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 _____	07/26/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS 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 Client #1 sustained a severe injury to the right eye. During the investigative process on July 10, 2013, an incident occurred during the 4:00 p.m. - 12:00 a.m. shift where Client #2 sustained a severe injury to his right eye and was transported to the emergency room via 911. Due to the nature of the information obtained, the Health Regulation and Licensing Administration's (HRLA), Intermediate Care Facilities Division initiated an on-site incident investigation on July 9, 2013. The purpose of the investigation was to determine if the facility was in compliance with the regulatory standards. The findings of this investigation were based on interviews with facility staff, review of the agency's administrative records, including the review of the incident management system. As a result of the investigation, a determination was made on July 26, 2013, that the facility failed to ensure compliance with the federal conditions of participation of governing body, client protection, facility staffing, and health care services. The state agency informed the facility's chief executive officer (CEO) and chief operating officer (COO) of the determination on July 26, 2013, at approximately 11:30 a.m. [Qualified Mental Retardation Professional	W 000	Received 8/30/13 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	TITLE	(X6) DATE
Shawn D. Sloan	COO	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 000	Continued From page 1 (QMRP) will be referred to as Qualified Intellectual Disabilities Professional (QIDP) within this report.]	W 000		
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: Based on observation, interview and record review, the governing body failed to maintain general operating direction over the facility. [See W104] The effects of these systemic practices revealed that the facility's governing body failed to adequately govern the facility in a manner that would ensure the health and safety of all clients. [See also W122 and W158]	W 102	W 102 & 104 ILS has provided on-going training to all staff to ensure that the individuals' health and safety is always maintained. ILS is in the process of developing a 'monitoring plan' to include 'evening and night facility supervisors' who will be monitoring 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.	8/27/13
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the governing body failed to ensure effective operating direction over the facility in order to maintain clients' health and safety, for five of the five clients in the investigation. (Clients #1, #2, #3, #4 and #5)	W 104	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. The previous management team – QIDP and FC were terminated as they failed to ensure staffing compliance, oversight of staff and adequate training of staff.	

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W 104	Continued From page 2 The findings include: 1. The governing body failed to make certain established staffing was maintained to ensure client health and safety. On July 10, 2013, Client #2 sustained an injury to his right eye and was transported by emergency medical services to a local hospital's emergency room. Interview with staff and the review of the facility's internal investigation revealed that the client fell in his bathroom during the 4:00 p.m. - 12:00 a.m. shift. Interview with the facility's former residential coordinator (RC) on July 18, 2013, beginning at 10:50 a.m., revealed that Client #2 received one to one (1:1) staffing support 16 hours per day, 7 days a week. According to the former RC, the client was to receive arm's length 1:1 staffing support from 8:00 a.m. through 12:00 a.m. Interview with the former qualified intellectual disabilities professional (QIDP) on July 19, 2013, via telephone, verified the former RC's statement. Surveyors investigation of the incident revealed that the client, who had an unsteady gait and requires 1:1 staff support, was not provided with staffing supervision. The investigation also revealed that the governing body failed to effectively manage their direct care staff to ensure client's safety. Interview with the facility's former RC and the former QIDP, who both were terminated, revealed that the governing body was informed on several occasions that the direct care staff were not complying with the staffing schedule. The failure	W 104	1a-e. The facility schedule has been revised to ensure that there is sufficient staff on duty to remain compliant and provide health and safety of the individuals. 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. 2a-d. The facility schedule has been revised to ensure that there is sufficient staff on duty to remain compliant. The QIDP and Facility Manager have been in-serviced on monitoring the schedule daily and notifying the HR department for relief or supplemental staffing for vacancies or call-outs. In the future the Facility Manager and the QIDP will ensure that there is daily oversight of the staff schedule so as to maintain the required ratios to remain compliant and prevent potential falls or incidents. 3. i. A falls risk assessment has been completed. ii. A soft mattress has been purchased to be pulled out from under the bed (which will cover	

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W 104	Continued From page 3 of the staff to follow the established schedule placed the clients at risk and contributed to staffing neglect which led to a client fall as evidenced by the following: a. On July 15, 2013, beginning at 10:10 a.m., an interview was conducted with direct support professional (DSP) #5 to ascertain the staff's knowledge of Client # 2's fall that occurred on July 10, 2013. According to DSP #5, on the night of the incident, he arrived to work at 12:35 p.m. DSP #5 revealed that he received a telephone call from DSP #8 around 4:15 p.m. wherein DSP #8 revealed that he would be late for work. Continued discussion with DSP #5 revealed that DSP #8 was scheduled to arrive for duty 4:00 p.m., but DSP #8 did not arrive until 9:09 p.m. DSP #5 also stated that his supervisor was made aware of the aforementioned staffing arrangement. Interview with the former RC and former QIDP on July 18, 2013 and July 19, 2013, respectively however, revealed that they were unaware of the staffing change. It should be noted that DSP #8 was assigned to be Client #2's 1:1 support staff on July 10, 2013. At the time of the investigation, the facility failed to ensure that the established schedule, that included Staff #8's assignment to provide 1:1 staffing support for Client #2, was maintained. b. On July 15, 2013, beginning at 1:13 p.m., interview with DSP #8 verified that he arrived to work at 9:09 p.m. on July 10, 2013. Further interview revealed he was assigned to Client #2 as his 1:1 staff for the evening. DSP #8 stated that he contacted DSP #5 via text message at approximately 6:00 p.m. on July 10, 2013, to inform him that he would be arriving to the facility a little later.	W 104	the length of the bed) to cushion any falls adjacent to the length of the bed. iii. The bed will always be kept at the lowest height setting. iv. There will always be 1 awake staff sitting at the door of the bedroom observing the individual whenever he is in his bed. v. All staff have been in-serviced on 1:1 job description, adaptive equipment, bed rails, unsteady gait/fall prevention and BSP. vi. Staff have been in-serviced on proper notification of management if they unable to fill their assigned shift. vii. FC meets with HR weekly – to review staff schedule, discuss vacancies and compliance issues. viii. Current staffing schedules will be posted on the bulletin board for each facility.	

