

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

PRINTED: 09/06/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G153	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/22/2012
NAME OF PROVIDER OR SUPPLIER COMP CARE II			STREET ADDRESS, CITY, STATE, ZIP CODE 1329 LONGFELLOW STREET NW WASHINGTON, DC 20011		
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W 000	<p>INITIAL COMMENTS</p> <p>On August 14, 2012, at approximately 10:25 a.m., the State Surveying Agency's (SSA) Office of Compliance, Quality Assurance and Investigations Division (OCQAID), was notified by Comprehensive Care II's program coordinator that on August 13, 2012, at 7:15 p.m. Client #1 eloped from the facility. The investigation revealed that while in the community unsupervised, Client #1 was assaulted then treated and released from Sibley Hospital's emergency room. The client was diagnosed with a head injury, general assault and acute alcohol intoxication. On August 14, 2012, at approximately 11:33 a.m. the facility's house manager notified the OCQAID that Client #1 was located at Ronald Reagan National Airport.</p> <p>A surveyor/investigator from the Health Regulation and Licensing Administration (HRLA) conducted an investigation from August 15, 2012, through August 21, 2012, to determine the facility's compliance with both federal participation and local licensure requirements for intermediate care facilities for persons with intellectual disabilities participating in the medicaid program. Based on the interview, record review, and the aforementioned findings, it was concluded that the facility failed to establish an effective and efficient system to ensure clients' continued safety. Therefore, a determination was made that conditions found, during the investigation, posed an immediate and serious threat to the health and safety of clients residing in the facility.</p> <p>On August 15, 2012, at approximately 4:06 p.m., the provider's administrator was notified that an</p>	W 000	<p><i>Received 9/25/12</i></p>		

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

John Markin

TITLE

Adm. Asst

(X6) DATE

9/25/12

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 4 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	<p>Continued From page 1</p> <p>immediate jeopardy (IJ) existed. On August 15, 2012, at approximately 10:19 p.m., the provider submitted a plan to address the IJ. The plan revealed a credible allegation of compliance as evidenced below:</p> <ol style="list-style-type: none"> 1. An emergency Human Rights Committee (HRC) meeting was held via telephone, on August 14, 2012, to address Client #1 absconding from the facility via the second floor exit door. The HRC recommended installing a door chime on the exit door. In addition, the HRC recommended that staff check on Client #1's whereabouts hourly to ensure he is safe and present in the facility. 2. On August 15, 2012, all staff received training on a newly developed documentation form to track Client #1's whereabouts while in and out of the facility. 3. On August 15, 2012, all staff received training on "What to do when Client #1 appears angry or not having a good day." 4. The two direct support staff (Staff #1 and Staff #2) involved in the incident will be taken off the schedule. 5. The driver was put on suspension. <p>On August 16, 2012, at approximately 12:00 p.m. a surveyor/investigator from HRLA's OCQAID revisited the facility to verify compliance. At 2:15 p.m., the surveyor/investigator notified the SSA and the qualified intellectual disabilities professional (QIDP) that the IJ was lifted. The facility was informed that although the IJ was</p>	W 000	<p>W 000 (1, 2, 3)</p> <ul style="list-style-type: none"> - An emergency Human Rights Committee (HRC) meeting was held via telephone, on August 14, 2012 to address Client #1 absconding from the facility via the second floor exit. The HRC recommended installing a door chime on the exit door. A door chime has been installed on the door to alert staff whenever Client #1 attempts to leave the facility. - A checklist was put in place to ensure that staff check Client #1 whereabouts hourly to ensure safety. - On August 15, 2012, all staff working with Client #1 received training on a newly developed documentation outlining steps to follow when Client #1 appears angry or having a bad day. 	08/15/12	08/15/12

