

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

PRINTED: 10/22/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G188	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/01/2010
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NAME OF PROVIDER OR SUPPLIER INNOVATIVE LIFE SOLUTIONS, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3259 'O' ST, SE WASHINGTON, DC 20020
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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W 000 INITIAL COMMENTS

W 000

The Health Regulation Licensing Administration (HRLA) received ten (10) unusual incidents reports via facsimile from the facility on September 23, 2010, at approximately 4:59 p.m. There were three allegations of verbal and physical abuse identified out of the 10 incidents received as specified below:

1. On September 23, 2010, at 8:00 a.m., the house manager received a report from Staff #1 that indicated another staff was observed yelling at Client #3 and pointing in her face. The staff was also observed cursing at the client and stating that "I'll f*** you up if you tell anyone I was drinking and smoking on the bus." Staff #1 observed Client #3 crying after the incident.
2. On September 23, 2010, Client #3 reported to Staff #1 that Staff #3 told her on September 22, 2010, that she would get her dogs to attack her [client] if she didn't listen.
3. On September 23, 2010, at 11:00 a.m., Client #6 reported to a direct care staff that while on vacation, Staff #3 pushed her down and dragged her on the floor and slapped her.

As a result of receiving the aforementioned incidents, an onsite investigation was conducted from September 29, 2010 through October 1, 2010 to verify compliance with the federal and state regulatory requirements. The findings of the investigation were based on interviews with clients, facility staff, nursing staff, administrative staff, and a review of client and administrative records, including unusual incident/investigation reports.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION
825 NORTH CAPITOL ST., N.E., 2ND FLOOR
WASHINGTON, D.C. 20002
11-24-10

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

TITLE

(X6) DATE

[Handwritten Signature] *[Handwritten Title: BEBE DREDA]* *[Handwritten Date: 11/24/10]*

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

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W 000	Continued From page 1 The results of the initial investigation revealed that the State Agency (SA) could not substantiate that Clients #3 and #6 were verbally and physically abused. Note: During the process of the onsite investigation, surveyors were informed on September 29, 2010 that an additional allegation of physical abuse (dated September 29, 2010) had been reported. Furthermore, as the initial investigation unfolded, Client #3 revealed that Client #6 was missing while on vacation.	W 000			
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on interview and record review, the governing body failed to exercise effective operating direction to ensure necessary staffing and the implementation/development of policies to maintain each client's health and safety, for one of six clients in the investigation. (Client #6) The findings include: 1. The facility failed to provide evidence of a policy for missing persons. (Cross refer to W149) On October 1, 2010, at approximately 5:15 p.m., review of an unusual incident report dated October 1, 2010, revealed that on September 18, 2010, at 7:00 a.m., while on vacation Client #6 was noted to be missing from her hotel room. Review of the incident report form revealed the incident had not been classified.	W 104	W104 1. ILS has developed a Missing Person/Elopement Policy. Missing person/elopement is defined as the unexpected or unauthorized absence of an individual for more than four (4) hours or an indeterminate amount of time or of any duration for an individual whose absence constitutes an immediate danger to that individual or others. IMC will provide training with all nursing and management staff on the Incident Management Policy and Procedures to include updates/changes made to the policy. ILS will provide ongoing training and competency testing to ensure compliance. ILS Executive Director will provide training for Senior Management on new policies.	10/08/10	

