STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	09G212		07/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE LIFE SOULTIONS, INC	7416 BLAIR ROAD, NW WASHINGTON, DC 20012

(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
W 159	Continued From page 30 April 13, 2013, revealed Client #1 had maladaptive behaviors that included physical aggression, self-injurious behaviors (physical discomfort from allergies), taking drinks and impulsiveness. Further review revealed that 1:1 supervision was needed for behavior support implementation and to ensure the safety of the client, given the high level of risk of several of his target behaviors. The BSP also added that 1:1 support staff should be between arm's length and five feet from the client during awaking hours. Note: It should be noted that on July 18, 2013, beginning at 10:50 a.m., interview with the former residential counselor (RC) revealed that it was her expectation that 1:1 staff were to remain within arm's length of their assigned clients throughout their shift. A telephone interview conducted with the former qualified intellectual disabilities professional on July 19, 2013, beginning at 1:33 p.m., verified the former RC's interview. 2. The QIDP failed to integrate services to ensure Client #3 received 1:1 support services as recommended. Interview with the former residential coordinator (RC) on July 18, 2013 beginning at 10:50 a.m. revealed that there were five clients residing in the facility. According to the former RC, three of the clients currently receive 1:1 staffing supports, sixteen hours per day, seven days a week. The former RC further revealed that Client #3 was recommended to receive 1:1 staffing support but didn't because the facility was not being compensated for that service. Further discussion	W 159		

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W 159	Continued From page 31 with the RC and review of Client #3's record on July 19, 2013 at approximately 12:31 p.m. revealed the client's individual support plan dated May 13, 2013, document 1:1 supervision was recommended. Further review of the client's record revealed a psychological assessment dated April 7, 2013 that documented, "Given [the client's] current gait deficits, it is recommended that he receive one to one staff support to ensure his safety." Interview with the former QIDP on June 19, 2013 beginning at 1:19 p.m. revealed that she was aware of the recommendation. According to the former QIDP, the 1:1 had not been implemented at the time of the investigation.	W 159		
W 185	483.430(c)(4) FACILITY STAFFING The facility must provide sufficient support staff so that direct care staff are not required to perform support services to the extent that these duties interfere with the exercise of their primary direct client care duties. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure there was a sufficient number of staff on duty to make certain chore activities did not interfere with established one to one duties and responsibilities, for one of three clients in the investigation. (Client #2) The finding includes: [Cross Refer to W104] On July 10, 2013, Client #2 sustained an injury to his right eye and was transported by emergency medical services to a	W 185	W 185 The facility schedule has been revised to ensure that there is sufficient staff on duty to remain compliant. The QIDP and Facility Manager have been in-serviced on monitoring the schedule daily and notifying the HR department for relief or supplemental staffing for vacancies or call-outs. In the future the Facility Manager and the QIDP will ensure that there is daily oversight of the staff so as to maintain the required ratios to remain compliant and provide safety. Attached : • Staff schedule • 1:1 job description • Disciplinary action for involved staff	8/22/13

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W 185	Continued From page 32 local hospital's emergency room. Interview with staff and the review of the facility's internal investigation revealed that the client fell in his bathroom during the 4:00 p.m. - 12:00 a.m. shift. On July 15, 2013, beginning at 1:13 p.m., interview with DSP #8 revealed he was scheduled to work with Client #2 as his 1:1 staff on July 10, 2013, during the 4:00 p.m. to 12:00 a.m. shift. At approximately 11:45 p.m., DSP #8 stated that he informed DSP #4 (who was on the computer doing his end of the shift notes) that he was going downstairs to the basement to start his chores and some laundry. DSP #8 stated that he was in the basement for approximately 5 to 7 minutes. DSP #8 stated that while walking back upstairs from the basement, he heard a thump/shuffle that came from Client #2's bedroom. He stated that he immediately dropped the mop and bucket and rushed to Client #2's bedroom. According to DSP #8, he had to complete the chores before his shift ended at midnight. Furthermore, DSP #8 revealed that there was usually a third staff on duty to assist with chores and to provide closer supervision to Clients #3 and #4. Interview with the former residential coordinator (RC) on July 18, 2013, at beginning 10:50 a.m., and review of records on July 19 2013, at approximately 3:00 p.m., confirmed that a third person should have been on duty to assist with chores and to provide closer supervision to Clients #3 and #4. Continued interview with the former RC revealed she was not aware that there were only two staff on duty that at the time of the incident on July 10, 2013.	W 185		
W 186	483.430(d)(1-2) DIRECT CARE STAFF	W 186		

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W 186	Continued From page 33 The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide sufficient staffing and one to one (1:1) supervision to protect clients from harm and to ensure their safety, for two of the four clients in the investigation. (Clients #1 and #2) The findings include: During the course of an investigation initiated on July 9, 2013, it was discovered that on July 10, 2013, Client #2 fell on his bathroom floor at 11:50 p.m. The client was taken to the emergency room via 911 and received several stitches to his right eyebrow. Direct Support Professional (DSP) #8 and DSP #4 failed to ensure Clients #1 and #2 were properly supervised and/or monitored in accordance with their behavior support plans (BSPs), as evidenced by the following: a. On July 15, 2013, beginning at 1:13 p.m., interview with DSP #8 revealed that he was assigned to work with Client #2 as his one to one (1:1) staff on July 10, 2013, during the 4:00 p.m. to 12:00 a.m. shift. DSP #8 stated that when he arrived to work at 9:09 p.m., all clients were in bed asleep. At approximately 10:30 p.m., DSP #8	W 186	W 186 The facility schedule has been revised to ensure that there is sufficient staff on duty to remain compliant and the staffing ratios meet the regulatory standards. The QIDP and Facility Manager have been in-serviced on monitoring the schedule daily and notifying the HR department for relief or supplemental staffing for vacancies or call-outs. In the future the Facility Manager and the QIDP will ensure that there is daily oversight of the staff so as to maintain the required ratios to remain compliant and provide safety. Attached : • Staff schedule • 1:1 job description • Disciplinary action for involved staff	8/22/13

