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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 000}	INITIAL COMMENTS On July 26, 2013, an investigation was concluded that revealed the facility failed to be in compliance with the conditions of participation of governing body, client protections, facility staffing and health care services. A follow-up survey was conducted from September 8, 2013 through September 9, 2013 that revealed the facility failed to regain compliance with the aforementioned conditions of participation. Specifically, observations revealed that one-to-one (1:1) staff failed to provide supervision in accordance with Client #1's and #5's Individual support plans. [See W186] The follow-up survey, therefore, was aborted to provide the facility a second opportunity to attain compliance. The state agency informed the facility's chief executive officer (CEO) of the determination on September 9, 2013, at approximately 3:45 p.m. The findings of the follow-up survey were based on observations, interviews with facility staff and review of the agency's administrative records, including the incident management system. [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]	{W 000}	Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002	
{W 102}	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.	{W 102}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kimberly Walker — TITLE: VP of IDD Services — (X6) DATE: 9/23/13

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

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{W 102}	Continued From page 1 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 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 two of the five clients in the investigation. (Clients #1 and #5) The findings include: Cross refer to W186 1. On September 8, 2013, at 10:36 p.m., Client #5 was observed seated alone on a sofa in the living room. The staff who was responsible for providing him one on one (1:1) support (Staff #2) was seated approximately 12 feet away, across the living room from the client. At approximately 10:45 p.m., and again at 11:12 p.m., Staff #3 was observed working at a computer in the dining	{W 104}	W 104 ILS has ensured clarification of services for all persons with 1:1 staffing. This clarification from the behavior specialist include the guidelines for the time services are to be rendered and staff expectation proximity to the individual. DSP staff were trained on 9/12/2013 Additional training to be held on 9/19/2013 and 9/26/13 by the behavior specialist, participants to include training for the LPN, Q, FC and DSP. Disciplinary action completed for staff who was using the phone. Staff also inservice on the 1:1 guidelines 9/19/2013 Staff training on shift protocol to ensure staff knowledge on expectations of staffing with the 1:1 and also during the evening hours. New physician orders completed with specifics on the 1:1 supports on 9/17/2013	

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{W 104}	Continued From page 2 room while Client #1 was observed in his bedroom, awake. Staff #3 was assigned to provide 1:1 support for Client #1 on that shift (4:00 p.m. - 12:00 a.m.). Observations revealed staff did not remain within arms reach of Clients #1 and #5 while they were awake. II. Interviews with management staff on September 9, 2013, revealed conflicting expectations regarding Client #1's and Client #5's 1:1 support needs. At 10:23 a.m., the qualified intellectual disabilities professional (QIDP, Staff #5) stated that 1:1's did not have to stay in the bedroom if their assigned client was asleep. The 1:1 staff could perform household chores or data entry elsewhere in the facility if their client was sleeping. By contrast, at approximately 12:00 p.m., the program director (Staff #6) stated that 1:1 staff should remain within arms reach of each client until their shift ended at midnight, regardless of whether the client was asleep or not. The medical and habilitation records of both Clients #1 and #5 reflected discrepancies regarding how 1:1 supports were to be provided. Their Individual Support Plans (dated April 11, 2013) said they should receive "1:1 for 16 hours per day." Their Physician's Orders (dated September 1, 2013) reflected: "1:1 supervision during waking hours" (with no further definition). There was no evidence that management sought clarification of the term "waking hours" for Clients #1 and #5 1:1 supports. At the time of the follow-up survey, the governing body failed to ensure that management sought clarification regarding the time frame to provide Clients #1 and #5 1:1 staffing, and failed to	{W 104}	The physician will confer and reflect the agreed upon recommendations with the specialist and reflect those recommendation on his orders ILS provides on-going training on the 1:1 guidelines, shift protocol, active treatment and home safety with all staff to ensure that the individuals' health and safety is always maintained. ILS adjusted the current schedule to include an additional person on the overnight to ensure supervision of all individuals An evening and night facility supervisor has started. He currently monitors evening and after hour staffing and programming for the individuals. ILS will ensure that random review of the staff time sheets is conducted periodically to make sure the schedule is being followed. ILS has added a VP of Disability services and an additional Program Director to specifically monitor the care of the individuals in the ICF program – thereby increasing the supervision and assistance. Both persons have been oriented and have their specific caseloads. The previous management team – QIDP and FC were terminated as they failed to ensure staffing	