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W 000	Continued From page 2 removed, the facility remained out of compliance with the conditions of participation in Governing Body, and Client Protections.	W 000	W 000 (4, 5) <ul style="list-style-type: none"> - The two Direct Care Staff (DCS) who were on shift at the time of the incident were each suspended for two days for failing to adequately supervise Client #1, and also failing to implement interventions specified in the Behavior Support Plan of Client #1. All staff have been trained on proactive strategies and behavior interventions. - The driver was suspended for five days for failing to communicate to other staff on duty what had transpired between him and Client #1 pertaining to the hat issue and how it will impact Client #1's demeanor. 	08/15/12	
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: Based on observation, interview and record review, the governing body failed to maintain general operating direction over the facility. [See W104]	W 102			
W 104	483.410(a)(1) GOVERNING BODY The effects of these systematic practices resulted in the governing body's failure to adequately govern the facility in a manner that would ensure clients' health and safety. [See also W122] 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 general operating direction over the facility to ensure clients' health and safety, for two of two clients residing in the facility. (Clients #1 and #2)	W 104			
			W 102 <ul style="list-style-type: none"> - Please see W 122 		

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W 104	<p>Continued From page 6</p> <p>At the time of the investigation , there was no evidence that the facility 's governing body had ensured effective protocols were established and maintained to make certain staff were provided clear instructions/guidance to utilize when Client #1 exhibited antecedents to eloping.</p> <p>II. The governing body failed to ensure that staff were provided clear instructions related to which client they were required to provide supervision to during their tour of duty .</p> <p>During a tour of the facility on August 15, 2012, at approximately 9:30 a.m., Client #2 was observed in his bedroom with a male staff (Staff #3) standing in the doorway of the room. Interview with Staff #3, at approximately 9:32 a.m. revealed that Client #2 receives 1:1 staffing support for 16 hours a day and he further indicated that he (Staff #3) provides 1:1 supervision from 8:00 a.m. - 4:00 p.m. Continued conversation with Staff #3 revealed that Client #2 gets aggressive and he must be with him at all times.</p> <p>Interview with the house manager (HM) on August 15, 2012, at approximately 3:00 p.m. revealed that there are two direct care staff on duty for the evening shift. When asked who was assigned to provide 1:1 services to Client #2 during the evening of August 13, 2012, the HM indicated that staffing assignments are selected by the staff. She stated that whomever's chart they pick, that is the client they [the staff] supervise. At the time of the investigation , the HM never provided either a definitive schedule or clear information that indicated the staffing</p>	W 104	<p>W 104, b(II)</p> <ul style="list-style-type: none"> - A staffing schedule has been put in place that clearly specifies client assignment per shift. - Such schedule will be put in place on a monthly basis so as to ensure that staff are fully aware of client assignment per shift. - Staff have been trained on Client #2's BSP, and the role of one-on-one staff. 	<p>09/01/12</p> <p>08/15/12</p>
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W 127	<p>Continued From page 10</p> <p>diagnosed with a head injury, general assault, and acute alcohol intoxication. It should be noted, however, that the exact circumstances related to his injuries, emergency room admission and release remain unknown. On August 14, 2012, at approximately 11:33 a.m. the facility's house manager notified the OCQIAD that Client #1 was located at Ronald Reagan National Airport</p> <p>On August 15, 2012, at approximately 9:30 a.m., a face to face interview was conducted with the facility's licensed practical nurse (LPN#1) to ascertain information about Client #1's elopement. According to LPN #1, Client #1 arrived home from his day program on August 13, 2012, "upset about something. He did not eat his dinner." Interview with Staff #1 and Staff #2 on August 15, 2012, at approximately 2:08 p.m. and 3:18 p.m. respectively, corroborated the nurse's statement about Client #1's demeanor when he arrived home.</p> <p>Interview with the HM on August 15, 2012, at 3:30 p.m. revealed that Client #1 was upset because he had been accused of stealing Staff #4's hat on the morning of August 13, 2012.</p> <p>Interview with Staff #4 on August 16, 2012, at approximately 2:13 p.m. revealed that as Client #1 was exiting the van on August 13, 2012, he observed his hat protruding from the client's back pocket. Staff #4 stated that he asked Client #1, "Where is my hat?" Client #1 responded by indicating that he did not know the location of the hat.</p> <p>On August 15, 2012, at approximately 3:00 p.m., the qualified intellectual disabilities professional (QIDP) was queried to ascertain if Client #1 had a behavior support plan. The QIDP responded in</p>	W 127	<p>W 127, A</p> <ul style="list-style-type: none"> - An emergency Human Rights Committee (HRC) meeting was held via telephone, on August 14, 2012 to address Client #1 absconding from the facility via the second floor exit. The HRC recommended installing a door chime on the exit door. A door chime has been installed on the door to alert staff whenever Client #1 attempts to leave the facility. - A checklist was put in place to ensure that staff check Client #1 whereabouts hourly to ensure safety. - On August 15, 2012, all staff working with Client #1 received training on a newly developed documentation outlining steps to follow when Client #1 appears angry or having a bad day. 	08/15/12	08/15/12

