PRINTED: 12/01/2022 FORM APPROVED Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING 950013 11/02/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2108 DAVID GRAVES DRIVE USPIRITUS-BROOKLAWN-PILOTS **LOUISVILLE, KY 40218** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) E 460 902 KAR 20:320 7(4)(c)2 Section 7. Admin and E 460 E 460 Oper of a Level I or II 8/5/22 All Residential Managers were retrained and (4) Direct-care staff for a Level I PRTF. reoriented to the policy and practice surrounding required ratios in the Level I PRTF Program. (c) In order to assure that the residents are adequately supervised and are cared for in a safe This included what required ratios were during and therapeutic manner, the direct-care staffing both sleeping and waking hours. plan for a Level I PRTF shall meet the requirements established in this paragraph. This included what procedures should be 2. At least one (1) direct-care staff followed in order to meet the policy and practices (i.e., who should cover shifts where member shall be assigned to direct-care events [call off, vacation, etc.] that could responsibilities for each three (3) residents during potentially allow a risk of operating out of normal waking hours when residents are not in ratio, who should be contacted in such school. circumstances, etc.). Residential Mangers will retrain all direct care staff working in a Level I PRTF on Level 12/16/22 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 8/5/22 staffing schedules for their assigned cottage(s) up This requirement is not met as evidenced by: to date and accurate. Based on interview, record review, and review of the facility policy, it was determined the facility Residential Director and/or Assistant failed to ensure that at least one (1) direct care Residential Director will routinely spot check monthly schedules created by the staff member was assigned to each three (3) Residential Managers to ensure they are residents during normal waking hours when the being updated timely and accurately. residents were not in school. Maintaining required ratios and keeping 8/5/22 & schedules adequately updated have both been On Sunday, 07/17/2022 from approximately 8:00 ongoing added as standing agenda items for discussion in AM to 2:00 PM, only two (2) staff were on duty to the bi-monthly (twice a month) Residential supervise and care for the nine (9) residents on Manager meeting. These items will continue to census at the cottage. In interview on 08/01 at be agenda items and will be discussed at each meeting by the Residential Director and/or

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

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

TITLE

President & CEO

issues with said items.

Continued on next page.

Assistant Residential Director to help ensure

consistency, that expectations surrounding these

items are being met, and to discuss any potential

(X6) DATE

rance

December 12, 2022



6SB011

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S		
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E 460	160 Continued From page 1		E 460	<ul> <li>A check box will be added to the Chan form that will verify that adequate staff</li> </ul>	ge of Shift	12/16/22	
	to monitor the regider	at to oppuse big/bor		ratios is in place before the off going d	ing to meet		
	to monitor the resident to ensure his/her well-being while he/she stayed alone for several			shift exits the cottage. All employees w			
	_			Level I PRTF will be informed of this n			
	hours in his/her room.  The findings include:			requirement.			
	The infalligs include.						
	Review of the facility	policy, titled Program					
		per: 6.01.02, Last Review,					
		ection B Direct Care Staffing					
		nized that youth needs may					
require an increased staff-to-youth ratio. Staffing							
		en needs arise for special					
		ions or at other times when					
	•	be anticipated such has					
	holidays, school brea	•	[			1	
	nondayo, concor broa	mo, ctoctora.					
	Continued review of t	the policy under Section C.					
		al Treatment Facilities, the					
		staffing ratio of at least 1 staff					
		waking hours and 1 staff per					
	9 kids during sleeping		,				
	3						
	Review of the Cottag	e's PRTF staff July 2022					
		n 07/17/2022 that two (2)					
	staff (YCW #1 and Sh	nift Supervisor #1) were					
		AM -2:00 PM. At 2:00 PM,					
	YCW #5 was schedul	-					
	PM-12:00 Midnight.						
	_						
	Review of camera co	verage footage from 8:30					
	AM to 2:00 PM, revea	aled only two (2) staff					
	persons, YCW #1 and	d Shift Supervisor #1 were in					
	the cottage working v	vith the residents.					
		2/2022 at 1:15 PM with YCW				i	
		ould be one (1) staff member					
		e (3) residents during					
	_	ted on 07/17/2022, while					
		on census, and the cottage					
	had 9 residents, there	e should have been 3 staff				ļ	

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  USPIRITUS-BROOKLAWN-PILOTS  A. BUILDING:  B. WING  11/02/2022  21/08 DAVID GRAVES DRIVE	AND PLAN OF	OF CORRECTION	F DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA CORRECTION IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  USPIRITUS-BROOKLAWN-PILOTS  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  2108 DAVID GRAVES DRIVE				A. BUILDING:	-		
USPIRITUS-BROOKLAWN-PILOTS 2108 DAVID GRAVES DRIVE			950013	B. WING	=	1	
USPIRITUS-BROOKLAWN-PILOTS	NAME OF PRO	PROVIDER OR SUPPLIER	VIDER OR SUPPLIER STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
I ACCION I P. 102 ABOVE	USPIRITUS	US-BROOKLAWN-PILOT	BROOKLAWN-PILOTS 2108 DAV	D GRAVES DR	IVE		
LOUISVILLE, KY 40218			LOUISVIL	LE, KY 40218			
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	PREFIX	(EACH DEFICIENC	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	(X5) COMPLETE DATE
E 460  Conlinued From page 2  on duly. 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 for 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 one (1) staff member per three should have been one (1) staff member per three of 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 to resident ratio was met. He stated he originally scheduled YCW #8 as the third staff person for the first shift to ensure the staff to resident at was met. He stated he originally scheduled YCW #8 as the third staff person for the first shift on 07/17/2022, but forgol YCW #8 did not work on Sundays. Residential Manager #1 said the could have		on duty. For example members had to imp was preferable to har any physical or emot resident, and the thir available to address in the cottage while t implementing an Em (ESI).  Interview, on 09/13/2 President (VP) of Re The Residential Man ensuring the appropricottages, but the Division Director may ensuring the staff to calling in staff or worthernselves.  Interview, on 08/18/2 Residential Manager the census at the colfor the first shift, from stated the staff-to-residents. He staff should have been or (3) residents. He staff should have been 3 day shift. He said he the staffing schedule person did not report should have notified found someone to fill unable to locate a stacottage, he would coensure the staff to restated he originally shird staff person for but forgot YCW #8 d	in 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 esident, and the third person would need to be evailable 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 hemselves.  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 lay 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 bound someone to fill the void. He stated if he was unable to locate a staff person to report to the stated he originally scheduled YCW #8 as the hird staff person for the first shift on 07/17/2022, but forgot YCW #8 did not work on Sundays.	E 460			

PRINTED: 12/01/2022 FORM APPROVED

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
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		950013			1 1/0.	2/2022
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LICOIDITII	C DDOOK! AWA! DII OT!		GRAVES DR	IVE		
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E 460	Continued From page	3	E 460	-		
	gotten YCW #11, an	as needed (PRN) staff				
	person, to fill in if son	neone at the cottage had				
		staff-to-resident ratio was not				
	_	Residential Manager #1			į	
		ould have had 3 staff on duty	-			
	_	ut he added that he thought			-	
		ad the ability to monitor the			ŀ	
	staff member to assis	022 with one (1) additional				
	Stall Illelliber to assis	striet.				
Interview with Director of Training and		or 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.					
	0	40/04/0000 0:00 Dtd				
		on 10/24/2022 at 3:09 PM				
		ential Services, revealed she with the staff to resident				
		the PRTF cottages. She				
		1 ratio was the law. Shesaid				
		one job was to keep the				
	•	aid with inadequate staffing,				
		en, and the residents needed				
		because they did not always				
		She stated on 07/17/2022			i	
		id not notify her leadership				
	_	short staffed, and since she				
		oyee she should have known				
		Manger #1, the Division				
		Division Director to get a				
		come in and cover the shift  The VP of Residential				
		staff person would have				
		ng Resident #1's needs on				
		ssisting other residents. She				
		ty on 07/17/2022 did not				
	follow the facility's sta					
	,					
			1	·	- (	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE St	
			A BUILDING	April 2	c	
		950013	B. WING	B. WING		2/2022
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	ATE, ZIP CODE		
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USPIKITU	S-BROOKLAWN-PILOTS	LOUISVILL	E, KY 40218			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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E 855	Continued From page	e 4	E 855	E 855		
E 855	Rights (12) A Level I or Leve cruel and unusual dis	e) (e) Section 8. Resident  el II PRTF shall prohibit all ciplinary measures including	E 855	<ul> <li>Jillian Parks and Amanda Whitlow did to work after the incident that occurred 7/17/2022. Deborah Francis, Jillian Pa Amanda Whitlow (staff who were invol- incident) were officially suspended on Employment of Deborah Francis and J was terminated 8/19/2022.</li> </ul>	on arks, and ved in the 7/20/2022.	Suspension 7/20/22 Termination 8/19/22
	the following: (e) Verbal abuse	e, ridicule, or humiliation;		Training on Client Rights and Respons Bellewood & Brooklawn Youth Rights. be provided at new hire orientation and (by September 30th each year, set up assign staff through the Relias Learning).	Training to dannually to auto-	8/15/22
	Based on interviews, coverage provided by	ot met as evidenced by: review of video camera v the facility, and policy		Management System). Updated Youth be more specific in what types of abus be protected from, to include shame, ri humiliation (see attachment).	n Rights to e youth will	12/8/22
	protect one (1) or ten Resident #1, from expridicule and humiliation On 07/17/2022 Shift Stanke Resident #1 state because she received the resident had been (1) hour before lunch, himself/herself. Resident out of his/her bedroor the residents were installed the resident was Supervisor #1 brough the resident's bedroor review, and per interview.	Supervisor #1 decided to ay in his/her bedroom all day d report from night staff that in misbehaving. About one, Resident #1 urinated on dent #1 stuck his/her hand in door (which was the way structed to make it known sistance) and Shift at dry clothes and a towel to in door. Per camera footage view with YCW #1, Shift		All existing staff were required to compadditional trainings by 9/2/22: Appropriance for the staff of the sta	iate ations; Off de tively hallenging r, specific icating and d by staff, ect for and of abuse ohysical, compliance ded in each	9/2/22
	room, turned to the of making bookmarks in this is what big boys/g themselves, and you	really pissed on yourself." f1 revealed two (2) of the okmarks heard Shift		Daily reviews of all Emergency Safety Interventions (ESPI) on business days weekends/holidays if necessary and the reviews of resident grievances are con- determine, in addition to any safety con- whether any youth rights are violated, include document and video reviews, wavailable. Any violations or concerns in documented, and the information is should be saff's supervisor for follow-up, white	and nrice-weekly nducted to ncerns, These when noted are nared with	9/1/22

FORM APPROVED Office of Inspector General (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: C B. WING 11/02/2022 950013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2108 DAVID GRAVES DRIVE USPIRITUS-BROOKLAWN-PILOTS **LOUISVILLE, KY 40218** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Continued from page 5 E 855 E 855 Continued From page 5 (cont.) include additional coaching, training, or disciplinary action. If there are safety issues The findings include: noted, these will be addressed immediately. Review of the facility's policy, titled Youth Monthly Safe Crisis Management (SCM) 9/1/22 Refreshers (1 hr) and annual Safe Crisis (Resident) Rights, not dated, revealed youth in Management (SCM) recertification (4 hrs) the residential program have the right to be provided to all cottage and clinical staff includes treated with consideration and respect for their review of Youth Rights and how to sensitively and human dignity and individuality including cultural effectively work with youth, especially when and personal values, and beliefs. In addition, the addressing particularly challenging or sensitive issues; this will include emphasizing that shame, resident had the right to receive adequate and humiliation, and/or ridicule is countertherapeutic humane services that included protection from and is not an acceptable intervention tool. neglect, verbal, mental, physical, and sexual Completion of all refreshers and annual Safe abuse. Crisis Management (SCM) recertification is recorded in staff's training record via Relias Review, of the facility policy titled Reporting of Learning Management System. 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

Office of Inspector General (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C. B. WING 950013 11/02/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2108 DAVID GRAVES DRIVE **USPIRITUS-BROOKLAWN-PILOTS LOUISVILLE, KY 40218** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)(EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) E 855 | Continued From page 6 E 855 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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE :		
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E 855	said he/she really did YCW #1 said she had Supervisor #1's state put Resident #1 in a l up. She said she sho someone, and she fe #1 said it was the firs implemented, that it v she really did not kno contacted. However, she reported her con- Traning and Professi- interviewed her for th investigation of the in  Interview, on 07/25/2 Supervisor #1, reveal other residents in the had urinated on hims not call out residents residents had that pre-	a big boy/girl. Resident #4 I not hear anything else. Id concerns about Shift ment that she was going to hold and make him/her throw uld have reported that to lit really bad about that. YCW t hold she had seen vas all very shocking, and w who she should have she said, after the incident, cerns to the Director of onal Development when he e facility's internal	E 855				
	However, the video of cottage milieu, revea 11:59 AM to 12:25:22 observed holding up colored paper while seated at the dining to color paper strips we YCW #1 was seated residents were drawin paper. At 12:35:30. Filong hallway and wall The resident paused looking at the other residents.	amera coverage of the led that on 07/17/2022 from 2 Shift Supervisor #1 was long rectangular pieces of the talked to the residents able. Markers and varied re observed on the table.					

Office of Inspector General (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: C B. WING 11/02/2022 950013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2108 DAVID GRAVES DRIVE **USPIRITUS-BROOKLAWN-PILOTS LOUISVILLE, KY 40218** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE. (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) E 855 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

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE 9	
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E 855	Continued From page	e 9	E 855	*		
E 855	inappropriate. He sai and he really had no Supervisor #2 said he like that occur at least cottage.  Interview, on 07/26/230, revealed if she thabusive toward a resimmediately talk with report the incident to residents were not in Interview, on 07/30/2#8, revealed abuse pevery month at Town staff.  Interview, on 07/28/2Resident #1's Resider revealed it was not uninate on themselve stated urinating on hibeen a means to ass not necessarily a con She said Shift Supervithe situation so that it Resident #1's peers thimself/herself. Said maintain his/her dign terse in their tone, or his/her for peers. The frequently enforce wit treatment was never when dealing with the	d that was unacceptable, words for that. Shift e had never seen anything t when he was on duty at the 022 at 4:20 PM with YCW# ought staff was being ident she would would that staff person, and then a supervisor. She stated the the facility to be abused. 022 at 2:54 PM with YCW prevention was discussed at Hall meetings for the PRTF 022 at 4:30 PM with the ential Therapist (#1), necommon for PRTF youth to s. Residential Therapist #1 mself/herselft could have ert some type of control, but iscious act on his/her part. Arisor #1 should have handled to did not become obvious to that he/she had urinated on staff must help the resident ity, and should never be shame a youth in front of a Therapist said we th staff that punitive acceptable. She stated a residents staff should never abusive treatment. She	E 855			
		022 at 12:20 PM with the ealed prior to the incidents of				
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Office of Inspector General (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ C B. WING 11/02/2022 950013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2108 DAVID GRAVES DRIVE **USPIRITUS-BROOKLAWN-PILOTS** LOUISVILLE, KY 40218 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) E 855 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 1085 E1085 902 KAR 20:320 10(3) Section 10. Quality E1085 Assurance 9/6/22 Implemented CLT-007 Speak Up for Client Safety-Intervening and Escalating Safety (3) A Level I or Level II PRTF shall record all Concerns policy (see attachment). This policy and procedure has been implemented to ensure incidents or accidents that present a direct or staff know that they can and should intervene in immediate threat to the health, safety or security any potentially dangerous situation. The policy of any resident or staff member. Examples of and procedure also ensures that staff know who incidents to be recorded include the following: to talk to about concerns. physical violence, fighting, absence without leave, Vice President of Residential Programming use or possession of drugs or alcohol, or 10/7/22 notifies the Chief Executive Officer (CEO) inappropriate sexual behavior. The record shall immediately of any of the following be kept on file and retained at the facility and situations: youth AWOL (Absent Without Leave), shall be made available for inspection by the youth injury or illness requiring outside medical licensure agency. 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. This requirement is not met as evidenced by: Continued on next page. Based on interview, record and policy review, it

FORM APPROVED Office of Inspector General (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 11/02/2022 950013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2108 DAVID GRAVES DRIVE USPIRITUS-BROOKLAWN-PILOTS **LOUISVILLE, KY 40218** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) E1085 Continued From page 11 11/1/22 Division Director for Residential (or Assistant Director as available) meets with the Residential was determined the facility failed to implement Managers at least twice a month to review each their Quality Assurance Program Processes to youth's progress and provide guidance on staff ensure the facility's administration remained fully needs. Division Director for Clinical (or Assistant aware of all incidents and any contributing factors Director for Clinical as available) meets with each that presented direct and immediate threats to therapist at least twice a month to review each youth's treatment progress and troubleshoot any the health, safety, and security of one (1) of ten barriers to success. Vice President of Residential (10) sampled Residents, Resident #1. Programming meets with Division Directors for Clinical and Residential for supervision and On 07/17/2022 at 2:25 PM Shift Supervisor #1 reviews treatment issues and supervisory issues related to staff, to provide consult and guidance and Youth Care Worker (YCW) #5 failed to on how to handle such situations. Vice President implement a kneeling cradle hold in accordance of Residential Programming then notifies the with the facility's Physical Holding Policy. The Chief Executive Officer of any potentially staff members placed Resident #1 in a restraint dangerous situations or other situations as appropriate. (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, Office of Inspector General (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 11/02/2022 950013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2108 DAVID GRAVES DRIVE USPIRITUS-BROOKLAWN-PILOTS **LOUISVILLE, KY 40218** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) E1085 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

FORM APPROVED Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING 11/02/2022 950013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2108 DAVID GRAVES DRIVE USPIRITUS-BROOKLAWN-PILOTS **LOUISVILLE, KY 40218** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 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.

Office of Inspector General (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING 11/02/2022 950013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2108 DAVID GRAVES DRIVE USPIRITUS-BROOKLAWN-PILOTS **LOUISVILLE, KY 40218** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRFFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) E1085 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

PRINTED: 12/01/2022 FORM APPROVED Office of Inspector General (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: C B. WING 11/02/2022 950013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2108 DAVID GRAVES DRIVE USPIRITUS-BROOKLAWN-PILOTS LOUISVILLE, KY 40218 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) E1085 E1085 Continued From page 15 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

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

considered.

Office of Inspector General (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING C B. WING 11/02/2022 950013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2108 DAVID GRAVES DRIVE **USPIRITUS-BROOKLAWN-PILOTS LOUISVILLE, KY 40218** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE tD (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) E1085 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 Interview, on 08/05/2022 at 11:10 AM with

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Office of Inspector General (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING C B. WING 11/02/2022 950013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2108 DAVID GRAVES DRIVE **USPIRITUS-BROOKLAWN-PILOTS LOUISVILLE, KY 40218** PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) E1085 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

FORM APPROVED Office of Inspector General (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING: C B. WING 11/02/2022 950013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2108 DAVID GRAVES DRIVE **USPIRITUS-BROOKLAWN-PILOTS LOUISVILLE, KY 40218** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) E1085 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

Office of Inspector General (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING: C B. WING 11/02/2022 950013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2108 DAVID GRAVES DRIVE USPIRITUS-BROOKLAWN-PILOTS **LOUISVILLE, KY 40218** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE DATE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) E1085 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

Office of Inspector General (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C B. WING 11/02/2022 950013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2108 DAVID GRAVES DRIVE **USPIRITUS-BROOKLAWN-PILOTS LOUISVILLE, KY 40218** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) E1085 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 VPof 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. E2130 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;

Office of Inspector General (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: C 11/02/2022 B. WING 950013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2108 DAVID GRAVES DRIVE USPIRITUS-BROOKLAWN-PILOTS **LOUISVILLE, KY 40218** PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETÉ PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) E2130 Continued From page 22 E2130 E2130 Cottage staff are to contact and obtain Process consultation from the Clinical Consultant on-call ffective for preventing the implementation of a physical 9/9/2022 hold, when at all possible, as youth is escalating. If the youth's Treatment Team Physician or the This requirement is not met as evidenced by: Policy and Clinical Consultant is not present and failure to procedure Based on interview, record, and policy review it intervene causes an immediate threat to the approved youth or others, staff trained in Safe Crisis was determined the facility failed to ensure Pilot's 12/9/2022 Management may initiate the physical holding Cottage Staff called the Clinical without prior approval and call the Clinical Consultant-on-Call on 07/17/2022 at 2:25 PM to Consultant as immediately as safely possible in obtain direction for preventing the implementation order to obtain consultation and for the Clinical Consultant to respond to the location. Please see of an Emergency Safety Intervention (ESI) in the updated policy and procedure attached that form of a physical hold for one (1) of ten (10) outlines these steps more clearly. sampled Residents, Resident #1. Clinical Consultants will be notified of any use of Process Youth Care Worker (YCW) #5 and YCW #1 physical holding and will provide consultation to effective the staff, and for PRTF youth, provide/write the entered Resident #1's bedroom (out of camera 1/22/2022 order for the use of the physical holding when view) at 2:25 PM, and YCW #5 secured the they arrive to assess the situation. The order will Policy and resident in a kneeling cradle hold. Per staff include the date and time of the order and the procedure interview and review of cottage camera footage, length of time for which the physical hold was approved three (3) staff were on duty at the time of the authorized. Clinical Consultants are clinically 12/9/2022 licensed professionals who meet the requirement hold, but there was no evidence that any of the 3 of "other licensed practitioners" allowed by the staff (YCW #1, YCW #5, or Shift Supervisor #1) Commonwealth to order physical holding, contacted the Clinical Consultant-on-call to seek seclusion, and conduct face-to-face assessments. assistance. Interview with YCW #1, a witness to Residential and Clinical leadership will monitor the physical hold that occurred in the resident's 9/1/22 this process through the daily review of bedroom (out of camera view), revealed the hold holds. Daily hold reviews began 9/1/2022. was not implemented per the facility'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

Office of Inspector General (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C B. WING\_ 11/02/2022 950013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2108 DAVID GRAVES DRIVE **USPIRITUS-BROOKLAWN-PILOTS LOUISVILLE, KY 40218** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) E2130 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.

FORM APPROVED Office of Inspector General (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 11/02/2022 950013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2108 DAVID GRAVES DRIVE **USPIRITUS-BROOKLAWN-PILOTS LOUISVILLE, KY 40218** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) E2130 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

FORM APPROVED Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: B. WING 11/02/2022 950013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2108 DAVID GRAVES DRIVE **USPIRITUS-BROOKLAWN-PILOTS LOUISVILLE, KY 40218** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) E2130 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.

PRINTED: 12/01/2022 FORM APPROVED Office of Inspector General (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 11/02/2022 950013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2108 DAVID GRAVES DRIVE USPIRITUS-BROOKLAWN-PILOTS **LOUISVILLE, KY 40218** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) E2130 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

Office of Inspector General (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: \_ С B. WING\_ 11/02/2022 950013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2108 DAVID GRAVES DRIVE **USPIRITUS-BROOKLAWN-PILOTS LOUISVILLE, KY 40218** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) E2130 E2130 Continued From page 27 camera, was very upsetting because that was not supposed to occur, either.

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N 000	Initial Comments		l N	000			
	An abbreviated surve	ev was initiated on	l				
		luded on 11/02/2022, to	1				
		7021. The complaint was					
		e facility was found to be out					
		e Conditions of Participation	i				
	at 42 CFR 483,354 U	•					
	Seclusion, Standard	level deficiencies were					
	identified at N0115, I	N0126, N0128, N0132,					
	N0165, N0170, N018		1				
		ns, interviews, record and					
	policy review it was d	etermined the two (2) staff,					
		YCW) #5, Shift Supervisor					
		Safe Crisis Management					
		ld, in accordance with the					
	-	ding policy, to prevent					
		g in the death of one (1) of					
		esident #1; the facility failed					
	12	ciplinary Treatment Team					
		Treatment and Behavior					
		it was determined on					
		W #5 triggered Resident #1's					
		ed the YCW to not become					
		holds for Resident #1; the					
		ct Resident #1 from an					
	unapproved seclusion						
	extended period of tir						
		M, when Shift Supervisor #1					
		r approval from clinicians or					
		p Resident #1 in his/her			RECEIVED		
		e heard from the night shift					
		had misbehaved; the facility			DEC 1 2 2022		
	· ·	dent #1 from experiencing			DEC 17 7077		
		ergency Safety Intervention			OFFICE OF INSPECTOR GENE	BAL	
	(ESI) a physical hol				DIVISION OF HEALTH CARE FACILITIES AND SE		
		revealed Resident #1 had					
	not placed himself/he	erself or others (staff nor					
LABORATORY	NOCTOR'S OF PROVINCES	SUPPLIED REPRESENTATIVE'S SIGNATURE	I		TITLE		(X6) DATE

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

President & CEO

December 12, 2022

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	residents) in harms w	ray before he/she was					
	secured in the hold by	-					
i		17/2022 at approximately					
	2:25 PM; the facility fa						
	monitored and address	ssed the physical and					
		ng of Resident #1, and did					
	not act on the residen	nt's symptoms of distress					
	while in the hold (vom	niting and crying) before					
	he/she became unres	sponsive and required					
		suscitation (CPR), and					
		al emergency department					
	(ED); the facility failed				İ		
ŀ	-	Resident #1's bedroom					
		ng the resident during the			1		
	time period (8:00 AM-						
	•	d without prior approval to					
		is/her room, not in the					
		lents, because he/she was					
		ehaved on the night shift;					
	*	sure Resident #1 was not					
		ng the timeout room area on					
		W #5 physically blocked the					
		lieu when the resident					
	*	e timeout area and re-enter					
	-	failed to provide evidence of					
	_	within 24 hours of a physical d (YCW #5, Shift Supervisor					
		Vorker YCW #1) where the					
	resident vomited duri						
		l and emotional distress,			<u> </u>		
		scious state, and died that	-				
		48 PM). Based on the					
		eopardy (IJ) was identified					
	_	2 at regulatory violation					
		led to implement Safe Crisis					
		nner that prevented physical					
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OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '		(X3) DATE SURVEY COMPLETED
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İ	18L013	B. WING		11/02/2022
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		N 00	10	June & love wis
				110
USE OF RESTRAINT CFR(s): 483,354	AND SECLUSION	N 10	<ul> <li>Suspended Deborah I and Amanda Whitlow</li> </ul>	as of
				terminated 8/19/2022.
	•		lana diaka kanandan	was identified on 9/6/22
			7/17/22, and Bellewoo notified on 8/22/22. Im was validated as remo order to remove Imme	od and Brooklawn was nmediate Jeopardy oved on 9/6/22. In ediate Jeopardy, the
This CONDITION is r	not met as evidenced by:			
	· ·		these actions received	
			All setters of	nd clinical staff were 9/1/22
				th required annual
			three (3) hou	r Safe Crisis
				t (SCM) Recertification
				te a standing and
				dle hold by September
Youth Care Worker (N Supervisor #1, failed Management (SCM), accordance with the fa to prevent serious har of one (1) of ten (10) s #1. It was determined the resident's treatme plans were revised aff on on 07/12/2022, and triggered Resident #1 behaviors resulted in	CCW) #5 and Shift to implement Safe Crisis a physical hold, in acility physical holding policy m that resulted in the death sampled residents, Resident the facility failed to ensure ent and behaviors support ter the Treatment Team met d determined that YCW #5 's attention-seeking him/her being secured in a		following add trainings by S • App Eme Situ • Spe Safe	taff also completed the 9/6/22 litional required September 6, 2022: propriate Responses to pregency Safety lations late Up for Client lety late Off Communication
	ROVIDER OR SUPPLIER S-BROOKLAWN-PILOTS  SUMMARY ST. (EACH DEFICIENCY REGULATORY OR LETTER COMPONENT OR LET	TOURIER OR SUPPLIER  S-BROOKLAWN-PILOTS  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 2  Officer (COO) were notified of the IJ on 08/22/2022 and 1:14 PM.  USE OF RESTRAINT AND SECLUSION	ROVIDER OR SUPPLIER S-BROOKLAWN-PILOTS  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 2 Officer (COO) were notified of the IJ on 08/22/2022 and 1:14 PM. 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 sectusion 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	ROVIDER OR SUPPLIER S-BROOKLAWN-PILOTS  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  COntinued From page 2  Officer (COO) were notified of the IJ on 08/22/2/2022 and 1:14 PM.  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 falled to comply with 42 Code of Federal Regulations (CFR) Part 483 Subpart G, the Condition of Participation for the use of restraint or seckusion 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 hold, in accordance with 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 VCW #5 triggered Resident #1's attention-seeking behaviors resulted in him/her being secured in a