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W 104	Continued From page 4 c. On July 16, 2013, beginning at 10:55 a.m., interview with DSP #7 revealed she was assigned to Clients #3 and #4 on July 10, 2013, during her shift from 2:00 p.m. to 10:00 p.m. DSP #7 stated that on July 10, 2013, just before 9:00 p.m., she was informed by DSP #5 (who was assigned 4:00 p.m. - 12:00 a.m. shift) that he was leaving at 9:00 p.m. DSP #7 also stated that she did not inform her supervisor, because she thought DSP #5 was the manager of the shift. d. Interview with the former RC on July 18, 2013, beginning at 10:50 a.m. revealed that DSP #5 and DSP #8 were scheduled to work the 4:00 p.m. to 12:00 a.m., shift on July 10, 2013. The former RC further revealed that she was not made aware that DSP #5 had arrived to work at 12:35 p.m. and ended his shift at 9:00 p.m. on July 10, 2013. She further stated that she was not made aware that DSP #7 had worked an extra hour and a half and that DSP #8 reported to work after 9:00 p.m. on July 10, 2013. e. Interview with the former QIDP, via telephone, on July 19, 2013, beginning at 1:33 p.m., revealed that she was not aware that on July 10, 2013, DSP #5, DSP #7 and DSP #8 had corroborated with each other regarding their schedule change. The former QIDP additionally stated that this was an ongoing concern. She stated that she had conducted training with staff to specifically address the chain of command when calling out and with regard to revising assigned schedules between staff members. Review of the staff in service training records on July 19, 2013, at approximately 2:00 p.m., revealed there was no documented evidence of the aforementioned training.	W 104	Attached: • staff schedule • emergency chain of command notification process • On-call staff list • Emergency staffing policy • 1:1 staff training • Falls risk assessment • Fall precaution and prevention • Clients' rights • Abuse and neglect • In-service for the above • Mattress purchase receipt • Disciplinary action for involved staff • Shift change report	8/22/13

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W 104	Continued From page 5 Note: A conference was held with the facility's senior management on July 26, 2013. According to discussion with the chief executive officer during the meeting, it was indicated that the governing body was concerned with the direct management of the facility and attributed many of their concerns to a management's failure to provide adequate oversight and supervision. 2. The governing body failed to ensure there was adequate staffing coverage at all times on all shifts, as evidenced by the following: a. Interview with the former RC on July 18, 2013, beginning at 10:50 a.m., revealed that there was no concrete staffing schedule in place during the 4:00 p.m. to 12:00 a.m. shift due to shortage of staff. Further interview with the former RC revealed the following staffing coverage was established for July 10, 2013. - DSP #4 was scheduled to work the 4:00 - 12:00 a.m. shift; - DSP #5 was scheduled to work the 4:00 - 12:00 a.m. shift; - DSP #6 was scheduled to work the 1:00 - 9:00 p.m. shift; - DSP #7 was scheduled to work the 2:00 - 10:00 p.m. shift; and - DSP #8 was scheduled to work the 4:00 - 12:00 a.m. shift. Continued interview with the former RC revealed that at the time of incident involving Client #2 on July 10, 2013, there were only two staff on duty (DSP #4 and DSP #8). There were four clients residing in the facility, two of which received 16 hours 1:1 staffing support. There should have	W 104		

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W 104	Continued From page 6 been at least three staff on duty and present in the facility during 4:00 p.m. - 12:00 a.m. shift. b. On July 11, 2013, at approximately 8:40 p.m., an onsite evening observation revealed three (3) DSPs working the 4:00 p.m. - 12:00 a.m. shift. At approximately 8:50 p.m., interview with DSP #6 revealed he was scheduled to get off at 9:00 p.m. Shortly afterwards, interview with DSP #7 revealed that she was scheduled to get off at 10:00 p.m., leaving only DSP #4 to supervise Clients #1, #2, #3 and #4. Interview with the former RC and former QIDP on July 11, 2013, at approximately 9:00 p.m., revealed they both were unaware that DSP #4 would be the only staff supervising the clients after 10:00 p.m. When asked to see a current staffing schedule, neither the former RC nor the former QIDP could produce a schedule. c. On July 18, 2013, at approximately 5:00 p.m., interview with DSP #9, via telephone, revealed that on July 11, 2013, he was assigned to work the overnight shift (12:00 a.m. - 8:00 a.m.). Further interview revealed he worked the overnight shift by himself. Interview with both the former RC and QIDP on July 11, 2013, at approximately 9:15 p.m., revealed that there should have been at least two staff working the overnight shift. A telephone interview conducted with the chief executive officer (CEO) on July 22, 2013, at approximately 12:00 p.m., verified that there should have been at least two staff present during the overnight shift. Review of the proposed staffing schedule on July 19 2013, at approximately 3:00 p.m., revealed that on July 10, 2013 and July 11, 2013, there were five (5) staff scheduled to work during the evening shift (1:00 - 9:00 p.m., 2:00 - 10:00 p.m., and 4:00 - 12:00 a.m. shift) and two (2) staff	W 104		

