy, revealed there were injuries on the decedent's body that appeared to be contusions (bruises) on various areas of his/her body and petechia visible in his/her eyes. The Deputy Coroner said petechia in the eyes can be a result of asphyxia or strangulation. She stated aggressive CPR may cause slight petechia in the eyes, but in Resident #1's case, there was more than slight petechia. In interview, on 08/09/2022 at 2:38 PM the county Medical Examiner, revealed Resident #1's case	E1085		

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E1085	Continued From page 18 was complicated, and not a lot of information was gained from the autopsy. He stated the resident had pinpoint hemorrhages in his/her eyes, and a target of his exam was to determine if there were any suspicious marks on the resident's neck, but he found nothing significant. However, he thought the eye hemorrhages were more extensive than what would occur by administering CPR. He stated he had questions about how the resident was restrained. He stated the case was very concerning. Interview, on 10/24/2022 at 3:09 PM with the Vice President (VP) of Residential Programming, revealed she was not aware the facility previously had issues with insufficient staffing, and that the other cottages were not meeting staffing quotas . She stated after she learned the details that surrounded the incident on 07/17/2022, she was made aware that only two (2) staff were on duty during the day shift at Resident #1's cottage, and yet, there were nine (9) residents on census. She stated she thought that since Shift Supervisor #1 was a seasoned employee at the facility, she should have known to contact Residential Manager #1 to secure staff coverage to meet the required one (1) staff for every three (3) residents requirement. She said anything could happen, because the residents under the care of the PRTF did not always make good choices, and if there had been a third person on duty, he or she may have been able to assist with monitoring Resident #1. Continued interview, on 10/25/2022 at 4:15 PM with the VP of Residential Services, revealed she would not have expected The Division Director or the Residential Therapist to report to her that YCW #5 had been identified as one who triggered Resident #1's behaviors. The VP of Residential	E1085		

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E1085	Continued From page 19 Services said her role was to provide residential and clinical oversight for all programs at the PRTF, but she had a Division Director and Assistant Division Director in place who addressed specific issues in the cottages, and the Division Directors were over the Cottage Residential Managers. She said the Division Directors did consult with her when they needed help with certain issues such as staff non-compliance, things like that, but she did not get updates on all residents all of the time. She stated she had not received reports or any concerns about Shift Supervisor #1's interactions with residents. The VP of Residential Services said she was not sure if Resident #1's treatment and behavior support plans should have been revised with the knowledge that YCW #5 appeared to trigger Resident #1's behaviors, that is, seeking out YCW #5 for attention that ended in physical holding. She said the facility did not always remove triggers from the resident's environment. However, it was a horrible day, and mistakes were made. The VP of Residential Services stated she was ultimately responsible for administrative and clinical oversight at the PRTF, but she was not informed that Clinical Staff determined YCW #5 appeared to trigger Resident #1's attention seeking behaviors, therefore she did not offer counsel and did not report or discuss the concern with others in leadership roles prior to 07/17/2022. She said she had not viewed the camera coverage of the 07/09/2022 incident when YCW #5 prevented Resident #1 from re-entering the milieu while he/she was in the timeout hallway. However, the facility recently developed protocols to include more thorough reviews of holds and other actions taken by staff to manage residents' behaviors. Interview, on 11/02/2022 at 2:15 PM with the	E1085		

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E1085	Continued From page 20 Chief Administrative Officer (CAO), revealed she oversaw the Quality Assurance Department which included two (2) staff members. She stated the staff reviewed and updated policies, reviewed incident and injury reports, conducted chart reviews, and ensured treatment plans met standards. As far as medical records, the staff mainly reviewed for completeness of the record, more than for accuracy of the content, because the staff did not have healthcare related backgrounds. She said through tracking and trending of incident-related data, they had not identified any patterns that were of concern regarding physical holds, or resident injuries sustained during holds. If there were identified trends in incidents or an isolated incident was determined to be serious, then the Medical Director, VP of Residential Programming, and the Division Director would take immediate action to address the issue. She said identified trends and serious isolated incidents would be presented to the Board of Directors for further review and guidance, as needed. The CAO stated there had been multiple discussions about staffing as related to call-ins, but the residential managers were responsible for making arrangements to ensure the staffing at the cottage was appropriate for the number of residents on census. She said sufficient staffing per the facility policy was essential for keeping the milieu as normal as possible, and for maintaining a safe environment for the residents. The CAO stated prior to the incident that resulted in the death of Resident #1, the QA and Clinical Staff only reviewed holds with questionable processes or injuries. However, since the 07/17/2022 incident, the QA and Clinical Teams reviewed every hold implemented at the facility to determine if there was non-compliance with process regardless of how minor the improper application might have been. She stated	E1085		

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E1085	Continued From page 21 the intent was to now examine all holds to ensure they were implemented in accordance with the facility's physical holding policy. Interview, on 11/02/2022 at 2:29 PM with the Chief Executive Officer (CEO), revealed the VP of Residential Services notified her of the incident, and that she in turn notified the Board Chairman of the resident's transfer to the hospital, and then about the death of the resident as more information became available. She said at first we thought the death was the result of a medical condition, but as the internal investigation progressed, the findings revealed our own polices and procedures were not followed. She said a meeting was called to inform the Governing Board Members, and then we waited for a full report from the Coroner. The CEO stated the facility's Quality and Compliance team reviewed incidents at the facility in regard to physical holding, but before 07/17/2022, there had been no identified patterns of staff non-compliance or resident injuries with physical holding that required Governing Body review, or a reason to develop a corrective action plan.	E1085		
E2130	902 KAR 20:320 15(4)(a) Section 15. Use of Emergency Safety Intervent (4) Orders for restraint or seclusion shall be: (a) By a physician or other licensed practitioner acting within his or her scope of practice who is trained in the use of emergency safety interventions;	E2130		

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E2130	Continued From page 22 This requirement is not met as evidenced by: Based on interview, record, and policy review it was determined the facility failed to ensure Pilot's Cottage Staff called the Clinical Consultant-on-Call on 07/17/2022 at 2:25 PM to obtain direction for preventing the implementation of an Emergency Safety Intervention (ESI) in the form of a physical hold for one (1) of ten (10) sampled Residents, Resident #1. Youth Care Worker (YCW) #5 and YCW #1 entered Resident #1's bedroom (out of camera view) at 2:25 PM, and YCW #5 secured the resident in a kneeling cradle hold. Per staff interview and review of cottage camera footage, three (3) staff were on duty at the time of the hold, but there was no evidence that any of the 3 staff (YCW #1, YCW #5, or Shift Supervisor #1) contacted the Clinical Consultant-on-call to seek assistance. Interview with YCW #1, a witness to the physical hold that occurred in the resident's bedroom (out of camera view), revealed the hold was not implemented per the facililty's physical holding policy or per the training she received through her Safe Crisis Management (SCM) certification. In addition, YCW #1 stated she did not think the hold was even necessary because Resident #1 only threatened to throw a plastic water bottle at her, and he/she called YCW #5 a stupid bitch, and threatened to hit her, but he/she never acted on the threat. YCW #1 said she thought Resident #1 was de-escalating because he/she was laughing with her (YCW#1). YCW #1 said she thought YCW #5 escalated the situation by getting involved when she apparently overheard Resident #1 say he/she was going to	E2130	E2130 • Cottage staff are to contact and obtain consultation from the Clinical Consultant on-call for preventing the implementation of a physical hold, when at all possible, as youth is escalating. If the youth's Treatment Team Physician or the Clinical Consultant is not present and failure to intervene causes an immediate threat to the youth or others, staff trained in Safe Crisis Management may initiate the physical holding without prior approval and call the Clinical Consultant as immediately as safely possible in order to obtain consultation and for the Clinical Consultant to respond to the location. Please see updated policy and procedure attached that outlines these steps more clearly. • Clinical Consultants will be notified of any use of physical holding and will provide consultation to the staff, and for PRTF youth, provide/write the order for the use of the physical holding when they arrive to assess the situation. The order will include the date and time of the order and the length of time for which the physical hold was authorized. Clinical Consultants are clinically licensed professionals who meet the requirement of "other licensed practitioners" allowed by the Commonwealth to order physical holding, seclusion, and conduct face-to-face assessments. • Residential and Clinical leadership will monitor this process through the daily review of holds. Daily hold reviews began 9/1/2022.	Process effective 9/9/2022 Policy and procedure approved 12/9/2022 Process effective 11/22/2022 Policy and procedure approved 12/9/2022 9/1/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	950013	A. BUILDING: _____ B. WING _____	C 11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
USPIRITUS-BROOKLAWN-PILOTS	2108 DAVID GRAVES DRIVE LOUISVILLE, KY 40218

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E2130	Continued From page 23 hit her (YCW #1) with the water bottle. During the course of the hold, Resident #1 vomited, cried, lost consciousness, and eventually required Cardiovascular Pulmonary Recussitation (CPR), and transfer to the hospital where he/she passed away at 4:48 PM that same day. The findings include: Review of the facility's policy, titled Physical Holding of Youth, Policy Number: CS-040, last review date, 03/25/2021, revealed for youth ages nine (9) and younger, staff was to call the Clinical Consultant at the initiation of the hold and every 15 minutes for the duration of the hold. Review of Resident #1's Comprehensive Assessment, dated 06/22/2022, revealed the resident had recently received inpatient treatment at a psychiatric hospital. The resident was hospitalized for aggressive and sexually acting out behaviors while in the care of foster parents. The resident currently had a state appointed guardian. The resident's date of birth was 08/10/2014. The resident had no known cardiac issues, but was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD), and Disruptive Mood Disorder. Review of camera footage of the facility's common living space on 07/17/2022 revealed at 2:25 PM, Resident #1 and YCW #1 were talking at the resident's doorway. At 2:27:48 PM YCW#5 approached the resident's door and went in the resident's room. YCW #1 followed YCW #5 into Resident's #1's room and closed the door. Further review of the camera footage revealed Shift Supervisor #1 entered Resident #1's room at 2:28:56 PM.	E2130		

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E2130	Continued From page 24 Interview, on 07/20/2022 at 5:22 PM YCW #1 who witnessed YCW #5 secure Resident #1 in a standing to kneeling cradle hold, revealed on 07/17/2022 at about 2:20 PM, Resident #1 stuck his/her hand out of the door which signaled staff he/she needed something. YCW #1 stated she went to the resident's door, and he/she had wet his/her pants. She said she was not sure why the resident urinated on himself/herself, but the resident had been in his/her bedroom all day. She said while she was talking to the resident at his/her door, he/she asked where Shift Supervisor #1 was. She said the resident picked up his/her plastic water bottle and threatened to throw the bottle at her (YCW#1). YCW #1 said she thought YCW #5 overheard Resident #1 threaten to hit her with the water bottle, and in about two (2) seconds YCW #5 was at Resident #1's doorway. YCW #1 stated YCW #5 walked into Resident #1's room, and that she (YCW#1) walked in behind YCW #5 because since she was new to the job she wanted to see how YCW #5 was going to handle the situation. She said YCW #5 put Resident #1's hands up against the bedroom wall and Resident #1 told YCW #5 he/she she was going to hit her like he/she did the other day, and the resident called YCW #5 a stupid bitch. YCW #1 stated YCW #5 did not explain why she put the resident's hands on the wall before implementing the hold. YCW #1 stated YCW #5 then secured the resident in a standing cradle hold that transitioned to kneeling cradle hold, because both individuals lost their balance, went down to the floor, and the hold transitioned to a kneeling cradle hold. YCW #1 said she held the resident's feet/legs and continued trying to calm the resident by laughing with him/her, because she (YCW#1) had accidentally sat in some of the resident's pee on the floor. YCW #1 said a few seconds later, Shift	E2130		

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E2130	Continued From page 25 Supervisor #1 entered the room, and told YCW #5 to move, and said,"I've got it." YCW #5 refused to be interviewed about the incident by the State Survey Agency (SSA) Surveyor. During a brief telephone interview, on 07/21/2022 at 9:45 AM YCW #5 stated she wanted to talk with the surveyor but had been advised by her attorney that she should not agree to be interviewed unless her legal counsel present. Mulitple phone attempts were made to arrange the interview, but YCW #5 did not respond, and ulimtately the SSA Surveyor was unable to obtain the interview. Interview, on 08/13/2022 at 5:09 PM with YCW #11, who had worked at the cottage where Resident #1 lived, revealed someone in the cottage was supposed to call the Clinical-on-Call Therapist at the beginning of a hold, as soon as possible. She stated if she was not actively holding the resident, she immediately called the Clinical-on-Call Therapist to inform them of the need for the Emergency Safety Intervention (ESI) or hold. Interview, on 08/15/2022 at 11:08 AM with Residential Therapist #5, revealed she thought it would be helpful for the staff to call the Clinical-on-Call when the resident was in the hold because the therapist could offer assistance and help the staff determine if the hold could be discontinued. Interview, on 08/15/2022 at 10:32 AM with Residential Therapist #4, revealed if there was sufficent staff in the cottage, then the Clinician-on-Call should be notified at the initiation of the hold.	E2130		

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E2130	Continued From page 26 Interview, on 08/10/2022 at 12:26 PM with Resident #1's Residential Therapist (#1), revealed the direct care staff at the cottage was supposed to call the Clinical-on-Call therapist at the beginning of the hold. She stated the therapist would help staff determine if other less restrictive interventions could be used instead of physical holding. Residential Therapist #1 said the Clinical-on-Call therapist would ask what was going on. She said if Resident #1 threatened to throw a plastic water bottle, she would ask who was in danger as a result of the resident's threat. She I would then talk with staff about other strategies they could use to de-escalate the situation. She offered an example such as saying, "Oh wait a minute, can we talk through this?" She stated she would remind the staff first try the least restrictive methods to de-escalate the resident's behavior. She stated a resident should never be secured in a hold as a form of punishment. She stated during the Treatment Team Meeting of 07/12/2022, the team identified that Resident #1 would demonstrate unsafe behavior when YCW #5 was on duty at the cottage. She said did not understand why the hold occured. She stated per the hold reports, it seemed the resident was seeking the holds as a form of comfort, and YCW #5 implemented each of Resident #1's previous holds. She stated YCW #5 had been counseled to disinvolve herself with any situations of physical management as it pertained to Resident #1. She stated YCW #5 was supposed to keep her distance from the resident, yet she was the first staff person to enter Resient #1's room on 07/17/2022 and secure him/her in a hold. Residential Therapist #1 said the resident's threat to hit a staff person with a plastic water bottle was not sufficient reason to secure the resident in a hold. Further, she said the fact that the resident was secured in a hold in his/her bedroom, off	E2130		

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E2130	Continued From page 27 camera, was very upsetting because that was not supposed to occur, either.	E2130		

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N 000	Initial Comments An abbreviated survey was initiated on 07/18/2022 and concluded on 11/02/2022, to investigate KY #00037021. The complaint was substantiated and the facility was found to be out of compliance with the Conditions of Participation at 42 CFR 483.354 Use of Restraint and Seclusion. Standard level deficiencies were identified at N0115, N0126, N0128, N0132, N0165, N0170, N0183, and N0189. Based on observations, interviews, record and policy review it was determined the two (2) staff, Youth Care Worker (YCW) #5, Shift Supervisor #1 failed implement Safe Crisis Management (SCM), a physical hold, in accordance with the facility's Physical Holding policy, to prevent serious harm resulting in the death of one (1) of ten (10) residents, Resident #1; the facility failed to ensure the Interdisciplinary Treatment Team revised Resident #1's Treatment and Behavior Support Plans, when it was determined on 07/12/2022, that YCW #5 triggered Resident #1's behaviors, and advised the YCW to not become involved in any future holds for Resident #1; the facility failed to protect Resident #1 from an unapproved seclusionary time-out for an extended period of time, from 8:00 AM to approximately 2:25 PM, when Shift Supervisor #1 decided, without prior approval from clinicians or management, to keep Resident #1 in his/her bedroom because she heard from the night shift staff that the resident had misbehaved; the facility failed to protect Resident #1 from experiencing an unnecessary Emergency Safety Intervention (ESI)-- a physical hold. Interview with an eyewitness, YCW #1 revealed Resident #1 had not placed himself/herself or others (staff nor	N 000		

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

President & CEO December 12, 2022

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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N 000	Continued From page 1	N 000		

residents) in harms way before he/she was secured in the hold by YCW#5 and Shift Supervisor #1 on 07/17/2022 at approximately 2:25 PM; the facility failed to ensure staff monitored and addressed the physical and psychosocial well-being of Resident #1, and did not act on the resident's symptoms of distress while in the hold (vomiting and crying) before he/she became unresponsive and required Cardiopulmonary Resuscitation (CPR), and transfer to the hospital emergency department (ED); the facility failed to ensure staff was immediately outside Resident #1's bedroom continuously assessing the resident during the time period (8:00 AM-2:00 PM) when Shift Supervisor #1 decided without prior approval to keep the resident in his/her room, not in the milieu with other residents, because he/she was told the resident misbehaved on the night shift; the facility failed to ensure Resident #1 was not prevented from leaving the timeout room area on 07/09/2022, when YCW #5 physically blocked the door back into the milieu when the resident attempted to leave the timeout area and re-enter the milieu; the facility failed to provide evidence of a debriefing session, within 24 hours of a physical hold with staff involved (YCW #5, Shift Supervisor #1, and Youth Care Worker YCW #1) where the resident vomited during the hold, showed symptoms of physical and emotional distress, lapsed into an unconscious state, and died that day (07/17/2022 at 4:48 PM). Based on the findings, Immediate Jeopardy (IJ) was identified to exist on 07/17/2022 at regulatory violation N0128, when staff failed to implement Safe Crisis Management in a manner that prevented physical harm that led to the death of Resident #1 on 07/17/2022. The facility's Vice President of Regional Programming and Chief Operating

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N 000	Continued From page 2 Officer (COO) were notified of the IJ on 08/22/2022 and 1:14 PM.	N 000		
N 100	USE OF RESTRAINT AND SECLUSION CFR(s): 483.354 Subpart G: Condition of Participation for the Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age Twenty One. This CONDITION is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policies, it was determined the facility failed to comply with 42 Code of Federal Regulations (CFR) Part 483 Subpart G, the Condition of Participation for the use of restraint or seclusion in a Psychiatric Residential Treatment Facility (PRTF) that provides inpatient psychiatric services for individuals under the age of twenty-one (21). It was determined that two (2) staff members, Youth Care Worker (YCW) #5 and Shift Supervisor #1, failed to implement Safe Crisis Management (SCM), a physical hold, in accordance with the facility physical holding policy to prevent serious harm that resulted in the death of one (1) of ten (10) sampled residents, Resident #1. It was determined the facility failed to ensure the resident's treatment and behaviors support plans were revised after the Treatment Team met on on 07/12/2022, and determined that YCW #5 triggered Resident #1's attention-seeking behaviors resulted in him/her being secured in a physical hold by YCW#5. Even though Clinical	N 100	N 100 • Suspended Deborah Francis, Jillian Parks, and Amanda Whitlow as of 7/20/2022. Employment of Deborah Francis and Jillian Parks was terminated 8/19/2022. 8/19/22 • Immediate Jeopardy was identified on 7/17/22, and Bellewood and Brooklawn was notified on 8/22/22. Immediate Jeopardy was validated as removed on 9/6/22. In order to remove Immediate Jeopardy, the following measures were taken. Please note that any staff who failed to comply with these actions received corrective action. 9/6/22 ○ All cottage and clinical staff were compliant with required annual three (3) hour Safe Crisis Management (SCM) Recertification Training, which included how to safely execute a standing and kneeling cradle hold by September 1, 2022. 9/1/22 ○ All existing staff also completed the following additional required trainings by September 6, 2022: 9/6/22 ▪ *Appropriate Responses to Emergency Safety Situations* ▪ *Speak Up for Client Safety* ▪ *Hand-Off Communication* Continued on next page	

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N 100	Continued From page 3 Staff directed YCW #5 to disinvolve herself with any future holds for Resident #1, she was the first staff person to enter the resident's room, and secure him/her final hold on 07/17/2022. In addition, it was determined the facility failed to protect Resident #1 from unapproved seclusionary time-out for an extended period of time from 8:00 AM-2:25 PM on 0717/2022, when Shift Supervisor #1 decided the resident must remain in his/her room, and not participate in the milieu with other residents and activities. The was because the night shift staff informed the Shift Supervisor #1 that the resident had threatened other residents and hit staff during the night. However, via interview with night shift staff and per review of camera coverage of the milieu, there was no evidence the resident inflicted harm on himself/herself or others at the cottage during the early morning hours of 07/17/2022. It was determined the facility failed to protect Resident #1 from an unnecessary Emergency Safety Intervention (a physical hold) on 07/17/2022 at 2:25 PM. Interview with YCW #1, an eyewitness, revealed Resident #1 had not placed himself/herself or others in harms way before he/she was secured in a standing to kneeling cradle hold by YCW#5 and Shift Supervisor #1. It was determined the facility failed to ensure staff monitored and addressed Resident #1's physical and psychosocial indicators of distress (vomiting and crying) before he/she became unresponsive and lapsed into an unconscious state and required CPR, as a result of a physical hold implemented on 07/17/2022 at 2:25 PM. In addition, it was determined that staff was not immediately outside Resident #1's bedroom from 8:00 AM to 2:25 PM, continuously assessing the resident after Shift Supervisor #1 decided to keep Resident #1 in his/her bedroom, and out of the	N 100	These trainings included information on how to safely and effectively interact with youth, especially during challenging or potentially unsafe situations. Further, specific steps were provided related to communicating and reporting any inappropriate, unsafe, or countertherapeutic behaviors exhibited by staff, especially those that do not show respect for human dignity, individuality, or cultural and personal beliefs, as well as any forms of abuse and neglect including verbal, mental, physical, and sexual abuse. Completion of and compliance with these additional trainings was recorded in each staff's training record via the Relias Learning Management System. o All cottage and clinical staff remain up to date with Safe Crisis Management (SCM) refreshers per policy. Attendance and compliance is recorded in each staff's training record via the Relias Learning Management System.	9/1/22 8/15/22 8/15/22

o All cottage and clinical staff reviewed and attested in writing to understand the Medical Tip Sheet and do's and don'ts specific to physical holds authored by the agency Medical Director by August 15, 2022.

o All cottage and clinical staff reviewed and attested to the review and understanding of the following policies and procedures by August 15, 2022:
- *Clients Rights and Responsibilities and Appendix Youth Rights*
- *Grievances- Resolving Client Complaints*