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W 186	Continued From page 34 stated that he walked the qualified intellectual disabilities professional (QIDP) #1 to her car because it was dark outside. At approximately 11:45 p.m., DSP #8 stated that he informed DSP #4 that he was going downstairs to the basement to start his chores and complete some laundry. He stated that he was in the basement for approximately five to seven minutes. DSP #8 stated that while walking back upstairs, he heard a thump/shuffle that came from Client #2's bedroom. According to DSP #8, he stated that he dropped the mop and bucket and rushed to the client's room. As he stepped inside the bedroom, he indicated he witnessed Client #2 falling to the floor in the bathroom. DSP #8 stated that DSP #4 came running behind him and after observing the client's injury he said, "I'm going to get the first aid kit." Client #2 sustained a severe injury to his upper right eyebrow and eventually went to a local hospital's emergency room via 911 emergency services. As a result of the injury, Client #2 received eleven stitches to his right eyebrow. When asked, DSP #8 stated that he knew he was supposed to remain within arm's length of Client #2 at all times in accordance with the BSP. On July 11, 2013, at approximately 5:00 p.m., review of Client #2's BSP dated April 13, 2013, revealed that although the client was ambulatory, his gait issue had deteriorated and his risk for falls had increased. Further review of Client #2's BSP revealed that one to one (1:1) staffing was needed for the implementation of the BSP and to ensure the safety of the client. The BSP also added that 1:1 support staff should be between arm's length and five feet from the client during awaking hours.	W 186		

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W 186	Continued From page 35 b. On July 11, 2013, at approximately 8:30 p.m., interview with DSP #4 revealed he was assigned to work with Client #1 as his 1:1 staff on July 10, 2013, during the 4:00 p.m. to 12:00 a.m. shift. At approximately 11:30 p.m., DSP #4 revealed that he was in the dining room area working on the computer to complete his evening notes while Client #1 remained asleep inside his bedroom. Between 11:40 p.m. - 11:45 p.m., DSP #4 stated that DSP #8 informed him that he was going downstairs to work on the laundry and to get the mop bucket. Admittedly, DSP #4 stated that he was not within arm's length at all times once the client went to be bed between 8:30 p.m. - 9:00 p.m. DSP #4 also stated that he remained outside of Client #1's bedroom and checked on him every 30 minutes. On July 10, 2013, beginning at approximately 5:10 p.m., review of the Client #1's BSP dated April 13, 2013, revealed Client #1 had maladaptive behaviors that included physical aggression, self-injurious behaviors (physical discomfort from allergies), taking drinks and impulsiveness. Further review revealed that 1:1 supervision was needed for behavior support implementation and to ensure the safety of the client, given the high level of risk of several of his target behaviors. The BSP also added that 1:1 support staff should be between arm's length and five feet from the client during awaking hours. On July 11, 2013, at approximately 4:00 p.m., review of the staff training records revealed all staff had received training on Client #1's and Client #2's BSP on June 20, 2013. However, there was no evidence that training had been effective.	W 186		

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W 186	Continued From page 36 Note: Interview with the facility's former residential coordinator (RC) on July 18, 2013, beginning at 10:50 a.m., revealed that Clients #1 and #2 received one to one (1:1) staffing support 16 hours per day, 7 days a week. According to the former RC, the clients were to receive arm's length 1:1 staffing support from 8:00 a.m. through 12:00 a.m., which was considered waking hours. Interview with the former qualified intellectual disabilities professional (QIDP) on July 19, 2013, via telephone, verified the former RC's statement.	W 186		
W 192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure staff was effectively trained to address a client's change in health status, for one of four clients in the investigation. (Client #3) The finding includes: The facility staff failed to ensure Client #2 received timely medical treatment to his injured right eye. [Cross Refer to W104] On July 10, 2013, Client #2 sustained an injury to his right eye and was transported by emergency medical services to a local hospital's emergency room. Interview with staff and the review of the facility's internal investigation revealed that the client fell in his bathroom during the 4:00 p.m. - 12:00 a.m. shift.	W 192	W 192 In the future the agency will ensure that all individuals requiring emergency medical attention receive it in the appropriate time. The agency has increased its professional oversight and has employed personnel for a VP of Disablity services position and a Program Director position for the ICF homes. All staff and management were re-in serviced on the revised Incident Management Process.	

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W 192	Continued From page 37 On July 15, 2013, beginning at 1:13 p.m., interview with DSP #8 revealed that on July 10, 2013, at approximately 12:00 a.m., he called the former residential coordinator (RC) to inform her of Client #2's injury to the right eye. Further interview with DSP #8 revealed that he received a call from the former qualified intellectual disabilities professional (QIDP) at approximately 12:10 a.m. who instructed him to send Client #2 to the emergency room via 911 emergency medical services. DSP #8 stated that he did not call emergency services right away because he was waiting for a phone call from the facility's nurse. DSP #8 further revealed that the former QIDP called back appropriately 20 minutes to see if Client #2 had gone to the emergency room and discovered that the client had not gone to the hospital. The former QIDP again, instructed DSP #8 to call 911. DSP #8 stated that he called 911 and Client #2 reached the hospital emergency room at approximately 1:00 a.m. In a telephone interview with the former QIDP on July 19, 2013, beginning at 1:33 p.m., it was revealed that she received a call from the former RC who informed her that Client #2 sustained a severe injury to the right eye on of July 10, 2013. The former QIDP revealed that she called the facility at approximately 12:05 a.m. and instructed DSP #8 to transport Client #2 to the hospital via the company van. The former QIDP stated that she called back to the facility approximately 25 minutes to ensure that Client #2 was transported to the hospital and again, she talked with DSP #8. The former QIDP revealed that DSP #8 and Client #2 were still in the facility. At that time, she instructed DSP #8 to send Client #2 to the emergency room, via 911. It should be noted, according to the investigation	W 192	Attached: • Incident Management Process with timelines • Emergency medical procedures • BSP & CPI training • 1:1 job description • Staff schedule • PT in-service • Active treatment • HRC – emergency approval for interim 1:1 staff • Acuity package to DHCF – receipt • Disciplinary action for involved staff •	8/25/13