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W 104	<p>Continued From page 2</p> <p>Interviews were conducted on October 1, 2010 to ascertain information regarding the incident. According to a telephonic interview with the Program Manager/Director of Nursing on that day at approximately 2:01 p.m. when asked why an incident report had not been generated for the incident prior to October 1, 2010, she stated that she needed clarification on how the incident should be classified. The PM/DON further stated that she would not classify this incident as missing person because the client was located within 10 to 20 minutes and unharmed. She also stated that it would not be elopement because it was not identified as a targeted behavior in the client's behavior support plan (BSP). Additional discussion with the PM/DON revealed that this issue had not been further addressed at the time of the Department of Health's investigation.</p> <p>On October 1, 2010, at approximately 1:50 p.m., the facility's qualified mental retardation professional (QMRP) was asked for the policy that describes and identifies what should occur if a client is missing. On the same day at approximately 5:00 p.m., the facility's Incident Management Coordinator (IMC) was also asked for the policy on missing persons. At the time of the investigation, the facility failed to provide evidence of a missing persons policy.</p> <p>2. (Cross refer to W183) The governing body failed to ensure sufficient staffing to meet the needs of clients.</p>	W 104	<p>W104</p> <p>2. The incident surrounding client #6 eloping occurred under unusual circumstances during vacation. Client #6 had no previous history of eloping or leaving staff supervision without permission. ILS will ensure 24 hour awake and on duty staff supervision for all individuals within the residential facility and in any other temporary living unit to ensure the deficiency is not a reoccurrence.</p> <p>10/08/10</p>
W 148	<p>483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS &</p> <p>The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not</p>	W 148	

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W 148	Continued From page 3 limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each client's legal guardian was notified of significant incidents, for one the six clients residing in the facility. (Client #6) The finding includes: (Cross refer to W149) On September 30, 2010, at approximately 4:45 p.m., Client #3 stated during an interview that Client #6 was missing for approximately one (1) hour while on vacation. Interview with the qualified mental retardation professional (QMRP) on the same day at approximately 5:05 p.m., confirmed that Client #6's 1:1 staff discovered the client missing from their hotel room on September 18, 2010, during the client's vacation. Continued interview with the facility's QMRP on October 1, 2010, at approximately 5:00 p.m., revealed that Client #6's guardian had not been informed of the incident.	W 148	W148 At the time of the incident, ILS did not define client #6 leaving staff supervision as eloping and/or missing persons. Client #6 was found within minutes of noticing she was not in her hotel room. Once it was determined a reportable incident, all necessary parties were notified according to ILS Incident Management Policy and Procedures. Program Director provided training with all nursing and management staff on 10/5/10 on the Incident Management Policy and Procedures to include updates/changes made to the policy and definitions of incidents classified as reportable. ILS will ensure timely notification per the new Missing Person/Elopement policy for all future occurrences. ILS will provide ongoing training and competency testing for management and staff to ensure future compliance.	10/08/10
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to establish and/or implement its incident management policies to ensure the health and	W 149	W149 See W104.1 and W148.	10/08/2010

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W 149	<p>Continued From page 4</p> <p>safety of one of the six clients residing in the facility. (Client #6)</p> <p>The finding includes:</p> <p>1. The facility failed to implement its incident management policy (IMP) as evidenced below: On October 1, 2010, at approximately 5:15 p.m., review of an unusual incident report dated October 1, 2010, that was generated by the Incident Management Coordinator (IMC), revealed that on September 18, 2010, at 7:00 a.m., the qualified mental retardation professional (QMRP) received a call from Client #6's 1:1 staff stating that the client was not in the hotel room. The QMRP immediately went to the client's room. When she arrived the client had returned and was with her 1:1 staff. The licensed practical nurse (LPN) coordinator was immediately notified and assessed the client for injuries, none were noted. The program director was also notified of this incident. It should be noted however, that interview with the IMC on October 1, 2010, at 5:00 p.m. revealed she was not notified of the incident until that day (October 1, 2010). Furthermore, the Department of Health was informed of the incident on September 30, 2010, through interview with Client #3 regarding another incident.</p> <p>Review of the incident management policy (IMP) on October 1, 2010, at approximately 10:15 a.m. revealed that "once a potential incident is witnessed or discovered," both verbal and written notification must be made. According to the policy regarding verbal notifications, "the employee that first witnessed or discovered the incident should immediately notify the Facility Coordinator, Qualified Mental Retardation</p>	W 149		

