

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

PRINTED: 07/03/2013
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 C 06/18/2013
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NAME OF PROVIDER OR SUPPLIER INNOVATIVE LIFE SOLUTIONS, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3259 'O' ST, SE WASHINGTON, DC 20020
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(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
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W 000	<p>INITIAL COMMENTS</p> <p>On June 10, 2013, at 2:00 p.m., the Department of Health, Office of Compliance, Quality Assurance and Investigation Division (OCQAID), was notified by telephone of an allegation of abuse that occurred on June 7, 2013, at 3:00 p.m. According to the information received, an individual was punched in the face by a day program direct support staff.</p> <p>Due to the nature of the information obtained from the administrative review, the Health Regulation and Licensing Administration's (HRLA), Intermediate Care Facilities Division, initiated an on-site investigation on June 12, 2013. The purpose was to determine if the facility was in compliance with the regulatory standards.</p> <p>The findings of this investigation were based on interviews with facility staff, review of the agency's administrative records, and including the review of the incident management system.</p> <p>As the investigation progressed, a determination was made on June 14, 2013, that the facility failed to ensure compliance with the federal conditions of participation of governing body and client protections. The state agency informed the facility's chief operating officer (COO) of the determination on June 14, 2013, at 1:14 p.m.</p> <p>[Qualified Mental Retardation Professional (QMRP) will be referred to as Qualified Intellectual Disabilities Professional (QIDP) within this report.]</p>	W 000	<p>Received 7/24/13 REVISITED</p> <p>Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002</p>	
W 102	483.410 GOVERNING BODY AND MANAGEMENT	W 102		

LABORATORY, DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Guan L. Guan</i>	TITLE 000	(X6) DATE 7/9/13
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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 The facility must ensure that specific governing body and management requirements are met.	W 102	W102 The Incident Management Policy and Procedure has been amended to ensure that in cases of abuse / neglect all notifications (verbal and written) to the appropriate parties is completed within 24hours and the target /perpetrator is out of contact with the individual immediately. Also the individual does not return to the day program until the QIDP ensures that the target / perpetrator is out of contact with the individual.	7/9/13	
W 104	483.410(a)(1) GOVERNING BODY 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] The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on interview and record review, the governing body failed to ensure contracted outside service providers operated in a manner to ensure clients remained protected from abuse, for one of one client in the investigation. (Client #1) The findings include: a. The governing body failed to establish a policy that ensured outside service providers received timely notification of allegations of abuse.	W 104	In the future the QIDP will ensure that the individual's health, safety and well-being is always maintained by ensuring and verifying that the target or perpetrator is out of contact with the individual immediately at the residential and day program sites. All staff was in-serviced on incident management policy and procedure. See attached: Revised Incident P&P and Process with timelines In-service record		

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W 104	Continued From page 2 On June 10, 2013, at 2:00 p.m., the Department of Health, Office of Compliance, Quality Assurance and Investigation Division (DOH/OCQAID), was notified by telephone of an allegation of abuse that occurred on June 7, 2013, at 3:00 p.m. According to the information received, Client #1 was punched in the face by a day program direct support staff. Review of the facility's preliminary investigative documents on June 13, 2013, at 2:45 p.m., revealed a statement from direct support professional (DSP #1) dated June 11, 2013. According to the statement, DSP #1 documented that on June 7, 2013, at 3:00 p.m., Client #1, DSP #1 and day program instructor (DPI #1) were in a classroom alone listening to music. DPI #1 asked Client #1 "Why the f**k are you in my class?" Client #1 responded by saying, "I don't want to watch the movie." DPI #1 replied "OK I got something for you." Reportedly, DPI #1 got up and closed the door. DPI #1 then told Client #1 to get up and stand in corner. Client #1 started to cry and said, "No [DPI #1], I'm sorry!" DPI #1 repeated herself by saying, "Stand the f**k up in the corner." When Client #1 did not stand up, DPI #1 took her fist and punched Client #1 in the nose. Shortly after the altercation, the residential van arrived to transport Client #1 back home. After boarding the van, Client #1 told the residential staff about the incident. DSP #1 was interviewed on June 14, 2013 at 11:33 a.m. According to DSP #1, the first time she reported the witnessed incident was after she boarded the residential van. DSP #1 indicated that she called her immediate supervisor, house	W 104	W104 The Incident Management Policy and Procedure has been amended to ensure that in cases of abuse / neglect all notifications (verbal and written) to the appropriate parties is completed within 24hours and the target /perpetrator is out of contact with the individual immediately. Also the individual does not return to the day program until the QIDP ensures that the target / perpetrator is out of contact with the individual. In the future the QIDP will ensure that the individual's health, safety and well-being is always maintained by ensuring and verifying that the target or perpetrator is out of contact with the individual immediately at the residential and day program sites. All staff was in-serviced on incident management policy and procedure. See attached: Revised Incident P&P and Process with timelines In-service record	7/9/13	

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W 104	<p>Continued From page 3</p> <p>manager (HM #1), to describe the details of the incident and was instructed by HM #1 to complete an incident report. When queried to ascertain if DSP #1 informed any management staff at the day program, DSP #1 indicated that she did not.</p> <p>According to the qualified intellectual disabilities professional (QIDP) #1, on June 10, 2013, at 9:10 a.m., she telephoned the day program director (DPD) #1 and informed DPD #1 that both Client #1 and DSP #1 stated DPI #1 punched the client in the nose on June 7, 2013. QIDP #1 stated that she then requested that the alleged perpetrator (DPI #1) have no contact with Client #1.</p> <p>On June 12, 2013, at 1:20 p.m., interview with DPD #1 confirmed that she received a call from HM #1 on June 7, 2013, but stated that the day program was not aware of the allegation of abuse until it was reported by Client #1 on June 10, 2013, at 10:55 a.m. DPD #1 further stated that the allegation of abuse should have been reported by DSP #1 when she observed it on June 7, 2013. DPD #1 was further queried to ascertain what measures were employed to protect Client #1 from further alleged abuse. According to DPD #1, she instructed DSP #2 and Client #1 to go to another classroom where DPI #1 was not present. DPD #1 further revealed that she then went to DPI #1's classroom and explained that there was an allegation of abuse levied against her and informed her to have no further contact with Client #1.</p> <p>Review of the facility's incident policy on June 13, 2013, at beginning at 1:39 p.m., revealed that the policy failed to stipulate instructions for facility staff to provide notification to outside service</p>	W 104			

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W 104	<p>Continued From page 4</p> <p>personnel if an incident occurs while a client is receiving outside services. Review of the contractual agreement between the facility and the day program on June 17, 2013 at 10:35 a.m. revealed a section entitled, "Compliance with Laws." According to the section, "Each party to this Agreement warrants and represents that it is currently in compliance, and that it shall use best efforts to maintain compliance, with all federal and District of Columbia statutes and regulations relevant to the provision of services under this Agreement, including those governing active treatment and ICF/ID [Intermediate Care Facility for individuals with intellectual disabilities] services."</p> <p>At the time of the investigation, the facility failed to have a reporting system that ensured all pertinent entities were timely notified of the allegations of abuse.</p> <p>b. The governing failed to ensure a client was protected from abuse.</p> <p>[Cross Refer W120] Interview was conducted with Client #1's current one to one support staff (DSP #2) on June 13, 2013, at 2:09 p.m., to ascertain information regarding the incident that occurred on June 7, 2013. According to DSP #2, shortly after arriving for duty on June 10, 2013, at 8:00 a.m., another DSP informed her that Client #1 alleged she was punched by a day program staff on June 7, 2013. DSP #2 recalled speaking with Client #1 and the client was hesitant about going back to the day program. DSP #2 further revealed that the residential supervisory staff had not provided her with any information regarding the June 7, 2013 allegation of abuse. Review of</p>	W 104			

