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

PRINTED: 10/18/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G237		10/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOLUNTEERS OF AMERICA	6520 1ST STREET, 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 156	Continued From page 20 October 2, 2013, beginning at 10:57 a.m., revealed an incident report dated January 16, 2013, indicating that a direct support staff (Staff #4) had accused another staff (Staff #5) of yelling at Client #3 while Staff #5 was assisting the client with bathing. According to the corresponding investigation report, dated January 30, 2013, the allegation of verbal abuse was assigned to the interim program director (IPD) #1 for investigation on January 18, 2013. Telephone interview with IPD #1 on October 4, 2013, at 10:00 a.m., revealed that he had reported his findings to the administrator nine business days after the allegation was made. At the time of the survey, there was no evidence that the results of all investigations were reported to the administrator or designated representative within five working days of the incident as required.	W 156	allegations made during the September 26th 2013 incident and the allegations made to HRLA surveyors. VOAC received the investigations findings with recommendations. VOAC will ensure all investigations are completed within the five day time frame according to the DOH regulations. Also, in all cases a 5 day preliminary report will be generated, to ensure there is a current update to all involved on the investigation, especially in cases where the investigation cannot be completed in the 5 day time frame due to uncooperative staff or unforeseen circumstances.	
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all staff received ongoing, effective training to ensure that they were competent in protecting clients' rights, for two of four clients residing in the facility. (Clients #1 and #3) The findings include:	W 189		

Anne Price 10.23.13

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W 189	Continued From page 21 I. Review of incident reports and investigations on October 2, 2013, beginning at 10:57 a.m., revealed an incident dated September 26, 2013. According to the incident report, Staff #1 informed the residential coordinator (RC) #1 that on September 24, 2013, (two days earlier) she overheard Client #1 telling a nurse (LPN) #1 that Staff #2 "hits her and calls her monkey." On October 2, 2013, at approximately 12:00 p.m., interview with RC #1 revealed all staff were trained to report all allegations of abuse immediately. On October 4, 2013, at 4:00 p.m., review of the in-service training records revealed all staff had received training on incident identification and reporting on August 27, 2013. The survey findings, however, revealed that the staff training had not been effective. II. [Cross-refer to W249] I. Continued review of staff in-service training records (regarding the aforementioned allegations of abuse) revealed that staff had received training on Client #1's BSP on August 15, 2013. On October 2, 2013, at 12:45 p.m., review of Client #1's BSP revealed staff should address allegations by asking a list of specified questions. A. Staff #1, who was the person who overheard Client #1 making the allegations on September 24, 2013, was interviewed in the facility on October 3, 2013, beginning at 10:50 a.m. When queried about the client's BSP, Staff #1 indicated that she was unaware of the list of specific questions outlined in the BSP. Twice, she stated	W 189	**W189** VOAC has conducted training on the BSP facilitated by the Psychologist. VOAC will ensure periodic review of the data collection and BSP by the QIDP to ensure the steps in the BSP are followed and documented if there are any instances of the behavior of making false allegations. Consultation with the assigned clinician will be arranged when needed. VOAC conducted incident investigation training (see attached). VOAC will continue to evaluate training and retrain staff to ensure that training is effective. By 10/30/13	

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	09GZ37		10/04/2013

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W 189	Continued From page 22 staff was expected to document the allegation on the behavior sheets. On October 3, 2013, at 11:14 a.m., review of Client #1's behavior data failed to show evidence that staff had documented the allegations of being hit or called names by other staff. Continued review of the client's record failed to show evidence that Client #1 was asked the list of questions (as per the BSP) on the day that she made the allegations. B. On October 4, 2013, at approximately 9:00 a.m., review of Client #1's behavior data revealed that on April 20, 2013, staff wrote that the client "called her mother and lied that she was not fed." There was no additional information noted on the behavior data sheet that would evidence that her allegation of mistreatment (food withheld) was followed by questioning by staff, in accordance with the client's BSP. On October 4, 2013, interview with RC #1 at 4:30 p.m. revealed that she knew little about that particular incident. The RC stated that to her knowledge the "behavior" had not been further investigated. There was no documented evidence that Client #1 was interviewed on the day that she made the allegation that staff had not fed her. Staff #1's signature was on the attendance sheet for the August 15, 2013 in-service. The survey findings, however, revealed that the training had not been effective.	W 189		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan,	W 249		

