

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

PRINTED: 06/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G055	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/16/2013
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NAME OF PROVIDER OR SUPPLIER BEHAVIOR RESEARCH ASSOCIATES	STREET ADDRESS, CITY, STATE, ZIP CODE 4288 1/2 SOUTHERN AVE, SE WASHINGTON, DC 20019
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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	INITIAL COMMENTS A recertification survey was conducted from May 15, 2013 through May 16, 2013. A sample of two clients was selected from a population of one female and three males with varying degrees of intellectual disabilities. This survey was initiated utilizing the fundamental survey process. The findings of the survey were based on observations in the home and at one day program, interviews with one client, direct support staff, nursing and administrative staff, as well as a review of client and administrative records, including incident reports. [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]	W 000		
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to report the results of investigations to the administrator or designated representative within five working days for an incident of neglect, for one of the four clients residing in the facility. (Client #3) The findings include:	W 156		

Received 7/5/13
Department of Health
Health Regulation & Licensing Administration
Intermediate Care Facilities Division
899 North Capitol St., N.E.
Washington, D.C. 20002

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Anne Gordon</i>	TITLE <i>Administrator</i>	(X8) DATE <i>6/30/13</i>
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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 156	Continued From page 1 Review of the facility's incident and investigation reports on May 15, 2013, beginning at 9:10 a.m., revealed the following incidents of neglect were not reported to the administrator or designated representative, as evidenced by: a. On September 29, 2012, Client #3 was sleeping, woke up, starting vomiting and had an elevated temperature. The client was transported to the emergency room via 911 emergency personnel, hospitalized until October 8, 2013 and diagnosed with sigmoid volvulus. During the course of the internal investigation dated November 19, 2013, it was discovered that Client #3 did not have a bowel movement on September 12 & 13, 2012. and there was no documentation indicating that the nurse was informed. Further review of the investigation revealed that IMC completed the investigation on November 30, 2013 (eleven days later). b. On July 28, 2013, direct support professional #1 (DSP1) assigned to Client #1 as her one to one staff, failed to provide p.m. care during the 4:00 p.m. to 12:00 a.m. shift. Reportedly, when Client #1 arrived home from the day program, she sat in a chair with a blanket that covered her. During a scheduled outing, Client #1 was not afforded the opportunity to go on the outing because she had been sitting on the chair soaked in urine. It was also revealed that when the clients' returned back from their outing, Client #1 was in bed alone while DSP1 was in the living room watching television. Review of the corresponding investigative report dated July 30, 2012, revealed incident management coordinator #1 (IMC1) completed the investigation on August 3, 2012. Further review revealed there was no	W 156	W156 Incident reports and incident investigation reports are now reviewed during weekly management team meetings on Mondays of each week. The administrator reviews and signs off incidents and investigation reports at that time or if that does not meet the 5 day requirement, the IMC/QIDP ensures that the administrator reviews incident reports and investigations within the required time frames and verifies the review via sign offs and dating in the proper areas...6-30-13 a. The LPNs check the bowel movement charts daily and indicates in Therap notes whether a bowel movement has occurred for Client #3. The RN reviews the data-based notes routinely...6-30-13 b. The staff member in question was terminated and the remaining staff was retrained on providing appropriate care and support as well as the circumstances that create neglect situations...6-30-13 The QIDP and home manager monitor the implementation of active treatment and staff support provided to the individuals served on a routine basis to ensure that supports are provided as prescribed and in a timely manner...6-30-13	

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W 156	Continued From page 2 documented evidence that the results of the investigation were reported to the administrator within five working days. Interview with the designated administrator/qualified intellectual disabilities professional #1 (QIDP1) on May 16, 2013, at approximately 1:30 p.m., revealed that the results for the aforementioned incidents were reviewed by her within five working days. QDIP1 however, could not produce any documented evidence that she had reviewed the results of the investigation within five working days.	W 156	W189 The PT will retrain all staff on the foot elevation protocol for Client #1...7-15-13 Before implementing the training, the PT will review the situation to take into consideration active periods when Client #1 is engaged in an activity verses sedate periods. This will be done to determine if the prescribed 15 minute intervals should be modified to allow for longer periods when the feet are not elevated (because Client #1 is engaged in an activity). If it is safe and reasonable to do so (extend time periods), the Physical Therapist will modify the protocol for active periods...7-15-13	
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 observation, interview and record review, the facility failed to ensure each staff was effectively trained to manage the provisions outlined in each client's physical therapy assessment, and failed to ensure staff was effectively trained to manage the provisions outlined in each client's nutritional and occupational assessment, for two of the two clients in the sample. (Clients #1 and #2) The findings include: 1. Facility staff failed to ensure Client #1's feet were elevated, as recommended by the physical therapist (PT).	W 189	All staff will be retrained on the meal support protocol with specific attention given to the directives to keep the head erect and encourage Client #2 to keep the eyes open. OT or nutrition will provide the training by...7-15-13. The QIDP and home manager will observe meal implementation at minimum once weekly (QIDP) or twice weekly (home manager) to ensure staff is following the protocol mandates consistently. On-the-spot training will be implemented and documented if staffs fail to perform as prescribed and other appropriate actions will be taken for repeat offenders...7-15-13	