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{W 104}	Continued From page 3 ensure that all staff were effectively trainied regarding the proximity to their assigned clients. ********** Previously, the July 26, 2013 investigation report included the following: 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.	{W 104}	compliance, oversight of staff and adequate training of staff. 1a-e. The facility schedule has been revised to include an addition staff on the overnight shift, this is 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. In addition, the HR department has composed an on call list and created a position for staff to be paid floaters. 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.	

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{W 104}	Continued From page 4 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 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	{W 104}	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 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. 9/20/13	

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{W 104}	Continued From page 5 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. 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	{W 104}	Attached; • Staff schedule • On-call staff list/floater schedule • Revised BSP • Staff Training • Revised Physician Orders • Staff 1:1 protocol	

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{W 104}	Continued From page 6	{W 104}		

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.

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.

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{W 104}	Continued From page 7 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 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	{W 104}		

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{W 104}	Continued From page 8 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 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.	{W 104}		

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{W 104}	Continued From page 9	{W 104}		

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 #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

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{W 104}	Continued From page 10 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 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}	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}	W 122 In the future the agency will ensure that staff will provide the individuals the opportunity and the freedom to exercise their rights. All staff were in-serviced on clients' rights, abuse, neglect, exploitation, client protection.	
{W 125}	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients.	{W 125}		

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{W 125}	Continued From page 11 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: 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.	{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.	9/20/13

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{W 125}	Continued From page 12 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 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	{W 154}		

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{W 154}	Continued From page 13 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 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	{W 154}	W 154 All staff involved were disciplined. All staff were in-serviced on all the individuals' BSP. 9/20/13 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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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 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

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{W 154}	Continued From page 15 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 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 chilin". 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	{W 154}		

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{W 154}	Continued From page 16 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, 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	{W 154}		

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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 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

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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).

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

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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 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

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{W 154}	Continued From page 20 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. 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	{W 156}		

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{W 156}	Continued From page 21 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: 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.	{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.	

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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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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. 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

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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 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).

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{W 156}	Continued From page 24 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 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 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. 9/20/13	
{W 159}	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL	{W 159}		

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{W 159}	Continued From page 25 Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on 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	{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.	9/20/13

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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 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

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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 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

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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 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

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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 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

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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 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

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{W 159}	Continued From page 31 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 April 13, 2013, revealed Client #1 had maladaptive behaviors that included physical aggression, self-injurious behaviors (physical discomfort from allergies), taking drinks and impulsiveness. Further review revealed that 1:1 supervision was needed for behavior support implementation and to ensure the safety of the client, given the high level of risk of several of his target behaviors. The BSP also added that 1:1 support staff should be between arm's length and five feet from the client during awaking hours. Note: It should be noted that on July 18, 2013, beginning at 10:50 a.m., interview with the former residential counselor (RC) revealed that it was her expectation that 1:1 staff were to remain within arm's length of their assigned clients throughout their shift. A telephone interview conducted with the former qualified intellectual disabilities professional on July 19, 2013, beginning at 1:33 p.m., verified the former RC's interview. 2. The QIDP failed to integrate services to ensure Client #3 received 1:1 support services as recommended. Interview with the former residential coordinator (RC) on July 18, 2013 beginning at 10:50 a.m. revealed that there were five clients residing in the facility. According to the former RC, three of the clients currently receive 1:1 staffing supports, sixteen hours per day, seven days a week. The former RC further revealed that Client #3 was	{W 159}		