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W 249	Continued From page 23 each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on interview and record review, the facility staff failed to ensure that each client's behavior support plan (BSP) was implemented consistently, for the one client in the sample with a BSP. (Client #1) The findings include: 1. Review of incident reports and investigations on October 2, 2013, beginning at 10:57 a.m., revealed an incident dated September 26, 2013. According to the incident report, Staff #1 informed the residential coordinator (RC) #1 that on September 24, 2013, she overheard Client #1 telling a nurse (LPN) #1 that Staff #2 "hits her and calls her monkey." Continued review of the incident report revealed that LPN #1 was heard telling the client she would "take care of it." Interview with the interim program director (IPD) #1 on October 2, 2013, at approximately 12:30 p.m., revealed that Client #1 had a target behavior of making false allegations. On October 2, 2013, at 12:45 p.m., review of Client #1's BSP, dated July 1, 2013, confirmed that making false allegations was a targeted maladaptive behavior. Continued review of the BSP revealed staff should address allegations by	W 249	W249 See W189 The assigned QIDP will ensure the BSP is followed by using the internal QA system to review and train where necessary to ensure compliance. VOAC has already conducted BSP training to include what to do in event of the individual making false allegations. By 10/30/13	

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W 249	Continued From page 24 asking the following questions: a. Are you certain what you're saying is true? b. Did anyone else witness the incident you're talking about? c. What is the person's name who witnessed the incident you're talking about? d. Were you injured during the incident? e. Show me where you were injured? f. Show me the place where the incident occurred. Further review of the BSP revealed "If the client insists that the allegation is true, especially during instances of alleged physical or verbal abuse or other serious allegations and her answers to the query questions suggest that the allegation might be true, then an investigation is required and referrals should be made." Staff #1 was interviewed in the facility on October 3, 2013, beginning at 10:50 a.m. She reiterated that she had heard Client #1 make the allegations of abuse on September 24, 2013. When queried about the client's BSP, Staff #1 indicated that she was unaware of the list of specific questions outlined in the BSP. Twice, she stated staff was expected to document the allegation on the behavior sheets. On October 3, 2013, at 11:14 a.m., review of Client #1's behavior data failed to show evidence that staff had documented the client's allegations of being hit or called names by other staff.	W 249		

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W 249	Continued From page 25 Continued review of the client's record failed to show evidence that Client #1 was asked the list of questions (as per the BSP) on the day that she made the allegations. II. On October 4, 2013, at approximately 9:00 a.m., review of Client #1's behavior data revealed that on April 20, 2013, staff wrote that the client "called her mother and lied that she was not fed." There was no additional information noted on the behavior data sheet that would evidence that her allegation of mistreatment (food withheld) was followed by questioning by staff, in accordance with the client's BSP. On October 4, 2013, interview with RC #1 at 4:30 p.m. revealed that she knew little about that particular incident. The RC stated that to her knowledge the "behavior" had not been further investigated. There was no documented evidence that Client #1 was interviewed on the day that she made the allegation that staff had not fed her. At the time of the survey, there was no evidence that facility staff had implemented Client #1's BSP as written.	W 249		

Carol Pree 10.25.13

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	HFD03-265		10/04/2013

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I 000	INITIAL COMMENTS A licensure survey was conducted from October 2, 2013 through October 4, 2013. A sample of two residents was selected from a population of four females with varying degrees of intellectual disabilities. The findings of the survey were based on observations in the home and two day programs, interviews with two clients, direct support staff, nursing and administrative staff, as well as a review of resident and administrative records, including incident reports. Note: The below are abbreviations that may appear throughout the body of this report Behavior Support Plan - BSP Department of Health - DOH Direct Support Professional - DSP Group Home for Individuals with Intellectual Disabilities - GHIID Health Regulation and Licensing Administration - HRLA Incident Management Coordinator - IMC Individual Support Plan - ISP Intermediate Care Facility - ICF Licensed Practical Nurse - LPN Qualified Intellectual Disabilities Professional - QIDP Residential Coordinator - RC	I 000		
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition,	I 229		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