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W 189	<p>Continued From page 3</p> <p>a. Observations conducted on May 15, 2013, beginning at 4:19 p.m. revealed the following:</p> <p>4:54 p.m. - Client #1 was observed sitting down at the dining table eating a snack, talking with her one to one (1:1) staff (Staff #2) and asking for her beads to make a necklace.</p> <p>5:12 p.m. - Client #1 sitting at dining table making a necklace out of different beads.</p> <p>5:33 p.m. - Client #1 sitting at dining table pouring salad from a zip lock bag into a large salad bowl with minimal assistance from her Staff #2.</p> <p>5:50 p.m. - Client #1 got up from the dining table and began walking to the bathroom for p.m. care using a walker. Ted stockings were also observed when the client got up from the dining chair.</p> <p>Review of Client #1 medical records on May 16, 2013, beginning at 9:46 a.m., revealed the client had diagnoses that included peripheral edema and peripheral vascular disease. Review of Client #1's physical therapy (PT) assessment dated May 1, 2013, on the same day at 12:58 p.m. revealed the client was to "elevate her lower extremities if sitting longer than fifteen (15) minutes."</p> <p>Interview with Staff #2 on May 16, 2013, at 4:12 p.m., confirmed that she did not elevate Client #1's feet while sitting at the dining table for more than 15 minutes. Further interview revealed that the client had edema of the lower legs and that the client's legs should have been elevated to keep pressure and the swelling down. When</p>	W 189		
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W 189	<p>Continued From page 4</p> <p>asked, Staff #1 stated that she has had training on Client #1's feet elevation, but could not recall the date.</p> <p>Review of the facility's staff in-service training record on May 16, 2013, at approximately 4:20 p.m., revealed all staff had received training on Client #1's foot elevation on September 12, 2012. Observations on May 15, 2013, however, revealed the training had not been effective.</p> <p>2. Facility staff failed to encourage Client #2 to keep his eyes open during dinner, as recommended by the nutritionist and occupational therapist.</p> <p>On May 15, 2013, beginning at 7:36 p.m., Staff #1 (1:1 staff for Client #2) was observed to feed Client #2 pureed spaghetti and zucchini during dinner. Client #2's eyes remained closed during the majority of the dinner. At approximately 7:40 p.m., Client #1 opened his eyes for a couple of seconds and then again. Staff #1 continued on with feeding the client while his eyes remained closed. Two)2) minutes later, Staff #1 was observed to squeeze ice tea from a water bottle into Client #2's mouth while his eyes remained closed. At no time did Staff #1 ask Client #2 to open his eyes throughout dinner.</p> <p>On May 16, 2013, at 1:00 p.m., review of Client #1's nutritional assessment (NA) dated August 1, 2012, recommended that staff "assist him [client] in holding his head up and keeping his eyes open during meals. At 1:37 p.m., review of the occupational therapy (OT) assessment dated July 31, 2012, revealed that staff was required to "encourage client to keep his head erect and</p>	W 189		

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W 189	<p>Continued From page 5</p> <p>eyes open when eating during mealtime 100% of the time."</p> <p>On May 16, 2013, at 4:30 p.m., interview with Staff #1 revealed that she did not encourage Client #2 to open his eyes. Staff #1 stated that the client "sleeps on and off all the time, so I just talk to him". Further interview revealed that she was train on Client #2's mealtime protocol.</p> <p>On May 16, 2013, at approximately 3:00 p.m., review of the staff in-service training records revealed that all staff had received training on Client #2's nutritional needs. Observations on May 14, 2013, however, indicated that the training had not been implemented or effective.</p>	W 189		
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Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0084	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/16/2013
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R 000 INITIAL COMMENTS

A recertification survey was conducted from May 15, 2013 through May 16, 2013. A sample of two clients was selected from a population of one female and three females with varying degrees of intellectual disabilities.

The findings of the survey were based on observations in the home and at one day program, interview with one client, interviews with direct support staff, nursing and administrative staff, as well as a review of client and administrative records, including incident reports.

