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

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 331}	Continued From page 60 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 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.	{W 331}		

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{W 331}	Continued From page 61 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 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}		

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{W 368}	Continued From page 62	{W 368}		
{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 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	{W 368}	W 368 Refer W 318,322,368	

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{W 368}	Continued From page 63 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}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0206	A. BUILDING: _____ B. WING _____	R 09/09/2013

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{I 000}	INITIAL COMMENTS On July 26, 2013, an investigation was concluded that revealed the facility failed to be in compliance with the federal conditions of participation of governing body, resident protections, facility staffing and health care services. A follow-up survey was conducted from September 8, 2013 through September 9, 2013 that revealed the facility failed to regain compliance with the aforementioned conditions of participation. Specifically, observations revealed that one-to-one (1:1) staff failed to provide supervision in accordance with Resident #1's and #5's individual support plans. [See I422] The follow-up survey, therefore, was aborted to provide the facility a second opportunity to attain compliance . The state agency informed the facility's chief executive officer (CEO) of the determination on September 9, 2013, at approximately 3:45 p.m. The findings of the follow-up survey were based on observations, interviews with facility staff and review of the agency's administrative records, including the incident management system. [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]	{I 000}		
{I 180}	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on interview and record review, the group home for individuals with intellectual disabilities	{I 180}		

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{I 180}	Continued From page 1 (GHIID) failed to provide adequate administrative support to ensure effective integration and coordination of each resident's habilitation and active treatment needs, for two of the five residents residing in the GHIID. (Residents #1 and #2) The findings include: [Cross refer to W159] On July 9, 2019, at 2:58 p.m., the Department of Health, Office of Compliance, Quality Assurance and Investigation Division (OCAQID), was notified by telephone of an unusual incident that occurred on the morning of July 9, 2013, at approximately 8:25 p.m. The caller revealed that Resident #1 sustained a severe injury to the right eye. During the investigative process on July 10, 2013, a second Incident occurred involving Resident #2 during the 4:00 p.m. to 12:00 a.m. shift. According to the information provided, Resident #2 sustained a severe injury to his right eye and was transported to the emergency room via 911. An onsite incident investigation was initiated on July 9, 2013. The results of the investigation revealed, the QIDP failed to coordinate and integrate services as indicated below: 1. [Cross refer to W249]. The QIDP failed to ensure staff implemented proactive strategies that were outlined in Resident #1's behavior support plan (BSP). 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 Resident #1 as his one to one (1:1) staffing	{I 180}	I 180 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.	9/20/13

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{I 180}	Continued From page 2 support on the morning of July 9, 2013, from 8:00 a.m. to 4:00 p.m. due to the resident's maladaptive behaviors of physical aggression and self-injurious behaviors (SIB). DSP #1 revealed that at 8:09 a.m., Resident #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 Resident #1 was redirected and "eventually stopped". At 8:25 a.m. until 8:36 a.m., Resident #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 Resident #2 to stop, but the resident 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 Resident #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 Resident #1 with his morning cup of coffee after 8:00 a.m. At approximately 8:10 a.m., Resident #1 was observed to hit himself in the face twice while drinking coffee. DSP #2 stated that she verbally prompted the resident to stop. According to DSP #2, Resident #1 stopped hitting himself and finished his coffee. DSP #2 stated that Resident #1 "signed for another cup of coffee" but did not get it. At 8:25 a.m., DSP #2 stated that Resident #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	{I 180}		