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Staff directed YCW #5 to disinvolve herself vany future holds for Resident #1, she was the 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 protect Resident #1 from unapproved seclusionary time-out for an extended period time from 8:00 AM-2:25 PM on 0717/2022, whift Supervisor #1 decided the resident must remain in his/her room, and not participate in milieu with other residents and activities. The because the night shift staff informed the Shi Supervisor #1 that the resident had threaten other residents and hit staff during the night. However, via interview with night shift staff a per review of camera coverage of the milieu, there was no evidence the resident inflicted to n himself/herself or others at the cottage duthe early morning hours of 07/17/2022. It was determined the facility failed to protect Resid #1 from an unnecessary Emergency Safety Intervention (a physical hold) on 07/17/2022. 2:25 PM. Interview with YCW #1, an eyewith 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 was determined the facility failed to ensure secured and addressed Resident #1's 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 8:00 AM to 2:25 PM, continuously assessing resident #1 in his/her bedroom, and out of the Resident #1 in his/her bedroom, and out of the Resident #1 in his/her bedroom, and out of the Resident #1 in his/her bedroom, and out of the Resident #1 in his/her bedroom, and out of the Resident #1 in his/her bedroom, and out of the Resident #1 in his/her bedroom, and out of the Resident #1 in his/her bedroom, and out of the Resident #1 in his/her bedroom, and out of the Resident #1 in his/her bedroom, and out of the Resident #1 in his/her bedroom.	vith e first d to l of when st o the e was ift ed nd harm oring s lent at ess, e g #1. It taff sical illing sive	policy. Attendis recorded in record via the Management  All cottage and reviewed and understand the and do's and physical holds agency Medical 15, 2022.  All cottage and reviewed and review and understand the and cottage and reviewed and review and understand the and cottage and review and understand the and cottage and review and understand the and cottage and review and understand the and cottage and review and understand the and cottage and review and understand the and cottage and review and understand the and cottage and review and understand the and cottage and cottage and review and understand the and cottage and co	effectively interally during entially during entially unsafe, specific steps of communicating propriate, unsafe, behaviors existed that down and dignity, tural and persany forms of a sing verbal, mential abuse. Comwith these and reded in each staff in Safe Crisis (SCM) refreshance and comeach staff's trace and comeach staff attested in which is authored by the definition of the derivation of the derivat	s were ng and afe, or hibited not  conal abuse ental, npletion iditional distring  remain  ners per pliance aining ng  iting to Sheet to the August	9/1/22 8/15/22

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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  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	N 100	milieu, because she s #1 had acted up (misi morning hours of 07/2 the facility failed to en Resident #1 from lead hallway on 07/09/202 blocked the door back resident tried to open It was determined the evidence of a debriefit twenty-four (24) hours Supervisor #1, and Y6 07/17/2022 when Res hold by YCW #5 and vomited, cried and the unconscious state, re transferred to a local where he expired on 8 Immediate Jeopardy 07/17/2022. The facilit Regional Programmir Officer (COO) were n 08/22/2022 at 1:14 Pl The facility provided a plan on 09/04/2022 al 09/06/2022. The State removal of the IJ on 0  1. All cottage and clin with the required three Training including how standing and kneeling September 1, 2022Training Director will compliance and docu complianceVice President will re	said staff reported Resident behaved) during the early 17/2022. It was determined issure staff did not prevent ving the time-out room 2 when YCW #5 physically k into the milieu when the the door to enter the milieu. I facility failed to provide ing session, within Is with YCW#5, Shift CW#1 who were on duty on Sident #1 was secured in a Shift Supervisor #1, en lapsed into an equired CPR, and was Emergency Department that same day at 4:48 PM. was identified to exist on ity's Vice President of ing, and the Chief Operating otified of the IJ on M.  an acceptable IJ removal Illeging removal of the IJ by e Survey Agency validated 19/06/2022, as alleged.  ical staff will be compliant e (3) hours Recertification w to safely execute a g cradle hold no later than  be responsible for tracking mentation to support	N 1	Reporting Abus or Exploitation Physical Holdin Seclusion of You Existing staff completed writte the information included in the policies. Completion and commercorded in each staff's trainity in the Relias Learning Mana System.  All cottage and clinical staff educated and attested to understanding of a Zero philosophy. Existing staff completed a test on under of this philosophy by Sep. 06, 2022.  Training was provided for cottage and clinical staff covered: 1, when it is appropriate to initiate seclusion, including appropriate of initial and conting authorization; 3, when it appropriate to initiate exist ime out, including appropriately of initial and conting authorization; 4, how to medical emergencies, in not limit to how to interve appropriately for youth we potential adverse reaction staff attested to understatinformation provided, and completed a written test this training.	g of Youth oth oth oth oth oth oth oth oth oth o	9/6/22	

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG			COMPLETION DATE	
N 100	All cottage and clini date with monthly SC Training Director will be	ical staff will remain up to M refreshers. De responsible for tracking	N 1	for Reduction of Seclusion and Restraint project implementation Six Core Strategy Steering Committee/Leadership Subcommet for the first time on Septem	n. The mittee ber 27,	9/4/22	
	review and attest in w Medical Tip Sheet and	mentation to support ical staff were informed to riting to understand the d do's and don'ts specific to ed by the agency medical		2022. On November 17, 2022, the Prevention Tools and Debriefing Subcommittees met for the first The Data Subcommittee is scheet to meet for the first time on January 2023.	time. eduled uary 4,	0/4/22	
	4. All cottage and clinicative and attest to refollowing policies and August 15, 2022): Appendix Clients right Youth rights Grievances- Resolving Reporting Abuse, Neg Physical Holding of Youth Existing staff will compincluded in the policie information and comp For the above items dup to and including tercomplete and follow the Director, Assistant Redirector, Assistant Clienter Clienter and Included in the defendence of the August 15 of the August 16 of the Aug	August 15, 2022.  ical staff were informed to eview and understanding the procedures (completed as and Responsibilities and ag Client Complaints glect or Exploitation bouth as New staff will receive elete test during orientation. isciplinary action will occur, remination if staff do not the action items. Residential sidential Director, Clinical inical Director, and will oversee their rts follow through on rsight by the Vice President. lanager will be consulted icision making, as well.		o Began daily reviews of all Emer Safety Physical Interventions (E business days and weekends/h if necessary and thrice-weekly r of resident grievances to determ addition to any safety concerns, whether any youth rights are vion These include document and vion reviews, when available. Any vion concerns noted are document and the information is shared with staff's supervisor for follow-up, may include additional coaching training, or disciplinary action, upon including termination of employs addition, the review information distributed to the executive team Bellewood and Brooklawn residictlinical, and quality leaders.  Ongoing monitoring/compliance procedu  • Updated Youth Rights document to its specific language emphasizing that you should be free from any type of shar ridicule, or humiliation (see attachment in the youth (and their guardians) at admitted to the procedure of th	SPI) on olidays eviews nine, in olated. deo olations ated, ith the which I, p to and ment. In is n and ential, res: nclude youth ne, ent). If given	9/1/22 Revised 12/8/22	
	5. All clinical and cotta attested to an underst	ge staff were educated and and and and and and a Zero Hold		Continued on next page			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED	
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N 100	of this philosophy by staff will receive inform during orientation. Ye provided and will be to Director.  -Quality Assurance wi incident report review  6. A facilitator and imposen identified for Six Reduction of Seclusion implementation.  -This evidence-based makeup of steering condocument title "Six Confectuation and Resicommittee will be massenior leadership staff of experience in areast leadership, clinical work.  7. Day Shift Supervise Worker #5 were put on 2022 and subsequent 2022. Youth care workeave July 20, 2022 put MPD and Crimes Againvestigation and the fill when Youth Care Worker will be required to Recertification, any notatest and complete the allowed to work.  8. A training will be deand clinical staff to be	replete test on understanding September 06, 2022. New mation and complete test arry refresher will be racked by the Training for all physical holds.  For and Restraint project for an and Restraint project for and Restraint project for and Restraint project for and Restraint project for and Restraint project for and Restraint project for Reduction traint, "The Steering for Reduction traint, "The Steering for Reduction for the project for the project	N	100	Monthly Safe Crisis Management (S Refreshers (1 hr) and annual Safe C Management (SCM) recertification (includes review of Youth Rights and sensitively and effectively work with especially when addressing particula challenging or sensitive issues; this include emphasizing that shame, humiliation, and/or ridicule is countertherapeutic and is not an act intervention tool. Completion of all refreshers and annual Safe Crisis Management (SCM) recertification is recorded in staff's training record via Learning Management System.  * Appropriate Responses to Emergen Safety Situations; Speak Up for Clie Safety; and Hand-Off Communication. These trainings will be completed by staff during New Hire Orientation, wi first three (3) weeks of employment, before working with youth. These trainclude information on how to safely effectively interact with youth, especially effectively interact with youth, especially countertherapeutic behaviors exhibit staff, especially those that do not sh respect for human dignity, individual cultural and personal beliefs, as wel forms of abuse and neglect including mental, physical, and sexual abuse. existing staff will complete these train on an annual basis, to be completed each year. Completion of and compl with these trainings is recorded in eastaff's training record via the Relias Learning Management System. Staff begin work nor continue work with youth! demonstrating understanding o concepts.  Continued on next page	crisis 4 hrs) — how to youth, arty will ceptable s Relias cy nt on. y all new ithin the and sially afe e and or ted by ow I as any g verbal, All mings I by 9/15 liance ach f cannot outh	

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N 100	to initiate a physical hinitiate a seclusion, in initial and continuatio appropriate to intimat including appropriate continuation authorize medical emergencies how to intervene appropotential adverse rea 9. Existing staff compitating. New staff will complete test during to be provided and will Director.  10. All cottage clinica attest to understanding the policy on Hand-O September 6, 2022. A provided and will be to Director.  A policy on seeking see ("Speak Up for Client Escalating Concerns, co-workers or supervin line with current pocottage and clinical stepolicy and attest to un requirement to follow 2022. Existing Staff winformation in the policy september 06, 2022. Information and compiling intervals.	mber: when is in appropriate old: when it is appropriate to cluding appropriate levels of a authorization: when it is e exclusionary time out, levels of initial and ation; how to respond to including but not limit to opriately for youth who have ctions.  Ileted a test as part of this I receive information and orientation. Yearly refresher II be tracked by he Training  I staff will be trained to and and and requirement to follow ff Communication by rearly refresher to be racked by the Training  upport and intervention Safety-Intervening and including when actions of isors is not appropriate and licy, is being developed. All aff will be trained to this inderstanding and the no later than September 06, will complete a test on the cy to be completed by New staff will receive the olete a test during reshers will be provided and	N	100	Zero Hold Philosophy Training: 6 Co	g new freshers linical ion and staff's ng ency ) on hys if s of ucted to are nd video ons or id the include iplinary on of cutive	9/1/22	

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				LOUISVILLE, KY 40218			
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N 100	Continued From page 8		N 10				
	11. All physical holds leadership to determing and/or training needs.	ne any corrective action					
	managers' meetings v	neetings and residential will include review and residential resindicated above, This eting minutes.	:				
	and monitoring of all a include but not limited cottage and written fe PEM model including feedback form; ongoin performance and com and training. In addition	sponsible for all oversight action items. This will to: ongoing observations in edback, which is part of utilizing the observationing supervision regarding apliance with procedures on, SCM refreshers have all the model and training					
N 115	INDIVIDUAL PLAN OF CFR(s): 441.155(c)	FCARE	N 11	5 N 115 i			
	team specified in §44 (1) Determine the service were required on an in (2) Recommend chan by the beneficiary's over inpatient.  (d) The development care as specified in the	vices being provided are or inpatient basis, and ges in the plan as indicated verall adjustment as an and review of the plan of is section satisfies the irements for - [paragraph		All clinical staff are to review and upor changes on the treatment plans and Behavior Support Plans depending or notated changes to clinical needs, trior coping strategies spoken about in treatment team or other designated meetings or conversations.  Continued on next page	on iggers,	Reminded 12/9/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED	
		18L013	B. WING	8. WING			C 02/2022
	ROVIDER OR SUPPLIER S-BROOKLAWN-PILOTS		STREET ADDRESS, CITY, STATE, ZIP CODE 2108 DAVID GRAVES DRIVE LOUISVILLE, KY 40218			7.11	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 115	This ELEMENT is not Based on interview, of and camera footage of determined the facility Treatment Plan and E one (1) of ten (10) sat #1. Record review and Treatment Team met Emergency Safety Inholds), and determine (YCW) #5 had been in 07/01/2022, 07/08/20 Interviews revealed the YCW #5 "triggered" FResident #1's Resider Residential Manager told YCW #5 to not sephysical holds. Hower #5 was the first staff promotion of the properties of #1 and took over the hold Supervisor #1 entered and took over the hold Supervisor #1 said shad been directed to physical hold. Intervient to assist by Review of the resident #1 continued to assist by Review of the resident	t met as evidenced by: linical record, policy review, of the cottage, it was y failed to revise the Behavior Support Plan, for impled residents, Resident d interview revealed the and discussed three (3) terventions (recent physical ad Youth Care Worker involved in all three holds on 122, and 07/09/2022.  The Treatment Team decided Resident #1's behaviors. Intial Therapist, and the where Resident #1 lived, acure Resident #1 in ver, interview revealed YCW person to enter Resident 022 at 2:25 PM and placed . Shortly afterward, Shift d the resident's bedroom	N	115	<ul> <li>In the discussion of cases in weekly supervisions with clinical supervisor. Behaviors Support Plan will be discuensure they are being updated as no include changes in triggers and copiskills. The Behavior Support plan will updated if there are situations impacy outh's treatment success. For examination impact of Emergency Safety Physical Interventions, such as physical holds particular youth care workers. If trigobserved to be significant while in the treatment facility, the Behavior Supposit be updated the same day in the section.</li> <li>Primary Therapists and program mawill review the updated Behavioral SPlanduring their weekly consultation the Oak program manager meets with Oak therapist each week).</li> <li>Once updated the therapist will share Behavior Support Plan with the program anager of that particular cottage at cottage staff.</li> <li>Facility policy, CS-004 Assessment, Treatment Planning and Reassessm states each client at the facility has a evaluation that gathers sufficient informed the development of recommendation services, an individualized treatment care, and reassessments to inform of treatment needs. This policy will be reviewed in clinical meeting annually beginning of the fiscal year and sign current clinicians. It will also be reviewed in clinicians during onboardin organization will ensure provision of comprehensive evaluation of the youthe oversight of the Clinical Director include key needs in assessment.</li> </ul>	the ussed to eeded to ing ill be cling the nple, the all s with gers are ne port Plan triggers unagers support is (i.e. ith the interest of the promotion of th	12/12/22 12/12/22 12/15/22

NAME OF PROVIDER OR SUPPLIER  USPRITUS—BROOKLAWN-PILOTS  ISLAMMARY STATEMENT OF DEPICIENCIES  (PA) ID  PREPRIX  REGOLATORY OR ISC IDENTIFYING INFORMATION)  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 VCW #5 to not place Recident #1 in a hold. During the hold on 07/11/2022, it which YCW #5 continued to participate in after Supervisor #1 entered and took over the kneeling gradle hold, the resident alipsed into an unconscious state, and eventually required Cardiopulmonary Resusciation (CPR) and subsequent transfer to the hospital for advanced life support. The resident did not recover, and was pronounced decessed on 07/11/2022, 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 and the facility) had an evaluation that gathered sufficient information for development of recommendations for services, and an individualized treatment plan of care, and reassessments and real process that occurred with contacts and services ongoing. Structured reassessments and real process that occurred with contacts and services ongoing. Structured reassessments and realment plan a 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 realment plan as retainent of the 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 realment plan as retainent of the control of the policy of the policy in the policy in the resident of the resident of the residence of the residence of the residence of the residence of the residence of the residence of the residence of the residence of the residence of the residence of the residence of the residence of the residence of the residence of the r	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l''		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
MAME OF PROVIDER OR SUPPLIER  USPIRITUS-BROOKLAWN-PILOTS  SUMMARY STATEMENT OF DEFICIENCIES PREEDED BY FULL REGULATORY OR ISE IDENTIFYING INFORMATION)  PREERIX FACE PROVIDER OR SUPPLIER TO DEFICIENCIES (ACH DEPRICEMENT WILES TO PRECEDED BY FULL REGULATORY OR ISE IDENTIFYING INFORMATION)  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 Suppervisor #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 of the clients. The purpose of the evaluation of the clients for total individualized treatment plan in the client and hisher family, as indicated. Reassessments and treatment plan in the client and hisher family, as indicated. 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				A BUILUI	NG		С	
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Countine   Countine	HODIDITH					2108 DAVID GRAVES DRIVE		
PREFIX TAG  REGULATORY OR ISC IDENTIFYING INFORMATION)  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 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 of cover the development of feinfuldualized treatment plan with the client and his/her family, as indicated. 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	USPIRITUS	S-BROOKLAWN-PILOTS				LOUISVILLE, KY 40218		
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 Ressessment, Policy Number: CS004, dated 06/02/2021, reveated 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 may be a find the purpose of the evaluation of the clients. The purpose of the evaluation of the clients. The purpose of the evaluation of the clients. The purpose of the exaluation was to clarify and identify the client's principle reasons for obtaining services. According to the policy, the evaluation of services provided and that are also provided and that adjustments were	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFI	PRÉFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRIA			COMPLETION
order to ensure the client continued to meet need for services provided and that adjustments were		Continued From page Plan, dated 06/28/20/2 evidence the facility of decisions made and of place Resident #1 in a 07/17/2022, in which participate in after Su took over the kneeling lapsed into an unconsequired Cardiopulmo and subsequent transadvanced life support recover, and was profuzed or and was profuzed to the facility of the findings include:  Review of the facility of the facility of the findings include:  Review of the facility of the facility of the development of record and an individualized reassessments to inform the finding of the evaluation that gather developments of the evaluation of	e 10 22, revealed there was no evised the plan to reflect the conveyed to YCW #5 to not a hold. During the hold on YCW #5 continued to pervisor #1 entered and g cradle hold, the resident scious state, and eventually mary Resuscitation (CPR) after to the hospital for the tresident did not mounced deceased on M.  policy, titled Assessment, and Reassessment, Policy and 06/02/2021, revealed at the facility) had an ared sufficient information for mendations for services, treatment plan of care, and form ongoing treatment of the policy revealed the provision of a ation of the clients. The ation was to clarify and inciple reasons for obtaining to the policy, the evaluation and of the individualized e client and his/her family, assment was a process that is and services ongoing.			DEFICIENCY)		
Lorenz or ord realitient dan as realitien		order to ensure the cli for services provided	ent continued to meet need and that adjustments were					

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NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
LICOIDITUI	PROOVI AWN BU OTS			2	108 DAVID GRAVES DRIVE			
USPIKITUS	S-BROOKLAWN-PILOTS			L	OUISVILLE, KY 40218			
(X4) ID		ATEMENT OF DEFICIENCIES	D		PROVIDER'S PLAN OF CORRECTION		(X5)	
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N 115			N	115				
	progressed toward dis	_						
	individual's response							
		eeds. Client was defined in					!	
		idual which included "youth"					l	
	(residents) at the facil	ity.						
	Review of the facility	policy, titled Assessment,						
	Treatment, Planning a	and Reassessment, Policy:						
	CS-004C, last review	date, April 12,2022,						
ĺ		Screening and Evaluation,						
	once a youth was adn							
ĺ		an of Care and Behavior						
		e initiated by the Director of						
		Id be completed by the						
	therapist within in twe	rity-lour (24) hours of red, signed and dated by the						
		or Support Plan (BSP),						
	would include situatio							
		dentified by the youth /family						
:	that would help contro	•				,		
	techniques that would	I assist in minimizing the						
		seclusions. In addition, the					!	
	behavioral support pla	an will include any history of						
		use or other trauma that						
		emotional trigger for youth						
		d/seclusion. The evaluation						
	•	e multiple assessments,						
		ychiatric, and psychosocial,						
	indicated. According t	ional assessments, as						
		essments, an individualized						
	treatment plan would							
		n within ten (10) days of						
		F programs. Continued						
	review of the policy re	. •						
		be assessed every thirty						
	(30) days to evaluate	the appropriateness of						
	continued treatment,	progress on goals and						
	objectives, and the ne	ed for revisions to the plan.						

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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1 1 1 1 1 1 1 1 1			ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
In addition reviewed the child progress team will improve This is us treatment during a Review of Assessman Psychiat admitted inpatient Assessman aggression while in the foster modestruction and peer resident in animal family concept the record representation and peer resident Review of 106/28/20 Resident three (3) Attention unspecific Post-Traincluded each ideal provided	and update (resident) is in the treatment ultilize a muthe treatment sually done out team meeting Behavioral Statement, dated 0 ric Resident in the resident psychiatric in the resident psychiatric in the resident psychiatric in the resident psychiatric in the resident psychiatric in the resident psychiatric in the resident psychiatric in the resident psychiatric in the resident psychiatric in the resident psychiatric in the resident psychiatric in the resident psychiatric in the resident protect in the problems well as tate at the psychiatric in the problems well-deficit hyperical in the problems well-deficit hyperical problems we	vior Support Plan would be d as necessary. When/if not making satisfactory nent program, the treatment ulti-disciplinary approach to it for that child (resident). Juring the scheduled ngs but can take place support Meeting.  1's Comprehensive 6/22/2022, revealed the al Treatment Facility (PRTF) on 06/22/2022, from an nospital. According to the dent had a history of ally acting out behaviors ster parents. Resident #1's d the resident was e, and aggressive with adults if review revealed the cked empathy and engaged e in foster care, and the rake care of him/her. Sheet in Resident #1's clinical admission to the facility, the appointed legal guardian.  1's Treatment Plan, dated cally signed by the on 06/30/2022, revealed ere identified to include ractivity disorder, if intellectual disabilities; and is Disorder (PTSD). The plan tives, and interventions, for em. Even though the plan bjectives to assist the ghis/her trauma history.	N	115				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		18L013	B. WING			11/	02/2022
NAME OF PR	ROVIDER OR SUPPLIER	•		:	STREET ADDRESS, CITY, STATE, ZIP CODE		
USPIRITUS	S-BROOKLAWN-PILOTS		1		2108 DAVID GRAVES DRIVE		
					LOUISVILLE, KY 40218		
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N 115	1 0	e the plan addressed the	N	115	5		
		Safety Interventions (ESIs),	}				
	, -	ls. There was no evidence					
		as modified as result of the					100
		7/12/2022 Treatment Team					
	•	/ #5 from securing Resident determined during the					
		d some of Resident #1's					
	negative behaviors/re						
	Review of Resident#	1's Behavior Support Plan					
		022, revealed situational					
		ma history, attending school,					
ĺ		y, and separation from					
		otoms or behaviors which					
	occurred just before o						
	included defiance, an	Further review, under the					
		any history of sexual or					
		er traumas that would be a					
		trigger if the youth was					
-	placed in a hold," a h						
		ocumented. The Trauma					
	-	f the BSP revealed the notionally abused, neglected					
	prior to age four (4), a						
ĺ	community violence is						
	prostitution, and unsa	*					
	Interview, on 10/21/2	022 at 1:10 PM with					
	•	nunity Based Services					
		er #2, who was one of					
		orkers prior to his/her					
		F, revealed Resident #1 helter with his/her mother					
	****	She stated since they were					
		the shelter during the day,					
		take Resident #1 and					
		nall. Resident #1's mother					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED	
	18L013	B. WING	B. WING		C 11/02/2022	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2108 DAVID GRAVES DRIVE		THOUSEVEE	
USPIRITUS-BROOKLAWN-PILOTS			LOUISVILLE, KY 40218			
PREFIX (EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
day Resident #1 state Vehicle (ATV) in the pedestrian and driving because his/her moth him/her. According to the mall in enforcement arreste Resident #1 and his/ state custody. Social Resident #1 was addressed to his/her dysfunctio  Further review of the evidence the plan was or/12/2022 Treatme YCW #5 triggered R should therefore avoid holds for Resident #1  Review of Resident #1  Review of Resident and his/her residential contract that occurred on 07/ on 07/01/2022, 07/0 Review of all three (Control of the Resident Review of the Resident Review of the Resident Review of the Resident Review of Resident #1  Review of the Resident Review of Resident #1 restroom for fighting the report, YCW #5 in Resident #1 assaulted.	pervise the children, and one riting driving an All Terrain mall, ended up hitting a not through a glass window ther was not supervising to DCBS Worker #2 Resident phed at the incident, but store obtified the police. Law downward Resident #1's mother, and ther siblings were placed in the worker #2 said afterwards mitted to several different sidential care facilities related the period of the police. Law downward worker #2 said afterwards mitted to several different sidential care facilities related the period of th	N	115			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF PR	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		
				2108 DAVID GRAVES DRIVE		
USPIRITUS	S-BROOKLAWN-PILOTS			LOUISVILLE, KY 40218		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		D	PROVIDER'S PLAN OF CORRECTION	(X5)	
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N 115	Continued From page		N 11	15	1	
		by the rules for asking				
		e cottage bathroom. The				
	•	sident assaulted YCW #5,				
-		resident in a single supine				
İ	_	e report, YCWs #7 and #9				
-		and assisted YCW #5; and assed from the hold at 7:29				
	AM.	ssed from the floid at 7.29				
	raist.					
	Review of the Resider	ntial Youth Physical Hold				
	Seclusion Report for a hold that occurred on					
		AM, revealed YCW #5 again				
	secured Resident #1	in a physical hold because				
		/she was not going to sit				
		anymore. After choice and				
		ts of change were made by				
		ative consequences the				
		mply and ran around the				
		er markers. According to the tempts to talk with the				
		ntinued to run around the				
		s, and attempting to climb				
	_	nt continued to refuse to				
	listen to direction prov					
		o a timeout room. Per the				
	report, YCW #5 tried t	to use proximity control				
		tance between the staff and				
		ey were in the hallway				
		ms were located, but the				
		ind then YCW #5 secured				
	the resident in a supin	ne torso hold at 11:34 AM.				
	Review of a hold sum	mary dated 07/09/2022,				
	revealed during choir					
	_	t with a peer and yelled at				
		walked to the timeout room				
		nile there, the resident hit				
	walls and yelled, YCV					
		her an expectation to go to				