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W 104	Continued From page 7 scheduled to work the overnight shift (12:00 a.m. - 8:00 a.m.). At the time of the investigation, however, the facility failed to ensure the staffing schedule was implemented as proposed. d. On July 20, 2013, beginning at approximately 11:10 p.m., an onsite visit was conducted to ensure the facility provided adequate staffing. DSP #11 was noted to answer the front door. Upon entering the facility, Client #5 was observed sitting on the sofa in the living room watching television while Clients #1, #2, #3 and #4 were in their bedrooms asleep. After entering the facility, observations revealed DSP #11 sitting on the sofa in the living room directly across from Client #5. At approximately 11:15 p.m., DSP #5 was observed sitting in a chair in Clients #1 and #2's (both who required 1:1 staff support for 16 awaking hours a day) bedroom and DSP #6 was sitting at the dining table working on paperwork. At approximately 11:20 p.m., interview with DSP #11 revealed that she was assigned to provide 1:1 staff supervision for Client #1 (from 4:00 p.m. - 12:00 a.m.). DSP #11 further revealed that at the the time of the interview, she was providing 1:1 staffing support to Client #5 because he was up watching television and walking around the facility. According to DSP #11, Client #5's assigned 1:1 worked from 4:00 p.m. until 9:00 p.m. on July 20, 2013. Interview with DSP #6 on July 20, 2013 at approximately 11:25 p.m., revealed that he was assigned to provide close supervision to Clients #3 and #4 from 4:00 -12:00 a.m. Interview with DSP #5 at 11:30 p.m. revealed that he was assigned to work with Client #2 from 4:00 p.m. - 12:00 a.m. According to DSP #5 however, he was providing supervision to both Clients #1 and	W 104		

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W 104	Continued From page 8 #2 since they both slept in the same bedroom. Review of the proposed staffing scheduled on July 22, 2013, at approximately 9:50 a.m., revealed there were five staff scheduled to work the evening shift, four from 4:00 p.m. - 12:00 a.m. and one from 4:00 p.m. - 9:00 p.m. At the time of the investigation, the facility failed to ensure the staffing schedule was implemented as proposed. 3. The governing body failed to ensure effective safeguards were implemented to maintain Client #2's safety in bed. On July 11, 2013, at approximately 4:30 p.m., observations revealed Client #2 lying in his bed wearing a soft blue protective helmet. When interviewed at 4:32 p.m., DSP #12 revealed that Client #2 was banging his head on the wall and therefore, the protective helmet had to remain on. Continued observations revealed Client #2 attempted to get out of his bed by rolling onto right side, placing both legs over the top of the bedrail, and trying to pull himself over the bedrail. At approximately 4:35 p.m., interview with DSP #12 revealed that Client #2 could climb over the bedrail to get out of the bed. Further interview with DSP #12 revealed Client #2 could also scoot to the end of bed where there was an opening and get out of bed. DSP #12 stated that Client #2 had a severe unsteady gait and mobility deficits that required one to one (1:1) supports as all times while in bed and while ambulating. Interivew with the former QIDP on July 11, 2013, at approximately 4:40 p.m., revealed that she was aware that Client #2 could climb over the bedrails. The QIDP stated that she was going to	W 104		

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W 104	Continued From page 9 address the concern with the interdisciplinary team. At the time of the investigation, the governing body failed to make certain Client #2 was provided with adequate systems/supports to ensure his health and safety.	W 104	W 122 In the future the agency will ensure that staff will provide the individuals the opportunity and the freedom to exercise their rights.	8/22/13
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on interview and record review, the facility failed to ensure the rights of each client to receive a shower [See W125]; failed to thoroughly investigate serious physical injuries and/or incidents of neglect [See W154]; and failed to report the results of investigation of an allegation of abuse/neglect to the administrator or designated representative within five working days [W156]. The effects of these systemic practices resulted in the failure of the facility to protect its clients and ensure their health and safety. [See also W158]	W 122	All staff were in-serviced on clients' rights, abuse, neglect, exploitation, client protection. The agency's Incident Management Coordinator was in-serviced on the revised Incident management P&P and the revised Incident management process – timelines for reporting and notification to all regulatory bodies and law enforcement agencies. The senior management team conducts weekly meetings to discuss incidents, issues and plans of corrections for all individuals and facilities. Attached: trainings	
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by:	W 125	• Clients' rights • Abuse and neglect • Disciplinary action for involved staff	

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W 125	Continued From page 10 Based on interview and record review, the facility failed to ensure the rights of each client to receive a shower, for one of the four clients in the investigation. (Client #2) The finding includes: On July 10, 2013, during the 4:00 p.m. - 12:00 a.m. shift, Client #2 fell in his bathroom at approximately 11:50 p.m. causing a severe injury to his right eye. Client #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 facility's internal investigation revealed the client 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 Client #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 Client #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 heard Client #2 mutter shower repeatedly. DSP #4 stated that DSP #5 did not give Client #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 Client #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 client after dinner although the client was asking to be showered. DSP #5 did state however, that the	W 125	W 125 The staff involved has been disciplined. In the future all staff will ensure that individuals' rights are never violated and they are encouraged and given the opportunity to exercise their rights at all times. A 'shift change report' has been developed so that staff will complete a written/computerized report to the oncoming staff on the status of each individual during their shift. All staff in the facility have been in-serviced on clients' rights, abuse/neglect, exploitation, ADLs. Attached: • Clients' rights • Abuse / neglect • ADLs • BSP • Progress notes • Shift change report	8/22/13