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N 100	Continued From page 4 milieu, because she said staff reported Resident #1 had acted up (misbehaved) during the early morning hours of 07/17/2022. It was determined the facility failed to ensure staff did not prevent Resident #1 from leaving the time-out room hallway on 07/09/2022 when YCW #5 physically blocked the door back into the milieu when the resident tried to open the door to enter the milieu. It was determined the facility failed to provide evidence of a debriefing session, within twenty-four (24) hours with YCW#5, Shift Supervisor #1, and YCW#1 who were on duty on 07/17/2022 when Resident #1 was secured in a hold by YCW #5 and Shift Supervisor #1, vomited, cried and then lapsed into an unconscious state, required CPR, and was transferred to a local Emergency Department where he expired on that same day at 4:48 PM. Immediate Jeopardy was identified to exist on 07/17/2022. The facility's Vice President of Regional Programming, and the Chief Operating Officer (COO) were notified of the IJ on 08/22/2022 at 1:14 PM. The facility provided an acceptable IJ removal plan on 09/04/2022 alleging removal of the IJ by 09/06/2022. The State Survey Agency validated removal of the IJ on 09/06/2022, as alleged. 1. All cottage and clinical staff will be compliant with the required three (3) hours Recertification Training including how to safely execute a standing and kneeling cradle hold no later than September 1, 2022. -Training Director will be responsible for tracking compliance and documentation to support compliance. -Vice President will review progress and assist in troubleshooting any issues	N 100	Continued from page 4 • *Reporting Abuse, Neglect or Exploitation* • *Physical Holding of Youth* • *Seclusion of Youth* Existing staff completed written test on the information included in these policies. Completion and compliance is recorded in each staff's training record via the Relias Learning Management System. ○ All cottage and clinical staff were educated and attested to an understanding of a Zero Hold philosophy. Existing staff completed a test on understanding of this philosophy by September 06, 2022.	9/6/22
			○ Training was provided for all cottage and clinical staff that covered: 1. when it is appropriate to initiate a physical hold; 2. when it is appropriate to initiate a seclusion, including appropriate levels of initial and continuation authorization; 3. when it is appropriate to initiate exclusionary time out, including appropriate levels of initial and continuation authorization; 4. how to respond to medical emergencies, including but not limit to how to intervene appropriately for youth who have potential adverse reactions. All staff attested to understanding the information provided, and all staff completed a written test as part of this training. Continued on next page	9/2/22

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USPIRITUS-BROOKLAWN-PILOTS	2108 DAVID GRAVES DRIVE LOUISVILLE, KY 40218

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N 100	Continued From page 5 2. All cottage and clinical staff will remain up to date with monthly SCM refreshers. Training Director will be responsible for tracking compliance and documentation to support compliance. 3. All cottage and clinical staff were informed to review and attest in writing to understand the Medical Tip Sheet and do's and don'ts specific to physical holds authored by the agency medical director no later than August 15, 2022. 4. All cottage and clinical staff were informed to review and attest to review and understanding the following policies and procedures (completed August 15, 2022): Appendix Clients rights and Responsibilities and Youth rights Grievances- Resolving Client Complaints Reporting Abuse, Neglect or Exploitation Physical Holding of Youth Seclusion of Youth Existing staff will complete test on the information included in the policies. New staff will receive information and complete test during orientation. For the above items disciplinary action will occur, up to and including termination if staff do not complete and follow the action items. Residential Director, Assistant Residential Director, Clinical Director, Assistant Clinical Director, and Residential Managers will oversee their respective direct reports follow through on expectations with oversight by the Vice President. A Human Resource Manager will be consulted and included in the decision making, as well. 5. All clinical and cottage staff were educated and attested to an understanding of a Zero Hold	N 100	○ A facilitator and implementation team was identified for Six Core Strategies for Reduction of Seclusion and Restraint project implementation. The Six Core Strategy Steering Committee/Leadership Subcommittee met for the first time on September 27, 2022. On November 17, 2022, the Prevention Tools and Debriefing Subcommittees met for the first time. The Data Subcommittee is scheduled to meet for the first time on January 4, 2023. ○ Began daily reviews of all Emergency Safety Physical Interventions (ESPI) on business days and weekends/holidays if necessary and thrice-weekly reviews of resident grievances to determine, in addition to any safety concerns, whether any youth rights are violated. These include document and video reviews, when available. Any violations or concerns noted are documented, and the information is shared with the staff's supervisor for follow-up, which may include additional coaching, training, or disciplinary action, up to and including termination of employment. In addition, the review information is distributed to the executive team and Bellewood and Brooklawn residential, clinical, and quality leaders. Ongoing monitoring/compliance procedures: • Updated Youth Rights document to include specific language emphasizing that youth should be free from any type of shame, ridicule, or humiliation (see attachment). This is posted in every living unit and given to youth (and their guardians) at admission. Continued on next page	9/4/22 9/1/22 Revised 12/8/22

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N 100	Continued From page 6 philosophy: -Existing Staff will complete test on understanding of this philosophy by September 06, 2022. New staff will receive information and complete test during orientation. Yearly refresher will be provided and will be tracked by the Training Director. -Quality Assurance will be monitored during incident report review of all physical holds. 6. A facilitator and implementation team have been identified for Six Core Strategies for Reduction of Seclusion and Restraint project implementation. -This evidence-based practice dictates the makeup of steering committee as indicated in the document title "Six Core Strategies for Reduction of Seclusion and Restraint, "The Steering Committee will be made up of executive and senior leadership staff that have significant years of experience in areas such as but not limited to leadership, clinical work, compliance and trauma. 7. Day Shift Supervisor #1 and Youth Care Worker #5 were put on paid leave on July 20, 2022 and subsequently terminated on August 19, 2022. Youth care worker #1 was put on paid leave July 20, 2022 pending final outcomes from LMPD and Crimes Against Children death investigation and the OIG continued investigation. If/when Youth Care Worker #1 returns to work, she will be required to be current on SCM Recertification, any needed SCM refreshers, attest and complete the tests before being allowed to work. 8. A training will be developed and for all cottage and clinical staff to be retrained and staff attesting to understanding and requirement to follow this	N 100	• Monthly Safe Crisis Management (SCM) Refreshers (1 hr) and annual Safe Crisis Management (SCM) recertification (4 hrs) – includes review of Youth Rights and how to sensitively and effectively work with youth, especially when addressing particularly challenging or sensitive issues; this will include emphasizing that shame, humiliation, and/or ridicule is countertherapeutic and is not an acceptable intervention tool. Completion of all refreshers and annual Safe Crisis Management (SCM) recertification is recorded in staff's training record via Relias Learning Management System. • *Appropriate Responses to Emergency Safety Situations*; *Speak Up for Client Safety*; and *Hand-Off Communication*. These trainings will be completed by all new staff during New Hire Orientation, within the first three (3) weeks of employment, and before working with youth. These trainings include information on how to safely and effectively interact with youth, especially during challenging or potentially unsafe situations. Further, specific steps are provided related to communicating and reporting any inappropriate, unsafe, or countertherapeutic behaviors exhibited by staff, especially those that do not show respect for human dignity, individuality, or cultural and personal beliefs, as well as any forms of abuse and neglect including verbal, mental, physical, and sexual abuse. All existing staff will complete these trainings on an annual basis, to be completed by 9/15 each year. Completion of and compliance with these trainings is recorded in each staff's training record via the Relias Learning Management System. Staff cannot begin work nor continue work with youth until demonstrating understanding of these concepts. Continued on next page	9/1/22 9/15/22

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N 100	Continued From page 7 information by September: when is in appropriate to initiate a physical hold: when it is appropriate to initiate a seclusion, including appropriate levels of initial and continuation authorization: when it is appropriate to intimate exclusionary time out, including appropriate levels of initial and continuation authorization; how to respond to medical emergencies, including but not limit to how to intervene appropriately for youth who have potential adverse reactions. 9. Existing staff completed a test as part of this training. New staff will receive information and complete test during orientation. Yearly refresher to be provided and will be tracked by he Training Director. 10. All cottage clinical staff will be trained to and attest to understanding and requirement to follow the policy on Hand-Off Communication by September 6, 2022. Yearly refresher to be provided and will be tracked by the Training Director. A policy on seeking support and intervention ("Speak Up for Client Safety-Intervening and Escalating Concerns," including when actions of co-workers or supervisors is not appropriate and in line with current policy, is being developed. All cottage and clinical staff will be trained to this policy and attest to understanding and the requirement to follow no later than September 06, 2022. Existing Staff will complete a test on the information in the policy to be completed by September 06, 2022. New staff will receive the information and complete a test during orientation. Yearly refreshers will be provided and tracked by the Training Director.	N 100	• *Zero Hold Philosophy Training: 6 Core Strategies* – New staff will receive information and complete test during new employee orientation, and yearly refreshers will be provided for all cottage and clinical staff by 9/15 of each year. Completion and compliance will be recorded in each staff's training record via the Relias Learning Management System. • Continue daily reviews of all Emergency Safety Physical Interventions (ESPI) on business days and weekends/holidays if necessary and thrice-weekly reviews of resident grievances which are conducted to determine, in addition to any safety concerns, whether any youth rights are violated. These include document and video reviews, when available. Any violations or concerns noted are documented, and the information is shared with the staff's supervisor for follow-up, which may include additional coaching, training, or disciplinary action, up to and including termination of employment. In addition, the review information is distributed to the executive team and Bellewood and Brooklawn residential, clinical, and quality leaders.	8/3/22 9/1/22

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N 100	Continued From page 8 11. All physical holds will be reviewed by leadership to determine any corrective action and/or training needs. 12. All physical hold data will be disseminated to leadership daily (M-F) instead of monthly, for ongoing review and determination of any additional action needed. 13. All clinical team meetings and residential managers' meetings will include review and reminders of procedures indicated above. This will be reflected in meeting minutes. 14. The VP will be responsible for all oversight and monitoring of all action items. This will include but not limited to: ongoing observations in cottage and written feedback, which is part of PEM model including utilizing the observation feedback form; ongoing supervision regarding performance and compliance with procedures and training. In addition, SCM refreshers have skill demonstration built in the model and training course.	N 100		
N 115	INDIVIDUAL PLAN OF CARE CFR(s): 441.155(c) The plan must be reviewed every 30 days by the team specified in §441.156 to- (1) Determine the services being provided are or were required on an inpatient basis, and (2) Recommend changes in the plan as indicated by the beneficiary's overall adjustment as an inpatient. (d) The development and review of the plan of care as specified in this section satisfies the utilization control requirements for - [paragraph and subparagraphs (1) and (2) relevant for	N 115	N 115 • All clinical staff are to review and update changes on the treatment plans and Behavior Support Plans depending on notated changes to clinical needs, triggers, or coping strategies spoken about in treatment team or other designated meetings or conversations. Continued on next page	Reminded 12/9/22

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N 115	Continued From page 9 utilization control hospitals only] This ELEMENT is not met as evidenced by: Based on interview, clinical record, policy review, and camera footage of the cottage, it was determined the facility failed to revise the Treatment Plan and Behavior Support Plan, for one (1) of ten (10) sampled residents, Resident #1. Record review and interview revealed the Treatment Team met and discussed three (3) Emergency Safety Interventions (recent physical holds), and determined Youth Care Worker (YCW) #5 had been involved in all three holds on 07/01/2022, 07/08/2022, and 07/09/2022. Interviews revealed the Treatment Team decided YCW #5 "triggered" Resident #1's behaviors. Resident #1's Residential Therapist, and the Residential Manager where Resident #1 lived, told YCW #5 to not secure Resident #1 in physical holds. However, interview revealed YCW #5 was the first staff person to enter Resident #1's room on 07/17/2022 at 2:25 PM and placed Resident #1 in a hold. Shortly afterward, Shift Supervisor #1 entered the resident's bedroom and took over the hold. Per interview, Shift Supervisor #1 said she did so because YCW #5 had been directed to not place Resident #1 in a physical hold. Interviews revealed YCW #5 did not leave Resident #1's room but remained and continued to assist by holding the resident's legs. Review of the resident's Behavior Support Plan, dated 06/22/2022 and the Outpatient Treatment	N 115	• In the discussion of cases in weekly clinical supervisions with clinical supervisor the Behaviors Support Plan will be discussed to ensure they are being updated as needed to include changes in triggers and coping skills. The Behavior Support plan will be updated if there are situations impacting the youth's treatment success. For example, the impact of Emergency Safety Physical Interventions, such as physical holds with particular youth care workers. If triggers are observed to be significant while in the treatment facility, the Behavior Support Plan will be updated the same day in the triggers section. • Primary Therapists and program managers will review the updated Behavioral Support Plan during their weekly consultations (i.e. the Oak program manager meets with the Oak therapist each week). • Once updated the therapist will share the Behavior Support Plan with the program manager of that particular cottage and cottage staff. • Facility policy, CS-004 Assessment, Treatment Planning and Reassessment, states each client at the facility has an evaluation that gathers sufficient information for development of recommendations for services, an individualized treatment plan of care, and reassessments to inform ongoing treatment needs. This policy will be reviewed in clinical meeting annually at the beginning of the fiscal year and signed by all current clinicians. It will also be reviewed by incoming clinicians during onboarding. The organization will ensure provision of a comprehensive evaluation of the youth with the oversight of the Clinical Director to include key needs in assessment.	12/12/22 12/12/22 12/12/22 12/15/22

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N 115	Continued From page 10 Plan, dated 06/28/2022, revealed there was no evidence the facility revised the plan to reflect the decisions made and conveyed to YCW #5 to not place Resident #1 in a hold. During the hold on 07/17/2022, in which YCW #5 continued to participate in after Supervisor #1 entered and took over the kneeling cradle hold, the resident lapsed into an unconscious state, and eventually required Cardiopulmonary Resuscitation (CPR) and subsequent transfer to the hospital for advanced life support. The resident did not recover, and was pronounced deceased on 07/17/2022 at 4:48 PM. The findings include: Review of the facility policy, titled Assessment, Treatment Planning and Reassessment, Policy Number: CS004, dated 06/02/2021, revealed each client (resident at the facility) had an evaluation that gathered sufficient information for development of recommendations for services, and an individualized treatment plan of care, and reassessments to inform ongoing treatment needs. Further review of the policy revealed the organization ensured provision of a comprehensive evaluation of the clients. The purpose of the evaluation was to clarify and identify the client's principle reasons for obtaining services. According to the policy, the evaluation drove the development of the individualized treatment plan with the client and his/her family, as indicated. Reassessment was a process that occurred with contacts and services ongoing. Structured reassessments and treatment plan reviews were completed at defined intervals in order to ensure the client continued to meet need for services provided and that adjustments were made in the treatment plan as treatment	N 115		

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N 115	Continued From page 11 progressed toward discharge based on the individual's response to treatment and/or additional identified needs. Client was defined in the policy as the individual which included "youth" (residents) at the facility. Review of the facility policy, titled Assessment, Treatment, Planning and Reassessment, Policy: CS-004C, last review date, April 12,2022, revealed in Subtitle, Screening and Evaluation, once a youth was admitted to a residential program, the Initial Plan of Care and Behavior Support Plan would be initiated by the Director of Admissions, and would be completed by the therapist within in twenty-four (24) hours of admission and reviewed, signed and dated by the clinician. The Behavior Support Plan (BSP), would include situational triggers and crisis triggers, techniques identified by the youth /family that would help control their behavior and techniques that would assist in minimizing the use of physical holds/seclusions. In addition, the behavioral support plan will include any history of sexual or physical abuse or other trauma that would be a significant emotional trigger for youth placed in physical hold/seclusion. The evaluation process would include multiple assessments, including medical, psychiatric, and psychosocial, trauma and any additional assessments, as indicated. According to the policy, upon completion of the assessments, an individualized treatment plan would be developed by the multi-disciplinary team within ten (10) days of admission to the PRTF programs. Continued review of the policy revealed the Individual Treatment Plan would be assessed every thirty (30) days to evaluate the appropriateness of continued treatment, progress on goals and objectives, and the need for revisions to the plan.	N 115		

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N 115	Continued From page 12 In addition, the Behavior Support Plan would be reviewed and updated as necessary. When/if the child (resident) is not making satisfactory progress in the treatment program, the treatment team will ultilize a multi-disciplinary approach to improve the treatment for that child (resident). This is usually done during the scheduled treatment team meetings but can take place during a Behavioral Support Meeting. Review of Resident #1's Comprehensive Assessment, dated 06/22/2022, revealed the Psychiatric Residential Treatment Facility (PRTF) admitted the resident on 06/22/2022, from an inpatient psychiatric hospital. According to the Assessment, the resident had a history of aggressive and sexually acting out behaviors while in the care of foster parents. Resident #1's foster mother reported the resident was destructive, disruptive, and aggressive with adults and peers. Continued review revealed the resident reportedly lacked empathy and engaged in animal cruelty while in foster care, and the family could no longer take care of him/her. Review of the Face Sheet in Resident #1's clinical record revealed upon admission to the facility, the resident had a state appointed legal guardian. Review of Resident #1's Treatment Plan, dated 06/28/2022, electronically signed by the Resident's Therapist, on 06/30/2022, revealed three (3) problems were identified to include Attention-deficit hyperactivity disorder, unspecified type; Mild intellectual disabilities; and Post-Traumatic Stress Disorder (PTSD). The plan included goals, objectives, and interventions, for each identified problem. Even though the plan provided goals and objectives to assist the resident in processing his/her trauma history,	N 115		

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N 115	Continued From page 13 there was no evidence the plan addressed the impact of Emergency Safety Interventions (ESIs), such as physical holds. There was no evidence the Treatment Plan was modified as result of the decisions made at a 07/12/2022 Treatment Team Meeting to keep YCW #5 from securing Resident #1 in a hold, as it was determined during the meeting she triggered some of Resident #1's negative behaviors/responses. Review of Resident #1's Behavior Support Plan (BSP), dated 06/22/2022, revealed situational triggers included trauma history, attending school, not getting his/her way, and separation from his/her siblings. Symptoms or behaviors which occurred just before crisis (crisis triggers) included defiance, and threatening and aggressive behavior. Further review, under the subheading, "Identify any history of sexual or physical abuse or other traumas that would be a significant emotional trigger if the youth was placed in a hold," a history of neglect and abandonment was documented. The Trauma History subheading of the BSP revealed the resident had been emotionally abused, neglected prior to age four (4), and had witnessed community violence including drug use, prostitution, and unsafe lifestyles. Interview, on 10/21/2022 at 1:10 PM with Department of Community Based Services (DCBS) Social Worker #2, who was one of Resident #1's case workers prior to his/her admission to the PRTF, revealed Resident #1 lived in a homeless shelter with his/her mother and two (2) brothers. She stated since they were not allowed to stay in the shelter during the day, his/her mother would take Resident #1 and his/her siblings to a mall. Resident #1's mother	N 115		

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N 115	Continued From page 14 reportedly did not supervise the children, and one day Resident #1 starting driving an All Terrain Vehicle (ATV) in the mall, ended up hitting a pedestrian and driving through a glass window because his/her mother was not supervising him/her. According to DCBS Worker #2 Resident #1's mother just laughed at the incident, but store owners at the mall notified the police. Law enforcement arrested Resident #1's mother, and Resident #1 and his/her siblings were placed in state custody. Social Worker #2 said afterwards Resident #1 was admitted to several different psychiatric and/or residential care facilities related to his/her dysfunctional behaviors. Further review of the BSP, revealed there was no evidence the plan was updated/modified after the 07/12/2022 Treatment Team's determination that YCW #5 triggered Resident #1's behaviors, and should therefore avoid becoming involved in holds for Resident #1. Review of Resident #1's clinical record, revealed the resident was placed in three (3) holds at his/her residential cottage prior to the final hold that occurred on 07/17/2022. The holds occurred on 07/01/2022, 07/08/2022, and 07/09/2022. Review of all three (3) Physical Hold Seclusion Reports, revealed YCW #5 was listed as the staff person who implemented all 3 holds. Review of the Resident Youth Physical Hold Seclusion Report, for a hold that occurred on 07/01/2022 at 07:19 AM, revealed YCW #5 secured Resident #1 in a hold in the cottage restroom for fighting and assault. According to the report, YCW #5 initiated a standing hold after Resident #1 assaulted her when she tried to offer choice and concern comments because the	N 115		

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resident did not abide by the rules for asking permission to go to the cottage bathroom. The report revealed the resident assaulted YCW #5, and she secured the resident in a single supine hold. According to the report, YCWs #7 and #9 came to the restroom and assisted YCW #5; and the resident was released from the hold at 7:29 AM.

Review of the Residential Youth Physical Hold Seclusion Report for a hold that occurred on 07/08/2022 at 11:32 AM, revealed YCW #5 again secured Resident #1 in a physical hold because the resident stated he/she was not going to sit and color with peers anymore. After choice and expectation statements of change were made by staff to avoid any negative consequences the resident refused to comply and ran around the table and threw his/her markers. According to the report, after several attempts to talk with the resident as he/she continued to run around the milieu throwing blocks, and attempting to climb on a table, the resident continued to refuse to listen to direction provided by YCW #5. The resident finally ran into a timeout room. Per the report, YCW #5 tried to use proximity control (reducing physical distance between the staff and the resident), while they were in the hallway where the timeout rooms were located, but the resident hit YCW #5 and then YCW #5 secured the resident in a supine torso hold at 11:34 AM.