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W 149	<p>Continued From page 5</p> <p>Professional (QMRP), and Incident Management Coordinator. The QMRP will notify direct care staff, nursing staff, guardian or emergency contact, Service Coordinator (SC), and Legal Representative/Attorney of the individual involved. " The policy further documented that the IMC had the responsibility of notifying the Department of Health (DOH) " as soon as possible, but within the first 24 hours of notification of the incident. "</p> <p>At the time of the investigation, the facility failed to provide evidence that all parties were notified in compliance with the incident management policy.</p> <p>2. Continued review of the incident management policy (IMP) on October 1, 2010, regarding documented notifications revealed the following:</p> <ul style="list-style-type: none"> - The employee that first witnessed or discovered the incident, with the assistance of the QMRP, will immediately complete an Incident Report Form. - The QMRP will document verbal notification to direct care staff, nursing staff, guardian or emergency contact, Service Coordinator (SC), and Legal Representative/Attorney of the individual involved on the incident report form under verbal notification. - The IMC will document verbal notification to the Department of Health. - The IMC will fax the incident report form, MCIS report and other supportive documents to the Department of Health within one business day of the incident. <p>At the time of the investigation, the facility failed to provide evidence that documentation of the</p>	W 149		

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W 149 Continued From page 6 W 149

incident occurred in compliance with the facility's incident management policy.

3. The facility failed to provide evidence of a policy for missing persons. On October 1, 2010, at approximately 5:15 p.m., review of an unusual incident report dated October 1, 2010, revealed that on September 18, 2010, at 7:00 a.m., while on vacation Client #6 was noted to be missing from her hotel room. Review of the incident report form revealed the incident had not been classified. Interviews were conducted on October 1, 2010 to ascertain information regarding the incident. According to a telephonic interview with the Program Manager/Director of Nursing on that day at approximately 2:01 p.m. when asked why an incident report had not been generated for the incident prior to October 1, 2010, she stated that she needed clarification on how the incident should be classified. The PM/DON further stated that she would not classify this incident as missing person because the client was located within 10 to 20 minutes and unharmed. She also stated that it would not be elopement because it was not identified as a targeted behavior in the client's behavior support plan (BSP). Additional discussion with the PM/DON revealed that this issue had not been further addressed at the time of the Department of Health's investigation.

On October 1, 2010, at approximately 1:50 p.m., the facility's qualified mental retardation professional (QMRP) was asked for the policy that describes and identifies what should occur if a client is missing. On the same day at approximately 5:00 p.m., the facility's Incident Management Coordinator (IMC) was also asked for the policy on missing persons. At the time of

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W 149	Continued From page 7 the investigation, the facility failed to provide evidence of a missing persons policy	W 149		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS	W 153	W153 See W148.	10/08/2010

The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.

This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all incidents of neglect were immediately reported to the administrator and to other officials in accordance with State law, for one of six clients (Clients #6) residing in the facility.

The finding includes:

(Cross Refer to W149) On October 1, 2010, at approximately 5:15 p.m., review of an unusual incident report dated October 1, 2010, that was generated by the Incident Management Coordinator (IMC), revealed that on September 18, 2010, at 7:00 a.m., the qualified mental retardation professional (QMRP) received a call from Client #6's 1:1 staff stating that the client was not in the hotel room. The QMRP immediately went to the client's room. When she arrived the client had returned and was with her 1:1 staff. The licensed practical nurse (LPN) coordinator was immediately notified and assessed the client for injuries, none were noted. The program director was also notified of this incident. It should be noted however, that

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interview with the IMC on October 1, 2010, at 5:00 p.m. revealed she was not notified of the incident until that day (October 1, 2010) Furthermore, the Department of Health not aware of the incident until September 30, 2010

W 153

W 154 483.420(d)(3) STAFF TREATMENT OF CLIENTS

W 154

W154
ILS has conducted a thorough investigation since defining the occurrence as an incident of elopement/missing person. ILS has developed a new policy to ensure that elopement and missing persons are clearly defined in non-conventional settings (i.e. during vacation) as well as ensuring implementation of awake, on-duty staff supervision for individuals regardless of environment. ILS will provide training on incident reporting. See also W148.

10/08/10

The facility must have evidence that all alleged violations are thoroughly investigated

This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to conduct a thorough investigation of an incident (neglect) that involved Client #6 leaving her hotel room unsupervised while on vacation.