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 _____	07/26/2013

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

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W 125	Continued From page 11 client 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 Client #2 as his 1:1 staff on July 10, 2013) revealed that while preparing the client for the emergency medical services; he noticed that the client's undergarments were soiled. He stated that he did not check to see if Client #2's undergarment was soiled after his arrival to work at 9:09 p.m. DSP #8 stated that the client 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 facility staff failed to ensure Client #2 received a shower in accordance with his rights.	W 125		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure an allegation of abuse and a serious physical injury was thoroughly investigated, for two of the four clients in the investigation. (Clients #1 and #2) The findings include: I. The facility failed to ensure an incident involving Client #2 was comprehensively investigated to make certain pertinent information was obtained to make an accurate disposition of the incident. Additionally, the investigation report	W 154		

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W 154	Continued From page 12 failed to address and identify conflicting statements. On July 11, 2013, at approximately 7:00 p.m., review of an unusual incident report revealed Client #2 fell on his bathroom floor on July 10, 2013 at 11:50 p.m. The client was taken to the emergency room via 911 emergency services and received several stitches. On July 23, 2013, at approximately 11:45 a.m., review of the facility's internal investigation completed on July 19, 2013, revealed the incident management coordinator (IMC) documented the disposition of the investigation as unsubstantiated and resolved. A. The facility's internal investigation revealed at approximately 11:50 p.m., direct support professional (DSP) #8 stated that when he reached to top of the stairs with the mop and bucket, he heard a shuffle that came from Client #2's room. DSP #8 stated that he immediately ran to Client #2's bedroom and witnessed the client fall head first on his bathroom floor. State Surveyor's face to face interview with DSP #8 on July 15, 2013, beginning at 1:13 p.m., revealed the staff member walked down to the basement area to start laundry and to get the mop and bucket at 11:45 p.m. DSP #8 stated that he was in the basement for 5 to 7 minutes. While coming back up the stairs, he revealed he heard a thump/shuffle coming from Client #2's bedroom. DSP #8 stated that he ran to Client #2's bedroom and as he entered the bedroom (with approximately one foot inside the bedroom), he found Client #2 lying on his side in the bathroom. According to the interview, DSP #8 further described his position in Client #2's	W 154	W 154 All staff involved were disciplined. All staff were in-serviced on all the individuals' BSP. The IMC was in-serviced on conducting a comprehensive and thorough investigation. In the future the agency shall place staff involved in an incident of neglect or abuse, on immediate administrative leave and ensure that a thorough investigation is conducted. Senior management staff will be involved during the investigatory process. The Incident Management process was revised to include senior management review and approval of all investigations prior to dissemination to regulatory agencies. The agency shall also make arrangements to schedule the IMC to attend an additional investigatory course. The governing body will ensure that staffs who are assigned to individuals as their 1:1 will have adequate skills, be knowledgeable and be physically fit to ensure the safety and protection of the individual at all times. The agency's IMC meets with senior administrators weekly to present a written report on the status of all incidents and investigations.	

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W 154	Continued From page 13 bedroom at the time of the incident. DSP #8 revealed that he was standing close to the entrance of the bedroom next to the client's dresser. A reenactment of the incident was conducted on July 19, 2013, at approximately 11:40 a.m. Based on observation of the facility, Surveyor #1 remained standing on the top of the stairs, while Surveyor #2 went into Client #2's bedroom and made shuffling sounds. There where large portable free standing air conditioner units observed in the living room and in Client #2' s bedroom, at the time of the reenactment, which made a loud noise when they were operating. Surveyor #1 could not here any sounds coming from Client #2's bedroom. Further observations revealed the entrance into the bathroom was not within the line of sight of a person entering the bedroom due to the obstruction of the wall and the placement of Client #2's dresser. In order to witness Client #2 falling inside his bathroom or to have already fallen, the DSP would have had to be inside the bedroom facing the bathroom. It should be noted, that DSP #8 also stated that the air conditioner units were on at the time the incident. Interview with the facility's former residential coordinator (RC) on July 18, 2013, beginning at 10:50 a.m., revealed that Client #2 received one to one (1:1) staffing support 16 hours per day, 7 days a week. According to the former RC, the client was to receive arm's length 1:1 staffing support from 8:00 a.m. through 12:00 a.m. Interview with the former qualified intellectual disabilities professional (QIDP) on July 19, 2013, via telephone, verified the former RC's statement. It should be noted that on July 10, 2013, during the evening shift (4:00 p.m. - 12:00 a.m.) DSP #8 was responsible for Client #2. The facility failed	W 154	8/22/13 Attached: • in-services – Incident management P&P, BSP, Abuse/neglect • Disciplinary action for involved staff	

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W 154	Continued From page 14 to identify the failure of the DSP to provide 1:1 supervision. B. The facility's internal investigation revealed DSP #4 was on the computer completing client notes at 11:45 p.m. when he heard a thump in the Client #2's bedroom. It should be noted that the computer area is located approximately eight feet from Client #2's bedroom. State Surveyor's face to face interview with DSP #4 on July 11, 2013, at 8:40 p.m. and July 15, 2013, at 2:03 p.m. respectively, revealed at approximately 10:45 p.m., he heard the thump and yelled out to DSP #8, "Go check on your man". DSP #8 stated that at the time he heard the thump, DSP #4 was "somewhere in the facility chillin". According to DSP #4, DSP #8 was not in the vicinity of Client #2 when he fell. C. The facility internal investigation failed to ensure all pertinent staff were interviewed regarding the July 10, 2013 incident. 1. On July 17, 2013, at 5:22 p.m., interview with DSP #9, via telephone, revealed he worked the overnight shift from 12:00 a.m. to 8:00 a.m. on July 11, 2013. Further interview with DSP #9 revealed that on the evening of July 10, 2013, he arrived for duty at approximately 11:44 p.m. DSP #9 stated that after talking with DSP #10 and clocking in, he walked upstairs were he observed DSP #8 and DSP #4 sitting at the dining room table treating the injury to Client #2's face. DSP #9 stated that he did not assist staff with the care of Client #2's injury. It should be noted, according to the investigation report and interviews conducted during the investigation, the exact time of the incident was not consistent. Interview with DSP #4 on July 11,	W 154		