Review of a hold summary dated 07/09/2022, revealed during choir practice in the milieu, Resident #1 got upset with a peer and yelled at him/her. Resident #1 walked to the timeout room by himself/herself. While there, the resident hit walls and yelled. YCW #5 stayed near the resident and gave him/her an expectation to go to

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USPIRITUS-BROOKLAWN-PILOTS	2108 DAVID GRAVES DRIVE LOUISVILLE, KY 40218

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N 115	Continued From page 16 the timeout room. The resident continued to yell and hit walls in the time out room. According to the report, when the resident did not get the attention he wanted, he/she started to hit YCW #5 and YCW #5 secured the resident in a supine torso at 6:39 PM. Review of camera footage of Resident #1 and YCW #5 together in the timeout room hallway on 07/09/2022 at 6:39 PM to 6:41 PM, revealed Resident #1 wanted to return through a hallway door to the milieu. The resident was trying to leave the hallway and enter the milieu. However, YCW #5 blocked the door while sitting in a rolling chair. The resident tried several times to open the door, but when unable to do so he/she struck YCW #5 three (3) times. YCW #5 then got up and secured Resident #1 in a supine torso hold on a dark colored throw rug in the hallway where the timeout rooms were located. According to the camera coverage time-stamp, the hold ended at 6:44 PM, when Shift Supervisor #1 entered the timeout room hallway, and walked with Resident #1 to a timeout room. Review, of the Youth Holds/Seclusion Report for Resident #1's hold of 07/17/2022, that began at 2:25 PM and ended time 2:35 PM, revealed Resident #1 repeatedly opened his/her door during the staff debriefing that started about 2:00 PM. YCW #5 and YCW #1 gave the resident the expectation to stay in his/her room during the debriefing, but the resident refused and started to leave his/her room. YCW #5 and YCW #1 used proximity control while using expectations for change. According to the report, YCW #5 and YCW #1 approached the resident in his/her room, and he/she started threatening to assault staff and yelled at the staff. Resident #1 aggressively	N 115		

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N 115	Continued From page 17 charged at YCW #5 and she attempted to secure the resident in a standing cradle hold, but while the resident tried to to pull away, both Resident #1 and YCW #5 lost their balance and sat down on the floor. Once on the floor, YCW #5 secured the resident in a kneeling cradle hold, and YCW #1 secured the resident's lower extremities. YCW #5 prompted Resident #1 to use Safe Crisis Management Strategies (SCS), and YCW #1 used empathy statements. Further review revealed Shift Supervisor #1 entered the resident's room and took over the hold, YCW #5 assumed securing of the resident's legs and feet, and YCW #1 stepped away from the hold. According to the summary, the resident vomited while in the seated cradle hold. According to the report, Shift Supervisor #1 and YCW #1 assumed that occurred because the resident had eaten lunch shortly before the hold was implemented. Interview, on 07/19/2022 at 7:19 PM with Shift Supervisor #1 revealed she took the resident his/her lunch at approximately 1:30 PM on 07/17/2022. Review of the camera coverage of the milieu and Resident #1's bedroom door, revealed Shift Supervisor #1 took Resident #1's lunch tray to his/her door on 07/17/2022 at 1:44 PM. Review of the Treatment Team Note, dated 07/12/2022, revealed the facility admitted Resident #1 on 06/22/2022 for aggression. The resident had a history of animal cruelty, and a personal history of neglect, suspected exposure to Domestic Violence (DV), and sexual abuse in his/her primary home. Review of the Team Meeting Attendees, revealed the Therapist, the Residential Program Manager, the Campus	N 115		

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N 115	Continued From page 18 Registered Nurse (RN), the Care Navigator, and the resident's Psychiatrist attended the meeting. The note stated Resident #1's behavioral triggers were discussed. According to the note, if the resident was told no, or was not allowed to do what he/she wanted when he/she wanted to, that triggered his/her behaviors. It was also noted Resident #1 knew how to temper his/her behaviors based on who (staff) was at the cottage, and if the resident thought he/she could get away with more. The note revealed when YCW #5 ignored Resident #1, the resident hit or charged at YCW #5, which caused a hold. When the resident threatened, spat at, or hit YCW #5 but there was no reaction, the resident became confused. However, when YCW #5 secured the resident in a hold, at times he/she would pinch or try to bite YCW #5 in the chest. However, as soon as another staff was heard coming, the resident calmed down, and then he/she would be released from the hold. Interview, on 08/10/2022 at 12:26 PM with Resident #1's Residential Therapist, revealed the Treatment Team met on 07/12/2022, and reviewed the resident's recent holds that occurred on 07/01/2022, 07/08/2022, and 07/09/2022, and determined YCW #5 triggered Resident #1's behaviors which ended with securing the resident in a hold. She said the team met with YCW #5 after the meeting because she said we thought Resident #1, was seeking out YCW#5 to be held. She stated she told YCW #5 she should avoid becoming involved in holds for Resident #1, because she triggered some of his/her behaviors. The Residential Therapist said YCW #5 expressed understanding and agreed with the plan. Resident #1's therapist stated she thought Residential Manager #1 talked with YCW #5	N 115		

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N 115	Continued From page 19 about re-assigning her to another cottage, but she was not involved in that conversation. Interview, on 08/01/2022 at 7:17 PM with Shift Supervisor #1, revealed on 07/17/2022, when she entered Resident #1's room, and saw YCW #5 had secured the resident in a hold, she told YCW #5 to move and she would take over the hold. Shift Supervisor #1 said she did so because YCW #5 had been recently directed to not secure Resident #1 in a hold because the resident targeted her, and he/she wanted to be held by YCW #5. Interview, on 07/29/2022 at 2:49 PM with the Residential Manager #1, revealed he had a conversation with YCW #5, on 07/14/2022, because the Treatment Team determined YCW #5 triggered some of Resident #1's behaviors. He said he instructed YCW #5 to not secure Resident #1 in a hold, but step away and allow other staff to intervene. He said he explained every resident was unique and had a treatment plan to address how to best care for them, and since Resident #1 had issues with her, she should avoid securing him/her in a hold. Residential Manager #1 stated he told YCW #5 that if a hold lasted less than five (5) minutes, it was unlikely the hold was necessary, and other methods should be used to de-escalate the situation. Residential Manager #1 said YCW #5 expressed understanding, and asked if there was anything else she needed to know. He stated his response was to be stern but fair when interacting with the residents. He said he told YCW #5 that if Resident #1 punched her, she should remember he/she is just seven (7), and a teaching conversation with the resident might suffice, rather than securing him/her in a hold.	N 115		

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N 115	Continued From page 20 Interview, on 08/22/2022 at 10:00 AM, with the Director of Training and Professional Development, revealed Resident #1's Residential Therapist nor Residential Manager #1 contacted him regarding their identified concerns with YCW #5's approach with Resident #1 and the recent series of holds she implemented prior to the final hold on 07/17/2022. He said he was not asked nor was he directed to increase monitoring of YCW #5, and/or provide her with additional education on physical holding and other SCM strategies. The Director of Training and Professional Development stated if management identified there was not a therapeutic relationship between Resident #1 and YCW #5, then they should have gotten to the bottom of what was causing the issue. He said one strategy would have been to minimize the staff person's contact with the resident, and if possible, do not permit the staff person to work with the resident. Interview on 08/05/2022 at 11:10 AM, with Resident #1's psychiatrist, revealed he attended the Treatment Team meeting on 07/12/2022, and learned Resident #1 had been in a series of recent holds. He stated one of the things staff brought to his attention was the holds generally occurred with the same female staff, and some of them were on the weekends. He said we examined what was going on with the resident and the female staff member, and wondered if it could be a dynamic of Resident #1's known past trauma. He stated we tried to drill down and determine what was triggering his/her response to YCW #5. Resident #1's psychiatrist stated the female staff member may have reminded the resident of someone in his/her past. He stated the team discussed preventing YCW #5 from	N 115		

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N 115	Continued From page 21 becoming involved in any of Resident #1's future holds. Interview, on 08/22/2022 at 12:20 PM with the Division Director, revealed Residential Manager #1 informed her of the conversation he had with YCW #5 about Resident #1 seeking her out for attention which ultimately ended in physical holding, and that he directed YCW #5 to not become involved in any of Resident #1's physical holds after theTreatment Team meeting that occurred on 07/12/2022. The Division Director stated Residential Manager #1 told her that he directed YCW #5 to let other staff implement the holding of Resident #1, if that became necessary. In terms of monitoring the cottage, The Division Director said she made scheduled rounds and visited the cottages when opportunities arose, but she had not identified any concerns with how Staff treated Resident #1 during his/her stay at the facility. Interview, on 08/22/2022 at 10:15 AM with the Vice President (VP) of Residential Services, revealed prior to Resident #1's final hold on 07/17/2022, she was not informed of any concerns Residential Manager #1 or Residential Therapist #1 had with the patterns of holds for Resident #1, in that they were all implemented by YCW #5. She stated she would not typically learn of those concerns unless there was a need for disciplinary action. The VP of Residential Services stated if the Residential Cottage Manager had concerns, he should have contacted The Division Director or Assistant Division Director. She stated if Residential Manager #1 gave YCW #5 specific direction to do or to not do something in the best interest of the resident, and the staff member did not comply,	N 115		

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N 115	Continued From page 22 then that should have been reported to the Division Director or Assistant Division Director. She stated if she had known there were concerns with YCW #5's or Shift Supervisor #1's performance, she would have wanted to make sure the staff directives were clear, that there was a clear plan for follow up, and a plan for what would occur next if the instruction had been effective, or if the staff had not complied with direction given by the Residential Manager. She stated after the 07/17/2022, incident she was told Residential Manager #1 and Resident #1's Residential Therapist (#1) had concerns about the pattern of holds implemented by YCW #5, and that the staff member was directed to avoid holds with Resident #1. She said the direction given was that if it looked like a hold was needed, then another staff at the cottage should take the lead. However, the VP of Residential Services said she was not aware of specific of details of those conversations with YCW #5. She said she was unsure if there were changes to the resident's treatment plan after the Treatment Team met on 07/12/2022. .	N 115		
N 126	PROTECTION OF RESIDENTS CFR(s): 483.356 (a)(1) Each resident has the right to be free from restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation.	N 126	N 126 • Suspended Deborah Francis, Jillian Parks, and Amanda Whitlow as of 7/20/2022. Employment of Deborah Francis and Jillian Parks was terminated 8/19/2022. • Please note that staff who failed to comply with these actions below received corrective action. Continued on next page	8/19/22

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N 126	Continued From page 23 This ELEMENT is not met as evidenced by: Based on review of the facility's video recorded footage of the interior of the Residential Cottage and the doorway to Resident #1's bedroom, facility policy review, and staff and resident interviews, it was determined the facility failed to protect one (1) of ten (10) sampled residents from unapproved seclusionary time-out for an extended period-of-time on 07/17/2022 from 8:00 AM to approximately 2:25 PM. Per interview, Shift Supervisor #1 stated she did not seek prior approval, but determined Resident #1 should stay in his/her bedroom for the first shift due to a report from night shift staff that the resident acted up during the early morning hours. In addition, interview with Youth Care Worker (YCW) #1 who worked the day shift at the cottage on 07/17/2022, Shift Supervisor #1 said Resident #1 ruined her church day, and that she was going to put Resident #1 in a hold, make him/her throw up, and that the resident was going to have a bad day. The findings include: Review of the facility policy, titled Seclusion of Youth, Policy Number: CS-058, last review date, 07/14/2022, revealed the use of seclusion would be under the ultimate direction of the treating psychiatrist. Use of seclusion should be based on history of the youth or solely on a history of dangerous behavior. Seclusion should not be used for the purpose of coercion, discipline, convenience or retaliation by staff. Seclusion should only be used when nonphysical and physical interventions have been ineffective or not viable and when there was an imminent risk of a	N 126	• All existing staff completed the following trainings by September 6, 2022: ○ *Appropriate Responses to Emergency Safety Situations* ○ *Speak Up for Client Safety* ○ *Hand-Off Communication* These trainings included information on how to safely and effectively interact with youth, especially during challenging or potentially unsafe situations. Further, specific steps are provided related to communicating and reporting any inappropriate, unsafe, or countertherapeutic behaviors exhibited by staff, especially those that do not show respect for human dignity, individuality, or cultural and personal beliefs, as well as any forms of abuse and neglect including verbal, mental, physical, and sexual abuse. These trainings also include specific education outlining the circumstances under when it is appropriate to initiate seclusion or exclusionary timeout, the process for obtaining authorization for use of seclusion or exclusionary timeout, time limits for use of seclusion or exclusionary timeout based on age of resident, requirements for monitoring and documentation during seclusion or exclusionary timeout, and the process for termination and debriefing the use of seclusion or exclusionary timeout. Completion of and compliance with these trainings was recorded in each staff's training record via the Relias Learning Management System. • All cottage and clinical staff reviewed and attested to the review and understanding of the following policies and procedures by August 15, 2022: ○ *Clients Rights and Responsibilities and Appendix Youth Rights* ○ *Grievances- Resolving Client Complaints* Continued on next page	9/6/22 8/15/22

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N 126	Continued From page 24 youth physically harming self, staff or others. Under the procedure subsection, the following steps were listed: Staff was to monitor the duration of seclusion, so as not to exceed the maximum duration allowed based on the age of the youth, for a youth 7-8 years old, one (1) hour. If seclusion needs to extend beyond the maximum time limit, then staff should contact the Clinical Consultant to provide a continuation order. According to the policy, one staff member should be assigned to monitor the events of the intervention, and the physical well-being and the psychological impact of the intervention on the youth (resident). Ensure staff immediately report any undesirable medical effects from seclusion to Nursing Staff and record in the resident's electronic health record (EHR). Ensure assigned staff maintain constant visual contact with the youth placed in seclusion, and under no circumstances should a youth remain in seclusion without a staff member present in the observation area. Ensure assigned staff document the youth's behavior and activity level on the Seclusion Chart throughout the youth's placement in seclusion at every five (5) minute intervals. In addition, ensure staff assess at the initiation of seclusion and every 15 minutes thereafter for the following: signs of injury, nutrition and hydration status, circulation and range of motion of extremities, vital signs, hygiene and elimination, physical and psychological status and comfort, and readiness for discontinuation of seclusion. Review of Resident #1's Comprehensive Assessment, dated 06/22/2022, revealed Psychiatric Residential Treatment Facility (PRTF) admitted the resident on 06/22/2022, from an inpatient psychiatric hospital.	N 126	○ *Reporting Abuse, Neglect or Exploitation* ○ *Physical Holding of Youth* ○ *Seclusion of Youth* Existing staff completed written test on the information included in these policies. Completion and compliance was recorded in each staff's training record via the Relias Learning Management System. • Training was provided for all cottage and clinical staff that covered: 1. when it is appropriate to initiate a physical hold; 2. when it is appropriate to initiate a seclusion, including appropriate levels of initial and continuation authorization; 3. when it is appropriate to initiate exclusionary time out, including appropriate levels of initial and continuation authorization (see attached policy); and 4. how to respond to medical emergencies, including but not limited to how to intervene appropriately for youth who have potential adverse reactions. All staff attested to understanding the information provided, and all staff completed a written test as part of this training. Completion and compliance is recorded in each staff's training record via the Relias Learning Management System.	9/2/22
			• A facilitator and implementation team was identified for Six Core Strategies for Reduction of Seclusion and Restraint project implementation. The Six Core Strategy Steering Committee/Leadership Subcommittee met for the first time on September 27, 2022. On November 17, 2022, the Prevention Tools and Debriefing Subcommittees met for the first time. The Data Subcommittee is scheduled to meet for the first time on January 4, 2023.	9/4/22
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N 126	Continued From page 25 Review of Resident #1's Treatment Plan, dated 06/28/2022, electronically signed by the Resident's Therapist, on 06/30/2022, revealed three (3) problems were identified to include Attention-deficit hyperactivity disorder, unspecified type; Mild intellectual disabilities; and Post-Traumatic Stress Disorder (PTSD). The plan included goals, objectives, and interventions, for each identified problem. Even though the plan provided goals and objectives to assist the resident in processing his/her trauma history, there was no evidence the plan addressed use of seclusionay time out as interventions for the identified problems nor to use unapproved seclusionary time out for an extended period-of-time. Review of facility provided video coverage of the cottage's common space with full view of Resident #1 bedroom door, on 07/17/2022, revealed staff did not stay nearby the resident's door, or frequently open the bedroom door to monitor his/her wellbeing from 8:00 AM until approximately 2:25 PM, when YCW #5 and YCW #1 entered the resident's room and closed the door. Review of the facility provided camera coverage of the cottage on 07/17/2022, revealed at 8:11 AM, Resident #1 was at his/her bedroom doorway, and seemed to speak briefly with Shift Supervisor #1. At 8:12 AM, Shift Supervisor #1 exited the cottage office, and entered Resident #1's bedroom. At 8:13 AM, Shift Supervisor #1 exited Resident #1's room. At 8:17 AM, YCW #6 was still seated in a rolling chair at Resident #1's door, and the cottage was still dark, no overhead lights on, but left at the end of her shift, about 8:30 AM. Resident #1 opened	N 126	• Began daily reviews of all Emergency Safety Physical Interventions (ESPI) and Seclusions on business days and weekends/holidays if necessary and thrice-weekly reviews of resident grievances to determine, in addition to any safety concerns, whether any youth rights are violated. These include document and video reviews, when available. Any violations or concerns noted are documented, and the information is shared with the staff's supervisor for follow-up, which may include additional coaching, training, or disciplinary action, up to and including termination of employment. In addition, the review information is distributed to the executive team and Bellewood and Brooklawn residential, clinical, and quality leaders. Ongoing monitoring/compliance procedures: • Monthly Safe Crisis Management (SCM) Refreshers (1 hr) and annual Safe Crisis Management (SCM) recertification (4 hrs) – includes review of Youth Rights and how to sensitively and effectively work with youth, especially when addressing particularly challenging or sensitive issues. Further, refreshers and recertifications will include the proper procedures related to the use of seclusion or exclusionary timeout. Completion of all refreshers and annual Safe Crisis Management (SCM) recertification is recorded in staff's training record via Relias Learning Management System. Continued on next page	9/1/22 9/1/22

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N 126	Continued From page 26 his/her door and stuck out his/her hand at 9:46 AM, 10:33 AM, 10:46 AM, 10:59 AM, 11:56 AM (resident was seen at his/her door wearing a yellow t-shirt and shorts), at 12:42 PM, and at 2:24 PM for the final time. At 12:15 PM, Shift Supervisor #1 went to Resident #1's door with folded clothing and a towel, waved the resident out of his/her room, said something to the other residents sitting at the dining table, and then took Resident #1 down the long hallway of the cottage. At 13:44 PM Shift Supervisor #1 took a red tray with food items into Resident #1's room. Resident #1 was not seen eating either meal (breakfast nor lunch) with the other residents, and was not seen making bookmarks with the other residents, and activity that started at 10:59 AM. Interview, 08/01/2022 at 7:17 PM, with Shift Supervisor #1, revealed she made the decision to keep Resident #1 in his/her bedroom on 07/17/2022, for the safety of the other residents in the cottage. She stated the night shift staff reported Resident #1 had bullied other residents, one of which was Resident #5. She said when she arrived at work about 8:00 AM, YCW #6 was sitting at Resident #1's doorway, and that YCW #6 told her Resident #1 had a rough night. Shift Supervisor #1 stated she let Shift Supervisor #2 know she was going to keep Resident #1 in his/her room. When asked by the SSA Surveyor if Shift Supervisor #2 said he was okay with that, Shift Supervisor #1 said Shift Supervisor #2 did not say he was not okay with her making Resident #1 stay in his/her room. Shift Supervisor #1 stated that keeping a resident in his/her room for long periods of time was not a part of any program used at the PRTF, but she checked on	N 126	• *Appropriate Responses to Emergency Safety Situations; Speak Up for Client Safety*; and *Hand-Off Communication.* These trainings will be completed by all new staff during New Hire Orientation, within the first three (3) weeks of employment, and before working with youth. These trainings include information on how to safely and effectively interact with youth, especially during challenging or potentially unsafe situations. Further, specific steps are provided related to communicating and reporting any inappropriate, unsafe, or countertherapeutic behaviors exhibited by staff, especially those that do not show respect for human dignity, individuality, or cultural and personal beliefs, as well as any forms of abuse and neglect including verbal, mental, physical, and sexual abuse. All existing staff will complete these trainings on an annual basis, to be completed by 9/15 each year. Completion of and compliance with these trainings is recorded in each staff's training record via the Relias Learning Management System. Staff cannot begin work nor continue work with youth until demonstrating understanding of these concepts. • *Zero Hold and Seclusion Philosophy Training: 6 Core Strategies* – New staff will receive information and complete test during new employee orientation, and yearly refreshers will be provided for all cottage and clinical staff by 9/15 of each year. Completion and compliance will be recorded in each staff's training record via the Relias Learning Management System. Continued on next page	9/15/22 8/3/22

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N 126	Continued From page 27 Resident #1 when the resident had taken two (2) showers on the day shift. She said the resident urinated twice on himself/herself, and one of those times was just before lunch. Per interview with YCW #1, on 07/20/2022 at 5:22 PM, she stated when she reported to work, she thought Shift Supervisor #1 told her that Resident #1 woke up at about 3:00 AM on 07/17/2022, and threatened a staff member. She said the resident threatened the staff member who was called over to sit at the resident's door because he/she reportedly misbehaved in middle of the night. She said Resident #1 called her a fat bitch. YCW #1 said Shift Supervisor #1 gave her (YCW#1) the update on Resident #1's night time behavior, and then told her she was upset with Resident #1 because he/she had ruined her church day, that she was going to hold/restrain the resident, and when she did she was going to make him/her throw up. Interview, on 07/20/2022 at 11:20 AM with YCW #6, revealed on 07/17/2022, YCW #7 asked her to come assist with Resident #1 because the resident got up between 4:00 to 5:00 AM, and tried to wake up other residents. She said YCW #7 told her she needed to assist the other residents as they were waking up, and she wanted to prevent Resident #1 from escalating while she was taking care of the other residents. YCW #6 said she sat in a chair at Resident #1's bedroom door. She said the resident kept opening his/her door, and wanted to go to the restroom. She said she went to the restroom and when she returned, the resident was out of his/her room, and he/she messed with the hand sanitizer on the table, and then returned to his/her room. She said before the end of the shift the	N 126	• Continue daily reviews of all Emergency Safety Physical Interventions (ESPI) on business days and weekends/holidays if necessary, including the use of seclusion and/or exclusionary timeout, and continued thrice-weekly reviews of resident grievances are conducted to determine, in addition to any safety concerns, whether any youth rights are violated. These include document and video reviews, when available. Any violations or concerns noted are documented, and the information is shared with the staff's supervisor for follow-up, which may include additional coaching, training, or disciplinary action, up to and including termination of employment. In addition, the review information is distributed to the executive team and Bellewood and Brooklawn residential, clinical, and quality leaders.	9/1/22

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N 126	Continued From page 28 resident spilled some water in his/her room and wanted to go get the mop. YCW #6 stated YCW #7 gave her some background information about Resident #1. She said Resident #1 liked to be held, and he/she seemed to like the physical touch, similar to a hug. She said Resident #1's therapist wanted staff to try strategies other than holds to change his/her behavior. YCW #6 said while she was sitting at Resident #1's door, the resident stated he/she was going to kick and hit her, and he/she pulled back his/her fist. She said it seemed the resident was trying to scare the her, but she said the resident never touched her. Review, of the facility provided camera coverage of the cottage milieu, from 12:00 AM until 6:30 AM, revealed Resident #1 was seen only twice in the milieu. At 1:56 AM the resident exited his/her room, and walked down the hallway toward the restroom. The resident was seen again at 6:04 AM. The resident was in the milieu touching pieces of toilet paper YCW #7 had torn, folded, and placed on a table. Resident #1 also tossed a football up and down, and looked at what seemed to be an I-pad or a large lighted phone with YCW #7. He/she was not observed having any contact with other residents, and there were no observations of the resident striking of having any physical contact with either staff, YCW #6 and YCW #7. Interview, on 07/30/2022 at 3:30 PM with Shift Supervisor #2, revealed staff should never keep a resident in his/her bedroom for long periods of time. He stated unless he/she was sleeping the resident should not stay in his/her bedroom more than thirty (30) minutes at a time; and during that time, the resident should have a backpack with activities to work on to stay busy. He said the	N 126		

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N 126	Continued From page 29 backpacks might include puzzles and coloring sheets. Additional interview on 08/03/2022 at 4:29 PM with Shift Supervisor #2, revealed Shift Supervisor #1 sent him a text on Sunday morning 07/17/2022, and gave him a report on Resident #1's behavior. He said in the text, Shift Supervisor #1 wrote that Resident #1 was "acting a fool." Shift Supervisor #2, said he was still sleeping when the text came in, so he did not contact Shift Supervisor #1 until later when he was on his way to church. Shift Supervisor #2 stated Shift Supervisor #1 did not ask him about, or inform him that she was going keep Resident #1 in his/her room all day. He stated he would not have told her that he thought that would be okay. Interview, on 07/29/2022 at 2:49 PM, with Residential Manager #1, revealed residents were not supposed to be kept in their bedrooms for long periods of time because that was a form of confinement. He said staff should maintain a homelike environment for the residents. He said the residents should not feel like it was a prison. Residential Manager #1 stated the Psychoeducational Model (PEM) was all about allowing the youth to process his/her mistake, and talk about the issue. He said upon their choice, a resident could go to a timeout room to process his/her behavior. He stated confining a resident to his/her bedroom as a form of punishment would never be an effective strategy for addressing the resident's negative behaviors. Interview, on 07/21/2022 at 4:40 PM with Resident #2, revealed he/she had never been told he/she had to stay in his/her room all day. The resident stated if he/she was in his/her room, and	N 126		

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N 126	Continued From page 30 needed something, he/she stuck his/he hand out the door and staff came to see what he/she needed. Interview, on 08/02/2022 at 3:45 PM, with Residential Therapist #1, revealed it was not acceptable practice to keep a youth in his/her bedroom for long periods of time during waking hours. She said that was in no way a part of the PRTF's system of consequences. She stated we try to teach the youth why they have earned consequences, and that required ongoing interaction with staff. Residential Therapist #1 stated one would need to consider what a youth in an escalated state of mind could potentially do to himself/herself if not continuously monitored while in his/her bedroom, unsupervised. Interview, on 08/02/2022 at 3:25 PM, with Residential Therapist #3, revealed she was on campus on 07/17/2022, working at the cottage next door to Pilots Cottage but was not contacted by any of Pilot's Cottage staff for assistance for managing the situation with Resident #1. She said she had no idea what was going on until her supervisor called and directed her to go to Pilot's Cottage because a resident there was unresponsive. She stated she heard sirens, and when she walked to Pilots Cottage, the ambulance had just pulled off with Resident #1 inside the truck. She said when she entered the cottage, Shift Supervisor #1, YCW #5, and YCW #1 were all crying, and very upset. She said Shift Supervisor #1 tried to explain what happened, but she was sobbing so hard, it was hard to make sense of what she was trying to say. She said Shift Supervisor #1 told her she thought Resident #1 seemed to be breathing before he/she left the cottage in the ambulance, and that EMS staff had	N 126		

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not delivered cardiac shock using the AED. Residential Therapist #3 said law enforcement was on the scene when she entered the cottage. She said the other youth in the cottage seemed confused, but soon additional staff arrived and took the residents to the gym, so they could get away from the cottage while the police were still there.

