

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

PRINTED: 07/10/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/02/2008
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NAME OF PROVIDER OR SUPPLIER WESTVIEW 01	STREET ADDRESS, CITY, STATE, ZIP CODE 3200 12TH STREET, NE WASHINGTON, DC 20017
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W 000	INITIAL COMMENTS On May 14, 2008 this office received an incident report from the group home regarding an allegation of physical abuse involving a group home staff and Client #1. According to the facility's investigative report, on May 5, 2008 the incident management coordinator received a telephone call from an anonymous individual who alleged that she observed a group home staff physically abusing Client #1. Additionally, the facility received three written complaints from outside individuals who stated that they were present at the Special Olympics on May 5, 2008 and observed the abuse. The investigation conducted by the group home concluded that the allegation was substantiated. An onsite visit was initiated on May 31, 2008 to examine the facility's incident management system and to verify the corrective action based on the group home's investigative findings.	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 observation, interview and record review, the governing body failed to provide general operating direction over the facility. The findings include: 1. The facility failed to ensure that it's policy and procedure on incident management and reporting were implemented as written. [See W149]	W 104	1. Upon the next reported allegation of abuse and all upcoming reported incidents, Westview, Inc.'s governing body will ensure that its Incident Management Policy and Procedures are implemented as written. Oversight of the Incident Management Coordinator will be conducted by the Administrator.	2008 JUL 14 P 3:53 RECEIVED DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 8/1/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>David R West J MD</i>	TITLE <i>Administrator</i>	(X6) DATE <i>July 14, 2008</i>
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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 104	Continued From page 1 2. The facility failed to timely address recommendations made as a result of findings identified during the internal investigation of an allegation of abuse. Interview with the incident management coordinator on May 31, 2008 revealed that the internal investigation initiated on 5/5/08 recommended the following: a) Suspension pending outcome of investigation. b) Transfer to a different group home within the agency c) Anger Management Classes d) Retrain staff assigned to Client #1 on how to implement her behavior support plan (BSP) Interview with the IMC revealed that the staff involved in the incident was not suspended until May 12, 2008, seven days after the complaint was received. Additionally, the interview with the IMC indicated that recommendations (b), and(), and (c) had not been implemented. Interview with the Qualified Mental Retardation Professional revealed that the staff were provided training on the client's BSP on May 2, 2008. There was no evidence that any futher training on BSPs had been provided to staff since the May 5, 2008 incident.	W 104	2. In the future; at the conclusion of the internal investigation conduct by the Incident Management Coordinator (IMC), all recommendations made, as a result of the findings, will be implemented immediately. Oversight will be conducted by the QMRP.	
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & 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 limited to, serious illness, accident, death, abuse, or unauthorized absence.	W 148	In the future the facility will notify not only Client # 1's but all client's parents, guardians, and other individuals involved in their lives within 24 hours of an allegation of abuse.	8/1/08

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W 148	Continued From page 2 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure parents/guardians were notified timely of an allegation of abuse involving Client #1. The finding includes: Interview with the facility's Incident Management Coordinator (IMC) revealed an allegation of abuse reported to the agency on May 5, 2008 at 11:30 AM. The Incident Management Coordinator (IMC) and the review of the facility's IMC's notification log revealed that the family/guardian was notified on 5/13/08 at 5:00 PM via telephone and the mail (8 days after the complaint was received). The agency's protocol stated that the parent/guardian should have been notified immediately. There was no evidence that the facility promptly notified the client's parent/guardian of the allegation of abuse.	W 148	In order not to alarm the parent, guardian, or others involved in the client's life, 24 hours will give the IMC sufficient time to implement the Westview, Inc.'s Incident Management Policy as well as initially substantiate the allegation. Even if the allegation is not substantiated within 24 hours, the IMC will still notify the parent or guardian that an allegation had occurred and that a full investigation will be conducted. At the conclusion of the investigation all persons will be informed of the final findings. Oversight will be conducted by the Administrator.	
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 implement its policy that ensured the health and safety of Client #1. The finding include: The review of an unusual incident dated May 14,	W 149	a. At the time of the allegation it was believed that Client #1 as well as the other clients were not in any immediate danger. However, in the future, Westview, Inc. will closely follow its policy and remove the staff member from all contact with the client they were alleged to have abused.	8/1/08