10.23.13

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I 229	Continued From page 1 recreation, total communications, and assistive technologies. This Statute is not met as evidenced by: Based on staff interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to ensure that staff received effective training on reporting requirements regarding incidents that present a significant risk to resident health and safety and residents' behavior support plans (BSPs), for one of four residents of the facility. (Resident #1) The findings include: I. Review of incident reports and investigations on October 2, 2013, beginning at 10:57 a.m., revealed an incident dated September 26, 2013. According to the incident report, Staff #1 informed the residential coordinator (RC) #1 that on September 24, 2013, (two days earlier) she overheard Resident #1 telling a nurse (LPN) #1 that Staff #2 "hits her and calls her monkey." On October 2, 2013, at approximately 12:00 p.m., interview with RC #1 revealed all staff were trained to report all allegations of abuse immediately. On October 4, 2013, at 4:00 p.m., review of the in-service training records revealed all staff had received training on incident identification and reporting on August 27, 2013. The survey findings, however, revealed that the staff training had not been effective. II. [Cross-refer to I422] I. Continued review of staff in-service training records (regarding the aforementioned allegations of abuse) revealed	I 229	3510.5 (f) (i)-VOAC completed training on Incident reporting and investigation. VOAC will continue to monitor this issue to ensure compliance with the DDS and VOAC internal policy. (ii)-VOAC has conducted training on the individual's BSP. Staff received clarification on how to implement the BSP with regards the behavior of making false allegation. VOAC will, through its internal QA audits, ensure the staffs are following the intervention steps in the plan if the individual make an allegation. By 10/30/13	

Comm Due 10.28.13

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I 229	Continued From page 2 that staff had received training on Resident #1's BSP on August 15, 2013. On October 2, 2013, at 12:45 p.m., review of Resident #1's BSP revealed staff should address allegations by asking a list of specified questions. A. Staff #1, who was the person who overheard Client #1 making the allegations on September 24, 2013, was interviewed in the facility on October 3, 2013, beginning at 10:50 a.m. When queried about the client's BSP, Staff #1 indicated that she was unaware of the list of specific questions outlined in the BSP. Twice, she stated staff was expected to document the allegation on the behavior sheets. On October 3, 2013, at 11:14 a.m., review of Client #1's behavior data failed to show evidence that staff had documented the allegations of being hit or called names by other staff. Continued review of the client's record failed to show evidence that Client #1 was asked the list of questions (as per the BSP) on the day that she made the allegations. B. On October 4, 2013, at approximately 9:00 a.m., review of Client #1's behavior data revealed that on April 20, 2013, staff wrote that the client "called her mother and lied that she was not fed." There was no additional information noted on the behavior data sheet that would evidence that her allegation of mistreatment (food withheld) was followed by questioning by staff, in accordance with the client's BSP. On October 4, 2013, interview with RC #1 at 4:30 p.m. revealed that she knew little about that particular incident. The RC stated that to her knowledge the "behavior" had not been further	I 229		

Connie Pope 10.23.13

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I 229	Continued From page 3 Investigated. There was no documented evidence that Client #1 was interviewed on the day that she made the allegation that staff had not fed her. Staff #1's signature was on the attendance sheet for the August 15, 2013 in-service. The survey findings, however, revealed that the training had not been effective.	I 229		
I 231	3510.5(h) STAFF TRAINING Each training program shall include, but not be limited to, the following: (h) Orientation programs for each new employee which shall include philosophy, organization, programs, practices and goals of the GHMRP as well as a review of applicable laws, regulations and agreements important to the operation of the GHMRP for the care and treatment of persons with mental retardation in the District of Columbia; and,.. This Statute is not met as evidenced by: Based on interview and review of staff in-service training records, the GHIID failed to include orientation programs for new employees that included a review of applicable laws, regulations and agreements important to the operation of the GHIID, including payments for medical services, for two of the four residents of the facility. The finding includes: Review of Resident # 1's financial records on October 4, 2013, beginning at approximately 4:45 p.m., revealed that the resident had paid $64.60 for a hospital bill with a check dated February 1, 2013. Similarly, review of Resident #3's financial	I 231	3510.5 (h) VOAC has reimbursed the individuals for the expenditures. VOAC will conduct training on individuals' funds and what the funds can be used for. VOAC through its internal QA process review financial records to ensure compliance. By 10/15/13	