AND PLAN OF CORRECTION   IDENTIFICATION NUMBER:   A. BUILDING CO	(X3) DATE SURVEY COMPLETED	
	С	
18L013 B. WING	11/02/2022	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  2108 DAVID GRAVES DRIVE  LOUISVILLE, KY 40218		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
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 millieu. The resident was trying to leave the hallway and enter the millieu. 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 thengot 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 07/11/2022, 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 apue 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 #1 and yelled at the staff. Resident #1 agressively		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	100013	D. WING	STREET ADDRESS, CITY, STATE, ZIP	CODE	11/02/2022	
USPIRITU	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 PREFI TAG		THE APPROPRIA		
N 115	the resident in a stand the resident tried to to #1 and YCW #5 lost to on the floor. Once on the resident in a knee #1 secured the resider #5 prompted Resident Management Strateg used empathy statem revealed Shift Supervised assumed securing of and YCW #1 stepped According to the sum while in the seated correport, Shift Supervised that occurred because funch shortly before the Interview, on 07/19/20 Supervisor #1 revealed his/her lunch at approximation of the Camera Resident #1's bedroo Supervisor #1 took Resident #1's bedroo Supervisor #1 took Resident #1 on 06/22 resident had a history personal history of net to Domestic Violence his/her primary home Meeting Attendees, resident #1 on Attend	and she attempted to secure ding cradle hold, but while pull away, both Resident heir balance and sat down the floor, YCW #5 secured ding cradle hold, and YCW and sower extremities. YCW at #1 to use Safe Crisis lies (SCS), and YCW #1 sents. Further review visor #1 entered the book over the hold, YCW #5 the resident's legs and feet, away from the hold.  I away from	N	115			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1110222022	
USPIRITUS	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)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
N 115	Registered Nurse (RN the resident's Psychia The note stated Residuere discussed. Accoresident was told no, what he/she wanted was told no.	N), the Care Navigator, and atrist attended the meeting. dent #1's behavioral triggers ording to the note, if the or was not allowed to do when he/she wanted to, that	N	115		
	Resident #1 knew hor behaviors based on wo cottage, and if the resiget away with more. The yCW #5 ignored Resident threatened at YCW #5, with the resident threatened but there was no react confused. However, wore sident in a hold, at it try to bite YCW #5 in the as another staff was the second process.	•				
	Treatment Team met reviewed the resident on 07/01/2022, 07/08 determined YCW #5 behaviors which ende in a hold. She said the after the meeting bec Resident #1, was see She stated she told Y becoming involved in because she triggere The Residential Therexpressed understan plan. Resident #1's the continuation of the state of the resident with the state of the resident #1's the reviewed with the state of the resident #1's the reviewed with the state of the resident #1's the reviewed with the resident #1's the reviewed with the resident #1's the reviewed with the resident #1's the reviewed with the resident #1's the reviewed with the resident #1's the reviewed with the resident #1's the reviewed with the resident #1's the reviewed with the reviewed with the resident #1's the reviewed with the resident #1's the reviewed with the revi	ntial Therapist, revealed the on 07/12/2022, and 's recent holds that occurred //2022, and 07/09/2022, and triggered Resident #1's ed with securing the resident e team met with YCW #5 ause she said we thought eking out YCW#5 to be held. CW #5 she should avoid holds for Resident #1, d some of his/her behaviors.				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER							
USPIRITUS	S-BROOKLAWN-PILOTS				2108 DAVID GRAVES DRIVE			
			:	LOUISVILLE, KY 40218				
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N 115	Continued From page	: 19	N	115	5			
		er to another cottage, but						
	she was not involved	_						
	Interview, on 08/01/20	022 at 7:17 PM with Shift						
		ed on 07/17/2022, when she						
	-	room, and saw YCW #5						
	had secured the resid	lent in a hold, she told YCW						
		vould take over the hold.						
		aid she did so because						
		cently directed to not secure						
	Resident #1 in a hold							
	YCW #5.	she wanted to be held by						
	Interview, on 07/29/20	022 at 2:49 PM with the						
	Residential Manager	#1, revealed he had a						
	conversation with YC	W #5, on 07/14/2022,						
	because the Treatme	nt Team determined YCW						
		Resident #1's behaviors. He						
	said he instructed YC					}		
		, but step away and allow						
		e. He said he explained						
		nique and had a treatment						
	•	o best care for them, and						
	since Resident #1 had	•						
	should avoid securing							
	_	#1 stated he told YCW #5						
		ss than five (5) minutes, it was necessary, and other						
	methods should be us	-						
		Manager #1 said YCW #5						
		ding, and asked if there was						
		eded to know. He stated his						
		tern but fair when interacting						
	-	said he told YCW #5 that if						
		her, she should remember						
	he/she is just seven (					i		
		resident might suffice,						
	rather than securing h	nim/her in a hold.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
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USPIRITUS	S-BROOKLAWN-PILOTS			2108 DAVID GRAVES DRIVE LOUISVILLE, KY 40218			
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N 115	Continued From page 20		N	115			
	Director of Training as Development, revealed Therapist nor Resident him regarding their id #5's approach with Reseries of holds she im hold on 07/17/2022. It nor was he directed to YCW #5, and/or proveducation on physical strategies. The Direct Professional Develop identified there was no between Resident #1 should have gotten to causing the issue. He have been to minimiz with the resident, and the staff person to work Interview on 08/05/20 Resident #1's psychiat the Treatment Team I learned Resident #1 I recent holds. He state brought to his attention occurred with the sand them were on the week examined what was goand the female staff in could be a dynamic of trauma. He stated we determine what was to YCW #5. Resident female staff member resident of someone	ed Resident #1's Residential Intial Manager #1 contacted entified concerns with YCW esident #1 and the recent aplemented prior to the final He said he was not asked to increase monitoring of tide her with additional I holding and other SCM for of Training and ament stated if management to a therapeutic relationship and YCW #5, then they the bottom of what was a said one strategy would be the staff person's contact of the s					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		18L013	B. WING			11/	02/2022
	ROVIDER OR SUPPLIER S-BROOKLAWN-PILOTS			21	TREET ADDRESS, CITY, STATE, ZIP CODE 108 DAVID GRAVES DRIVE OUISVILLE, KY 40218		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	D PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 115	Interview, on 08/22/2 Division Director, reversity informed her of the YCW #5 about Residual attention which ultimate holding, and that he observed in a holds after the Treatm occurred on 07/12/20 stated Residential Madirected YCW #5 to be holding of Resident # In terms of monitoring Director said she madivisited the cottages with shad not identified Staff treated Resident the facility.  Interview, on 08/22/20 Vice President (VP) or revealed prior to Resident #1, in that the YCW #5. She stated if the Manager had concern contacted The Division Division Director. She Manager #1 gave YC or to not do something.	any of Resident #1's future  022 at 12:20 PM with the ealed Residential Manager a conversation he had with ent #1 seeking her out for ately ended in physical lirected YCW #5 to not ny of Resident #1's physical ent Team meeting that  22. The Division Director anager #1 told her that he et other staff implement the  1, if that became necessary, the cottage, The Division de scheduled rounds and then opportunities arose, but any concerns with how that the fresidential Services, dent #1's final hold on not informed of any Manager #1 or Residential the patterns of holds for ney were all implemented by she would not typically learn less there was a need for ne VP of Residential Residential Cottage ns, he should have an Director or Assistant	N	115			

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				2108 DAVID GRAVES DRIVE		
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1 ( ) [ ] / (	ACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	_	(XS) COMPLETION DATE
then that Division She stall with YC's performs sure the a clear production she stall told Resident the pattern and that holds will given was then and lead. He said she those converse was unsure sident Team more stall told Resident Team more sident Team more si	Director or A ed if she had W #5's or She ance, she wo staff directive lan for follow cour next if the cour next if the cour next if the staff mential Therapisem of holds in the staff mential Therapisem of holds in the staff mential the staff mential the staff at wever, the V was not awanversations ure if there we streatment pet on 07/12/20 CTION OF R: 483.356 (a)(sident has the or seclusion of coercion, d	e been reported to the assistant Division Director.  I known there were concerns ift Supervisor #1's build have wanted to make ses were clear, that there was a up, and a plan for what he instruction had been ff had not complied with a Residential Manager.  107/17/2022, incident she was ager #1 and Resident #1's to t (#1) had concerns about a mplemented by YCW #5, and the cottage should take the P of Residential Services are of specific of details of with YCW #5. She said she were changes to the cotage should take the P of Residential Services are of specific of details of with YCW #5. She said she were changes to the cotage should take the P of Residential Services are of specific of details of with YCW #5. She said she were changes to the cotage should take the P of Residential Services are of specific of details of with YCW #5. She said she were changes to the cotage should take the P of Residential Services are of specific of details of with YCW #5. She said she were changes to the CO22.	N 1		Francis 9/2022.	3/19/22

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					LOUISVILLE, KY 40218		
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N 126	Based on review of the footage of the interior and the doorway to R facility policy review, interviews, it was determined to the from unapproved sec extended period-of-tin AM to approximately Supervisor #1 stated approval, but determined in his/her bedroom for report from night shift up during the early minterview with Youth (worked the day shift a 07/17/2022, Shift Supruined her church day put Resident #1 in a hand that the resident day.  The findings include:  Review of the facility Youth, Policy Number	t met as evidenced by: the facility's video recorded of the Residential Cottage esident #1's bedroom, and staff and resident ermined the facility failed to (10) sampled residents fusionary time-out for an me on 07/17/2022 from 8:00 2:25 PM. Per interview, Shift she did not seek prior fined Resident #1 should stay or the first shift due to a staff that the resident acted forming hours. In addition, Care Worker (YCW) #1 who	N	126	All existing staff completed the follow trainings by September 6, 2022:  Appropriate Responses to Emergency Safety Situation Speak Up for Client Safety Hand-Off Communication  These trainings included information to safety and effectively interact with especially during challenging or pote unsafe situations. Further, specific sprovided related to communicating a reporting any inappropriate, unsafe, countertherapeutic behaviors exhibit staff, especially those that do not shrespect for human dignity, individual cultural and personal beliefs, as well forms of abuse and neglect including mental, physical, and sexual abuse. trainings also include specific educa outlining the circumstances under wappropriate to initiate seclusion or exclusionary timeout, the process for obtaining authorization for use of secret or exclusionary timeout, time limits for seclusion or exclusionary timeout on age of resident, requirements for monitoring and documentation durin seclusion or exclusionary timeout, a process for termination and debriefing use of seclusion or exclusionary timeout, a process for termination and debriefing use of seclusion or exclusionary timeout, a process for termination and debriefing use of seclusion or exclusionary timeout, a process for termination and debriefing use of seclusion or exclusionary timeout, a process for termination and debriefing use of seclusion or exclusionary timeout, a process for termination and debriefing use of seclusion or exclusionary timeout, a process for termination and debriefing use of seclusion or exclusionary timeout, a process for termination and debriefing use of seclusion or exclusionary timeout, a process for termination and debriefing use of seclusion or exclusionary timeout, a process for termination and debriefing use of seclusion or exclusionary timeout, and the remarks of the following termination and debriefing use of seclusions.	ns on how youth, entially steps are and or ted by ow lity, or I as any g verbal, These tion hen it is or use based of the eout. These steps are the second	
	be under the ultimate psychiatrist. Use of se history of the youth or dangerous behavior. used for the purpose convenience or retalic should only be used with physical interventions.	direction of the treating eclusion should be based on solely on a history of Seclusion should not be of coercion, discipline, ation by staff. Seclusion			All cottage and clinical staff reviewer attested to the review and understar of the following policies and procedu August 15, 2022:	nding ures by sibilities	8/15/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY
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	ROVIDER OR SUPPLIER S-BROOKLAWN-PILOTS			2	STREET ADDRESS, CITY, STATE, ZIP CODE 2108 DAVID GRAVES DRIVE LOUISVILLE, KY 40218		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 126	youth physically harm Under the procedure steps were listed: Sta duration of seclusion, maximum duration all the youth, for a youth If seclusion needs to maximum time limit, the Clinical Consultant to order. According to the should be assigned to intervention, and the psychological impact youth (resident). Ensuany undesirable medi Nursing Staff and recelectronic health recostaff maintain constar youth placed in seclus circumstances should without a staff memberarea. Ensure assigne behavior and activity I throughout the youth's every five (5) minutes ther signs of injury, nutrition circulation and range vital signs, hygiene ar psychological status a for discontinuation of Review of Resident # Assessment, dated 06 Psychiatric Residential	sing self, staff or others. subsection, the following ff was to monitor the so as not to exceed the lowed based on the age of 7-8 years old, one (1) hour. extend beyond the hen staff should contact the provide a continuation le policy, one staff member of monitor the events of the physical well-being and the of the intervention on the lure staff immediately report local effects from seclusion to ord in the resident's ord (EHR). Ensure assigned at visual contact with the sion, and under no a youth remain in seclusion for present in the observation of staff document the youth's level on the Seclusion Chart as placement in seclusion at orderefter for the following: on and hydration status, of motion of extremities, and elimination, physical and and comfort, and readiness seclusion.  1's Comprehensive 6/22/2022, revealed al Treatment Facility (PRTF) on 06/22/2022, from an	N	126	<ul> <li>Reporting Abuse, Neglect Exploitation</li> <li>Physical Holding of Youth</li> <li>Seclusion of Youth</li> <li>Existing staff completed written the information included in thes policies. Completion and compl was recorded in each staff's tra record via the Relias Learning Management System.</li> <li>Training was provided for all cottage clinical staff that covered: 1. when it appropriate to initiate a physical hole when it is appropriate levels of initial continuation authorization; 3. when appropriate to initiate exclusionary to including appropriate levels of initial continuation authorization (see attaction policy); and 4. how to respond to me emergencies, including but not limite how to intervene appropriately for you have potential adverse reactions. At attested to understanding the inform provided, and all staff completed a vitest as part of this training. Completic compliance is recorded in each staff training record via the Relias Learning Management System.</li> <li>A facilitator and implementation tear identified for Six Core Strategies for Reduction of Seclusion and Restrain project implementation. The Six Cor Strategy Steering Committee/Leade Subcommittee met for the first time September 27, 2022. On November 2022, the Prevention Tools and Deb Subcommittees met for the first time Data Subcommittee is scheduled to the first time on January 4, 2023.</li> <li>Continued on next page</li> </ul>	test on e iance ining e and is d; 2. clusion, and it is me out, and ched edical ed to outh who I staff lation written on and 's ng m was at e rship on 17, oriefing . The	9/4/22

NAME OF PROVIDER OR SUPPLIER  USPIRITUS-BROOKLAWN-PILOTS  SITERT ADDRESS, CITY, STATE, ZIP CODE  2108 DAVID GRAVES DRIVE  LOUISVILLE, KY 40218  PROVIDERS PLAN OF CORRECTION (EACH OFFICIENCY MUST BE PRECEDED BY FULL TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY MUST BE PRECEDED BY FULL TAG  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 seclusionary time out for an extended period-of-lime.  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 approvinceded 2:56 BM until approvinceded 2:56 BM until approvinceded 2:56 BM until approvinceded 2:56 BM until approvinceded problem. Event Provinced Video  Safety Physical Interventions (GESPI) and Weekends/holidadys if necessary and thrice- weekly reviews of resident grievances to determine, in addition to any safety concerns, noted are documented, and the information is distributed to the executive team and Bellewood and Brooklawn residential, clinical, and quality leaders.  Monthly Safe Crisis Management (SCM) Refreshers Qia Physical Interventions of the information is distributed to the executive team and Bellewood and Brooklawn residential, clinical, and quality leaders.  Monthly Safe Crisis Management (SCM) Refreshers Qia Physical Interventions of the information is distributed to the executive team and Belle		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A, BUILDING			(X3) DATE SURVEY COMPLETED	
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USPIRITUS-BROOKLAWN-PILOTS  2108 DAVID GRAVES DRIVE LOUISVILLE, KY 40218  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY)  N 126  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 seclusionary time out as interventions for the identified problems nor to use unapproved seclusionary time out as interventions for 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 BM, when VCWW #6 send			18L013	B. WING		11/	02/2022	
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 resident in processing his/her trauma history, there was no evidence the plan addressed use of 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 07/11/2022, 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. Heap XCM. #8 end YCM. #4 end YCM. #					2108 DAVID GRAVES DRIVE			
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 approviments. In addition, the review information is distributed to the executive team and Bellewood and Brooklawn residential, clinical, and quality leaders.  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.  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 wor	PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION	
#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	Review of Resident # 06/28/2022, electronic Resident's Therapist, three (3) problems we Attention-deficit hyper unspecified type; Mild Post-Traumatic Stres plan included goals, of or each identified proprovided goals and of resident in processing there was no evidence seclusionary time out period-of-time.  Review of facility provectage's common speculationary time out period-of-time.  Review of facility provectage's common speculated staff did not door, or frequently opmonitor his/her wellbe approximately 2:25 Pill entered the resident door.  Review of the facility provectage on 07/1 AM, Resident #1 was doorway, and seemed Supervisor #1. At 8:13 exited the cottage offill #1's bedroom. At 8:13 exited Resident #1's residen	1's Treatment Plan, dated cally signed by the on 06/30/2022, revealed ere identified to include ractivity disorder, I intellectual disabilities; and s Disorder (PTSD). The bjectives, and interventions, oblem. Even though the plan ojectives to assist the g his/her trauma history, e the plan addressed use of as interventions for the or to use unapproved for an extended rided video coverage of the ace with full view of door, on 07/17/2022, stay nearby the resident's en the bedroom door to being from 8:00 AM until M, when YCW #5 and YCW int's room and closed the provided camera coverage 7/2022, revealed at 8:11 at his/her bedroom door to speak briefly with Shift 2 AM, Shift Supervisor #1 ce, and entered Resident at AM, Shift Supervisor #1 com. was still seated in a rolling door, and the cottage was I lights on, but left at the end	N 126	Safety Physical Interventions (ESPI) Seclusions on business days and weekends/holidays if necessary and weekly reviews of resident grievance determine, in addition to any safety concerns, whether any youth rights violated. These include document at reviews, when available. Any violatic concerns noted are documented, an information is shared with the staff's supervisor for follow-up, which may additional coaching, training, or disc action, up to and including terminatine employment. In addition, the review information is distributed to the execteam and Bellewood and Brooklawn residential, clinical, and quality leads.  Ongoing monitoring/compliance procedu.  Monthly Safe Crisis Management (S Refreshers (1 hr) and annual Safe C Management (SCM) recertification (includes review of Youth Rights and sensitively and effectively work with especially when addressing particular challenging or sensitive issues. Further refreshers and recertifications will in the proper procedures related to the seclusion or exclusionary timeout. Completion of all refreshers and ann Safe Crisis Management (SCM) recertification is recorded in staff's trecord via Relias Learning Managen System.	) and d thrice- es to  are nd video ons or nd the include ciplinary on of cutive ers.  Crisis 4 hrs) — how to youth, arly her, clude use of mual raining		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		(X3) DATE S COMPL	
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		18L013	B WING_		11/0	02/2022
	ROVIDER OR SUPPLIER S-BROOKLAWN-PILOTS			STREET ADDRESS, CITY, STATE, ZIP CODE 2108 DAVID GRAVES DRIVE LOUISVILLE, KY 40218		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
N 126	AM, 10:33 AM, 10:46 (resident was seen at yellow t-shirt and short 2:24 PM for the final to 2:24 PM for the final to 2:24 PM for the final to 2:24 PM for the final to 2:24 PM for the final to 2:24 PM for the final to 2:24 PM for the final to 2:25 PM, Shift Sure with a something to the dining table, and then long hallway of the conditional to 2:24 PM Shift Sure with food items into R #1 was not seen eating nor lunch) with the other seen making bookma and activity that started Interview, 08/01/2022 Supervisor #1, reveal keep Resident #1 in hoot/17/2022, for the set the cottage. She state reported Resident #1 one of which was Resident #1 one of which was Resident #1 stated thow she was going to this/her room. When a Shift Supervisor #1 stated know she was not ok Resident #1 stay in hi #1 stated that keeping for long periods of time for l	k out his/her hand at 9:46 AM, 10:59 AM, 11:56 AM this/her door wearing a rts), at 12:42 PM, and at ime.  pervisor #1 went to th folded clothing and a dent out of his/her room, other residents sitting at the took Resident #1 down the ottage. pervisor #1 took a red tray esident #1's room. Resident ang either meal (breakfast arer residents, and was not arks with the other residents, and at 10:59 AM.  at 7:17 PM, with Shift ed she made the decision to alis/her bedroom on afety of the other residents in ad the night shift staff had bullied other residents, sident #5. She said when bout 8:00 AM, YCW #6 was so doorway, and that YCW at had a rough night. Shift she let Shift Supervisor #2 so keep Resident #1 in sked by the SSA Surveyor if aid he was okay with that, aid Shift Supervisor #2 did	N 1	<ul> <li>Appropriate Responses to Emergence Safety Situations; Speak Up for Clier Safety; and Hand-Off Communication. These trainings will be completed by staff during New Hire Orientation, wit first three (3) weeks of employment, before working with youth. These trainclude information on how to safely effectively interact with youth, especi during challenging or potentially unsa situations. Further, specific steps are provided related to communicating are reporting any inappropriate, unsafe, countertherapeutic behaviors exhibite staff, especially those that do not sho respect for human dignity, individualicultural and personal beliefs, as well forms of abuse and neglect including mental, physical, and sexual abuse. existing staff will complete these train on an annual basis, to be completed each year. Completion of and compli with these trainings is recorded in eastaff's training record via the Relias Learning Management System. Staff begin work nor continue work with yountil demonstrating understanding of concepts.</li> <li>Zero Hold and Seclusion Philosophy Training: 6 Core Strategies – New streceive information and complete tes new employee orientation, and yearly refreshers will be provided for all cott and clinical staff by 9/15 of each year. Completion and compliance wirecorded in each staff's training record the Relias Learning Management Systems.</li> <li>Continued on next page</li> </ul>	all new thin the and inings and ially afe or ed by ow ity, or as any property of the second is the s	9/15/22

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
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		18L013	B. WING				02/2022
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				2	108 DAVID GRAVES DRIVE		
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 126	showers on the day surinated twice on him those times was just the last stated when thought Shift Supervise threatened a staff me threatened a staff me threatened the staff me threatened the staff me to sit at the resident's reportedly misbehave said Resident #1 called said Shift Supervisor update on Resident # then told her she was because he/she had reshe was going to hold when she did she was throw up.  Interview, on 07/20/20/46, revealed on 07/17 to come assist with Reresident got up betwee tried to wake up other #7 told her she needed residents as they were wanted to prevent Reswhile she was taking of YCW #6 said she satis bedroom door. She said she when she returned, the his/her room, and he/sanitizer on the table,	e resident had taken two (2) hift. She said the resident self/herself, and one of before lunch.  W #1, on 07/20/2022 at 5:22 she reported to work, she sor #1 told her that Resident 3:00 AM on 07/17/2022, and mber. She said the resident nember who was called over door because he/she ed in middle of the night. She ed her a fat bitch. YCW #1 #1 gave her (YCW#1) the 1's night time behavior, and upset with Resident #1 ruined her church day, that l/restrain the resident, and is going to make him/her  022 at 11:20 AM with YCW //2022, YCW #7 asked her esident #1 because the en 4:00 to 5:00 AM, and residents. She said YCW d to assist the other e waking up, and she sident #1 from escalating care of the other residents. in a chair at Resident #1's aid the resident kept and wanted to go to the lee went to the restroom and	N	126	Safety Physical Interventions (ESPI) business days and weekends/holida necessary, including the use of sect and/or exclusionary timeout, and co thrice-weekly reviews of resident gri are conducted to determine, in addit any safety concerns, whether any you rights are violated. These include do and video reviews, when available, violations or concerns noted are documented, and the information is with the staff's supervisor for follow-which may include additional coachitraining, or disciplinary action, up to including termination of employment addition, the review information is distributed to the executive team and Bellewood and Brooklawn residential clinical, and quality leaders.	on  ys if usion ntinued evances tion to buth cument Any shared up, ng, and the	9/1/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	l D		PROVIDER'S PLAN OF CORRECTION		(X5)
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N 126	Continued From page		N.	126			
		water in his/her room and					
		mop. YCW #6 stated YCW					
		ckground information about	1				:
		d Resident #1 liked to be					
		med to like the physical					
		g. She said Resident #1's					
		to try strategies other than					
		er behavior, YCW #6 said					
		at Resident #1's door, the e was going to kick and hit					
		back his/her fist, She said					
		t was trying to scare the					
		esident never touched her.					
	Review, of the facility	provided camera coverage					
		from 12:00 AM until 6:30				1	
	_	nt #1 was seen only twice in					
	the milieu. At 1:56 AM	I the resident exited his/her					
	room, and walked dov	vn the hallway toward the					
		nt was seen again at 6:04					
		in the milieu touching					
		YCW #7 had torn, folded,	İ				
		. Resident #1 also tossed a					
		and looked at what seemed					
		ge lighted phone with YCW					
		bserved having any contact					
	with other residents, a						
		sident striking of having any either staff, YCW #6 and					
	YCW #7.	eliner stalt, 1 CVV #0 allu					
	, Ott III.						
	Interview, on 07/30/20	022 at 3:30 PM with Shift					
		ed staff should never keep a					
		froom for long periods of					
		s he/she was sleeping the					
		ay in his/her bedroom more		ļ			
		es at a time; and during that		i			
		uld have a backpack with		i			
		stay busy. He said the		ļ			

-	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	l ' '		CONSTRUCTION	(X3) DATE : COMPI	SURVEY LETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	D PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 126	Continued From page backpacks might inclusheets.  Additional interview of with Shift Supervisor Supervisor #1 sent hi 07/17/2022, and gave #1's behavior. He said #1 wrote that Resider Shift Supervisor #2, s when the text came in Supervisor #1 until la to church. Shift Super Supervisor #1 did not him that she was goir his/her room all day. It told her that he though Interview, on 07/29/2/Residential Manager not supposed to be known periods of time be confinement. He said homelike environment the residents should residential Manager Psychoeducational Manager P	and one of the state of the sta		126			
	for addressing the result interview, on 07/21/2: Resident #2, revealed he/she had to stay in	sident's negative behaviors.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 2108 DAVID GRAVES DRIVE		_
USFIRITU	S-BROOKEAWW-FILOTS				LOUISVILLE, KY 40218		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 126	Interview, on 08/02/24 Residential Therapist acceptable practice to bedroom for long peri hours. She said that v PRTF's system of cor try to teach the youth consequences, and tl interaction with staff. stated one would nee in an escalated state to himself/herself if no while in his/her bedro  Interview, on 08/02/24 Residential Therapist campus on 07/17/202 next door to Pilots Co by any of Pilot's Cotta managing the situation said she had no idea supervisor called and Cottage because a re unresponsive. She st when she walked to F ambulance had just p inside the truck. She cottage, Shift Superv #1 were all crying, an Supervisor #1 tried to she was sobbing so h sense of what she was Shift Supervisor #1 to	e/she stuck his/he hand out me to see what he/she  022 at 3:45 PM, with  #1, revealed it was not of keep a youth in his/her lide of time during waking was in no way a part of the ensequences. She stated we why they have earned that required ongoing Residential Therapist #1 and to consider what a youth of mind could potentially do not continuously monitored from, unsupervised.  022 at 3:25 PM, with the first at the cottage of the continuously monitored for my with Resident #1. She what was going on until her all directed her to go to Pilot's resident there was atted she heard sirens, and	N	120			
	#1 seemed to be brea						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X:	3) DATE S	
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NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
HEDIDITH	S-BROOKLAWN-PILOTS			2108 DAVID GRAVES DRIVE			
951 1141100	3-DICOGREATIV-1 IEOTO			LOUISVILLE, KY 40218			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		JLD BE		(X5) COMPLETION DATE
N 126	not delivered cardiac Residential Therapist was on the scene who She said the other yo confused, but soon at took the residents to taway from the cottage there.  Interview, on 07/29/26 Residential Manager residents had express meetings they had iss Supervisor #1 interact based on that information with her about it. He shad been overbearing came to spirituality. H Supervisor #1 staff mraise the residents, but therapeutic intervention help the staff understandents like they wo Residential Manager not have a full understandents remain there was very important the residents remain there them of any previous He stated if the staff in similar to what the resubjected to, how cousaid how could Residential for each of the staff in staff if treated happened to Residentife on 07/17/2022 mainterested to the staff in the staf	shock using the AED.  #3 said law enforcement en she entered the cottage, uth in the cottage seemed dditional staff arrived and the gym, so they could get e while the police were still  D22 at 2:49 PM, with #1, revealed a lot of sed in Treatment Team sues with how Shift ted with them. He said ation he decided to speak stated Shift Supervisor #1 g with the residents when it le stated he told Shift embers were not there to ut to treat them using ons. He stated he tried to and they must treat the build want to be treated.  #1 said direct care staff may standing of the trauma the d prior to admission, so it hat staff interactions with the apeutic and not remind negative life experiences, members' behaviors were sidents had previously been uld that be therapeutic. He ent #1 engender his/her similarly. He stated what tt #1, in his/her last hours of	N	126			
		ntial Therapist, revealed the					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL1		ONSTRUCTION		(3) DATE SURVEY COMPLETED	
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NAME OF PR	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
USPIRITUS	S-BROOKLAWN-PILOTS			LO	UISVILLE, KY 40218			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
N 126	Continued From page treatment team had to alternative plan to rev		N	126				
	behavior, because the most residents had no	e points system utilized for ot been effective. She said						
	stickers when he/she the plan never include	lan to give Resident #1 met expectations. She said ed isolating the resident, so						
	he did not have a cha Resident #1 should he 07/17/2022, so he/sho	ave been in the milieu on						
	opportunities to earn							
	time seclusion should	s therapist stated the only be used, would be if it was						
	quarantine due to a co	tion, or if the child was in ontagious disease. The sion should not have been						
	considered since Res	ident #1 was only seven (7)						
		y he/she had to stay in						
	Resident #1 had pent	nd a youth as young as up energy, and it should not						
	his/her peers in the m	she would want to re-join ilieu. Additional interview, I1 AM with Residential						
	Therapist #1, for Resi							
	should never be force	and his/her peers and staff d by staff and the decision						
	to do so should never (1) staff member.	be the decision of only one						
	would have been hard conceptualize why he	atrist, revealed given intellectual disabilities, it I for the resident to /she was being kept in						
	his/her room all day. I	le stated that action on the						