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W 104	<p>Continued From page 5</p> <p>DSP #2's corresponding written statement dated June 10, 2013 on June 14, 2013 at 10:45 a.m. revealed that the staff member noted Client #1 was "seemed scared" upon arrival to her day program.</p> <p>Continued discussion with DSP #2 on June 13, 2013, revealed that Client #1 had been in the company of the alleged perpetrator of the June 7, 2013 incident after it occurred. Specifically, DSP #2 indicated that Client #1 arrived to the day program on June 10, 2013 between 10:15 a.m. and 10:30 a.m. Shortly after the client's arrival, day program instructor (DPI #1) was noted to approach Client #1 and state repeatedly, "Really [Client #1]! I hit you?", while simultaneously clapping her hands in rhythm with her words. According to DSP #2, DPI #1 pulled her hair up to secure it in place then postured herself in a threatening gesture. DSP #2 stated that she then requested DPI #1 to leave the room.</p> <p>On June 12, 2013, at 1:15 p.m., interview was conducted with the day program director (DPD #1) to determine the director's knowledge of the June 7, 2013 incident. According to DPD #1, it was revealed that the day program was not aware of the incident until June 10, 2013, at approximately 10:55 a.m. DPD #1 indicated that Client #1 self-reported the incident to the director shortly after arriving to the day program. It should be noted however, that interview with the facility's QIDP #1 on June 13, 2013 at 3:17 p.m. revealed that on June 10, 2013 at 9:10 a.m., DPD #1 was informed of the allegation of abuse. QIDP #1 further stated that she requested that the alleged perpetrator have no contact with Client #1.</p>	W 104			

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W 104	Continued From page 6 On June 13, 2013, at 3:57 p.m., interview with the residential incident management coordinator (IMC #1) revealed that she and QIDP #1 went to the day program on June 10, 2013, at 12:30 p.m. and witnessed DPI #1 there. IMC #1 was informed by DPI #1 that she would be on administrative leave at the end of the day due to the allegation of abuse that occurred on June 7, 2013. It should be noted that further interview with DSP #2 on June 13, 2013, at 2:14 p.m., revealed that Client #1 remained at the day program until the end of the day. A telephone interview with the facility's chief executive officer (CEO #1) on June 14, 2013, at beginning at 1:17 p.m., revealed the facility has a contractual agreement with the outside service provider to render active treatment services weekdays. In accordance with the agreement, the outside service provider is required to ensure all clients are protected from abuse. Although QIDP #1 and IMC #1 acknowledged they were informed of Client #1's allegation of abuse on June 7, 2013, the interventions implemented failed to prevent further abuse of Client #1.	W 104			
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the day program addressed	W 120			

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W 120	<p>Continued From page 7</p> <p>the needs of clients to make certain clients were protected from abuse, for one of one client in the investigation. (Client #1)</p> <p>The finding includes:</p> <p>On June 10, 2013, at 2:00 p.m., the Department of Health, Office of Compliance, Quality Assurance and Investigation Division (DOH/OCQAID), was notified by telephone of an allegation of abuse that occurred on June 7, 2013, at 3:00 p.m. According to the information received, Client #1 was punched in the face by a day program direct support staff.</p> <p>Review of the facility's preliminary investigative documents on June 13, 2013, at 2:45 p.m., revealed a statement from direct support professional (DSP #1) dated June 11, 2013. According to the statement, DSP #1 documented that on June 7, 2013, at 3:00 p.m., Client #1, DSP #1 and day program instructor (DPI #1) were in a classroom alone listening to music. DPI #1 asked Client #1 "Why the f**k are you in my class?" Client #1 responded by saying, "I don't want to watch the movie." DPI #1 replied "OK I got something for you." Reportedly, DPI #1 got up and closed the door. DPI #1 then told Client #1 to get up and stand in corner. Client #1 started to cry and said, "No [DPI #1], I'm sorry!" DPI #1 repeated herself by saying, "Stand the f**k up in the corner." When Client #1 did not stand up, DPI #1 took her fist and punched Client #1 in the nose.</p> <p>Interview with the qualified intellectual disabilities professional (QIDP #1), on June 13, 2013, at 3:17 p.m., she telephoned the day program director</p>	W 120	<p>W120</p> <p>The Incident Management Policy and Procedure has been amended to ensure that in cases of abuse / neglect all notifications (verbal and written) to the appropriate parties is completed within 24hours and the target /perpetrator is out of contact with the individual immediately. Also the individual does not return to the day program until the QIDP ensures that the target / perpetrator is out of contact with the individual.</p> <p>In the future the QIDP will ensure that the individual's health, safety and well-being is always maintained by ensuring and verifying that the target or perpetrator is out of contact with the individual immediately at the residential and day program sites.</p> <p>All staff was in-serviced on incident management policy and procedure.</p> <p>See attached:</p> <p>Revised Incident P&P and Process with timelines</p> <p>In-service record</p>	7/9/13

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W 120	<p>Continued From page 8</p> <p>(DPD #1) on June 10, 2013 at 9:10 a.m. and informed DPD #1 that both Client #1 and DSP #1 stated DPI #1 punched the client in the nose on June 7, 2013. QIDP #1 stated that she then requested that the alleged perpetrator (DPI #1) have no contact with Client #1.</p> <p>On June 12, 2013, at 1:20 p.m., interview with DPD #1 revealed that the day program was not aware of the allegation of abuse until it was reported by Client #1 on June 10, 2013, at 10:55 a.m. DPD #1 further stated that the allegation of abuse should have been reported by DSP #1 when she observed it on June 7, 2013. DPD #1 was further queried to ascertain what measures were employed to protect Client #1 from further abuse. According to DPD #1, she instructed DSP #2 and Client #1 to go to another classroom where DPI #1 was not present. DPD #1 further revealed that she then went to DPI #1's classroom and explained that there was an allegation of abuse levied against her and informed her to have no further contact with Client #1.</p> <p>Interview was conducted with Client #1's current one to one support staff (DSP #2) on June 13, 2013, at 2:09 p.m., to ascertain information regarding the incident that occurred on June 7, 2013. According to DSP #2, Client #1 was hesitant about going back to the day program on June 10, 2013. Review of DSP #2's corresponding written statement dated June 10, 2013 on June 14, 2013 at 10:45 a.m. revealed that the staff member noted Client #1 "seemed scared" upon arrival to her day program.</p> <p>Continued discussion with DSP #2 on June 13,</p>	W 120			

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W 122	At the time of the investigation, the facility failed to ensure the day program addressed Client #1's need to be protected from further potential abuse after the allegation of abuse was reported. 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 implement policies and procedures to ensure client's health and safety [See W149]; failed to report all allegations of abuse, neglect and mistreatment immediately to the Department of Health [W153]; failed to ensure protection from further potential abuse while an investigation was in progress [W155]; and failed to report the results of investigation of an allegation of abuse to the administrator or designated representative within five working days [W156].	W 122	In the future the QIDP will ensure that the individual's health, safety and well-being is always maintained by ensuring and verifying that the target or perpetrator is out of contact with the individual immediately at the residential and day program sites. All staff was in-serviced on incident management policy and procedure. See attached: Revised Incident P&P and Process with timelines In-service record	

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W 122	Continued From page 10	W 122			
W 149	<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 interviews and record review, the facility failed to ensure policies were developed and implemented to protect clients from abuse, for one of one client in the investigation. (Client #1)</p> <p>The findings include:</p> <p>I. The facility failed to ensure policies and procedures were developed and implemented to make certain all pertinent parties were notified timely of allegations of abuse.</p> <p>a. On June 10, 2013, at 2:00 p.m., the Department of Health, Office of Compliance, Quality Assurance and Investigation Division (DOH/OCQAID), was notified by telephone of an allegation of abuse that occurred on June 7, 2013, at 3:00 p.m. According to the information received, Client #1 was punched in the face by a day program direct support staff. The verbal notification was provided by the agency's incident management coordinator (IMC #1).</p> <p>Review of the corresponding unusual incident</p>	W 149	<p>W149</p> <p>The Incident Management Policy and Procedure has been amended to ensure that in cases of abuse / neglect all notifications (verbal and written) to the appropriate parties is completed within 24hours and the target /perpetrator is out of contact with the individual immediately. Also the individual does not return to the day program until the QIDP ensures that the target / perpetrator is out of contact with the individual.</p> <p>In the future the QIDP will ensure that the individual's health, safety and well-being is always maintained by ensuring and verifying that the target or perpetrator is out of contact with the individual immediately at the residential and day program sites.</p> <p>All staff was in-serviced on incident management policy and procedure.</p> <p>See attached:</p> <p>Revised Incident P&P and Process with timelines</p> <p>In-service record</p>	7/9/13	

