

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

PRINTED: 08/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G188	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 07/26/2013
NAME OF PROVIDER OR SUPPLIER INNOVATIVE LIFE SOLUTIONS, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3259 'O' ST, SE WASHINGTON, DC 20020		
(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 000}	INITIAL COMMENTS On June 14, 2013, an investigation was concluded that revealed the facility failed to be in compliance with the conditions of participation of governing body and client protections. A follow-up survey was conducted from July 25, 2013 through July 26, 2013 that revealed the facility failed to regain compliance with the aforementioned conditions of participation. The state agency informed the facility's chief operating officer (COO) of the determination on July 29, 2013, at approximately 1:00 p.m. In conjunction with the follow-up survey, an investigation was conducted concerning an allegation received by the Department of Health (DOH) on July 17, 2013, which indicated the agency's health certificates were invalid. Specifically, it was alleged that health certificates were altered to ensure compliance with established regulatory standards. The results of the investigation revealed the allegation was unsubstantiated. The findings of the follow-up survey were based on interviews with facility staff and review of the agency's administrative records, including the incident management system.	{W 000}			
{W 102}	[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report. 483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.	{W 102}			

Received 8/20/13
Department of Health
Health Regulation & Licensing Administration
Intermediate Care Facilities Division
899 North Capitol St., N.E.
Washington, D.C. 20002

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Gwan J. Gwan TITLE: COO (X6) DATE: 8/28/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{W 102}	Continued From page 1	{W 102}	W 102 , 104, 122, 149		
{W 104}	<p>This CONDITION is not met as evidenced by: Based on interview and record review, the governing body failed to maintain general operating direction over the facility. [See W104]</p> <p>The effects of these systematic practices resulted in the governing body's failure to adequately govern the facility in a manner that would ensure clients' health and safety. [See also W122] 483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the governing body failed to exercise operating direction over the facility in order to maintain the health and the safety of one of four clients with maladaptive behaviors. (Client #2)</p> <p>The findings include:</p> <p>The facility's governing body failed to develop and implement adequate safeguards to maintain Client #2's health and safety.</p> <p>On July 5, 2013, via telephone (hotline), Innovative Life Solutions (ILS) self-reported an allegation of abuse to the Office of Compliance, Quality Assurance and Investigation Division (OCQAID). Review of the incident report alleged</p>	{W 104}	<p>The governing body has met with the interdisciplinary team for this individual and has developed measures to ensure the health and safety of this individual.</p> <ol style="list-style-type: none"> 1. The BSP target area of - 'leave staff supervision 'plan was amended to ensure that the plan provided 24 point steps staff would follow to intervene this type of behavior from escalating and ensure the health and safety of the individual at all times. 2. The staff were re-trained on the BSP - especially the 'proactive measures' staff should take to avert harmful situations from occurring especially when she threatens to elope or leaves staff supervision. CPEP will be used only when recommended by the psychiatrist. Training was also done on 2 person escort and physical guidance usage to protect the individual from harm and preserve her health and well-being. 3. The QIDP has developed a more structured environment. The individual's personal schedule has been revised to include her outings and programming. She will work with her 1:1 staff to plan her outings for the week. 		