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W 149	<p>Continued From page 3</p> <p>2008 revealed on May 5, 2008 at 11:30 AM, the Incident Management Coordinator (IMC) received a telephone call from an anonymous female who alleged that she witnessed Client #1 being abused by a group home staff at the Special Olympics. She indicated that she notified the administrator and then began the investigation.</p> <p>The review of the agency's incident management protocol on June 2, 2008 revealed the following:</p> <p>a) When a staff member witnessed an incident or was informed of an incident, they must assess the situation and ensure that the consumer involved was no longer in danger and/others were free from harm.</p> <p>b) The shift supervisor of designated staff must then call the nursing coordinator.</p> <p>The IMC indicated that she reported the complaint to the administrator.</p> <p>c) The shift supervisor or staff member should then call the Incident management Coordinator to inform her of the incident. If the staff person is directly involved in the incident, i.e. abuse or neglect, the IMC will inform the shift supervisor to clock the involved staff member out until further notice.</p> <p>Interview the IMC indicated that the allegation of abuse was made against the shift supervisor and that she continued to work in the group home until 5/12/08.</p> <p>d) The IMC will immediately call Answers Please to report the incident. Thereafter, the IMC will via telephone notify, the Qualified Mental Retardation</p>	W 149b.	<p>At the next IMC training session, the staff will be instructed to follow Westview, Inc.'s policy and call the nurse at the first sign of an allegation of any type in order for the client to be examined by the nurse and/or medical facility for any possible physical harm.</p> <p>c. The IMC was notified by the evening Shift Supervisor, however, the accused staff person worked on a different shift, therefore, instructions were not given by the IMC to clock the involved staff person out. However, in the future, when the staff member is not on site at the time of the report, he/she will be notified immediately via phone, by the IMC, and/or a letter describing the allegation and instructions not to report for duty as scheduled until the conclusion of the investigation and/or further notice.</p> <p>d. See W148</p>	<p>8/1/08</p> <p>8/1/08</p>

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W 149	<p>Continued From page 4</p> <p>Professional(QMRP), the residential manager, the administrator, any involved family members, the case manager, attorney, guardian and the Department of Health. The written incident report will be completed and forwarded to the appropriate officials immediately upon its completion or within twenty-four after the incident occurred.</p> <p>Interview with the IMC revealed that the interagency notification were done on 5/5/08 immediately after the allegation was received. Further interview with the IMC and the review of the incident notification log indicated that the family member/guardian was not notified until 5/13/08. DOH and the case manager were not informed of the allegation until 5/14/08.</p> <p>e) The investigative report, including findings and recommendation should be forwarded to the administrator and other appropriate officials within five business days after the incident occurred. Other individuals involved in the consumer's care will receive written notification of the findings and recommendations made by the IMC.</p> <p>Interview with the IMC revealed the investigation of the allegation was initiated immediately on 5/5/08. The investigation continued to be ongoing and was completed on 5/19/08 (14 days after the investigation was initiated).</p> <p>f) The incident will be reviewed by the Human Rights Committee (HRC) for approval/disapproval and for additional recommendations.</p> <p>Interview with the IMC revealed that at the time of the incident investigation, the incident had not yet been reviewed by the HRC).</p>	W 149	<p>e. The next Investigative Report including its findings and recommendations will be forwarded to the Administrator and other appropriate officials within five business days after the alleged incident has occurred. Other individuals involved in the client's care will also receive written notification of the findings and recommendations made by the IMC within the specified time frame. Oversight will be conducted by the Administrator.</p> <p>f. This incident will be reviewed by the Human Rights Committee (HRC) at its July meeting. In the future, the QMRP will ensure that all incidents and allegations of abuse and other reported incidents, if any, are reviewed at the monthly HRC meeting.</p>	8/1/08