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W 192	Continued From page 38 report and interviews conducted during the investigation, the exact time of the incident was not consistent. Interview with DSP #4 on July 11, 2013, at 8:40 p.m. revealed the documented time of the incident was incorrect. DSP #4 revealed that the incident occurred some time between 10:40 p.m. and 10:45 p.m. Interview with DSP #8 on July 15, 2013, beginning at 1:13 p.m., however revealed the incident occurred at 11:50 p.m. At the time of the investigation, the specific time of the incident remained unknown. On July 19, 2013 at 6:28 p.m., the Health Regulation and Licensing Administration received a copy of the emergency medical services event chronology for the incident involving Client #2 on July 10-11, 2013. According to the document, emergency medical services recieved a request for assistance from the facility at 12:33 a.m. on July 11, 2013. The ambulance arrived to transport Client #2 at 12:41 a.m. At the time of the investigation, the facility failed to ensure staff were effectively trained to ensure client's received timely emergency medical services.	W 192		
W 193	483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on interview and record verification, the facility's staff failed to demonstrate the skills and techniques necessary to implement each client's behavior support plan (BSP), for one of the four clients in the investigation with maladaptive behaviors. (Client #1)	W 193		

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W 193	Continued From page 39 The finding includes: [Cross refer to W249.1]. Review of an unusual incident report on July 9, 2013, at approximately 3:50 p.m., revealed Client #1 engaged in a self-injurious behavior (SIB) that resulted in an injury to his right eye (swollen, red and puffy). Reportedly, Client #1 hit himself on the right side of his face several times non-stop from 8:25 a.m. to 8:36 a.m. The client was taken to the ophthalmologist and was diagnosed with a contusion to the right eye. On July 17, 2013, at approximately 12:30 p.m., review of the facility's internal investigation, completed on July 16, 2013, revealed the IMC documented that the aforementioned allegation of abuse and neglect was resolved and was unsubstantiated. In a face to face interview with DSP #1 on July 10, 2013, beginning at 9:48 a.m., the staff member revealed he/she was assigned to Client #1 as his one to one (1:1) staffing support on the morning of July 9, 2013, from 8:00 a.m. to 4:00 p.m. due to the client's maladaptive behaviors of physical aggression and self-injurious behaviors (SIB). DSP #1 revealed that at 8:09 a.m., Client #1 was sitting in a chair in the living room drinking coffee and was observed to "smack" himself on the right side of his face with his right hand five (5) times. DSP #1 stated that Client #1 was redirected and "eventually stopped". At 8:25 a.m. until 8:36 a.m., Client #1 began hitting himself again "extremely hard" on the right side of his face non-stop to the point where swelling was observed underneath his right eye and on the right side of his face. DSP #1 stated DSP #3 verbally prompted Client #2 to stop, but the client did not respond and continued to hit himself. DSP	W 193	W 193 All staff were re in-serviced on the BSP, CPI and 1:1 training. The psychologist will be providing on-going training to equip the staff in recognizing attachment needs, non-verbal communication, positive behavioral supports, emotional vs intelligence expression, executive functioning, therapeutic activities and games and learning principles. These training courses will be provided to the staff on an on-going basis. Attached: • Course outline and schedule • Active Treatment • 1:1 job description and training • BSP & CPI training • Staff schedule • PT in-service • Active treatment • HRC – emergency approval for interim 1:1 staff • Acuity package to DHCF – receipt • Disciplinary action for involved staff	8/26/13

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W 193	Continued From page 40 #1 stated that she provided no other intervention. When queried about implementing the BSP, DSP #1 replied by saying, "I was shocked! What could I do, he's stronger that I am." DSP #1 stated that she had received training on Client #1's behavior support plan (BSP) and crisis prevention interventions (CPI). Interview with DSP #2 on July 10, 2013, beginning at 10:44 a.m. revealed that on the morning of July 9, 2013, she provided Client #1 with his morning cup of coffee after 8:00 a.m. At approximately 8:10 a.m., Client #1 was observed to hit himself in the face twice while drinking coffee. DSP #2 stated that she verbally prompted the client to stop. According to DSP #2, Client #1 stopped hitting himself and finished his coffee. DSP #2 stated that Client #1 "signed for another cup of coffee" but did not get it. At 8:25 a.m., DSP #2 stated that Client #1 began slapping himself with his right hand to the right side of his face "extremely hard". The slaps were "very loud and it was scary. I was shocked!" DSP #2 stated that she provided no intervention. DSP #2 then stated that DSP #3 walked toward Client #1 and verbally prompted the client to calm down but was unsuccessful. Interview with DSP #3 on July 10, 2013, beginning at 11:16 a.m., revealed that on the morning of July 9, 2013, he was the 1:1 staff for Client #2. DSP #3 revealed that he was positioned in the living room with Client #1 at the time the injury occurred. At approximately 8:25 a.m., DSP #3 stated that he observed Client #1 hit himself 4 to 5 times in the face "very hard". DSP #3 stated that DSP #1 (who was assigned as Client #1's 1:1 support staff) jumped up and moved away from Client #1. DSP #3 verbally	W 193		