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W 154	Continued From page 15 2013, at 8:40 p.m. revealed the documented time of the incident was incorrect. DSP #4 revealed that the incident occurred some time between 10:40 p.m. and 10:45 p.m. Interview with DSP #8 on July 15, 2013, beginning at 1:13 p.m., however revealed the incident occurred at 11:50 p.m. At the time of the investigation, the specific time of the incident remained unknown. 2. On July 19, 2013, at 11:27 a.m., a telephone interview conducted with DSP #10 that revealed he worked the overnight shift from 12:00 a.m. to 8:00 a.m. on July 11, 2013. Further interview with DSP #10 revealed that on the evening July 10, 2013, he arrived for duty between 11:45 p.m. - 12:00 a.m. DSP #10 stated that when he clocked in, DSP #9 was downstairs in the basement. While walking upstairs, DSP #8 and DSP #4 were observed cleaning Client #2's face in the dining room area. Shortly clocking in, DSP #10 revealed that he went to the hospital to relieve the 1:1 staff for Client #5. Note: On July 23, 2013, at approximately 11:45 a.m., review of the facility's time cards confirmed that DSP #9 clocked in to the facility at 11:44 p.m. and DSP #10 clocked in to the facility at 11:48 p.m., which would have put both DSP #9 and DSP #10 in position to have witnessed the incident and/or assisted with treating the client's injury on the night of July 10, 2013. II. Review of an unusual incident report on July 9, 2013, at approximately 3:50 p.m., revealed Client #1 engaged in a self-injurious behavior (SIB) that resulted in an injury to his right eye (swollen, red and puffy). Reportedly, Client #1 hit himself on the right side of his face several times non-stop	W 154		

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W 154	Continued From page 17 redirected and "eventually stopped". At 8:25 a.m. until 8:36 a.m., Client #1 began hitting himself again "extremely hard" on the right side of his face non-stop to the point where swelling was observed underneath his right eye and on the right side of his face. DSP #1 stated DSP #3 verbally prompted Client #2 to stop, but the client did not respond and continued to hit himself. DSP #1 stated that she provided no other intervention. When queried about implementing the BSP, DSP #1 replied by saying, "I was shocked! What could I do, he's stronger that I am." DSP #1 stated that she had received training on Client #1's behavior support plan (BSP) and crisis prevention interventions (CPI). B. The facility's internal investigation failed to address DSP #1's failure to implement the BSP. The facility's internal investigation revealed on July 9, 2013, at 8:09 p.m., DSP #2 described that Client #1 began slapping his face at 8:25 a.m. while drinking coffee in the living room. DSP #2 stated that Client #1 hit himself multiple times which caused staff to verbally prompt him to stop. However, his behavior continued despite their efforts. State Surveyor's face to face interview with DSP #2 on July 10, 2013, beginning at 10:44 a.m. revealed that on the morning of July 9, 2013, she provided Client #1 with his morning cup of coffee after 8:00 a.m. At approximately 8:10 a.m., Client #1 was observed to hit himself in the face twice while drinking coffee. DSP #2 stated that she verbally prompted the client to stop. According to DSP #2, Client #1 stopped hitting himself and finished his coffee. DSP #2 stated that Client #1 "signed for another cup of coffee" but did not get	W 154		

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W 154	Continued From page 16 from 8:25 a.m. to 8:36 a.m. The client was taken to the ophthalmologist and was diagnosed with a contusion to the right eye. On July 17, 2013, at approximately 12:30 p.m., review of the facility's internal investigation, completed on July 16, 2013, revealed the IMC documented that the aforementioned allegation of abuse and neglect was resolved and was unsubstantiated. Continued review of the investigation revealed that the staff's failure to provide interventions to assist Client #1 during the noted behavior was not documented. Additionally, the investigation failed to address the conflicting information noted below: A. The facility's internal investigation revealed that on July 9, 2013, at 8:09 p.m., DSP #1 documented that Client #1 "smacked" himself in the face 2-3 times while sitting in the living with his peers and staff drinking coffee. DSP #1 stated that after the 2-3 hits, a "huge knot" formed underneath the client's right eye. DSP #1 further stated that Client #1 started hitting himself again in the face and eye at approximately 8:25 a.m. DSP #1 asked Client #1 to calm down and offered the client water. In a face to face interview with DSP #1 on July 10, 2013, beginning at 9:48 a.m., the staff member revealed he/she was assigned to Client #1 as his one to one (1:1) staffing support on the morning of July 9, 2013, from 8:00 a.m. to 4:00 p.m. due to the client's maladaptive behaviors of physical aggression and self-injurious behaviors (SIB). DSP #1 revealed that at 8:09 a.m., Client #1 was sitting in a chair in the living room drinking coffee and was observed to "smack" himself on the right side of his face with his right hand five (5) times. DSP #1 stated that Client #1 was	W 154		