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W 149	Continued From page 5	W 149		
W 153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that an allegations of physical abuse were immediately reported to other officials in accordance with State law, for Client #1.</p> <p>The finding includes:</p> <p>The facility's incident management coordinator (IMC) was interviewed on May 31, 2008 and again on June 2, 2008. The interviews and the review of an unusual incident report dated May 14, 2008 revealed the following:</p> <p>On May 5, 2008 at 11:30 AM, the incident management coordinator received a telephone call from an anonymous female who stated that she witnessed Client #1 being abused by a group home staff while at the Special Olympics Tryouts. The incident report stated that on May 8, 2008 a witness statement was received via facsimile. This statement also alleged that on 5/5/08 a group home staff was observed abusing Client #1 at the Special Olympics.</p>	W 153	<p>In the future, all government officials, including DOH and DDS, will be notified by the IMC of an incident within in 24 hours of its occurrence via telephone and/or written documentation, i.e. Unusual Incident Report. Oversight will be conducted by the Administrator.</p>	8/1/08

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W 153	Continued From page 6	W 153		
W 155	<p>Further review of the incident report revealed a full investigation was in progress and that the Department of Health (DOH) was being notified on May 14, 2008. Written notification of the incident was faxed to the DOH on 5/14/08 at 1:00 PM, nine days after the incident occurred. There was no evidence the facility reported the allegation of abuse immediately to other officials in accordance with state law and in accordance with its own established procedures.</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS</p> <p>The facility must prevent further potential abuse while the investigation is in progress.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide evidence that Client #1 was protected from further potential abuse while an allegation of abuse was investigated.</p> <p>The finding includes:</p> <p>[Cross Refer W153] A complaint was received on 5/5/08 alleging that the shift supervisor abused Client #1. Interview with Incident Manager Coordinator (IMC) revealed the supervisor continued to work at the facility until May 12, 2008, seven days after the complaint was received.</p>	W 155	<p>At the time of the allegation it was believed that Client #1 as well as the other clients were not in any immediate danger. However, in the future, Westview, Inc. will closely follow its policy and remove the staff member involved from all contact with the client they were alleged to have abused as well as other clients residing in the home. Oversight will be conducted by the QMRP.</p>	8/1/08
W 156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS</p> <p>The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law</p>	W 156	See W149 e	

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W 156	Continued From page 7 within five working days of the incident. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to provide evidence that the results of all investigations were submitted to the officials in accordance with State law within five working days. The findings include: The facility's incident management coordinator (IMC) was interviewed on May 31, 2008 and again on June 2, 2008. The IMC indicated the internal investigation was initiated on May 5, 2008 and was concluded on May 19, 2008. Based on the witness statements and interviews conducted, the IMC concluded that the allegation of abuse to Client #1 was substantiated. There was no evidence, however that the result of the investigation was reported to the administrator within five working day of the incident. [See also W153]	W 156			
W 157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure it's corrective actions recommended to protect Client #1 from potential further abuse had been timely implemented. The findings includes:	W 157	At the time of the alleged abuse, it was believed that Client #1, as well as the other clients residing in the home, was free from potential further abuse. However, in the future, the QMRP will ensure that involved staff member is removed from client contact immediately after an alleged abuse has been reported.	8/1/08	