The finding includes:

(Cross Refer to W149) The facility failed to implement its incident management policy (IMP) for investigating incidents, as evidenced below:

Interview with the incident management coordinator (IMC) on October 1, 2010, at approximately 5:00 p.m., revealed that she was not informed that Client #6 had left the hotel room unsupervised (on September 18, 2010), until October 1, 2010. She stated that she discovered the incident while conducting an investigation of another incident. On October 1, 2010, the IMC generated an incident report for aforementioned incident and acknowledged that an investigation should have completed.

Interviews were conducted with facility staff on October 1, 2010 and October 4, 2010, to ascertain information regarding the events that

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W 154 Continued From page 9

look place during Client #6's absence. The interviews revealed that the Qualified Mental Retardation Professional (QMRP), Program Manager/Director of Nursing, and the Chief Executive Officer were informed of the incident at the time it occurred. The interviews however, failed to provide evidence that the IMC had been immediately notified of the incident.

Review of the incident management policy (IMP) on October 1, 2010, at approximately 10:15 a.m., revealed that the IMC will complete an investigation within 4 business days of notification of the incident and submit it to the program director for final approval.

At the time of the Department of Health investigation, 13 days after the incident, there was no evidence that it had been thoroughly investigated by the facility.

W 154

W 159 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL

Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional

This STANDARD is not met as evidenced by. Based on interview, and record review, the facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by the qualified mental retardation professional (QMRP) for one of six clients residing in the investigation (Client #6)

The finding includes:

1. (Cross refer W249). The QMRP failed to

W 159

W159

Client #6 BSP has been modified to include length of time and provisions for one to one supervision. QMRP provided training with staff on 1:1 protocol and client #6 BSP on 9/30/10 to include adjustments/updates and effective implementation.

10/08/10

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W 159	Continued From page 10 ensure services were coordinated to effectively implement Client #6's behavior support plan. 2. (Cross refer to W240). The QMRP failed to ensure that the behavior support plan (BSP) identified the length of time and how to provide one to one supervision.	W 159		
W 183	483.430(c)(2) FACILITY STAFFING There must be responsible direct care staff on duty and awake on a 24-hour basis, when clients are present, to take prompt, appropriate action in case of injury, illness, fire or other emergency, in each defined residential living unit housing: (i) Clients for whom a physician has ordered a medical care plan; (ii) Clients who are aggressive, assaultive or security risks; (iii) More than 16 clients; or (iv) Fewer than 16 clients within a multi-unit building. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure sufficient staffing to meet the needs of clients who are aggressive, suicidal, and assaultive or pose a security risk for one of six clients residing in the facility. (Client #6) The finding includes: (Cross-refer to W149) Telephonic interview with Staff #3 on October 4, 2010, at 10:13 a.m., revealed that she was assigned to provide 1:1 supervision of Client #6 from 8:00 a.m. to 12:00 a.m. daily while on vacation. She further revealed that while on vacation she and Client #6 shared a	W 183	W183 See W104.2	10/08/2010

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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W 183 Continued From page 11

hotel room. On September 18, 2010, between 5:45 a.m. and 6:00 a.m., Staff #3 stated that after waking up, she discovered that Client #6 was not in her bed. Upon checking the bathroom, she determined that the client had left the hotel room while she [staff] was asleep. According to Staff #3, the last time she saw Client #6 was prior to their going to sleep between 10:00 p.m. and 11:00 p.m. on September 17, 2010. Further interview with Staff #3 revealed that she and the QMRP located Client #6 in the pool area, approximately 15 minutes after she was discovered missing. Staff #3 further revealed that the client was found being monitored by a hotel employee that appeared to a "cleaning lady".

W 183

On September 30, 2010, at approximately 5:45 p.m., review of Client #6's behavior support plan (BSP) dated June 2010, revealed the client had targeted behaviors of physical aggression (e.g., pushing, hitting, scratching and biting others), self-injurious behaviors, verbal aggression, property destruction, inappropriate sexual behavior and/or comments, making statements or gestures indicating suicidal ideation, agitation and hallucinations and thought distortion. Further review of the BSP revealed Client #6 required 1:1 supervision. The supervision is needed for BSP implementation, and to ensure the safety of Client #6, given the "high level of risk" of several of her target behaviors, as well as the frequency of target behaviors requiring direct staff interventions/support.