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NAME OF PROVIDER OR SUPPLIER INNOVATIVE LIFE SOLUTIONS, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3259 'O' ST, SE WASHINGTON, DC 20020		
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W 149	<p>Continued From page 11</p> <p>report on June 12, 2013 at approximately 3:00 p.m. revealed that chief executive officer (CEO #1) was notified of the incident on June 10, 2013. A telephone interview with the CEO #1 on June 14, 2013, at approximately 1:17 p.m., confirmed that CEO #1 had no knowledge of the incident until June 10, 2013 (three days after the incident occurred). Further review of the incident report revealed that the Department of Health was notified on June 10, 2013.</p> <p>Interview was conducted with IMC #1 on June 13, 2013, at approximately 4:00 p.m., to obtain detailed information regarding the incident. According to IMC #1, she was informed of the allegation of abuse on June 7, 2013, at 5:30 p.m. Continued discussion with IMC #1 revealed that she was responsible for notifying external agencies of all allegations of abuse. IMC # 1 revealed that she was required to notify the DOH of all allegations of abuse immediately by telephone, then follow up with written notification within twenty-four hours or the next business day. Further interview with CEO #1 on June 14, 2013 at approximately 1:17 p.m. confirmed IMC #1's statement regarding DOH notification. Further discussion with IMC #1 on June 13, 2013 verified that the agency did not provide notification to the DOH until June 10, 2013.</p> <p>On June 13, 2013, at 11:23 a.m., the chief operating officer (COO #1) presented the agency's incident management policy for review. According to the policy, the "executive director will immediately be notified of discovery of reportable incidents." Continued review of the policy revealed that all abuse should be reported. The policy further revealed that the "incident manager</p>	W 149			

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W 149	<p>Continued From page 12 or designee will notify...appropriate state offices..." The policy however, failed to identify a specific timeframe for the notification.</p> <p>At the time of the investigation, the facility failed to ensure that the allegation of abuse was reported immediately to the administrator and to other officials as required.</p> <p>b. DSP #1 was interviewed on June 14, 2013 at 11:33 a.m., to ascertain information regarding the June 7, 2013 incident. According to DSP #1, the first time she reported the witnessed incident was after she boarded the residential van. DSP #1 indicated that she called her immediate supervisor, house manager (HM #1), to describe the details of the incident and was instructed by HM #1 to complete an incident report. When queried to ascertain if DSP #1 informed any management staff at the day program, DSP #1 indicated that she did not.</p> <p>According to interview on June 13, 2013 at 3:17 p.m. with the qualified intellectual disabilities professional (QIDP #1), on June 10, 2013, at 9:10 a.m., she informed day program director (DPD #1) that both Client #1 and DSP #1 stated day program instructor (DPI #1) punched the client in the nose on June 7, 2013. It should be noted that review of QIDP #1's corresponding written statement dated June 10, 2013 on June 14, 2013 at 11:30 a.m. revealed that QIDP #1 questioned HM #1 about why DSP #1 failed to report the incident to the day program.</p> <p>On June 12, 2013, at 1:20 p.m., interview with DPD #1 confirmed that she received a call from HM #1 on June 7, 2013, but stated that the day</p>	W 149			

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W 149	<p>Continued From page 13</p> <p>program was not aware of the allegation of abuse until it was reported by Client #1 on June 10, 2013, at 10:55 a.m. DPD #1 further stated that the allegation of abuse should have been reported by DSP #1 when she observed it on June 7, 2013.</p> <p>Review of the facility's incident policy on June 13, 2013, at beginning at 1:39 p.m., revealed that policy failed to stipulate instructions for facility staff to provide notification to outside service personnel if an incident occurs while a client is receiving outside services.</p> <p>At the time of the investigation, the facility failed to develop and implement a policy to ensure pertinent parties were timely notified of incidents of abuse.</p> <p>II. The facility failed to ensure a policy had been developed and implemented to make certain client's received timely medical intervention after witnessed physical abuse.</p> <p>On June 13, 2013, at 11:43 a.m., interview with the licensed practical nurse coordinator (LPNC #1) revealed that on June 7, 2013, at approximately 4:50 p.m., she received a telephone call from the facility's house manager (HM #1) stating that Client #1 was hit in the nose by DPI #1.</p> <p>Interview with LPN #1 on June 13, 2013, at 5:08 p.m., revealed she arrived to the home on June 7, 2013, at approximately 4:45 p.m. LPN #1 stated that DSP #1 reported that Client #1's nose was swollen prior to the client arriving home from the day program. According to LPN #1, upon</p>	W 149		

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W 149	<p>Continued From page 14</p> <p>assessment of Client #1's nose, it did not appear to be swollen.</p> <p>On June 13, 2013, at 5:05 p.m., review of LPN #1's nursing progress note dated June 7, 2013, at 5:00 p.m., revealed "[Client #1] came downstairs for p.m. medication and was complaining that her nose is hurting. Staff reported individual was punched in her nose by a staff at the day program. Individual's nose was swelling. Nurse assessed the site, no swelling noted. Upon touch, complained of pain. Nursing coordinator aware to notify primary care physician (PCP #1). New order to give Tylenol 325 milligrams (mgs.) for pain."</p> <p>On June 13, 2013, at 5:15 p.m. review of DSP #4's shift note (12:00 a.m. to 8:00 a.m.) dated June 8, 2013, revealed, "[Client #1] stated her nose was hurting and her side. Staff looked at her nose and it appeared to have slight bruising and swelling. When she went to take her medication we told the nurse and she gave her pain medication and looked at her nose."</p> <p>On June 13, 2013, at 11:23 a.m., the chief operating officer (COO #1) presented the agency's incident management policy for review. Review of the facility's incident policy on June 13, 2013, at beginning at 1:39 p.m., revealed the policy documented that the facility "will ensure safety by sending all individuals's involved in allegations of physical abuse to the emergency room for evaluation to ensure their medical well being." Continued review of the policy however, failed to identify a specific timeframe to obtain the emergency room evaluation.</p>	W 149			

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W 149	Continued From page 15	W 149			
W 153	<p>Continued interview with with LPNC #1 on June 13, 2013 at 5:08 p.m. and further record review revealed Client #1 was taken for an x-ray on June 12, 2013 (five days after the assault). At the time of the investigation, the facility failed to ensure its incident management policy was comprehensive and indicated a specific timeframe for emergency room evaluation after physical abuse.</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS</p> <p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the administrator and the state surveying agency were notified of an allegation of abuse immediately, for one of one client included in the investigation. (Client #1)</p> <p>The finding includes:</p> <p>On June 10, 2013, at 2:00 p.m., the Department of Health, Office of Compliance, Quality Assurance and Investigation Division (DOH/OCQAID), was notified by telephone of an allegation of abuse that occurred on June 7, 2013, at 3:00 p.m. According to the information received, Client #1 was punched in the face by a day program direct support staff. The verbal notification was provided by the agency's incident</p>	W 153	<p>W153</p> <p>The Incident Management Policy and Procedure has been amended to ensure that in cases of abuse / neglect all notifications (verbal and written) to the appropriate parties is completed within 24hours and the target /perpetrator is out of contact with the individual immediately. Also the individual does not return to the day program until the QIDP ensures that the target / perpetrator is out of contact with the individual.</p> <p>In the future the QIDP will ensure that the individual's health, safety and well-being is always maintained by ensuring and verifying that the target or perpetrator is out of contact with the individual immediately at the residential and day program sites.</p> <p>All staff was in-serviced on incident management policy and procedure.</p> <p>See attached:</p> <p>Revised Incident P&P and Process with timelines</p> <p>In-service record</p>	7/9/13	