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W 157	Continued From page 8 [Cross refer W156 .] Review of an unusual incident report revealed on 5/5/08 Client #1 was allegedly abused by a group home staff. Interview with the Incident Manager Coordinator (IMC) and review of the agency's investigative report were conducted on 5/31/08 and on 6/2/08. Based on the witness statements and interviews conducted, the IMC concluded that the allegation of abuse to Client #1 by the group home staff person was substantiated on 5/19/08. Further interview with the IMC indicated the management team convened on 5/19/08 to discuss the outcome of the investigation. As a result of the findings, the administrator deemed it necessary to inform the employee that she was suspended until further notice. Interview with the employee confirmed that she had the aforementioned conversation with the administrator, however that had not received written notification regarding her employment status.	W 157	The involved staff person will be notified verbally if he/she is on sight as well as in writing describing the allegations and instructions not to return to work until the conclusion of the investigation and/or further notice. If the staff member involved is not on sight at the time of the report he/she will receive notification via telephone as well as in writing.	8/1/08
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, interview and record, the facility failed to ensure continuous training was provided to each employee to enable them to effectively and competently implement Client #1's behavior support plan. The finding includes:	W 189	1. All staff including the 4 staff that missed the Behavior Support Plan (BSP) training on 05/02/08 will be retrained on Client #1's BSP by 08/01/08. In the future, training on all BSPs will be conducted biannually and as needed by the Psychologist and/or Behavior Specialist.	8/1/08

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W 189	<p>Continued From page 9</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) revealed that Client #1 was approved to have 1:1 staff supervision 17 hours Monday through Friday and 24 hours/day due to her maladaptive behaviors which included the following:</p> <ul style="list-style-type: none"> a) verbal tantrums (yelling and accusing) b) conversing with non-existent persons c) non compliance with direct request d) Property destruction e) Aggression to others f) Playing with feces/rectal digging g) Inappropriate sexual behaviors (public masturbation, grabbing breasts) <p>The review of Client #1's individual support plan (ISP) dated 10/07 revealed a support recommendation for annual and as needed training on implementation of goals and objectives, documentation of progress and the behavior support plan. Further review of the ISP staffing needs indicated that the person assigned as the 1:1 would be responsible for implementation of the Active Treatment Plan and the Personal Behavior Support Plan, as well as other areas of care in the client's life.</p> <p>The review of available training record revealed the behavior specialist conducted a staff training on the individual BSPs on 7/12/07. Interview with the Qualified Mental Retardation Professional (QMRP) and the record revealed that the behavior specialist also provided training on behavior management and the BSPs on 5/2/08. Review of the current staff schedule however failed to revealed provide evidence that four (4) of the twenty (20) staff had not attended the training</p>	W 189		

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W 189	<p>Continued From page 10 sessions.</p> <p>Further interview and record review revealed that both group home staff on the field with Client #1 at the Special Olympics were present at the training on 5/2/08. Interview and record review however indicated that on 5/5/08 when the client was observed to be "about to go into a behavior" the staff informed the shift supervisor who was also on the field. At that time, the custody of the client was changed from the assigned 1:1 to the shift supervisor.</p> <p>According to the BSP, staff should observe for signs of deteriorating behavior and act promptly. If staff notices her getting upset, staff should intervene before she has a full fledged episode. Staff should take control the moment the client is observed to start lose control. As she calms down, tell her exactly what to do. There was no evidence the 1:1 staff remained with the client to provide immediate intervention when the client was observed to be "about to go into a behavior". There was no evidence staff were effectively trained on the client's BSP proactive strategies designed to prevent a full fledged behavioral episode.</p> <p>2. Interview with the Qualified Mental Retardation Professional on June 2, 2008 revealed that shift notes are maintained to inform staff on the clients' daily status when they arrive on duty. The review of the data collection for May 5, 2008 revealed that Client #1 exhibited significant be targeted behaviors at the Special Olympic Tryouts during the day shift. The review of the daily shift notes for May 5, 2008 (7:00 Am - 3:30 PM shift) indicated that the client attended the Special Olympic Tryouts and returned to the facility. "She</p>	W 189	<p>2. All staff will receive training on proper and accurate documentation of events occurring on their shift in regards to the client (s) he/she is assigned to by 08/01/08 by the QMRP. In the future, training will be conducted bimonthly and as needed.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/02/2008
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NAME OF PROVIDER OR SUPPLIER WESTVIEW 01	STREET ADDRESS, CITY, STATE, ZIP CODE 3200 12TH STREET, NE WASHINGTON, DC 20017
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W 189	Continued From page 11 ate her breakfast and lunch. She went into some behavior issues and then started playing with her ball and looking at TV." There was no evidence staff was trained to provide an accurate accounting significant events that occurred during the shift.	W 189		
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I 000	<p>INITIAL COMMENTS</p> <p>On May 14, 2008 this office received an incident report from the group home regarding an allegation of physical abuse involving a group home staff and Resident #1. According to the facility's investigative report, on May 5, 2008 the incident management coordinator received a telephone call from an anonymous individual who alleged that she observed a group home staff physically abusing Resident #1. Additionally, the facility received three written complaints from outside individuals who stated that they were present at the Special Olympics on May 5, 2008 and observed the abuse.</p> <p>The investigation conducted by the group home concluded that the allegation was substantiated. An onsite visit was initiated on May 31, 2008 to examine the facility's incident management system and to verify the corrective action based on the group home's investigative findings.</p>	I 000		
I 222	<p>3510.3 STAFF TRAINING</p> <p>There shall be continuous, ongoing in-service training programs scheduled for all personnel.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record, the facility failed to ensure continuous training was provided to each employee to enable them to effectively and competently implement Client #1's behavior support plan.</p> <p>The finding includes:</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) revealed that Client #1 was approved to have 1:1 staff supervision 17 hours Monday through Friday and 24 hours/day due to</p>	I 222	<p>1. See W 189 #1</p>	<p>8/1/08</p>