At the time of the investigation, there was no evidence that the facility had ensured awake and on duty staff in Client #6's residential living unit (hotel room), during the night.

W 240 483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN

W 240

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G188	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/01/2010
NAME OF PROVIDER OR SUPPLIER INNOVATIVE LIFE SOLUTIONS, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3289 'O' ST, SE WASHINGTON, DC 20020	
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W 240	Continued From page 12 The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure that the behavior support plan (BSP) identified the length of time and how to provide one to one supervision, for one of six clients residing in the facility (Client #6). The finding includes: (Cross refer to W149 and W249). On October 1, 2010, at approximately 5:15 p.m., review of an unusual incident report dated October 1, 2010, revealed that on September 18, 2010, at 7:00 a.m., while on vacation Client #6 was noted to be missing from her hotel room. Telephonic interview with Staff #3 on October 4, 2010, at 10:13 a.m., revealed that she was assigned to provide 1:1 supervision of Client #6 from 8:00 a.m. to 12:00 a.m. daily while on vacation. She further revealed that while on vacation she and Client #6 shared a hotel room. According to Staff #3, the last time she saw Client #6 was prior to their going to sleep between 10:00 p.m. and 11:00 p.m. on September 17, 2010. On September 18, 2010, between 5:45 a.m. and 6:00 a.m., Staff #3 stated that after waking up, she discovered that Client #6 was not in her bed. Interview with the QMRP on October 1, 2010 at 1:46 p.m. revealed Client #6 had a behavior support plan (BSP) that had been approved by the Human Rights Committee (HRC). The	W 240 W240 See W159.	10/08/2010	

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W 240 Continued From page 13 W 240

QMRP also stated that the BSP required that the client be provided 1:1 supervision for sixteen (16) hours a day (waking hours) to address her maladaptive behaviors. Review of Client #6's behavior support plan (BSP) dated June 2010 on September 30, 2010, at approximately 5:45 p.m., revealed that Client #6 required 1:1 supervision. The BSP however, failed to identify the length of time Client #6 was to be provided with 1:1 support services. Additionally, the plan failed to provide methodologies on how to implement the 1:1 supervision.

W 249 483.440(d)(1) PROGRAM IMPLEMENTATION

W 249 W249
See W104.2 and W159.

10/08/2010

As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that as soon as the interdisciplinary team (IDT) formulated a client's individual program plan (IPP), each client received continuous active treatment services, in sufficient number and frequency to support the achievement of the objectives identified in the IPP, for one of six of the clients residing in the facility. (Client #6)

The finding includes:

(Cross refer to W183) The facility failed to

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W 249 Continued From page 14 W 249

ensure 1:1 supervision for Client #6 in accordance with her behavior support plan (BSP), as evidenced below:

On September 30, 2010, at approximately 4:45 p.m., Client #3 stated during an interview that Client #6 was missing for approximately one (1) hour while on vacation. Interview with the qualified mental retardation professional (QMRP) on the same day at approximately 5:05 p.m., confirmed that Client #6's 1:1 staff discovered her missing from the hotel room when she awoke one morning, during the vacation.

Telephonic interview with Staff #3 on October 4, 2010, at 10:13 a.m., revealed that she was assigned to provide 1:1 supervision of Client #6 from 8:00 a.m. to 12:00 a.m. daily while on vacation. She further revealed that while on vacation she and Client #6 shared a hotel room. According to Staff #3, the last time she saw Client #6 was prior to their going to sleep between 10:00 p.m. and 11:00 p.m. on September 17, 2010. On September 18, 2010, between 5:45 a.m. and 6:00 a.m., Staff #3 stated that after waking up, she discovered that Client #6 was not in her bed.

Interview with the QMRP on October 1, 2010 at 1:46 p.m. revealed Client #6 had a behavior support plan (BSP) that had been approved by the Human Rights Committee (HRC). The QMRP also stated that the BSP required that the client be provided 1:1 supervision for sixteen (16) hours a day (waking hours) to address her maladaptive behaviors.