Interview, on 07/29/2022 at 2:49 PM, with Residential Manager #1, revealed a lot of residents had expressed in Treatment Team meetings they had issues with how Shift Supervisor #1 interacted with them. He said based on that information he decided to speak with her about it. He stated Shift Supervisor #1 had been overbearing with the residents when it came to spirituality. He stated he told Shift Supervisor #1 staff members were not there to raise the residents, but to treat them using therapeutic interventions. He stated he tried to help the staff understand they must treat the residents like they would want to be treated. Residential Manager #1 said direct care staff may not have a full understanding of the trauma the residents experienced prior to admission, so it was very important that staff interactions with the residents remain therapeutic and not remind them of any previous negative life experiences. He stated if the staff members' behaviors were similar to what the residents had previously been subjected to, how could that be therapeutic. He said how could Resident #1 engender his/her trust in staff if treated similarly. He stated what happened to Resident #1, in his/her last hours of life on 07/17/2022 made his skin boil.

Interview, on 08/10/2022 at 12:26 PM, with Resident #1's Residential Therapist, revealed the

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treatment team had to come up with an alternative plan to reward Resident #1's good behavior, because the points system utilized for most residents had not been effective. She said staff implemented a plan to give Resident #1 stickers when he/she met expectations. She said the plan never included isolating the resident, so he did not have a chance to earn stickers. Resident #1 should have been in the milieu on 07/17/2022, so he/she could have had opportunities to earn the rewards for demonstrating good behavior, and making good choices. Resident #1's therapist stated the only time seclusion should be used, would be if it was an approved intervention, or if the child was in quarantine due to a contagious disease. The therapist stated seclusion should not have been considered since Resident #1 was only seven (7) years old. She said he/she would have likely been unable to process why he/she had to stay in his/her room all day. She said Resident #1 probably got bored, and a youth as young as Resident #1 had pent up energy, and it should not be surprising that he/she would want to re-join his/her peers in the milieu. Additional interview, on 09/12/2022 at 10:41 AM with Residential Therapist #1, for Resident #1, revealed exclusionary timeout or seclusion of a resident away from the milieu and his/her peers and staff should never be forced by staff and the decision to do so should never be the decision of only one (1) staff member.

Interview, on 08/05/2022 at 11:10 AM, with Resident #1's psychiatrist, revealed given Resident #1's known intellectual disabilities, it would have been hard for the resident to conceptualize why he/she was being kept in his/her room all day. He stated that action on the

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part of the staff member (Shift Supervisor #1), demonstrated her lack of understanding of a typical seven (7) year old's behavior. He stated when the resident's bedroom door was shut, the resident was not interacting with staff, and there should be ongoing interaction with staff during the resident's waking hours. The physician stated there must be an order before secluding a resident, and the intervention must be carefully planned to minimize risk of harm.

Per interview, on 08/18/2022 at 4:15 PM, with the Division Director, the facility staff was not providing adequate treatment if the resident was kept in his/her bedroom for inappropriate behaviors. She said bigger conversations among the clinicians and the managers should occur to develop a plan with more appropriate interventions to manage his/her behaviors. She stated the resident's Residential Therapist, the Residential Manager and perhaps school staff would meet to further develop or revise the resident's treatment plan to include appropriate approaches for managing his/her behaviors.

Interview with the Vice President (VP) of Residential Programming on 08/22/2022 at 10:15 AM, revealed placing a child in timeout for an extended period of time must have prior approval from the clinical staff and managers. She said they would first want to know why the staff person (Shift Supervisor #1) or direct care staff thought that was a necessary intervention for managing the resident's behavior. The VP of Residential Programming said Shift Supervisor #1 implemented exclusionary time out and seclusion without first going through the approval process. She could not say why Shift Supervisor #1 did that, but she wanted to know. She said

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N 126	Continued From page 34 management was still not in the head of the staff members on duty that day, and that managers would probably never receive an explanation that would be satisfactory.	N 126		
N 128	PROTECTION OF RESIDENTS CFR(s): 483.356(a)(3) Restraint or seclusion must not result in harm or injury to the resident and must be used only- This ELEMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility's physical holding policy, camera footage of the cottage, and the Fire and Emergency Medical Services (EMS) Patient Care Record, it was determined the facility failed to ensure staff implemented Safe Crisis Management (SCM), in accordance with the facility's policy for Physical Holding to prevent serious harm that resulted in the death of (1) of ten (10) sampled residents, Resident #1. On 07/17/2022 at 2:25 PM, Youth Care Worker (YCW) #5 and Shift Supervisor #1 secured the resident in a standing to kneeling cradle hold. During the hold, which was implemented off camera in the resident's bedroom, the resident vomited, lapsed into an unconscious state, and required life saving support in the form of Cardiopulmonary Resuscitation (CPR). The resident was transferred to the local children's hospital by Emergency Medical Services (EMS) and expired at 4:48 PM that same day.	N 128	N 128 • Suspended Deborah Francis, Jillian Parks, and Amanda Whitlow as of 7/20/2022. Employment of Deborah Francis and Jillian Parks was terminated 8/19/2022. 8/19/22 • Please note that any staff who failed to comply with these actions received corrective action. • All cottage and clinical staff were compliant with required annual three (3) hour Safe Crisis Management (SCM) Recertification Training, which included how to safely execute a standing and kneeling cradle hold by September 1, 2022. 9/1/22 • All existing staff completed the following trainings by September 6, 2022: 9/6/22 o *Appropriate Responses to Emergency Safety Situations* o *Speak Up for Client Safety* o *Hand-Off Communication* These trainings included information on how to safely and effectively interact with youth, especially during challenging or potentially unsafe situations. Continued on next page	

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N 128	Continued From page 35 Interview with YCW #1 on 07/20/2022 at 5:22 PM, who witnessed the hold, revealed she did not think the hold was implemented per the facility's physical holding policy or per the training she received through her own SCM certification. She stated Shift Supervisor #1 pushed the resident forward when she took over the hold from YCW #5. YCW #1 said per the SCM instruction provided by the facility's SCM trainers, staff was not supposed to place pressure on the resident's back because it could cause him/her to throw up, or do damage to the inside of the resident's body. Interview, on 08/05/2022 at 5:00 PM, with the Social Service Worker from Child Protective Services (CPS), who attended the interview YCW #1 gave to the Police Detective earlier that day, on 08/05/2022, revealed YCW #1 told the detective that Shift Supervisor #1 was frustrated with Resident #1 due to some of his/her behaviors as reported by a staff person who worked with the resident on the night shift. YCW #1 stated Shift Supervisor #1 used extreme force when she took over the holding of Resident #1. YCW #1 said Shift Supervisor #1 pushed the resident's body so far forward while implementing the kneeling cradle hold that the resident's nose almost touched the floor. Continued interview with YCW #1, on 07/20/2022 at 5:22 PM, revealed while Shift Supervisor #1 and YCW #5 were holding Resident #1, YCW #5 told her to go check on the other residents in the cottage. YCW #1 said when she returned to Resident #1's doorway, she heard Shift Supervisor #1 say to Resident #1,"Go ahead throw up, throw up!" She said when she looked in the doorway, the resident was still in the hold, and he/she had thrown up a lot of clear liquid and	N 128	Further, specific steps were provided related to communicating and reporting any inappropriate, unsafe, or countertherapeutic behaviors exhibited by staff, especially those that do not show respect for human dignity, individuality, or cultural and personal beliefs, as well as any forms of abuse and neglect including verbal, mental, physical, and sexual abuse. Completion of and compliance with these additional trainings was recorded in each staff's training record via the Relias Learning Management System. • All cottage and clinical staff remain up to date with Safe Crisis Management (SCM) refreshers per policy. Attendance and compliance is recorded in each staff's training record via the Relias Learning Management System. 9/1/22 • All cottage and clinical staff reviewed and attested in writing to understand the Medical Tip Sheet and do's and don'ts specific to physical holds authored by the agency Medical Director by August 15, 2022. 8/15/22 • All cottage and clinical staff reviewed and attested to the review and understanding of the following policies and procedures by August 15, 2022: 8/15/22 o *Appendix Clients Rights and Responsibilities and Youth Rights* o *Grievances- Resolving Client Complaints* o *Reporting Abuse, Neglect or Exploitation* o *Physical Holding of Youth* o *Seclusion of Youth* Existing staff completed written test on the information included in these policies. Completion and compliance is recorded in each staff's training record via the Relias Learning Management System.	

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N 128	Continued From page 36 chunks of food. YCW #1 said YCW #5 told her to go get the impact cushion. YCW #1 said when she looked at Resident #1 through the doorway, the resident was not saying anything, but he/she was crying. YCW #1 said she left the doorway to get the impact cushion, but could not find it. She said she quickly returned to the resident's door, and YCW #5 said she would go get the cushion. But, YCW #1 said as YCW #5 was leaving the room she told her (YCW #1) to watch Shift Supervisor #1. YCW #1 said she did not know why YCW #5 told her to watch Shift Supervisor #1. Brief interview on 07/21/2022 at 9:45 AM with YCW #5, revealed she would only speak to State Survey Agency (SSA) Surveyor in the presence of her attorney. However, multiple attempts were made to arrearage an interview, but YCW #5 did not respond to any additional voice messages left on her phone after 07/21/2022. Per electronic mail (e-mail) communication on 07/29/2022 at 7:35 PM, from the Vice President of Residential Services, the facility's attorney reached out to YCW #5's attorney to encourage YCW #5 to grant the State Survey Agency (SSA) Surveyor an interview, but after multiple unsuccessful attempts to contact YCW #5, the SSA Surveyor was unable to conduct an interview with YCW #5. The findings include: Review of the facility's policy, titled Physical Holding of Youth, Policy Number: CS-040, last review date 03/25/2021, revealed the purpose of the policy was to provide guidelines for the use of physical holding of youth (residents), to ensure	N 128	• All cottage and clinical staff were educated and attested to an understanding of a Zero Hold philosophy. Existing staff completed a test on understanding of this philosophy by September 06, 2022. • Training was provided for all cottage and clinical staff that covered: 1. when it is appropriate to initiate a physical hold; 2. when it is appropriate to initiate a seclusion, including appropriate levels of initial and continuation authorization; 3. when it is appropriate to initiate exclusionary time out, including appropriate levels of initial and continuation authorization; and 4. how to respond to medical emergencies, including but not limited to how to intervene appropriately for youth who have potential adverse reactions. All staff attested to understanding the information provided, and all staff completed a written test as part of this training. Completion and compliance is recorded in each staff's training record via the Relias Learning Management System. • A facilitator and implementation team was identified for Six Core Strategies for Reduction of Seclusion and Restraint project implementation. The Six Core Strategy Steering Committee/Leadership Subcommittee met for the first time on September 27, 2022. On November 17, 2022, the Prevention Tools and Debriefing Subcommittees met for the first time. The Data Subcommittee is scheduled to meet for the first time on January 4, 2023. Continued on next page	9/6/22 9/2/22 9/4/22

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N 128	Continued From page 37 the minimization of the risk of harm. Further, the Leadership was committed to the organizations' philosophy concerning the use of physical holding of youth that included: the prevention of emergencies that have the potential to lead to the use of physical holding of youth (residents); preserving the safety and dignity of the youth (resident) when physical holding was used; the use of the least restrictive emergency safety intervention that was most likely to be effective in resolving the emergency safety situation; discontinuing the physical hold as soon as possible when the youth (resident) regains control of his/her behavior; prohibiting the used of physical holding of youth (residents) for any other purpose, such as coercion, discipline, convenience, or retaliation by staff; the use of physical holding is not based on the history of past physical holding of youth or solely on a history of dangerous behavior; and prohibiting the use of physical holding techniques that restrict the flow of air to the youth's lungs. Record review of a Treatment Team Note, dated 07/12/2022, revealed the facility admitted Resident #1, on 06/22/2022, for aggression. The resident had a history of animal cruelty, and a personal history of neglect, suspected exposure to Domestic Violence (DV), and sexual abuse in his/her primary home. Review of Resident #1's Comprehensive Assessment, dated 06/22/2022, revealed the resident had recently received inpatient treatment at a psychiatric hospital. The resident was hospitalized for aggressive and sexually acting out behaviors while in the care of foster parents. The resident (age 7) currently had a state appointed guardian. Resident #1's weight on	N 128	• Began daily reviews of all Emergency Safety Physical Interventions (ESPI) on business days and weekends/holidays if necessary and thrice-weekly reviews of resident grievances to determine, in addition to any safety concerns, whether any youth rights are violated. These include document and video reviews, when available. Any violations or concerns noted are documented, and the information is shared with the staff's supervisor for follow-up, which may include additional coaching, training, or disciplinary action, up to and including termination of employment. In addition, the review information is distributed to the executive team and Bellewood and Brooklawn residential, clinical, and quality leaders. Ongoing monitoring/compliance procedures: • Updated Youth Rights document to include specific language emphasizing that youth should be free from any type of shame, ridicule, or humiliation (see attachment). This is posted in every living unit and given to youth (and their guardians) at admission. • Monthly Safe Crisis Management (SCM) Refreshers (1 hr) and annual Safe Crisis Management (SCM) recertification (4 hrs) – includes review of Youth Rights and how to sensitively and effectively work with youth, especially when addressing particularly challenging or sensitive issues; this will include emphasizing that shame, humiliation, and/or ridicule is countertherapeutic and is not an acceptable intervention tool. Completion of all refreshers and annual Safe Crisis Management (SCM) recertification is recorded in staff's training record via Relias Learning Management System.	9/1/22 Revised 12/8/22 9/1/22

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N 128	Continued From page 38 admission (06/22/2022) was 114 pounds, and he/she was four (4) feet, 4 inches tall, with a 29.1 % Body Mass Index (BMI). The resident had no known cardiac issues, but was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD), and Disruptive Mood Disorder. Review of Resident #1's Behavior Support Plan (BSP), dated 06/22/2022, revealed situational triggers included trauma history, attending school, not getting his/her way and separation from his/her siblings. Symptoms or behaviors which occurred just before crisis (crisis triggers) included defiance, threatening and aggressive behavior. Further, under the subheading, "Identify any history of sexual or physical abuse or other traumas that would be a significant emotional trigger if the youth was placed in a hold," a history of neglect and abandonment was listed. Continued review of the resident's clinical record, revealed since admission and prior to 07/17/2022, Resident #1 had been placed in three (3) holds that occurred on 07/01/2022, 07/08/2022, and 07/09/2022 Interview, on 07/23/2022 at 6:05 PM, with YCW #7, revealed Resident #1 seemed to need nurturing and for example, she said the resident would often wake up in the middle of the night and wanted her to put a blanket over him/her, and that Resident #1 asked her to do so about 3:00 AM on 07/17/2022. She said sometimes the resident would wake up and ask questions such as, "Is there going to be school tomorrow?" She said once I answered his/her question (s) or gave the resident some attention he/she would go back to sleep. She said this became a pattern of behavior with Resident #1. She said Resident #1	N 128	• *Appropriate Responses to Emergency Safety Situations*; *Speak Up for Client Safety*; and *Hand-Off Communication.* These trainings will be completed by all new staff during New Hire Orientation, within the first three (3) weeks of employment, and before working with youth. These trainings include information on how to safely and effectively interact with youth, especially during challenging or potentially unsafe situations. Further, specific steps are provided related to communicating and reporting any inappropriate, unsafe, or countertherapeutic behaviors exhibited by staff, especially those that do not show respect for human dignity, individuality, or cultural and personal beliefs, as well as any forms of abuse and neglect including verbal, mental, physical, and sexual abuse. All existing staff will complete these trainings on an annual basis, to be completed by 9/15 each year. Completion of and compliance with these trainings is recorded in each staff's training record via the Relias Learning Management System. Staff cannot begin work nor continue work with youth until demonstrating understanding of these concepts. • *Zero Hold Philosophy Training: 6 Core Strategies* – New staff will receive information and complete test during new employee orientation, and yearly refreshers will be provided for all cottage and clinical staff by 9/15 of each year. Completion and compliance will be recorded in each staff's training record via the Relias Learning Management System. Continued on next page	9/15/22 8/3/22

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N 128	Continued From page 39 told her that he/she had pooped in the bathroom, and had put it on the bathroom wall. YCW #7 said she cleaned up the bathroom wall. YCW #7 said Resident #1 was part of the reason she asked YCW #6 to come assist her on the morning of 07/17/2022, mainly because the residents had been sleeping a long time, and it was time for them to get up. She said she was working in the kitchen, and she called her supervisor and asked for some help because two (2) or three (3) of the residents had gotten up, and it was time for the others to get up, too. She said she needed YCW #6 to keep an eye on Resident #1, in case his/her behavior escalated. She stated she needed to help the eight (8) other residents get showers and assist with changing their beds because some of the them had bed wetting behaviors. YCW #7 said Resident #1 seemed more like a two (2) year old than a seven (7) year old. She said the resident longed for touch. She said he/she liked it when she helped him/her with school work. She stated Resident #1 really wanted 1:1 attention. She said Resident #1 was only seven (7) years old, and she did not believe he/she was capable of hurting her or anyone else. She said she never thought Resident #1 needed to be placed in a hold during the times she took care of him/her. Review of camera footage from 07/17/2022 revealed at 2:25 PM, Resident #1 and YCW #1 were talking at the resident's doorway. At 2:27:48 PM YCW #5 approached the resident's door and went in the resident's room. YCW #1 followed YCW #5 into Resident's #1's room and the door closed. Further review of the camera footage, revealed Shift Supervisor #1 entered Resident #1's room at 2:28:56 PM. Review, of camera footage, dated 07/17/2022,	N 128	• Continue daily reviews of all Emergency Safety Physical Interventions (ESPI) on business days and weekends/holidays if necessary and thrice-weekly reviews of resident grievances which are conducted to determine, in addition to any safety concerns, whether any youth rights are violated. These include document and video reviews, when available. Any violations or concerns noted are documented, and the information is shared with the staff's supervisor for follow-up, which may include additional coaching, training, or disciplinary action, up to and including termination of employment. In addition, the review information is distributed to the executive team and Bellewood and Brooklawn residential, clinical, and quality leaders.	9/1/22

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N 128	Continued From page 40 timestamp 2:31 PM, revealed YCW #1 exited Resident #1's bedroom and spat into a trash can just outside the resident's room, then re-entered the room at 2:35:18 PM. YCW #1 again exited the resident's bedroom at 02:35:49 PM, and ran toward the kitchen. She returned to the bedroom at 02:36:13 PM with a cloth. YCW #1 then held the resident's door open. YCW #1 left the doorway again, and within seconds, she returned with a container. Per interview with YCW #1 on 07/20/2022 at 4:12 PM, the container she took to the room after the resident was unconscious, had ice water in it, which Shift Supervisor #1 instructed her to bring to the room. YCW #1 said Shift Supervisor #1 poured the cold water over Resident #1 to try to arouse the resident. At 02:39:10 PM, YCW #1 exited the resident's room, and unlocked the cottage office. Per interview with The Division Director on 07/18/2022 at 4:45 PM, YCW #1 was getting a phone to call 911. Per continued review of the camera footage, YCW #1 entered Resident #1's room with the phone at 02:39:40 PM. Continued review of the camera coverage revealed at 2:45 PM Shift Supervisor #1 left Resident #1's room and entered the common living area, then ran right back into the resident's room. The Shift Supervisor again quickly exited the resident's room, and then went to the cottage office and appeared that she obtained a phone. At 2:47 both Shift Supervisor #1 and YCW #1 were in the common space, but YCW #5 could not be seen.	N 128		

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N 128	Continued From page 41 Per interview with the Residential Director on 07/18/2022 at 4:45 PM, who was viewing the camera footage with the State Survey Agency (SSA) Surveyor, revealed YCW #5 was still in the bedroom with Resident #1. At 02:48 PM Shift Supervisor #1 and YCW #1 remained in the common living space. At 02:49:25 PM, first responders entered Resident #1's bedroom and Shift Supervisor #1 followed them into the room. Shift Supervisor #1 quickly exited the room, and at 2:50 PM four (4) additional emergency responders entered Resident #1's bedroom. YCW #5 exited the room, and started bending over from the waist, and then sat down on a chair in the common living area. Continued review of the Camera Coverage for 07/17/2022, revealed EMS staff transferred Resident #1 out of his/her bedroom to the floor of the common living space at 2:55:09 PM and continued with chest compressions. At 2:59:35 PM, two (2) EMS staff placed a backboard on a stretcher parked where EMS staff continued to deliver chest compressions while Resident #1 was on the cottage floor. Two (2) police officers were seen in the common space, as well. EMS staff continued to deliver chest compressions , and at 3:06:25 PM, EMS staff transferred the resident to the stretcher and moved the resident out of the cottage at 3:07: 49 PM. Review of the Fern Cree Fire & Emergency Medical Services (EMS) Patient Care Record, dated 07/17/2022, revealed the following: Primary impression by the EMS personnel was Suffocation or Asphyxia; Secondary Impression	N 128		

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N 128	Continued From page 42 was documented as Cardiac Arrest; Protocol used was Pediatric Pulseless Arrest; Onset time was recorded as 14:40.00 on 07/17/2022; Chief Complaint, Cardiac Arrest; injury documented as suffocation/Asphyxiation-Mechanical threat to breathing as cause of asphyxiation. The 911 call was recorded as received at: 14:40:56; dispatched at 14:44:14; responders enroute at 14:44:19; personnel at scene 14:50:00; at patient at 14:51:00; departed scene with patient at 15:11:29, and at destination at 15:22:23. Review of the Hospital Emergency Department (ED) Documentation, dated 07/17/2022, revealed Resident #1 arrived at the ED at 3:24 PM. According to the report, the resident arrived in the ED with an endotracheal tube in place and a Lucas device (a mechanical CPR System placed at the victim's chest, that delivers quality chest compressions during prolonged cardiac resuscitation attempts.) Interventions including continued chest compressions, administration of cardiac stimulating medications, replacement of the endotracheal tube, frequent pulse checks, lab work, as well as other attempts at life saving measures were constantly administered by the ED physicians and nurses until the resident was pronounced dead at 4:48 PM. According to the report, two (2) nurses, a Chaplin, and a Louisville Metro Police Detective were at the resident's bedside at the time of death. It was recorded in the ED flowsheet that Resident #1 was a foster child with no parents. Review of the Pediatric Attending Physician's Attestation, dated 07/17/2022 at 4:53 PM, Resident #1 arrived at the ED from Brooklawn in full cardiac arrest. The physician documented that per the EMS report the resident had been restrained at the PRTF due to an outburst, and the resident reportedly	N 128		