[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]

R 000

R 125 4701.5 BACKGROUND CHECK REQUIREMENT

The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check.

This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure criminal background checks were conducted for all jurisdictions in which the employee had worked or resided within the 7 years prior to the check, for one of one maintenance employee. (Staff #3)

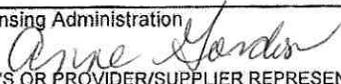
The finding includes:

On May 15, 2013, at approximately 4:00 p.m., Staff #3 was observed in the facility. Review of

R 125

R125

The staff in question is a maintenance person that does not provide direct services to the individuals. BRA was not aware that such a person needed a criminal background check but has since corrected the problem (See: attached copy of the criminal background check)...6-30-13

Health Regulation & Licensing Administration

 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
 STATE FORM 5899 EL4811

TITLE Administrator (X6) DATE 6/30/13
 If continuation sheet 1 of 2

Health Regulation & Licensing Administration

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R 125	Continued From page 1 the personnel record beginning at 2:20 p.m., revealed that a background check was not obtained. On May 16, 2013, at approximately 3:30 p.m., interview with the qualified intellectual disabilities professional (QIDP #1) revealed that Staff #3 has been working for several years, but a background check was never obtained.	R 125		

Health Regulation & Licensing Administration

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I 000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from May 15, 2013 through May 16, 2013. A sample of two residents was selected from a population of one female and three males with varying degrees of intellectual disabilities.</p> <p>The findings of the survey were based on observations in the home and at one day program, interviews with one client, direct support staff, nursing and administrative staff, as well as a review of resident and administrative records, including incident reports.</p> <p>[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]</p>	I 000		
I 206	<p>3509.6 PERSONNEL POLICIES</p> <p>Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties.</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 all health care professionals had current health certificates on file, for one of four registered nurses (RN). (RN #2).</p> <p>The finding includes:</p>	I 206	<p>Chapter 35</p> <p>3509.6</p> <p>The updated health certificate has been obtained from the RN (See: attached copy)...6-30-13 BRA will ensure that quarterly personnel file audits are implemented to identify file update issues in a timely manner so as to proactively notify the relevant staff or clinician and retrieve/file the document in a timely manner...6-30-13</p>	

Health Regulation & Licensing Administration

TITLE

(X6) DATE

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

STATE FORM

6899

EL4811

If continuation sheet 1 of 7

Health Regulation & Licensing Administration

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I 206	Continued From page 1 On May 15, 2013, beginning at approximately 2:20 p.m., review of the personnel records for all employees, including licensed professionals, revealed there was no evidence of a current physician's health inventory/certificate for RN #2. Interview with the qualified intellectual disabilities professional (QIDP #1) and the house manager (HM #1) on the same day at approximately 4:00 p.m., revealed they will retrieve the aforementioned document.	I 206		
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for individuals with intellectual disabilities (GHID) failed to ensure each staff was effectively trained to manage the provisions outlined in each resident's physical therapy assessment, and failed to ensure staff was effectively trained to manage the provisions outlined in each resident's nutritional and occupational assessment, for two of the two residents in the sample. (Residents #1 and #2) The findings include: 1. Facility staff failed to ensure Resident #1's feet were elevated, as recommended by the physical therapist (PT). a. Observations conducted on May 15, 2013, beginning at 4:19 p.m. revealed the following: 4:54 p.m. - Resident #1 was observed sitting down at the dining table eating a snack, talking	I 222	3510.3 The PT will retrain all staff on the foot elevation protocol for Client #1...7-15-13 Before implementing the training, the PT will review the situation to take into consideration active periods when Client #1 is engaged in an activity verses sedate periods. This will be done to determine if the prescribed 15 minute intervals should be modified to allow for longer periods when the feet are not elevated (because Client #1 is engaged in an activity). If it is safe and reasonable to do so (extend time periods), the Physical Therapist will modify the protocol for active periods...7-15-13	