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W 153	Continued From page 16 management coordinator (IMC #1). Review of the corresponding unusual incident report on June 12, 2013 at approximately 3:00 p.m. revealed that chief executive officer (CEO #1) was notified of the incident on June 10, 2013. A telephone interview with the CEO #1 on June 14, 2013, at approximately 1:17 p.m., confirmed that CEO #1 had no knowledge of the incident until June 10, 2013 (three days after the incident occurred). Further review of the incident report confirmed that the Department of Health was notified on June 10, 2013. At the time of the investigation, the facility failed to ensure that the allegation of abuse was reported immediately to the administrator and to other officials in accordance with state law.	W 153		
W 155	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must prevent further potential abuse while the investigation is in progress. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure a client was protected from further abuse while an investigation was in progress, for one of one client in the investigation. (Client #1) The finding includes: On June 10, 2013, at 2:00 p.m., the Department of Health, Office of Compliance, Quality Assurance and Investigation Division (DOH/OCQAID), was notified by telephone of an	W 155		

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W 155	<p>Continued From page 17</p> <p>allegation of abuse that occurred on June 7, 2013, at 3:00 p.m. According to the information received, Client #1 was punched in the face by a day program direct support staff.</p> <p>Review of the facility's preliminary investigative documents on June 13, 2013, at 2:45 p.m., revealed a statement from direct support professional (DSP #1) dated June 11, 2013. According to the statement, DSP #1 documented that on June 7, 2013, at 3:00 p.m., Client #1, DSP #1 and day program instructor (DPI #1) were in a classroom alone listening to music. DPI #1 asked Client #1 "Why the f**k are you in my class?" Client #1 responded by saying, "I don't want to watch the movie." DPI #1 replied "OK I got something for you." Reportedly, DPI #1 got up and closed the door. DPI #1 then told Client #1 to get up and stand in corner. Client #1 started to cry and said, "No [DPI #1], I'm sorry!" DPI #1 repeated herself by saying, "Stand the f**k up in the corner." When Client #1 did not stand up, DPI #1 took her fist and punched Client #1 in the nose.</p> <p>According to the qualified intellectual disabilities professional (QIDP #1), on June 10, 2013, at 9:10 a.m., she telephoned the day program director (DPD #1) and informed DPD #1 that both Client #1 and DSP #1 stated DPI #1 punched the client in the nose on June 7, 2013. QIDP #1 stated that she then requested that the alleged perpetrator (DPI #1) have no contact with Client #1.</p> <p>On June 12, 2013, at 1:20 p.m., interview with DPD #1 revealed that the day program was not aware of the allegation of abuse until it was reported by Client #1 on June 10, 2013, at 10:55</p>	W 155	<p>W155</p> <p>The Incident Management Policy and Procedure has been amended to ensure that in cases of abuse / neglect all notifications (verbal and written) to the appropriate parties is completed within 24hours and the target /perpetrator is out of contact with the individual immediately. Also the individual does not return to the day program until the QIDP ensures that the target / perpetrator is out of contact with the individual.</p> <p>In the future the QIDP will ensure that the individual's health, safety and well-being is always maintained by ensuring and verifying that medical attention is received and the target or perpetrator is out of contact with the individual immediately at the residential and day program sites.</p> <p>All staff was in-serviced on incident management policy and procedure.</p> <p>See attached:</p> <p>Revised Incident P&P and Process with timelines</p> <p>In-service record</p>	7/9/13	

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W 155	<p>Continued From page 18</p> <p>a.m. DPD #1 was further queried to ascertain what measures were employed to protect Client #1 from further alleged abuse. According to DPD #1, she instructed DSP #2 and Client #1 to go to another classroom where DPI #1 was not present. DPD #1 further revealed that she then went to DPI #1's classroom and explained that there was an allegation of abuse levied against her and informed her to have no further contact with Client #1.</p> <p>Interview was conducted with Client #1's current one to one support staff (DSP #2) on June 13, 2013, at 2:09 p.m., to ascertain information regarding the incident that occurred on June 7, 2013. According to DSP #2, shortly after arriving for duty on June 10, 2013, at 8:00 a.m., another DSP informed her that Client #1 alleged she was punched by a day program staff on June 7, 2013. DSP #2 recalled speaking with Client #1 and the client was hesitant about going back to the day program. DSP #2 further revealed that the residential supervisory staff had not provided her with any information regarding the June 7, 2013 allegation of abuse. Review of DSP #2's corresponding written statement dated June 10, 2013 on June 14, 2013 at 10:45 a.m. revealed that the staff member noted Client #1 "seemed scared" upon arrival to her day program.</p> <p>Continued discussion with DSP #2 on June 13, 2013, revealed that Client #1 had been in the company of the alleged perpetrator of the June 7, 2013 incident after it occurred. Specifically, DSP #2 indicated that Client #1 arrived to the day program on June 10, 2013 between 10:15 a.m. and 10:30 a.m. Shortly after the client's arrival, day program instructor (DPI #1) was noted to</p>	W 155			

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W 155	<p>Continued From page 19</p> <p>approach Client #1 and state repeatedly, "Really [Client #1]! I hit you?", while simultaneously clapping her hands in rhythm with her words. According to DSP #2, DPI #1 pulled her hair up to secure it in place then postured herself in a threatening gesture. DSP #2 stated that she then requested DPI #1 to leave the room.</p> <p>On June 13, 2013, at 3:57 p.m., interview with the residential incident management coordinator (IMC #1) revealed that she and QIDP #1 went to the day program on June 10, 2013, at 12:30 p.m. and witnessed DPI #1 there. IMC #1 was informed by DPI #1 that she would be on administrative leave at the end of the day due to the allegation of abuse that occurred on June 7, 2013. It should be noted that further interview with DSP #2 on June 13, 2013, at 2:14 p.m., revealed that Client #1 remained at the day program until the end of the day.</p> <p>Although QIDP #1 and IMC #1 acknowledged they were informed of Client #1's allegation of abuse at her day program on June 7, 2013, the subsequent interventions implemented failed to prevent further abuse of Client #1.</p>	W 155		
W 156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to report the results of an abuse</p>	W 156		

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W 156	<p>Continued From page 20</p> <p>investigation to the administrator or designated representative within five working days of the incident, for one of one client in the investigation. (Client #1)</p> <p>The finding includes:</p> <p>On June 10, 2013, at 2:00 p.m., the Department of Health, Office of Compliance, Quality Assurance and Investigation Division (DOH/OCQAID), was notified by telephone of an allegation of abuse that occurred on June 7, 2013, at 3:00 p.m. According to the information received, Client #1 was punched in the face by a day program direct support staff. The verbal notification was provided by the agency's incident management coordinator (IMC #1).</p> <p>Interview with the facility's IMC #1 on June 13, 2013, at 3:57 p.m., revealed the investigation was in process, but had not been completed. It should be noted that review of the completed investigation report dated June 17, 2013 on June 18, 2013 at approximately 3:00 p.m., failed to provide evidence of a date for when the administrator or designee received the results of the investigation. Continued review of the investigative report revealed that the investigation was signed and dated by the IMC #1 (the person that completed the investigation) and signed, not dated, by the quality assurance coordinator.</p> <p>Interview with the chief executive officer (CEO #1) on June 14, 2013, at 1:22 p.m., confirmed that IMC #1 had made significant progress with the investigation, but had not completed it and the results had not been reported to the administrator</p>	W 156	<p>W156</p> <p>The Incident Management Policy and Procedure / Process has been amended to reflect strict timelines</p> <p>ILS has developed an electronic compliance program which also tracks and trends timelines at least quarterly, to avoid undue delays in completion and submission of all investigations.</p> <p>In the future the COO/CEO/Senior Administrator will ensure that reports are reviewed by them and submitted with policy timelines.</p> <p>See attached:</p> <p>Revised Incident P&P and Process with timelines</p> <p>In-service record</p>	7/9/13	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 C 06/18/2013
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W 156	Continued From page 21 (CEO #1). At the conclusion of the investigation, there was no evidence that the result of the aforementioned investigation was provided to CEO #1 or the designated representative within five working days of the incident.	W 156			
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the staff received ongoing training to assure that they were competent in protecting, monitoring, and reporting allegations of abuse for one of one client in the investigation. (Client #1) The findings include: On June 10, 2013, at 2:00 p.m., the Department of Health, Office of Compliance, Quality Assurance and Investigation Division (DOH/OCQAID), was notified by telephone of an allegation of abuse that occurred on June 7, 2013, at 3:00 p.m. According to the information received, Client #1 was punched in the face by a day program direct support staff. I. The facility failed to ensure that the staff received ongoing training to facilitate timely reporting of the incident that occurred on June 7, 2013.	W 189	W189 a. The IMC received training on the amended Incident Management Policy and Procedure / Process which reflect strict timelines to ensure all disciplines and agencies are notified of incidents. ILS has developed an electronic compliance program to avoid undue delays in reporting, completion and submission of all investigations. One of the components of this electronic system is to track & trend efficiency timelines, at least quarterly. In the future the COO/CEO/Senior Administrator will ensure that reports are reviewed by them and submitted within policy timelines. b. All staff was in-serviced on Incident Management P&P c. All management staff was in-serviced on Incident Management P&P See attached: Revised Incident P&P and Process with timelines In-service record	7/9/13	