Connie Prue 10.23.13

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I 231	Continued From page 4 records on October 4, 2013, at approximately 5:00 p.m., revealed that a check dated February 1, 2013, for $31.29 paid towards a hospital bill. When asked about the hospital payments on October 4, 2013, at approximately 5:15 p.m., the facility's director of intellectual disabilities stated that the residents should not have paid for medical bills. Further interview revealed that the residential coordinator (RC) #1 had paid the hospital bills without knowing that the residents were not required to pay medical bills. She further indicated that this had not been discussed during orientation training. The director of intellectual disabilities then stated that the residents would be reimbursed.	I 231		
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident 's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and review of resident records, including incident reports and investigations, the group home for individuals with intellectual disabilities (GHIID) failed to ensure that all incidents that present a risk to residents' health and safety were reported immediately to	I 379	3519.10 VOAC has reviewed the cause of this deficiency and assigned a different investigator to look into the allegations made by the individual to HRLA and the allegation regarding food withholding. The investigation was completed and recommendations made to the	

Connie Price 10-28-13

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I 379	Continued From page 5 the Department of Health, Health Regulation and Licensing Administration (DOH/HRLA), for one of four residents of the facility. (Resident #1) The findings include: I. On October 2, 2013, beginning at 10:57 a.m., review of an incident report dated September 26, 2013, revealed that Staff #1 had informed the residential coordinator (RC) #1 that on September 24, 2013, she overheard Resident #1 tell a nurse (LPN #1) that Staff #2 "hits her and calls her monkey." On October 2, 2013, at 4:48 p.m., interview with the residential coordinator (RC) #1 confirmed that the incident had not been reported to HRLA. II. On October 4, 2013, at approximately 9:00 a.m., review of Resident #1's behavior data revealed that on April 20, 2013, staff wrote that the resident "called her mother and fled that she was not fed." There was no evidence that her allegation of mistreatment (food withheld) was reported to the facility's administrator or to HRLA. On October 4, 2013, interview with RC #1 at 4:30 p.m. confirmed that the "behavior" had not been reported as an incident and to her knowledge it had not been further investigated. It should be noted that on October 2, 2013, at 12:45 p.m., review of Resident #1's BSP, dated July 1, 2013, had revealed that it addressed a targeted behavior of making false allegations. According to the BSP, the resident should be interviewed immediately and if she insists that the allegation is true and her answers to a list of query questions suggest that the allegation might be true, then an investigation is required and	I 379	VOAC administrator. The assigned QIDP will ensure the staff understand the steps to take when an allegation is made that appears to be a part of the individual's target behavior in her BSP. VOAC will ensure through its QA process that staff follows the BSP and asked the questions as outlined in the BSP before making a determination that the issue is one of a behavior rather than an incident. The Program Director via the Incident management Coordinator will ensure the policy for reporting incident and for investigation is followed once the determination is made that the allegation is not a behavior. By 10/30/13	

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	HFD03-265		10/04/2013

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STREET ADDRESS, CITY, STATE, ZIP CODE: 6520 1ST STREET, NW WASHINGTON, DC 20012