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W 193	Continued From page 41 prompted the [client] to calm down and asked, "Are you ok?" DSP #3 then stated that Client #1 continued to hit himself in the face repeatedly and that's when DSP #3 walked over to the client and placed the client's hands on his legs with my hands on top of his hands and said, "Calm down, its ok." DSP #3 stated that when he walked back over to his client, Client #1 began hitting himself again. DSP #3 stated that he informed DSP #1 to go get Client #1 some water. DSP #3 went back over to Client #1 and the client used his left hand to shield the DSP from his space, and continued to hit himself in the face. At that time, DSP #3 noticed with each hit, Client #1's face began to get red and underneath his eye began to puff up. According to DSP #3, shortly after drinking some water, Client #1 hit himself a few more time. DSP #3 stated that he walked over to Client #1 and stated, "That's enough" in a firm voice. On July 10, 2013, at approximately 2:00 p.m., review of the Client #1's BSP revealed it included interventions to address the client's targeted behavior of SIB. The BSP stated that if the client begins to engage in SIB, staff should first attempt to verbally redirect him away from this and toward an activity. "For example, staff may offer to take the client for a walk, offer choices, engage the client in an activity using his hands, etc." If Client #1 does not respond to verbal redirection, and presents a danger to himself or others, staff may refer to the crisis intervention plan, which includes one or two person escort and/or any relevant blocks or releases to assist Client #1. At the time of the investigation, there was no evidence the aforementioned interventions were utilized to address Client #1's observed behavior. It should be noted, that review of the staff training records on July 11, 2013, at approximately 4:00	W 193		

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W 193	Continued From page 42 p.m., revealed all staff had received training on Client #1's BSP on June 19, 2013. Further review of the records revealed DSP #1, DSP #2 and DSP #3 all received Crisis Prevention Intervention (CPI) training on May 7, 2013 and May 9, 2013.	W 193		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION 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 observation, interview and record review, the facility staff failed to ensure each client's behavior support plan (BSP) was implemented consistently, for two of the four clients in the investigation with maladaptive behaviors. (Clients #1 and #2) The findings include: 1. On July 9, 2013, the facility staff failed to implement proactive strategies that were outlined in Client #1's behavior support plan (BSP), as evidenced by the following: In a face to face interview with DSP #1 on July 10, 2013, beginning at 9:48 a.m., the staff member revealed he/she was assigned to Client #1 as his one to one (1:1) staffing support on the	W 249	W 249 All staff were re in-serviced on the BSP, CPI and 1:1 training. The psychologist will be providing on-going training to equip the staff in recognizing attachment needs, non-verbal communication, positive behavioral supports, emotional vs intelligence expression, executive functioning, therapeutic activities and games and learning principles. These training courses will be provided to the staff on an on-going basis. Attached: • In service – BSP and CPI • Introduction to Mental Health, group dynamics, activity therapies, general psychology, human growth & development, child & adolescent psychology, introduction to abnormal psychology and educational psychology - Course outline and schedule • Active Treatment • 1:1 job description and training	8/26/13

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W 249	Continued From page 43 morning of July 9, 2013, from 8:00 a.m. to 4:00 p.m. due to the client's maladaptive behaviors of physical aggression and self-injurious behaviors (SIB). DSP #1 revealed that at 8:09 a.m., Client #1 was sitting in a chair in the living room drinking coffee and was observed to "smack" himself on the right side of his face with his right hand five (5) times. DSP #1 stated that Client #1 was redirected and "eventually stopped". At 8:25 a.m. until 8:36 a.m., Client #1 began hitting himself again "extremely hard" on the right side of his face non-stop to the point where swelling was observed underneath his right eye and on the right side of his face. DSP #1 stated DSP #3 verbally prompted Client #2 to stop, but the client did not respond and continued to hit himself. DSP #1 stated that she provided no other intervention. When queried about implementing the BSP, DSP #1 replied by saying, "I was shocked! What could I do, he's stronger that I am." DSP #1 stated that she had received training on Client #1's behavior support plan (BSP) and crisis prevention interventions (CPI). Interview with DSP #2 on July 10, 2013, beginning at 10:44 a.m. revealed that on the morning of July 9, 2013, she provided Client #1 with his morning cup of coffee after 8:00 a.m. At approximately 8:10 a.m., Client #1 was observed to hit himself in the face twice while drinking coffee. DSP #2 stated that she verbally prompted the client to stop. According to DSP #2, Client #1 stopped hitting himself and finished his coffee. DSP #2 stated that Client #1 "signed for another cup of coffee" but did not get it. At 8:25 a.m., DSP #2 stated that Client #1 began slapping himself with his right hand to the right side of his face "extremely hard". The slaps were "very loud and it was scary. I was shocked!" DSP #2 stated	W 249		