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{W 104}	<p>Continued From page 2</p> <p>that a client's assigned one on one staff yelled at the client. Reportedly, the one on one staff hit the client in the face with an open palm repeatedly. During the course of the investigation it was discovered that the client was subsequently evaluated at a local hospital's emergency room. After returning home, the client left staff's supervision and independently went into the community. The client was noted to exhibit risky behavior of attempting to enter a busy street.</p> <p>The State Survey Agency (SSA's) pre-survey revealed that the client has a history of elopement and risk taking behaviors while out in the community which have resulted in the need for law enforcement, Comprehensive Psychiatric Emergency Program (CPEP) interventions to include emergency medications and a routine medication increase. Currently Client #2 requires one on one supervision daily, during waking hours to provide active treatment and to ensure health and safety.</p> <p>Review of Client #2's psychological assessment, dated July 23, 2012, on July 26, 2013, at 2:32 p.m., revealed the client lacks the cognitive judgment and academic skills to understand the implications of her decisions. Additionally, the psychological assessment revealed that the client does not travel independently, although she does understand some community survival signs.</p> <p>The review of Client #2's recent incidents revealed the client left staff supervision (May 9, 2013, May 19, 2013, July 5, 2013, and July 14, 2013). According to review of the incident reports on July 26, 2013, at 2:17 p.m., the following was noted:</p>	{W 104}	<ol style="list-style-type: none"> 4. The QIDP has also developed an informal program for her to track her survival skills which will be incorporated in her daily schedule. 5. An elopement protocol has been developed with timelines and parameters to notify law enforcement and to utilize proactive measures to avert harmful situations from occurring. 6. A high risk for abuse and neglect tool has been created and all individuals at this facility have been assessed and a plan of care has been incorporated for them. 7. The Agency has employed a VP of Disability services and a Program Director for the ICF homes to increase the level of supervision and assistance. 8. The staffing schedule has been revised to ensure the 1:1 staffing is provided. 9. Emergency staffing Policy has been revised – with an on-call staff list 10. The management staff – QIDP & FC have developed a rotating schedule to ensure 		

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{W 104}	Continued From page 3 a. On July 14, 2013, at 6:00 p.m., Client #2 exhibited maladaptive behaviors, left the supervision of her one on one (Staff #1), and refused to comply with staff requests and refused to come back. Staff #1 then caught up with the client. They remained in the community after walking for more than 90 minutes, and traveling on foot for a distance greater than one and a half mile from the facility. The client began to knock on strangers' doors, became verbally abusive, and engaged in an unsafe behavior of lying down on a busy street. Staff #1 required the assistance of two individuals in the community to direct traffic to prevent Client #2 from being struck by a car. As Staff #1 was calling 911, the police, fire department and ambulance arrived to the scene. The paramedics stated that they were told that someone had been hit and that they had come to assess the individual. b. On July 5, 2013, Client #2 was taken to the emergency room (ER) for an assessment after being hit on her face by her one on one staff. Upon her arrival back to the facility around 8:30 p.m. the client refused to exit the van. After entering the home, she immediately left staff supervision, and went into the community on a busy street. c. On May 9, 2013, at 4:30 p.m., Client #2 appeared to be agitated and absconded from the facility. About 30 minutes later, the client arrived at the police station. The client remained agitated and requested to be taken to the Comprehensive Psychiatric Emergency Program (CPEP). The client was transported to CPEP by the police	{W 104}	there is management supervision during waking hours. 11. The Incident Management Coordinator has been re-trained on the Incident Management P&P, and the elopement protocol, the below mentioned trainings and reporting and notification timelines and parameters All staff have been trained in: <ul style="list-style-type: none"> • BSP – proactive measures • Elopement protocol • CPI – physical guidance techniques, 2 person escort or hold • Incident management, reporting and notification • 1:1 job description • Individual's daily personal schedule • Active treatment • Recreation calendar – weekly • IPP – survival skills • Psychotropic medications • ABC data record • CPEP • High Risk assessment tool for – abuse & neglect 	8/27/13	