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N 128	Continued From page 43 stopped breathing and lost pulses. The Physician documented it was unclear how long it was from the time the resident stopped breathing to recognition of a loss of pulses. Interview with First Responder #1 on 08/09/2022 at 8:47 AM, revealed she was the first to arrive at the scene. She said when she walked into the cottage, the patient (Resident #1) was on the floor in a bedroom that was just off the large common living space, and two (2) staff were performing CPR. She one (1) of the two (2) female staff said they had been dealing with the resident's behavior problems throughout the day and he/she had been aggressive with staff. The staff person said just before the resident became unresponsive, they had placed him/her in an approved hold. She said one (1) of the staff members implemented the hold for about 2 minutes, and then the other staff member took over the hold. She said that staff person said she felt the resident stop resisting the hold, and something had changed, so she released the resident and noted the he/she was unresponsive. First Responder #1 described the 2 staff members as a Caucasian female with dark blonde/light brown hair, maybe in her 40's; and a black female maybe a little older, in her 50's. She said both women were about five (5) feet 5 inches tall. First Responder #1 said she saw vomit on the floor, but she did not recall seeing vomit debris on the resident's mouth. The First Responder stated we do not always use a portable suction machine while on scene, but she believed it was used on the patient because one (1) of the EMTs said get the suction machine. Interview, on 07/20/2022 at 5:22 PM with YCW #1, revealed Shift Supervisor #1 took Resident	N 128		

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N 128	Continued From page 44 #1's lunch to his/her room on 07/17/2022 at about 1:30 PM. Review of cottage camera video revealed Shift Supervisor #1 took a tray with food on it to Resident #1 at 13:44.54, about 45 minutes before YCW #5 secured the resident in a hold. Interview, on 07/30/2022 at 5:42 PM with the Lead Emergency Medical Technician (EMT) #1, revealed First Responders were on the scene administering CPR when she arrived. She said they told her the resident was pulseless and apneic (not breathing). She said the the resident was placed on a monitor and was in asystole (meaning there was no detection of electrical or mechanical activity of the heart). She said there were many people present in the cottage, and multiple stories were told. She said staff explained the resident had an altercation, and was placed in a bear hug. She said the staff person said they were not cutting off the resident's air. She said the staff tried to demonstrate they were placing the resident's hands at his/her side during the hug. She said the staff was trying to explain they were not trying to choke the resident, but had him/her in a bear hug. The Lead EMT said there was vomit everywhere when they tried to intubate the resident. She said it was in the resident's mouth and throat, running down his/her cheek and on the floor. She said it seemed he/she had recently eaten. The Lead EMT said in the ambulance, between compressions, they cut off the residents clothes and did a full body assessment. She said there were no obvious marks on the resident's neck, and no signs of trauma to his/her back. Interview, on 07/31/2022 at 6:01 PM with EMT #2, revealed when she arrived on scene, fire	N 128		

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N 128	Continued From page 45 fighters were already there administering CPR. She said one facility staff member, a black female, was running around and screaming, breathe, please breathe, as she called the patient's name. EMT #2 stated we moved the patient (Resident #1) out of the bedroom. She said when the Lead EMT #1 tried to intubate the patient (Resident #1), his/her airway was full of vomit. She said, "It was such a large amount we had to suction it out before we could intubate him/her." EMT #2 stated staff told her the patient (Resident #1) had been in an "isolation room," so she wondered if the room had camera coverage to monitor the youth if he/she had been in isolation. Observation, on 07/18/2022 at 4:40 PM of Pilot's Cottage, revealed eight (8) residents were in the cottage with Shift Supervisor #1 and the Pilots Residential Manager. Interview, on 07/18/2022 at 4:55 PM with the Residential Manager confirmed the census at the cottage was now 8 residents, and on 07/17/2022, nine (9) residents were at the cottage, including Resident #1. Observation of Resident #1's bedroom revealed the resident's meal tray (from 07/17/2022) was on a small desk in the room, with opened packages, a cup, and a napkin. A black cushion, about 16 inches x 16 inches, was on the floor, and a dark brown substance was seen on the tiled floor near the resident's bed. In addition, a plastic water bottle was observed on the resident's bed. Interview with the Division Director during the observation, revealed law enforcement wanted the room to remain unchanged until the detectives completed their investigation. Interview, on 07/19/2022 at 2:17 PM with Shift Supervisor #1, revealed on 07/17/2022 she came	N 128		

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N 128	Continued From page 46 to work at 8:00 AM and was scheduled to work sixteen (16) hours. She said she received a report from YCW #7 who worked the night shift. She stated YCW #7 reported Resident #1 had been knocked things off tables, squirted hand sanitizer, and threatened a couple of residents when they came out of their rooms to go to the bathroom. She said YCW # 7 stated the resident also threatened to kill staff. Shift Supervisor #1 stated at approximately 2:00 PM, YCW #5 arrived to work and during the debriefing, she told YCW #5 that Resident #1 acted out during the night shift. Shift Supervisor #1 said Resident #1 stuck his/her hand out of his/her room door during the debriefing session, and YCW #1 went to speak with him/her. Shift Supervisor #1 said she did not learn what the resident wanted. Shift Supervisor #1 said she was watching when YCW #5 followed by YCW #1 entered Resident #1's room. She said she watched from the cottage office to see what would occur, and wondered if the two (2) staff would escort the resident to a timeout room. She said when that did not happen, she went to the resident's room, and found that YCW #5 had secured the resident in a kneeling cradle hold, and YCW #1 was holding the the residents feet and legs. Shift Supervisor #1 said she could not recall the exact time, but at some point she took over the hold, but YCW #5 did not leave the room. Shift Supervisor #1 said the resident remained resistant and fought to get out of the hold. She stated the resident was was fighting the hold so much, they did not try to move him/her out of the bedroom, or try to transition him/her to a timeout room. The Shift Supervisor said there was no indication the resident was having respiratory distress while he/she was in the hold. She said the resident may have had some underlying medical conditions because he/she	N 128		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
USPIRITUS-BROOKLAWN-PILOTS	2108 DAVID GRAVES DRIVE LOUISVILLE, KY 40218

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N 128	Continued From page 47 was a very large child for his/her age, and at times his/her breathing could sound loud and coarse. Shift Supervisor #1 stated Resident #1 had already thrown up when she entered the room, and that was the only episode of vomiting he/she had. She said YCW #1 told her the resident also urinated. She said both happened before she entered the bedroom. Shift Supervisor #1 stated when she took over the hold, the resident kept "bucking back," and one of his/her hands got loose. She stated we asked the resident to use his/her Safe Crisis Strategies (SCS), but he/she did not say anything and continued fight to get out of the hold. She stated, then, Resident #1's body became dead weight. She stated when she felt this change occur, she released the hold. She said his/her eyes were closed. Shift Supervisor #1 said kids often become exhausted during a hold, so she tried to arouse Resident #1 by tapping his/her face. Shift Supervisor #1 said she told YCW #1 to bring a wet wash cloth. She said she took the resident's pulse and his/her wrist and neck, and she felt the resident's pulse. She said YCW #5 also took the resident's pulse. Shift Supervisor #1 said she began to shake the resident at little, and then we poured cold water over him, but the resident did not respond. Shift Supervisor #1 stated she started to panic and YCW #5 initiated CPR. Shift Supervisor #1 said when Resident #1 went limp, she released his/her arms, leaned him/her back on herself. She stated his/her eyes were closed, and she was tapping the resident's cheek and calling his/her name. She said she checked the resident's pulse and he/she had a pulse. She said she looked at the resident's stomach and thought he/she was breathing, but had passed out. She said she kept tapping him/her, and we	N 128		

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N 128	Continued From page 48 went ahead and initiated CPR. Shift Supervisor #1 said she thought that if the patient had a pulse, don't do CPR, but she also learned if the patient was unresponsive, then start CPR. Shift Supervisor #1 said YCW #1 called 911, but she said she was upset with the EMS personnel because they did not seem to be in a hurry, and they were rude. Shift Supervisor #1 said it surprised her that YCW #5 placed Resident #1 in a hold. She said the cottage did not have many holds because the staff talk with the residents, and use Psycho Education Model (PEM) statements to avoid implementing holds. She said she asked YCW #5 why she implemented the hold, and YCW #5 told her that Resident #1 assaulted her, but Shift Supervisor #1 said she was not sure where the resident hit YCW #5. Shift Supervisor #1 said she was not okay with the hold occurring in the resident's bedroom. She said she did not instruct YCW #5 or YCW #1 to secure the resident in a hold. She said, "My instruction was to have Resident #1 stay in his/her room." Interview, on 07/20/2022 at 4:12 PM with YCW #1, revealed she had been employed at the facility since mid May 2022. She said she was trained in Safe Crisis Management (SCM), which included training and certification in physical holding of residents and other means to calm a resident to prevent holding, if possible. She said the Training and Professional Development Coordinator provided the training. She stated physical holding should be the last resort for managing a resident's behavior. She said staff should assist the resident with using Safe Crisis Strategies (SCS), which were non-physical, such as deep breathing, or counting on their fingers.	N 128		

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N 128	Continued From page 49 YCW #1 said she reported to work on 07/17/2022 at about 8:15-8:19 AM. She said Shift Supervisor #1 reported to work before she did. She said Shift Supervisor #1 gave her an update on the residents. YCW #1 said Shift Supervisor #1 told her she was upset with Resident #1 because he/she had ruined her church day. She said Shift Supervisor #1 told the resident at about 8:45 AM that she was going to hold (restrain) him/her and make him/her throw up. YCW #1 said at about 8:45 AM she heard Shift Supervisor#1 tell Resident #1 that she was going to hold him/her and she was going to make him/her throw up. She said after she said that to Resident #1, Shift Supervisor #1 sent a text message to another staff member and she told her (YCW #1) that she texted that Resident #1 had lost his/her mind, and that she could not even talk to the resident right now. YCW #1 said she did not know who Shift Supervisor sent the text to, and she was unsure why the supervisor wanted her to know she had sent the text message. YCW #1 stated Shift Supervisor #1's voice tone was very aggressive toward Resident #1, and she seemed very upset with the resident. YCW #1 stated at about 2:00 PM YCW #5 reported to work and Shift Supervisor #1 gave her a report on Resident #1's behavior during the night shift. And, she told her YCW #7 had written on the white board that during the night shift Resident #1 tried to fight with two (2) residents, threatened staff, and smeared poop on the bathroom wall. YCW #1 said about 2:20 PM, Resident #1 stuck his/her hand out of the door which signaled staff he/she needed something. She said the resident told her he/she had wet his/her pants. She said	N 128		

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N 128	Continued From page 50 she was not sure why the resident urinated on himself/herself, but the resident had been in his/her bedroom all day. She stated earlier in the day, Resident #1 had urinated and pooped in his/her pants. She said while she was talking to the resident at his/her door, he/she asked where Shift Supervisor #1 was. She said the resident picked up his/her plastic water bottle and threatened to throw his/her plastic water bottle at her (YCW#1). YCW #1 said she and Resident #1 just started laughing, and that she did not take it as a serious threat. She said Resident #1 liked to laugh and joke a little, and that seemed to calm him/her. YCW #1 said she thought YCW #5 overheard Resident #1 threaten to hit her with the water bottle, and in about two (2) seconds YCW #5 was at Resident #1's doorway. YCW #1 stated YCW #5 walked into Resident #1's room, and that she (YCW#1) walked in behind YCW #5 because since she was new to the job she wanted to see how YCW #5 was going to handle the situation. She said YCW #5 put Resident #1's hands up against the bedroom wall and Resident #1 told YCW #5 he/she she was going to hit her like he/she did the other day, and the resident called YCW #5 a stupid bitch. YCW #1 stated YCW #5 did not explain why she put the resident's hands on the wall before implementing the hold. YCW #1 stated YCW #5 then placed the resident in a standing to kneeling cradle hold. YCW #1 said she held the resident's feet/legs, and tried to continue calming the resident by laughing with him/her, because she (YCW#1) had accidentally sat in some of the resident's pee on the floor. YCW #1 said a few seconds later, Shift Supervisor #1 entered the room, and told YCW #5 to move, and said, "I've got it." YCW #1 said Shift Supervisor #1 took over the hold and when she did, the Shift Supervisor pushed Resident #1	N 128		

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forward. YCW #1 said per her SCM training, the person implementing the hold was not supposed to do that because the resident could throw up, and that action could also cause damage to the inside of the resident's body. She said YCW #5 asked her to go check on the other residents in the cottage. YCW #1 said when she returned to Resident #1's doorway, she heard Shift Supervisor #1 say to Resident #1, "Go ahead throw up, throw up!" She said when she looked in the doorway, the resident was still in the hold, and he/she had thrown up a lot of clear liquid and chunks of food. YCW #1 said YCW #5 told her to get the impact cushion. YCW #1 said when she looked at Resident #1 through the doorway, the resident was not saying anything, but he/she was crying. YCW #1 said she went to get the impact cushion, but could not find it. She said she quickly returned to the resident's doorway, and YCW #5 said she would go get the cushion. YCW #1 said as YCW #5 was leaving the room she told her (YCW #1) to watch Shift Supervisor #1. YCW #1 said she did not know why YCW #5 told her to watch Shift Supervisor #1. YCW #1 said YCW #5 came back with the cushion in just a few seconds. YCW #1 said she went to check on another resident (Resident #3). She said Resident #3 had tears in his/her eyes, and said, "I want to save Resident #1 because he/she is only seven (7) years old. They need to ban holds, and that he/she wished it was him/her being held instead of Resident #1." YCW #1 said she stayed with Resident #3 one (1) to two (2) minutes, and then returned to Resident #1's doorway because she heard Shift Supervisor #1 say, "Lay him/her down on the floor." YCW #1 said there was a discharge on Resident #1's lips, and that it was yellow and crusty looking--that was the color of his/her lips. YCW #1 said she asked, "What do I

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N 128	Continued From page 52 need to do?" She said Shift Supervisor #1 told her to get a wet cloth, and then some cold/ice water, so she got the bucket of cold water, too. She said Shift Supervisor #1 dumped the bucket of water onto Resident #1, and then Shift Supervisor #1 started giving the resident CPR. She said Shift Supervisor #1 and YCW #5 switched back and forth with chest compressions and giving the resident breaths. She said Shift Supervisor #1 told her to call 911, and the Shift Supervisor #1 started yelling that she needed to call Residential Manager #1. She said YCW #5 continued giving the resident CPR. YCW #1 said she put down the phone so YCW #5 could talk to the 911 dispatch person. YCW #1 said she thought the Emergency Medical Staff (EMS) arrived at 2:47 PM, because when she looked at of the call on her phone, it was (8) minutes long. YCW #1 said she had concerns about Shift Supervisor #1's statement that she was going to put Resident #1 in a hold and make him/her throw up. She said she should have reported that to someone, and she felt really bad about that. YCW #1 said it was the first hold she had seen implemented, that it was all very shocking, and she really did not know who she should have contacted on 07/17/2022. However, she said she did report her concerns to the Director of Traning and Professional Development, who was conducting the internal investigation of the incident. Interview, on 07/21/2022 at 4:40 PM with Resident #2, revealed when staff explained what happened to Resident #1, he/she cried and thought about killing himself/herself, but he/she did not do that. Resident #2 stated he/she had been placed in a hold, but that he/she tried to take deep breaths or talk to staff when feeling like	N 128		

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N 128	Continued From page 53 he/she was getting angry. Interview, on 07/21/2022 at 5:20 PM with Resident #3, revealed he/she was upset that Resident #1 was placed in a hold. He/she stated he heard the ambulance coming, and that he/she could not get out of his/her room. Resident #3 said he/she pushed YCW #5 when she checked on him because he/she was trying to get out of his/her room. Resident #3 stated he/she wished the hold had happened to him/her rather than Resident #1 because Resident #1 had not lived as long as him/her. The resident said he/she knew there was nothing he/she could do but he/she wanted to see what was going on with Resident #1 during the hold. Interview on 07/21/2022 at 5:40 PM with Resident #4, revealed holds made him/her think the staff was trying to harm the residents. He/she said the holds were supposed to happen in the milieu or in the timeout room. Resident #4 said on 07/17/2022 after the incident, staff took us to the gym, and that he/she wanted to stay in the gym because the cops had been at the cottage looking at things. Interview, on 07/26/2022 at 4:45 PM with the Training and Professional Development Coordinator, revealed the direct care staff was trained in Safe Crisis Management (SCM). He stated he trained direct care staff to keep the resident and staff safe if they must implement a hold. He said the staff person should not push the resident forward with their body weight when implementing the kneeling cradle hold. He stated if a staff member placed pressure on the resident's torso when securing him/her, that could make it difficult for the resident to breathe. He	N 128		

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N 128	Continued From page 54 said the staff member should secure the resident's hands/wrists at the resident's hips or waist, and avoid applying pressure to the resident's stomach. He stated if the resident had eaten near the time of the hold, placing pressure on the stomach could cause the resident to vomit. Further, the Training and Professional Development Coordinator stated pushing forward on the resident's torso, could cause the staff person's or the resident's secured hands to shift, moving them onto the resident's stomach. He said that a shift in hand placement could result in pressure on the resident's stomach and internal organs, and make it difficult for the resident to breathe. The Training and Professional Development Coordinator stated facilities have been shut down related to negative outcomes from improper use of holds. Interview, on 08/22/2022 at 10:00 AM with the Director of Training and Professional Development, revealed the staff securing a resident in a kneeling cradle hold should have one knee on the floor, and one knee up with a foot on the floor. He stated the staff should maintain a straight posture. He stated if the resident was fighting or resisting, the staff should assess his or her posture, and if they should readjust their position to protect the resident from risks of vomiting or other injury. He said perhaps involvement of another staff person, and use of a different hold should be considered. The Director of Training and Professional Development stated staff should never tell a resident secured in a hold to go ahead and throw up. He stated it was not acceptable for the staff to lean forward placing pressure on the youth during a kneeling cradle hold because that could affect the youth's ability to breathe causing positional asphyxiation and/or	N 128		

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N 128	Continued From page 55 causing the youth to vomit. Interview, on 07/23/2022 at 5:51 PM with YCW #3, revealed he/she had worked with Resident #1, during his/her stay at the cottage and worked on 07/15/2022. He stated early into his/her admission, Resident #1 had a rough time getting use to the cottage routines, and did not always follow the rules. However, YCW #3 said he saw improvement with Resident #1's behavior later in his/her stay. YCW #3 stated staff should not place a resident in a hold unless he/she becomes a threat to himself/herself, or others. YCW #3 stated we were not trained to place a resident in a hold because he/she referred to a staff member using vulgar language. or threw something at the staff member. Instead, he stated the resident would earn negative consequences for threatening to throw something. He stated staff should apply the Psychoeducational Model (PEM), which included the use of calming statements to deescalate the resident if he/she was upset. Interview, on 07/24/2022 at 3:13 PM with YCW #4, revealed he worked with Resident #1 on Thursday (07/14/2022) before the incident on 07/17/2022. He stated he noticed that Resident #1 liked to be out of his/her bedroom early each day. He stated the resident would curse at staff, but to him, it was not severe. YCW #4 stated he noted there was tension between Resident #1 and YCW #5, and on 07/15/2022, while passing medications, he heard a verbal altercation between Resident #1 and YCW #5. YCW #4 said he intervened because Resident #1 threatened to throw a shoe at YCW #5. YCW #4 stated he talked with Resident #1, asked him/her to give him the shoe. He stated the resident handed him	N 128		

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N 128	Continued From page 56 the shoe, and then went to his/her bedroom. Continued interview with YCW #4 revealed the greatest risk to a resident when in a hold was positional asphyxiation. He stated holds should occur in the milieu where the event could be recorded via camera. He stated holds should only be used if the resident was a threat to himself or others. He stated if the resident yelled, cursed, or even spat in the face of a staff person, those actions would not warrant securing the resident in a hold. YCW #4 stated anything could happen when a resident was in a hold. He stated the resident could swallow vomit. He stated the staff person placing the hold should never lean on the resident. He said the staff person's back should remain straight up and down. YCW #4 said if the resident started crying, then he would still hold the resident's wrists but loosen up on the hold. YCW #4 stated staff was supposed to try to talk with a resident when he/she was upset, and maybe go to the timeout room with the resident and talk with them. He stated staff should not put their hands on a resident just because the resident might be yelling out. He stated at times staff bring their feelings to work. He stated he had worked with Shift Supervisor #1, but he did not think she brought her problems to work. However, he could tell when she was frustrated. When asked by the State Survey Agency (SSA) Surveyor if he thought Shift Supervisor #1 had any issues coping with Resident #1's behavior, YCW #4 said he was not sure about that, because he had not worked with her very much during Resident #1's stay at the facility. Interview, on 07/30/2022 at 2:54 PM with YCW #8, staff should not implement holds off camera, in residents' bedrooms, because there would not	N 128		

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N 128	Continued From page 57 be a record of hold. YCW #8 said if a resident vomited, the staff person should release the hold and allow the resident to recover or go to the bathroom. He stated the resident could be ill. He stated the staff person's chest and body should be against the resident's back, but the staff person should not bend over or place pressure on the resident. He said the youth's (resident's) body should be upright/straight against the staff person's chest. Review of the Coroner's Report, dated 07/18/2022, and signed by the Deputy Coroner, revealed the decedent underwent an autopsy on 07/18/2022. Remarks after the autopsy, revealed there were injuries on the decedent's body that appeared to be contusions (bruises) on various areas of his/her body and petechia visible in his/her eyes. The Deputy Coroner said petechia in the eyes can be a result of asphyxia or strangulation. She stated aggressive CPR may cause slight petechia in the eyes, but in Resident #1's case, there was more than slight petechia. Interview, on 07/19/2022 at 11:30 AM with the Department of Community Based Services (DCBS) Supervisor, revealed an on-call DCBS staff left her a phone message on 07/17/2022, late afternoon, about a call from the facility where Resident #1 lived about an emergency there. She said she had a feeling it was about Resident #1. The DCBS Supervisor said Resident #1's assigned DCBS Guardian contacted her because she had the physician from the hospital ED on the phone. She said she heard the physician say over a three- way- call that Resident #1 was placed in a hold at the PRTF Cottage, and staff noticed the resident stopped breathing. She said the doctor said staff at the PRTF initiated CPR, and then	N 128		

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N 128	Continued From page 58 EMTs arrived, continued with CPR, and transferred him/her to the hospital. The DCBS Supervisor said the physician said staff at the ED were able to get a pulse a couple of times, but the resident never regained consciousness, and the time of death was called at 4:48 PM. The DCBS Supervisor stated the physician said she was sending Resident #1's body to the coroner for autopsy because the situation was suspicious, and she did not understand why it took so long to get the resident to the hospital. In interview, on 08/09/2022 at 2:38 PM with the county medical examiner, revealed Resident #1's case was complicated, and not a lot of findings after the autopsy. He stated the resident had pinpoint hemorrhages in his/her eyes, and a target of his exam was to determine if there were any suspicious marks on the resident's neck, but he found nothing significant. The Medical Examiner stated the resident experienced pretty extensive CPR. However, he stated he thought the eye hemorrhages were more extensive than what would occur by administering CPR. The medical examiner said he was waiting on the toxicology report, which was a standard part of the the examination. The Medical Examiner said the possible cause of death was asphyxia. He said he had questions about how the resident was being restrained. He stated he could not comment at this time on when he would have a statement of his findings. He stated it would take as long as it took to obtain the information he needed to conclusively state his findings. Interview on 08/05/2022 at 11:10 AM with Resident #1's Psychiatrist revealed nonphysical management of a resident's behavior should always be the first-line intervention. He stated in	N 128		

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N 128	Continued From page 59 lieu of holds, staff should try verbal interventions such as verbal de-escalation, and or ask the resident to go to the timeout room to process the anger or other issues they had. He said physical intervention should only be used if the resident became a threat to himself/herself or others. He stated he was unsure how Resident #1's history of neglect and abandonment would affect his/her response to physical holds. He stated Resident #1 had a history of exposure to adult sexual activity, and stated the resident's mother was a prostitute. He said it was known the resident's mother abandoned him/her leaving the resident at places unsupervised, and it was also suspected the resident may have been sexually abused. Interview, on 08/22/2022 at 10:15 AM with the Vice President (VP) of Residential Programming, revealed it was everyone's responsibility, at all levels of the organization to keep the residents safe. She stated that included all youth care workers, residential managers, behavioral/clinical staff, and directors such as herself. The VP of Residential Programming stated she was notified within about 10-15 minutes after 911 was called on 07/17/2022, that Resident #1 became unresponsive and required CPR. She said she left home and drove to the cottage. The VP of Residential Programming said she wanted to know what behavior the resident exhibited that was dangerous, that is, what led the staff to determine a hold was necessary. She stated she wanted to know why the hold was implemented in the resident's bedroom, and why couldn't staff transition the resident out of his/her room into camera view before securing him/her in the hold. She said ideally, if a hold was necessary, it should be implemented in an area where the intervention could be captured on camera. The	N 128		

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N 128	Continued From page 60 VP of Residential Services stated if YCW #1 had concerns about how Resident #1 was treated, and how the hold was implemented, she should have contacted Residential Manager #1 immediately. She said she knew YCW #1 would have had his phone number.	N 128		

N 132	PROTECTION OF RESIDENTS
	CFR(s): 483.356(b)
	
	Emergency safety intervention. An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the resident's chronological and developmental age; size; gender; physical, medical, and psychiatric condition; and personal history (including any history of physical or sexual abuse).
	