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{I 180}	Continued From page 3 shocked!" DSP #2 stated that she provided no intervention. DSP #2 then stated that DSP #3 walked toward Resident #1 and verbally prompted the resident 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 Resident #2. DSP #3 revealed that he was positioned in the living room with Resident #1 at the time the injury occurred. At approximately 8:25 a.m., DSP #3 stated that he observed Resident #1 hit himself 4 to 5 times in the face "very hard". DSP #3 stated that DSP #1 (who was assigned as Resident #1's 1:1 support staff) jumped up and moved away from Resident #1. DSP #3 verbally prompted the [resident] to calm down and asked, "Are you ok?" DSP #3 then stated that Resident #1 continued to hit himself in the face repeatedly and that's when DSP #3 walked over to the resident and placed the resident'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 resident, Resident #1 began hitting himself again. DSP #3 stated that he informed DSP #1 to go get Resident #1 some water. DSP #3 went back over to Resident #1 and the resident 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, Resident #1's face began to get red and underneath his eye began to puff up. According to DSP #3, shortly after drinking some water, Resident #1 hit himself a few more time. DSP #3 stated that he walked over to Resident #1 and stated, "That's enough" in a firm voice. On July 10, 2013, beginning at approximately	{I 180}		

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{I 180}	Continued From page 4 5:10 p.m., review of Resident #1's BSP dated April 13, 2013, revealed Resident #1 had maladaptive 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 resident, given the high level of risk of several of his target behaviors. Continued review of the BSP revealed that if Resident #1 engaged in SIB, staff should implement the following proactive strategies: a. Whenever possible, he [resident] 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 Resident #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 Resident #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 resident 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 resident 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 Resident #1 became agitated and began to present a danger to himself or others, staff may	{I 180}		

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{I 180}	Continued From page 5 use the least restrictive, least intrusive strategy possible. Implement a program-approved by the GHIID. For example, staff could use supportive physical techniques, one or two person escort and/or any relevant blocks or releases to assist Resident #1. 2. The QIDP failed to ensure Residents #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 Resident #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 residents 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 Resident #2's bedroom. According to DSP #8, he stated that he dropped the mop and bucket and rushed to the resident's room. As he stepped inside the bedroom, he indicated he witnessed Resident #2 falling to the floor in the bathroom. DSP #8 stated that DSP #4 came running behind him and after observing the resident's injury he said, "I'm going to get the first aid kit." Resident #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	{I 180}		

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{I 180}	Continued From page 6 the injury, Resident #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 Resident #2 at all times in accordance with the BSP. On July 11, 2013, at approximately 5:00 p.m., review of Resident #2's BSP dated April 13, 2013, revealed that although the resident was ambulatory, his gait issue had deteriorated and his risk for falls had increased. Further review of Resident #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 resident. The BSP also added that 1:1 support staff should be between arm's length and five feet from the resident 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 Resident #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 Resident #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 resident went to be bed between 8:30 p.m. - 9:00 p.m. DSP #4 also stated that he remained outside of Resident #1's bedroom and checked on him every 30 minutes. On July 10, 2013, beginning at approximately 5:10 p.m., review of the Resident #1's BSP dated April 13, 2013, revealed Resident #1 had maladaptive behaviors that included physical	{I 180}		

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{I 180}	Continued From page 7 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 resident, 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 resident 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 residents 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 Resident #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 residents residing in the GHIID. According to the former RC, three of the residents currently receive 1:1 staffing supports, sixteen hours per day, seven days a week. The former RC further revealed that Resident #3 was recommended to receive 1:1 staffing support but didn't because the GHIID was not being compensated for that service. Further discussion with the RC and review of Resident #3's record on July 19, 2013 at approximately	{I 180}		

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{I 180}	Continued From page 8 12:31 p.m. revealed the resident's individual support plan dated May 13, 2013, document 1:1 supervision was recommended. Further review of the resident's record revealed a psychological assessment dated April 7, 2013 that documented, "Given [the resident'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.	{I 180}		
{I 246}	3511.4 DIRECT CARE STAFF RATIOS The initial daily direct care staff ratios shall be determined by the Department of Human Services (DHS) based upon the characteristics of the individuals proposed to be served or served by the GHMRP as described in the Individual Habilitation Plans or based upon the GHMRP ' s description of the individuals to be served. This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to provide sufficient staffing and one to one (1:1) supervision to protect residents from harm and to ensure their safety, for two of the four residents in the investigation. (Residents #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, Resident #2 fell on his bathroom floor at	{I 246}	I 246 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. 9/20/13	