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL1 A. BUILDI	TIPLE CONSTRUCTION  NG		(X3) DATE SU COMPLE	
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HEDIDITH	S-BROOKLAWN-PILOTS			2108 DAVID GRAVES DRIVE			
USFIRITU	S-BROOKLAWN-FILOTS			LOUISVILLE, KY 40218			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD B	_	(X5) COMPLETION DATE
N 126	demonstrated her lac typical seven (7) year	per (Shift Supervisor #1), k of understanding of a rold's behavior. He stated	N	126			
	resident was not inter should be ongoing interesident's waking hou there must be an order	rvention must be carefully					
	Division Director, the providing adequate to kept in his/her bedrood behaviors. She said the clinicians and the develop a plan with minterventions to mana stated the resident's Residential Manager would meet to further resident's treatment papproaches for mana Interview with the Vic Residential Program.	reatment if the resident was om for inappropriate bigger conversations among managers should occur to more appropriate age his/her behaviors. She Residential Therapist, the and perhaps school staff develop or revise the blan to include appropriate aging his/her behaviors.					
	extended period of tin from the clinical staff they would first want (Shift Supervisor #1) that was a necessary the resident's behavi Programming said S implemented exclusi- without first going thr	me must have prior approval and managers. She said to know why the staff person or direct care staff thought intervention for managing or. The VP of Residential hift Supervisor #1 onary time out and seclusion ough the approval process.					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '		ECONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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	CHARACTE	ATTURE OF OFFICE LONG	<u> </u>	-	PROVIDER'S PLAN OF CORRECTION		N/P)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 126	Continued From page		N 1	126			
	members on duty that would probably never would be satisfactory				11.100		
N 128	PROTECTION OF RECFR(s): 483.356(a)(3	3)	N 1	128	<ul> <li>N 128</li> <li>Suspended Deborah Francis, Jillian and Amanda Whitlow as of</li> </ul>	Parks,	8/19/22
		nust not result in harm or and must be used only-			7/20/2022. Employment of Deborah and Jillian Parks was terminated 8/1	9/2022.	
					<ul> <li>Please note that any staff who failed comply with these actions received corrective action.</li> </ul>	to	
	Based on observation review of the facility's camera footage of the Emergency Medical S	t met as evidenced by:  n, interview, record review, physical holding policy, e cottage, and the Fire and Gervices (EMS) Patient Care			<ul> <li>All cottage and clinical staff were co- with required annual three (3) hour S Crisis Management (SCM) Recertific Training, which included how to safe execute a standing and kneeling cra- by September 1, 2022.</li> </ul>	Safe cation ely	9/1/22
	ensure staff implement Management (SCM), facility's policy for Physerious harm that resisten (10) sampled resisten (10) sampled resisten (10) #5 and Shift Stresident in a standing During the hold, which camera in the resident vomited, lapsed into a required life saving succardiopulmonary Resistent was transferr	in accordance with the visical Holding to prevent ulted in the death of (1) of dents, Resident #1. On M, Youth Care Worker upervisor #1 secured the to kneeling cradle hold. In was implemented off this bedroom, the resident an unconscious state, and upport in the form of suscitation (CPR). The red to the local children's y Medical Services (EMS)			All existing staff completed the follow trainings by September 6, 2022:	ns ation on eract	9/6/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL*		-	(X3) DATE:	
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		18L013	B. WING			11/	02/2022
USPIRITU	ROVIDER OR SUPPLIER  S-BROOKLAWN-PILOTS  SUMMARY ST	ATEMENT OF DEFICIENCIES	i ib	2	STREET ADDRESS, CITY, STATE, ZIP CODE 2108 DAVID GRAVES DRIVE LOUISVILLE, KY 40218  PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		COMPLETION
N 128	Interview with YCW # who witnessed the ho think the hold was im physical holding polic received through her stated Shift Supervise forward when she too #5. YCW #1 said per provided by the facilit not supposed to place back because it could or do damage to the i  Interview, on 08/05/2 Social Service Worke Services (CPS), who #1 gave to the Police on 08/05/2022, revea detective that Shift So with Resident #1 due behaviors as reported worked with the resid #1 stated Shift Super when she took over th YCW #1 said Shift So resident's body so far the kneeling cradle he almost touched the fle  Continued interview wat 5:22 PM, revealed and YCW #5 were ho told her to go check of cottage. YCW #1 said Resident #1's doorwa Supervisor #1 say to throw up, throw up!" S the doorway, the resident	1 on 07/20/2022 at 5:22 PM, old, revealed she did not plemented per the facility's y or per the training she own SCM certification. She or #1 pushed the resident old over the hold from YCW the SCM instruction y's SCM trainers, staff was a pressure on the resident's I cause him/her to throw up, inside of the resident's body.  22 at 5:00 PM, with the or from Child Protective attended the interview YCW Detective earlier that day, led YCW #1 told the upervisor #1 was frustrated to some of his/her of by a staff person who ent on the night shift. YCW visor #1 used extreme force the holding of Resident #1. Intervisor #1 pushed the forward while implementing old that the resident's nose por.	N	128	Further, specific steps were prove related to communicating and reany inappropriate, unsafe, or countertherapeutic behaviors exby staff, especially those that do show respect for human dignity, individuality, or cultural and persbeliefs, as well as any forms of a and neglect including verbal, me physical, and sexual abuse. Cor of and compliance with these adtrainings was recorded in each straining record via the Relias Learning record via the Relias Learning refreshers per policy. Attendance and compliance is recorded in each staff training record via the Relias Learning Management System.  All cottage and clinical staff reviewed attested in writing to understand the Tip Sheet and do's and don'ts specific physical holds authored by the agency Medical Director by August 15, 2022.  All cottage and clinical staff reviewed attested to the review and understand of the following policies and procedu August 15, 2022:  Appendix Clients Rights and Responsibilities and Youth Grievances- Resolving Client Complaints  Reporting Abuse, Neglect of Exploitation  Physical Holding of Youth  Seclusion of Youth  Existing staff completed written the information included in these policies. Completion and complication  chibited not sonal abuse ental, mpletion iditional staff's arning ip to SCM) d sonal and Medical ic to cy d and iding res by d and iding res by d and iding res by the corrections or test on each is record	9/1/22 8/15/22	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL1 A. BUILDII			DINSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		18L013	B. WING_				11/	02/2022
NAME OF P	ROVIDER OR SUPPLIER					EET ADDRESS, CITY, STATE, ZIP CODE		
USPIRITUS	S-BROOKLAWN-PILOTS			-		I DAVID GRAVES DRIVE JISVILLE, KY 40218		
	CHRIADVET	ATEMPAIT OF RESIDIEMPIES			I	PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFII TAG			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION
N 128	go get the impact cus she looked at Resider the resident was not swas crying. YCW #1 sget the impact cushio said she quickly returned YCW #5 said she But, YCW #1 said as room she told her (YCSupervisor #1, YCW #1.	#1 said YCW #5 told her to hion. YCW #1 said when int #1 through the doorway, saying anything, but he/she said she left the doorway to in, but could not find it. She ned to the resident's door, would go get the cushion. YCW #5 was leaving the	N ·	128		All cottage and clinical staff were ed and attested to an understanding of Hold philosophy. Existing staff comptest on understanding of this philosose September 06, 2022.  Training was provided for all cottage clinical staff that covered: 1. when it appropriate to initiate a physical hold when it is appropriate to initiate a se including appropriate levels of initial continuation authorization; 3. when it appropriate to initiate exclusionary to including appropriate levels of initial continuation authorization; and 4, hor respond to medical emergencies, including the initial continuation authorization; and 4, hor respond to medical emergencies, including appropriately for youth who have po	a Zero leted a phy by and is d; 2. clusion, and t is me out, and ow to cluding	9/6/22
	YCW #5, revealed sh Survey Agency (SSA) her attorney. Howeve made to arrearage an	21/2022 at 9:45 AM with e would only speak to State ) Surveyor in the presence of er, multiple attempts were n interview, but YCW #5 did dditional voice messages left 1/21/2022.				adverse reactions. All staff attested understanding the information provid all staff completed a written test as put this training. Completion and complication recorded in each staff's training recorded the Relias Learning Management Sy A facilitator and implementation tear	to led, and led, and leart of leance is leard via lestem. In was	
	07/29/2022 at 7:35 Pl of Residential Service reached out to YCW a YCW #5 to grant the S Surveyor an interview unsuccessful attempt	-mail) communication on M, from the Vice President es, the facility's attorney #5's attorney to encourage State Survey Agency (SSA) v, but after multiple s to contact YCW #5, the nable to conduct an interview				identified for Six Core Strategies for Reduction of Seclusion and Restrair project implementation. The Six Core Strategy Steering Committee/Leade Subcommittee met for the first time of September 27, 2022. On November 2022, the Prevention Tools and Deb Subcommittees met for the first time Data Subcommittee is scheduled to the first time on January 4, 2023.	nt e rship on 17, riefing . The	9/4/22
	The findings include:				Co	ontinued on next page		
	Holding of Youth, Pol review date 03/25/20 the policy was to prov	s policy, titled Physical icy Number: CS-040, last 21, revealed the purpose of ride guidelines for the use of outh (residents), to ensure						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l		CONSTRUCTION		SURVEY
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		18L013	B. WING			11/	/02/2022
	ROVIDER OR SUPPLIER S-BROOKLAWN-PILOTS			21	TREET ADDRESS, CITY, STATE, ZIP CODE 108 DAVID GRAVES DRIVE DUISVILLE, KY 40218		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 128	Leadership was comphilosophy concerning of youth that included emergencies that have use of physical holding preserving the safety (resident) when physical holding the least restrict intervention that was resolving the emerger discontinuing the physical holding of your possible when the you of his/her behavior; prophysical holding of your pose, such as coerconvenience, or retaling physical holding is not past physical holding is not past physical holding in history of dangerous to the use of physical horestrict the flow of air to the use of	e risk of harm. Further, the nitted to the organizations' g the use of physical holding the prevention of e the potential to lead to the g of youth (residents); and dignity of the youth cal holding was used; the dive emergency safety most likely to be effective in necy safety situation; sical hold as soon as atth (resident) regains control orbibiting the used of the facility admitted of the youth or solely on a pehavior; and prohibiting lding techniques that to the youth's lungs.  The resident was sive and sexual abuse in the resident was sive and sexually acting the care of foster parents.	N	128	Began daily reviews of all Emergence Safety Physical Interventions (ESPI) business days and weekends/holida necessary and thrice-weekly reviews resident grievances to determine, in to any safety concerns, whether any rights are violated. These include do and video reviews, when available. A violations or concerns noted are documented, and the information is swith the staff's supervisor for follow-which may include additional coaching training, or disciplinary action, up to a including termination of employment addition, the review information is distributed to the executive team and Bellewood and Brooklawn residential clinical, and quality leaders.  Ongoing monitoring/compliance procedured by the process of the proce	on ys if s of addition youth cument Any shared up, ng, and il, res: nclude youth ne, nt). I given nission.  CM) risis hrs) — how to youth, rty vill	9/1/22 Revised 12/8/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE S	SURVEY LETED
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NAME OF PR	ROVIDER OR SUPPLIER			S1	FREET ADDRESS, CITY, STATE, ZIP CODE		
				21	108 DAVID GRAVES DRIVE		
USPIRITUS	S-BROOKLAWN-PILOTS			L	OUISVILLE, KY 40218		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	D		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL ,SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
N 128	he/she was four (4) fe % Body Mass Index ( known cardiac issues Attention Deficit Hype and Disruptive Mood  Review of Resident # (BSP), dated 06/22/2 triggers included trau not getting his/her wa his/her siblings. Sym occurred just before of included defiance, the behavior. Further, un- any history of sexual traumas that would be trigger if the youth wa of neglect and aband  Continued review of the revealed since admis 07/17/2022, Residen three (3) holds that of 07/08/2022, and 07/08/2022, and 07/08/2022, and 07/08/2022. Seresident would often wake up and wanted her to put that Resident #1 aske AM on 07/17/2022. Seresident would wake as, "Is there going to said once I answered the resident some att to sleep. She said thi	22) was 114 pounds, and set, 4 inches tall, with a 29.1 BMI). The resident had no is, but was diagnosed with eractivity Disorder (ADHD), Disorder.  21's Behavior Support Plan 022, revealed situational ma history, attending school, ay and separation from ptoms or behaviors which crisis (crisis triggers) reatening and aggressive der the subheading, "Identify or physical abuse or other e a significant emotional as placed in a hold," a history forment was listed.  The resident's clinical record, sion and prior to the thing the thing to the thing to the thing the thing the middle of the night at a blanket over him/her, and sed her to do so about 3:00 the said sometimes the up and ask questions such be school tomorrow?" She disiner a pattern of	N	128	Appropriate Responses to Emergen Safety Situations; Speak Up for Clie Safety; and Hand-Off Communication. These trainings will be completed by staff during New Hire Orientation, wi first three (3) weeks of employment, before working with youth. These trainclude information on how to safely effectively interact with youth, especially during challenging or potentially unsituations. Further, specific steps are provided related to communicating a reporting any inappropriate, unsafe, countertherapeutic behaviors exhibits staff, especially those that do not shore respect for human dignity, individual cultural and personal beliefs, as well forms of abuse and neglect including mental, physical, and sexual abuse. existing staff will complete these train on an annual basis, to be complete each year. Completion of and comp with these trainings is recorded in extaff's training record via the Relias Learning Management System. Staff begin work nor continue work with y until demonstrating understanding of concepts.  Zero Hold Philosophy Training: 6 Constrategies — New staff will receive information and complete test during employee orientation, and yearly reliable to provided for all cottage and of staff by 9/15 of each year. Complet compliance will be recorded in each training record via the Relias Learning Management System.  Continued on next page	nt on. y all new ithin the and ainings and cially cafe e and or ted by ow lity, or I as any g verbal, All inings I by 9/15 liance ach of these ore g new freshers clinical ion and staff's	
	as, "Is there going to said once I answered the resident some att to sleep. She said thi	be school tomorrow?" She I his/her question (s) or gave ention he/she would go back			Continued on next page		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL1 A. BUILDI		ECONSTRUCTION	(X3) DATE COMP	SURVEY
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NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HEDIDITH	S-BROOKLAWN-PILOTS			2	108 DAVID GRAVES DRIVE		
OSF II (110	J-DROOKEAIIII-IEOIG			L	OUISVILLE, KY 40218		-
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 128	and had put it on the bashe cleaned up the bashe cleaned up the bashe cleaned up the bashe cleaned up the bashe cleaned up the bashe cleaned up the bashe called for some seleping a long them to get up. She skitchen, and she called for some help becaus residents had gotten to others to get up, too. 3 #6 to keep an eye on behavior escalated. Shelp the eight (8) other assist with changing the them had bed wet said Resident #1 seer old than a seven (7) yresident longed for towhen she helped him stated Resident #1 resche said Residen	ad pooped in the bathroom, bathroom wall. YCW #7 said athroom wall. YCW #7 said of the reason she asked ist her on the morning of ecause the residents had time, and it was time for aid she was working in the id her supervisor and asked in two (2) or three (3) of the up, and it was time for the She said she needed YCW Resident #1, in case his/her the stated she needed to be residents get showers and their beds because some of ting behaviors. YCW #7 med more like a two (2) year ear old. She said the uch. She said the uch. She said the liked it was only seven (7) years elieve he/she was capable the else. She said she never needed to be placed in a she took care of him/her.  Itage from 07/17/2022 Resident #1 and YCW #1 ident's doorway. At 2:27:48 the the resident's door and froom. YCW #1 followed t's #1's room and the door of the camera footage, isor #1 entered Resident	N	128	Safety Physical Interventions (ESPI business days and weekends/holida necessary and thrice-weekly review resident grievances which are condidetermine, in addition to any safety concerns, whether any youth rights violated. These include document a reviews, when available. Any violatic concerns noted are documented, an information is shared with the staff's supervisor for follow-up, which may additional coaching, training, or discaction, up to and including terminatic employment. In addition, the review information is distributed to the execteam and Bellewood and Brooklawn residential, clinical, and quality leaders.	on ys if s of ucted to are nd video ons or d the include iplinary on of	9/1/22

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		18L013	B. WING				02/2022
	ROVIDER OR SUPPLIER S-BROOKLAWN-PILOTS			STREET ADDRESS, CITY, STATE, ZIP CODE 2108 DAVID GRAVES DRIVE LOUISVILLE, KY 40218			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD BE		(X5) COMPLETION DATE
N 128	Resident #1's bedroo just outside the reside the resident's bedroo toward the kitchen. Stat 02:36:13 PM with a the resident's door op doorway again, and with a container.  Per interview with YC PM, the container she resident was unconst which Shift Supervisor to the room. YCW #1 poured the cold water arouse the resident.  At 02:39:10 PM, YCW room, and unlocked the room and unlocked the resident.  Per interview with The 07/18/2022 at 4:45 PM phone to call 911.  Per continued review YCW #1 entered Resident #1's room a living area, then ran room. The Shift Superthe resident's room, and appeared the resident's room, and appeared the call appeared the resident's room, and soffice and appeared the 2:47 both Shift Superthe resident's room, and office and appeared the resident's room, and soffice and appeared the resident's room and soffice and appeared the resident's room, and soffice and appeared the resident's room and soffice and appeared the resident's room.	revealed YCW #1 exited on and spat into a trash can ent's room, then re-entered PM. YCW #1 again exited on at 02:35:49 PM, and ran the returned to the bedroom a cloth. YCW #1 then held ben. YCW #1 left the vithin seconds, she returned PM #1 on 07/20/2022 at 4:12 to took to the room after the clous, had ice water in it, or #1 instructed her to bring said Shift Supervisor #1 over Resident #1 to try to PM #1 exited the resident's he cottage office.  Be Division Director on M, YCW #1 was getting a point of the camera footage, ident #1's room with the M.	N	128			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1''		ECONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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NAME OF DE	ROVIDER OR SUPPLIER	100013	D. Wille		STREET ADDRESS, CITY, STATE, ZIP CODE	11/	0212022
NAME OF T	TO AIDEN ON 3D1 1 FIEN				2108 DAVID GRAVES DRIVE		
USPIRITUS	S-BROOKLAWN-PILOTS			L	OUISVILLE, KY 40218		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
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N 128	Continued From page	41	N	128			
	07/18/2022 at 4:45 PI camera footage with (SSA) Surveyor, reve bedroom with Reside  At 02:48 PM Shift Surremained in the common with Resident #1's bedroof followed them into the quickly exited the roof additional emergency Resident #1's bedroof and started bending to sat down on a chair in Continued review of the common living sprontinued with chester PM, two (2) EMS staffstretcher parked whe deliver chest compression was on the cottage flower seen in the comstaff continued to deliver the staff ervisor #1 and YCW #1 mon living space.  responders entered m and Shift Supervisor #1 e room. Shift Supervisor #1 m, and at 2:50 PM four (4) v responders entered m. YCW #5 exited the room, over from the waist, and then in the common living area.  the Camera Coverage for EMS staff transferred sher bedroom to the floor of ace at 2:55:09 PM and compressions. At 2:59:35 if placed a backboard on a re EMS staff continued to ssions while Resident #1 oor. Two (2) police officers imon space, as well. EMS iver chest compressions, MS staff transferred the mer and moved the resident						
	Review of the Fern C Medical Services (EM dated 07/17/2022, rev impression by the EM	ree Fire & Emergency /IS) Patient Care Record, vealed the following: Primary					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A: BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		18L013	B. WING_		11/	02/2022
NAME OF PR	ROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STATE, ZIP CODE		
HERIDITH	S-BROOKLAWN-PILOTS			2108 DAVID GRAVES DRIVE		
USPIRITUS	S-BRUUNLAWN-FILUTS			LOUISVILLE, KY 40218		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 128	used was Pediatric P was recorded as 14:4 Complaint, Cardiac A suffocation/Asphyxial breathing as cause of was recorded as rece dispatched at 14:44:1 14:44:19; personnel at at 14:51:00; departed 15:11:29, and at dest Review of the Hospita (ED) Documentation, Resident #1 arrived at According to the repo ED with an endotrach Lucas device (a mediat the victim's chest, compressions during resuscitation attempt continued chest com cardiac stimulating m the endotracheal tube work, as well as othe measures were cons ED physicians and ne pronounced dead at a report, two (2) nurses Metro Police Detectiv bedside at the time o the ED flowsheet that child with no parents. Attending Physician's 07/17/2022 at 4:53 P ED from Brooklawn in	Cardiac Arrest; Protocol ulseless Arrest; Onset time 10.00 on 07/17/2022; Chief rrest; injury documented as tion-Mechanical threat to f asphyxiation. The 911 call eived at: 14:40:56; 14; responders enroute at at scene 14:50:00; at patient f scene with patient at tination at 15:22:23.  al Emergency Department dated 07/17/2022, revealed at the ED at 3:24 PM. bot, the resident arrived in the heal tube in place and a hanical CPR System placed that delivers quality chest prolonged cardiac s.) Interventions including pressions, administration of hedications, replacement of e, frequent pulse checks, lab or attempts at life saving tantly administered by the turses until the resident was 4:48 PM. According to the s, a Chaplin, and a Louisville we were at the resident's f death. It was recorded in t Resident #1 was a foster . Review of the Pediatric	N 1			
	physician documente	ed that per the EMS report n restrained at the PRTF due				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
USPIRITUS	S-BROOKLAWN-PILOTS				2108 DAVID GRAVES DRIVE		
					LOUISVILLE, KY 40218		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
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N 128	Continued From page	<b>.</b> 43	N	128	3		:
		d lost pulses. The Physician	i				
		nclear how long it was from	İ				
	the time the resident	stopped breathing to					
	recognition of a loss of	of pulses.					
	Interview State Start St						
		esponder #1 on 08/09/2022 she was the first to arrive at					
	· ·	when she walked into the					
		Resident #1) was on the					
		at was just off the large					
		, and two (2) staff were					
	performing CPR. She	one (1) of the two (2)					
		had been dealing with the					
		roblems throughout the day					
		aggressive with staff. The					İ
		before the resident became					j
		ad placed him/her in an aid one (1) of the staff					
		ed the hold for about 2					
		other staff member took					
		id that staff person said she					
	felt the resident stop i	resisting the hold, and					
		ed, so she released the					
		e he/she was unresponsive.					
	First Responder #1 de		-				
		sian female with dark					
	_	ir, maybe in her 40's; and a a little older, in her 50's. She					
	•	e about five (5) feet 5 inches					;
		#1 said she saw vomit on					
	,	not recall seeing vomit					
	debris on the resident	_					
	Responder stated we						
		nine while on scene, but she					
		on the patient because one					
	(1) of the EMTs said of	get the suction machine.					
	Interview, on 07/20/20	022 at 5:22 PM with YCW					
	#1, revealed Shift Sup	pervisor #1 took Resident					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	0	(X3) DATE SURVEY COMPLETED	
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		18L013	B. WING_			11/	02/2022
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
USPIRITUS	S-BROOKLAWN-PILOTS			2108 DAVID GRAVES DRIVE			
	3-BICOREATIN-1 IEOTO			LOUISVILLE, KY 40218			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APP	OULD BE	=	(X5) COMPLETION DATE
				DEFICIENCY)			
N 128	Continued From page	÷ 44	N 1	28			
	#1's lunch to his/her re	oom on 07/17/2022 at about					
	Review of cottage car Supervisor #1 took a	mera video revealed Shift					
		54, about 45 minutes before		i i			
	YCW #5 secured the	•					
	-	022 at 5:42 PM with the					
		dical Technician (EMT) #1,					
	-	nders were on the scene					
		hen she arrived. She said lent was pulseless and					
		). She said the the resident					
		itor and was in asystole					
	-	o detection of electrical or					
		the heart). She said there					
		esent in the cottage, and					
	multiple stories were t						
	explained the residen	t had an altercation, and					
	was placed in a bear l	hug. She said the staff					
	person said they were						
	resident's air. She sa						
		re placing the resident's	i	ļ			
		during the hug. She said the					
		plain they were not trying to					
		ut had him/her in a bear hug.					
		nere was vomit everywhere					
		bate the resident. She said				ļ	
		s mouth and throat, running nd on the floor. She said it					
		ecently eaten. The Lead					
	EMT said in the ambu						
		ut off the residents clothes					
		sessment. She said there					
		ks on the resident's neck,					
	and no signs of traum	· ·					
	Interview, on 07/31/20	022 at 6:01 PM with EMT					
		e arrived on scene, fire					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		18L013	B. WING	_		11/	02/2022
NAME OF PR	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
USPIRITUS	S-BROOKLAWN-PILOTS			2	2108 DAVID GRAVES DRIVE		
Corner	-DROOKEAMIN ILOIS			L	LOUISVILLE, KY 40218		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE
N 128	She said one facility semale, was running a breathe, please breat patient's name. EMT patient (Resident #1) said when the Lead Epatient (Resident #1) vomit. She said, "It with had to suction it out be him/her." EMT #2 sta (Resident #1) had be she wondered if the not omoritor the youth it isolation.  Observation, on 07/12. Cottage, revealed eigcottage with Shift Sur Residential Manager. 4:55 PM with the Rest the census at the cott and on 07/17/2022, nottage, including Re Resident #1's bedroomeal tray (from 07/17 in the room, with open napkin. A black cushi inches, was on the fix substance was seen resident's bed. In add was observed on the with the Division Dire revealed law enforce remain unchanged untheir investigation.  Interview, on 07/19/2/	there administering CPR. staff member, a black around and screaming, the, as she called the #2 stated we moved the out of the bedroom. She EMT #1 tried to intubate the , his/her airway was full of as such a large amount we refore we could intubate ted staff told her the patient en in an "isolation room," so oom had camera coverage f he/she had been in  8/2022 at 4:40 PM of Pilot's pht (8) residents were in the pervisor #1 and the Pilots . Interview, on 07/18/2022 at sidential Manager confirmed tage was now 8 residents, ine (9) residents were at the sident #1. Observation of om revealed the resident's f/2022) was on a small desk med packages, a cup, and a on, about 16 inches x 16 oor, and a dark brown on the tiled floor near the litton, a plastic water bottle resident's bed. Interview ctor during the observation, ment wanted the room to ntil the detectives completed	N	128			
	Supervisor #1, reveal	ed on 07/17/2022 she came					