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W 127	<p>Continued From page 11</p> <p>the affirmative and further revealed that the client had a known history of eloping. Continued discussion with the QIDP revealed that Client #1 had not had any incidents of eloping in the past year. The QIDP revealed that staff were aware of Client #1's elopement history and also stated that they were aware that an antecedent to his eloping included times when he was upset. According to the QIDP however, there were no written protocols for staff to implement should they observe Client #1 upset.</p> <p>Review of Client #1's behavior support plan (BSP) dated June 13, 2013, on August 15, 2012, at approximately 2:00 p.m. verified that "Typically antecedents to his absconding incidents have been situations where he feels he has violated a rule or disappointed a person whom he looks up to. [Client #1] has always shown a strong need for staff approval. Absconding is one of the ways in which he handles the stress he feels when he has done something he believes to be wrong and he anticipates staff disapproval. Other antecedents are delusional or distorted thinking, frustration, stress and during times when he is not adequately monitored." The plan further reflected that fear and guilt about having taken clothing that did not belong to him would provoke an episode of absconding.</p> <p>B. Continued discussion was held with the QIDP on August 15, 2012, to ascertain information regarding what interventions staff should employ when Client #1 exhibited antecedent behaviors to eloping. The QIDP stated that when Client #1 exhibits those behaviors staff should engage the client in conversation to see what is bothering him. Further review of Client #1's BSP revealed that it contained proactive strategies to be</p>	W 127			

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W 127	<p>Continued From page 13 revealed a credible allegation of compliance as evidenced below:</p> <ul style="list-style-type: none"> - An emergency Human Rights Committee (HRC) meeting was held via telephone, on August 14, 2012, to address Client #1 absconding from the facility via the second floor exit door. The HRC recommended installing a door chime on the exit door. In addition, the HRC recommended that staff check on Client #1's whereabouts hourly to ensure he is safe and present in the facility. - On August 15, 2012, all staff received training on a newly developed documentation form to track Client #1's whereabouts while in and out of the facility. - On August 15, 2012, all staff received training on "What to do when Client #1 appears angry or not having a good day." - The two direct support staff (Staff #1 and Staff #2) involved in the incident will be taken off the schedule. - The driver was put on suspension. <p>On August 16, 2012, at approximately 12:00 p.m. a surveyor/investigator from HRLA's OCQAID revisited the facility to verify compliance. At 2:15 p.m., the surveyor/investigator notified the SSA and the qualified intellectual disabilities professional (QIDP) that the IJ was lifted. The facility was informed that although the IJ was removed, the facility remained out of compliance with the conditions of participation in Governing Body, and Client Protections,</p>	W 127	<p>W 127, B</p> <ul style="list-style-type: none"> - The two Direct Care Staff (DCS) who were on shift at the time of the incident were each suspended for two days for failing to adequately supervise Client #1, and also failing to implement interventions specified in the Behavior Support Plan of Client #1. All staff have been trained on proactive strategies and behavior interventions. - The driver was suspended for five days for failing to communicate to other staff on duty what had transpired between him and Client #1 pertaining to the hat issue and how it will impact Client #1's demeanor. 	<p>08/15/12</p> <p>08/15/12</p>