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1379	Continued From page 6 referrals should be made. There was no documented evidence, however, that Resident #1 was interviewed on the day she made the allegation that staff had not fed her. III. On October 2, 2013, at 11:26 a.m., review of an incident report dated January 16, 2013, revealed that a direct support staff (Staff #4) accused another staff (Staff #5) of yelling at Resident #3 while Staff #5 was assisting the resident with bathing. The allegation was reported to HRLA two days later, via telephone voice mail, on January 18, 2013, at 4:50 p.m. At the time of the survey, the GHIID failed to ensure that all allegations of abuse or mistreatment were reported immediately to HRLA.	1379		
1422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for individuals with intellectual disabilities (GHIID) staff failed to ensure each resident's behavior support plan (BSP) was implemented consistently, for the one resident in the sample with a BSP. (Resident #1) The findings include: 1. Review of incident reports and investigations on October 2, 2013, beginning at 10:57 a.m., revealed an incident dated September 26, 2013. According to the incident report, Staff #1 informed	1422	3521.3 VOAC has already conducted staff training on incident reporting and the BSP to address the staff understanding of the behavior of making false allegations. VOAC will ensure that staff follows the steps in the BSP and ask the list of questions as outlined in the BSP. The assigned Incident Manager will further ensure that staff members that are placed on leave remain on	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
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1422	Continued From page 7 the residential coordinator (RC) #1 that on September 24, 2013, she overheard Resident #1 telling a nurse (LPN) #1 that Staff #2 "hits her and calls her monkey." Continued review of the incident report revealed that LPN #1 was heard telling the resident she would "take care of it." Interview with the interim program director (IPD) #1 on October 2, 2013, at approximately 12:30 p.m., revealed that Resident #1 had a target behavior of making false allegations. On October 2, 2013, at 12:45 p.m., review of Resident #1's BSP, dated July 1, 2013, confirmed that making false allegations was a targeted maladaptive behavior. Continued review of the BSP revealed staff should address allegations by asking the following questions: a. Are you certain what you're saying is true? b. Did anyone else witness the incident you're talking about? c. What is the person's name who witnessed the incident you're talking about? d. Were you injured during the incident? e. Show me where you were injured? f. Show me the place where the incident occurred. Further review of the BSP revealed "If the resident insists that the allegation is true, especially during instances of alleged physical or verbal abuse or other serious allegations and her answers to the query questions suggest that the allegation might be true, then an investigation is	1422	leave until the investigation is complete and findings are given to the VOAC administrator for a decision to be made. VOAC will ensure that there is documentation in the individual's record that shows the staff followed the BSP. This documentation should include asking the questions and getting an answer that confirms that the individual is making a false allegation or not. If no evidence of a behavior, the staff that the allegation is made against will be placed on leave pending the outcome of the investigation. By 10/30/13 The Incident Manager will ensure all notification is made for incident, as evidenced by the QIDP or designee verifying the contacts logs, progress notes, phone verification and documentation of such. By 10/30/13 VOAC will ensure family members are notified as part of the required notification process evidenced by the QIDP or designee as evidenced by verifying the contacts logs, progress notes, phone verification and documentation of such; also review of the incident in the monthly IRC. By 10/30/13	

Connie Pree 10-23-13

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I 422	Continued From page 8	I 422		
	required and referrals should be made."			
	Staff #1 was interviewed in the facility on October 3, 2013, beginning at 10:50 a.m. She reiterated that she had heard Resident #1 make the allegations of abuse on September 24, 2013. When queried about the resident's BSP, Staff #1 indicated that she was unaware of the list of specific questions outlined in the BSP. Twice, she stated staff was expected to document the allegation on the behavior sheets.			
	On October 3, 2013, at 11:14 a.m., review of Resident #1's behavior data failed to show evidence that staff had documented the resident's allegations of being hit or called names by other staff. Continued review of the resident's record failed to show evidence that Resident #1 was asked the list of questions (as per the BSP) on the day that she made the allegations.			
	II. On October 4, 2013, at approximately 9:00 a.m., review of Resident #1's behavior data revealed that on April 20, 2013, staff wrote that the resident "called her mother and lied that she was not fed." There was no additional information noted on the behavior data sheet that would evidence that her allegation of mistreatment (food withheld) was followed by questioning by staff, in accordance with the resident's BSP.			
	On October 4, 2013, interview with RC #1 at 4:30 p.m. revealed that she knew little about that particular incident. The RC stated that to her knowledge the "behavior" had not been further investigated.			
	There was no documented evidence that Resident #1 was interviewed on the day that she made the allegation that staff had not fed her.			