Review of Client #6's behavior support plan (BSP) dated June 2010 on September 30, 2010, at approximately 5:45 p.m., revealed that Client #6

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(X4) (I) PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	(I) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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W 249 Continued From page 15
required 1:1 supervision. W 249

At the time of the investigation, there was no evidence that the facility had provided Client #6 with 1:1 supervision as required by her BSP

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1 000 INITIAL COMMENTS

1 000

The Health Regulation Licensing Administration (HRLA) received ten (10) unusual incidents reports via facsimile from the GHMRP on September 23, 2010, at approximately 4:59 p.m. There were three allegations of verbal and physical abuse identified out of the 10 incidents received as specified below:

1. On September 23, 2010, at 8:00 a.m., the house manager received a report from Staff #1 that indicated another staff was observed yelling at Resident #3 and pointing in her face. The staff was also observed cursing at the resident and stating that "I'll f*** you up if you tell anyone I was drinking and smoking on the bus." Staff #1 observed Resident #3 crying after the incident.
2. On September 23, 2010, Resident #3 reported to Staff #1 that Staff #3 told her on September 22, 2010, that she would get her dogs to attack her (Resident) if she didn't listen.
3. On September 23, 2010, at 11:00 a.m., Resident #6 reported to a direct care staff that while on vacation, Staff #3 pushed her down and dragged her on the floor and slapped her.

As a result of receiving the aforementioned incidents, an onsite investigation was conducted from September 29, 2010 through October 1 2010 to verify compliance with the federal and state regulatory requirements. The findings of the investigation were based on interviews with residents, GHMRP staff, nursing staff, administrative staff, and a review of resident and administrative records, including unusual incident/investigation reports.

The results of the initial investigation revealed

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION
825 NORTH CAPITOL ST., N.E., 2ND FLOOR
WASHINGTON, D.C. 20002
11.24.10

Health Regulation Administration

LABORATORY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

DPWP

5HSD11

(X6) DATE

If continuation sheet 1 of 1

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1 000	Continued From page 1 that the State Agency (SA) could not substantiate that Residents #3 and #6 were verbally and physically abused. Note: During the process of the onsite investigation, surveyors were informed on September 29, 2010 that an additional allegation of physical abuse (dated September 29, 2010) had been reported. Furthermore, as the initial investigation unfolded, Resident #3 revealed that Resident #6 was missing while on vacation.	1 000		
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1 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Rehabilitation plans. This Statute is not met as evidenced by: Based on interview, and record review, the group home for mentally retarded persons (GHMRP) failed to ensure that each resident's active treatment program was integrated, coordinated and monitored by the qualified mental retardation professional (QMRP), for one of six residents residing in the investigation. (Resident #6) The finding includes: 1. (Cross refer citation 1422.1). The QMRP failed to ensure services were coordinated to effectively implement Resident #6's behavior support plan. 2. (Cross refer citation 1422.2). The QMRP failed to ensure that Resident #6's behavior support plan (BSP) identified the length of time and how to provide one to one supervision.	1 180	1180 See W159.	10/08/2010
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1370	Continued From page 2	1370		
1370	3519.1 EMERGENCIES	1370	1370 See W104.1.	10/08/2010
	<p>Each GHMRP shall maintain written policies and procedures which address emergency situations, including fire or general disaster, missing persons, serious illness or trauma, and death.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the governing body failed to exercise effective operating direction to ensure necessary staffing and the implementation/development of policies to maintain each resident's health and safety, for one of six residents in the investigation. (Resident #6)</p> <p>The findings include:</p> <p>1. The facility failed to provide evidence of a policy for missing persons. On October 1, 2010, at approximately 5:15 p.m., review of an unusual incident report dated October 1, 2010, revealed that on September 18, 2010, at 7:00 a.m., while on vacation Resident #6 was noted to be missing from her hotel room. Review of the incident report form revealed the incident had not been classified. Interviews were conducted on October 1, 2010 to ascertain information regarding the incident. According to a telephonic interview with the Program Manager/Director of Nursing on that day at approximately 2:01 p.m. when asked why an incident report had not been generated for the incident prior to October 1, 2010, she stated that she needed clarification on how the incident should be classified. The PM/DON further stated that she would not classify this incident as missing person because the resident was located within 10 to 20 minutes and unharmed. She also stated that it would not be elopement because it</p>			