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{W 104}	<p>Continued From page 4 where she was evaluated, medicated with Ativan 1 milligram (mg.) and Seroquel 300 mgs., and was then released back to the facility.</p> <p>d. On May 19, 2013, at 7:30 p.m., Client #2 became agitated while traveling to the facility on the van. Upon arrival at the home, the client remained agitated, refused to enter the facility, and began walking up and down the street on which the home was located. As a result, the client was transported to CPEP for evaluation, where she was treated and released.</p> <p>Interview with the agency's chief operating officer (COO) on July 25, 2013, at 9:47 a.m. revealed all staff were trained on Client #2's behavior support plan and the incident management policy.</p> <p>Review of the governing body's findings of the investigations for the aforementioned incidents revealed the following measures are necessary to better protect individuals from harm. 1) Continue to provide individuals health and safety at all times; 2) staff training on 1:1 protocol; and 3) staff training on behavior support.</p> <p>Although there was evidence that staff were trained on Client #2's behavior support plan, the governing body failed to enact sufficient symptoms to the ensure client's health and safety.</p>	{W 104}	<p>In the future the governing body will ensure that the health and safety of the individuals is always maintained. The VP of disability services and the PD will generate a weekly report on the status of the individuals and develop plans of care as needed to ensure the health and well-being of the individuals.</p>	
{W 122}	<p>483.420 CLIENT PROTECTIONS</p> <p>The facility must ensure that specific client protections requirements are met.</p>	{W 122}		

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{W 122}	Continued From page 5	{W 122}			
{W 149}	<p>This CONDITION is not met as evidenced by: Based on interview and record review, the facility failed to implement policies and procedures to ensure client's health and safety [See W149].</p> <p>The effects of these systemic practices resulted in the failure of the facility to protect its clients and ensure their health and safety.</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to establish and implement policies to ensure the safety during behavioral episodes for one of the four clients (Client #1) with maladaptive behaviors that resided in the facility.</p> <p>The findings include:</p> <p>The facility failed to ensure its incident management/elopement/leave without notification policy specified parameters/time frames for notification of law enforcement to protect individuals from harm.</p> <p>[Cross Refer to W104] Review of incident reports on July 26, 2013, at 2:17 p.m., and interview with qualified intellectual disabilities professional on July 9, 2013, revealed the following information:</p> <p>a. On July 14, 2013, at 6:00 p.m., Client #2</p>	{W 149}			

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{W 149}	<p>Continued From page 6</p> <p>exhibited maladaptive behaviors, left the supervision of her one on one (Staff #1), and refused to comply with staff requests and refused to come back. They remained in the community after walking for more than 90 minutes, and traveling on foot for a distance greater than one and a half mile from the facility. The client began to knock on strangers' doors, became verbally abusive, and engaged in an unsafe behavior of lying down on a busy street. One of neighbors called the police and Staff #1 required the assistance of two individuals in the community to direct traffic to prevent Client #2 from being hit by a car.</p> <p>According to interview with qualified intellectual disabilities professional (QIDP) #2 on July 26, 2013 at 2:50 p.m. it was revealed that the incident management coordinator was notified of the aforementioned incident at 4:15 p.m. on July 14, 2013.</p> <p>b. On July 5, 2013, Client #2 was taken to the emergency room (ER) for an assessment after being hit on her face by her one on one staff. Upon her arrival back to the facility around 8:30 p.m. the client refused to exit the van. After entering the home, she immediately left staff supervision, and went into the community on a busy street for an estimated time of 30 to 40 minutes.</p> <p>Interviews with staff on July 9, 2013, revealed Staff #1 required the assistance of multiple staff to coach the client to return to the facility. Interview with the IMC (post survey on August 13, 2013) revealed that she was notified of the incident on the date it occurred; she however,</p>	{W 149}		
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{W 149}	<p>Continued From page 7 could not indicate a specific time of notification.</p> <p>c. On May 9, 2013, at 4:30 p.m., Client #2 appeared to be agitated and absconded from the facility. About 30 minutes later, the client arrived at the police station. The client remained agitated and requested to be taken to the Comprehensive Psychiatric Emergency Program (CPEP). The client was transported to CPEP by the police.</p> <p>On July 26, 2013, at 4:39 p.m., the facility's policy entitled "Leave without notification (Elopement)" was reviewed. According to the policy, "The unexpected or unauthorized absence of any duration for a person whose absence constitutes an immediate danger to that person or others" is considered as "leave without authorization or elopement." Further review of the elopement policy revealed the incident manager or designee will notify law enforcement. Continued review of the policy however, failed to specify parameters/timeframes for notification of law enforcement. At the time of the investigation, the facility failed to ensure the IMC notified the police as required by the established policy for the above noted incidents. Additionally the facility failed to ensure the aforementioned policy was comprehensive and documented specific timeframes for the notification of law enforcement.</p> <p>2. The facility failed to implement it's policy on reporting incidents that pose a risk to client health or safety to the Department of Health as required.</p> <p>Interview with the QIDP on July 9, 2013 revealed that on July 5, 2013, Client #2 was taken to the emergency room (ER) for an assessment after</p>	{W 149}			