Carol Rose 10-23-13

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1422	Continued From page 9 At the time of the survey, there was no evidence that facility staff had implemented Resident #1's BSP as written.	1422		
1500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observations, interviews and record review, the group home for individuals with intellectual disabilities (GHIID) failed to observe and protect residents' rights in accordance with federal regulations 42 CFR 483 Sub-Part 1 (for Intermediate Care Facilities for Individuals with Intellectual Disabilities) and Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) that governs the care and rights of individuals with intellectual disabilities, for one of four residents of the facility. (Resident #1) The findings include: I. [483.470(g)(2)] The GHIID failed to ensure that all residents were protected from further potential abuse while investigations of abuse were in progress, as follows: A. Review of incident reports and investigations on October 2, 2013, beginning at 10:57 a.m., revealed an incident dated September 26, 2013. According to the incident report, Staff #1 informed	1500	See 3521.3	

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1500	Continued From page 11 that the first interviews conducted with Resident #1 and Staff #2 were dated September 30, 2013. On October 2, 2013, at 6:20 p.m., the IPD informed the survey team that Staff #2 "is placed on leave immediately pending the outcome of further investigation..." On October 3, 2013, at 12:50 p.m., review of Staff #2's payroll summary records confirmed that she had worked in the facility while the investigation was ongoing (on September 27, 2013, September 30, 2013 and October 1, 2013, the 10:00 p.m.–6:00 a.m. shift). It should be noted that during an interview on October 2, 2013, at 3:49 p.m., Resident #1 informed the survey team that Staff #2 gets frustrated and shakes her, then tells her to tell her mother. She also described Staff #2 as "mean and aggressive... evil." When asked if anyone had verbally abused her, Resident #1 stated that Staff #2 called "me a monkey." At the time of the survey, there was no evidence that the facility implemented its policy to prevent further potential abuse of its residents, while investigations were being conducted. II. [Title 7, Chapter 13, § 7-1305.10(f), formerly § 6-1970(f)] The GHIID failed to demonstrate protection of residents' rights to have their family notified whenever an allegation of abuse is made, as follows: Review of the aforementioned incident report dated September 26, 2013 (Resident #1's allegations of abuse) revealed no evidence that the resident's sister had been notified of the allegations.	1500		

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I 500	Continued From page 12 On October 2, 2013, at 5:40 p.m., interview with the residential coordinator (RC) #1 confirmed that Resident #1's sister was not notified of the aforementioned incident. In an attempt to interview family members, the surveyor telephoned Resident #1's sister on October 4, 2013, at approximately 12:00 p.m. The sister, however, did not return the message before the survey ended. III. [483.420(b)(1)(i)] The GHIID failed to ensure that residents' funds entrusted to the facility for management were spent appropriately, for two of four residents of the facility, as follows: Review of Resident # 1's financial records on October 4, 2013, beginning at approximately 4:45 p.m., revealed that the resident had paid $64.60 for a hospital bill with a check dated February 1, 2013. Similarly, review of Resident #3's financial records on October 4, 2013, at approximately 5:00 p.m., revealed that a check dated February 1, 2013, for $31.29 paid towards a hospital bill. When asked about the hospital payments on October 4, 2013, at approximately 5:15 p.m., the facility's director of intellectual disability operations stated that the residents should not have paid for medical bills. Further interview revealed that the residential coordinator (RC) #1 had paid the hospital bills without knowing that the residents were not required to pay medical bills. She further indicated that this had not been discussed during orientation training. The director of intellectual disability operations then stated that the residents would be reimbursed.	I 500	VOAC reimbursed the individuals for the expenditure from their funds. VOAC will ensure that this doesn't happen again by ensuring the random and periodic quality assurance reviews occur as scheduled. Assistance in this area is also provided by the VOAC finance office. By 10/15/13	

Connie Price 10.23.13