-	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION NG	(X3) DATE:			
		18L013	B. WING_		11/0	02/2022		
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE				
USPIRITUS	S-BROOKLAWN-PILOTS		2108 DAVID GRAVES DRIVE					
OSFIRITO.	-DICONLAIM-I ILOIO		- 1	LOUISVILLE, KY 40218				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		3E	(X5) COMPLETION DATE		
N 128	sixteen (16) hours. SI report from YCW #7 v She stated YCW #7 v been knocked things sanitizer, and threate when they came out to bathroom. She said Y also threatened to kill stated at approximate to work and during the #5 that Resident #1 a shift. Shift Supervisor his/her hand out of his debriefing session, and with him/her. Shift Sulearn what the resident #1 said she was water by YCW #1 entered Fishe watched from the would occur, and wor would escort the resident said when that did not resident's room, and secured the resident and YCW #1 was hold and legs. Shift Supervisor remained resistant art hold. She stated the rehold so much, they did out of the bedroom, of a timeout room. The was no indication the respiratory distress with the said the resident said the resident was no indication the respiratory distress with the said the resident said the resident was no indication the respiratory distress with the said the resident said the resident was no indication the respiratory distress with the said the resident said the re	and was scheduled to work the said she received a who worked the night shift. eported Resident #1 had off tables, squirted hand ned a couple of residents of their rooms to go to the CW # 7 stated the resident I staff. Shift Supervisor #1 ely 2:00 PM, YCW #5 arrived the debriefing, she told YCW toted out during the night the #1 said Resident #1 stuck the sher room door during the the YCW #1 went to speak the pervisor #1 said she did not that wanted. Shift Supervisor thing when YCW #5 followed the staff the two (2) staff dent to a timeout room. She tot happen, she went to the found that YCW #5 had in a kneeling cradle hold, ding the the residents feet visor #1 said she could not but at some point she took the was was fighting the id not try to move him/her for try to transition him/her to Shift Supervisor said there	N	128				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		401.040	B. WING			C 11/02/2022	
		18L013	B. WHYG	_		11/	02/2022
NAME OF PI	ROVIDER OR SUPPLIER			l	STREET ADDRESS, CITY, STATE, ZIP CODE		
HEDIDITH	S-BROOKLAWN-PILOTS				2108 DAVID GRAVES DRIVE		
USFIRITO.	3-DROOKLAWN-ILOIS				LOUISVILLE, KY 40218		
(X4) ID PREFIX	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
TAG	NEGOEATORI GRE	SO DETAIL THE IN COMMITTEE			DEFICIENCY)		
N 128	,		N	128	3		
		I for his/her age, and at					
		ig could sound loud and	1				
	l	sor #1 stated Resident #1					
		p when she entered the					
	1	e only episode of vomiting					
	he/she had. She said						
		I. She said both happened					
	l .	e bedroom. Shift Supervisor					
	#1 stated when she to	•					
	hands got loose. She	g back," and one of his/her					
		r Safe Crisis Strategies					
		I not say anything and					
		out of the hold. She stated,					
		ody became dead weight.					
	l '	felt this change occur, she					
		e said his/her eyes were					
	closed. Shift Supervis	•					
		uring a hold, so she tried to					
		y tapping his/her face. Shift					
	l .	ne told YCW #1 to bring a					
		said she took the resident's					
		st and neck, and she felt the					
		said YCW #5 also took the					
	•	Supervisor #1 said she					
		esident at little, and then we					
	poured cold water over	er him, but the resident did					
	not respond, Shift Su	pervisor #1 stated she					
	started to panic and '	YCW #5 initiated CPR.					
		aid when Resident #1 went					
	''	s/her arms, leaned him/her					
		stated his/her eyes were					
		apping the resident's cheek					
		me. She said she checked					
		nd he/she had a pulse. She					
		e resident's stomach and					
		reathing, but had passed ot tapping him/her, and we					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		18L013	B, WING			C 11/02/2022	
	ROVIDER OR SUPPLIER S-BROOKLAWN-PILOTS	102010		S1 21	TREET ADDRESS, CITY, STATE, ZIP CODE 108 DAVID GRAVES DRIVE DUISVILLE, KY 40218		V&1 & V & A.
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 128	went ahead and initia #1 said she thought the pulse, don't do CPR, patient was unresponship she said she was upstocause they did not they were rude. Shift surprised her that YC a hold. She said the cholds because the stand use Psycho Educatatements to avoid in she asked YCW #5 whold, and YCW #5 to assaulted her, but Sh was not sure where the Supervisor #1 said she did not instruction was to have said she did not instruction was not sure where the said she did not instruction was not sure where the said she did not instruction was not sure where the said she did not instruction was not sure where the said she did not instruction was not sure where the said she did not instruction was not sure where the said she did not instruction was not sure where the said she did not instruction was not sure where the said she did not instruction was not sure where the said she did not instruction was not sure where the said she did not instruction was not sure where the said she	ted CPR. Shift Supervisor that if the patient had a but she also learned if the asive, then start CPR.  aid YCW #1 called 911, but tet with the EMS personnel seem to be in a hurry, and Supervisor #1 said it tw #5 placed Resident #1 in cottage did not have many aff talk with the residents,	N	128			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		18L013	B, WING_		11	C /02/2022	
	ROVIDER OR SUPPLIER S-BROOKLAWN-PILOTS			STREET ADDRESS, CITY, STATE, ZIP CODE 2108 DAVID GRAVES DRIVE LOUISVILLE, KY 40218			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	*	DBE	(X5) COMPLETION DATE	
N 128	at about 8:15-8:19 AM #1 reported to work b Supervisor #1 gave h residents. YCW #1 sa her she was upset with he/she had ruined he Supervisor #1 told the that she was going to make him/her throw us 8:45 AM she heard Si Resident #1 that she and she was going to She said after she sai Supervisor #1 sent a staff member and she texted that Resident # that she could not eve now. YCW #1 said sh Supervisor sent the te why the supervisor we sent the text message Supervisor #1's voice toward Resident #1, a with the resident.  YCW #1 stated at abo reported to work and s a report on Resident # night shift. And, she to on the white board tha Resident #1 tried to fig threatened staff, and s bathroom wall.  YCW #1 said about 2 his/her hand out of th he/she needed somet	orted to work on 07/17/2022  M. She said Shift Supervisor efore she did. She said Shift er an update on the aid Shift Supervisor #1 told the Resident #1 because or church day. She said Shift er resident at about 8:45 AM to hold (restrain) him/her and the p. YCW #1 said at about thift Supervisor#1 tell was going to hold him/her make him/her throw up. It that to Resident #1, Shift text message to another the told her (YCW #1) that she is told her (YCW #1) that she is told her (YCW #1) that she is told not know who Shift exit to, and she was unsure eanted her to know she had the exit to, and she was unsure eanted her to know she had the exit tone was very aggressive and she seemed very upset to the exit Shift Supervisor #1 gave her is behavior during the old her YCW #7 had written at during the night shift ght with two (2) residents,	N ·	128			

STATEMENT OF DE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				_		(	
		18L013	B. WING			11//	02/2022
NAME OF PROVI	DER OR SUPPLIER			S1	TREET ADDRESS, CITY, STATE, ZIP CODE		
				21	108 DAVID GRAVES DRIVE		
USPIRITUS-BR	ROOKLAWN-PILOTS			L	OUISVILLE, KY 40218		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 128 Co shihir his da his the Sh pic thre he just as lau hir ov was #5 YC sh sir hoo Sh ag YC dic on #1 sta sh co hir sa YC St. #5 Sh	mself/herself, but the sher bedroom all day, Resident #1 had sher pants. She sa the resident at his/her hift Supervisor #1 worked up his/her plast reatened to throw her (YCW#1). YCW #5 the started laughing, a serious threat. Sugh and joke a little m/her. YCW #1 said retheard Resident #6 was at Resident #6 was at Resident #6 was at Resident #6 (YCW#1) walked the eyCW #5 was going a said YCW #5 was going a said YCW #5 pull painst the bedroom CW #5 he/she she was new to be said YCW #5 pull painst the bedroom CW #5 he/she she was new to be said YCW #5 the she wall before implied the resident worth, and the resident worth, and a few said ycw #1 said a few said pervisor #1 entered to move, and said hift Supervisor #1 to the said sit Supervisor #1 to the said said said said supervisor #1 to the said said supervisor #1 to the said said said said supervisor #1 to the said said supervisor #1 to the said said said said said said said supervisor #1 to the said said said said said said said said	the resident urinated on e resident had been in ay. She stated earlier in the urinated and pooped in id while she was talking to roor, he/she asked where as. She said the resident stic water bottle and is/her plastic water bottle at it said she and Resident #1 and that she did not take it he said Resident #1 liked to and that seemed to calm if she thought YCW #5 threaten to hit her with the bout two (2) seconds YCW in doorway. YCW #1 stated Resident #1's room, and that in behind YCW #5 because the job she wanted to see ing to handle the situation. It Resident #1's hands up wall and Resident #1 told was going to hit her like tay, and the resident in a cradle hold. YCW #1 said is feet/legs, and tried to resident by laughing with a (YCW#1) had accidentally sident's pee on the floor.	N	128	DEFICIENCY)		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDII	NG_		l .	_
		18L013	B. WING				C /02/2022
		105013	0: ******		**************************************	11/	0212022
NAME OF PE	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
USPIRITUS	S-BROOKLAWN-PILOTS				2108 DAVID GRAVES DRIVE		,
********	J-01/4-01/10-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1			L	OUISVILLE, KY 40218		
(X4) ID	1	ATEMENT OF DEFICIENCIES	ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	_	(X5) COMPLETION
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	TAG	K.	CROSS-REFERENCED TO THE APPROPRIA		DATE
					DEFICIENCY)		
N 128	Continued From page	∍51	N 1	128			
	1	d per her SCM training, the					
	person implementing	the hold was not supposed					
	to do that because the	e resident could throw up,					
	and that action could	also cause damage to the					
		's body. She said YCW #5	ļ				
	asked her to go check	k on the other residents in					
1	_	said when she returned to					
	Resident #1's doorwa						
		Resident #1, "Go ahead					
		She said when she looked in	İ		į		
		dent was still in the hold, and					f
	i '	a lot of clear liquid and	Ì				
		#1 said YCW #5 told her to					
	1 *	on. YCW #1 said when she					
	1	1 through the doorway, the					
		ng anything, but he/she was					
		she went to get the impact					
	1	t find it. She said she quickly					
	1	ent's doorway, and YCW #5 t the cushion. YCW #1 said					
		ing the room she told her					
	1	hift Supervisor #1. YCW #1					
	1 '	why YCW #5 told her to					
		or #1. YCW #1 said YCW #5					
	came back with the co						
		id she went to check on					
	another resident (Res						
	,	s in his/her eyes, and said, "I					
	1	nt #1 because he/she is only					
		They need to ban holds, and					
		was him/her being held					
	1	1." YCW #1 said she stayed					
		(1) to two (2) minutes, and					
		dent #1's doorway because					ľ
j		rvisor #1 say, "Lay him/her					
		CW #1 said there was a					
	discharge on Resider	nt #1's lips, and that it was	Ì				
	-	king-that was the color of					
	his/her lips. YCW #1 :	said she asked, "What do I					

	TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION ADDITIONAL STRUCTION STRUCTION STRUCTION ASSURED STRUC			OMPLETED  C		
		18L013	B. WING			11/02/2022
	ROVIDER OR SUPPLIER S-BROOKLAWN-PILOTS		<u></u>	STREET ADDRESS, CITY, STATE, ZIP CODE 2108 DAVID GRAVES DRIVE LOUISVILLE, KY 40218		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
N 128	her to get a wet cloti water, so she got the She said Shift Superof water onto Reside Supervisor #1 started She said Shift Superof switched back and for and giving the resident supervisor #1 told here. The supervisor #1 started call Residential Marcontinued giving the she put down the pitche 911 dispatch per thought the Emergen arrived at 2:47 PM, of the call on her phy YCW #1 said she has supervisor #1's staft put Resident #1 in a up. She said she she someone, and she if implemented, that if she really did not known and Professional Deconducting the interior incident.  Interview, on 07/21/2 Resident #2, reveal happened to Resident #1. Resident #2, reveal happened to Resident was been placed in a horizontal said in a horizontal said in a horizontal said in a horizontal said in a horizontal said said thought about killing did not do that. Resident #2, reveal happened to Reside thought about killing did not do that. Resident #2, reveal happened in a horizontal said the said thought about killing did not do that. Resident #2, reveal happened in a horizontal said the said thought about killing did not do that. Resident #2, reveal happened in a horizontal said the said thought about killing did not do that. Resident #2, reveal happened in a horizontal said the said	ge 52 aid Shift Supervisor #1 told h, and then some cold/ice e bucket of cold water, too. rvisor #1 dumped the bucket ent #1, and then Shift ed giving the resident CPR. rvisor #1 and YCW #5 forth with chest compressions ent breaths. She said Shift ter to call 911, and the Shift ed yelling that she needed to hager #1. She said YCW #5 e resident CPR. YCW #1 said hone so YCW #5 could talk to rson. YCW #1 said she ency Medical Staff (EMS) because when she looked at one, it was (8) minutes long. and concerns about Shift tement that she was going to hold and make him/her throw foll really bad about that. YCW rst hold she had seen that was all very shocking, and how who she should have (2022. However, she said she erns to the Director of Traning evelopment, who was mal investigation of the  (2022 at 4:40 PM with led when staff explained what lent #1, he/she cried and led himself/herself, but he/she lident #2 stated he/she had lident #2 stated he/she had lident #2 stated he/she had lident #2 stated he/she had lident #3 staff when feeling like	N 1:	28		

_	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		18L013	B, WING _		11/	02/2022
	ROVIDER OR SUPPLIER S-BROOKLAWN-PILOTS			STREET ADDRESS, CITY, STATE, ZIP CODE 2108 DAVID GRAVES DRIVE LOUISVILLE, KY 40218		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (		(X5) COMPLETION DATE
N 128	Resident #1 was place he heard the ambular could not get out of his aid he/she pushed in on him because he/si his/her room. Resident the hold had happened Resident #1 because as long as him/her. To knew there was nothing he/she wanted to see Resident #1 during the linterview on 07/21/20/244, revealed holds moved the timeout room. Re 07/17/2022 after the gym, and that he/she because the cops had at things.  Interview, on 07/26/27 Training and Profess Coordinator, revealed trained in Safe Crisis stated he trained dire resident and staff saff hold. He said the staff resident forward with implementing the kneif a staff member place resident's torso when	o22 at 5:20 PM with d he/she was upset that sed in a hold. He/she stated nee coming, and that he/she is/her room. Resident #3 /CW #5 when she checked he was trying to get out of nt #3 stated he/she wished ed to him/her rather than Resident #1 had not lived he resident said he/she ing he/she could do but what was going on with he hold.  O22 at 5:40 PM with Resident ade him/her think the staff re residents. He/she said the do happen in the milieu or in sident #4 said on incident, staff took us to the wanted to stay in the gym dependent of the direct care staff was Management (SCM). He cot care staff to keep the fe if they must implement a ff person should not push the their body weight when seeling cradle hold. He stated	N 1			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		1					c
		18L013	B. WING			11/	02/2022
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
, <u>.</u>				2	108 DAVID GRAVES DRIVE		
USPIRITU	S-BROOKLAWN-PILOTS			Ιι	OUISVILLE, KY 40218		
	CHMMADVCT	TATEMENT OF DEFICIENCIES	l ID		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	COMPLETION DATE
N 128	Continued From page	e 54	N	128			
	said the staff membe						
		its at the resident's hips or					
	waist, and avoid appl						
		te stated if the resident had					
		of the hold, placing pressure	1		İ		
	on the stomach could	cause the resident to vomit.					
	Further, the Training	and Professional					
		nator stated pushing forward					
	on the resident's tors	o, could cause the staff					
		ent's secured hands to shift,					
		e resident's stomach. He					
		nd placement could result in					
		lent's stomach and internal					
	_	difficult for the resident to					
	breathe. The Training	_					
		nator stated facilities have					
		ted to negative outcomes					
	from improper use of	noids.					
	Interview, on 08/22/2	2022 at 10:00 AM with the					
	Director of Training a						
		led the staff securing a	ļ				
		cradle hold should have					
	one knee on the floor	r, and one knee up with a					
	foot on the floor. He	stated the staff should					
	maintain a straight pe	osture. He stated if the					
	resident was fighting	or resisting, the staff should					
	assess his or her pos	sture, and if they should					
		n to protect the resident from					
		ther injury. He said perhaps					
		er staff person, and use of a					
		be considered. The Director					
	_	essional Development stated					
		ll a resident secured in a hold					
	_	w up. He stated it was not					
		aff to lean forward placing					
		h during a kneeling cradle					
		ould affect the youth's ability					
	to breathe causing p	ositional asphyxiation and/or					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	(X2) MULTIPLE CONSTRUCTION A, BUILDING		X3) DATE SURVEY COMPLETED C
		18L013	B. WING_			11/02/2022
	ROVIDER OR SUPPLIER S-BROOKLAWN-PILOTS			STREET ADDRESS, CITY, STATE, ZIP CO 2108 DAVID GRAVES DRIVE LOUISVILLE, KY 40218	DOE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG		ION SHOULD BE HE APPROPRIAT	(X5) COMPLETION DATE
N 128	#3, revealed he/she #1, during his/her sta on 07/15/2022. He stadmission, Resident use to the cottage ror follow the rules. How improvement with Rehis/her stay. YCW #3 place a resident in a a threat to himself/he stated we were not tradicted we were not tradicted we were not tradicted with the stated we were not tradicted with the stated we were not tradicted with the stated we were not tradicted with the stated we were not tradicted with the stated we were not tradicted would earn negative threatening to throw should apply the Psy (PEM), which includes statements to deescow was upset.  Interview, on 07/24/2/#4, revealed he work Thursday (07/14/2020 He stated the rebut to him, it was not noted there was tens and YCW #5, and or medications, he head between Resident # he intervened becauthrow a shoe at YCV talked with Resident	vomit.  2022 at 5:51 PM with YCW had worked with Resident by at the cottage and worked cated early into his/her #1 had a rough time getting utines, and did not always ever, YCW #3 said he saw esident #1's behavior later in 8 stated staff should not hold unless he/she becomes erself, or others. YCW #3 rained to place a resident in a ereferred to a staff member lie. or threw something at the d, he stated the resident consequences for something. He stated staff rechoeducational Model	N ·	128		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>*</sup> A. BUILDI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDI	1110	<del></del>	,	С
		18L013	B. WING			1	02/2022
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	·	
					2108 DAVID GRAVES DRIVE		
USPIRITU	S-BROOKLAWN-PILOTS				LOUISVILLE, KY 40218		
(X4) ID		ATEMENT OF DEFICIENCIES	10		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD 8	_	(X5) COMPLETION
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		CROSS-REFERENCED TO THE APPROPRIA		DATE
					DEFICIENCY)		
			İ				
N 128	Continued From page		l N	128	3		
	the shoe, and then we	ent to his/her bedroom.					
	Continued interview v	vith YCW #4 revealed the	1				
	greatest risk to a resid	dent when in a hold was					
		n. He stated holds should					5
		nere the event could be					
		He stated holds should only					
		it was a threat to himself or					
		e resident yelled, cursed, or of a staff person, those					
		rrant securing the resident in					
		d anything could happen					
		in a hold. He stated the					
	resident could swallo	w vomit. He stated the staff					
	person placing the ho	old should never lean on the					
		staff person's back should					
		d down. YCW #4 said if the					
		g, then he would still hold					
		out loosen up on the hold.					
		was supposed to try to talk					
		he/she was upset, and					
		out room with the resident e stated staff should not put					
	their hands on a resid	•					
		ing out. He stated at times					
		gs to work. He stated he had					
	,	pervisor #1, but he did not					3
	think she brought her						
	_	Il when she was frustrated.					
	When asked by the S	tate Survey Agency (SSA)					
		t Shift Supervisor #1 had					
		h Resident #1's behavior,					
	YCW #4 said he was	•			i		
		vorked with her very much					
	during Resident #1's	stay at the facility.					
	Interview, on 07/30/20	022 at 2:54 PM with YCW					
		nplement holds off camera,					
		s, because there would not			MAAAAAA		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL1	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		18L013	B. WING_			11/	02/2022
	ROVIDER OR SUPPLIER S-BROOKLAWN-PILOTS			STREET ADDRESS, CITY, STATE, ZIP CODE 2108 DAVID GRAVES DRIVE			
				LOUISVILLE, KY 40218			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC (DENTIFYING INFORMATION)	ID PREFII TAG		HOULD BI		(X5) COMPLETION DATE
N 128	be a record of hold. Y vomited, the staff person and allow the residen bathroom. He stated stated the staff person be against the residen person should not betthe resident. He said should be upright/straperson's chest.  Review of the Corone 07/18/2022, and sign revealed the deceder 07/18/2022. Remarks there were injuries on appeared to be contuareas of his/her body his/her eyes. The Dejin the eyes can be an strangulation. She stacause slight petechia #1's case, there was Interview, on 07/19/20 Department of Comm (DCBS) Supervisor, restaff left her a phone late afternoon, about Resident #1 lived abording the DCBS Supervisor assigned DCBS Guarshe had the physiciar phone. She said she lated a three- way- call that a hold at the PRTF Coresident stopped breat	CW #8 said if a resident son should release the hold to recover or go to the the resident could be ill. He n's chest and body should nt's back, but the staff and over or place pressure on the youth's (resident's) body alight against the staff et's Report, dated ed by the Deputy Coroner, at underwent an autopsy on a after the autopsy, revealed at the decedent's body that sions (bruises) on various and petechia visible in buty Coroner said petechia result of asphyxia or asted aggressive CPR may in the eyes, but in Resident more than slight petechia.  D22 at 11:30 AM with the nunity Based Services evealed an on-call DCBS message on 07/17/2022, a call from the facility where but an emergency there. She git was about Resident #1.	N	128			

_ ,, .,	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A: BUILDIN	IPLE CONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED	
		18L013	B. WING_		C 11/02/2022		
	ROVIDER OR SUPPLIER S-BROOKLAWN-PILOTS			STREET ADDRESS, CITY, STATE, ZIP CODE 2108 DAVID GRAVES DRIVE LOUISVILLE, KY 40218			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
N 128	Supervisor said the p were able to get a put resident never regain time of death was cal Supervisor stated the sending Resident #1' autopsy because the and she did not unde get the resident to the In interview, on 08/09 county medical exam case was complicate after the autopsy. He pinpoint hemorrhage target of his exam was any suspicious marks he found nothing sign Examiner stated the extensive CPR. How the eye hemorrhages what would occur by medical examiner said toxicology report, whithe the examination, the possible cause of said he had questions was being restrained comment at this time statement of his finding as long as it took to oneeded to conclusive Interview on 08/05/20 Resident #1's Psychimanagement of a resident accomment of a resident was called the possible cause of said took to one of the conclusive on 08/05/20 Resident #1's Psychimanagement of a resident was called to the conclusive on 08/05/20 Resident #1's Psychimanagement of a resident was called the property of the proper	the hospital. The DCBS hysician said staff at the ED lise a couple of times, but the ed consciousness, and the led at 4:48 PM. The DCBS physician said she was s body to the coroner for situation was suspicious, retand why it took so long to a hospital.  1/2022 at 2:38 PM with the iner, revealed Resident #1's d, and not a lot of findings stated the resident had as to determine if there were s on the resident's neck, but inficant. The Medical resident experienced pretty ever, he stated he thought administering CPR. The id he was waiting on the ich was a standard part of The Medical Examiner said if death was asphyxia. He is about how the resident . He stated he could not on when he would have a ings. He stated it would take blain the information he elly state his findings.	N 1	128			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF IDENTIFICATION NUMBER: A, BUILDING			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		18L013	B. WING			C 11/02/2022	
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I WANTE OF F	NOVIDEN ON SOFT LIER				2108 DAVID GRAVES DRIVE		
USPIRITUS	S-BROOKLAWN-PILOTS						
				1	LOUISVILLE, KY 40218		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 128	Continued From page lieu of holds, staff sho such as verbal de-escresident to go to the tianger or other issues intervention should or became a threat to his stated he was unsure of neglect and abandaresponse to physical #1 had a history of exactivity, and stated the prostitute. He said it womother abandoned his places unsupervised, the resident may have linterview, on 08/22/20 Vice President (VP) or evealed it was every levels of the organizar safe. She stated that it workers, residential m staff, and directors su Residential Programm within about 10-15 mi on 07/17/2022, that Residential Residentia	e 59 build try verbal interventions calation, and or ask the imeout room to process the they had. He said physical half be used if the resident mself/herself or others. He how Resident #1's history comment would affect his/her holds. He stated Resident posure to adult sexual e resident's mother was a was known the resident's m/her leaving the resident at and it was also suspected a been sexually abused.  D22 at 10:15 AM with the f Residential Programming, one's responsibility, at all tion to keep the residents included all youth care nanagers, behavioral/clinical ch as herself. The VP of ning stated she was notified nutes after 911 was called		128	DEFICIENCY)		
:	Residential Programn	o the cottage. The VP of ning said she wanted to he resident exhibited that s, what led the staff to					
	determine a hold was wanted to know why the the resident's bedroor transition the resident camera view before so She said ideally, if a high should be implemented	necessary. She stated she he hold was implemented in n, and why couldn't staff out of his/her room into ecuring him/her in the hold.					