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{W 149}	Continued From page 8 being hit on her face by her one on one staff. Upon her arrival back to the facility around 8:30 p.m. the client refused to exit the van. After entering the home, she immediately left staff supervision, and went into the community on a busy street for an estimated time of 30 to 40 minutes. Review of the facility's Incident management policy on July 26, 2013, at approximately 4:37 p.m. revealed that the policy classified elopement as an incident. Additionally, the policy documented that the incident management coordinator will make verbal notification to the appropriate state offices for incident's affecting the health safety of the individual. A completed incident reporting form must be received by the appropriate state offices within one working day of discovery. At the time of the survey, there was no evidence that Client #2's elopement was reported to the Department of Health as required.	{W 149}	W 149 – cross refer W 102, 104, 122 The incident management coordinator has been in-serviced on the Incident management process and timelines and the elopement procedure and reporting guidelines and timelines. Attached : <ul style="list-style-type: none">• Revised Incident management process• In-service record	8/26/13	
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on staff interview and record verification, the qualified intellectual disabilities professional (QIDP) failed to coordinate, integrate, and monitor services for one of four clients with maladaptive behaviors. (Client #2)	W 159	W 159 Cross refer W 102, 104, 122, 149		

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W 159	<p>Continued From page 9</p> <p>The finding includes: Cross refer to W149. The QIDP failed to ensure time, distance, and when to notify law enforcement were incorporated into the behavior support plan (BSP) for Client #2, to address "leaving staff supervision/risk taking behaviors."</p> <p>a. On July 14, 2013, at 6:00 p.m., Client #2 exhibited maladaptive behaviors, left the supervision of her one on one (Staff #1), and refused to comply with staff requests and refused to come back. They remained in the community after walking for more than 90 minutes, and traveling on foot for a distance greater than one and a half mile from the facility. The client began to knock on strangers' doors, became verbally abusive, and engaged in an unsafe behavior of lying down on a busy street. One of neighbors called the police and Staff #1 required the assistance of two individuals in the community to direct traffic to prevent Client #2 from being hit by a car.</p> <p>b. On July 5, 2013, Client #2 was taken to the emergency room (ER) for an assessment after being hit on her face by her one on one staff. Upon her arrival back to the facility around 8:30 p.m. the client refused to exit the van. After entering the home, she immediately left staff supervision, and went into the community on a busy street for an estimated time of 30 to 40 minutes.</p> <p>Interview with QIDP #1 and QIDP #2 on July 26, 2013, at 2:47 p.m., revealed Client #2 had a BSP dated July 26, 2012, which addressed "leaving staff supervision." QIDP #2 revealed, however, that the BSP did not clearly define time and</p>	W 159			

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W 159	Continued From page 10 distance, nor when to request additional support (e.g. staff or police). On July 26, 2013, at 3:05 p.m., review of the BSP instructed that the one on one staff support should remain within line of sight of the resident, though no more than 10 feet from her. If the client becomes upset and begins to leave staff supervision, the staff should: (1) Encourage her to return; (2) May follow her for a short time, to ensure her safety; and (3) If Client #2 does not return to staff supervision, follow "elopement/missing person procedures." At the time of the survey, the QIDP failed to coordinate with the interdisciplinary team to ensure times, distance and when to notify law enforcement were incorporated into the behavior support plan.	W 159			