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W 154	Continued From page 18 it. At 8:25 a.m., DSP #2 stated that Client #1 began slapping himself with his right hand to the right side of his face "extremely hard". The slaps were "very loud and it was scary. I was shocked!" DSP #2 stated that she provided no intervention. DSP #2 then stated that DSP #3 walked toward Client #1 and verbally prompted the client to calm down but was unsuccessful. C. The facility failed to identify the DSP's neglect of service provision which permitted the client to continue exhibiting self-injurious behaviors without appropriate intervention. The facility's internal investigation revealed on July 9, 2013, at 8:09 p.m., that DSP #3 observed Client #1 at approximately 8:25 a.m. slapping himself with his right hand against the right side of his face causing his eye to become red and swollen. The statement reflected that DSP #3 approached Client #1 and attempted to calm him down but was unsuccessful. State Surveyor's face to face interview with DSP #3 on July 10, 2013, beginning at 11:16 a.m., revealed that on the morning of July 9, 2013, he was the 1:1 staff for Client #2. DSP #3 revealed that he was positioned in the living room with Client #1 at the time the injury occurred. At approximately 8:25 a.m., DSP #3 stated that he observed Client #1 hit himself 4 to 5 times in the face "very hard". DSP #3 stated that DSP #1 (who was assigned as Client #1's 1:1 support staff) jumped up and moved away from Client #1. DSP #3 verbally prompted the [client] to calm down and asked, "Are you ok?" DSP #3 then stated that Client #1 continued to hit himself in the face repeatedly and that's when DSP #3	W 154		

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W 154	Continued From page 19 walked over to the client and placed the client's hands on his legs with my hands on top of his hands and said, "Calm down, its ok." DSP #3 stated that when he walked back over to his client, Client #1 began hitting himself again. DSP #3 stated that he informed DSP #1 to go get Client #1 some water. DSP #3 went back over to Client #1 and the client used his left hand to shield the DSP from his space, and continued to hit himself in the face. At that time, DSP #3 noticed with each hit, Client #1's face began to get red and underneath his eye began to puff up. According to DSP #3, shortly after drinking some water, Client #1 hit himself a few more time. DSP #3 stated that he walked over to Client #1 and stated, "That's enough" in a firm voice. At the time of the investigation, the facility failed to ensure a comprehensive and thorough investigation was conducted.	W 154		
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to report the results of alleged allegations of abuse and neglect and injuries of unknown origin to the administrator or designated representative within five working days of the incident, for three of the five clients involved in investigation. (Clients #1, #2 and #5) The findings include:	W 156		

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W 156	Continued From page 20 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 Client #1 sustained a severe injury to the right eye. During the investigative process on July 10, 2013, a second incident occurred involving Client #2 during the 4:00 p.m. to 12:00 a.m. shift. According to the information provided, Client #2 sustained a severe injury to his right eye and was transported to the emergency room via 911. Review of the facility's incident and investigation reports on July 10, 2013, at approximately 1:20 p.m. and on July 17, 2013, at 12:27 p.m., respectively revealed the results of the investigations for the following allegations of abuse/neglect and injuries of unknown origin were not reported to the administrator or designated representative within five working days, as evidenced by the following: a. On July 9, 2013, Client #2 was sitting in the living room and at 8:09 a.m., the client began smacking his face and head with his right hand on the right side of his face. At 8:25 a.m., Client #2 repeated the smacks to the right side of his face consistently until he stopped at 8:36 a.m. which resulted in a severe injury to his right eye (swollen, red and puffy). It should be noted that interview with the facility's former residential coordinator (RC) on July 18, 2013, beginning at 10:50 a.m., revealed that Client #2 received one to one (1:1) staffing support 16 hours per day, 7 days a week.	W 156	W156 The Incident Management Process was revised to include senior administration review and approval and signature on all investigations within the 5day period. The agency's IMC meets with senior administrators weekly to present a written report on the status of all incidents and investigations. In the future the agency's senior administrators will ensure that they are involved in the investigatory process for all serious reportable incident investigations. A tracking and trending system has been developed to ensure all investigations are completed according to state and federal guidelines. Attached: • Incident Management Process • Incident tracking and trending system • Disciplinary action for involved staff	8/22/13

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W 156	Continued From page 21 According to the former RC, the client was to receive arm's length 1:1 staffing support from 8:00 a.m. through 12:00 a.m. Interview with the former qualified intellectual disabilities professional (QIDP) on July 19, 2013, via telephone, verified the former RC's statement. Review of the corresponding investigative report revealed the incident management coordinator (IMC) completed and signed the investigation on July 16, 2013. Further review revealed there was no documented evidence that the results of the investigation were reported to the administrator within five working days of the incident. b. On July 10, 2013, at 11:50 p.m., Client #2 fell on his bedroom floor injuring his right eyebrow and was transported to a local hospital emergency room via 911. Further review of the incident report revealed the client was kept overnight and received several stitches. Review of the corresponding investigative report revealed IMC completed the investigation on July 19, 2013. Further review revealed the administrator reviewed and signed the results of the investigation on July 23, 2013 (13 days after the incident). c. On June 29, 2013, at 8 p.m., Client #5 fainted in the bathroom. The nurse was notified and he was taken to the hospital emergency room and admitted. Review of the corresponding investigative report revealed the IMC completed the investigation on July 5, 2013. Further review revealed the administrator reviewed and signed the results of the investigation on July 22, 2013 (23 days after the incident). d. On May 17, 2013, at 7:30 a.m., staff	W 156		

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	09G212	A. BUILDING _____ B. WING _____	07/26/2013