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1370	Continued From page 3 was not identified as a targeted behavior in the resident's behavior support plan (BSP). Additional discussion with the PM/DON revealed that this issue had not been further addressed at the time of the Department of Health's investigation. On October 1, 2010, at approximately 1:50 p.m., the facility's qualified mental retardation professional (QMRP) was asked for the policy that describes and identifies what should occur if a resident is missing. On the same day at approximately 5:00 p.m., the facility's Incident Management Coordinator (IMC) was also asked for the policy on missing persons. At the time of the investigation, the facility failed to provide evidence of a missing persons policy. (See also Federal Deficiency Report Citations W104 and W149)	1370		
1379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all incidents that present a risk to resident's health and well-being were	1379	1379 See W148.	10/08/2010

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1379	Continued From page 4 reported immediately to the Department of Health, Health Regulation and Licensing Administration (DOH/HRLA), for one of the six residents in the facility. (Resident #6) The finding includes: On October 1, 2010, at approximately 5:15 p.m., review of an unusual incident report dated October 1, 2010, that was generated by the Incident Management Coordinator (IMC), revealed that on September 18, 2010, at 7:00 a.m., the qualified mental retardation professional (QMRP) received a call from Resident #6's 1:1 staff stating that the resident was not in the hotel room. The QMRP immediately went to the resident's room. When she arrived the resident had returned and was with her 1:1 staff. The licensed practical nurse (LPN) coordinator was immediately notified and assessed the resident for injuries, none were noted. The program director was also notified of this incident. It should be noted however, that interview with the IMC on October 1, 2010, at 5:00 p.m. revealed she was not notified of the incident until that day (October 1, 2010). Furthermore, the Department of Health not aware of the incident until September 30, 2010. (See also Federal Deficiency Report Citation W153)	1379	
1422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan. This Statute is not met as evidenced by: Based on staff interview and record review, the	1422	1422 See W159. 10/08/2010

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1422	Continued From page 5 Group Home for Persons with Mental Retardation (GHMRP) failed to provide training and assistance in accordance with Individual Support Plans for one of six residents in the sample (Residents 6) The findings include: The facility failed to ensure 1:1 supervision for Resident #6 in accordance with her behavior support plan (BSP), as evidenced below: On September 30, 2010, at approximately 4:45 p.m., Resident #3 stated during an interview that Resident #6 was missing for approximately one (1) hour while on vacation. Interview with the qualified mental retardation professional (QMRP) on the same day at approximately 5:05 p.m., confirmed that Resident #6's 1:1 staff discovered her missing from the hotel room when she awoke one morning during the vacation. Telephonic interview with Staff #3 on October 4, 2010, at 10:13 a.m., revealed that she was assigned to provide 1:1 supervision of Resident #6 from 8:00 a.m. to 12:00 a.m. daily while on vacation. She further revealed that while on vacation she and Resident #6 shared a hotel room. According to Staff #3, the last time she saw Resident #6 was prior to their going to sleep between 10:00 p.m. and 11:00 p.m. on September 17, 2010. On September 18, 2010, between 5:45 a.m. and 6:00 a.m., Staff #3 stated that after waking up, she discovered that Resident #6 was not in her bed. Interview with the QMRP on October 1, 2010 at 1:46 p.m. revealed Resident #6 had a behavior support plan (BSP) that had been approved by the Human Rights Committee (HRC). The	1422		

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I 422 Continued From page 6

I 422

QMRP also stated that the BSP required that the Resident be provided 1:1 supervision for sixteen (16) hours a day (waking hours) to address her maladaptive behaviors

Review of Resident #6's behavior support plan (BSP) dated June 2010 on September 30, 2010, at approximately 5:45 p.m., revealed that Resident #6 required 1:1 supervision.

At the time of the investigation, there was no evidence that the facility had provided Resident #6 with 1:1 supervision as required by her BSP.

(See also Federal Deficiency Report Citation W249)