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W 189	<p>Continued From page 22</p> <p>a. Review of the corresponding unusual incident report on June 12, 2013, at approximately 3:00 p.m. revealed that chief executive officer (CEO #1) was notified of the incident on June 10, 2013. A telephone interview with the CEO #1 on June 14, 2013, at approximately 1:17 p.m., confirmed that CEO #1 had no knowledge of the incident until June 10, 2013 (three days after the incident occurred). Further review of the incident report revealed that the Department of Health was notified on June 10, 2013.</p> <p>Interview was conducted with incident management coordinator (IMC #1) on June 13, 2013, at approximately 4:00 p.m., to obtain detailed information regarding the incident. According to IMC #1, she was informed of the allegation of abuse on June 7, 2013, at 5:30 p.m. Continued discussion with IMC #1 revealed that she was responsible for notifying external agencies of all allegations of abuse. IMC # 1 revealed that she was required to notify the DOH of all allegations of abuse immediately by telephone, then follow up with written notification within twenty-four hours or the next business day. Further interview with CEO #1 on June 14, 2013 at approximately 1:17 p.m. confirmed IMC #1's statement regarding DOH notification. Additional discussion with IMC #1 on June 13, 2013 verified that the agency did not provide notification to the DOH until June 10, 2013.</p> <p>On June 13, 2013, at 11:23 a.m., the chief operating officer (COO #1) presented the agency's incident management policy for review. According to the policy, the "executive director will immediately be notified of discovery of reportable</p>	W 189			

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W 189	<p>Continued From page 23</p> <p>incidents." Continued review of the policy revealed that all abuse should be reported. The policy further revealed that the "incident manager or designee will notify...appropriate state offices..."</p> <p>Interview was conducted with IMC #1 on June 13, 2013, at 4:00 p.m. to ascertain if incident management training was received. At the time of the investigation, documentation of IMC #1's training was not provided.</p> <p>b. On June 12, 2013, at 1:20 p.m., interview with day program director (DPD #1) revealed that the day program was not aware of the allegation of abuse until it was reported by Client #1 on June 10, 2013, at 10:55 a.m. DPD #1 further stated that the allegation of abuse should have been reported by direct support professional (DSP #1) when she observed it on June 7, 2013.</p> <p>Interview with DSP #1 on June 14, 2013, at 11:33 a.m., revealed that the first time she reported the incident was after she boarded the residential van. DSP #1 indicated that she called her immediate supervisor, house manager (HM #1), to describe the details of the incident. When queried to ascertain if DSP #1 informed any management staff at the day program, DSP #1 indicated that she did not.</p> <p>According to interview with qualified intellectual disabilities professional (QIDP #1) on June 13, 2013 at 3:17 p.m., she informed day program director (DPD #1) on June 10, 2013 at 9:10 a.m. that there was an allegation of abuse involving Client #1 and day program instructor (DPI #1) on June 7, 2013. It should be noted that review of</p>	W 189			

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W 189	<p>Continued From page 24</p> <p>QIDP #1's corresponding written statement dated June 10, 2013 on June 13, 2013 at 11:30 a.m. revealed that QIDP #1 questioned house manager (HM #1) about why DSP #1 failed to report the incident to the day program.</p> <p>Interview with the facility's QIDP #1 on June 13, 2013 at 3:17 p.m. was conducted to ascertain if training was provided on timely notification of allegations of abuse that occur while receiving outsidess services. At the time of the investigation, there was no evidence training was provided.</p> <p>c. Interview with supervisory registered nurse (RN #1) on June 13, 2013, at 3:03 p.m., revealed she was not aware that the incident involving Client #1 on June 7, 2013 until June 9, 2013 (two days later). According to RN #1, the facility's nursing policy requires that licensed practical nurse coordinator (LPNC #1) immediately notify the RN if a client has an injury or if there is an allegation of abuse.</p> <p>At the time of the investigation, the facility failed to ensure nursing staff reported allegations of neglect to all internal parties as required.</p> <p>II. The facility failed to ensure staff received ongoing training on procedures to protect the individual from further abuse and harm.</p> <p>Interview with DSP #2 on June 13, 2013, at 2:09 p.m., revealed that Client #1 had been in the company of the alleged perpetrator after the June 7, 2013 incident. Specifically, DSP #2 indicated that shortly after arriving for duty on June 10, 2013, at 8:00 a.m., another DSP informed her</p>	W 189		
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W 189	<p>Continued From page 25</p> <p>that Client #1 alleged she was punched by a day program staff on June 7, 2013. DSP #2 recalled speaking with Client #1 and the client was hesitant about going back to the day program. DSP #2 further revealed that the residential supervisory staff had not provided her with any information regarding the June 7, 2013 allegation of abuse. Continued discussion with DSP #2 on June 13, 2013, revealed DSP #2 and Client #1 arrived to the day program on June 10, 2013 between 10:15 a.m. and 10:30 a.m. Shortly after the client's arrival, DPI #1 was noted to approach Client #1 and state repeatedly, "Really [Client #1]! I hit you? ", while simultaneously clapping her hands in rhythm with her words. According to DSP #2, DPI #1 pulled her hair up to secure it in place then postured herself in a threatening gesture. DSP #2 stated that she then requested DPI #1 to leave the room.</p> <p>On June 13, 2013, at 3:57 p.m., interview with the residential incident management coordinator (IMC #1) revealed that she and QIDP #1 went to the day program on June 10, 2013, at 12:30 p.m. and witnessed DPI #1 there. IMC #1 was informed by DPI #1 that she would be on administrative leave at the end of the day due to the allegation of abuse that occurred on June 7, 2013. It should be noted that further interview with DSP #2 on June 13, 2013, at 2:14 p.m., revealed that Client #1 remained at the day program until the end of the day.</p> <p>Interview with QIDP #1 on June 13, 2013 at 3:17 p.m. was conducted to ascertain if training was provided on protecting clients from further abuse and harm. At the time of the investigation, there was no evidence training was provided.</p>	W 189			

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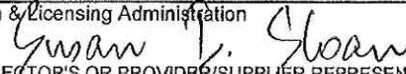
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I 000	<p>INITIAL COMMENTS</p> <p>On June 10, 2013, at 2:00 p.m., the Department of Health, Office of Compliance, Quality Assurance and Investigation Division (OCQAID), was notified by telephone of an allegation of abuse that occurred on June 7, 2013, at 3:00 p.m. According to the information received, an individual was punched in the face by a day program direct support staff.</p> <p>Due to the nature of the information obtained from the administrative review, the Health Regulation and Licensing Administration's (HRLA), Intermediate Care Facilities Division, initiated an on-site investigation on June 12, 2013. The purpose was to determine if the facility was in compliance with the regulatory standards.</p> <p>The findings of this investigation were based on interviews with facility staff, review of the agency's administrative records, and including the review of the incident management system.</p> <p>As the investigation progressed, a determination was made on June 14, 2013, that the facility failed to ensure compliance with the federal conditions of participation of governing body and client protections. The state agency informed the facility's chief operating officer (COO) of the determination on June 14, 2013, at 1:14 p.m.</p> <p>[Qualified Mental Retardation Professional (QMRP) will be referred to as Qualified Intellectual Disabilities Professional (QIDP) within this report.]</p>	I 000		
I 002	<p>3500.2 GENERAL PROVISIONS</p> <p>Each GHMRP licensee and residence director shall demonstrate that he or she understands that</p>	I 002		