	This ELEMENT is not met as evidenced by:
	Based on interview, clinical record review, and review of the facility policy, it was determined the facility failed to protect one (1) of ten (10) sampled residents from an unnecessary Emergency Safety Intervention (ESI). On 07/17/2022 at approximately 2:25 PM, Shift Supervisor #1 and Youth Care Worker (YCW) #5 secured Resident #1 in a kneeling cradle hold. During the hold, the resident vomited, became unresponsive, required Cardiopulmonary Resuscitation (CPR), and subsequent transfer to a local hospital emergency department (ED) where he/she passed away the same day. Per
		N 132	N 132
			• Suspended Deborah Francis, Jillian Parks, and Amanda Whitlow as of 7/20/2022. Employment of Deborah Francis and Jillian Parks was terminated 8/19/2022. — 8/19/22
			• Please note that any staff who failed to comply with these actions received corrective action.
			• All cottage and clinical staff were compliant with required annual three (3) hour Safe Crisis Management (SCM) Recertification Training, which included how to safely execute a standing and kneeling cradle hold by September 1, 2022. — 9/1/22
			• All existing staff completed the following trainings by September 6, 2022: — 9/6/22
			  ○ *Appropriate Responses to Emergency Safety Situations*
			  ○ *Speak Up for Client Safety*
			  ○ *Hand-Off Communication*
			These trainings included information on how to safely and effectively interact with youth, especially during challenging or potentially unsafe situations.
			
			Continued on next page	

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N 132	Continued From page 61 interview with YCW #1, the resident did not hit any staff member just before he/she was placed in the hold, but only threatened to throw his/her plastic water bottle at her (YCW #1). YCW #1 stated Resident #1 did not hit YCW #5 just before the YCW placed the resident in a hold in the resident's bedroom, out of camera view. The findings include: Review of the facility policy titled, Physical Holding of Youth, Policy Number: CS-040, last reviewed, 07/14/2022, revealed the organization's philosophy about the use of physical holding of youth (residents) included the prevention of emergencies that have the potential to lead to the use of physical holding of youth (residents); the use of nonphysical interventions, with input from the youth (resident) and parent or guardian, as the preferred interventions for addressing behavioral emergencies involving youth (residents) to minimize the use of physical holding. In addition, the agency was committed to preserving the safety and dignity of the youth (resident) when physical holding was used; and permitting the use of physical holding only when nonphysical interventions were ineffective or not viable and when there was an imminent risk of a youth (resident) physically harming self, staff, or others, and use of the least restrictive emergency safety intervention that would most likely be effective in resolving the emergency safety situation. Interview, with YCW #1 on 07/20/2022 at 5:22 PM, revealed about 2:20 PM, Resident #1 stuck his/her hand out of the door. She stated that was the way residents were supposed to signal to staff they needed something. She said Resident #1	N 132	Further, specific steps were provided related to communicating and reporting any inappropriate, unsafe, or countertherapeutic behaviors exhibited by staff, especially those that do not show respect for human dignity, individuality, or cultural and personal beliefs, as well as any forms of abuse and neglect including verbal, mental, physical, and sexual abuse. Completion of and compliance with these additional trainings was recorded in each staff's training record via the Relias Learning Management System. • All cottage and clinical staff remain up to date with Safe Crisis Management (SCM) refreshers per policy. Attendance and compliance is recorded in each staff's training record via the Relias Learning Management System. 9/1/22 • All cottage and clinical staff reviewed and attested in writing to understand the Medical Tip Sheet and do's and don'ts specific to physical holds authored by the agency Medical Director by August 15, 2022. 8/15/22 • All cottage and clinical staff reviewed and attested to the review and understanding of the following policies and procedures by August 15, 2022: 8/15/22 o *Appendix Clients Rights and Responsibilities and Youth Rights* o *Grievances- Resolving Client Complaints* o *Reporting Abuse, Neglect or Exploitation* o *Physical Holding of Youth* o *Seclusion of Youth* Existing staff completed written test on the information included in these policies. Completion and compliance is recorded in each staff's training record via the Relias Learning Management System.	

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N 132	Continued From page 62 told her he/she had peed in his/her pants. She said she was not sure why the resident urinated on himself/herself, but the resident had been in his/her bedroom all day. She stated earlier in the day, Resident #1 had urinated and pooped in his/her pants. She said while she was talking to the resident at his/her door, he/she asked where Shift Supervisor #1 was. She said the resident picked up his/her plastic water bottle and threatened to throw it at her. YCW #1 said she and Resident #1 just started laughing, and that she did not take it as a serious threat. She said Resident #1 liked to laugh and joke a little, and that seemed to calm him/her. She stated she thought YCW #5 must have heard Resident #1 threaten to throw his/her water bottle, and that YCW #5 was over at the resident's door in about two (2) seconds. She stated she followed YCW #5 into the resident's bedroom. She said since she was new, she wanted to see how YCW #5 was going to handle the situation. She stated she did not think a hold was even necessary because Resident #1 only threatened to throw the plastic water bottle. She said Resident #1 did call YCW #5 a stupid bitch, and threatened to hit her, but the resident did not hit YCW #5 with the bottle or anything. He/she did not hit me with anything before YCW #5 secured him/her in the hold, and she thought the resident was de-escalating because he/she was laughing with her (YCW#1). YCW #1 said she thought YCW #5 escalated the situation by getting involved when she apparently overheard Resident #1 say he/she was going to hit her (YCW #1) with the water bottle. YCW #1 stated once the resident was in the hold, and she was securing his/her feet, she was trying to calm the resident by talking and laughing with the him/her. She said she was trained that as soon as the resident was calm, the hold could end. She	N 132	• All cottage and clinical staff were educated and attested to an understanding of a Zero Hold philosophy. Existing staff completed a test on understanding of this philosophy by September 06, 2022.	9/6/22
			• Training was provided for all cottage and clinical staff that covered: 1. when it is appropriate to initiate a physical hold; 2. when it is appropriate to initiate a seclusion, including appropriate levels of initial and continuation authorization; 3. when it is appropriate to initiate exclusionary time out, including appropriate levels of initial and continuation authorization; and 4. how to respond to medical emergencies, including but not limited to how to intervene appropriately for youth who have potential adverse reactions. All staff attested to understanding the information provided, and all staff completed a written test as part of this training. Completion and compliance is recorded in each staff's training record via the Relias Learning Management System.	9/2/22
			• A facilitator and implementation team was identified for Six Core Strategies for Reduction of Seclusion and Restraint project implementation. The Six Core Strategy Steering Committee/Leadership Subcommittee met for the first time on September 27, 2022. On November 17, 2022, the Prevention Tools and Debriefing Subcommittees met for the first time. The Data Subcommittee is scheduled to meet for the first time on January 4, 2023.	9/4/22
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N 132	Continued From page 63 said she was trying to calm Resident #1 down, so he/she could get out of the hold as soon as possible. Interview, on 07/26/2022 at 4:20 PM with YCW #30 who was working in Pilot's Cottage, revealed the Training and Professional Development Coordinator provided training on how to handle a resident's behaviors. She stated she was trained to try to listen to and talk with the resident because they may not be over some traumatic experiences in their lives. She said she was instructed to continue to watch a resident when he/she was upset and angry, but not to secure the resident in a hold just because he/she might call me names or curse at me. In addition, she said staff should not secure a resident in a hold in an area of the cottage that was not monitored by a camera. She said staff should move the resident to a camera covered/more open space in order to obtain staff assistance with the hold. Interview, on 07/23/2022 at 5:51 PM with YCW #3, revealed direct care staff members were not trained to secure a resident in a hold just because he/she referred to a staff member using vulgar language, or threw something at the staff. Instead, he stated the resident should earn negative consequences for threatening to throw something. He stated direct care staff should apply strategies within the Psychoeducational Model (PEM). For example, he said the staff should first try using calming statements to deescalate the resident when he/she was upset. Interview, on 07/24/2022 at 3:13 PM with YCW #4 revealed residents should not be secured in physical holds unless they became a threat to himself/herself or others. He stated if the resident	N 132	• Began daily reviews of all Emergency Safety Physical Interventions (ESPI) on business days and weekends/holidays if necessary and thrice-weekly reviews of resident grievances to determine, in addition to any safety concerns, whether any youth rights are violated. These include document and video reviews, when available. Any violations or concerns noted are documented, and the information is shared with the staff's supervisor for follow-up, which may include additional coaching, training, or disciplinary action, up to and including termination of employment. In addition, the review information is distributed to the executive team and Bellewood and Brooklawn residential, clinical, and quality leaders. Ongoing monitoring/compliance procedures: • Updated Youth Rights document to include specific language emphasizing that youth should be free from any type of shame, ridicule, or humiliation (see attachment). This is posted in every living unit and given to youth (and their guardians) at admission. • Monthly Safe Crisis Management (SCM) Refreshers (1 hr) and annual Safe Crisis Management (SCM) recertification (4 hrs) – includes review of Youth Rights and how to sensitively and effectively work with youth, especially when addressing particularly challenging or sensitive issues; this will include emphasizing that shame, humiliation, and/or ridicule is countertherapeutic and is not an acceptable intervention tool. Completion of all refreshers and annual Safe Crisis Management (SCM) recertification is recorded in staff's training record via Relias Learning Management System.	9/1/22 Revised 12/8/22 9/1/22

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N 132	Continued From page 64 yelled, cursed, or even spat in the face of a staff person, those actions would not warrant securing the resident in a hold. He stated when a resident escalated, staff should walk and talk with the youth about cursing, for example, to calm the resident, using positive talk therapy. YCW #4 stated just because a youth was hollering, yelling, or cursing staff should not put their hands on the youth. YCW #4 stated he did not think staff members had been sufficiently trained in SCM, because ongoing monthly training was essential to ensure compliance with SCM techniques, and that may not have happened during the pandemic. Resident #1's Clinical Record, revealed he/she had been secured in three (3) holds near the time of his/her final hold on 07/17/2022. The resident had been placed in physical holds on 07/01/2022, 07/08/2022, and on 07/09/2022. Review of the hold summaries for all three holds revealed YCW #5 had initated all three of the holds. Interview, on 07/29/2022 at 2:49 PM with the Residential Manager #1, revealed trauma was his first reaction when he learned about the incident and the outcome for Resident #1. He said he just tried to get to the hospital to be with Resident #1. He stated he asked himself, what did he not say to YCW #5? He said he felt a sense of accountability, but he had given YCW #5 a direct order on 07/14/2022 to not secure Resident #1 in a hold. He said he did not understand why she did not follow the directive, and he felt anger. He said he had since had concerns about how the remaining cottage residents would now perceive the holds process. He stated he asked the campus trainer to come talk with the residents after the incident with Resident #1 that took	N 132	• *Appropriate Responses to Emergency Safety Situations*; *Speak Up for Client Safety*; and *Hand-Off Communication*. These trainings will be completed by all new staff during New Hire Orientation, within the first three (3) weeks of employment, and before working with youth. These trainings include information on how to safely and effectively interact with youth, especially during challenging or potentially unsafe situations. Further, specific steps are provided related to communicating and reporting any inappropriate, unsafe, or countertherapeutic behaviors exhibited by staff, especially those that do not show respect for human dignity, individuality, or cultural and personal beliefs, as well as any forms of abuse and neglect including verbal, mental, physical, and sexual abuse. All existing staff will complete these trainings on an annual basis, to be completed by 9/15 each year. Completion of and compliance with these trainings is recorded in each staff's training record via the Relias Learning Management System. Staff cannot begin work nor continue work with youth until demonstrating understanding of these concepts. • *Zero Hold Philosophy Training: 6 Core Strategies* – New staff will receive information and complete test during new employee orientation, and yearly refreshers will be provided for all cottage and clinical staff by 9/15 of each year. Completion and compliance will be recorded in each staff's training record via the Relias Learning Management System. Continued on next page	9/15/22 8/3/22

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N 132	Continued From page 65 his/her life. Interview, on 07/26/2022 at 4:45 PM with the Training and Professional Development Coordinator, revealed the facility utilized a system whereby residents earned positive and/or negative consequences based on their behaviors and choices. He stated by design, the Psychoeducational Model (PEM) encouraged positive responses and behaviors, and discouraged negative behaviors. He said if the resident was cursing at him, he would say something like, "I know you are upset, but you have used bad language so you have earned a negative consequence." The Training And Professional Development Coordinator said if a resident threatened to throw something or hit him, he would use statements such as, "can we talk?, or Let's not do this, or You are making me feel unsafe." He stated if a resident charged at him, threw something and was close enough to strike, he would try to block the thrown item. He stated each instance was situational, but in most cases he would stand by and see what the resident tried to do, and he would use PEM statements to try to de-escalate the situation. Interview, on 08/22/2022 at 09:30 AM with the Director of Training and Professional Development, revealed during the course of his internal investigation, he could not determine why YCW #5 secured Resident #1 in a hold on 07/17/2022 becaue the hold and events in the room were off camera. He stated he was unable to discern from his investigation that there was an emergency situation in Resident #1's room that necessitated implentation of a physicial intervention. However, he stated if a resident called a female a derogatory name, or threatened	N 132	• Continue daily reviews of all Emergency Safety Physical Interventions (ESPI) on business days and weekends/holidays if necessary and thrice-weekly reviews of resident grievances which are conducted to determine, in addition to any safety concerns, whether any youth rights are violated. These include document and video reviews, when available. Any violations or concerns noted are documented, and the information is shared with the staff's supervisor for follow-up, which may include additional coaching, training, or disciplinary action, up to and including termination of employment. In addition, the review information is distributed to the executive team and Bellewood and Brooklawn residential, clinical, and quality leaders.	9/1/22

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N 132	Continued From page 66 to throw a water bottle at the staff, but did not act on the threat, then those behaviors would not warrent implementation of physical management, such as a hold. Interview, on 07/21/2022 at 4:40 PM with Resident #2, revealed when staff explained what happened to Resident #1, he/she cried and thought about killing himself/herself. However, he/she did not do that. Resident #2 stated he/she had been placed in a hold in the past, but he/she tried to take deep breaths or talk to staff when feeling like he/she was getting angry to avoid getting into a hold. Interview, on 07/21/2022 at 5:20 PM with Resident #3, revealed he/she was upset that Resident #1 was placed in a hold. He stated he heard the ambulance coming, and that he/she could not get out of his/her room. The resident said he/she pushed YCW #5 when she checked on him because he/she was trying to get out of his room. Resident #3 stated he/she wished the hold had happened to him/her rather than Resident #1 because Resident #1 had not lived as long as him/her. The resident said he/she knew there was nothing he/she could do but he/she wanted to see what was going on with Resident #1 during the hold. Interview on 07/21/2022 at 5:40 PM with Resident #4, revealed holds made him/her think the staff was trying to harm the residents. Resident #1 said the holds were supposed to happen in the milieu or in the timeout room. Resident #4 said after the incident on 07/17/2022, staff members took us to the gym. Resident #4 said he/she wanted to stay in the gym because the cops had been at the cottage looking at things.	N 132		

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USPIRITUS-BROOKLAWN-PILOTS	2108 DAVID GRAVES DRIVE LOUISVILLE, KY 40218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 132	Continued From page 67 Interview, on 07/26/2022 at 4:10 PM with Resident #8, revealed Resident #1 was his/her friend and the way the resident died made him/her sad. But, the resident said he/she was also happy because he/she thought Resident #1 went to heaven. Interview, on 08/10/2022 at 12:26 PM with Resident #1's Therapist (Residential Therapist #1), revealed during the Treatment Team Meeting on 07/12/2022, the team identified that Resident #1 would demonstrate unsafe behavior when YCW #5 was on duty at the cottage. She did not understand why the incident even happened. She stated per the hold reports, it seemed the resident was seeking the holds as a form of comfort. She stated YCW #5 had been counseled to disinvolve herself with any situations of physical management as it pertained to Resident #1. She stated YCW #5 was supposed to keep her distance from the resident. Interview, on 08/05/2022 at 11:10 AM with Resident #1's Psychiatrist, revealed nonphysical management of a resident's behavior should always be the first-line intervention. He stated instead of holds staff should first try verbal interventions to de-escalate the resident, and/or ask the resident to go to the timeout room to process their anger or other issues they had. He said physical intervention should only be used if the resident became a threat to himself or others. Interview, on 07/21/2022 at 10:40 AM with the Vice President (VP) of Residential Services, revealed Safe Crisis Management (SCM) was so much more than just physical interventions. She stated whenever possible, staff should use the	N 132		

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N 132	Continued From page 68 least restrictive SCM strategies such as verbal de-escalation of a resident using voice modulation and proximity control. She said staff should maintain a calming tone of voice when talking with the resident who was upset. She said use of physical holding should be a last resort, and should only be used if the resident became a threat to himself/herself or to someone else.	N 132		
N 165	MONITORING DURING AND AFTER RESTRAINT CFR(s): 483.362(a) Clinical staff trained in the use of emergency safety interventions must be physically present, continually assessing, and monitoring the physical and psychological well-being of the resident and the safe use of restraint throughout the duration of the emergency safety intervention. This STANDARD is not met as evidenced by: Based on observation, interview, record review, facility policy review, and review of camera footage of the milieu, it was determined the facility failed to ensure staff monitored to address the physical and psychosocial well-being, as delineated in the facility's physical holding policy, for one (1) of ten (10) sampled residents, Resident #1, When staff secured the resident in a hold, on 07/17/2022 at approximately 2:25 PM,YCW #5 and Shift Supervisor #1 secured Resident #1 in a standing to kneeling cradle hold. YCW #1 said during the hold, the resident began to cry, vomited while in the hold, and soon became unresponsive. However, there was no evidence the staff acted on the changes to	N 165	N 165 • Suspended Deborah Francis, Jillian Parks, and Amanda Whitlow as of 7/20/2022. Employment of Deborah Francis and Jillian Parks was terminated 8/19/2022. • Please note that any staff who failed to comply with these actions received corrective action. • All cottage and clinical staff were compliant with required annual three (3) hour Safe Crisis Management (SCM) Recertification Training, which included how to safely execute a standing and kneeling cradle hold by September 1, 2022. • All existing staff completed the following trainings by September 6, 2022: o *Appropriate Responses to Emergency Safety Situations* o *Speak Up for Client Safety* o *Hand-Off Communication* These trainings included information on how to safely and effectively interact with youth, especially during challenging or potentially unsafe situations. Continued on next page	8/19/22 9/1/22 9/6/22

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N 165	Continued From page 69 prevent the resident from continuing to suffer from psychological and physiological distress prior to becoming unresponsive, and eventually requiring Cardiopulmonary Resuscitation (CPR), and transfer to the hospital emergency department (ED), where he/she passed away that same day. The findings include: Review of the facility policy, titled Physical Holding of Youth, Policy Number CS-040, dated 03/25/2021, revealed a staff member not physically holding the youth, should be assigned to observe the youth's physical well-being and psychological impact of the intervention and to be the timekeeper. Additional review of the policy revealed staff was to report any undesirable psychological effects from physical holding to the Psychiatric Regional Treatment Facility (PRTF) Clinical Consultant and the youth's therapist, and document on the Youth Incident Report. Review, of the Physical Hold Summary, dated 07/17/2022 at 2:25 PM, did not reveal YCW #5, who initiated the hold nor Shift Supervisor #1 or YCW#1, took immediate action during the hold when Resident #1 showed signs of psychological and physiological distress, before he/she lapsed into an unresponsive state, even though YCW #1 said she heard the resident throw up, and heard him/her crying during the hold. In addition, during the time of the hold, there was no evidence that any of the staff contacted a Clinical-on-Call Therapist in order to seek additional guidance/assistance since the resident threw up, and was crying while secured in the hold. Interview, on 07/20/2022 at 4:12 PM with YCW	N 165	Further, specific steps were provided related to communicating and reporting any inappropriate, unsafe, or countertherapeutic behaviors exhibited by staff, especially those that do not show respect for human dignity, individuality, or cultural and personal beliefs, as well as any forms of abuse and neglect including verbal, mental, physical, and sexual abuse. Completion of and compliance with these additional trainings was recorded in each staff's training record via the Relias Learning Management System. • All cottage and clinical staff remain up to date with Safe Crisis Management (SCM) refreshers per policy. Attendance and compliance is recorded in each staff's training record via the Relias Learning Management System.	9/1/22 8/15/22
			• All cottage and clinical staff reviewed and attested in writing to understand the Medical Tip Sheet and do's and don'ts specific to physical holds authored by the agency Medical Director by August 15, 2022. • All cottage and clinical staff reviewed and attested to the review and understanding of the following policies and procedures by August 15, 2022: o *Appendix Clients Rights and Responsibilities and Youth Rights* o *Grievances- Resolving Client Complaints* o *Reporting Abuse, Neglect or Exploitation* o *Physical Holding of Youth* o *Seclusion of Youth* Existing staff completed written test on the information included in these policies. Completion and compliance is recorded in each staff's training record via the Relias Learning Management System.	8/15/22