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W 189	<p>483.430(e)(1) STAFF TRAINING PROGRAM</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure staff was provided with initial and continuing training that enabled them to perform their duties effectively, efficiently, and competently, for two of the two clients with maladaptive behaviors. (Clients #1 and #2)</p> <p>The findings include:</p> <p>I. The facility failed to ensure staff were provided with effective training to make certain interventions were implemented to address Client #1's behavior of eloping.</p> <p>a. On August 14, 2012, at approximately 10:25 a.m., the State Surveying Agency's (SSA) Office of Compliance Quality Assurance and Investigations Division (OCQAID), was notified by Comprehensive Care II's program coordinator on August 13, 2012, at 7:15 p.m. that Client #1 eloped from the facility. At approximately 11:33 a.m. on August 14, 2012, the house manager (HM) notified the OCQAID that Client #1 was found at Ronald Reagan National Airport.</p> <p>On August 15, 2012, at approximately 9:30 a.m., a face to face interview was conducted with facility's licensed practical nurse (LPN#1) to ascertain information about Client #1's</p>	W 189			

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W 189	<p>Continued From page 15</p> <p>elopement. According to LPN #1, Client #1 arrived home from his day program on August 13, 2012, "upset about something. He did not eat his dinner." Interview with Staff #1 and Staff #2 on August 15, 2012, at approximately 2:08 p.m. and 3:18 p.m. respectively, corroborated the nurse's statement about Client #1's demeanor when he arrived home.</p> <p>Interview with the HM on August 15, 2012, at 3:30 p.m. revealed that Client #1 was upset because he had been accused of stealing Staff #4's hat on the morning of August 13, 2012. Interview with Staff #4 on August 16, 2012, at approximately 2:13 p.m. revealed that as Client #1 was exiting the van on August 13, 2012, he observed his hat protruding from the client's back pocket. Staff #4 stated that he asked Client #1, "Where is my hat?" Client #1 responded by indicating that he did not know the location of the hat.</p> <p>On August 15, 2012, at approximately 3:00 p.m., the qualified intellectual disabilities professional (QIDP) was queried to ascertain if Client #1 had a behavior support plan. The QIDP responded in the affirmative and further revealed that the client had a known history of eloping. Continued discussion with the QIDP revealed that Client #1 had not had any incidents of eloping in the past year. The QIDP revealed that staff were aware of Client #1's elopement history and also stated that they were aware that an antecedent to his eloping included times when he was upset.</p> <p>Review of Client #1's behavior support plan (BSP) dated June 13, 2013, on August 15, 2012, at approximately 2:00 p.m. verified that</p>	W 189	<p>W 189</p> <ul style="list-style-type: none"> - The two Direct Care Staff (DCS) who were on shift at the time of the incident were each suspended for two days for failing to adequately supervise Client #1, and also failing to implement interventions specified in the Behavior Support Plan of Client #1. All staff have been trained on proactive strategies and behavior interventions. - The driver was suspended for five days for failing to communicate to other staff on duty what had transpired between him and Client #1 pertaining to the hat issue and how it will impact Client #1's demeanor. 	<p>08/15/12</p> <p>08/15/12</p>

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W 189	<p>Continued From page 16</p> <p>"Typically antecedents to his absconding incidents have been situations where he feels he has violated a rule or disappointed a person whom he looks up to. [Client #1] has always shown a strong need for staff approval. Absconding is one of the ways in which he handles the stress he feels when he has done something he believes to be wrong and he anticipates staff disapproval. Other antecedents are delusional or distorted thinking, frustration, stress and during times when he is not adequately monitored." The plan further reflected that fear and guilt about having taken clothing that did not belong to him would provoke an episode of absconding.</p> <p>b. Continued discussion was held with the QIDP on August 15, 2012, to ascertain information regarding what interventions staff should employ when Client #1 exhibited antecedent behaviors to eloping. The QIDP stated that when Client #1 exhibits those behaviors staff should engage the client in conversation to see what is bothering him. Further review of Client #1's BSP revealed that it contained proactive strategies to be utilized for incidents when Client #1 takes something that did not belong to him. The plan reflected that the staff should talk to the client about how he wants others to respect his belongings and should assist the client with returning the item. Review of the facility's training records on August 22, 2012, at 10:00 a.m. verified that staff were trained on Client #1's BSP on April 21, 2012.</p> <p>Interviews with Staff #1 and Staff #2 (the staff members on duty when the client eloped) on August 15, 2012, at approximately 2:08 p.m. and</p>	W 189	<p>W 189</p> <ul style="list-style-type: none"> - On August 15, 2012, all staff working with Client #1 received training on a newly developed documentation outlining steps to follow when Client #1 appears angry or having a bad day. - On every shift, at least one staff will be on the first floor, and one in the living room so that all four residents of the facility are adequately monitored at all times. The House Manager and QIDP will regularly visit the facility unannounced so as to ensure compliance by staff in terms of adequately supervising all four clients. 	08/15/12	08/15/12