Health Regulation & Licensing Administration

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{1 000}	INITIAL COMMENTS On June 14, 2013, an investigation was concluded that revealed the facility failed to be in compliance with the conditions of participation of governing body and client protections. A follow-up survey was conducted from July 25, 2013 through July 26, 2013 that revealed the facility failed to regain compliance with the aforementioned conditions of participation. The state agency informed the facility's chief operating officer (COO) of the determination on July 29, 2013, at approximately 1:00 p.m. In conjunction with the follow-up survey, an investigation was conducted concerning an allegation received by the Department of Health (DOH) on July 17, 2013, which indicated the agency's health certificates were invalid. Specifically, it was alleged that health certificates were altered to ensure compliance with established regulatory standards. The results of the investigation revealed the allegation was unsubstantiated. The findings of the follow-up survey were based on 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.	{1 000}		
1 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been performed and that the employee's health status	1 206		

Health Regulation & Licensing Administration
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Man J. Sloan

TITLE

COO

(X6) DATE

8/2/13

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0195	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/26/2013
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1206	Continued From page 1 would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to ensure that all employees and consultants had current certificates on file, for 2 of 67 records reviewed. (Consultants #14 and #17). The findings include: On July 25, 2013, at 10:40 a.m., interview with the agency's human resources manager revealed that it was the policy to ensure that employees, licensed professionals, and consultants maintain a current health certificate on file with the administrative office. Beginning at 1:52 p.m., a review of a sampling of the agency's personnel files was conducted. The review of the files revealed incomplete health certificates, as evidenced below: a. Consultant #17's tuberculin test was dated September 17, 2012. Further review of the health forms revealed there was no current physician's health inventory/certificate available for Consultant #17. b. Consultant #14's tuberculin test was dated February 19, 2013. Review of the health certificate, which was signed by the certified nurse practitioner, revealed it noted that the individual was free from communicable disease. Further review of the form, however, revealed it	1206 1206	The health certificates have been updated. In the future the HR department will ensure that there are quarterly audits of all personnel folders to ensure health certificates have been completed. ILS has developed an electronic audit and tickler system which completes monthly automated audits with reminders to key HR and management personnel. Attached: <ul style="list-style-type: none">• Health certificates for #14 and #17 staff• Automated iManage HR audit system record	8/26/13
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I 206	Continued From page 2 was not dated to verify when the health inventory/certificate was completed. The human resources manager was notified on July 25, 2013, at 4:32 p.m., and acknowledged that the two health files were incomplete.	I 206		
I 223	3510.4 STAFF TRAINING Each training program agenda and record of staff participation shall be maintained in the GHMRP and available for review by regulatory agencies. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the each training program agenda and record of staff participation shall be maintained in the GHID, and available for review by regulatory agencies, for three of four training's reviewed. The findings include: Interview with the chief operating officer on July 25, 2013 at 9:47 a.m., revealed the staff had received training on incident management, abuse and neglect and the residents behavior support plans. On July 26, 2013, at 4:27 p.m., the review of training records revealed although there was evidence that staff training had been conducted, the was the name of the individual who presented the training was not included on the training forms for the following dates: 1. June 24, 2013 - Infection control, seizures, OSHA, Protocols, Dental, HMCP, Signs and Symptoms of illness.	I 223	I 223 Training forms have been revised to include the name of the teacher/presenter and a synopsis of the material along with the staff signatures. In the future the Training Specialist and the QIDP will ensure that all training records are signed by the specific trainer and presenter. Attached: • Sample training / in-service record	8/26/13

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I 223	Continued From page 3 2. July 10, 2013 - Incident Management Procedures It should be noted that further review of the training records revealed a training sign in form dated July 7, 2013 indicated training was conducted by the behavioral specialist on behavior support plans (BSPs) for Residents #1, #2, #3, and #4. Although the sign in form included signatures of staff, and the behavior specialists name was typed on the form; no signature was included to verify who conducted the training.	I 223		
{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 (GHID) failed to ensure that all incidents that present a risk to residents' health and safety were reported immediately to the Department of Health, Health Regulation and Licensing Administration (DOH/HLRA), for one of the six residents of the facility. (Resident #2)	{I 379}		