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{I 246}	Continued From page 9 11:50 p.m. The resident 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 Residents #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 Resident #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 residents 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 Resident #2's bedroom. According to DSP #8, he stated that he dropped the mop and bucket and rushed to the resident's room. As he stepped inside the bedroom, he indicated he witnessed Resident #2 falling to the floor in the bathroom. DSP #8 stated that DSP #4 came running behind him and after observing the resident's injury he said, "I'm going to get the first aid kit." Resident #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, Resident #2 received eleven stitches to his right eyebrow. When asked, DSP #8 stated	{I 246}		

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{I 246}	Continued From page 10	{I 246}		

that he knew he was supposed to remain within arm's length of Resident #2 at all times in accordance with the BSP.

On July 11, 2013, at approximately 5:00 p.m., review of Resident #2's BSP dated April 13, 2013, revealed that although the resident was ambulatory, his gait issue had deteriorated and his risk for falls had increased. Further review of Resident #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 resident. The BSP also added that 1:1 support staff should be between arm's length and five feet from the resident 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 Resident #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 Resident #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 resident went to be bed between 8:30 p.m. - 9:00 p.m. DSP #4 also stated that he remained outside of Resident #1's bedroom and checked on him every 30 minutes.

On July 10, 2013, beginning at approximately 5:10 p.m., review of the Resident #1's BSP dated April 13, 2013, revealed Resident #1 had maladaptive behaviors that included physical aggression, self-injurious behaviors (physical discomfort from allergies), taking drinks and

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{I 246}	Continued From page 11 impulsiveness. Further review revealed that 1:1 supervision was needed for behavior support implementation and to ensure the safety of the resident, 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 resident 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 Resident #1's and Resident #2's BSP on June 20, 2013. However, there was no evidence that training had been effective. Note: Interview with the GHIID's former residential coordinator (RC) on July 18, 2013, beginning at 10:50 a.m., revealed that Residents #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 residents 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.	{I 246}		
{I 401}	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident.	{I 401}		

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{I 401}	Continued From page 12 This Statute is not met as evidenced by: Based on interview and record review, the group home for individual with intellectual disabilities (GHIID) failed to ensure the provision of general care by making certain a resident's bowel movements were comprehensively monitored and treatment was rendered consistently. Additionally, the GHIID failed to ensure a resident received timely emergency medical services, for one of five residents in the investigation. (Resident #5) The findings include: [Cross refer to W322] 1. The GHIID failed to ensure Resident #5's order for milk of magnesia was clarified and understood to make certain it was administered consistently. Interview with the GHIID'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 Resident #5's bowel movements. Review of Resident #5's July 2013 physician's orders (POS) on July 30, 2013, at approximately 4:02 p.m. revealed the resident had diagnoses that included sigmoid diverticula. Additional review of the resident's POS from January 2013 through July 2013 revealed the resident 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).	{I 401}	I 401 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.	9/20/13

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{I 401}	Continued From page 13 Review of the Resident #5's record on July 30, 2013, at 2:50 p.m. revealed that resident's daily bowel movement frequency was being documented by GHIID 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, Resident #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 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, Resident #5 "appeared as if he was attempting to have a bowel movement, just grunting." It should be noted that the record indicated the resident had a small hard bowel movement on 3/13/13.	{I 401}	• 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: • 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	9/20/13

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{I 401}	Continued From page 14 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 resident'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 resident 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 GHIID's licensed practical nurse coordinator (LPN #1) on August 7, 2013 at 4:40 p.m. to ascertain information regarding the administration of the resident's prescribed MOM. According to the LPN #1, the MOM is administered when Resident #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 resident had no bowel movement for three days.	{I 401}		