Health Regulation & Licensing Administration

 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE *COO*

(X6) DATE
7/9/13

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I 002	<p>Continued From page 1</p> <p>the provisions of D.C. Law 2-137, D.C. Code, Title 6, Chapter 19 govern the care and rights of mentally retarded persons in addition to this chapter.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the group home for individuals with intellectual disabilities (GHIID) licensee and residential director failed to demonstrate understanding of the laws and regulations regarding the care and rights of individuals with intellectual disabilities, specifically related to ensuring the protection of resident's from abuse, for one of one resident in the investigation. (Resident #1)</p> <p>The findings include:</p> <p>§ 7-1305.10. Mistreatment, neglect or abuse prohibited; (formerly §6 -1970)</p> <p>(e) Alleged instance of mistreatment, neglect or abuse of any customer shall be reported immediately to the director...</p> <p>On June 10, 2013, at 2:00 p.m., the Department of Health, Office of Compliance, Quality Assurance and Investigation Division (DOH/OCQAID), was notified by telephone of an allegation of abuse that occurred on June 7, 2013, at 3:00 p.m. According to the information received, Client #1 was punched in the face by a day program direct support staff. The verbal notification was provided by the agency's incident management coordinator (IMC #1).</p> <p>Review of the corresponding unusual incident report on June 11, 2013 at approximately 3:00</p>	I 002	<p>I002</p> <p>In the future ILS staff will follow the amended Incident Management P&P to ensure the timelines are in accordance with the law.</p> <p>All staff was in-serviced on Incident Management P&P</p> <p>See attached:</p> <p>Revised Incident P&P and Process with timelines</p> <p>In-service record – incident management and abuse, neglect, clients rights, grievance, HRC</p>	7/9/13

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I 002	Continued From page 2 p.m. revealed that chief executive officer (CEO #1) was notified of the incident on June 10, 2013. A telephone interview with the CEO #1 on June 14, 2013, at approximately 1:17 p.m., confirmed that CEO #1 had no knowledge of the incident until June 10, 2013 (three days after the incident occurred). Further review of the incident report confirmed that the Department of Health was notified on June 10, 2013. At the time of the investigation, the facility failed to ensure that the allegation of abuse was reported immediately to the administrator and to other officials in accordance with state law.	I 002		
I 160	3507.1 POLICIES AND PROCEDURES Each GHMRP shall have on site a written manual describing the policies and procedures it will follow which shall be as detailed as is necessary to meet the needs of each resident served and provide guidance to each staff member. 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 maintain a policies and procedures manual on site, and ensure that incident management policies provided sufficient guidance to staff regarding reporting time frames and how to protect each resident ' s safety while attending outside day programs, for one of the one resident in the investigation. (Resident #1) The findings include: I. The GHIID failed to maintain a policies and procedures manual on site, as follows:	I 160	1160 i. In the future ILS will ensure that all sites will have a current Policy and Procedure Manual. ii.&iii. The Incident Management Policy and Procedure has been amended to ensure that in cases of abuse / neglect all notifications (verbal and written) to the appropriate parties is completed within 24hours and the target /perpetrator is out of contact with the individual immediately. Also the individual does not return to the day program until the QIDP ensures that the target / perpetrator is out of contact with the individual. Cross refer W155	7/9/13

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I 160	<p>Continued From page 3</p> <p>On June 13, 2013, at approximately, 10:40 a.m., a request was made of the chief operating officer for policies that address reporting allegations of abuse. A second request was made on June 14, 2013, at approximately 12:50 p.m. House manager (HM #1) revealed that the policies were not in the facility. According to HM #1, there was an available set of policies located at another facility. At the time of the investigation, the facility failed to provide a complete copy of the facility's policy and procedure manual for review.</p> <p>II. The Incident Management policy that was presented for review on June 13, 2013, at 11:23 a.m., failed to specify the expected time frames regarding reporting allegations of abuse timely to outside entities (i.e. law enforcement, Department of Health, etc.), as follows:</p> <p>The GHIID Incident Management policy (not dated) reflected that " For all types of abuse, the Incident Manager or designee will notify Law Enforcement, appropriate state offices, family/ legal guardian/ advocates ... " There was no time frame indicated. When asked on June 13, 2013, at 4:00 p.m., the facility's incident manager stated that she was expected to notify outside entities " immediately. "</p> <p>III. The Incident Management policy that was presented for review on June 13, 2013, at 11:23 a.m., failed to provide sufficient guidance to staff regarding how a resident's safety needs would be addressed after an allegation of abuse was received, as follows:</p> <p>An investigation was initiated after it was reported that a day program instructor (DPI #1) had punched Resident #1 in the face on June 7, 2013, at 3:00 p.m. According to DSP #2 (Resident #1's</p>	I 160		

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I 160	<p>Continued From page 4</p> <p>new one to one support staff), revealed that on June 10, 2013, Resident #1 was hesitant about going back to the day program. Review of DSP #2's corresponding written statement dated June 10, 2013 on June 14, 2013 at 10:45 a.m. revealed that the staff member noted Resident #1 was "seemed scared" upon arrival to her day program.</p> <p>Although the resident was noted to be hesitant, information revealed during the investigation revealed that the resident was escorted back to the day program on June 10, 2013. Specifically, discussion with DSP #2 on June 13, 2013, at 2:09 p.m., revealed that Resident #1 had been in the company of the alleged perpetrator on June 10, 2013. DSP #2 indicated that Resident #1 arrived to the day program on June 10, 2013 between 10:15 a.m. and 10:30 a.m. Shortly after the resident's arrival, DPI #1 was noted to approach Resident #1 and state repeatedly, "Really [Resident #1]! I hit you?", while simultaneously clapping her hands in rhythm with her words. According to DSP #2, DPI #1 pulled her hair up to secure it in place then postured herself in a threatening gesture. DSP #2 stated that she then requested DPI #1 to leave the room.</p> <p>On June 13, 2013, at 3:57 p.m., interview with the residential incident management coordinator (IMC #1) revealed that she and qualified intellectual disabilities professional (QIDP #1) went to the day program on June 10, 2013, at 12:30 p.m. and witnessed DPI #1 there. IMC #1 was informed by DPI #1 that she would be on administrative leave at the end of the day due to the allegation of abuse that occurred on June 7, 2013. It should be noted that further interview with DSP #2 on June 13, 2013, at 2:14 p.m.,</p>	I 160		

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I 160	<p>Continued From page 5</p> <p>revealed that Resident #1 remained at the day program until the end of the day.</p> <p>Although QIDP #1 and IMC #1 acknowledged they were informed of Resident #1's allegation of abuse at her day program on June 7, 2013, the subsequent interventions implemented failed to prevent further abuse of Resident #1. Review of the The GHIID's Incident Management policy (not dated) on June 13, 2013 at approximately 1:39 p.m. failed to reflect what measures were to be taken while an allegation such as this was under investigation.</p> <p>(See also Federal Deficiency Report Citation W155)</p>	I 160		
I 222	<p>3510.3 STAFF TRAINING</p> <p>There shall be continuous, ongoing in-service training programs scheduled for all personnel.</p> <p>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 the staff received ongoing training to assure that they were competent in protecting, monitoring, and reporting allegations of abuse for one of one client in the investigation. (Client #1)</p> <p>The findings include:</p> <p>On June 10, 2013, at 2:00 p.m., the Department of Health, Office of Compliance, Quality Assurance and Investigation Division (DOH/OCQAID), was notified by telephone of an allegation of abuse that occurred on June 7,</p>	I 222		