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N 165	Continued From page 70 #1, revealed YCW #5 secured Resident #1 in the standing to kneeling cradle hold from the back of the resident, and she (YCW #1) was securing the resident's feet and legs. She said Shift Supervisor #1 entered the room, and told YCW #5 to move, and said, "I've got it." YCW #1 said Shift Supervisor #1 took over the hold and when she did, the Shift Supervisor pushed Resident #1 forward. YCW #1 said per her Safe Crisis Management (SCM) training, the person implementing the hold was not supposed to do that because the resident could throw up, and pushing the youth forward could also cause damage to the inside of his/her body. She said YCW #5 asked her to go check on the other residents in the cottage. YCW #1 said when she returned to Resident #1's doorway, she heard Shift Supervisor #1 say to Resident #1, "Go ahead throw up, throw up!" She said when she looked in the doorway, the resident was still in the hold, and he/she had thrown up a lot of clear liquid and chunks of food. YCW #1 said YCW #5 told her to get the impact cushion. YCW #1 said when she looked at Resident #1 through the doorway, the resident was not saying anything, but he/she was crying. YCW #1 said she went to get the impact cushion, but could not find it. She said she quickly returned to the resident's doorway. She stated YCW #5 said she would go get the cushion, but before YCW #5 left the doorway she said watch Shift Supervisor #1. YCW #1 said she was unsure why YCW #5 told her to do that. YCW #1 said she had concerns about Shift Supervisor #1's statement that she was going to put Resident #1 in a hold and make him/her throw up. She said she should have reported that to someone, and she felt really bad that she did not	N 165	• All cottage and clinical staff were educated and attested to an understanding of a Zero Hold philosophy. Existing staff completed a test on understanding of this philosophy by September 06, 2022.	8/6/22
			• Training was provided for all cottage and clinical staff that covered: 1. when it is appropriate to initiate a physical hold; 2. when it is appropriate to initiate a seclusion, including appropriate levels of initial and continuation authorization; 3. when it is appropriate to initiate exclusionary time out, including appropriate levels of initial and continuation authorization; and 4. how to respond to medical emergencies, including but not limited to how to intervene appropriately for youth who have potential adverse reactions. All staff attested to understanding the information provided, and all staff completed a written test as part of this training. Completion and compliance is recorded in each staff's training record via the Relias Learning Management System.	9/2/22
			• A facilitator and implementation team was identified for Six Core Strategies for Reduction of Seclusion and Restraint project implementation. The Six Core Strategy Steering Committee/Leadership Subcommittee met for the first time on September 27, 2022. On November 17, 2022, the Prevention Tools and Debriefing Subcommittees met for the first time. The Data Subcommittee is scheduled to meet for the first time on January 4, 2023.	9/4/22
			Continued on next page	

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N 165	Continued From page 71 make the report. YCW #1 said it was the first hold she had seen implemented, that it was all very shocking, and she really did not know who she should have contacted on 07/17/2022 when the hold was occurring. However, she said after the incident she did report her concerns about Shift Supervisor #1 to the Director of Training and Professional Development, who was conducting the internal investigation of the incident. Interview, on 08/13/2022 at 5:09 PM with YCW #11, revealed every staff member involved in the hold was responsible for monitoring the resident's breathing, the rise and fall of his/her chest, circulation, or any indicators the resident was having pain. She stated if the resident vomited, she would immediately release the hold, and clean them up. She said she would check the resident's stomach for any bruising, and contact the facility nurse, if she found bruising. She said we check the placement of our hands. She said the staff member securing the resident in the hold should never place pressure on the resident's stomach or internal organs. Interview, on 07/19/2022 at 7:19 PM with Shift Supervisor #1 revealed she took the resident his/her lunch at approximately 1:30 PM on 07/17/2022. Review of the camera coverage of the milieu and Resident #1's bedroom door, revealed Shift Supervisor #1 took Resident #1's lunch tray to his/her door at 1:44 PM on 07/17/2022. Interview, on 07/23/2022 at 5:51 PM with YCW #8, revealed staff should always attempt to de-escalate a resident's behavior by first talking with them, using the PsychoEducational Model	N 165	• Began daily reviews of all Emergency Safety Physical Interventions (ESPI) on business days and weekends/holidays if necessary and thrice-weekly reviews of resident grievances to determine, in addition to any safety concerns, whether any youth rights are violated. These include document and video reviews, when available. Any violations or concerns noted are documented, and the information is shared with the staff's supervisor for follow-up, which may include additional coaching, training, or disciplinary action, up to and including termination of employment. In addition, the review information is distributed to the executive team and Bellewood and Brooklawn residential, clinical, and quality leaders. Ongoing monitoring/compliance procedures: • Updated Youth Rights document to include specific language emphasizing that youth should be free from any type of shame, ridicule, or humiliation (see attachment). This is posted in every living unit and given to youth (and their guardians) at admission. • Monthly Safe Crisis Management (SCM) Refreshers (1 hr) and annual Safe Crisis Management (SCM) recertification (4 hrs) – includes review of Youth Rights and how to sensitively and effectively work with youth, especially when addressing particularly challenging or sensitive issues; this will include emphasizing that shame, humiliation, and/or ridicule is countertherapeutic and is not an acceptable intervention tool. Completion of all refreshers and annual Safe Crisis Management (SCM) recertification is recorded in staff's training record via Relias Learning Management System.	9/1/22 Revised 12/8/22 9/1/22

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N 165	Continued From page 72 (PEM) Strategies to help the resident process his/her thoughts and hopefully avoid use of physical holding. However, YCW #8 said if a hold was unavoidable, then while holding the resident, staff should monitor for any signs of distress, and make sure the resident was breathing normally. He said staff should monitor the color of the the resident's hands and face. He said if the youth vomits, staff should stop the hold and check the resident's breathing, and assess if the resident is gagging, if he/she was able to speak, and was the resident having was confusion or unclear thoughts. He stated any of these signs or symptoms of distress should be documented in the hold report summary, and should be reported to the nursing staff. He stated a nurse was always on call. Interview, on 07/20/2022 at 10:40 AM with Residential Cottage Manager #1, revealed staff should always assess a resident's breathing whenever he/she has been secured in a hold. He stated the staff implementing the hold should be checking their own posture, because placing too much weight on the resident may take away the resident's ability to breathe. He stated if the resident vomited while secured in the hold, that was a sign the resident was in distress or having difficulty breathing, and staff should stop the hold. He said a youth could not hurt anyone if he/she was vomiting. Residential Cottage Manager #1 said holds should not be implemented in a resident's bedroom because there were no cameras in the bedrooms, and actions taken by the staff nor the resident's status during the hold could not be documented by video for later review. The Residential Cottage Manager said his thought process would have been to move the resident from the bedroom into the milieu. He	N 165	• *Appropriate Responses to Emergency Safety Situations*; *Speak Up for Client Safety*; and *Hand-Off Communication.* These trainings will be completed by all new staff during New Hire Orientation, within the first three (3) weeks of employment, and before working with youth. These trainings include information on how to safely and effectively interact with youth, especially during challenging or potentially unsafe situations. Further, specific steps are provided related to communicating and reporting any inappropriate, unsafe, or countertherapeutic behaviors exhibited by staff, especially those that do not show respect for human dignity, individuality, or cultural and personal beliefs, as well as any forms of abuse and neglect including verbal, mental, physical, and sexual abuse. All existing staff will complete these trainings on an annual basis, to be completed by 9/15 each year. Completion of and compliance with these trainings is recorded in each staff's training record via the Relias Learning Management System. Staff cannot begin work nor continue work with youth until demonstrating understanding of these concepts. • *Zero Hold Philosophy Training: 6 Core Strategies* – New staff will receive information and complete test during new employee orientation, and yearly refreshers will be provided for all cottage and clinical staff by 9/15 of each year. Completion and compliance will be recorded in each staff's training record via the Relias Learning Management System. Continued on next page	9/15/22 8/3/22

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N 165	Continued From page 73 said there were interventions such as a hook transport staff could have used to move the resident to a more public space with camera coverage. He stated he did not think the staff there on 07/17/2022 would have had difficulty transferring Resident #1 to a more public area due to his/her size. He said by doing so, the hold and staff interventions would have been documented for later review. Interview, on 08/10/2022 at 12:26 PM with Resident #1's Therapist, revealed while a resident was secured in a hold, the staff involved should continuously monitor the resident for signs that he/she was calming or de-escalating so the ESI could be ended as quickly as possible. She stated the staff should monitor for any signs of physiological distress, such as respiratory distress, a change in the resident's skin color, any neurological changes, or indicators of decreased circulation. She said the clinical on call staff would not do a physical assessment after the hold ended, but if the resident complained of pain or an injury, then the facility's nursing staff should be notified. Interview, on 08/02/2022 at 3:25 PM with Residential Therapist #3 revealed she was on campus on 07/17/2022, working at the cottage next door to Resident #1's ottage, but she was not contacted by any of the staff at the cottage for assistance with managing the situation with Resident #1. She said she had no idea what was going on until her supervisor called and directed her to go next door because a resident was unresponsive. She stated she heard sirens, and when she walked up to the cottage, the ambulance had just pulled off with Resident #1 in transport to the hospital. She said when she	N 165	• Continue daily reviews of all Emergency Safety Physical Interventions (ESPI) on business days and weekends/holidays if necessary and thrice-weekly reviews of resident grievances which are conducted to determine, in addition to any safety concerns, whether any youth rights are violated. These include document and video reviews, when available. Any violations or concerns noted are documented, and the information is shared with the staff's supervisor for follow-up, which may include additional coaching, training, or disciplinary action, up to and including termination of employment. In addition, the review information is distributed to the executive team and Bellewood and Brooklawn residential, clinical, and quality leaders.	9/1/22

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N 165	Continued From page 74 entered the cottage Shift Supervisor #1, YCW #5 and YCW #1 were all crying, and very upset. She said Shift Supervisor #1 tried to explain what happened but she was sobbing so hard it was hard to make sense of what she was trying to say. She said it seemed she was telling her she thought Resident #1 seemed to be breathing before he/she left the cottage in the ambulance, and that EMS staff had not delivered cardiac shock using the Automated External Defibrillator (AED). Therapist #3 said law enforcement was on the scene when she entered the cottage. She said the youth seemed confused and eventually more staff arrived and took the residents to the gym so they could get away from the cottage for awhile.	N 165		
N 170	MONITORING DURING AND AFTER SECLUSION CFR(s): 483.364(a) Clinical staff, trained in the use of emergency safety interventions, must be Physically present in or immediately outside the seclusion room, continually assessing, monitoring, and evaluating the physical and psychological well-being of the resident in seclusion. Video monitoring does not meet this requirement. This STANDARD is not met as evidenced by: Based on staff interviews, policy review, and review of the facility's video camera footage of the Residential Cottage, on 07/17/2022, the facility failed to ensure staff was immediately outside Resident #1's bedroom continuously assessing the resident on 07/17/2022 from approximately 8:00 AM to 2:25 PM. Shift Supervisor #1 stated	N 170	N 170 • All cottage and clinical staff reviewed and attested to the review and understanding of the following policies and procedures by August 15, 2022: o *Clients Rights and Responsibilities and Appendix Youth Rights* o *Grievances- Resolving Client Complaints* o *Reporting Abuse, Neglect or Exploitation* o *Physical Holding of Youth* o *Seclusion of Youth* Existing staff completed written test on the information included in these policies. Completion and compliance is recorded in each staff's training record via the Relias Learning Management System. Continued on next page	8/15/22

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

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N 170	Continued From page 75 she decided, without prior approval, to have Resident #1 stay in his/her room for the first shift because night shift reported the resident was misbehaving during the early morning hours. Video Coverage of the common space, with full view of Resident #1's bedroom door, revealed staff did not stay by the resident's door from 8:00 AM-2:00 PM, or frequently open the bedroom door to assess the resident. Interview with the resident's psychiatrist revealed given Resident #1's known intellectual disabilities, it would have been hard for the resident to conceptualize why he/she was being kept in his/her room all day. He stated that action on the part of the part of the staff member demonstrated her lack of understanding of typical seven-year-old behavior. The findings include: Review of the facility policy, titled Seclusion of Youth, Policy Number: CS-058, last review date, 07/14/2022, revealed the use of seclusion would be under the ultimate direction of the treating psychiatrist. Use of seclusion should not be based on history of the youth or solely on a history of dangerous behavior; seclusion should not be used for the purpose of coercion, discipline, convenience or retaliation by staff; seclusion should only be used when nonphysical and physical interventions have been ineffective or not viable and when there was an imminent risk of a youth physically harming self, staff, or others. Under the procedure subsection of the facility's policy, the following steps were listed: Staff was to monitor the duration of seclusion so as not to exceed the maximum duration allowed	N 170	• Training was provided for all cottage and clinical staff that covered: 1. when it is appropriate to initiate a physical hold; 2. when it is appropriate to initiate a seclusion, including appropriate levels of initial and continuation authorization; 3. when it is appropriate to initiate exclusionary time out, including appropriate levels of initial and continuation authorization; and 4. how to respond to medical emergencies, including but not limited to how to intervene appropriately for youth who have potential adverse reactions. All staff attested to understanding the information provided, and all staff completed a written test as part of this training. Completion and compliance is recorded in each staff's training record via the Relias Learning Management System. • All existing staff completed the following trainings by September 6, 2022: o *Appropriate Responses to Emergency Safety Situations* o *Speak Up for Client Safety* o *Hand-Off Communication* These trainings included information on how to safely and effectively interact with youth, especially during challenging or potentially unsafe situations. Further, specific steps are provided related to communicating and reporting any inappropriate, unsafe, or countertherapeutic behaviors exhibited by staff, especially those that do not show respect for human dignity, individuality, or cultural and personal beliefs, as well as any forms of abuse and neglect including verbal, mental, physical, and sexual abuse. Continued on next page	9/2/22 9/6/22

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N 170	Continued From page 76 based on the age of the youth, for a youth 7-8 years old, one (1) hour; If seclusion needed to extend beyond the maximum time limit, then staff should the Clinical Consultant to provide a continuation order; One staff member should be assigned to monitor the events of the intervention, and the physical well-being and the psychological impact of the intervention on the youth; Ensure staff immediately report any undesirable medical effects from seclusion to Nursing Staff and record in the resident's electronic health record (EHR); Ensure assigned staff maintain constant visual contact with the youth placed in seclusion, and under no circumstances should a youth remain in seclusion without a staff member present in the observation area; and ensure assigned staff document the youth's behavior and activity level on the Seclusion Chart throughout the youth's placement in seclusion at every five (5) minute intervals. In addition, ensure staff assess the resident at the initiation of seclusion and every 15 minutes thereafter for the following: signs of injury; nutrition and hydration status, circulation and range of motion of extremities, vital signs, hygiene and elimination, physical and psychological status and comfort, and readiness for discontinuation of seclusion. Review of facility provided video coverage of the cottage's common space with full view of Resident #1's bedroom door, on 07/17/2022, revealed staff did not stay nearby the resident's door, or frequently open the door to assess the resident's well-being from 8:00 AM until approximately 2:25 PM, when YCW #5 and YCW #1 entered the resident's room and closed the door.	N 170	These trainings also include specific education outlining the circumstances under when it is appropriate to initiate seclusion or exclusionary timeout (including defining what constitutes a seclusion or exclusionary timeout), the process for obtaining authorization for use of seclusion or exclusionary timeout, time limits for use of seclusion or exclusionary timeout based on age of resident, requirements for monitoring and documentation of such during seclusion or exclusionary timeout, and the process for termination and debriefing the use of seclusion or exclusionary timeout. Completion of and compliance with these trainings was recorded in each staff's training record via the Relias Learning Management System. • A facilitator and implementation team was identified for Six Core Strategies for Reduction of Seclusion and Restraint project implementation. The Six Core Strategy Steering Committee/Leadership Subcommittee met for the first time on September 27, 2022. On November 17, 2022, the Prevention Tools and Debriefing Subcommittees met for the first time. The Data Subcommittee is scheduled to meet for the first time on January 4, 2023.	9/4/22 9/1/22
			• Began daily reviews of all Emergency Safety Physical Interventions (ESPI) on business days and weekends/holidays if necessary and thrice-weekly reviews of resident grievances to determine, in addition to any safety concerns, whether any youth rights are violated. These include document and video reviews, when available. Continued on next page	

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	18L013	A. BUILDING _____ B. WING _____	C 11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
USPIRITUS-BROOKLAWN-PILOTS	2108 DAVID GRAVES DRIVE LOUISVILLE, KY 40218

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N 170	Continued From page 77 Observation, on 07/18/2022 at 4:20 PM of Resident #1's bedroom after his/her death, revealed the door to the bedroom was solid with no window or other opening through which to view the resident from outside the room. Interview, 08/01/2022 at 7:17 PM with Shift Supervisor #1, revealed she made the decision to keep Resident #1 in his/her bedroom on 07/17/2022 for the safety of the other residents in the cottage. She said night shift staff reported Resident #1 had bullied other residents during the night. The Shift Supervisor said when she arrived at work about 8:00 AM, YCW #6 was sitting at Resident #1's doorway, and YCW #6 told her Resident #1 had a rough night. Shift Supervisor #1 said she let Shift Supervisor #2 know she was going to keep Resident #1 in his/her room. When asked by the SSA Surveyor if Shift Supervisor #2 said he was okay with that, Shift Supervisor #1 said Shift Supervisor #2 did not say he was not okay with me making Resident #1 stay in his/her room. Shift Supervisor #1 stated that keeping a resident in his/her room for the day was not a part of any program used at the PRTF, but she checked on Resident #1 when the resident had to take two (2) showers, because he/she had urinated on urinated on himself/herself twice. Additional review of the video coverage of the cottage, revealed residents in the milieu were served breakfast at the dining table in the milieu at 10:06 AM. YCW #1 and Shift Supervisor #1 sat at the table with the other residents, talking but neither staff person took Resident #1 his/her breakfast until 10:41 AM, when YCW #1 got up from the table and took Resident #1's breakfast to his/her door.	N 170	Any violations or concerns noted are documented, and the information is shared with the staff's supervisor for follow-up, which may include additional coaching, training, or disciplinary action, up to and including termination of employment. In addition, the review information is distributed to the executive team and Bellewood and Brooklawn residential, clinical, and quality leaders. Ongoing monitoring/compliance procedures: • Monthly Safe Crisis Management (SCM) Refreshers (1 hr) and annual Safe Crisis Management (SCM) recertification (4 hrs) – includes review of Youth Rights and how to sensitively and effectively work with youth, especially when addressing particularly challenging or sensitive issues. Further, refreshers and recertifications will include the proper procedures related to the use of seclusion or exclusionary timeout. Completion of all refreshers and annual Safe Crisis Management (SCM) recertification is recorded in staff's training record via Relias Learning Management System. • *Appropriate Responses to Emergency Safety Situations*; *Speak Up for Client Safety*; and *Hand-Off Communication*. These trainings will be completed by all new staff during New Hire Orientation, within the first three (3) weeks of employment, and before working with youth. These trainings include information on how to safely and effectively interact with youth, especially during challenging or potentially unsafe situations. Continued on next page	9/1/22 9/15/22

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N 170	Continued From page 78 Interview, on 08/02/2022 at 1:15 PM with YCW #9, revealed keeping a resident in his/her room for long periods (many hours at a time) was not a Safe Crisis Management (SCM) strategy, per the training he received. He stated if the resident had to be in his/her room for a long time, then a staff person would be assigned to 1:1 observation of the resident. He stated he had never seen a youth kept in his/her room for many hours at a time, and he had been employed by the facility for four (4) years. Interview, on 08/10/2022 at 12:26 PM with Residential Therapist #1, Resident #1's therapist, revealed the primary concern with keeping Resident #1 in his/her room/secluded from others, would be his/her diagnosis or Post Traumatic Stress Disorder (PTSD). She stated how would it feel to be left in a room and not frequently checked on. She said that type of treatment would trigger memories related to the parental abandonment Resident #1 experienced earlier in his/her life. She stated Resident #1's older sibling was basically left to take care of Resident #1 and another sibling. She stated Resident #1's father was in prison, and his/her mother did not have the family support nor did she have the necessary tools to navigate raising children. Interview, on 08/18/2022 at 4:15 PM with the Division Director, revealed in order to ensure the resident remained safe in his/her bedroom, staff would have to frequently observe and check on the resident's wellbeing while he/she spent long periods of time (hours) away from the milieu without continuous interaction with staff and peers.	N 170	Further, specific steps are provided related to communicating and reporting any inappropriate, unsafe, or countertherapeutic behaviors exhibited by staff, especially those that do not show respect for human dignity, individuality, or cultural and personal beliefs, as well as any forms of abuse and neglect including verbal, mental, physical, and sexual abuse. All existing staff will complete these trainings on an annual basis, to be completed by 9/15 each year. Completion of and compliance with these trainings is recorded in each staff's training record via the Relias Learning Management System. Staff cannot begin work nor continue work with youth until demonstrating understanding of these concepts. • *Zero Hold and Seclusion Philosophy Training: 6 Core Strategies* – New staff will receive information and complete test during new employee orientation, and yearly refreshers will be provided for all cottage and clinical staff by 9/15 of each year. Completion and compliance will be recorded in each staff's training record via the Relias Learning Management System. • Continue daily reviews of all Emergency Safety Physical Interventions (ESPI) on business days and weekends/holidays if necessary, including the use of seclusion and/or exclusionary timeout, and continued thrice-weekly reviews of resident grievances are conducted to determine, in addition to any safety concerns, whether any youth rights are violated. These include document and video reviews, when available. Continued on next page	8/3/22 9/1/22

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N 170	Continued From page 79 Interview, on 08/05/2022 at 11:10 AM with Resident#1's psychiatrist, revealed it concerned him that Resident #1's door remained closed without staff frequently assessing the resident's wellbeing. He stated that action taken by the staff showed lack of understanding of 7-year-old behavior. He stated with Resident #1's known intellectual disability, isolating him/her from the other youth without frequent contact with staff would be hard for him/her to conceptualize. He said why would anyone want to punish the resident knowing he/she would not understand why that was occurring. In addition, Resident #1's psychiatrist stated one of Resident#1's past traumatic experiences was he/she had been locked in a room. Interview with the Vice President (VP) of Residential Programming on 08/22/2022 at 10:15 AM, revealed placing a youth in timeout for an extended period of time must have prior approval from the clinical staff and managers. She said they would first want to know why the staff person (Shift Supervisor #1) or direct care staff thought that was a necessary for managing the resident's behavior, and that heightened monitoring of the resident would have been necessary per policy, if the seclusion was approved and implemented. The VP of Residential Programming said Shift Supervisor #1 implemented seclusion without first going through the approval process. She said management was still not in the head of the staff members on duty that day, and that managers would probably never receive an explanation that would be satisfactory.	N 170	Any violations or concerns noted are documented, and the information is shared with the staff's supervisor for follow-up, which may include additional coaching, training, or disciplinary action, up to and including termination of employment. In addition, the review information is distributed to the executive team and Bellewood and Brooklawn residential, clinical, and quality leaders.	
N 183	APPLICATION OF TIME OUT CFR(s): 483.368(a)	N 183		

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

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N 183	Continued From page 80 A resident in time out must never be physically prevented from leaving the time out area. This STANDARD is not met as evidenced by: Based on observation, interview, record and policy review, review of a Youth Hold Seclusion Report, 07/09/2022, and review of camera coverage, it was determined the facility failed to ensure one (1) of ten (10) sampled residents, Resident #1, was not prevented from leaving the timeout area (hallway where the timeout rooms were located) on 07/09/2022. Review of video camera coverage provided by the facility revealed YCW #5 blocked the hallway exit door back into the milieu by placing herself (seated in a rolling chair) in front of the door as Resident #1 attempted to open the door to re-enter the milieu. After Resident #1 was unable to open the door to re-enter the milieu, the resident struck YCW #5, and the YCW subsequently secured the resident in a hold. The findings include: Review of the facility policy, titled Seclusion of Youth, policy Number: CS-058, last reviewed 07/14/2022, revealed the subsection, Definitions: Time out was defined as the restriction of a youth for a period of time to a designated area from which the youth is not physically prevented from leaving, for the purpose of the youth an opportunity to regain self-control; Seclusion was defined as the involuntary confinement of a youth alone in a room or an area which the youth is physically prevented from leaving; Unlatched Seclusion was defined as when a youth is	N 183	N 183 • All existing staff completed the following trainings by September 6, 2022: o *Appropriate Responses to Emergency Safety Situations* o *Speak Up for Client Safety* o *Hand-Off Communication* These trainings included information on how to safely and effectively interact with youth, especially during challenging or potentially unsafe situations. These trainings included specific education outlining the circumstances under which it is appropriate to initiate seclusion, the process for obtaining authorization for use of seclusion, time limits for use of seclusion based on age of resident, requirements for monitoring and documentation during seclusion, and the process for termination and debriefing the use of seclusion. Completion of and compliance with these trainings was recorded in each staff's training record via the Relias Learning Management System. • All cottage and clinical staff reviewed and attested to the review and understanding of the following policies and procedures by August 15, 2022: o *Clients Rights and Responsibilities and Appendix Youth Rights* o *Seclusion of Youth* Existing staff completed written test on the information included in these policies. Completion and compliance is recorded in each staff's training record via the Relias Learning Management System. Continued on next page	9/6/22 8/15/22