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W 189	<p>Continued From page 17</p> <p>3:18 p.m. respectively, revealed that during the time of Client #1's elopement (August 13, 2012 at approximately 7:15 p.m.), neither Staff #1 nor Staff #2 were in close proximity of Client #1. According to the staff, the client was upstairs alone, while Staff #1 was on the first floor and Staff #2 was in the basement. Continued discussion with the staff members revealed that neither staff attempted to implement any of the aforementioned techniques with Client #1 when they observed he was upset.</p> <p>At the time of the investigation, the facility failed to provide evidence that staff were effectively trained to make certain interventions to address Client #1's behavior of eloping were implemented.</p> <p>II. The facility failed to ensure that staff were provided effective training related to the supervision of Client #2.</p> <p>During a tour of the facility on August 15, 2012, at approximately 9:30 a.m., Client #2 was observed in his bedroom with a male staff (Staff #3) standing in the doorway of the room. Interview with Staff #3, at approximately 9:32 a.m. revealed that Client #2 receives 1:1 staffing support for 16 hours a day and he further indicated that he (Staff #3) provides 1:1 supervision from 8:00 a.m. - 4:00 p.m. Continued conversation with Staff #3 revealed that Client #2 gets aggressive and he must be with him at all times.</p> <p>Interview with the house manager (HM) on August 15, 2012, at approximately 3:00 p.m. revealed that there are two direct care staff on</p>	W 189	<p>W 189</p> <ul style="list-style-type: none"> - On August 15, 2012, all staff working with Client #1 received training on a newly developed documentation outlining steps to follow when Client #1 appears angry or having a bad day. - On every shift, at least one staff will be on the first floor, and one in the living room so that all four residents of the facility are adequately monitored at all times. The House Manager and QIDP will regularly visit the facility unannounced so as to ensure staff that staff are complying with adequately supervising all four clients. 	<p>08/15/12</p> <p>08/15/12</p>

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

PRINTED: 09/06/2012
FORM APPROVED
OMB NO. 0938-0391

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W 189	<p>Continued From page 18</p> <p>duty for the evening shift. When asked who was assigned to provide 1:1 services to Client #2 during the evening of August 13, 2012, the HM indicated that staffing assignments are selected by the staff. She stated that whomever's chart they pick, that is the client they [the staff] supervise.</p> <p>Interviews with Staff #1 and Staff #2 on August 15, 2012, at approximately 2:08 p.m. and 3:18 p.m. respectively, revealed that neither staff indicated Client #2 was their assigned client. Staff #2 further indicated that Client #2 only received 1:1 staffing support from 8:00 a.m. to 4:00 p.m. The staff member indicated that Client #2 was to be checked on every half hour to forty-five minutes. He further stated that Client #2 comes down stairs frequently so they see him. Continued discussion with the two staff members revealed that during the time of Client #1's elopement (August 13, 2012 at approximately 7:15 p.m.), neither Staff #1 nor Staff #2 were in close proximity of Clients #1 and #2. According to the staff, both clients were upstairs and Staff #1 was on the first floor while Staff #2 was in the basement.</p> <p>Review of Client #2's June 6, 2012, BSP on August 15, 2012, at approximately 4:00 p.m. verified that the client required sixteen (16) hours of 1:1 supervision. The BSP further reflected that the 1:1 staff should:</p> <p>1. Be physically present at arm's length from [Client #2] during waking hours, while at home at the day program, while on outings and while in the community (from 6:00 a.m. to 10:00 p.m.) in order to ensure minimized physical aggression</p>	W 189	<p>W 189</p> <ul style="list-style-type: none"> - A staffing schedule has been put in place that clearly specifies client assignment per shift. - Such schedule will be put in place on a monthly basis so as to ensure that staff are fully aware of client assignment per shift. - Staff have been trained on Client #2's BSP, and the role of one-on-one staff. 	<p>09/01/12</p> <p>08/15/12</p>	