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{I 401}	Continued From page 15 At the time of the investigation, the GHIID failed to ensure the resident's order for MOM was clarified in order to ensure it was consistently administered as needed. Additionally, the GHIID failed to ensure nurses documented specified how the medication was effective and the date and time of the effectiveness. 2. The GHIID's nursing personnel failed to ensure Resident #5 received prescribed medications as ordered. Interview with the GHIID'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 Resident #5's bowel movements. Review of Resident #5's July 2013 physician's orders (POS) on July 30, 2013, beginning at 4:02 p.m. revealed the resident had diagnoses that included sigmoid diverticula. Further review of the resident'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 Resident #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 resident received the prescribed colace as ordered. According to the May 2013 MAR, Resident #5 failed to receive the colace (to be initiated on May 3, 2013) for the entire month.	{I 401}		

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{I 401}	Continued From page 16 3. The GHIID failed to ensure Resident #5 received timely emergency medical services. Review of Resident #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 Resident #5 had experienced having "loose stools all day." The note further reflected that the resident 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 resident 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 Resident #3's primary care physician (PCP) was notified at 8:34 p.m. and ordered that the resident 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, Resident #5 was observed to have fainted twice while in the shower during evening care shortly after 8:00 p.m. DSP #12 confirmed that Resident #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 resident'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 Resident #5 to the emergency room. Further discussion with DSP #12 revealed that the LPNC was informed that there was only two staff in the GHIID and if a staff person left there would not be enough staff	{I 401}		

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{I 401}	Continued From page 17 present to supervise the resident's that remained home. According to DSP #12, Resident #5 had to wait in the GHIID until the house manager arrived in order to be escorted to the emergency room. DSP #12 revealed that the house manager arrived to the GHIID at 11:00 p.m. (three hours after the incident occurred). At the time of the investigation, the GHIID failed to ensure Resident #5 received timely emergency medical services. Note: According to DSP #12, DSP #5 escorted Resident #5 to the hospital in the residential van alone. It should be further noted that Resident #5 receives 1:1 staffing support, 16 hours per day, seven days per week. (See also W186)	{I 401}		
{I 422}	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide sufficient staffing and one to one (1:1) supervision to ensure each resident's safety, for two of the five residents in the investigation. (Residents #1 and #5) The findings include: I. On September 8, 2013, at 10:30 p.m., Staff #1 was in the lower level of the facility. He informed the survey team that he was assigned to provide one to one (1:1) support for Resident #5 on that shift (4:00 p.m. - 12:00 a.m.). Resident #5 was not with him at the time. At 10:36 p.m., the surveyors went upstairs and observed Staff #2	{I 422}	I 422 See W186 ILS has ensured clarification of services for all persons with 1:1 staffing. This clarification from the behavior specialist include the guidelines for the time services are to be rendered and staff expectation proximity to the individual. DSP staff were trained on 9/12/2013 Additional training to be held on 9/19/2013 and 9/26/13 by the behavior specialist, participants to include training for the LPN, Q, FC and DSP. Disciplinary action completed for staff who was using the phone. Staff also inservice on the 1:1 guidelines 9/19/2013	9/20/13