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I 222	Continued From page 6 2013, at 3:00 p.m. According to the information received, Resident #1 was punched in the face by a day program direct support staff. I. The facility failed to ensure that the staff received ongoing training to facilitate timely reporting of the incident that occurred on June 7, 2013. a. Review of the corresponding unusual incident report on June 12, 2013 at approximately 3:00 p.m. revealed that chief executive officer (CEO #1) was notified of the incident on June 10, 2013. A telephone interview with the CEO #1 on June 14, 2013, at approximately 1:17 p.m., confirmed that CEO #1 had no knowledge of the incident until June 10, 2013 (three days after the incident occurred). Further review of the incident report revealed that the Department of Health was notified on June 10, 2013. Interview was conducted with incident management coordinator (IMC #1) on June 13, 2013, at approximately 4:00 p.m., to obtain detailed information regarding the incident. According to IMC #1, she was informed of the allegation of abuse on June 7, 2013, at 5:30 p.m. Continued discussion with IMC #1 revealed that she was responsible for notifying external agencies of all allegations of abuse. IMC # 1 revealed that she was required to notify the DOH of all allegations of abuse immediately by telephone, then follow up with written notification within twenty-four hours or the next business day. Further interview with CEO #1 on June 14, 2013 at approximately 1:17 p.m. confirmed IMC #1's statement regarding DOH notification. Additional discussion with IMC #1 on June 13, 2013 verified that the agency did not provide notification to the DOH until June 10, 2013.	I 222	I 222 a. The IMC received training on the amended Incident Management Policy and Procedure / Process which reflect strict timelines to ensure all disciplines and agencies are notified of incidents. ILS has developed an electronic compliance program to avoid undue delays in reporting, completion and submission of all investigations. One of the components of this electronic system is to track & trend efficiency timelines, at least quarterly. In the future the COO/CEO/Senior Administrator will ensure that reports are reviewed by them and submitted within policy timelines. b. All staff was in-serviced on Incident Management P&P c. All management staff was in-serviced on Incident Management P&P See attached: Revised Incident P&P and Process with timelines In-service record – incident management and abuse, neglect, clients rights, grievance, HRC	7/9/13

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I 222	<p>Continued From page 7</p> <p>On June 13, 2013, at 11:23 a.m., the chief operating officer (COO #1) presented the agency's incident management policy for review. According to the policy, the "executive director will immediately be notified of discovery of reportable incidents." Continued review of the policy revealed that all abuse should be reported. The policy further revealed that the "incident manager or designee will notify...appropriate state offices..." .</p> <p>Interview was conducted with IMC #1 on June 13, 2013, at 4:00 p.m. to ascertain if incident management training was received. At the time of the investigation, documentation of IMC #1's training was not provided.</p> <p>b. On June 12, 2013, at 1:20 p.m., interview with day program director (DPD #1) revealed that the day program was not aware of the allegation of abuse until it was reported by Resident #1 on June 10, 2013, at 10:55 a.m. DPD #1 further stated that the allegation of abuse should have been reported by direct support professional (DSP #1) when she observed it on June 7, 2013.</p> <p>Interview with DSP #1 on June 14, 2013, at 11:33 a.m., revealed that the first time she reported the incident was after she boarded the residential van. DSP #1 indicated that she called her immediate supervisor, house manager (HM #1), to describe the details of the incident. When queried to ascertain if DSP #1 informed any management staff at the day program, DSP #1 indicated that she did not.</p> <p>According to interview with qualified intellectual disabilities professional (QIDP #1) on June 13, 2013 at 3:17 p.m., she informed day program</p>	I 222		

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I 222	Continued From page 8 director (DPD #1) on June 10, 2013 at 9:10 a.m. that there was an allegation of abuse involving Client #1 and day program instructor (DPI #1) on June 7, 2013. It should be noted that review of QIDP #1's corresponding written statement dated June 10, 2013 on June 13, 2013 at 11:30 a.m. revealed that QIDP #1 questioned house manager (HM #1) about why DSP #1 failed to report the incident to the day program. Interview with the facility's QIDP #1 on June 13, 2013 at 3:17 p.m. was conducted to ascertain if training was provided on timely notification of allegations of abuse that occur while receiving outsidess services. At the time of the investigation, there was no evidence training was provided. c. Interview with supervisory registered nurse (RN #1) on June 13, 2013, at 3:03 p.m., revealed she was not aware that the incident involving Client #1 on June 7, 2013 until June 9, 2013 (two days later). According to RN #1, the facility's nursing policy requires that licensed practical nurse coordinator (LPNC #1) immediately notify the RN if a client has an injury or if there is an allegation of abuse. At the time of the investigation, the facility failed to ensure nursing staff reported allegations of neglect to all internal parties as required. II. The facility failed to ensure staff received ongoing training on procedures to protect the individual from further abuse and harm. Interview with DSP #2 on June 13, 2013, at 2:09 p.m., revealed that Resident #1 had been in the company of the alleged perpetrator after the June 7, 2013 incident. Specifically, DSP #2 indicated	I 222			

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I 222	Continued From page 9 that shortly after arriving for duty on June 10, 2013, at 8:00 a.m., another DSP informed her that Resident #1 alleged she was punched by a day program staff on June 7, 2013. DSP #2 recalled speaking with Resident #1 and the client was hesitant about going back to the day program. DSP #2 further revealed that the residential supervisory staff had not provided her with any information regarding the June 7, 2013 allegation of abuse. Continued discussion with DSP #2 on June 13, 2013, revealed DSP #2 and Resident #1 arrived to the day program on June 10, 2013 between 10:15 a.m. and 10:30 a.m. Shortly after the client's arrival, DPI #1 was noted to approach Resident #1 and state repeatedly, "Really [Resident #1]! I hit you?", while simultaneously clapping her hands in rhythm with her words. According to DSP #2, DPI #1 pulled her hair up to secure it in place then postured herself in a threatening gesture. DSP #2 stated that she then requested DPI #1 to leave the room. On June 13, 2013, at 3:57 p.m., interview with the residential incident management coordinator (IMC #1) revealed that she and QIDP #1 went to the day program on June 10, 2013, at 12:30 p.m. and witnessed DPI #1 there. IMC #1 was informed by DPI #1 that she would be on administrative leave at the end of the day due to the allegation of abuse that occurred on June 7, 2013. It should be noted that further interview with DSP #2 on June 13, 2013, at 2:14 p.m., revealed that Resident #1 remained at the day program until the end of the day. Interview with QIDP #1 on June 13, 2013 at 3:17 p.m. was conducted to ascertain if training was provided on protecting clients from further abuse and harm. At the time of the investigation, there	I 222			

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I 222	Continued From page 10 was no evidence training was provided.	I 222		
I 379	<p>3519.10 EMERGENCIES</p> <p>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.</p> <p>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 immediately notify the Department of Health, of an allegation of abuse as required, for one of one resident in the investigation. (Resident #1)</p> <p>The finding includes:</p> <p>On June 10, 2013, at 2:00 p.m., the Department of Health, Office of Compliance, Quality Assurance and Investigation Division (DOH/OCQAID), was notified by telephone of an allegation of abuse that occurred on June 7, 2013, at 3:00 p.m. According to the information received, Resident #1 was punched in the face by a day program direct support staff. The verbal notification was provided by the agency's incident management coordinator (IMC #1).</p> <p>Review of the corresponding unusual incident report on June 11, 2013 at approximately 3:00</p>	I 379	<p>I379</p> <p>The Incident Management Policy and Procedure has been amended to ensure that in cases of abuse / neglect all notifications to the appropriate parties is completed within 24hours and the target /perpetrator is out of contact with the individual immediately.</p> <p>The Incident Management Process clearly defines notification and reporting timelines.</p> <p>The IMC received training on the amended Incident Management Policy and Procedure / Process which reflect strict timelines to ensure all disciplines and agencies are notified of incidents. ILS has developed an electronic compliance program to avoid undue delays in reporting, completion and submission of all investigations. One of the components of this electronic system is to track & trend efficiency timelines, at least quarterly.</p> <p>See attached:</p> <p>Revised Incident P&P and Process with timelines In-service record</p>	7/9/13

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I 379	Continued From page 11 p.m. revealed that chief executive officer (CEO #1) was notified of the incident on June 10, 2013. A telephone interview with the CEO #1 on June 14, 2013, at approximately 1:17 p.m., confirmed that CEO #1 had no knowledge of the incident until June 10, 2013 (three days after the incident occurred). Further review of the incident report confirmed that the Department of Health was notified on June 10, 2013. At the time of the investigation, the facility failed to ensure that the allegation of abuse was reported immediately to the Department of Health as required.	I 379		
I 500	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 one resident in the investigation. (Resident #1) The findings include: On June 10, 2013, at 2:00 p.m., the Department of Health, Office of Compliance, Quality	I 500		