Health Regulation Administration

Dred R West Jr MD

Administrator

TITLE

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

July 14, 2008

(X6) DATE

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I 222	<p>Continued From page 1</p> <p>her maladaptive behaviors which included the following:</p> <ul style="list-style-type: none"> a) verbal tantrums (yelling and accusing) b) conversing with non-existent persons c) non compliance with direct request d) Property destruction e) Aggression to others f) Playing with feces/rectal digging g) Inappropriate sexual behaviors (public masturbation, grabbing breasts) <p>The review of Client #1's individual support plan (ISP) dated 10/07 revealed a support recommendation for annual and as needed training on implementation of goals and objectives, documentation of progress and the behavior support plan. Further review of the ISP staffing needs indicated that the person assigned as the 1:1 would be responsible for implementation of the Active Treatment Plan and the Personal Behavior Support Plan, as well as other areas of care in the client's life.</p> <p>The review of available training record revealed the behavior specialist conducted a staff training on the individual BSPs on 7/12/07. Interview with the Qualified Mental Retardation Professional (QMRP) and the record revealed that the behavior specialist also provided training on behavior management and the BSPs on 5/2/08. Review of the current staff schedule however failed to revealed provide evidence that four (4) of the twenty (20) staff had not attended the training sessions.</p> <p>Further interview and record review revealed that both group home staff on the field with Client #1 at the Special Olympics were present at the training on 5/2/08. Interview and record review</p>	I 222		

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I 222	Continued From page 2 however indicated that on 5/5/08 when the client was observed to be "about to go into a behavior" the staff informed the shift supervisor who was also on the field. At that time, the custody of the client was changed from the assigned 1:1 to the shift supervisor. According to the BSP, staff should observe for signs of deteriorating behavior and act promptly. If staff notices her getting upset, staff should intervene before she has a full fledged episode. Staff should take control the moment the client is observed to start lose control. As she calms down, tell her exactly what to do. There was no evidence the 1:1 staff remained with the client to provide immediate intervention when the client was observed to be "about to go into a behavior". There was no evidence staff were effectively trained on the client's BSP proactive strategies designed to prevent a full fledged behavioral episode. 2. Interview with the Qualified Mental Retardation Professional on June 2, 2008 revealed that shift notes are maintained to inform staff on the clients' daily status when they arrive on duty. The review of the data collection for May 5, 2008 revealed that Client #1 exhibited significant be targeted behaviors at the Special Olympic Tryouts during the day shift. The review of the daily shift notes for May 5, 2008 (7:00 Am - 3:30 PM shift) indicated that the client attended the Special Olympic Tryouts and returned to the facility. "She ate her breakfast and lunch. She went into some behavior issues and then started playing with her ball and looking at TV." There was no evidence staff was trained to provide an accurate accounting significant events that occurred during the shift.	I 222	2. See W 189 #2	8/1/08	