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W 189	<p>Continued From page 19 against others and absconding.</p> <p>2. The 1:1 staff person may monitor Client #2 at visual distance if the client is in a room with no other occupants.</p> <p>Interview with the QIDP on August 15, 2012, at approximately 4:00 p.m., verified that Client #2 required sixteen hours of 1:1 supervision. When queried to ascertain information about how client supervision is assigned to staff, the QIDP indicated that staff are aware of their assignments. The QIDP further indicated that Staff #2 was assigned to supervise Client #2 on the evening of August 13, 2012. Review of the facility's training records on August 22, 2012 at approximately 10:25 a.m. revealed that the staff received training on Client #2's BSP and proactive strategies on April 21, 2012.</p> <p>Continued discussion with the QIDP on the evening of August 15, 2012, revealed that the QIDP acknowledged that neither Staff #1 nor Staff #2 provided 1:1 supervision to Client #2 as outlined in his BSP.</p> <p>At the time of the investigation, the facility failed to ensure staff were provided effective training necessary to implement the required staffing support for Client #2.</p>	W 189	<p>W 189</p> <ul style="list-style-type: none"> - A staffing schedule has been put in place that clearly specifies client assignment per shift. - Such schedule will be put in place on a monthly basis so as to ensure that staff are fully aware of client assignment per shift. - Staff have been trained on Client #2's BSP, and the role of one-on-one staff. 	09/01/12	08/15/12

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1 000	<p>INITIAL COMMENTS</p> <p>On August 14, 2012, at approximately 10:25 a.m., the State Surveying Agency's (SSA) Office of Compliance, Quality Assurance and Investigations Division (OCQAID), was notified by Comprehensive Care II's program coordinator that on August 13, 2012, at 7:15 p.m. Resident #1 eloped from the group home for persons with intellectual disabilities (GHPID) GHPID. The investigation revealed that while in the community unsupervised, Resident #1 was assaulted then treated and released from Sibley Hospital's emergency room. The client was diagnosed with a head injury, general assault and acute alcohol intoxication. On August 14, 2012, at approximately 11:33 a.m. the GHPID's house manager notified the OCQAID that Resident #1 was located at Ronald Reagan National Airport</p> <p>A surveyor/investigator from the Health Regulation and Licensing Administration (HRLA) conducted an investigation from August 15, 2012, through August 21, 2012, to determine the GHPID's compliance with both federal participation and local licensure requirements for intermediate care facilities for persons with intellectual disabilities participating in the medicaid program. Based on the interview, record review, and the aforementioned findings, it was concluded that the GHPID failed to establish an effective and efficient system to ensure clients' continued safety. Therefore, a determination was made that conditions found, during the investigation, posed an immediate and serious threat to the health and safety of clients residing in the GHPID.</p> <p>On August 16, 2012, at approximately 12:00 p.m. a surveyor/investigator from HRLA's OCQAID revisited the GHPID to verify compliance. At</p>	1 000		

Health Regulation & Licensing Administration

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

TITLE
Adm. Asst.

(X6) DATE
9/25/12

Health Regulation & Licensing Administration

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I 000	Continued From page 1 2:15 p.m., the surveyor/investigator notified the SSA and the qualified intellectual disabilities professional (QIDP) that the conditions that posed a threat to resident health and safety had been abated. The GHPID was informed that although the immediate concern was removed, the GHPID remained out of compliance with the federal and local licensure requirements.	I 000			
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 observations, interviews and record review, the group home for persons with intellectual disabilities (GHPID) failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and federal regulations 42 CFR 483 Sub-Part 1 (for Intermediate Care Facilities for Persons with Mental Retardation), for two of two residents of the GHPID. (Residents #1 and #2) The finding includes: Chapter 13, § 7-1305.10. Mistreatment, neglect or abuse prohibited; use of restraints; seclusion; time-out procedures[formerly § 6-1970] (a) Mistreatment, neglect or abuse in any form of any customer shall be prohibited...	I 500			