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W 156	Continued From page 22 discovered a bruise on Client #2's left side around the rib cage. According to the incident report, the bruise was found while preparing the client for his shower. Staff could not determine the bruise's origin. Review of the corresponding investigative report dated June 5, 2013, revealed the IMC completed the investigation on June 19, 2013. Further review revealed the administrator reviewed and signed the results of the investigation on June 19, 2013 (30 days after the incident). It should be noted that according to the investigation, the facility's director of nursing described the bruise as "pretty bad" and ordered for Client #2 to be transported via 911 emergency services to the hospital. The facility's registered nurse also described the size of the bruising to be measured at approximately "15 centimeters (cm) x 15 cm". e. On May 6, 2013, at approximately 4:30 p.m., the residential coordinator alleged that she witnessed a staff member physically abusing Client #2 by bending and twisting his left arm and yelling at him during a community outing. Review of the corresponding investigation dated June 17, 2013 revealed the IMC completed the investigation on June 17, 2013. Further review of the investigation revealed the administrator signed off on the results of the investigation on June 17, 2013 (41 days after the incident). At the conclusion of the incident/investigation review, the facility failed to provide evidence that the results of the aforementioned investigations were reviewed by the administrator or designated representative within five working days of the incidents as required.	W 156		
W 158	483.430 FACILITY STAFFING	W 158		

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W 158	Continued From page 23 The facility must ensure that specific facility staffing requirements are met. This CONDITION is not met as evidenced by: Based on observations, staff interviews, and record review, the qualified intellectual disabilities professional (QIDP) failed to integrate and coordinate services to ensure staff were available and effectively trained to provide habilitation services in accordance with each client's needs [See W159]; failed to ensure there was a sufficient number of staff on duty to make certain chore activities did not interfere with established one to one duties and responsibilities [W185]; failed to provide sufficient staffing and one to one (1:1) supervision to protect clients from harm and to ensure their safety [See W186]; failed to ensure staff were effectively trained to address a client's change in health status [See W192]; and failed to ensure staff demonstrated the skills and techniques necessary to implement each client's behavior support plan [See W193]. The effects of these systemic practices resulted in the facility's failure to provide adequate staffing and ensure each client's health and safety. [See also W104 and W122]	W 158	W 158 (cross refer W 104, W 122) The facility schedule has been revised to ensure that there is sufficient staff on duty to remain compliant and maintain the mandated staff: individual ratios. 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 schedule so as to maintain the required ratios to remain compliant and prevent potential falls or incidents and provide safety. Attached: • staff schedule • emergency chain of command notification process • On-call staff list • Emergency staffing policy • 1:1 staff training • Disciplinary action for involved staff	8/22/13
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:	W 159		

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W 159	Continued From page 24 Based on interview and record review, the qualified intellectual disabilities professional (QIDP) failed to integrate and coordinate services to ensure staff were available and effectively trained to provide habilitation services in accordance with each client's needs, for two of the five clients residing in the facility. (Clients #1 and #2) The findings include: 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 Client #1 sustained a severe injury to the right eye. During the investigative process on July 10, 2013, a second incident occurred involving Client #2 during the 4:00 p.m. to 12:00 a.m. shift. According to the information provided, Client #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 Client #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	W 159	W 159 The facility schedule has been revised to ensure that there is sufficient staff on duty to remain compliant. The QIDP and Facility Manager have been in-serviced on monitoring the schedule daily and notifying the HR department for relief or supplemental staffing for vacancies or call-outs. In the future the Facility Manager and the QIDP will ensure that there is daily oversight of the staff so as to maintain the required ratios to remain compliant and provide safety. An acuity package requesting a 1:1 staff has been submitted to DHCF for Client#3 to formally request a 1:1 staff for him. In the interim the staffing schedule has been revised to provide more oversight of the individuals. All staff were in-serviced on the individual's BSPs. 1:1 job description, staff schedule, PT – ambulation with gait belt training and active treatment.	

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W 159	Continued From page 25 member revealed he/she was assigned to Client #1 as his one to one (1:1) staffing support on the morning of July 9, 2013, from 8:00 a.m. to 4:00 p.m. due to the client's maladaptive behaviors of physical aggression and self-injurious behaviors (SIB). DSP #1 revealed that at 8:09 a.m., Client #1 was sitting in a chair in the living room drinking coffee and was observed to "smack" himself on the right side of his face with his right hand five (5) times. DSP #1 stated that Client #1 was redirected and "eventually stopped". At 8:25 a.m. until 8:36 a.m., Client #1 began hitting himself again "extremely hard" on the right side of his face non-stop to the point where swelling was observed underneath his right eye and on the right side of his face. DSP #1 stated DSP #3 verbally prompted Client #2 to stop, but the client did not respond and continued to hit himself. DSP #1 stated that she provided no other intervention. When queried about implementing the BSP, DSP #1 replied by saying, "I was shocked! What could I do, he's stronger that I am." DSP #1 stated that she had received training on Client #1's behavior support plan (BSP) and crisis prevention interventions (CPI). Interview with DSP #2 on July 10, 2013, beginning at 10:44 a.m. revealed that on the morning of July 9, 2013, she provided Client #1 with his morning cup of coffee after 8:00 a.m. At approximately 8:10 a.m., Client #1 was observed to hit himself in the face twice while drinking coffee. DSP #2 stated that she verbally prompted the client to stop. According to DSP #2, Client #1 stopped hitting himself and finished his coffee. DSP #2 stated that Client #1 "signed for another cup of coffee" but did not get it. At 8:25 a.m., DSP #2 stated that Client #1 began slapping himself with his right hand to the right side of his	W 159	Attached: • BSP & CPI training • 1:1 job description • Staff schedule • PT in-service • Active treatment • HRC – emergency approval for interim 1:1 staff • Acuity package to DHCF – receipt • Disciplinary action for involved staff	8/25/13