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I 379	Continued From page 3	I 379	See W 153	8/1/08
I 379	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 allegations of abuse were immediately reported to other officials in accordance with State law, for Resident #1. The finding includes: The finding includes: The facility's incident management coordinator (IMC) was interviewed on May 31, 2008 and again on June 2, 2008. The interviews and the review of an unusual incident report dated May 14, 2008 revealed the following: On May 5, 2008 at 11:30 AM, the incident management coordinator received a telephone call from an anonymous female who stated that she witnessed Resident #1 being abused by a group home staff while at the Special Olympics Tryouts. The incident report stated that on May 8, 2008 a witness statement was received via facsimile. This statement also alleged that on 5/5/08 a group home staff was observed abusing	I 379		

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I 379	Continued From page 4 Resident #1 at the Special Olympics. Further review of the incident report revealed a full investigation was in progress and that the Department of Health (DOH) was being notified on May 14, 2008. Written notification of the incident was faxed to the DOH on 5/14/08 at 1:00 PM, nine days after the incident occurred. There was no evidence the facility reported the allegation of abuse immediately to other officials in accordance with state law and in accordance with its own established procedures.	I 379		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. The finding includes: 1. (Cross Refer 3519.10). The facility failed to ensure that all allegations of abuse were immediately reported for Resident #1. Review of unusual incident reports on May 31, 2008 at 10:45 AM revealed that there was an allegation that Resident #1 was abused by a direct care staff at th Special Olympic Tryouts on May 5, 2008. There was no evidence that the	I 500	1. See W 153	8/1/08

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I 500	<p>Continued From page 5</p> <p>incident was reported to the Department of Health (DOH) until May 14, 2008, nine days after the incident.</p> <p>2. The facility failed to ensure that the written report of the investigation was concluded timely.</p> <p>Interview with the Incident Management Coordinator (IMC) revealed that the investigation of the May 5, 2008 allegation of abuse commenced immediately after the group home for mentally retarded persons (GHMRP) was notified and concluded on 5/13/08. There was no evidence the result of the investigation was reported to the Department of Health (DOH) until May 14, 2008. There was no evidence the GHMRP ensure the results of the investigation were submitted to the officials within five working days.</p> <p>3. The facility failed to ensure that an allegation of mistreatment/ abuse of a resident was verbally reported immediately and timely in writing to the parent/guardian.</p> <p>Interview with the facility's Incident Management Coordinator (IMC) revealed an allegation of abuse was reported to the agency on May 5, 2008 at 11:30 AM. Further interview with the Incident Management Coordinator (IMC) and the review of the facility's IMC's notification log revealed that the family/guardian was not notified of the allegation until 5/13/08 at 5:00 PM via telephone and the mail.</p> <p>The review of the agency's incident management protocol revealed that the parent/guardian should have been notified immediately. There was no evidence that the facility promptly notified the</p>	I 500	<p>2. See W 104 #2</p> <p>3. See W 148</p>	

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I 500	<p>Continued From page 6</p> <p>resident's parent/ guardian of the allegation of abuse.</p> <p>4. The facility failed to ensure that Resident #1 was protected from further potential abuse while an allegation of abuse was investigated.</p> <p>Further interview with the IMC and the review of records revealed the supervisor continued to work at the facility until May12, 2008. According to the IMC, after the Disciplinary Committee met on May 19, 2008 and the supervisor was informed that she was placed on suspension until further notice. Interview with the IMC on 5/31/08 indicated that investigation concluded that some mistreatment may have occurred. Further interview with the IMC revealed that the staff against whom the allegation was made had been indirectly requested to resign. There was no evidence the group home for mentally retarded persons GHMRP promptly implemented measures to protect the resident from potential abuse while the investigation was being conducted.</p>	I 500	<p>4. See W 149 a</p> <p>See W 149 c</p> <p>See W 155</p> <p>See W 157</p>	8/1/08
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