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{1379}	Continued From page 4 The finding includes: On July 5, 2013, Resident #2 was taken to the emergency room (ER) for an assessment after being hit on her face by her one on one staff. Subsequently, the police were called to the facility and the perpetrator was arrested. The nurse immediately completed an assessment of Resident #2 to determine if any injuries were evident. The primary care physician (PCP) was notified and ordered that the resident be transported to the emergency room (ER) for an evaluation. Upon her arrival back to the facility around 8:30 p.m. she was reportedly apprehensive or fearful for going into the home and remained on the van for approximately an hour. Interviews with Staff #1 on July 9, 2013, revealed that after entering the home, she left staff supervision, and went into the community. The staff revealed that Resident #2 proceeded from the home to a busy street, and attempted to go into the traffic several times. According to staff, four other individuals from the home followed them into the community to coach the resident to return home. Staff #2 had just completed her shift approximately at 9:00 p.m. at the facility and was waiting at the bus stop located next to the church, and went over to assist them. At the time of the investigation, there was no evidence that an incident report was completed for Resident #2's elopement or that the incident was reported to the Department of Health.	{1379}	I 379, 500 The governing body has met with the interdisciplinary team for this individual and has developed measures to ensure the health and safety of this individual. 1. The BSP target area of - 'leave staff supervision' plan was amended to ensure that the plan provided 24 point steps staff would follow to intervene this type of behavior from escalating and ensure the health and safety of the individual at all times. 2. The staff were re-trained on the BSP - especially the 'proactive measures' staff should take to avert harmful situations from occurring especially when she threatens to elope or leaves staff supervision. CPEP will be used only when recommended by the psychiatrist. Training was also done on 2 person escort and physical guidance usage to protect the individual from harm and preserve her health and well-being.	
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Continued From page 5

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 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 (GHIID), for one of six residents in the facility. (Resident #2)

The findings include:

The GHIID failed to ensure Resident #2 was protected from abuse and potential harm.

§ 7-1305.10. Mistreatment, neglect or abuse prohibited; (formerly §6 -1970)

(a) Mistreatment, neglect or abuse in any form of any customer shall be prohibited.

The facility failed to establish and implement policies to ensure the safety during behavioral episodes for Resident #2.

The review of an incident report on July 26, 2013, at 2:17 p.m., revealed that on July 14, 2013, at 6:00 p.m., Resident #2 exhibited maladaptive behaviors, left the supervision of her one on one

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3. The QIDP has developed a more structured environment. The individual's personal schedule has been revised to include her outings and programming. She will work with her 1:1 staff to plan her outings for the week.
4. The QIDP has also developed an informal program for her to track her survival skills which will be incorporated in her daily schedule.
5. An elopement protocol has been developed with timelines and parameters to notify law enforcement and to utilize proactive measures to avert harmful situations from occurring.
6. A high risk for abuse and neglect tool has been created and all individuals at this facility have been assessed and a plan of care has been incorporated for them.
7. The Agency has employed a VP of Disability services and a Program Director for the ICF homes to increase the level of supervision and assistance.
8. The staffing schedule has been revised to ensure the 1:1 staffing is provided.
9. Emergency staffing Policy has been revised – with an on-call staff list
10. The management staff – QIDP & FC have developed a rotating schedule to ensure