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{W 159}	Continued From page 32 recommended to receive 1:1 staffing support but didn't because the facility was not being compensated for that service. Further discussion with the RC and review of Client #3's record on July 19, 2013 at approximately 12:31 p.m. revealed the client's individual support plan dated May 13, 2013, document 1:1 supervision was recommended. Further review of the client's record revealed a psychological assessment dated April 7, 2013 that documented, "Given [the client's] current gait deficits, it is recommended that he receive one to one staff support to ensure his safety." Interview with the former QIDP on June 19, 2013 beginning at 1:19 p.m. revealed that she was aware of the recommendation. According to the former QIDP, the 1:1 had not been implemented at the time of the investigation.	{W 159}		
{W 185}	483.430(c)(4) FACILITY STAFFING The facility must provide sufficient support staff so that direct care staff are not required to perform support services to the extent that these duties interfere with the exercise of their primary direct client care duties. This STANDARD is not met as evidenced by: Based on interview and record review, the facility 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, for one of three clients in the investigation. (Client #2) The finding includes:	{W 185}	W 185 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.	9/20/13

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{W 185}	Continued From page 33 [Cross Refer to W104] 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. On July 15, 2013, beginning at 1:13 p.m., interview with DSP #8 revealed he was scheduled to work with Client #2 as his 1:1 staff on July 10, 2013, during the 4:00 p.m. to 12:00 a.m. shift. At approximately 11:45 p.m., DSP #8 stated that he informed DSP #4 (who was on the computer doing his end of the shift notes) that he was going downstairs to the basement to start his chores and some laundry. DSP #8 stated that he was in the basement for approximately 5 to 7 minutes. DSP #8 stated that while walking back upstairs from the basement, he heard a thump/shuffle that came from Client #2's bedroom. He stated that he immediately dropped the mop and bucket and rushed to Client #2's bedroom. According to DSP #8, he had to complete the chores before his shift ended at midnight. Furthermore, DSP #8 revealed that there was usually a third staff on duty to assist with chores and to provide closer supervision to Clients #3 and #4. Interview with the former residential coordinator (RC) on July 18, 2013, at beginning 10:50 a.m., and review of records on July 19 2013, at approximately 3:00 p.m., confirmed that a third person should have been on duty to assist with chores and to provide closer supervision to Clients #3 and #4. Continued interview with the former RC revealed she was not aware that there were only two staff on duty that at the time of the incident on July 10, 2013.	{W 185}		

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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
{W 186}	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide sufficient staffing and one to one (1:1) supervision to ensure each client's safety, for two of the five clients in the investigation. (Clients #1 and #5) The findings include: I. On September 8, 2013, at 10:30 p.m., Staff #1 was in the lower level of the facility. He informed the survey team that he was assigned to provide one to one (1:1) support for Client #5 on that shift (4:00 p.m. - 12:00 a.m.). Client #5 was not with him at the time. At 10:36 p.m., the surveyors went upstairs and observed Staff #2 speaking on a telephone while seated in the living room. Client #5 was observed seated alone on a sofa across the living room from Staff #2 (approximately 12 feet away from the staff). No other persons were in the living room at the time. At 11:00 p.m., Staff #2 stated that she had agreed to provide temporary 1:1 support for Client #5 while Staff #1 stepped away. Observations on September 8, 2013 revealed that staff did not continuously remain within arms reach of Client #5, as directed by the client's one to one protocol (reviewed September 9, 2013, at	{W 186}	W 186 Refer to W104 The facility schedule has been revised to ensure that there is sufficient staff on duty to remain compliant and the staffing ratios meet the regulatory standards. The QIDP and Facility Manager have been in-serviced on monitoring the schedule daily and notifying the HR department for relief or supplemental staffing for vacancies or call-outs. In the future the Facility Manager and the QIDP will ensure that there is daily oversight of the staff so as to maintain the required ratios to remain compliant and provide safety. 9/20/13	

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	09G212	A. BUILDING _____ B. WING _____	R 09/09/2013