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W 249	Continued From page 44 that she provided no intervention. DSP #2 then stated that DSP #3 walked toward Client #1 and verbally prompted the client to calm down but was unsuccessful. Interview with DSP #3 on July 10, 2013, beginning at 11:16 a.m., revealed that on the morning of July 9, 2013, he was the 1:1 staff for Client #2. DSP #3 revealed that he was positioned in the living room with Client #1 at the time the injury occurred. At approximately 8:25 a.m., DSP #3 stated that he observed Client #1 hit himself 4 to 5 times in the face "very hard". DSP #3 stated that DSP #1 (who was assigned as Client #1's 1:1 support staff) jumped up and moved away from Client #1. DSP #3 verbally prompted the [client] to calm down and asked, "Are you ok?" DSP #3 then stated that Client #1 continued to hit himself in the face repeatedly and that's when DSP #3 walked over to the client and placed the client's hands on his legs with my hands on top of his hands and said, "Calm down, its ok." DSP #3 stated that when he walked back over to his client, Client #1 began hitting himself again. DSP #3 stated that he informed DSP #1 to go get Client #1 some water. DSP #3 went back over to Client #1 and the client used his left hand to shield the DSP from his space, and continued to hit himself in the face. At that time, DSP #3 noticed with each hit, Client #1's face began to get red and underneath his eye began to puff up. According to DSP #3, shortly after drinking some water, Client #1 hit himself a few more time. DSP #3 stated that he walked over to Client #1 and stated, "That's enough" in a firm voice. On July 10, 2013, beginning at approximately 5:10 p.m., review of Client #1's BSP dated April 13, 2013, revealed Client #1 had maladaptive	W 249		

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W 249	Continued From page 45 behaviors that included physical aggression, SIB (physical discomfort from allergies), taking drinks and impulsiveness. Further review revealed that 1:1 supervision is needed for behavior support implementation, and to ensure the safety of the client, given the high level of risk of several of his target behaviors. Continued review of the BSP revealed that if Client #1 engaged in SIB, staff should implement the following proactive strategies: a. Whenever possible, he [client] should be redirected before he actually attempts to engage him in this behavior. b. As soon as it is feasible, staff should attempt to identify the stimulus for this behavior. This includes if Client #1 is only beginning to become agitated. If a stimulus can be ID, staff should attempt to address this as soon as possible. c. If Client #1 begins to engage in SIB, staff should first attempt to verbally redirect him away from this and toward an activity. For example, staff may offer to take the client for a walk, offer an activity using his hands, assist with the laundry, offer choices, etc. Staff may say in a calm but firm voice, "Please stop (state behavior)!" d. If the client does not respond to verbal redirection and continues to engage in SIB, staff should refer to the crisis intervention plan. Review of the crisis intervention plan revealed that if Client #1 became agitated and began to present a danger to himself or others, staff may use the least restrictive, least intrusive strategy possible. Implement a program-approved by the	W 249		

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W 249	Continued From page 46 facility. For example, staff could use supportive physical techniques, one or two person escort and/or any relevant blocks or releases to assist Client #1. At the time of the investigation, the facility failed to ensure Client #1's BSP was implemented as outlined. 2. Direct Support Professional (DSP) #8 and DSP #4 failed to ensure Clients #1 and #2 were properly supervised and/or monitored in accordance with their behavior support plans (BSPs), as evidenced by the following: a. On July 15, 2013, beginning at 1:13 p.m., interview with DSP #8 revealed that he was assigned to work with Client #2 as his one to one (1:1) staff on July 10, 2013, during the 4:00 p.m. to 12:00 a.m. shift. DSP #8 stated that when he arrived to work at 9:09 p.m., all clients were in bed asleep. At approximately 10:30 p.m., DSP #8 stated that he walked the qualified intellectual disabilities professional (QIDP) #1 to her car because it was dark outside. At approximately 11:45 p.m., DSP #8 stated that he informed DSP #4 that he was going downstairs to the basement to start his chores and complete some laundry. He stated that he was in the basement for approximately five to seven minutes. DSP #8 stated that while walking back upstairs, he heard a thump/shuffle that came from Client #2's bedroom. According to DSP #8, he stated that he dropped the mop and bucket and rushed to the client's room. As he stepped inside the bedroom, he indicated he witnessed Client #2 falling to the floor in the bathroom. DSP #8 stated that DSP #4	W 249		

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W 249	Continued From page 47 came running behind him and after observing the client's injury he said, "I'm going to get the first aid kit." Client #2 sustained a severe injury to his upper right eyebrow and eventually went to a local hospital's emergency room via 911 emergency services. As a result of the injury, Client #2 received eleven stitches to his right eyebrow. When asked, DSP #8 stated that he knew he was supposed to remain within arm's length of Client #2 at all times in accordance with the BSP. On July 11, 2013, at approximately 5:00 p.m., review of Client #2's BSP dated April 13, 2013, revealed that although the client was ambulatory, his gait issue had deteriorated and his risk for falls had increased. Further review of Client #2's BSP revealed that one to one (1:1) staffing was needed for the implementation of the BSP and to ensure the safety of the client. The BSP also added that 1:1 support staff should be between arm's length and five feet from the client during awaking hours. b. On July 11, 2013, at approximately 8:30 p.m., interview with DSP #4 revealed he was assigned to work with Client #1 as his 1:1 staff on July 10, 2013, during the 4:00 p.m. to 12:00 a.m. shift. At approximately 11:30 p.m., DSP #4 revealed that he was in the dining room area working on the computer to complete his evening notes while Client #1 remained asleep inside his bedroom. Between 11:40 p.m. - 11:45 p.m., DSP #4 stated that DSP #8 informed him that he was going downstairs to work on the laundry and to get the mop bucket. Admittedly, DSP #4 stated that he was not within arm's length at all times once the client went to be bed between 8:30 p.m. - 9:00 p.m. DSP #4 also stated that he remained	W 249		