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	E CONSTRUCTION	(X3) DATE : COMPI	SURVEY LETED
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NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2108 DAVID GRAVES DRIVE		
USPIRITUS	S-BROOKLAWN-PILOTS			LOUISVILLE, KY 40218		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE
N 128	concerns about how I and how the hold was have contacted Reside immediately. She said have had his phone in PROTECTION OF RECFR(s): 483.356(b)  Emergency safety introduced intervention manner that is safe, pappropriate to the several safety intervention that is safe, pappropriate to the several safety intervention that is safe, pappropriate to the several safety intervention manner that is safe, pappropriate to the several safety intervention manner that is safe, pappropriate to the several safety intervention manner that is safe, pappropriate to the several safety intervention manner that is safe, pappropriate to the several safety intervention manner that is safe, pappropriate to the several safety intervention manner that is safe, pappropriate to the several safety intervention manner that is safe, pappropriate to the several safety intervention manner that is safe, pappropriate to the several safety intervention manner that is safe, pappropriate to the several safety intervention manner that is safe, pappropriate to the several safety intervention manner that is safe, pappropriate to the several safety intervention manner that is safe, pappropriate to the several safety intervention manner that is safe, pappropriate to the several safety intervention manner that is safety intervention safety intervention manner that is safety intervention safety intervention safety intervention manner that is safety intervention safety	vices stated if YCW #1 had Resident #1 was treated, implemented, she should dential Manager #1 d she knew YCW #1 would number. ESIDENTS  ervention. An emergency ust be performed in a proportionate, and verity of the behavior, and ogical and developmental ysical, medical, and and personal history	N 128	<ul> <li>Suspended Deborah Francis, Jillian and Amanda Whitlow as of 7/20/2022. Employment of Deborah and Jillian Parks was terminated 8/1</li> <li>Please note that any staff who failed comply with these actions received corrective action.</li> <li>All cottage and clinical staff were co with required annual three (3) hour \$1.00.</li> </ul>	n Francis 19/2022. If to mpliant Safe	8/19/22 9/1/22
	Based on interview, or review of the facility processed for facility failed to protect sampled residents from the facility failed to protect sampled residents from the facility failed from the failed from the facility failed from the facility failed from the facility failed from the failed	om an unnecessary tervention (ESI). On imately 2:25 PM, Shift outh Care Worker (YCW) #5 in a kneeling cradle hold. esident vomited, became		Crisis Management (SCM) Recertific Training, which included how to safe execute a standing and kneeling craby September 1, 2022.  All existing staff completed the follow trainings by September 6, 2022:  Appropriate Responses to Emergency Safety Situation  Speak Up for Client Safety  Hand-Off Communication  These trainings included inform how to safely and effectively intwith youth, especially during challenging or potentially unsafe situations.  Continued on next page	ely Indie hold wing  ns ation on eract	9/6/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER			ı	STREET ADDRESS, CITY, STATE, ZIP CODE		
USPIRITUS	S-BROOKLAWN-PILOTS		2108 DAVID GRAVES DRIVE				
					LOUISVILLE, KY 40218		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE .	(X5) COMPLETION DATE
N 132	interview with YCW # any staff member just in the hold, but only the plastic water bottle at stated Resident #1 di the YCW placed the resident's bedroom, of The findings include: Review of the facility Holding of Youth, Pol reviewed, 07/14/2022 philosophy about the youth (residents) include emergencies that have use of physical holdin use of nonphysical in the youth (resident) at the preferred interver behavioral emergence (residents) to minimiz holding. In addition, the preserving the safety (resident) when phys permitting the use of nonphysical intervent viable and when there youth (resident) phys others, and use of the safety intervention the effective in resolving situation.  Interview, with YCW PM, revealed about 2 his/her hand out of the the way residents we	e1, the resident did not hit t before he/she was placed meatened to throw his/her ther (YCW #1). YCW #1 d not hit YCW #5 just before resident in a hold in the but of camera view.  policy titled, Physical licy Number: CS-040, last 2, revealed the organization's use of physical holding of uded the prevention of we the potential to lead to the ng of youth (residents); the tterventions, with input from and parent or guardian, as ntions for addressing	N	132	Further, specific steps were pro- related to communicating and re- any inappropriate, unsafe, or countertherapeutic behaviors es by staff, especially those that de show respect for human dignity individuality, or cultural and per- beliefs, as well as any forms of and neglect including verbal, m physical, and sexual abuse. Co of and compliance with these as trainings was recorded in each training record via the Relias Le Management System.  All cottage and clinical staff remain of date with Safe Crisis Management ( refreshers per policy. Attendance ar compliance is recorded in each staff training record via the Relias Learni Management System.  All cottage and clinical staff reviewe attested in writing to understand the Tip Sheet and do's and don'ts speci physical holds authored by the ager Medical Director by August 15, 2022  All cottage and clinical staff reviewe attested to the review and understand of the following policies and procede August 15, 2022:  Appendix Clients Rights ar Responsibilities and Youth Grievances- Resolving Clie Complaints Reporting Abuse, Neglect Exploitation Physical Holding of Youth Existing staff completed written the information included in thes policies. Completion and compl recorded in each staff's training via the Relias Learning Manage System.	eporting  xhibited o not , sonal abuse ental, mpletion dditional staff's earning  up to SCM) nd f's ng d and Medical fic to ncy 2. d and nding ures by a Rights ent or  test on se liance is precord	9/1/22 8/15/22

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIS		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		18L013	B. WING				02/2022
NAME OF PE	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE		
				210			
USPIRITUS	S-BROOKLAWN-PILOTS			LC	DUISVILLE, KY 40218		
(VA) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF CORRECTION	- 7	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
N 132	Continued From page told her he/she had p said she was not sure on himself/herself, but his/her bedroom all diday, Resident #1 had his/her pants. She sa the resident at his/her Shift Supervisor #1 w picked up his/her plast threatened to throw it and Resident #1 just she did not take it as Resident #1 liked to lathat seemed to calm thought YCW #5 must threaten to throw his/YCW #5 was over at two (2) seconds. She #5 into the resident's she was new, she was was going to handle to did not think a hold w Resident #1 only three water bottle. She said #5 a stupid bitch, and the resident did not hanything. He/she did before YCW #5 security she thought the resident #1 only three water bottle. She said the resident did not hanything. He/she did before YCW #5 security she thought the resident #1 said she tho situation by getting in overheard Resident #1 hit her (YCW #1) with stated once the resident entire the residence was not stated once the resident #1 with stated with stated with stated with stated with stated with stated with stated with stated with stated with stated with stated with stated with stated with stated with stated with stated with	eed in his/her pants. She why the resident urinated at the resident had been in ay. She stated earlier in the urinated and pooped in id while she was talking to r door, he/she asked where as. She said the resident stic water bottle and at her. YCW #1 said she started laughing, and that a serious threat. She said augh and joke a little, and him/her. She stated she at have heard Resident #1 her water bottle, and that the resident's door in about stated she followed YCW bedroom. She said since inted to see how YCW #5 he situation. She stated she as even necessary because statened to throw the plastic d Resident #1 did call YCW I threatened to hit her, but it YCW #5 with the bottle or not hit me with anything red him/her in the hold, and ent was de-escalating laughing with her (YCW#1). ught YCW #5 escalated the volved when she apparently #1 say he/she was going to i the water bottle. YCW #1 ent was in the hold, and she	N 13	•		ucated a Zero pleted a pophy by e and is d; 2. eclusion, and it is ime out, and ow to cluding etential to ded, and part of is produced in the ership on 17, priefing e. The	9/4/22
	was securing his/her the resident by talking him/her. She said she	feet, she was trying to calm g and laughing with the e was trained that as soon alm, the hold could end. She					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>1</sup> A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		18L013	B. WING			1	/02/2022
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				2	2108 DAVID GRAVES DRIVE		
USPIRITU	S-BROOKLAWN-PILOTS			ı	LOUISVILLE, KY 40218		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		DATE
N 132		e 63 calm Resident #1 down, so	N	132	business days and weekends/holida	) on ays if	9/1/22
	he/she could get out of possible.				necessary and thrice-weekly review resident grievances to determine, in to any safety concerns, whether any	addition youth	
	Intensions on 07/26/20	022 at 4:20 PM with YCW			rights are violated. These include do and video reviews, when available.		
		in Pilot's Cottage, revealed			violations or concerns noted are	-arry	
	_	essional Development			documented, and the information is	shared	
	_	training on how to handle a			with the staff's supervisor for follow-		
		She stated she was trained			which may include additional coach		
	to try to listen to and t	alk with the resident			training, or disciplinary action, up to including termination of employmen		
		t be over some traumatic			addition, the review information is	1. 164	
		ves, She said she was			distributed to the executive team an	đ	
		to watch a resident when			Bellewood and Brooklawn residentia	al,	
		i angry, but not to secure			clinical, and quality leaders.		
		just because he/she might					
		se at me. In addition, she			Ongoing monitoring/compliance procedu	ires:	i
		secure a resident in a hold in			<ul> <li>Updated Youth Rights document to</li> </ul>	inaluda	]
	a camera. She said s	that was not monitored by			specific language emphasizing that		Revised
		covered/more open space in			should be free from any type of sha	me.	12/8/22
		ssistance with the hold.			ridicule, or humiliation (see attachm	ent).	
	order to obtain stain a	osistance with the noid.			This is posted in every living unit an		
	Interview, on 07/23/20	022 at 5:51 PM with YCW			to youth (and their guardians) at add	nission.	
		re staff members were not					
		sident in a hold just because			<ul> <li>Monthly Safe Crisis Management (S Refreshers (1 hr) and annual Safe (</li> </ul>		9/1/22
		taff member using vulgar			Management (SCM) recertification (		[
	language, or threw so	0 0			includes review of Youth Rights and		i
	Instead, he stated the	resident should earn			sensitively and effectively work with		
	negative consequenc	es for threatening to throw	1		especially when addressing particul	arly	
	_	direct care staff should			challenging or sensitive issues; this	will	
		n the Psychoeducational			include emphasizing that shame,		
	, ,	ample, he said the staff			humiliation, and/or ridicule is countertherapeutic and is not an acc	nontoble	
	should first try using o				intervention tool. Completion of all	ehrapie.	
	deescalate the reside	nt when he/she was upset.			refreshers and annual Safe Crisis Management (SCM) recertification is	R	
		022 at 3:13 PM with YCW #4			recorded in staff's training record via		
		ould not be secured in			Learning Management System.		
		they became a threat to	1				ļ
	himself/herself or other	ers. He stated if the resident					i l

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''		ECONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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_		18L013	B. WING			11/	02/2022
	ROVIDER OR SUPPLIER			"	STREET ADDRESS, CITY, STATE, ZIP CODE 2108 DAVID GRAVES DRIVE		
USPIRITU	S-BROOKLAWN-PILOTS			ι	LOUISVILLE, KY 40218		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 132	yelled, cursed, or ever person, those actions the resident in a hold escalated, staff should youth about cursing, resident, using positive stated just because a or cursing staff should youth. YCW #4 stated members had been secause ongoing more to ensure compliance that may not have harpandemic.  Resident #1's Clinical had been secured in of his/her final hold on had been placed in pleased of his/her final hold on had been placed in pleased of hold summaries for a #5 had initated all threat the stated he asked her of the toget to the host her stated he asked her order on 07/14/2022 a hold. He said he did did not follow the direstal her holds process. Here is the holds process.	en spat in the face of a staff is would not warrant securing. He stated when a resident id walk and talk with the for example, to calm the ve talk therapy. YCW #4 is youth was hollering, yelling, id not put their hands on the id he did not think staff is ufficiently trained in SCM, in they training was essential is with SCM techniques, and in ppened during the in 07/17/2022. The resident in hysical holds on 07/01/2022, 17/09/2022. Review of the ill three holds revealed YCW is ee of the holds.  1022 at 2:49 PM with the incident Resident #1. He said he just in pital to be with Resident #1. It imself, what did he not say the felt a sense of it had given YCW #5 a direct to not secure Resident #1 in id not understand why she is estated he asked the incidents would now perceive it is stated he asked the	N	132	Appropriate Responses to Emergen Safety Situations; Speak Up for Clie Safety; and Hand-Off Communication. These trainings will be completed by staff during New Hire Orientation, wi first three (3) weeks of employment, before working with youth. These trainclude information on how to safely effectively interact with youth, especially effectively interact with youth, especially effectively interact with youth, especially effectively interact with youth, especially effectively interact with youth, especially effectively interact with youth, especially effectively interact with youth, especially effectively interact with youth, especially effectively effectively interact with youth, especially those that do not should report the safe, countertherapeutic behaviors exhibits staff, especially those that do not should respect for human dignity, individual cultural and personal beliefs, as welforms of abuse and neglect including mental, physical, and sexual abuse. existing staff will complete these train on an annual basis, to be completed each year. Completion of and complete each year. Completion of and complete each year. Completion of and complete each year. Staff begin work nor continue work with yuntil demonstrating understanding of concepts.  **Zero Hold Philosophy Training: 6 Continued on and complete test during employee orientation, and yearly refull be provided for all cottage and containing record via the Relias Learning Management System.  *Continued on next page**	nt on. v all new ithin the and ainings and cially afe e and or ted by ow lity, or I as any g verbal, All inings I by 9/15 liance ach or f cannot outh f these ore g new reshers linical ion and staff's	
	remaining cottage re- the holds process. H campus trainer to cor	sidents would now perceive					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
HEDIDITH	PROOKLAWN BU OTS			210	08 DAVID GRAVES DRIVE		
USPIRITU	S-BROOKLAWN-PILOTS			LO	DUISVILLE, KY 40218		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD E			(X5) COMPLETION DATE
N 132	Training and Professi Coordinator, revealed whereby residents ea negative consequence and choices. He state Psychoeducational M positive responses and discouraged negative resident was cursing something like, "I kno have used bad languated negative consequence Professional Develop resident threatened to the would use stateme or Let's not do this, or unsafe." He stated if a threw something and he would try to block the each instance was sith he would stand by and to do, and he would ude-escalate the situated interview, on 08/22/26 Director of Training and Development, revealed internal investigation, YCW #5 secured Reson 07/17/2022 because the room were off camera to discern from his invenergency situation in necessitated implentatintervention. However	222 at 4:45 PM with the onat Development I the facility utilized a system med positive and/or es based on their behaviors ed by design, the lodel (PEM) encouraged and behaviors, and behaviors. He said if the at him, he would say we you are upset, but you age so you have earned a re." The Training And ment Coordinator said if a positive throw something or hit him, ents such as, "can we talk?," You are making me feel a resident charged at him, was close enough to strike, the thrown item. He stated usational, but in most cases disee what the resident tried se PEM statements to try to item.  222 at 09:30 AM with the med Professional and during the course of his he could not determine why sident #1 in a hold on the hold and events in the at He stated he was unable restigation that there was an in Resident #1's room that	N 1	32	Continue daily reviews of all Emerge Safety Physical Interventions (ESPI) business days and weekends/holida necessary and thrice-weekly review: resident grievances which are conductermine, in addition to any safety concerns, whether any youth rights violated. These include document areviews, when available. Any violatic concerns noted are documented, an information is shared with the staff's supervisor for follow-up, which may additional coaching, training, or discaction, up to and including terminatic employment. In addition, the review information is distributed to the execteam and Bellewood and Brooklawn residential, clinical, and quality leads.	on ys if s of ucted to are nd video ons or id the include iplinary on of cutive	9/1/22

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER A. BUILDIN			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		18L013	B. WING			11/02/2022	
NAME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
UCDIDITU	DDOOM AWA BILOTS			210	08 DAVID GRAVES DRIVE		
USPIKITUS	S-BROOKLAWN-PILOTS			LC	DUISVILLE, KY 40218		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 132	Continued From page to throw a water bottle on the threat, then the warrent implementation such as a hold.  Interview, on 07/21/20 Resident #2, revealed happened to Resident thought about killing the/she did not do that had been placed in a tried to take deep bre feeling like he/she wagetting into a hold.  Interview, on 07/21/20 Resident #3, revealed Resident #1 was place the ambulance could not get out of his said he/she pushed Yon him because he/sh his room. Resident #3 hold had happened to Resident #1 because as long as him/her. The knew there was nothing he/she wanted to see Resident #1 during the Interview on 07/21/20 #4, revealed holds may was trying to harm the said the holds were s	e at the staff, but did not act ose behaviors would not on of physical management,  022 at 4:40 PM with did when staff explained what at #1, he/she cried and himself/herself. However, t. Resident #2 stated he/she hold in the past, but he/she aths or talk to staff when as getting angry to avoid  022 at 5:20 PM with did he/she was upset that ted in a hold. He stated he coming, and that he/she is/her room. The resident CW #5 when she checked he was trying to get out of a stated he/she wished the or him/her rather than Resident #1 had not lived the resident said he/she ng he/she could do but what was going on with		132			
	took us to the gym. R	07/17/2022, staff members esident #4 said he/she gym because the cops had poking at things.					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		18L013	B. WING	B. WING		11/02/2022	
	ROVIDER OR SUPPLIER S-BROOKLAWN-PILOTS		·	STREET ADDRESS, C 2108 DAVID GRAVE LOUISVILLE, KY			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH C	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIA DEFICIENCY)		
N 132	Continued From page	e 67	N	132			
	friend and the way the him/her sad. But, the also happy because hwent to heaven.  Interview, on 08/10/2 Resident #1's Therap #1), revealed during ton 07/12/2022, the ter #1 would demonstrat YCW #5 was on duty understand why the instated per the hold rewas seeking the hold stated YCW #5 had be herself with any situal management as it perstated YCW #5 was some distance from the resident #1's Psychia management of a resident #1's Psychia management of a resident #1's Psychia management of a resident #1's Psychia management of a resident #1's Psychia management of a resident to go process their anger of said physical intervertier the resident became interview, on 07/21/2 Vice President (VP) or revealed Safe Crisis in much more than just	d Resident #1 was his/her e resident died made resident said he/she was he/she thought Resident #1  022 at 12:26 PM with hist (Residential Therapist he Treatment Team Meeting ham identified that Resident e unsafe behavior when at the cottage. She did not incident even happened. She ports, it seemed the resident is as a form of comfort. She here counseled to disinvolve tions of physical rained to Resident #1. She supposed to keep her ident.  022 at 11:10 AM with atrist, revealed nonphysical ident's behavior should e intervention. He stated					

-	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	ECONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	ROVIDER OR SUPPLIER S-BROOKLAWN-PILOTS		:	STREET ADDRESS, CITY, STATE, ZIP CODE 2108 DAVID GRAVES DRIVE LOUISVILLE, KY 40218		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 165	least restrictive SCM de-escalation of a res modulation and proxishould maintain a cal talking with the reside use of physical holdin and should only be us threat to himself/hers MONITORING DURIF RESTRAINT CFR(s): 483.362(a)  Clinical staff trained in safety interventions in continually assessing and psychological we the safe use of restratof the emergency safe.  This STANDARD is represented by the milieu, facility failed to ensure facility failed to ensure the physical and psychological and psychological well and psychological well and psychological well and psychological well and psychological well and psychological well and psychological well and psychological well and psychological well as a facility failed to ensure facility failed to ensure the physical and psychological well and psychological well and psychological well and psychological well as a facility failed to ensure facility failed to ensure the physical and psychological well and psychological well and psychological well as a facility failed to ensure facility failed to ensure the physical and psychological well as a facility failed to ensure failed f	strategies such as verbal sident using voice mity control. She said staff ming tone of voice when set who was upset. She said ag should be a last resort, sed if the resident became a self or to someone else. NG AND AFTER  In the use of emergency must be physically present, and monitoring the physical self-being of the resident and int throughout the duration sety interview, record review, and review of camera it was determined the estaff monitored to address shosocial well-being, as ity's physical holding policy, sampled residents, saff secured the resident in a lat approximately 2:25 the Supervisor #1 secured ding to kneeling cradle hold, the hold, and soon se. However, there was no	N 165	<ul> <li>N 165</li> <li>Suspended Deborah Francis, Jillian and Amanda Whitlow as of 7/20/2022. Employment of Deborah and Jillian Parks was terminated 8/1</li> <li>Please note that any staff who failed comply with these actions received corrective action.</li> <li>All cottage and clinical staff were conwith required annual three (3) hour SCrisis Management (SCM) Recertific Training, which included how to safe execute a standing and kneeling craby September 1, 2022.</li> <li>All existing staff completed the follow trainings by September 6, 2022:         <ul> <li>Appropriate Responses to Emergency Safety Situation</li> <li>Speak Up for Client Safety</li> <li>Hand-Off Communication</li> </ul> </li> <li>These trainings included information of the safety and effectively into with youth, especially during challenging or potentially unsafe situations.</li> <li>Continued on next page</li> </ul>	Francis 9/2022. I to mpliant Safe cation ely dle hold ving	8/19/22 9/1/22

NAME OF PROVIDER OR SUPPLIER  USPIRITUS-BROOKLAWN-PILOTS  USPIRITUS-BROOKLAWN-PILOTS  DIAMARY STATEMENT OF DEPICIENCIES  GRACH DEPICIENCY WAST BE PRECEDED BY FULL REQULATORY OR USC DENTEYING INFORMATION)  PREFIX TAG  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 (DPR), and transfer to the hobding to the same day.  The findings include:  Review of the facility policy, tilled Physical Holding of Youth, Policy Number CS-040, dated 03/25/2021, revealed staff member not physically holding are youth solved by substance and psychological mpact of the intervention and to be the time-keeper. Additional review of the policy revealed staff was to report any undesirable psychological first from physical holding network of the Psychiatric Regional Treatment Facility (PRTF) Clinical Consultant and the youth's therapist, and document on the Youth holdent Report.  Review, of the Physical Hold Summary, dated 07/17/2022 at 2.25 PM, did not reveal YCW #5, who initiated the hold one Shift Supervisor #1 or YCW#1, took immediate action during the hold when Resident #15 hours of special from the procedure shall be psychological distress state, even through YCW #1 said she heard the resident throw up, and heard him/her crying during the hold.  The regist in order to seek addition, during the time of the hold, there was no evidence that any of the staff contacted a Clinical-in-Call Therapist in order to seek addition, during uplance/assistance since the resident throw up, and heard him/her crying during the hold.  The resident in order to seek additional quidance/assistance since the resident throw up, and was crying while secured in the hold.		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT		E CONSTRUCTION		LETED
MANE OF PROVIDER OR SUPPLIER  USPIRITUS-BROOKLAWN-PLOTS  (X4)ID PREFIX (SECHOSECTION STATELLIST OF DEFICICIONIES)  (X4)ID PREFIX (SECHOSECTION SECHOSECTION)  (SECHOSECTION SHOULD BE CROSS-BEFERENCED TO THE APPROPRIATE DEFICIENCY)  (SECHOSECTION SHOULD BE CROSS-BEFERENCED TO THE APPROPRIATE DEFICIENCY)  (PREFIX TADO  (PREFI			18I A12	B. WING				
IN 165  In 165	NAME OF PR	ROVIDER OR SUPPLIER	101013	a, wino,		STREET ADDRESS, CITY, STATE, ZIP CODE	117	02/2022
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 effects from physical holding to the timekeeper. Additional review of 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-ion-Call Therapist in order to seek additional guidance/assistance since the resident threw up, and was crying while secured in the hold.					16	•••		
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 hotding the youth, should be assigned to observe the youths physical 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 07/177/2022 at 2:25 PM, did not reveal YCW #5, who initiated the hold nor Shift Supervisor #1 or YCW#1, took immediale action during the hold when Resident #1 showed signs of psychological and physiological distress, before he/she lapsed into an unresponsive state, even through 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 white secured in the hold.	PREFIX	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
Interview, on 07/20/2022 at 4:12 PM with YCW via the Relias Learning Management System.	N 165	prevent the resident f from psychological ar prior to becoming unrequiring Cardiopulm and transfer to the hodepartment (ED), who same day.  The findings include:  Review of the facility Holding of Youth, Pol 03/25/2021, revealed physically holding the to observe the youth's psychological impact the timekeeper. Addit revealed staff was to psychological effects Psychiatric Regional Clinical Consultant at document on the You Review, of the Physic 07/17/2022 at 2:25 P who initiated the hold YCW#1, took immed when Resident #1 sh and physiological disinto an unresponsive said she heard the rehim/her crying during the time of the hold, t any of the staff conta Therapist in order to guidance/assistance and was crying while	rom continuing to suffer and physiological distress esponsive, and eventually onary Resuscitation (CPR), spital emergency ere he/she passed away that policy, titled Physical icy Number CS-040, dated a staff member not eyouth, should be assigned is physical well-being and of the intervention and to be be be be be be be be be be be be be	N	165	related to communicating and rany inappropriate, unsafe, or countertherapeutic behaviors exby staff, especially those that do show respect for human dignity individuality, or cultural and perbeliefs, as well as any forms of and neglect including verbal, mphysical, and sexual abuse. Co of and compliance with these attrainings recorded in each training record via the Relias Lemanagement System.  All cottage and clinical staff remained date with Safe Crisis Management (refreshers per policy. Attendance are compliance is recorded in each staff training record via the Relias Learni Management System.  All cottage and clinical staff reviewe attested in writing to understand the Tip Sheet and do's and don'ts speciphysical holds authored by the ager Medical Director by August 15, 2022.  All cottage and clinical staff reviewe attested to the review and understand of the following policies and proceding.  All cottage and clinical staff reviewe attested to the review and understand of the following policies and proceding.  Appendix Clients Rights are Responsibilities and Youth Grievances- Resolving Clience Complaints  Reporting Abuse, Neglect Exploitation  Physical Holding of Youth Seclusion of Youth Existing staff completed written the information included in thespolicies. Completion and complete corded in each staff's training via the Relias Learning Management and staff straining via the Relias Learning Management and staff's training via the Relias Learning Management and staff's training via the Relias Learning Management and staff's training via the Relias Learning Management and staff's training via the Relias Learning Management and staff's training via the Relias Learning Management and staff's training via the Relias Learning Management and staff's training via the Relias Learning Management and staff's training via the Relias Learning Management and staff's training via the Relias Learning Management and staff's training via the Relias Learning Management and staff's training via the Relias Learning Management	eporting  khibited or not a constant abuse ental, mpletion ditional staff's earning  up to SCM) and Medical fic to a constant abuse ental, mpletion differ to a constant abuse ental, mpletion and a constant abuse ental and a constant abuse ental ental abuse e	9/1/22 8/15/22