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I 500	Continued From page 2 The GIDP failed to ensure systems were designed and implemented to make certain clients were not subject to neglect, for two of two residents. (Residents #1 and #2) A. On August 14, 2012, at approximately 10:25 a.m., the State Surveying Agency's (SSA) Office of Compliance, Quality Assurance and Investigations Division (OCQAID), was notified by Comprehensive Care II's program coordinator that on August 13, 2012, at 7:15 p.m. Resident #1 eloped from the GHPID. The investigation revealed that while in the community unsupervised, Resident #1 was assaulted, then treated and released from Sibley Hospital's emergency room on August 13, 2012 at 11:53 p.m. According to the review of emergency room discharge summary report on August 15, 2012 at approximately 12:45 p.m., the client was diagnosed with a head injury, general assault, and acute alcohol intoxication. It should be noted, however, that the exact circumstances related to his injuries, emergency room admission and release remain unknown. On August 14, 2012, at approximately 11:33 a.m. the GHPID's house manager notified the OCQAID that Resident #1 was located at Ronald Reagan National Airport On August 15, 2012, at approximately 9:30 a.m., a face to face interview was conducted with the GHPID's licensed practical nurse (LPN#1) to ascertain information about Resident #1's elopement. According to LPN #1, Resident #1 arrived home from his day program on August 13, 2012, "upset about something. He did not eat his dinner." Interview with Staff #1 and Staff #2 on August 15, 2012, at approximately 2:08 p.m. and 3:18 p.m. respectively, corroborated the nurse's statement about Resident #1's	I 500	I 500, A - A daily hourly dialogue tracking log has been put in place to be used by staff during a hourly discussion with Client #1 after arriving home from the day program or an activity outside the facility so as to enable staff to determine the demeanor of Client #1. - All staff, including the driver have been retrained on Client #1's Behavior Support Plan (BSP). Emphases of the training were implementation of proactive strategies to behavior aversion, and behavior intervention strategies. - A summary of behavior intervention strategies has been put in place which clearly outlines staff's role when Client #1 is upset. Staff have been trained on the newly developed document. - The facility's psychologist will train staff semi-annually on Client #1's BSP and Client #2's BSP.	09/15/12 08/15/12 08/15/12 08/31/12

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I 500	Continued From page 3 demeanor when he arrived home. Interview with the HM on August 15, 2012, at 3:30 p.m. revealed that Resident #1 was upset because he had been accused of stealing Staff #4's hat on the morning of August 13, 2012. Interview with Staff #4 on August 16, 2012, at approximately 2:13 p.m. revealed that as Resident #1 was exiting the van on August 13, 2012, he observed his hat protruding from the client's back pocket. Staff #4 stated that he asked Resident #1, "Where is my hat?" Resident #1 responded by indicating that he did not know the location of the hat. On August 15, 2012, at approximately 3:00 p.m., the qualified intellectual disabilities professional (QIDP) was queried to ascertain if Resident #1 had a behavior support plan. The QIDP responded in the affirmative and further revealed that the client had a known history of eloping. Continued discussion with the QIDP revealed that Resident #1 had not had any incidents of eloping in the past year. The QIDP revealed that staff were aware of Resident #1's elopement history and also stated that they were aware that an antecedent to his eloping included times when he was upset. According to the QIDP however, there were no written protocols for staff to implement should they observe Resident #1 upset. Review of Resident #1's behavior support plan (BSP) dated June 13, 2013, on August 15, 2012, at approximately 2:00 p.m. verified that "Typically antecedents to his absconding incidents have been situations where he feels he has violated a rule or disappointed a person whom he looks up to. [Resident #1] has always shown a strong need for staff approval. Absconding is one of the ways in which he handles the stress he feels when he has done something he believes to be wrong and he	I 500			