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{W 186}	Continued From page 35 11:50 a.m.). II. On September 8, 2013, at 10:37 p.m., Staff #3 was observed seated in the dining room, making entries on a computer. At approximately 10:45 p.m., Staff #3 remained at the computer while Client #1 was observed in his bed in an adjoining room. The client's eyes were open, his knees were folded up and he was fidgeting with both of his hands. A similar observation was made of Client #1 (awake in bed) at 11:12 p.m. A short time earlier, at 11:00 p.m., Staff #3 had stated he was assigned to provide 1:1 support for Client #1 on that shift (4:00 p.m. - 12:00 a.m.). Observations on September 8, 2013 revealed that Client #1's assigned 1:1 staff did not remain within arms reach of the client while he was awake. III. On September 9, 2013, beginning at 10:23 a.m., interview with the qualified intellectual disabilities professional (QIDP, Staff #5) revealed that it was her understanding that Clients #1 and #5 received 1:1 staffing for "16 hours awake ...from when they wake up until they go to sleep ... the 1:1 does not have to stay in the bedroom if <the client> is asleep." The QIDP further stated that it was acceptable for Client #1's and #5's 1:1 staff to leave their respective bedrooms if the clients were sleeping. The staff could then perform household chores or data entry or provide stand-in support for the 1:1 that was assigned to supervise Client #2. By contrast, interview with the program director (Staff #6), beginning at approximately 12:00 p.m. revealed that 1:1 staff should remain within arms reach of each client throughout their shift. It was	{W 186}		

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{W 186}	Continued From page 36	{W 186}		

her understanding that there should be two staff in the bedroom shared by Clients #1 and #2 until the evening shift ends at midnight. [Note: Client #2 received 1:1 support 24 hours a day, 7 days a week.] Similarly, Client #5's 1:1 should remain in his bedroom (and within arms reach) until the shift ended at midnight.

Review of Client #1's medical and habilitation records on September 9, 2013, beginning at approximately 12:00 p.m. revealed discrepancies regarding his prescribed 1:1 supports, as follows:
- Individual Support Plan dated April 11, 2013: "I am assigned a 1:1 for 16 hours per day;"
- Behavior Support Plan dated April 11, 2013: "It is recommended that <client's name> receive one-to-one staff supervision;"
- Physician's Orders dated September 1, 2013: "1:1 supervision during waking hours."

There was no one on one protocol observed in Client #1's records; however, Staff #6 stated that the same protocol observed in Client #5's record applied to Clients #1 and #5 as well. There was no evidence that the facility sought clarification of the term "waking hours" for Clients #1 and #5.

****

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

During the course of an investigation initiated on July 9, 2013, it was discovered that on July 10, 2013, Client #2 fell on his bathroom floor at 11:50 p.m. The client was taken to the emergency room via 911 and received several stitches to his right eyebrow.

Direct Support Professional (DSP) #8 and DSP

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{W 186}	Continued From page 37 #4 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 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.	{W 186}		

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{W 186}	Continued From page 38 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 April 13, 2013, revealed Client #1 had maladaptive behaviors that included physical aggression, self-injurious behaviors (physical discomfort from allergies), taking drinks and impulsiveness. Further review revealed that 1:1 supervision was needed for behavior support implementation and to ensure the safety of the	{W 186}		