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{I 422}	Continued From page 18 speaking on a telephone while seated in the living room. Resident #5 was observed seated alone on a sofa across the living room from Staff #2 (approximately 12 feet away from the staff). No other persons were in the living room at the time. At 11:00 p.m., Staff #2 stated that she had agreed to provide temporary 1:1 support for Resident #5 while Staff #1 stepped away. Observations on September 8, 2013 revealed that staff did not continuously remain within arms reach of Resident #5, as directed by the resident's one to one protocol (reviewed September 9, 2013, at 11:50 a.m.). II. On September 8, 2013, at 10:37 p.m., Staff #3 was observed seated in the dining room, making entries on a computer. At approximately 10:45 p.m., Staff #3 remained at the computer while Resident #1 was observed in his bed in an adjoining room. The resident's eyes were open, his knees were folded up and he was fidgeting with both of his hands. A similar observation was made of Resident #1 (awake in bed) at 11:12 p.m. A short time earlier, at 11:00 p.m., Staff #3 had stated he was assigned to provide 1:1 support for Resident #1 on that shift (4:00 p.m. - 12:00 a.m.). Observations on September 8, 2013 revealed that Resident #1's assigned 1:1 staff did not remain within arms reach of the resident while he was awake. III. On September 9, 2013, beginning at 10:23 a.m., interview with the qualified intellectual disabilities professional (QIDP, Staff #5) revealed that it was her understanding that Residents #1 and #5 received 1:1 staffing for "16 hours awake ...from when they wake up until they go to sleep	{I 422}	Staff training on shift protocol to ensure staff knowledge on expectations of staffing with the 1:1 and also during the evening hours. New physician orders completed with specifics on the 1:1 supports on 9/17/2013 The physician will confer and reflect the agreed upon recommendations with the specialist and reflect those recommendation on his orders ILS provides on-going training on the 1:1 guidelines, shift protocol, active treatment and home safety with all staff to ensure that the individuals' health and safety is always maintained. ILS adjusted the current schedule to include an additional person on the overnight to ensure supervision of all individuals An evening and night facility supervisor has started. He currently monitors evening and after hour staffing and programming for the individuals. ILS will ensure that random review of the staff time sheets is conducted periodically to make sure the schedule is being followed.	9/20/13

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{I 422}	Continued From page 19 ... the 1:1 does not have to stay in the bedroom if <the resident> is asleep." The QIDP further stated that it was acceptable for Resident #1's and #5's 1:1 staff to leave their respective bedrooms if the residents were sleeping. The staff could then perform household chores or data entry or provide stand-in support for the 1:1 that was assigned to supervise Resident #2. By contrast, interview with the program director (Staff #6), beginning at approximately 12:00 p.m. revealed that 1:1 staff should remain within arms reach of each resident throughout their shift. It was her understanding that there should be two staff in the bedroom shared by Residents #1 and #2 until the evening shift ends at midnight. [Note: Resident #2 received 1:1 support 24 hours a day, 7 days a week.] Similarly, Resident #5's 1:1 should remain in his bedroom (and within arms reach) until the shift ended at midnight. Review of Resident #1's medical and habilitation records on September 9, 2013, beginning at approximately 12:00 p.m. revealed discrepancies regarding his prescribed 1:1 supports, as follows: - Individual Support Plan dated April 11, 2013: "I am assigned a 1:1 for 16 hours per day;" - Behavior Support Plan dated April 11, 2013: "It is recommended that <resident's name> receive one-to-one staff supervision;" - Physician's Orders dated September 1, 2013: "1:1 supervision during waking hours." There was no one on one protocol observed in Resident #1's records; however, Staff #6 stated that the same protocol observed in Resident #5's record applied to Residents #1 and #5 as well. There was no evidence that the facility sought clarification of the term "waking hours" for Residents #1 and #5.	{I 422}	ILS has added a VP of Disability services and an additional Program Director to specifically monitor the care of the individuals in the ICF program – thereby increasing the supervision and assistance. Both persons have been oriented and have their specific caseloads. The previous management team – QIDP and FC were terminated as they failed to ensure staffing compliance, oversight of staff and adequate training of staff. 9/20/13	

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	HFD03-0206	A. BUILDING: _____ B. WING _____	R 09/09/2013

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{I 422}	Continued From page 20	{I 422}		

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Previously, the July 26, 2013 investigation report included the following:

During the course of an investigation initiated on July 9, 2013, it was discovered that on July 10, 2013, Resident #2 fell on his bathroom floor at 11:50 p.m. The resident 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 Residents #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 Resident #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 residents 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 Resident #2's bedroom. According to DSP #8, he stated that he dropped the mop and bucket and rushed to the resident's room. As he stepped inside the bedroom, he indicated he witnessed Resident #2 falling to the floor in the bathroom. DSP #8 stated