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I 500	<p>Continued From page 6</p> <p>- The driver was put on suspension.</p> <p>C. During a tour of the GHPID on August 15, 2012, at approximately 9:30 a.m., Resident #2 was observed in his bedroom with a male staff (Staff #3) standing in the doorway of the room. Interview with Staff #3, at approximately 9:32 a.m. revealed that Resident #2 receives 1:1 staffing support for 16 hours a day and he further indicated that he (Staff #3) provides 1:1 supervision from 8:00 a.m. - 4:00 p.m. Continued conversation with Staff #3 revealed that Resident #2 gets aggressive and he must be with him at all times.</p> <p>Interview with the house manager (HM) on August 15, 2012, at approximately 3:00 p.m. revealed that there are two direct care staff on duty for the evening shift. When asked who was assigned to provide 1:1 services to Resident #2 during the evening of August 13, 2012, the HM indicated that staffing assignments are selected by the staff. She stated that whomever's chart they pick, that is the client they [the staff] supervise. At the time of the investigation, the HM never provided either a definitive schedule or clear information that indicated the staffing assignment for the evening of August 13, 2012.</p> <p>Interviews with Staff #1 and Staff #2 on August 15, 2012, at approximately 2:08 p.m. and 3:18 p.m. respectively, revealed that neither staff indicated Resident #2 was their assigned client. Staff #2 further indicated that Resident #2 only received 1:1 staffing support from 8:00 a.m. to 4:00 p.m. The staff member indicated that Resident #2 was to be checked on every half hour to forty-five minutes. He further stated that Resident #2 comes down stairs frequently so</p>	I 500	<p>I 500, C</p> <ul style="list-style-type: none"> - A staffing schedule has been put in place that clearly specifies client assignment per shift. - Such schedule will be put in place on a monthly basis so as to ensure that staff are fully aware of client assignment per shift. - Staff have been trained on Client #2's BSP, and the role of one-on-one staff. 	<p>09/01/12</p> <p>08/15/12</p>

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I 500	Continued From page 5 Based on the aforementioned findings, it was concluded that the GHPID failed to establish an effective and efficient system to ensure clients' continued safety. Therefore, a determination was made that conditions found posed an immediate and serious threat to the health and safety of residents residing in the GHPID. On August 15, 2012, at approximately 4:06 p.m., the provider's administrator was notified that an immediate jeopardy (IJ) existed. On August 15, 2012, at approximately 10:19 p.m., the provider submitted a plan to address the IJ. The plan revealed a credible allegation of compliance as evidenced below: - An emergency Human Rights Committee (HRC) meeting was held via telephone, on August 14, 2012, to address Resident #1 absconding from the GHPID via the second floor exit door. The HRC recommended installing a door chime on the exit door. In addition, the HRC recommended that staff check on Resident #1's whereabouts hourly to ensure he is safe and present in the GHPID. - On August 15, 2012, all staff received training on a newly developed documentation form to track Resident #1's whereabouts while in and out of the GHPID. - On August 15, 2012, all staff received training on "What to do when Resident #1 appears angry or not having a good day." - The two direct support staff (Staff #1 and Staff #2) involved in the incident will be taken off the schedule.	I 500	I 500, B (1,2, 3) - An emergency Human Rights Committee (HRC) meeting was held via telephone, on August 14, 2012 to address Client #1 absconding from the facility via the second floor exit. The HRC recommended installing a door chime on the exit door. A door chime has been installed on the door to alert staff whenever Client #1 attempts to leave the facility. - A checklist was put in place to ensure that staff check Client #1 whereabouts hourly to ensure safety. - On August 15, 2012, all staff working with Client #1 received training on a newly developed documentation outlining steps to follow when Client #1 appears angry or having a bad day.	 08/15/12 08/15/12 08/15/12

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I 500	Continued From page 8 Staff #2 provided 1:1 supervision to Resident #2 as outlined in his BSP. At the time of the investigation, the GHPID failed to ensure staff were provided clear instructions on their staffing assignments in order to provide for the health and safety of the clients.	I 500	I 500, C - A staffing schedule has been put in place that clearly specifies client assignment per shift. - Such schedule will be put in place on a monthly basis so as to ensure that staff are fully aware of client assignment per shift. - Staff have been trained on Client #2's BSP, and the role of one-on-one staff.	 09/01/12 08/15/12