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W 159	Continued From page 26 face "extremely hard". The slaps were "very loud and it was scary. I was shocked!" DSP #2 stated that she provided no intervention. DSP #2 then stated that DSP #3 walked toward Client #1 and verbally prompted the client to calm down but was unsuccessful. Interview with DSP #3 on July 10, 2013, beginning at 11:16 a.m., revealed that on the morning of July 9, 2013, he was the 1:1 staff for Client #2. DSP #3 revealed that he was positioned in the living room with Client #1 at the time the injury occurred. At approximately 8:25 a.m., DSP #3 stated that he observed Client #1 hit himself 4 to 5 times in the face "very hard". DSP #3 stated that DSP #1 (who was assigned as Client #1's 1:1 support staff) jumped up and moved away from Client #1. DSP #3 verbally prompted the [client] to calm down and asked, "Are you ok?" DSP #3 then stated that Client #1 continued to hit himself in the face repeatedly and that's when DSP #3 walked over to the client and placed the client's hands on his legs with my hands on top of his hands and said, "Calm down, its ok." DSP #3 stated that when he walked back over to his client, Client #1 began hitting himself again. DSP #3 stated that he informed DSP #1 to go get Client #1 some water. DSP #3 went back over to Client #1 and the client used his left hand to shield the DSP from his space, and continued to hit himself in the face. At that time, DSP #3 noticed with each hit, Client #1's face began to get red and underneath his eye began to puff up. According to DSP #3, shortly after drinking some water, Client #1 hit himself a few more time. DSP #3 stated that he walked over to Client #1 and stated, "That's enough" in a firm voice. On July 10, 2013, beginning at approximately	W 159		

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W 159	Continued From page 27 5:10 p.m., review of Client #1's BSP dated April 13, 2013, revealed Client #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 client, given the high level of risk of several of his target behaviors. Continued review of the BSP revealed that if Client #1 engaged in SIB, staff should implement the following proactive strategies: a. Whenever possible, he [client] should be redirected before he actually attempts to engage him in this behavior. b. As soon as it is feasible, staff should attempt to identify the stimulus for this behavior. This includes if Client #1 is only beginning to become agitated. If a stimulus can be ID, staff should attempt to address this as soon as possible. c. If Client #1 begins to engage in SIB, staff should first attempt to verbally redirect him away from this and toward an activity. For example, staff may offer to take the client for a walk, offer an activity using his hands, assist with the laundry, offer choices, etc. Staff may say in a calm but firm voice, "Please stop (state behavior)!" d. If the client does not respond to verbal redirection and continues to engage in SIB, staff should refer to the crisis intervention plan. Review of the crisis intervention plan revealed that if Client #1 became agitated and began to present a danger to himself or others, staff may	W 159		

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W 159	Continued From page 28 use the least restrictive, least intrusive strategy possible. Implement a program-approved by the facility. For example, staff could use supportive physical techniques, one or two person escort and/or any relevant blocks or releases to assist Client #1. 2. The QIDP failed to ensure Clients #1 and #2 were properly supervised and/or monitored in accordance with their behavior support plans (BSPs), as evidenced by the following: a. On July 15, 2013, beginning at 1:13 p.m., interview with DSP #8 revealed that he was assigned to work with Client #2 as his one to one (1:1) staff on July 10, 2013, during the 4:00 p.m. to 12:00 a.m. shift. DSP #8 stated that when he arrived to work at 9:09 p.m., all clients were in bed asleep. At approximately 10:30 p.m., DSP #8 stated that he walked the qualified intellectual disabilities professional (QIDP) #1 to her car because it was dark outside. At approximately 11:45 p.m., DSP #8 stated that he informed DSP #4 that he was going downstairs to the basement to start his chores and complete some laundry. He stated that he was in the basement for approximately five to seven minutes. DSP #8 stated that while walking back upstairs, he heard a thump/shuffle that came from Client #2's bedroom. According to DSP #8, he stated that he dropped the mop and bucket and rushed to the client's room. As he stepped inside the bedroom, he indicated he witnessed Client #2 falling to the floor in the bathroom. DSP #8 stated that DSP #4 came running behind him and after observing the client's injury he said, "I'm going to get the first aid kit." Client #2 sustained a severe injury to his upper right eyebrow and eventually went to a local hospital's emergency room via 911	W 159		

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emergency services. As a result of the injury, Client #2 received eleven stitches to his right eyebrow. When asked, DSP #8 stated that he knew he was supposed to remain within arm's length of Client #2 at all times in accordance with the BSP.

On July 11, 2013, at approximately 5:00 p.m., review of Client #2's BSP dated April 13, 2013, revealed that although the client was ambulatory, his gait issue had deteriorated and his risk for falls had increased. Further review of Client #2's BSP revealed that one to one (1:1) staffing was needed for the implementation of the BSP and to ensure the safety of the client. The BSP also added that 1:1 support staff should be between arm's length and five feet from the client during awaking hours.

b. On July 11, 2013, at approximately 8:30 p.m., interview with DSP #4 revealed he was assigned to work with Client #1 as his 1:1 staff on July 10, 2013, during the 4:00 p.m. to 12:00 a.m. shift. At approximately 11:30 p.m., DSP #4 revealed that he was in the dining room area working on the computer to complete his evening notes while Client #1 remained asleep inside his bedroom. Between 11:40 p.m. - 11:45 p.m., DSP #4 stated that DSP #8 informed him that he was going downstairs to work on the laundry and to get the mop bucket. Admittedly, DSP #4 stated that he was not within arm's length at all times once the client went to be bed between 8:30 p.m. - 9:00 p.m. DSP #4 also stated that he remained outside of Client #1's bedroom and checked on him every 30 minutes.

On July 10, 2013, beginning at approximately 5:10 p.m., review of the Client #1's BSP dated