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{I 422}	Continued From page 21 that DSP #4 came running behind him and after observing the resident's injury he said, "I'm going to get the first aid kit." Resident #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, Resident #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 Resident #2 at all times in accordance with the BSP. On July 11, 2013, at approximately 5:00 p.m., review of Resident #2's BSP dated April 13, 2013, revealed that although the resident was ambulatory, his gait issue had deteriorated and his risk for falls had increased. Further review of Resident #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 resident. The BSP also added that 1:1 support staff should be between arm's length and five feet from the resident 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 Resident #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 Resident #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 resident went to be bed between 8:30 p.m. - 9:00 p.m. DSP #4 also stated that he remained outside of Resident #1's bedroom and checked	{I 422}		

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{I 422}	Continued From page 22 on him every 30 minutes. On July 10, 2013, beginning at approximately 5:10 p.m., review of the Resident #1's BSP dated April 13, 2013, revealed Resident #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 resident, 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 resident 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 Resident #1's and Resident #2's BSP on June 20, 2013. However, there was no evidence that training had been effective. Note: Interview with the facility's former residential coordinator (RC) on July 18, 2013, beginning at 10:50 a.m., revealed that Residents #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 residents 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.	{I 422}		
{I 500}	3523.1 RESIDENT'S RIGHTS	{I 500}		

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{I 500}	Continued From page 23 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 individuals with intellectual disabilities (GHIID) 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 Individuals with Intellectual Disabilities), for one of four residents in the investigations. (Resident #2) The finding includes: On July 10, 2013, during the 4:00 p.m. - 12:00 a.m. shift, Resident #2 fell in his bathroom at approximately 11:50 p.m. causing a severe injury to his right eye. Resident #2 was transported by emergency medical services to a local hospital's emergency room and kept overnight for observation. Interview with staff and the review of the GHIID's internal investigation revealed the resident received eleven sutures to the right eye. On July 11, 2013, at 8:40 p.m., interview conducted with direct support professional (DSP) #4 revealed he was assigned to work with Resident #1 on July 10, 2013, during the 4:00 p.m. to 12:00 a.m. shift. Further interview revealed that when he arrived to work on July 10, 2013, DSP #5 was assigned to Resident #2 as his one to one (1:1) staff. After dinner between 7:00 p.m. and 8:00 p.m., DSP #4 stated that he	{I 500}	I 500 The staffs involved were disciplined, terminated, re-trained and/or transferred out from the facility. All staff were in-serviced on individuals' rights, abuse & neglect, emergency procedure and communication, ADLs, BSP and Introduction to Mental Health, human development and psychology. 9/20/13	

Health Regulation & Licensing Administration

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{I 500}	Continued From page 24 heard Resident #2 mutter shower repeatedly. DSP #4 stated that DSP #5 did not give Resident #2 a shower prior to leaving his shift at 9:00 p.m. As a result of not receiving a shower, DSP #4 stated that Resident #2 remained awake and muttered shower throughout the night. On July 15, 2013, beginning at 10:10 a.m., interview with DSP #5 revealed he was Client #2's 1:1 support staff from 12:35 p.m. to 9:00 p.m. on July 10, 2013. DSP #5 confirmed during his interview that he did not shower the resident after dinner although the resident was asking to be showered. DSP #5 did state however, that the resident was showered earlier that evening at approximately 5:00 p.m. after having a bowel movement (BM) accident. On July 15, 2013, beginning at 1:13 p.m., interview with DSP #8 (assigned to Resident #2 as his 1:1 staff on July 10, 2013) revealed that while preparing the resident for the emergency medical services; he noticed that the resident's undergarments were soiled. He stated that he did not check to see if Resident #2's undergarment was soiled after his arrival to work at 9:09 p.m. DSP #8 stated that the resident wanted a shower and that's probably why he was awake and tried to go to the bathroom to take a shower. At the time of the investigation, the GHIID staff failed to ensure Resident #2 received a shower in accordance with his rights.	{I 500}		