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{W 186}	Continued From page 39 client, given the high level of risk of several of his target behaviors. The BSP also added that 1:1 support staff should be between arm's length and five feet from the client during awaking hours. On July 11, 2013, at approximately 4:00 p.m., review of the staff training records revealed all staff had received training on Client #1's and Client #2's BSP on June 20, 2013. However, there was no evidence that training had been effective. Note: Interview with the facility's former residential coordinator (RC) on July 18, 2013, beginning at 10:50 a.m., revealed that Clients #1 and #2 received one to one (1:1) staffing support 16 hours per day, 7 days a week. According to the former RC, the clients were to receive arm's length 1:1 staffing support from 8:00 a.m. through 12:00 a.m., which was considered waking hours. Interview with the former qualified intellectual disabilities professional (QIDP) on July 19, 2013, via telephone, verified the former RC's statement.	{W 186}		
{W 192}	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure staff was effectively trained to address a client's change in health status, for one of four clients in the investigation. (Client #3) The finding includes:	{W 192}	W 192 In the future the agency will ensure that all individuals requiring emergency medical attention receive it in the appropriate time. The agency has increased its professional oversight and has employed personnel for a VP of Intellectual Disability services position and a Program Director position for the ICF homes. All staff and management were re-in serviced on the revised Incident Management Process. 9/20/13	

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{W 192}	Continued From page 40	{W 192}		

The facility staff failed to ensure Client #2 received timely medical treatment to his injured right eye.
[Cross Refer to W104] 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.

On July 15, 2013, beginning at 1:13 p.m., interview with DSP #8 revealed that on July 10, 2013, at approximately 12:00 a.m., he called the former residential coordinator (RC) to inform her of Client #2's injury to the right eye. Further interview with DSP #8 revealed that he received a call from the former qualified intellectual disabilities professional (QIDP) at approximately 12:10 a.m. who instructed him to send Client #2 to the emergency room via 911 emergency medical services. DSP #8 stated that he did not call emergency services right away because he was waiting for a phone call from the facility's nurse. DSP #8 further revealed that the former QIDP called back appropriately 20 minutes to see if Client #2 had gone to the emergency room and discovered that the client had not gone to the hospital. The former QIDP again, instructed DSP #8 to call 911. DSP #8 stated that he called 911 and Client #2 reached the hospital emergency room at approximately 1:00 a.m.

In a telephone interview with the former QIDP on July 19, 2013, beginning at 1:33 p.m., it was revealed that she received a call from the former RC who informed her that Client #2 sustained a severe injury to the right eye on of July 10, 2013.

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{W 192}	Continued From page 41 The former QIDP revealed that she called the facility at approximately 12:05 a.m. and instructed DSP #8 to transport Client #2 to the hospital via the company van. The former QIDP stated that she called back to the facility approximately 25 minutes to ensure that Client #2 was transported to the hospital and again, she talked with DSP #8. The former QIDP revealed that DSP #8 and Client #2 were still in the facility. At that time, she instructed DSP #8 to send Client #2 to the emergency room, via 911. 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, 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. On July 19, 2013 at 6:28 p.m., the Health Regulation and Licensing Administration received a copy of the emergency medical services event chronology for the incident involving Client #2 on July 10-11, 2013. According to the document, emergency medical services recieved a request for assistance from the facility at 12:33 a.m. on July 11, 2013. The ambulance arrived to transport Client #2 at 12:41 a.m. At the time of the investigation, the facility failed to ensure staff were effectively trained to ensure client's received timely emergency medical services.	{W 192}		
{W 193}	483.430(e)(3) STAFF TRAINING PROGRAM	{W 193}		

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{W 193}	Continued From page 42 Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on interview and record verification, the facility's staff failed to demonstrate the skills and techniques necessary to implement each client's behavior support plan (BSP), for one of the four clients in the investigation with maladaptive behaviors. (Client #1) The finding includes: [Cross refer to W249.1]. 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 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. 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	{W 193}	W 193 All staff were re in-serviced on the BSP, CPI and 1:1 training. The psychologist will be providing on-going training to equip the staff in recognizing attachment needs, non-verbal communication, positive behavioral supports, emotional vs intelligence expression, executive functioning, therapeutic activities and games and learning principles. These training courses will be provided to the staff on an on-going basis. 9/20/13	

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{W 193}	Continued From page 43 #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 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.	{W 193}		

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{W 193}	Continued From page 44 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, at approximately 2:00 p.m., review of the Client #1's BSP revealed it included interventions to address the client's targeted behavior of SIB. The BSP stated that if the client 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	{W 193}		