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N 183	Continued From page 81 physically prevented from leaving a time out area. Review of a Youth Hold Seclusion Report, dated 07/09/2022 beginning at 6:39 PM, revealed during a group choir practice led by Shift Supervisor #1 in the cottage, Resident #1 became upset with a peer, and Shift Supervisor #1 told him/her to go to the timeout room to cool down. While in timeout the resident reportedly hit walls, slammed the timeout room door and earned a -200 point consequence for those behaviors. YCW #5 stayed in the time out area with Resident #1 to monitor his/her behavior. The resident walked out of the timeout room in to the hallway where the timeout rooms were located, but YCW #5 gave him/her the expectation to return to the timeout room. Resident #1 refused and earned an additional -400 points. According to the report, YCW #5 continued to monitor the resident and he/she again hit the walls, and per the report, when the resident did not receive the attention he/she wanted, the resident started to hit and kick YCW#5 and subsequently earned another -600 points in consequences. Review of the facility's camera coverage, dated 07/09/2022 at 6:39 PM, revealed Resident #1 was in the doorway of one of the timeout rooms. YCW #5 was in the timeout room hallway. Resident #1 walked out of the timeout room and started hitting his/her head on the room's padded door casing. The resident walked to the door that exited to the milieu. However, YCW #5 sat in a rolling type chair in front of the door leading back to the milieu which prevented Resident #1 from leaving the timeout hallway area. At 6:40 PM when the resident could not get the door open, he/she began to strike YCW#5 three (3) times, and subsequently, YCW #5 got up from the chair	N 183	• Additional training was provided for all cottage and clinical staff that covered when it is appropriate to initiate a seclusion, including appropriate levels of initial and continuation authorization, monitoring, and documentation. All staff attested to understanding the information provided, and all staff completed a written test as part of this training. Completion and compliance is recorded in each staff's training record via the Relias Learning Management System. • A facilitator and implementation team was identified for Six Core Strategies for Reduction of Seclusion and Restraint project implementation. The Six Core Strategy Steering Committee/Leadership Subcommittee met for the first time on September 27, 2022. On November 17, 2022, the Prevention Tools and Debriefing Subcommittees met for the first time. The Data Subcommittee is scheduled to meet for the first time on January 4, 2023. • Began daily reviews of all Emergency Safety Physical Interventions (ESPI) and Seclusions on business days and weekends/holidays if necessary and continued thrice-weekly reviews of resident grievances to determine, in addition to any safety concerns, whether any youth rights or policies are violated. These include document and video reviews, when available. Any violations or concerns noted are documented, and the information is shared with the staff's supervisor for follow-up, which may include additional coaching, training, or disciplinary action, up to and including termination of employment. In addition, the review information is distributed to the executive team and Bellewood and Brooklawn residential, clinical, and quality leaders. Continued on next page	9/15/22 9/4/22 9/1/22

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N 183	Continued From page 82 and was seen securing Resident #1 in a hold on a black rectangular shaped rug in the timeout hallway. According to the documentation in the report, she secured Resident #1 in a supine torso hold. At 6:44 PM Shift Supervisor #1 entered the timeout hallway, and the hold ended. Shift Supervisor #1 walked Resident #1 back into one of the timeout rooms. He/she stayed in the timeout room a few seconds, re-entered the milieu with Shift Supervisor #1, and rejoined his/her peers for choir practice. Observation on 08/02/2022 at 4:30 PM revealed the cottage had (2) time-out rooms. The rooms' walls and the doors were padded with about three (3) inch thick blue mats from ceiling to the floor, with soft surface flooring, as well. The time-out rooms' doors had a small, approximately 8 inch by 8 inch window. There was a door from the common living space into the time-out room hallway. The hallway floors were tiled, and there was one industrial type black rectangular area rug on the hallway floor. Telephone interview with Shift Supervisor (SS) #4 on 10/18/2022 at 2:00 PM revealed if a youth was in the time out room and staff shut the door or prevented the youth from leaving the time out room that was not okay and it equaled seclusion. Continued review of the Resident Physical Hold Seclusion Report, dated 07/09/2022, revealed Residential Therapist #5, gave the order for the hold implemented by YCW #5 at 6:39 PM. Interview, on 08/22/2022 at 9:35 AM with the Director of Traning and Professional Development, revealed if a resident was prevented from exiting the timeout hallway by	N 183	Ongoing monitoring/compliance procedures: • Monthly Safe Crisis Management (SCM) Refreshers (1 hr) and annual Safe Crisis Management (SCM) recertification (4 hrs) – includes review of Youth Rights and how to sensitively and effectively work with youth, especially when addressing particularly challenging or sensitive issues. Further, refreshers and recertifications will include the proper procedures related to the appropriate use of seclusion. Completion of all refreshers and annual Safe Crisis Management (SCM) recertification is recorded in staff's training record via Relias Learning Management System.	9/1/22
			• *Appropriate Responses to Emergency Safety Situations*; *Speak Up for Client Safety*; and *Hand-Off Communication*. These trainings will be completed by all new staff during New Hire Orientation, within the first three (3) weeks of employment, and before working with youth. These trainings include education on proper procedures related to appropriate use of seclusion. All existing staff will complete these trainings on an annual basis, to be completed by 9/15 each year. Completion of and compliance with these trainings is recorded in each staff's training record via the Relias Learning Management System.	9/15/22
			• *Zero Hold and Seclusion Philosophy Training: 6 Core Strategies* – New staff will receive information and complete test during new employee orientation, and yearly refreshers will be provided for all cottage and clinical staff by 9/15 of each year. Completion and compliance will be recorded in each staff's training record via the Relias Learning Management System.	8/3/22
			Continued on next page	

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N 183	Continued From page 83 blocking the door, that was considered a latched seclusion, because the staff person would be blocking the egress into the milieu. He stated no one had informed him about the incident on 07/09/2022, and he had not viewed camera coverage of Resident #1 and YCW #5 in the timeout hallway with YCW preventing the resident from exiting back into the milieu. Interview, on 08/15/2022 at 11:08 AM with Residential Therapist #5, revealed the definition of timeout was a resident going to the time out room or area to cool down while using his/her Safe Crisis Strategies (SCS). She said sometimes staff monitored a resident in time-out and other times the resident walked into the time-out area on their own. She said staff should not prevent the resident from leaving the time-out room hallway if they wanted to rejoin staff and peers in the milieu. Residential Therapist #5 said if the exit way was blocked that would become seclusion. Interview, on 08/10/2022 at 12:26 PM with Resident #1's therapist (Residential Therapist #1), revealed if a resident was in a timeout room or the timeout room hallway, he/she should not be prevented from leaving the time out area to re-enter the milieu via the exit door to the common living space. She stated time out was based on the premise that time out was voluntary, and if the resident was prevented from re-entering the milieu, that would become seclusion rather than time out. Residential Therapist #1 stated Resident #1 had experienced trauma by parental neglect and abandonment, and keeping the resident secluded in an area without the freedom to re-enter the milieu could have triggered his/her aggressive actions toward	N 183	• Continue daily reviews of all Emergency Safety Physical Interventions (ESPI) on business days and weekends/holidays if necessary, including the use of seclusion, and thrice-weekly reviews of resident grievances are conducted to determine, in addition to any safety concerns, whether any youth rights or policies are violated. These include document and video reviews, when available. Any violations or concerns noted are documented, and the information is shared with the staff's supervisor for follow-up, which may include additional coaching, training, or disciplinary action, up to and including termination of employment. In addition, the review information is distributed to the executive team and Bellewood and Brooklawn residential, clinical, and quality leaders.	9/1/22

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N 183	Continued From page 84 YCW #5 when she blocked the door that led back into the cottage milieu. Interview, on 08/05/2022 at 11:10 AM with Resident #1's psychiatrist, revealed the resident should make the decision to go to time out, or he/she could be escorted to the time out room. The physician said timeout was voluntary, and the resident should not be prohibited from leaving the timeout area.	N 183		
N 189	POST INTERVENTION DEBRIEFINGS CFR(s): 483.370(b) Within 24 hours after the use of restraint or seclusion, all staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, must conduct a debriefing session that includes, at a minimum, a review and discussion of - 483.370(b)(1) The emergency safety situation that required the intervention, including discussion of the precipitating factors that led up to the intervention; This ELEMENT is not met as evidenced by: Based on staff interviews, record, and policy review, it was determined the facility failed to provide evidence of a debriefing session, per the facility policy specifics, with staff within twenty-four (24) hours of physical hold that proved to be fatal for one (1) of ten (10) sampled residents, Resident #1. On 07/17/2022 at 2:25 PM, YCW #5 secured Resident #1 in a kneeling cradle hold, off camera,	N 189	N 189 • The initial debriefing following the hold for Ja'ceon Terry on 7/17/22 was not done in the usual way, due to law enforcement beginning an investigation in addition to other agency investigations (Child Protective Services, Office of Inspector General, etc.) that would be starting. It was not appropriate for leadership and staff to talk together about the details of what happened in a large group due to the investigation and also the trauma staff were experiencing. Psychological First Aid standards would not suggest at that early moment to share narratives about a traumatic event so early after it occurred. It was also not necessary to discuss ways to prevent future holds with Ja'ceon. • Bellewood and Brooklawn completed a formal root cause analysis to identify areas for improvement in our processes and root causes to the event on 7/17/2022 that led to a death. Staff involved in this process included residential and clinical directors, Vice President of Residential Programming, and executive leadership. Continued on next page	9/9/22

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N 189	Continued From page 85 in the resident's bedroom. Shift Supervisor #1 soon entered the room, took over the hold, and YCW #5 secured the residents legs and feet. Per interview with YCW #1, who witnessed the hold in Resident #1's bedroom, revealed the resident vomited while secured in the hold, began to cry, and soon lapsed into an unconscious state. After the resident could not be aroused, YCW #5 and Shift Supervisor #1 initiated CPR and Emergency Medical Services (EMS) was summoned to the facility. The resident was transported to a local Emergency Department (ED) for advanced life support, however the resident did not respond and was pronounced dead at 4:48 PM that same day. The findings include: Review, of the facility policy, titled Physical Holding of Youth, Policy Number: CS040, last review date, 03/25/2022, revealed as soon as possible, but no later than the end of the shift, debrief face-to-face with all staff involved following each episode of physical holding. This debriefing should address the following: What led to the incident and evaluate the interventions used prior to the physical holding as well as the Safe Crisis Management (SCM) techniques used; Identify what could have been handled differently, including possible strategies to prevent the future use of physical holding; Ascertain that the physical well-being, psychological comfort, and right to privacy of the youth were addressed; Assess the impact of the holding on the youth's emotional functioning; identify any modifications needed to the youth's treatment and service plan. Interview on 07/20/2022 at 5:22 PM with YCW #1, who witnessed the events that led up to Resident	N 189	Ongoing monitoring/compliance procedures: • Each Physical Hold/Seclusion Report includes a mandatory debriefing with both the youth and the staff, and the form has been updated with new prompts to ensure each regulatory area of the debriefing is addressed. Quality Improvement does an administrative review of every Physical Hold/Seclusion Report form, including the debriefing section. • A facilitator and implementation team was identified for Six Core Strategies for Reduction of Seclusion and Restraint project implementation. The Six Core Strategies for Reducing Seclusion and Restraint Use subcommittee for Rigorous Debriefing (one of the six core strategies) has been formed and has begun meeting (first meeting 11/17/2022). This team will work through plans to bolster our debriefing process to inform policy, procedures, and practices to avoid repeats in the future. The subcommittee will also work to decrease the effects, as much as possible, to both youth and staff from restraint and seclusion.	Form revised 12/9/22 9/4/22 11/17/22

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	18L013	A. BUILDING _____ B. WING _____	C 11/02/2022

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N 189	Continued From page 86 #1's hold and death on 07/17/2022 at 2:25 PM, revealed she worked through the day shift with Shift Supervisor #1 starting at 8:30 AM. She stated Shift Supervisor #1 told her she was upset with Resident #1 and she was going to make the resident stay in his/her room for the first shift because the resident had misbehaved during the night. YCW #1 said at about 8:45 AM she heard Shift Supervisor#1 tell Resident #1 that she was going to hold him/her and she was going to make him/her throw up. She said after she said that to Resident #1, Shift Supervisor #1 sent a text to another staff member and she told her (YCW #1) that she texted that Resident #1 had lost his/her mind, and that she could not even talk to the resident right now. YCW #1 said she was not sure who the Shift Supervisor sent the text to, and she did not know why Shift Supervisor #1 wanted her to know she had sent the text message. YCW #1 stated Shift Supervisor #1's voice tone was very aggressive toward Resident #1, and she seemed very upset with the resident. YCW #1 said Resident #1 remained in his/her room most of the day except for going to take a shower because he/she had urinated on himself/herself. She said Shift Supervisor #1 also had the resident eat his/her breakfast and lunch in his/her room. YCW #1 said YCW #5 arrived about 2:00 PM to work the second shift. She said about 2:20 PM, Resident #1 opened his/her door and stuck out his/her hand to gain the attention of staff. Continued interview on 07/20/2022 at 8:38 PM with YCW #1, revealed she went to talk with Resident #1, when he/she opened his/her door at about 2:20 PM. She said the resident stated he/she had urinated on himself/herself. During the conversation, YCW #1 said Resident #1	N 189		

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N 189	Continued From page 87 threatened to throw his/her plastic water bottle at her (YCW #1), but he/she did not actually do so. She said YCW #5 heard Resident #1's threat, walked over to the resident's door, and entered the room, which did not have camera coverage. YCW #1 said she followed YCW #5 into the room mainly because she wanted to see how YCW #5 would handle Resident #1's behavior. YCW #1 stated Resident #1 threatened to hit YCW #5 and called her a "stupid bitch." However, according to YCW #1, the resident did not hit anyone prior to the hold. YCW #1 stated YCW #5 placed the resident's hands up on a wall, and then secured him/her in a standing cradle hold. She said both YCW #5 and Resident #1 lost their balance, and landed on the floor. She said YCW #5 secured the resident in a kneeling cradle hold. She stated Shift Supervisor #1 entered the bedroom and took over the hold. Prior to the hold of 07/17/2022, Resident #1 had been secured in three (3) other holds, which occurred on 07/01/2022, 07/08/2022, and 07/09/2022. Review of Physical Hold Seclusion Reports, dated 07/01/2022, 07/08/2022, and 07/09/2022, revealed all 3 holds were initiated by YCW #5. On 07/12/2022, The Treatment Team met and determined YCW #5 triggered Resident #1's behaviors. Right after the meeting on 07/12/2022, YCW #5 was directed by Treatment Team Members to not become involved in any other holds for Resident #1. However, per the facility's camera coverage of the milieu and Resident #1's open door, and interiew with YCW #1, she was the first staff member to enter and secure Resident #1 in the hold on 07/17/2022. Continued interview, on 07/20/2022 at 5:22 PM with YCW #1, revealed she really did not think the	N 189		

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physical hold was even necessary because Resident #1 had been laughing with her before YCW #5 entered the resident's room. YCW #5 said she often laughed and joked with the resident and that seemed to calm him/her. She said even after YCW #5 secured the resident in the hold, and she (YCW #1) held his/her feet, she and the resident still laughed with each other, and he/she seemed to calm down. Further, she stated the resident did not throw anything at her and did not hit anyone before YCW #5 secured Resident #1 in the hold.

Review, of the Youth Physical Hold Seclusion Report, dated 07/17/2022, revealed YCW #1, YCW #5, and Shift Supervisor #1 were listed as staff present for the incident. Review of the summary narrative revealed the staff documented the following: "Resident was escalated from earlier in the day. Throughout the day, he/she continued to struggle off and on with regulating his/her mood and being able to remain safe in the milieu. Resident repeatedly opened his/her door when Staff (YCW #5 and YCW #1) gave expectations to close his/her door, due to staff debriefing. Resident refused and then started to come out of his/her room. Staff (YCW #5 and YCW #1) used proximity control while also using expectations for change. Staff (YCW #5 and YCW #1) approached Resident in his/her room. Resident started threatening to assault staff and yelling at Staff (YCW #5 and YCW #1). Resident then aggressively charged at YCW #5. Staff (YCW #5) attempted to secure the resident in a standing cradle. Resident was combative in attempting to pull away from staff while still also trying to assault them. These actions from the resident caused both resident and staff to become unbalanced and both resident and staff

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N 189	Continued From page 89 landed on the floor. Once on the floor, Staff (YCW #5) secured Resident at 2:25 PM in a kneeling cradle with Staff (YCW #5) securing lower extremities (legs) and Staff (YCW #5) securing upper extremities (arms in cradle position). Staff (YCW #5) prompted Resident to use his/her SCS while Staff (YCW #1) used empathy statements. Staff (Shift Supervisor #1) entered the room and took over for Staff YCW #5) on the upper extremities. Staff (YCW#5) left the room to get the impact cushion Resident continued to refuse to use his/her SCSs. Resident then vomited while in the seated cradle. Staff (Shift Supervisor #1 and YCW #1) assumed this was because he/she had eaten lunch shortly beforehand. Staff (YCW #1) became unable to secure his/her lower extremities due to her feeling nauseous. Staff (YCW #1 release his/her lower extremities came out of the room. Staff (YCW #5) first grabbed the impact cushion and then went back to Resident's room and began securing his/her lower extremities and Staff (YCW #5) continued to monitor Resident from her position on the lower extremities. Staff (YCW #5 and Shift Supervisor #1), continue to prompt resident to use his/her SCS. Resident argued and refused. Resident continued to struggle in an attempt to pull out of the restraint. But then he/she quickly stopped. Resident then appeared to become unconscious. Staff (YCW #5 and Shift Supervisor #1) immediately released the hold at 2:35 PM and started to assess the resident. Staff (YCW #5 and Shift Supervisor #1) continued to pat the resident and try to get a response. Staff YCW #5 began to put her fingers in his/her mouth to see if anything was blocking his/her airway. Staff (YCW#5) was able to scoop out vomit out of his.her mouth."	N 189		

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N 189	Continued From page 90 Continued review of the report revealed staff used a cold wash cloth and cold water on the resident to try to arouse him/her. The report indicated the staff thought the resident was breathing resident by his/her chest rising and falling but he/she was still not responding to verbal prompts. Staff (YCW #5 and Shift Supervisor #1) started CPR, and YCW #1 called 911. Continued review of the Physical Hold Seclusion report, under subcategory Processing/Contracting for safety Summary staff debriefing interventions and youth response, revealed, "Staff debriefing with agency leadership." Interview, on 07/20/2022 at 10:40 AM with Residential Manager #1, revealed he reviewed the video of the incident, and he said he did not see Resident #1 come out of his/her room before YCW #5 and YCW #1 entered the resident's room. Interview, on 07/20/2022 at 8:38 PM with YCW #1, revealed Shift Supervisor #1 took Resident #1 his/her lunch at about 1:30 PM. However, review of the camera coverage, revealed the Shift Supervisor took the lunch tray to Resident #1's room at 01:44 PM, which was 41 minutes before the hold was implemented according the Youth Physical Hold Seclusion Report, dated 07/17/2022. In addition, YCW #1 stated she had concerns about the comments Shift Supervisor #1 made to Resident #1 throughout the day, prior to the implementation of the hold, but she did not report her concerns to other supervisors or facility managers, on 07/17/2022, before the resident was placed in the hold, and subsequently passed away. YCW #1 also stated the hold was not	N 189		

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N 189	Continued From page 91 implemented in a manner consistent with her recent training and certification. She stated Shift Supervisor #1 placed extreme force on the resident pushing him/her so far forward that his/her nose almost touched the floor. YCW #1 stated that could have caused the resident to vomit. In interview, on 08/01/ 2022 at 07:17 PM, Shift Supervisor #1 stated she took over the hold in the resident's room because she knew YCW #5 had recently been directed to not become involved in holds implemented to manage Resident #1's behaviors. Interview, on 07/29/2022 at 2:49 PM, revealed after the incident, he went to the hospital to be with Resident #1. He stated it was very traumatic, but while there he began to think how the other residents would now perceive physical holding. Interview, on 08/02/2022 at 3:25 PM with Residential Therapist #3, revealed she received a call from the Assistant Clinical Director (her supervisor) who explained a resident was unconscious at the cottage next to the cottage where she was working, and she wanted her to go over there to see what had happened. She said when she arrived, the ambulance pulled off with the resident onboard. The cottage staff was very upset, and YCW #5 was crying and breathing heavily. YCW #1 had tears in her eyes, and Shift Supervisor #1 was sobbing so heavily, it was hard to make sense of what she was trying to tell me about the incident. She said the Supervisor stated another staff (she did not identify who) initiated the hold because the resident had been defiant, and would not keep his/her door shut during the routine staff	N 189		

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debriefing. She said she thought the Shift Supervisor said he/she was secured in a kneeling cradle hold, but that she (Shift Supervisor #1) took over the hold. Residential Therapist #3 said she did not know why Shift Supervisor #1 assumed holding of the resident. Residential Therapist #3 stated she took the residents to the gym on campus for awhile and talked with them. She said when she returned to the cottage later that day, she found out Resident #1 had passed away.

Additional interview, on 10/06/2022 at 11:03 AM with Residential Therapist #3, revealed she walked over to the cottage on 07/17/2022 at about 3:00 PM and stayed until about 9:30 PM. She said after the policed finished questioning the staff involved (YCW #1, YCW #5, and Shift Supervisor #1), management staff including The VP of Residential Services, The Clinical Director, The Assistant Clinical Director, The Chief Operating Officer (COO), Residential Manager #1, Resident #1's Residential Therapist, and The Division Director spent time reminiscing about Resident #1 and his/her stay at the cottage. She stated management asked the direct care staff what they needed from them. She stated there was no formal debriefing session regarding the incident. She said there were no conversations that evening about what precipitated the hold, what occurred during the hold, or what could have been done differently.

Interview, on 08/18/2022 at 2:35 PM with th VP of Residential Services, revealed by the end of the evening on 07/17/2022 many management staff arrived at the cottage and supported staff by allowing them to catch their breath and express their feelings, because the residents who had

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N 189	Continued From page 93 been taken to the gym for pizza were about to return to the cottage. The VP of Residential Services said we discussed ongoing supports for the cottage staff affected, by offering our Employee Assistance Program, as providing as staff trained in Psychological First Aid onsite during the days after the incident. She stated there was no additional meeting the next day with the 3 staff involved in the hold. The State Survey Agency (SSA) Surveyor asked the facility to provide written evidence of a debriefing session that occurred within twenty-four (24) hours of the incident and covered the topics as delineated in the facility policy, but no documentation of a formal debriefing was provided for review.	N 189		