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W 249	Continued From page 48 outside of Client #1's bedroom and checked on him every 30 minutes. On July 10, 2013, beginning at approximately 5:10 p.m., review of the Client #1's BSP dated April 13, 2013, revealed Client #1 had maladaptive behaviors that included physical aggression, self-injurious behaviors (physical discomfort from allergies), taking drinks and impulsiveness. Further review revealed that 1:1 supervision was needed for behavior support implementation and to ensure the safety of the client, given the high level of risk of several of his target behaviors. The BSP also added that 1:1 support staff should be between arm's length and five feet from the client during awaking hours. Note: It should be noted that on July 18, 2013, beginning at 10:50 a.m., interview with the former residential counselor (RC) revealed that it was her expectation that 1:1 staff were to remain within arm's length of their assigned clients throughout their shift. A telephone interview conducted with the former qualified intellectual disabilities professional on July 19, 2013, beginning at 1:33 p.m., verified the former RC's interview.	W 249		
W 318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on interviews and record verification, the facility failed to provide preventive health care	W 318	W 318/W 322 The agency has developed a system to ensure that all individuals receive appropriate and timely medical attention and oversight. • The assigned caseload for the medication administration nursing staff has been reduced. • All nursing staff have received an in-service on telephone triaging – also received a text book – telephone triage • All nurses meet with the DON, for weekly training and submission of a weekly report on the status of the individuals in their case load. • The DON submits a weekly health status report to the senior management team.	

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W 318	Continued From page 49 services to meet one client's assessed needs [See W322] and failed to ensure skilled nursing services, to ensure one client's health and safety [See W331]. The effects of these systemic practices resulted in the demonstrated failure of the facility to provide health care services.	W 318	• The bowel movement management process has been revised to increase nurse oversight and accountability at the residential and day program locations. • The PRN laxative process and procedure has been developed for individuals receiving laxatives and for those individuals who need to have their BMs monitored on a daily basis	8/25/13
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the provision of general care by making certain a client's bowel movements were comprehensively monitored and treatment was rendered consistently. Additionally, the facility failed to ensure a client received timely emergency medical services, for one of five clients in the investigation. (Client #5) The finding includes: 1. The facility failed to ensure Client #5's order for milk of magnesia was clarified and understood to make certain it was administered consistently. Interview with the facility's former house manager on July 22, 2013, beginning at 11:00 a.m. revealed there was a concern regarding the management and documentation of Client #5's bowel movements.	W 322	• The medication nurse involved with this situation has been placed on administrative leave pending the closure of this investigation • A weekly system of RN Supervisor oversight of all MARs to ensure accuracy in medication administration. • All the nursing and direct support staff have been in-serviced on the following: • Medication administration policy and procedure – address physician's signature for verbal orders, PRN orders, MARs – documentation of PRN orders and efficacy of PRN medication • Emergency medical procedure, transportation and notification process • 'PRN laxative' process and procedure and documentation • Daily BM monitoring procedure • Medication nurse schedule • 1:1 job description – function during emergencies	

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W 322	Continued From page 50 Review of Client #5's July 2013 physician's orders (POS) on July 30, 2013, at approximately 4:02 p.m. revealed the client had diagnoses that included sigmoid diverticula. Additional review of the client's POS from January 2013 through July 2013 revealed the client was prescribed medications including Surfak (for constipation discontinued on May 3, 2013), Ducosate Sodium (stool softener ordered to begin on May 3, 2013) and Milk of Magnesia (as needed for constipation). Review of the Client #5's record on July 30, 2013, at 2:50 p.m. revealed that client's daily bowel movement frequency was being documented by facility staff on a form entitled, "Bowel Elimination Record." According to the bowel movement records from January 2013 to July 2013, the following was noted: February 2013 2/9/13 - no bowel movement noted. The elimination record documented that milk of magnesium had been given. 2/16/13 - 2/18/13 - no bowel movement noted. The elimination record further documented that on 2/17/13, Client #5 "complained of stomach pain, sat on the toilet, but no bowel movement." 2/22/13 -2/23/13 - no bowel movement noted. Review of the corresponding February 2013 MAR on July 30, 2013 beginning at 5:44 p.m. verified that MOM was administered on February 9, 2013. Continued review of the MAR revealed that the MOM was given at 7:00 p.m. for constipation. The nurse documented that the results of the medication was "effective" but, the nurse failed to document the time he/she verified the	W 322	The agency has developed a system to ensure that all individuals receive appropriate and timely medical attention and oversight. • The assigned caseload for the medication administration nursing staff has been reduced. • All nursing staff have received an in-service on telephone triaging – also received a text book – telephone triage • All nurses meet with the DON, for weekly training and submission of a weekly report on the status of the individuals in their case load. • The DON submits a weekly health status report to the senior management team. • The bowel movement management process has been revised to increase nurse oversight and accountability at the residential and day program locations. • The PRN laxative process and procedure has been developed for individuals receiving laxatives and for those individuals who need to have their BMs monitored on a daily basis • The medication nurse involved with this situation has been placed on administrative leave pending the closure of this investigation • A weekly system of RN Supervisor oversight of all MARs to ensure accuracy in medication administration. • All the nursing and direct support staff have been in-serviced on the following:	