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I 500	<p>Continued From page 12</p> <p>Assurance and Investigation Division (DOH/OCQAID), was notified by telephone of an allegation of abuse that occurred on June 7, 2013, at 3:00 p.m. According to the information received, Client #1 was punched in the face by a day program direct support staff. The verbal notification was provided by the agency's incident management coordinator (IMC #1).</p> <p>I. The GHIID failed to ensure allegations of abuse were reported as required.</p> <p>§ 7-1305.10. Mistreatment, neglect or abuse prohibited; (formerly §6 -1970)</p> <p>(e) Alleged instance of mistreatment, neglect or abuse of any customer shall be reported immediately to the director...</p> <p>Review of the corresponding unusual incident report on June 12, 2013 at approximately 3:00 p.m. revealed that chief executive officer (CEO #1) was notified of the incident on June 10, 2013. A telephone interview with the CEO #1 on June 14, 2013, at approximately 1:17 p.m., confirmed that CEO #1 had no knowledge of the incident until June 10, 2013 (three days after the incident occurred).</p> <p>Further review of the incident report confirmed that the Department of Health was notified on June 10, 2013. At the time of the investigation, the facility failed to ensure that the allegation of abuse was reported immediately to the administrator and to other officials in accordance with state law.</p> <p>(See also Federal Deficiency Report Citation W153)</p>	I 500	<p>I 500</p> <p>The Incident Management Policy and Procedure has been amended to ensure that in cases of abuse / neglect all notifications (verbal and written) to the appropriate parties is completed within 24hours and the target /perpetrator is out of contact with the individual immediately. Also the individual does not return to the day program until the QIDP ensures that the target / perpetrator is out of contact with the individual.</p> <p>In the future the QIDP will ensure that the individual's health, safety and well-being is always maintained by ensuring and verifying that the target or perpetrator is out of contact with the individual immediately at the residential and day program sites.</p> <p>All staff was in-serviced on incident management policy and procedure.</p> <p>See attached:</p> <p>Revised Incident P&P and Process with timelines</p> <p>In-service record</p> <p>CROSS REFER W 153</p>	7/9/13

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I 500	<p>Continued From page 13</p> <p>II. The GHIID failed to ensure an allegation of abuse involving Resident #1 was investigated timely.</p> <p>§ 7-1305.10. Mistreatment, neglect or abuse prohibited; (formerly §6 -1970)</p> <p>(e) ...There shall be a written report that the allegation has been thoroughly and promptly investigated...</p> <p>Interview with the facility's IMC#1 on June 13, 2013, at 3:57 p.m., revealed the investigation was in process but had not been completed. It should be noted that review of the completed investigation report dated June 17, 2013 on June 12, 2013 at approximately 3:00 p.m., failed to provide evidence of a date for when the administrator or designee received the results of the investigation. Continued review of the investigative report revealed that the investigation was signed and dated by the IMC #1 (the person that completed the investigation) and signed, not dated, by the quality assurance coordinator. Interview with the chief executive officer (CEO #1) on June 14, 2013, at 1:22 p.m., confirmed that IMC #1 had made significant progress with the investigation, but had not completed it and the results had not been reported to the administrator (CEO #1). At the conclusion of the investigation, there was no evidence that the result of the aforementioned investigation was provided to CEO #1 or the designated representative within five working days of the incident.</p> <p>(See also Federal Deficiency Report Citation W156)</p> <p>III. The GHIID failed to ensure Resident #1 was</p>	I 500		

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I 500	<p>Continued From page 14</p> <p>protected from further potential abuse.</p> <p>§ 7-1305.10. Mistreatment, neglect or abuse prohibited; (formerly §6 -1970)</p> <p>(a) Mistreatment, neglect or abuse in any form of any customer shall be prohibited.</p> <p>Review of the facility's preliminary investigative documents on June 13, 2013, at 2:45 p.m., revealed a statement from direct support professional (DSP #1) dated June 11, 2013. According to the statement, DSP #1 documented that on June 7, 2013, at 3:00 p.m., Resident #1, DSP #1 and day program instructor (DPI #1) were in a classroom alone listening to music. DPI #1 asked Resident #1 "Why the f**k are you in my class?" Resident #1 responded by saying, "I don't want to watch the movie." DPI #1 replied "OK I got something for you." Reportedly, DPI #1 got up and closed the door. DPI #1 then told Client #1 to get up and stand in corner. Resident #1 started to cry and said, "No [DPI #1], I'm sorry!" DPI #1 repeated herself by saying, "Stand the f**k up in the corner." When Client #1 did not stand up, DPI #1 took her fist and punched Client #1 in the nose.</p> <p>According to the qualified intellectual disabilities professional (QIDP #1), on June 10, 2013, at 9:10 a.m., she telephoned the day program director (DPD #1) and informed DPD #1 that both Resident #1 and DSP #1 stated DPI #1 punched the client in the nose on June 7, 2013. QIDP #1 stated that she then requested that the alleged perpetrator (DPI #1) have no contact with Client #1.</p> <p>On June 12, 2013, at 1:20 p.m., interview with DPD #1 stated that the day program was not</p>	I 500		

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I 500	<p>Continued From page 15</p> <p>aware of the allegation of abuse until it was reported by Client #1 on June 10, 2013, at 10:55 a.m. DPD #1 was further queried to ascertain what measures were employed to protect Resident #1 from further alleged abuse. According to DPD #1, she instructed DSP #2 and Resident #1 to go to another classroom where DPI #1 was not present. DPD #1 further revealed that she then went to DPI #1's classroom and explained that there was an allegation of abuse levied against her and informed her to have no further contact with Resident #1.</p> <p>Interview was conducted with Resident #1's current one to one support staff (DSP #2) on June 13, 2013, at 2:09 p.m., to ascertain information regarding the incident that occurred on June 7, 2013. According to DSP #2, shortly after arriving for duty on June 10, 2013, at 8:00 a.m., another DSP informed her that Resident #1 alleged she was punched by a day program staff on June 7, 2013. DSP #2 recalled speaking with Resident #1 and the client was hesitant about going back to the day program. DSP #2 further revealed that the residential supervisory staff had not provided her with any information regarding the June 7, 2013 allegation of abuse. Review of DSP #2's corresponding written statement dated June 10, 2013 on June 14, 2013 at 10:45 a.m. revealed that the staff member noted Resident #1 was "seemed scared" upon arrival to her day program.</p> <p>Continued discussion with DSP #2 on June 13, 2013, revealed that Client #1 had been in the company of the alleged perpetrator of the June 7, 2013 incident after it occurred. Specifically, DSP #2 indicated that Resident #1 arrived to the day program on June 10, 2013 between 10:15 a.m. and 10:30 a.m. Shortly after the client's arrival,</p>	I 500		

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 06/18/2013
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) COMPLETE DATE
I 500	Continued From page 16 day program instructor (DPI #1) was noted to approach Resident #1 and state repeatedly, "Really [Resident #1]! I hit you?", while simultaneously clapping her hands in rhythm with her words. According to DSP #2, DPI #1 pulled her hair up to secure it in place then postured herself in a threatening gesture. DSP #2 stated that she then requested DPI #1 to leave the room. On June 13, 2013, at 3:57 p.m., interview with the residential incident management coordinator (IMC #1) revealed that she and QIDP #1 went to the day program on June 10, 2013, at 12:30 p.m. and witnessed DPI #1 there. IMC #1 was informed by DPI #1 that she would be on administrative leave at the end of the day due to the allegation of abuse that occurred on June 7, 2013. It should be noted that further interview with DSP #2 on June 13, 2013, at 2:14 p.m., revealed that Client #1 remained at the day program until the end of the day. Although QIDP #1 and IMC #1 acknowledged they were informed of Resident #1's allegation of abuse at her day program on June 7, 2013, the subsequent interventions implemented failed to prevent further abuse of Resident #1.	I 500		