N 165   Summary Statement or Deprice Cities   Summary Statement or Department or Deprice Cities   Summary Statement or Department or Dep		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE : COMPI	SURVEY LETED
STREET ADDRESS. CITY, STATE, IP POOR 210B DATU GRAVES DRIVE  LUSPIRITUS-BROOKLAWN-PILOTS  LOUISVILLE, KY. 40218  D PROVIDER'S PLAND CORRECTION CONSTRUCTION OF CORRECTION CANCERS. CITY ACTION SHOULD BE CARCHEROFICED WIST BE PRECEDED BY FULL REQUATORY OR LSC IDENTIFYING INFORMATION)  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 said she had only YCW #5 to move, and said, "Tve got!. "YCW #1 said Shift Supervisor #1 entered the room, and told YCW #5 to move, and said," Tve got!. "YCW #1 said of shift Supervisor #1 forward. "YCW #1 said of her President selection, 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 #3 sake her to go check on the other residents in the cottage. "YCW #1 said when she toked in the doorway, the resident was still in the hold, and he/she had from up in bot of clear liquid and chunks of food, YCW #1 said when she looked in the doorway, the resident was still in the hold, and he/she had throw up in bot of clear liquid and chunks of food, YCW #1 said when she looked in the doorway, the resident was still in the hold, and he/she had throw up in bot of clear liquid and chunks of food, 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, the resident got the first time on September 27, 2022, the Provention Tools and Debriefing Subcommittees the food in the first time on September 17, 2022, the Provention Tools and Debriefing Subcommittees for the first time on September 17, 2022, the Provention Tools and Debriefing Subcommittees for the first time on September 17, 2022, the Provention Tools and Debriefing Subcommittees the for the first time on September 17, 2022, the Provention Tools and Debriefing Subcommittees the for the first time on September 27, 2022. On November 17, 2022,						(	0
USPIRITUS-BROOKLAWN-PILOTS  IN 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 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 fould hold ycw #5 saked her to go check not he other residents in the cottage. YCW #1 said when she looked in the doorway, the resident was still in the hold, and he/she had throw up. In through the doorway, the resident was still in the hold, and he/she had throw up stall when she looked at Resident #1 story ycw; YcW #5 said when she looked in the doorway, the resident was still in the hold, and he/she had throw up stall when she looked at Resident #1 story ycw; YcW #5 said when she looked in the doorway, the resident was still in the hold, and he/she had throw up stall when she looked at the doorway, the resident was still in the hold, and he/she had throw up stall when she looked at the doorway, the resident was still in the hold, and he/she had chrow up. The said when she looked the body that through the doorway, the resident was still in the hold, and he/she had chrow up. She said when she looked in the doorway, the resident was still in the hold, and he/she had throw up? She said when she looked in the doorway, the resident was still in the hold, and he/she had crying. YcW #1 said she went to get the impact cushion, but before YcW #5 still 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. YcW #1 said she head to have the said she went to get the impact cushion, but before YcW #5 told her to do that.  YcW #1 said she had concerns about Shift Supervisor #1. YcW #1 said she head to have the said she went to get the imp			18L013	B. WING		11/0	02/2022
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 took over the hold and when she did, the Shift Supervisor #1 sot own way. The resident she from the day on the beauting to kneeling of the legislation of the proprietable of the	USPIRITUS	S-BROOKLAWN-PILOTS			2108 DAVID GRAVES DRIVE LOUISVILLE, KY 40218		1751
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 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 outlined by the said she had throw up, throw up! "She said when she returned to Resident #1 so doorway, she heard Shift Supervisor #1 say to Resident #3 sid oneway, she resident was still in the hold, and he/she had thrown up a lot of clear (iquid and chunks of food, YCW #1 said yCW #5 told her to get the impact cushion. VCW #1 said yCW #5 told her to get the impact cushion. VCW #1 said ycw #1 said she quickly returned to the resident was not saying anything, but he/she was crying. YCW #1 said though the doorway, the resident #3 to doorway. She stated YCW #5 side he 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 concems about Shift Supervisor #1 in a hold and make himher throw	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION DATE
someone, and she felt really bad that she did not	N 165	#1, revealed YCW #5 standing to kneeling of the resident, and she resident's feet and leg #1 entered the room, and said, "I've got it." Supervisor #1 took of did, the Shift Supervis forward. YCW #1 said Management (SCM) implementing the hole that because the resi- pushing the youth for damage to the inside YCW #5 asked her to residents in the cottag returned to Resident Shift Supervisor #1 said ahead throw up, throw looked in the doorway hold, and he/she had liquid and chunks of f told her to get the imp when she looked at F doorway, the resident but he/she was crying get the impact cushio said she quickly retur doorway. She stated get the cushion, but it doorway she said wa YCW #1 said she was her to do that.  YCW #1 said she had Supervisor #1's state put Resident #1 in a h up. She said she sho	secured Resident #1 in the cradle hold from the back of (YCW #1) was securing the gs. She said Shift Supervisor and told YCW #5 to move, YCW #1 said Shift ver the hold and when she sor pushed Resident #1 diper her Safe Crisis training, the person diwas not supposed to do dent could throw up, and ward could also cause of his/her body. She said go check on the other ge. YCW #1 said when she #1's doorway, she heard ay to Resident #1, "Go w up!" She said when she y, the resident was still in the thrown up a lot of clear good. YCW #1 said YCW #5 pact cushion. YCW #1 said Resident #1 through the training anything, gr. YCW #1 said she went to ge, but could not find it. She great to the resident's YCW #5 said she would go before YCW #5 left the toth Shift Supervisor #1. It is unsure why YCW #5 told.	N 16	and attested to an understanding of Hold philosophy. Existing staff comptest on understanding of this philosome September 06, 2022.  Training was provided for all cottage clinical staff that covered: 1, when it appropriate to initiate a physical hold when it is appropriate to initiate a seincluding appropriate levels of initial continuation authorization; 3, when it appropriate to initiate exclusionary to including appropriate levels of initial continuation authorization; and 4, he respond to medical emergencies, in but not limited to how to intervene appropriately for youth who have post adverse reactions. All staff attested understanding the information provided it staff completed a written test as put this training. Completion and complimerecorded in each staff's training re	a Zero pleted a phy by  and is d; 2. clusion, and it is ime out, and out to cluding  tential to ded, and bart of ance is ord via ystem.  m was  at ership on 17, oriefing e. The	9/2/22

NAME OF PROVIDER OR SUPPLIER  USPRITTUS-BROOKLAWN-PILOTS  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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 staid test of the resident womited, 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 the staff member securing the resident to hold should never place pressure on the resident's stomach for internal organs.  B. WRING  STREET ADDRESS CITY, STATE, ZIP CODE 2108 ADVID GRAVES DRIVE  LOUISVILLE, KY 40218  PROVIDER'S PLAN OF CORRECTION (EACH		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A, BUILDING				(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  USPIRITUS-BROOKLAWN-PILOTS  SUMMARY STATEMENT OF DEFICIENCIES  DEFINITION (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFY/NG INFORMATION)  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 07/17/20/22 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 was having pain. She stated we check the placement of our hands. She said the staff member securing the resident's towards the staff member securing the resident's towards the staff member securing the resident's stomach or internal organs.  * Monthly Safe Crisis Management (SCM) governore.  * Monthly Safe Crisis Management (SCM) governore.  * Monthly Safe Crisis Management (SCM) governore.  * Monthly Safe Crisis Management (SCM) governore.  * Monthly Safe Crisis Management (SCM) governore.				A, BOILDI	_	<del></del>		c	
USPIRITUS-BROOKLAWN-PILOTS  2100 DAVID GRAVES DRIVE LOUISVILLE, KY 40218  DEFICIENCY TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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 women 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's stomach or internal organs.  2100 INTERDICTION (ACCIONATION SHOULDE (RACH CORRECTIVE ACTION SHOULDE (REACH CORRECTIVE ACTION SHOULD SHOULD SHOULD SHOULD SHOULD SHOULD SHOULD			18L013	B. WING		, (5 · · · · · · ·		_	
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PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  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's stomach or internal organs.  Professional Emergency Safety Physical Interventions (ESPI) on business days and weekends/holidays if necessary and thrice-weekly reviews of resident greateness 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		CHIMADVET	ATEMENT OF OFFICIENCIES					l rye)	
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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  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.	N 165	make the report. YCV she had seen implem shocking, and she res should have contacte hold was occurring. Hincident she did report Supervisor #1 to the It Professional Develop the internal investigate Interview, on 08/13/2/#11, revealed every shold was responsible breathing, the rise and circulation, or any ind having pain. She state she would immediate clean them up. She stresident's stomach for the facility nurse, if she we check the placementhe staff member seet should never place prostomach or internal of Interview, on 07/19/20 Supervisor #1 revealed his/her lunch at appro 07/17/2022.  Review of the camera Resident #1's bedroo Supervisor #1 took Rehis/her door at 1:44 Pinterview, on 07/23/20/#8, revealed staff should-escalate a resident #1 should escalate #1 should escalate a resident #1 should escalate	W#1 said it was the first hold ented, that it was all very ally did not know who she d on 07/17/2022 when the lowever, she said after the ther concerns about Shift Director of Training and ment, who was conducting ion of the incident.  Director of Training and ment, who was conducting ion of the incident.  Director of Training and ment, who was conducting ion of the resident.  Director of Training and ment, who was conducting ion of the resident.  Director of Training and ment, who was conducting ion of the resident.  Director of Training and in the for monitoring the resident's dealt of his/her chest, icators the resident was ed if the resident vomited, lay release the hold, and aid she would check the rany bruising, and contact the found bruising. She said ent of our hands the resident is the hold ent of our hands are sellent to the hold ent of our hands at the hold ent of our hands are sellent to the hold ent of our hands at the hold ent of our hands at the hold ent of our hands at the hold ent of our hands at the hold ent of our hands at the hold ent of our hands at the hold ent of our hands at the hold ent of our hands at the hold ent of our hands at the hold ent of our hands at the hold ent of the hold ent of the hold ent of our hands at the hold ent of the hold ent of the hold ent of the hold ent of the hold ent of the hold ent of the hold ent of the hold ent of the hold ent of the hold ent of the hold ent of the hold ent of the hold ent of the hold ent of the hold ent of th	N		Safety Physical Interventions (ESPI) business days and weekends/holidal necessary and thrice-weekly review resident grievances to determine, in to any safety concerns, whether any rights are violated. These include do and video reviews, when available, violations or concerns noted are documented, and the information is with the staff's supervisor for follow-which may include additional coachi training, or disciplinary action, up to including termination of employment addition, the review information is distributed to the executive team and Bellewood and Brooklawn residential clinical, and quality leaders.  Ongoing monitoring/compliance procedu  Updated Youth Rights document to specific language emphasizing that should be free from any type of shar ridicule, or humiliation (see attachment This is posted in every living unit and to youth (and their guardians) at admitted to the view of Youth Rights and sensitively and effectively work with especially when addressing particular challenging or sensitive issues; this include emphasizing that shame, humiliation, and/or ridicule is countertherapeutic and is not an accintervention tool. Completion of all refreshers and annual Safe Crisis Management (SCM) recertification is recorded in staff's training record via	on bys if s of addition youth ocument Any shared up, ng, and t. In dail, ares: include youth me, ent). d given mission.  CM) crisis 4 hrs) — how to youth, arly will ceptable	Revised 12/8/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER S-BROOKLAWN-PILOTS		STREET ADDRESS, CITY, STATE, ZIP CODE 2108 DAVID GRAVES DRIVE LOUISVILLE, KY 40218					
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N 165	(PEM) Strategies to his/her thoughts and physical holding. How was unavoidable, the staff should monitor for make sure the reside. He said staff should resident's hands and vomits, staff should sresident's breathing, gagging, if he/she was the resident having withoughts. He stated a symptoms of distress the hold report summe to the nursing staff. Hon call.  Interview, on 07/20/2 Residential Cottage is should always assess whenever he/she has stated the staff imples checking their own promuch weight on the resident's ability to bresident vomited while was a sign the reside difficulty breathing, and He said a youth could was vomiting. Reside said holds should not resident's bedroom be cameras in the bedroof the staff nor the resident roversew. The Resident thought process wou	help the resident process hopefully avoid use of vever, YCW #8 said if a hold on while holding the resident, or any signs of distress, and not was breathing normally. In monitor the color of the the face. He said if the youth top the hold and check the and assess if the resident is as able to speak, and was reas confusion or unclear any of these signs or should be documented in eary, and should be reported the stated a nurse was always.  O22 at 10:40 AM with Manager #1, revealed staff is a resident's breathing is been secured in a hold. He menting the hold should be osture, because placing too esident may take away the reathe. He stated if the e secured in the hold, that not was in distress or having and staff should stop the hold. If not hurt anyone if he/she ential Cottage Manager #1	N	165	<ul> <li>Appropriate Responses to Emergen Safety Situations; Speak Up for Clie Safety; and Hand-Off Communication. These trainings will be completed by staff during New Hire Orientation, whirst three (3) weeks of employment, before working with youth. These trainclude information on how to safely effectively interact with youth, especially effectively interact with youth, especially effectively interact with youth, especially effectively interact with youth, especially effectively interact with youth, especially effectively interact with youth, especially effectively interact with youth, especially effectively interact with youth, especially effectively effectively interact with youth, especially end or an exporting any inappropriate, unsafe, countertherapeutic behaviors exhibits staff, especially those that do not shouse existing any inappropriate, unsafe, countertherapeutic behaviors exhibits staff, especially those that do not shouse existing staff will complete these training staff will complete these training staff will complete these training record via the Relias Learning Management System. Staff begin work nor continue work with yuntil demonstrating understanding or concepts.</li> <li>Zero Hold Philosophy Training: 6 Constrategies – New staff will receive information and complete test during employee orientation, and yearly religions and complete test during employee orientation, and yearly religions will be provided for all cottage and containing record via the Relias Learning Management System.</li> <li>Continued on next page</li> </ul>	ont on. y all new ithin the and ainings and cially cafe e and or ted by ow lity, or l as any g verbal, All inings 1 by 9/15 liance ach of cannot outh of these ore g new freshers clinical ion and staff's		

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N 165	said there were intervitransport staff could be resident to a more purcoverage. He stated be there on 07/17/2022 of transferring Resident due to his/her size. He and staff intervention documented for later linterview, on 08/10/2 Resident #1's Therap was secured in a hole continuously monitor he/she was calming of could be ended as quistated the staff should physiological distress distress, a change in neurological changes circulation. She said not do a physical assended, but if the resident injury, then the fact notified.  Interview, on 08/02/2 Residential Therapistic campus on 07/17/20/2 next door to Residen not contacted by any assistance with mana Resident #1. She said going on until her sugher to go next door burresponsive. She silven she walked up ambulance had just per silven in the staff should be resident with mana second should be resident with mana second should be resident #1. She said going on until her sugher to go next door burresponsive. She silven she walked up ambulance had just per silven she walked u	ventions such as a hook have used to move the blic space with camera he did not think the staff would have had difficulty #1 to a more public area e said by doing so, the hold s would have been review.  022 at 12:26 PM with hist, revealed while a resident d, the staff involved should the resident for signs that or de-escalating so the ESI hickly as possible. She d monitor for any signs of s, such as respiratory the resident's skin color, any s, or indicators of decreased the clinical on call staff would essment after the hold dent complained of pain or cility's nursing staff should be  022 at 3:25 PM with t #3 revealed she was on 22, working at the cottage t #1's ottage, but she was of the staff at the cottage for aging the situation with d she had no idea what was bervisor called and directed ecause a resident was tated she heard sirens, and	N '	165	Continue daily reviews of all Emergy Safety Physical Interventions (ESPI business days and weekends/holidat necessary and thrice-weekly review resident grievances which are condidetermine, in addition to any safety concerns, whether any youth rights violated. These include document a reviews, when available. Any violatic concerns noted are documented, ar information is shared with the staff's supervisor for follow-up, which may additional coaching, training, or discaction, up to and including terminatie employment. In addition, the review information is distributed to the exert team and Bellewood and Brooklawr residential, clinical, and quality lead	on ays if sof ucted to are nd video ons or ad the sinclude ciplinary on of cutive	9/1/22

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N 165	entered the cottage S and YCW #1 were all said Shift Supervisor happened but she was hard to make sense of say. She said it seems thought Resident #1 before he/she left the and that EMS staff has shock using the Auto (AED). Therapist #3 staff has seen when she can be said the youth seems more staff arrived and gyrn so they could ge awhile.	chift Supervisor #1, YCW #5 crying, and very upset. She #1 tried to explain what is sobbing so hard it was of what she was trying to ned she was telling her she seemed to be breathing cottage in the ambulance, ad not delivered cardiac mated External Defibrillator said law enforcement was on entered the cottage. She ad confused and eventually d took the residents to the it away from the cottage for	N	165 170 N 170				
	SECLUSION CFR(s): 483.364(a)  Clinical staff, trained safety interventions, or immediately outside continually assessing the physical and psycresident in seclusion, meet this requirement.  This STANDARD is Based on staff intervireview of the facility's Residential Cottage, failed to ensure staff Resident #1's bedroot the resident on 07/17	in the use of emergency must be Physically present in le the seclusion room, g, monitoring, and evaluating chological well-being of the Video monitoring does not			All cottage and clinical staff rev and attested to the review and understanding of the following and procedures by August 15, or Clients Rights and A Youth Rights or Grievances- Resolving Complaints or Reporting Abuse, Neg Exploitation or Physical Holding of Youth Physical Hold	policies 2022: appendix g Client alect or buth test on se liance is g record	8/15/22	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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N 170	she decided, without Resident #1 stay in his because night shift remisbehaving during the Video Coverage of the view of Resident #1's staff did not stay by the AM-2:00 PM, or frequency for the resident's psychiatris #1's known intellectuate been hard for the resident's psychiatris #1's known intellectuate been hard for the resident's psychiatris #1's known intellectuate he/she was being key stated that action on staff member demonstrated in the facility Youth, Policy Number 07/14/2022, revealed be under the ultimate psychiatrist. Use of shased on history of the history of dangerous not be used for the pediscipline, convenient seclusion should only and physical intervenor not viable and where isk of a youth physicothers.  Under the procedure policy, the following staff was to monitor the staff was to monitor th	prior approval, to have is/her room for the first shift sported the resident was he early morning hours. It is bedroom space, with full bedroom door, revealed he resident's door from 8:00 lently open the bedroom sident. Interview with the trevealed given Resident all disabilities, it would have ident to conceptualize why of in his/her room all day. He the part of the part of the strated her lack of call seven-year-old behavior.  I the use of seclusion of rr: CS-058, last review date, if the use of seclusion would be direction of the treating eclusion should not be no youth or solely on a behavior; seclusion should urpose of coercion, ce or retaliation by staff; when the been ineffective in there was an imminent ally harming self, staff, or	N 1		Training was provided for all cottage clinical staff that covered: 1. when it appropriate to initiate a physical hole when it is appropriate to initiate a seincluding appropriate levels of initial continuation authorization; 3. when appropriate to initiate exclusionary trincluding appropriate levels of initial continuation authorization; and 4. he respond to medical emergencies, in but not limited to how to intervene appropriately for youth who have positive adverse reactions. All staff attested understanding the information proviall staff completed a written test as this training. Completion and complimented in each staff's training received in each staff's training received in each staff's training received the Relias Learning Management Staff exponses to Emergency Safety Situation Speak Up for Client Safety Hand-Off Communication  These trainings included inform how to safely and effectively intwith youth, especially during challenging or potentially unsafficuations. Further, specific step provided related to communicar reporting any inappropriate, unscountertherapeutic behaviors e by staff, especially those that dishow respect for human dignity individuality, or cultural and perbeliefs, as well as any forms of and neglect including verbal, methods and neglect including verbal, methods and neglect including verbal, methods and next page.	is d; 2. eclusion, and it is ime out, and ow to cluding blential to ded, and part of ance is ord via ystem. wing  ms  ation on teract e os are ting and safe, or xhibited o not r, sonal abuse	9/6/22

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	ROVIDER OR SUPPLIER S-BROOKLAWN-PILOTS			STREET ADDRESS, CITY, STATE, ZIP CODE 2108 DAVID GRAVES DRIVE LOUISVILLE, KY 40218			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 170	years old, one (1) hor extend beyond the m should the Clinical Cocontinuation order; O assigned to monitor transfer intervention, and the psychological impact youth; Ensure staff in undesirable medical Nursing Staff and recelectronic health recestaff maintain constaryouth placed in seclucircumstances should without a staff membarea; and ensure assignated the seclusion Chart through the seclusion at every and seclusion at every and seclusion of seclusion thereafter for the folk nutrition and hydratic range of motion of expectation of seclusion thereafter for the folk nutrition and hydratic range of motion of expectation of seclusion of seclusion thereafter for the folk nutrition and hydratic range of motion of expectation of seclusion of motion of expectation of seclusion of motion of seclusion of received staff did not door, or frequently of resident's well-being approximately 2:25 Fermion of the seclusion of t	the youth, for a youth 7-8  ar; If seclusion needed to aximum time limit, then staff consultant to provide a ne staff member should be the events of the physical well-being and the of the intervention on the formediately report any effects from seclusion to ord in the resident's ord (EHR); Ensure assigned that visual contact with the sion, and under no at a youth remain in seclusion the present in the observation digned staff document the activity level on the aghout the youth's placement five (5) minute intervals.  aff assess the resident at the and every 15 minutes the wing: signs of injury; on status, circulation and tremities, vital signs, son, physical and and comfort, and readiness seclusion.  wided video coverage of the space with full view of our door, on 07/17/2022, stay nearby the resident's over the door to assess the	N	170	These trainings also include speeducation outlining the circumst under when it is appropriate to i seclusion or exclusionary timeor (including defining what constitus eclusion or exclusionary timeor process for obtaining authorizat use of seclusion or exclusionary timeout, time limits for use of se or exclusionary timeout based of resident, requirements for more and documentation of such duri seclusion or exclusionary timeout the process for termination and debriefing the use of seclusion or exclusionary timeout. Completic and compliance with these train was recorded in each staff's train record via the Relias Learning Management System.  A facilitator and implementation tear identified for Six Core Strategies for Reduction of Seclusion and Restrain project implementation. The Six Core Strategy Steering Committee/Leade Subcommittee met for the first time of September 27, 2022. On November 2022, the Prevention Tools and Deb Subcommittees met for the first time Data Subcommittees is scheduled to the first time on January 4, 2023.  Began daily reviews of all Emergence Safety Physical Interventions (ESPI) business days and weekends/holidanecessary and thrice-weekly reviews resident grievances to determine, in to any safety concerns, whether any rights are violated. These include do and video reviews, when available.  Continued on next page	ances initiate ut utes a ut), the item for or or of oings ining ut, and or or of oings ining ut, and or on of oings ining ut, and or or of oings ining ut, and or or of oings ining ut, and or or of oings ining ut, and or or of oings ining ut, and or or of oings ining ut, and or or or of oings ining ut, and or or of oings ining ut, and or or or or or or or or or or or or or	9/1/22

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		18L013	B. WING			11/	02/2022
	ROVIDER OR SUPPLIER S-BROOKLAWN-PILOTS			2	TREET ADDRESS, CITY, STATE, ZIP CODE 108 DAVID GRAVES DRIVE OUISVILLE, KY 40218		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 170	no window or other of view the resident from view the resident from laterview, 08/01/2022 Supervisor #1, reveal keep Resident #1 in h 07/17/2022 for the sat the cottage. She said Resident #1 had bullinght. The Shift Superat work about 8:00 All Resident #1's doorware Resident #1 had a row #1 said she let Shift Sigoing to keep Reside asked by the SSA Susaid he was okay with said Shift Supervisor okay with me making room. Shift Supervisor okay with me making room. Shift Supervisor of any program used checked on Resident take two (2) showers, urinated on urinated of Additional review of the cottage, revealed resident to the table with the oneither staff person to breakfast until 10:41 in the table with the oneither staff person to breakfast until 10:41 in the table with the oneither staff person to breakfast until 10:41 in the table with the oneither staff person to breakfast until 10:41 in the table with the oneither staff person to breakfast until 10:41 in the table with the oneither staff person to breakfast until 10:41 in the table with the oneither staff person to breakfast until 10:41 in the table with the oneither staff person to breakfast until 10:41 in the table with the oneither staff person to breakfast until 10:41 in the table with the oneither staff person to breakfast until 10:41 in the table with the oneither staff person to breakfast until 10:41 in the table with the oneither staff person to breakfast until 10:41 in the table with the oneither staff person to breakfast until 10:41 in the table with the oneither staff person to breakfast until 10:41 in the table with the oneither staff person to breakfast until 10:41 in the table with the oneither staff person to breakfast until 10:41 in the table with the oneither staff person to breakfast until 10:41 in the table with the oneither staff person to breakfast until 10:41 in the table with the oneither staff person to breakfast until 10:41 in the table with the oneither staff person to be table with the oneither staff person to be table with the oneith	B/2022 at 4:20 PM of m after his/her death, he bedroom was solid with bening through which to n outside the room.  If at 7:17 PM with Shift ed she made the decision to his/her bedroom on fety of the other residents in night shift staff reported ed other residents during the risor said when she arrived M, YCW #6 was sitting at high. Shift Supervisor H2 high night. Shift Supervisor #2 high night. Shift Supervisor #2 high nis/her room. When reveyor if Shift Supervisor #2 high not say he was not Resident #1 stay in his/her or #1 stated that keeping a bim for the day was not a part	N		Any violations or concerns noted are documented, and the information is with the staff's supervisor for follow-which may include additional coachi training, or disciplinary action, up to including termination of employment addition, the review information is distributed to the executive team and Bellewood and Brooklawn residential clinical, and quality leaders.  Ongoing monitoring/compliance procedu  Monthly Safe Crisis Manageme (SCM) Refreshers (1 hr) and an Safe Crisis Management (SCM) recertification (4 hrs) – includes of Youth Rights and how to sen and effectively work with youth, especially when addressing par challenging or sensitive issues. refreshers and recertifications winclude the proper procedures refreshers and recertifications winclude the proper procedures refreshers and recertifications of the use of seclusion or exclustimeout. Completion of all refres and annual Safe Crisis Manage (SCM) recertification is recorded staff's training record via Relias Learning Management System.  Appropriate Responses to Emer Safety Situations; Speak Up for Safety, and Hand-Off Community These trainings will be complete new staff during New Hire Orier within the first three (3) weeks comployment, and before workin youth. These trainings include information on how to safely an effectively interact with youth, especially during challenging or potentially unsafe situations.  Continued on next page	shared up, ng, and t. In  d t. In  d t. In  res:  nt inual  review sitively  ticularly Further, vill elated sionary shers ment d in  rgency Client ication, ed by all ntation, of g with  d	9/15/22

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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NAME OF P	ROVIDER OR SUPPLIER			57	TREET ADDRESS, CITY, STATE, ZIP CODE				
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				L	OUISVILLE, KY 40218				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREFIX TAG	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
N 170	Interview, on 08/02/20 #9, revealed keeping for long periods (man Safe Crisis Managem training he received. It to be in his/her room it person would be assist the resident. He state youth kept in his/her retime, and he had beer four (4) years.  Interview, on 08/10/20 Residential Therapist revealed the primary is Resident #1 in his/her others, would be his/h Traumatic Stress Disc how would it feel to be frequently checked or treatment would trigge parental abandonmer earlier in his/her life. So older sibling was basi Resident #1 and anot Resident #1 and anot Resident #1's father w mother did not have th she have the necessal children.  Interview, on 08/18/20 Division Director, reveresident remained saf would have to frequer the resident's wellbein	a resident in his/her room y hours at a time) was not a ent (SCM) strategy, per the de stated if the resident had for a long time, then a staff gned to 1:1 observation of d he had never seen a com for many hours at a n employed by the facility for  222 at 12:26 PM with #1, Resident #1's therapist, concern with keeping room/secluded from her diagnosis or Post order (PTSD). She stated the left in a room and not h. She said that type of the resident #1 experienced She stated Resident #1's cally left to take care of ther sibling. She stated was in prison, and his/her the family support nor did try tools to navigate raising  222 at 4:15 PM with the tealed in order to ensure the te in his/her bedroom, staff titly observe and check on the gwhile he/she spent long a way from the milieu	N 1		Further, specific steps are provirelated to communicating and reany inappropriate, unsafe, or countertherapeutic behaviors exby staff, especially those that do show respect for human dignity individuality, or cultural and perbeliefs, as well as any forms of and neglect including verbal, me physical, and sexual abuse. All staff will complete these training annual basis, to be completed beach year. Completion of and compliance with these trainings recorded in each staff's training via the Relias Learning Manage System. Staff cannot begin work continue work with youth until demonstrating understanding of concepts.  * Zero Hold and Seclusion Philosophy Training: 6 Core Strategies — New streceive information and complete tenew employee orientation, and year refreshers will be provided for all cot and clinical staff by 9/15 of each year. Completion and compliance we recorded in each staff's training recorded in each staff's training recorded in each staff's training recorded in each staff's training recorded in each staff's training recorded in each staff's training recorded in each staff's training recorded in each staff's training recorded in each staff's training recorded in each staff's training recorded in each staff's training recorded in each staff's training recorded in each staff's training recorded in each staff's training recorded in each staff's training recorded to Relias Learning Management Systems days and weekends/holida necessary, including the use of section and/or exclusionary timeout, and conthrice-weekly reviews of resident grid are conducted to determine, in additional safety concerns, whether any yorights are violated. These include do and video reviews, when available.  Continued on next page	eporting  chibited o not , sonal abuse ental, existing gs on an by 9/15  is record ement k nor  f these  taff will st during ly ly ltage will be ord via ystem. ency on ys if usion ntinued evances ion to outh	9/1/22		