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W 322	Continued From page 51 medication's effectiveness. Furthermore, there was no evidence to support how the medication was determined to be effective. March 2013 3/10/13 - 3/12/13 - no bowel movement noted. The elimination record further documented that on 3/12/13, Client #5 "appeared as if he was attempting to have a bowel movement, just grunting." It should be noted that the record indicated the client had a small hard bowel movement on 3/13/13. Review of the corresponding March 2013 MAR on July 30, 2013 beginning at 5:46 p.m. revealed no evidence that the MOM was given the entire month of March 2013. May 2013 5/5/13 - no bowel movement noted. 5/9/13 - 5/12/13 - no bowel movement noted. 5/24/13 - 5/26/13 - no bowel movement noted. 5/28/13 - 5/29/13 - no bowel movement noted. There was no area on the available bowel movement elimination record to document a description of the client's bowel elimination on 5/30/13 - 5/31/13. Review of the corresponding March 2013 MAR on July 30, 2013 beginning at 5:50 p.m. revealed MOM was administered on May 12, 2013 (8:00 p.m.), May 26, 2013 (4:00 p.m.), and May 31, 2013 (6:00 p.m.), because the client had not had a bowel movement for three days. The nurse(s) documented that the results of the medication was "effective" on May 12, 2013 and May 31, 2013 but failed to document any results on May 26, 2013. Additionally, the nurse(s) failed to document the time he/she verified the	W 322	• Medication administration policy and procedure – address physician's signature for verbal orders, PRN orders, MARs – documentation of PRN orders and efficacy of PRN medication • Emergency medical procedure, transportation and notification process • 'PRN laxative' process and procedure and documentation • Daily BM monitoring procedure • Medication nurse schedule • 1:1 job description – function during emergencies	8/25/13

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W 322	Continued From page 52 medication's effectiveness and exactly what constituted the medication's effectiveness. Interview was conducted with the facility's licensed practical nurse coordinator (LPN #1) on August 7, 2013 at 4:40 p.m. to ascertain information regarding the administration of the client's prescribed MOM. According to the LPN #1, the MOM is administered when Client #5 had not had a bowel movement for three consecutive days. Interview with the chief executive officer on August 8, 2013 at 4:05 p.m. verified that the MOM was to be given when the client had no bowel movement for three days. At the time of the investigation, the facility failed to ensure the client's order for MOM was clarified in order to ensure it was consistently administered as needed. Additionally, the facility failed to ensure nurses documented specified how the medication was effective and the date and time of the effectiveness. 2. The facility's nursing personnel failed to ensure Client #5 received prescribed medications as ordered. Interview with the facility's former house manager on July 22, 2013 beginning at 11:00 a.m. revealed there was a concern regarding the management and documentation of Client #5's bowel movements. Review of Client #5's July 2013 physician's orders (POS) on July 30, 2013, beginning at 4:02 p.m. revealed the client had diagnoses that included sigmoid diverticula. Further review of the client's POS at 4:25 p.m. revealed a May 3, 2013 (10:00 a.m.) telephone order that documented to	W 322		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G212		07/26/2013

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W 322	Continued From page 53 discontinue "Surfak 240 milligram (mg) softgel. Start Colace 50 mg/5 milliliter (ml), take 2 teaspoonful by mouth daily for stool softener." Review of the Client #5's medication administration records (MAR) from May 2013 through July 2013 on July 30, 2013, beginning at 6:00 p.m. failed to provide evidence that the client received the prescribed colace as ordered. According to the May 2013 MAR, Client #5 failed to receive the colace (to be initiated on May 3, 2013) for the entire month. 3. The facility failed to ensure Client #5 received timely emergency medical services. Review of Client #5's record on July 30, 2013, at 3:00 p.m., revealed a nursing note dated June 29, 2013 (8:30 p.m.). According to the note, staff reported that Client #5 had experienced having "loose stools all day." The note further reflected that the client had not eaten, was "barely drinking anything and [was] un-alert (passing out every now and then). Continued review of the note revealed that staff indicated that the client was "still seeping out stool and was not able to leave the bathroom or remain alert." Additional review of the June 29, 2013 nursing note revealed that Client #3's primary care physician (PCP) was notified at 8:34 p.m. and ordered that the client be sent to the emergency room due to his "level of consciousness." Interview was conducted with direct support professional (DSP) #12 on August 8, 2013, beginning at 3:35 p.m. According to DSP #12, Client #5 was observed to have fainted twice while in the shower during evening care shortly	W 322		

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W 322	Continued From page 54 after 8:00 p.m. DSP #12 confirmed that Client #5 had been observed having loose stools all day. Continued discussion with DSP #12 revealed that he/she immediately notified the licensed practical nurse coordinator (LPNC), via telephone, of the client's condition. DSP #12 revealed that LPNC called back at approximately 9:00 p.m. (an hour later) and instructed the staff member to transport Client #5 to the emergency room. Further discussion with DSP #12 revealed that the LPNC was informed that there was only two staff in the facility and if a staff person left there would not be enough staff present to supervise the client's that remained home. According to DSP #12, Client #5 had to wait in the facility until the house manager arrived in order to be escorted to the emergency room. DSP #12 revealed that the house manager arrived to the facility at 11:00 p.m. (three hours after the incident occurred). At the time of the investigation, the facility failed to ensure Client #5 received timely emergency medical services. Note: According to DSP #12, DSP #5 escorted Client #5 to the hospital in the cliential van alone. It should be further noted that Client #5 receives 1:1 staffing support, 16 hours per day, seven days per week. (See also W186)	W 322		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that (1) nursing personnel provided each client with prescribed medications	W 331		

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W 331	Continued From page 55 as ordered; and (2) failed to ensure a client's bowel movements were comprehensively monitored and treatment was rendered consistently. for one of three clients residing in the facility. (Client #5) The findings include: 1. The facility's nursing personnel failed to ensure Client #5 received prescribed medications as ordered. Interview with the facility's former house manager on July 22, 2013 beginning at 11:00 a.m. revealed there was a concern regarding the management and documentation of Client #5's bowel movements. Review of Client #5's July 2013 physician's orders (POS) on July 30, 2013, beginning at 4:02 p.m. revealed the client had diagnoses that included sigmoid diverticula. Further review of the client's POS at 4:25 p.m. revealed a May 3, 2013 (10:00 a.m.) telephone order that documented to discontinue "Surfak 240 milligram (mg) softgel. Start Colace 50 mg/5 milliliter (ml), take 2 teaspoonful by mouth daily for stool softener." Review of the Client #5's medication administration records (MAR) from May 2013 through July 2013 on July 30, 2013, beginning at 6:00 p.m. failed to provide evidence that the client received the prescribed colace as ordered. According to the May 2013 MAR, Client #5 failed to receive the colace (to be initiated on May 3, 2013) for the entire month. 2. The facility nursing personnel failed to ensure Client #5's order for milk of magnesia was	W 331	W 331 Refer W 318,322	