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{1 500}	<p>Continued From page 6</p> <p>(Staff) #1, and refused to comply with staff requests. According to the corresponding investigation report dated July 14, 2013, at 4:15 p.m., Resident #2 left the facility and refused to come back. After being away from the facility for approximately 90 minutes, the resident knocked on strangers' doors, became verbally abusive and engaged in an unsafe behavior. Specifically, the resident was observed to lie down on a busy street. Staff #1 was noted to follow Resident #2 and to attempt to coach and redirect the resident out of the street, however she refused to get up. The staff required the assistance of two individuals in the community to direct traffic and prevent the resident from being struck by a car. Therefore, Staff #1 telephoned facility coordinator (FC) #1 for assistance. FC #1 then instructed Staff #1 to call the police. As Staff #1 was calling 911, the police, fire department and ambulance arrived to the scene. The paramedics stated that they were told that someone had been hit and that they had come to assess the individual.</p> <p>(a) Review of the facility's elopement policy on July 26, 2013, at 4:39 p.m., revealed "Leave without notification (elopement)" is "The unexpected or unauthorized absence of any duration for a person whose absence constitutes an immediate danger to that person or others." Further review of the elopement policy revealed the incident manager will notify law enforcement. It should be noted, however, the policy failed to identify a time frame for the notification of law enforcement.</p> <p>Although the review of the incident investigation revealed the incident manager was notified on July 14, 2013, at 4:15 p.m., when Resident #2 walked away from staff supervision and was followed by Staff #1, there was no evidence that</p>	{1 500}	<p>there is management supervision during waking hours.</p> <p>11. The Incident Management Coordinator has been re-trained on the Incident Management P&P, and the elopement protocol, the below mentioned trainings and reporting and notification timelines and parameters</p> <p>All staff have been trained in:</p> <ul style="list-style-type: none"> • BSP – proactive measures • Elopement protocol • CPI – physical guidance techniques, 2 person escort or hold • Incident management, reporting and notification • 1:1 job description • Individual's daily personal schedule • Active treatment • Recreation calendar – weekly • IPP – survival skills • Psychotropic medications • ABC data record • CPEP • High Risk assessment tool for – abuse & neglect 	
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{1 500}	Continued From page 7 the incident manager notified law enforcement in accordance with the facility's policy. (b) On July 26, 2013, at 3:05 p.m., review of the BSP dated July 26, 2012, revealed a target behavior of "leaving staff supervision" was identified. According to the BSP, "While this leaving may be very functional, (e.g., walking away from a situation, rather than becoming verbally or physically aggressive), this 'leaving' can include, leaving staff supervision, and engaging in "risk-taking behavior." The BSP instructed that, the one on one staff support should remain within line of sight of the resident, though no more than 10 feet from her. According to the BSP, there are times when Resident #2 will become upset and will begin to leave staff supervision. This may occur when out in the community, and may also occur in the resident, when she opens the front door and begins to walk outside and down the walkway. There are also times when Resident #2 will indicate she is planning to leave the residence without supervision. Staff should: · Encourage her to return; · May follow her for a short time, to ensure her safety; and · If Resident #2 does not return to staff supervision, follow "elopement/missing person procedures." 2. The facility failed to implement it's policy on reporting incidents that pose a risk to resident health or safety to the Department of Health as required. Interview with the QIDP #2 on July 9, 2013 revealed that on July 5, 2013, Resident #2 was taken to the emergency room (ER) for an	{1 500}	In the future the governing body will ensure that the health and safety of the individuals is always maintained. The VP of disability services and the PD will generate a weekly report on the status of the individuals and develop plans of care as needed to ensure the health and well-being of the individuals.	8/27/13

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assessment after being hit on her face by her one on one staff. Upon her arrival back to the facility around 8:30 p.m. the resident refused to exit the van. After entering the home, the resident immediately left staff supervision, and was followed by Staff #1 on a busy street. They remained in the community for an estimated time of 30 to 40 minutes. According to interview with Staff #1, the police were not notified.

Review of the facility's incident management policy on July 26, 2013, at approximately 4:37 p.m. revealed that the policy classified elopement as an incident. Additionally, the policy documented that the incident management coordinator will make verbal notification to the appropriate state offices for incident's affecting the health safety of the individual. A completed incident reporting form must be received by the appropriate state offices within one working day of discovery.

Further review of this incident revealed it was not reported to the Department of Health as required.

At the time of the revisit, the facility failed to ensure Resident #2's right to be protected from potential harm.

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