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	ROVIDER OR SUPPLIER  S-BROOKLAWN-PILOTS			2	TREET ADDRESS, CITY, STATE, ZIP CODE  108 DAVID GRAVES DRIVE  OUISVILLE, KY 40218		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 170	him that Resident #1' without staff frequent wellbeing. He stated showed lack of under behavior. He stated v intellectual disability, other youth without fr would be hard for him said why would anyor resident knowing he/s why that was occurrin psychiatrist stated on traumatic experience locked in a room.  Interview with the Vio Residential Programs AM, revealed placing extended period of tir from the clinical staff they would first want (Shift Supervisor #1) that was a necessary behavior, and that he resident would have the seclusion was ap The VP of Residentia Supervisor #1 implen going through the ap management was stii members on duty tha would be satisfactory	o22 at 11:10 AM with atrist, revealed it concerned by assessing the resident's that action taken by the staff restanding of 7-year-old with Resident #1's known isolating him/her from the equent contact with staff n/her to conceptualize. He ne want to punish the she would not understand ng. In addition, Resident #1's se of Resident#1's past s was he/she had been  se President (VP) of ming on 08/22/2022 at 10:15 se a youth in timeout for an me must have prior approval and managers. She said to know why the staff person or direct care staff thought of for managing the resident's sightened monitoring of the been necessary per policy, if proved and implemented. all Programming said Shift mented seclusion without first proval process. She said all not in the head of the staff at day, and that managers ar receive an explanation that		170	Any violations or concerns note documented, and the informatic shared with the staff's supervision follow-up, which may include at coaching, training, or disciplina action, up to and including term of employment. In addition, the information is distributed to the executive team and Bellewood Brooklawn residential, clinical, quality leaders.	on is or for dditional ry ination review	
N 183	APPLICATION OF TI CFR(s): 483.368(a)	ME OUT	N	183			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING	(X3) DATE SURVEY COMPLETED		
		18L013	B. WING		11/	02/2022
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HEDIDITH	B-BROOKLAWN-PILOTS		2	2108 DAVID GRAVES DRIVE		
USPIKITUS	-BROOKLAWN-FILO13		1	OUISVILLE, KY 40218		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 183	Continued From page	≥ 80	N 183	N 183		
·	A resident in time out prevented from leaving	must never be physically ng the time out area.		All existing staff completed the follow trainings by September 6, 2022:     Appropriate Responses to Emergency Safety Situation Speak Up for Client Safety Hand-Off Communication	ns	9/6/22
	Based on observation policy review, review Report, 07/09/2022, a coverage, it was dete ensure one (1) of ten Resident #1, was not timeout area (hallway were located) on 07/0 camera coverage pro YCW #5 blocked the the milieu by placing chair) in front of the dattempted to open the After Resident #1 ware-enter the milieu, the	rmined the facility failed to (10) sampled residents, prevented from leaving the where the timeout rooms 09/2022. Review of video vided by the facility revealed hallway exit door back into herself (seated in a rolling		These trainings included inform how to safely and effectively int with youth, especially during challenging or potentially unsafe situations. These trainings incluspecific education outlining the circumstances under which it is appropriate to initiate seclusion process for obtaining authorizatuse of seclusion, time limits for seclusion based on age of resic requirements for monitoring and documentation during seclusion the process for termination and debriefing the use of seclusion. Completion of and compliance these trainings was recorded in staff's training record via the Relearning Management System.	e the tion for use of dent, din, and with each elias	
	Youth, policy Numbe 07/14/2022, revealed Time out was defined for a period of time to which the youth is no leaving, for the purpo opportunity to regain defined as the involution alone in a room or an	self-control; Seclusion was ntary confinement of a youth area which the youth is from leaving; Unlatched		All cottage and clinical staff reviewe attested to the review and understal of the following policies and procedu August 15, 2022:     Clients Rights and Responand Appendix Youth Rights     Seclusion of Youth      Existing staff completed written the information included in thes policies. Completion and complete recorded in each staff's training via the Relias Learning Manage System.  Continued on next page	nding ures by sibilities s test on e liance is record	8/15/22

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED	
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(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	10	i	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI: TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
N 183	Continued From page physically prevented.  Review of a Youth Ho 07/09/2022 beginning during a group choir progression of the became upset with a state of the time	from leaving a time out area.  Old Seclusion Report, dated g at 6:39 PM, revealed cractice led by Shift cottage, Resident #1 peer, and Shift Supervisor to the timeout room to cool ut the resident reportedly hit meout room door and consequence for those stayed in the time out area conitor his/her behavior. The off the timeout room in to the meout rooms were located, con/her the expectation to room. Resident #1 refused conal -400 points. According 5 continued to monitor the again hit the walls, and per resident did not receive the ted, the resident started to and subsequently earned in consequences.  Is camera coverage, dated M, revealed Resident #1 of one of the timeout room and head on the room's padded dent walked to the door that However, YCW #5 sat in a ont of the door leading back revented Resident #1 from		183	Additional training was provided for cottage and clinical staff that covere it is appropriate to initiate a seclusion including appropriate levels of initial continuation authorization, monitorindocumentation. All staff attested to understanding the information provided all staff completed a written test as particularly this training. Completion and compliate recorded in each staff's training recorded in each staff's training recorded in each staff's training recorded in each staff's training recorded in each staff's training recorded in each staff's training recorded in each staff's training recorded in each staff's training recorded in each staff's training recorded in each staff's training recorded for Six Core Strategies for Reduction of Seclusion and Restrain project implementation. The Six Core Strategy Steering Committee/Leade Subcommittee met for the first time September 27, 2022. On November 2022, the Prevention Tools and Deb Subcommittees met for the first time Data Subcommittee is scheduled to the first time on January 4, 2023.  Began daily reviews of all Emergent Safety Physical Interventions (ESPI Seclusions on business days and weekends/holidays if necessary and continued thrice-weekly reviews of rigrievances to determine, in addition safety concerns, whether any youth policies are violated. These include document and video reviews, when available. Any violations or concerns are documented, and the information shared with the staff's supervisor for up, which may include additional contraining, or disciplinary action, up to including termination of employment addition, the review information is distributed to the executive team and distributed to the executive team and distributed to the executive team and distributed to the executive team and distributed to the executive team and distributed to the executive team and distributed to the executive team and distributed to the executive team and distributed to the executive team and distributed to the executive team and distributed to the executive te	all d when n, and ng, and ded, and bart of ance is ord via ystem. n was nt re riship on 17, oriefing e. The meet for cy ) and desident to any rights or s noted n is r follow- aching, and t. In d	9/1/22	
	when the resident co he/she began to strik	allway area. At 6:40 PM uld not get the door open, e YCW#5 three (3) times,			Bellewood and Brooklawn residentia clinical, and quality leaders.			
	and subsequently, Yo	CW #5 got up from the chair			Continued on next page			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED		
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USPIKITUS	S-BROOKLAWN-PILOTS			L	OUISVILLE, KY 40218		
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					Ongoing monitoring/compliance procedu	res:	
N 183	and was seen securing a black rectangular sliphallway. According to report, she secured Richard Rold. At 6:44 PM Shift timeout hallway, and Supervisor #1 walked of the timeout rooms. timeout room a few somilieu with Shift Superhis/her peers for choice.	ng Resident #1 in a hold on haped rug in the timeout the documentation in the desident #1 in a supine torso to Supervisor #1 entered the the hold ended. Shift the Resident #1 back into one He/she stayed in the econds, re-entered the ervisor #1, and rejoined repractice.	N	183	Monthly Safe Crisis Management (S Refreshers (1 hr) and annual Safe C Management (SCM) recertification (a includes review of Youth Rights and sensitively and effectively work with especially when addressing particular challenging or sensitive issues. Furth refreshers and recertifications will interested to the appropriate use of seclusion. Completellal refreshers and annual Safe Crisis Management (SCM) recertification is recorded in staff's training record via Learning Management System.	crisis 4 hrs) how to youth, arly her, clude letion of	9/1/22
	walls and the doors w (3) inch thick blue ma with soft surface floor rooms' doors had a si by 8 inch window. The common living space hallway. The hallway was one industrial typ on the hallway floor.  Telephone interview w on 10/18/2022 at 2:00 in the time out room a prevented the youth f	me-out rooms. The rooms' were padded with about three ats from ceiling to the floor, ring, as well. The time-out mall, approximately 8 inch ere was a door from the into the time-out room floors were tiled, and there be black rectangular area rug  with Shift Supervisor (SS) #4 D PM revealed if a youth was and staff shut the door or from leaving the time out			<ul> <li>Appropriate Responses to Emergent Safety Situations; Speak Up for Clies Safety; and Hand-Off Communication These trainings will be completed by staff during New Hire Orientation, wifirst three (3) weeks of employment, before working with youth. These trainclude education on proper procedurelated to appropriate use of seclusive existing staff will complete these trainon an annual basis, to be completed each year. Completion of and complewith these trainings is recorded in eastaff's training record via the Relias Learning Management System.</li> </ul>	nt on. / all new ithin the and sinings ures on. All inings I by 9/15	9/15/22
	Continued review of the Seclusion Report, data Residential Therapist hold implemented by Interview, on 08/22/20 Director of Traning ard Development, revealed	he Resident Physical Hold ted 07/09/2022, revealed #5, gave the order for the YCW #5 at 6:39 PM.			<ul> <li>Zero Hold and Seclusion Philosophy Training: 6 Core Strategies – New st receive information and complete tes new employee orientation, and yearl refreshers will be provided for all cot and clinical staff by 9/15 of each year. Completion and compliance w recorded in each staff's training reco the Relias Learning Management Sy</li> <li>Continued on next page</li> </ul>	taff will st during ly tage vill be ord via	8/3/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
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NAME OF P	ROVIDER OR SUPPLIER		1	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
			2108 DAVID GRAVES DRIVE				
USPIRITU	S-BROOKLAWN-PILOTS			L	LOUISVILLE, KY 40218		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 183	blocking the door, that seclusion, because the blocking the egress in one had informed him 07/09/2022, and he he coverage of Resident timeout hallway with 16 from exiting back into 17 limiterview, on 08/15/20 Residential Therapist of timeout was a residence of timeout was a residence of timeout was a residence of timeout was a residence of timeout was a residence of timeout was a residence of timeout was a residence of timeout was a residence of timeout was a residence of timeout area on their not prevent the residence of the way was blocked on the milieu. Resident #1's theraping the timeout room he prevented from less or the timeout room he prevented from less	at was considered a latched the staff person would be not the milieu. He stated no nad not viewed camera if and YCW #5 in the YCW preventing the resident the milieu.  D22 at 11:08 AM with #5, revealed the definition dent going to the time out down while using his/her is (SCS). She said itored a resident in time-out esident walked into the rown. She said staff should ent from leaving the time-out wanted to rejoin staff and esidential Therapist #5 said tocked that would become  D22 at 12:26 PM with st (Residential Therapist dent was in a timeout room tallway, he/she should not aving the time out area to a the exit door to the . She stated time out was e that time out was voluntary, is prevented from , that would become	N	183	Safety Physical Interventions (ESPI) business days and weekends/holida necessary, including the use of sect and thrice-weekly reviews of resider grievances are conducted to determ addition to any safety concerns, whe any youth rights or policies are viola These include document and video when available. Any violations or conted are documented, and the infois shared with the staff's supervisor follow-up, which may include additic coaching, training, or disciplinary act oand including termination of empl In addition, the review information is distributed to the executive team an Bellewood and Brooklawn residential clinical, and quality leaders.	on lys if usion, at line, in ether ted. reviews, ncems rmation for anal tion, up oyment.	9/1/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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001 110100	- Dittoritori		1	OUISVILLE, KY 40218			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
N 183	Continued From page YCW #5 when she blo into the cottage milieu	ocked the door that led back	N 183				
N 189	should make the deci he/she could be esco The physician said tin resident should not be timeout area. POST INTERVENTIO CFR(s): 483.370(b) Within 24 hours after seclusion, all staff inv safety intervention, at and administrative state debriefing session that review and discussion 483.370(b)(1) The em that required the inter	atrist, revealed the resident sion to go to time out, or red to the time out room. neout was voluntary, and the e prohibited from leaving the ON DEBRIEFINGS  the use of restraint or olved in the emergency and appropriate supervisory aff, must conduct a at includes, at a minimum, a nof-	N 189	<ul> <li>The initial debriefing following the hod Ja'ceon Terry on 7/17/22 was not do the usual way, due to law enforceme beginning an investigation in additionother agency investigations (Child Protective Services, Office of Inspective Services, Office of Inspective Services, office of Inspective Service</li></ul>	one in ent on to otor . It was taff to at e aff were id early		
	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.			<ul> <li>Bellewood and Brooklawn completer formal root cause analysis to identify for improvement in our processes ar causes to the event on 7/17/2022 th a death. Staff involved in this proces included residential and clinical direct Vice President of Residential Programand executive leadership.</li> </ul>	areas ad root at led to ss ctors,	9/9/22	
		5 PM, YCW #5 secured ling cradle hold, off camera,		Continued on next page			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		=0	A BOILD	_			С
		18L013	B. WING			11/	02/2022
,	ROVIDER OR SUPPLIER S-BROOKLAWN-PILOTS			2	STREET ADDRESS, CITY, STATE, ZIP CODE 1108 DAVID GRAVES DRIVE LOUISVILLE, KY 40218		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 189	in the resident's bedresoon entered the roor YCW #5 secured the interview with YCW # Resident #1's bedroo vomited while secure and soon lapsed into the resident could no Shift Supervisor #1 in Medical Services (EM facility. The resident Emergency Departme support, however the and was pronounced day.  The findings include: Review, of the facility Holding of Youth, Pol review date, 03/25/20 possible, but no later debrief face-to-face of following each episood debriefing should add to the incident and evused prior to the phys Safe Crisis Managem Identify what could have including possible struse of physical holding physical well-being, pright to privacy of the Assess the impact of emotional functioning needed to the youth's Interview on 07/20/20	m, took over the hold, and residents legs and feet. Per id, who witnessed the hold in im, revealed the resident d in the hold, began to cry, an unconscious state. After the aroused, YCW #5 and bitiated CPR and Emergency (IS) was summoned to the was transported to a local ent (ED) for advanced life resident did not respond dead at 4:48 PM that same (IC) PM that same (IC) PM the was transported to a local ent (ED) for advanced life resident did not respond dead at 4:48 PM that same (IC) Number: CS040, last (IC) Number: CS040, last (IC) PM that led was the following: What led waluate the interventions sical holding as well as the ment (SCM) techniques used; are been handled differently, rategies to prevent the future	N	189	<ul> <li>Each Physical Hold/Seclusion Reported includes a mandatory debriefing with the youth and the staff, and the form been updated with new prompts to each regulatory area of the debriefing addressed. Quality Improvement do administrative review of every Physical Hold/Sectusion Report form, including debriefing section.</li> <li>A facilitator and implementation teat identified for Six Core Strategies for Reduction of Seclusion and Restrain project implementation. The Six Core Strategies for Reducing Seclusion at Restraint Use subcommittee for Rig Debriefing (one of the six core strate has been formed and has begun mer (first meeting 11/17/2022). This teat work through plans to bolster our deprocess to inform policy, procedured practices to avoid repeats in the futt subcommittee will also work to decreffects, as much as possible, to bott and staff from restraint and seclusion.</li> </ul>	ort h both h has ensure ng is es an ical ng the m was ont re and horous eeting m will ebriefing s, and ure. The h youth	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		18L013	B. WING			1	02/2022
	ROVIDER OR SUPPLIER S-BROOKLAWN-PILOTS			STREET ADDRESS, CITY, STATE, ZIP CODE 2108 DAVID GRAVES DRIVE LOUISVILLE, KY 40218		1	Var av est
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BI		(XS) COMPLETION DATE
N 189	revealed she worked Shift Supervisor #1 st stated Shift Supervisor with Resident #1 and resident stay in his/he because the resident night. YCW #1 said a Shift Supervisor#1 te going to hold him/her him/her throw up. She Resident #1, Shift Su another staff member that she texted that R mind, and that she coresident right now. YO sure who the Shift Su and she did not know wanted her to know s message. YCW #1 st voice tone was very a #1, and she seemed YCW #1 said Resider room most of the day shower because he/s himself/herself. She shad the resident eat h in his/her room. YCW about 2:00 PM, Resident stuck out his/her staff.	through the day shift with arting at 8:30 AM. She or #1 told her she was upset she was going to make the er room for the first shift had misbehaved during the tabout 8:45 AM she heard Il Resident #1 that she was and she was going to make a said after she said that to pervisor #1 sent a text to and she told her (YCW #1) esident #1 had lost his/her ould not even talk to the CW #1 said she was not pervisor sent the text to, why Shift Supervisor #1 he had sent the text ated Shift Supervisor #1's aggressive toward Resident except for going to take a he had urinated on said Shift Supervisor #1 also his/her breakfast and lunch #1 said YCW #5 arrived the second shift. She said lent #1 opened his/her door hand to gain the attention of	N	189			
	with YCW #1, revealed Resident #1, when he about 2:20 PM. She she/she had urinated of	and the went to talk with state of the went to talk with state opened his/her door at said the resident stated on himself/herself. During W #1 said Resident #1					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		67.	A. BOILDING	·	С	
		18L013	B. WING		11/02/2022	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
USPIRITUS	S-BROOKLAWN-PILOTS			2108 DAVID GRAVES DRIVE LOUISVILLE, KY 40218		
(VA) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	<u> </u>	PROVIDER'S PLAN OF CORRECTION	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION	
N 189	Continued From page		N 18	9		
		is/her plastic water bottle at				
ľ		/she did not actually do so. ard Resident #1's threat,				
		sident's door, and entered				
,		ot have camera coverage.				
		owed YCW #5 into the room				
:		wanted to see how YCW #5				
		nt #1's behavior. YCW #1 reatened to hit YCW #5 and				
		itch." However, according to				
		t did not hit anyone prior to				
		ted YCW #5 placed the				
	•	n a wall, and then secured cradle hold. She said both				
		nt #1 lost their balance, and				
		the said YCW #5 secured				
		ling cradle hold. She stated				
	Shift Supervisor #1 er took over the hold.	ntered the bedroom and				
	took over the nota.					
		7/17/2022, Resident #1 had				
		e (3) other holds, which				
	occurred on 07/01/20	*				
:		of Physical Hold Seclusion /2022, 07/08/2022, and				
		all 3 holds were initiated by				
		022, The Treatment Team				
		YCW #5 triggered Resident				
	#1's behaviors. Right					
		was directed by Treatment of become involved in any				
		ent #1. However, per the				
	facility's camera cove	rage of the milieu and				
		oor, and interiew with YCW				
		staff member to enter and				
	secure resident#1 if	the hold on 07/17/2022.				
		on 07/20/2022 at 5:22 PM ed she really did not think the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		18L013	B. WING				C
NAME OF B	SOLUBED OF CUIDOUES	102013	1 5: 11:110	STREET ADDRESS, CITY, STATE, ZIP CODE		717	02/2022
NAME OF PE	ROVIDER OR SUPPLIER			, , ,			
USPIRITUS	S-BROOKLAWN-PILOTS			2108 DAVID GRAVES DRIVE			
				LOUISVILLE, KY 40218			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION}	PREFIX TAG		HOULD BE		(X5) COMPLETION DATE
N 189	Continued From page physical hold was ever Resident #1 had beer YCW #5 entered their said she often laugher resident and that seer said even after YCW: the hold, and she (YC and the resident still labe/she seemed to call the resident did not the not hit anyone before #1 in the hold.  Review, of the Youth Report, dated 07/17/2 YCW #5, and Shift Sustaff present for the insummary narrative rethe following: "Reside earlier in the day. The continued to struggle his/her mood and beir milieu. Resident repeated by the Staff (YCW #5 and Shift (YCW #5 and	e 88 en necessary because in laughing with her before resident's room. YCW #5 id and joked with the imed to calm him/her. She iff secured the resident in it w #1) held his/her feet, she aughed with each other, and im down. Further, she stated irrow anything at her and did irrow #5 secured Resident  Physical Hold Seclusion 2022, revealed YCW #1, ippervisor #1 were listed as icident. Review of the ivealed the staff documented int was escalated from oughout the day, he/she off and on with regulating ing able to remain safe in the atedly opened his/her door			- NOP NIA		
	then aggressively cha (YCW #5) attempted to standing cradle. Residual attempting to pull awatrying to assault them resident caused both	#5 and YCW #1). Resident arged at YCW #5. Staff to secure the resident in a dent was combative in any from staff while still also are actions from the resident and staff to and both resident and staff					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	577		"""	_			С
		18L013	B. WING			11/	02/2022
	ROVIDER OR SUPPLIER S-BROOKLAWN-PILOTS			ŀ	STREET ADDRESS, CITY, STATE, ZIP CODE 2108 DAVID GRAVES DRIVE		
	o bitoonbattii ileoto			L	OUISVILLE, KY 40218		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 189	landed on the floor. O (YCW #5) secured Re kneeling cradle with S lower extremities (leg securing upper extrer position). Staff (YCW use his/her SCS while empathy statements. entered the room and #5) on the upper extre the room to get the im continued to refuse to Resident then vomite Staff (Shift Superviso this was because he/s beforehand. Staff (YCV extremities came out #5) first grabbed the i went back to Residen securing his/her lower (YCW #5) continued to position on the lower and Shift Supervisor r resident to use his/he refused. Resident cor attempt to pull out of the/she quickly stoppe to become unconscio Supervisor #1) immed 2:35 PM and started to (YCW #5 and Shift Su pat the resident and to YCW #5 began to put to see if anything was	ence on the floor, Staff esident at 2:25 PM in a Staff (YCW #5) securing s) and Staff (YCW #5) mities (arms in cradle #5) prompted Resident to e Staff (YCW #1) used Staff (Shift Supervisor #1) I took over for Staff YCW emities. Staff (YCW#5) left epact cushion Resident to use his/her SCSs. d while in the seated cradle. or #1 and YCW #1) assumed she had eaten lunch shortly EW #1) became unable to extremities due to her feeling V #1 release his/her lower of the room. Staff (YCW mpact cushion and then the stremities and Staff to monitor Resident from her extremities. Staff (YCW #5 #1), continue to prompt or SCS. Resident argued and entinued to struggle in an	N	189			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL <sup>*</sup> A, BUILDI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
							С
		18L013	B. WING			11/	02/2022
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
11SDIDITI I	S-BROOKLAWN-PILOTS				2108 DAVID GRAVES DRIVE		
USFIRITU	S-BROOKLAVIN-FILOTS				LOUISVILLE, KY 40218		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)	16	
			1			-	
N 189	Continued From page	200	l N	490			
14 103			l IN	189	<sup>3</sup>		
		he report revealed staff th and cold water on the					
		se him/her. The report					
	-	ught the resident was					
		his/her chest rising and					
		s still not responding to					
}	verbal prompts. Staff						
		d CPR, and YCW #1 called					
	911.						
,							
		he Physical Hold Seclusion					
	-	gory Processing/Contracting					
	*	taff debriefing interventions					
	with agency leadersh	revealed, "Staff debriefing					
	with agency leadersh	ıp.					
	Interview, on 07/20/20	022 at 10:40 AM with					
		#1, revealed he reviewed					
	_	ent, and he said he did not					
		e out of his/her room before					
	YCW #5 and YCW #1	entered the resident's					
	room.						
	•	022 at 8:38 PM with YCW					
	-	pervisor #1 took Resident #1					
		1:30 PM. However, review					
	of the camera coverage	ge, revealed the Shift Inch tray to Resident #1's				ļ	
	•	nich tray to Resident #1's					
		ented according the Youth					
	Physical Hold Seclusi						
	-	on, YCW #1 stated she had					
		omments Shift Supervisor					
		#1 throughout the day, prior					
		of the hold, but she did not					
	-	o other supervisors or facility					
	_	2022, before the resident					
		d, and subsequently passed					
	away. YCW #1 also s	stated the hold was not					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
			A. BUILDI	NG_			С		
		18L013	B, WING_				/02/2022		
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
USPIRITU:	S-BROOKLAWN-PILOTS				2108 DAVID GRAVES DRIVÉ LOUISVILLE, KY 40218				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	i 10		PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE		
N 189	Continued From page	91	N	189					
	recent training and ce Supervisor #1 placed resident pushing him/ his/her nose almost to	nner consistent with her entification. She stated Shift extreme force on the there is a forward that outlied the floor. YCW #1 e caused the resident to							
	Supervisor #1 stated s resident's room becau recently been directed	/ 2022 at 07:17 PM, Shift she took over the hold in the use she knew YCW #5 had d to not become involved in manage Resident #1's							
	after the incident, he with Resident #1. He sout while there he beg	022 at 2:49 PM, revealed went to the hospital to be stated it was very traumatic, gan to think how the other perceive physical holding.							
	call from the Assistant supervisor) who expla unconscious at the co where she was working o over there to see w said when she arrived with the resident onbovery upset, and YCW breathing heavily. YCV and Shift Supervisor # was hard to make sen to tell me about the inc Supervisor stated ano identify who) initiated	#3, revealed she received a It Clinical Director (her lained a resident was lottage next to the cottage long, and she wanted her to lowhat had happened. She It, the ambulance pulled off loard. The cottage staff was loard. The cottage staff was loard was crying and loard was sobbing so heavily, it loase of what she was trying loident. She said the lother staff (she did not lother the hold because the liant, and would not keep							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		18L013	B. WING				C /02/2022
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE		-
			ĺ	2	2108 DAVID GRAVES DRIVE		
USPIRITUS-BROOKLAWN-PILOTS				LOUISVILLE, KY 40218			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			ID ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX (EACH CORRECTIVE ACTION SHOULI			COMPLETION DATE
N 189	Continued From page	92	N ·	189			
	debriefing. She said she thought the Shift						
	Supervisor said he/sh	ne was secured in a kneeling					
		the (Shift Supervisor #1)					
		esidential Therapist #3 said					
	she did not know why						
	_	he resident. Residential he took the					
		while and talked with them.					
		eturned to the cottage later					
		ut Resident #1 had passed					
	away.						
	Additional interview	on 10/06/2022 at 11:03 AM					
		apist #3, revealed she					
		ttage on 07/17/2022 at					
		ayed until about 9:30 PM.					
		iced finished questioning the					
		1, YCW #5, and Shift					
		gement staff including The			į		
	The Assistant Clinical	vices, The Clinical Director,					
		OO), Residential Manager					
		sidential Therapist, and The					
		nt time reminiscing about					
	Resident #1 and his/h	ner stay at the cottage. She					
		asked the direct care staff					
		m them. She stated there					
		ing session regarding the ere were no conversations					
		nat precipitated the hold,					
		the hold, or what could have					
	been done differently.						
	Intoniou na 60/40/0/	000 at 0.05 DM with the VD					
		022 at 2:35 PM with th VP es, revealed by the end of					
		/2022 many management					
		tage and supported staff by					
		h their breath and express					
		e the residents who had					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(	(X3) DATE SURVEY COMPLETED		
		18L013	B. WING				02/2022	
NAME OF PROVIDER OR SUPPLIER  USPIRITUS-BROOKLAWN-PILOTS				STREET ADDRESS, CITY, STATE, ZIP CODE  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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPROFILE DEFICIENCY)		JLD BE			
N 189	return to the cottage. Services said we disc the cottage staff affect Employee Assistance staff trained in Psychological their was no addition the 3 staff involved in The State Survey Age the facility to provide debriefing session that twenty-four (24) hours the topics as delinear	n for pizza were about to The VP of Residential cussed ongoing supports for cted, by offering our e Program, as providing as plogical First Aid onsite the incident. She stated al meeting the next day with the hold. ency (SSA) Surveyor asked written evidence of a	N	189				