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W 331	Continued From page 56 clarified to make certain it was administered consistently. Interview with the facility's former house manager on July 22, 2013, beginning at 11:00 a.m. revealed there was a concern regarding the management and documentation of Client #5's bowel movements. Review of Client #5's July 2013 physician's orders (POS) on July 30, 2013, at approximately 4:02 p.m. revealed the client had diagnoses that included sigmoid diverticula. Additional review of the client's POS from January 2013 through July 2013 revealed the client was prescribed medications including Surfak (for constipation discontinued on May 3, 2013), Ducosate Sodium (stool softener ordered to begin on May 3, 2013) and Milk of Magnesia (as needed for constipation). Review of the Client #5's record on July 30, 2013, at 2:50 p.m. revealed that client's daily bowel movement frequency was being documented by facility staff on a form entitled, "Bowel Elimination Record." According to the bowel movement records from January 2013 to July 2013, the following was noted: February 2013 2/9/13 - no bowel movement noted. The elimination record documented that milk of magnesium had been given. 2/16/13 - 2/18/13 - no bowel movement noted. The elimination record further documented that on 2/17/13, Client #5 "complained of stomach pain, sat on the toilet, but no bowel movement." 2/22/13 -2/23/13 - no bowel movement noted.	W 331		

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W 331	Continued From page 57 Review of the corresponding February 2013 MAR on July 30, 2013 beginning at 5:44 p.m. verified that MOM was administered on February 9, 2013. Continued review of the MAR revealed that the MOM was given at 7:00 p.m. for constipation. The nurse documented that the results of the medication was "effective" but, the nurse failed to document the time he/she verified the medication's effectiveness. Furthermore, there was no evidence to support how the medication was determined to be effective. March 2013 3/10/13 - 3/12/13 - no bowel movement noted. The elimination record further documented that on 3/12/13, Client #5 "appeared as if he was attempting to have a bowel movement, just grunting." It should be noted that the record indicated the client had a small hard bowel movement on 3/13/13. Review of the corresponding March 2013 MAR on July 30, 2013 beginning at 5:46 p.m. revealed no evidence that the MOM was given the entire month of March 2013. May 2013 5/5/13 - no bowel movement noted. 5/9/13 - 5/12/13 - no bowel movement noted. 5/24/13 - 5/26/13 - no bowel movement noted. 5/28/13 - 5/29/13 - no bowel movement noted. There was no area on the available bowel movement elimination record to document a description of the client's bowel elimination on 5/30/13 - 5/31/13. Review of the corresponding March 2013 MAR on July 30, 2013 beginning at 5:50 p.m. revealed MOM was administered on May 12, 2013 (8:00	W 331		

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W 331	Continued From page 58 p.m.), May 26, 2013 (4:00 p.m.), and May 31, 2013 (6:00 p.m.), because the client had not had a bowel movement for three days. The nurse(s) documented that the results of the medication was "effective" on May 12, 2013 and May 31, 2013 but failed to document any results on May 26, 2013. Additionally, the nurse(s) failed to document the time he/she verified the medication's effectiveness and exactly what constituted the medication's effectiveness. Interview was conducted with the facility's licensed practical nurse coordinator (LPN #1) on August 7, 2013 at 4:40 p.m. to ascertain information regarding the administration of the client's prescribed MOM. According to the LPN #1, the MOM is administered when Client #5 had not had a bowel movement for three consecutive days. Interview with the chief executive officer on August 8, 2013 at 4:05 p.m. verified that the MOM was to be given when the client had no bowel movement for three days. At the time of the investigation, the facility failed to ensure the client's order for MOM was clarified in order to ensure it was consistently administered as needed. Additionally, the facility failed to ensure nurses documented specified how the medication was effective and the date and time of the effectiveness.	W 331		
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, interview and record	W 368		

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W 368	Continued From page 59 review, the facility failed to ensure that a client's stool softener was administered in accordance with physician's orders, for one of three clients residing in the facility. (Client #1) The findings include: Interview with the facility's former house manager on July 22, 2013 beginning at 11:00 a.m. revealed there was a concern regarding the management and documentation of Client #3's bowel movements. Review of Client #3's July 2013 physician's orders (POS) on July 30, 2013, at 4:02 p.m. revealed the client had diagnoses that included sigmoid diverticula. Further review of the client's POS at 4:25 p.m. revealed a May 3, 2013 (10:00 a.m.) telephone order that documented to discontinue "Surfak 240 milligram (mg) softgel. Start Colace 50 mg/5 milliliter (ml), take 2 teaspoonful by mouth daily for stool softener." Review of the Client #3's medication administration records (MAR) from May 2013 through July 2013 on July 30, 2013, beginning at 6:00 p.m. revealed no evidence that the prescribed colace had been administered during the month of May 2013. The May 2013 MAR however, verified the discontinuance of the Surfak on May 3, 2013. At the time of the investigation, the facility failed to provide evidence that Client #3's prescribed colace was initiated during the month of May 2013 as ordered.	W 368	W 368 Refer W 318,322,368	