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I 222	<p>Continued From page 2</p> <p>with her one to one (1:1) staff (Staff #2) and asking for her beads to make a necklace.</p> <p>5:12 p.m. - Resident #1 sitting at dining table making a necklace out of different beads.</p> <p>5:33 p.m. - Resident #1 sitting at dining table pouring salad from a zip lock bag into a large salad bowl with minimal assistance from her Staff #2.</p> <p>5:50 p.m. - Resident #1 got up from the dining table and began walking to the bathroom for p.m. care using a walker. Ted stockings were also observed when the resident got up from the dining chair.</p> <p>Review of Resident #1 medical records on May 16, 2013, beginning at 9:46 a.m., revealed the resident had diagnoses that included peripheral edema and peripheral vascular disease. Review of Resident #1's physical therapy (PT) assessment dated May 1, 2013, on the same day at 12:58 p.m. revealed the resident was to "elevate her lower extremities if sitting longer than fifteen (15) minutes."</p> <p>Interview with Staff #2 on May 16, 2013, at 4:12 p.m., confirmed that she did not elevate Resident #1's feet while sitting at the dining table for more than 15 minutes. Further interview revealed that the resident had edema of the lower legs and that the resident's legs should have been elevated to keep pressure and the swelling down. When asked, Staff #1 stated that she has had training on Resident #1's feet elevation, but could not recall the date.</p> <p>Review of the GHIID's staff in-service training record on May 16, 2013, at approximately 4:20</p>	I 222	<p>All staff will be retrained on the meal support protocol with specific attention given to the directives to keep the head erect and encourage Client #2 to keep the eyes open. OT or nutrition will provide the training by... 7-15-13.</p> <p>The QIDP and home manager will observe meal implementation at minimum once weekly (QIDP) or twice weekly (home manager) to ensure staff is following the protocol mandates consistently. On-the-spot training will be implemented and documented if staffs fail to perform as prescribed and other appropriate actions will be taken for repeat offenders... 7-15-13</p>	
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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) COMPLETE DATE
I 222	<p>Continued From page 3</p> <p>p.m., revealed all staff had received training on Resident #1's foot elevation on September 12, 2012. Observations on May 15, 2013, however, revealed the training had not been effective.</p> <p>2. Facility staff failed to encourage Resident #2 to keep his eyes open during dinner, as recommended by the nutritionist and occupational therapist.</p> <p>On May 15, 2013, beginning at 7:36 p.m., Staff #1 (1:1 staff for Resident #2) was observed to feed Resident #2 pureed spaghetti and zucchini during dinner. Resident #2's eyes remained closed during the majority of the dinner. At approximately 7:40 p.m., Resident #1 opened his eyes for a couple of seconds and then again. Staff #1 continued on with feeding the resident while his eyes remained closed. Two (2) minutes later, Staff #1 was observed to squeeze ice tea from a water bottle into Resident #2's mouth while his eyes remained closed. At no time did Staff #1 ask Resident #2 to open his eyes throughout dinner.</p> <p>On May 16, 2013, at 1:00 p.m., review of Resident #1's nutritional assessment (NA) dated August 1, 2012, recommended that staff "assist him [resident] in holding his head up and keeping his eyes open during meals. At 1:37 p.m., review of the occupational therapy (OT) assessment dated July 31, 2012, revealed that staff was required to "encourage resident to keep his head erect and eyes open when eating during mealtime 100% of the time."</p> <p>On May 16, 2013, at 4:30 p.m., interview with Staff #1 revealed that she did not encourage Resident #2 to open his eyes. Staff #1 stated that the resident "sleeps on and off all the time, so I</p>	I 222		

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I 222	Continued From page 4 just talk to him". Further interview revealed that she was train on Resident #2's mealtime protocol. On May 16, 2013, at approximately 3:00 p.m., review of the staff in-service training records revealed that all staff had received training on Resident #2's nutritional needs. Observations on May 14, 2013, however, indicated that the training had not been implemented or effective.	I 222		
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans; 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 have on file for review, current training in cardiopulmonary resuscitation (CPR) for one of five licensed practical nurses (LPN) and one of four registered nurses (RN). (LPN #1 and RN #1) The finding includes: 1. Review of the personnel records on May 15, 2013, beginning at 2:20 p.m., revealed the GHIID failed to have available for review a current CPR certification for the LPN (LPN #1). 2. Similarly, review of the personnel records on May 15, 2013, beginning at 2:20 p.m., revealed the GHIID failed to have available for review a	I 227	3510.5 The QIDP will ensure that all CPR cards are received monthly before the expiration date as they expire by tracking all CPR cards due on a weekly/monthly basis.6/30/13	

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I 227	Continued From page 5 current CPR certification for the RN (RN #1). Interview with the qualified intellectual disabilities professional (QIDP #1) and the house manager (HM #1) on the same day at approximately 4:00 p.m. revealed they will retrieve it from LPN #1 and RN #1.	I 227	3519.10 Incidents are reported to the administrator immediately and the administrator ensures that the IMC submits all reports to the appropriate entities including DOH/HLRA in a timely manner. This requirement is also reviewed in the weekly management team meetings. Documentation of submission is retained and filed...6-30-13	
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and record review, the group home for individuals with intellectual disabilities (GHIID) failed to ensure that all incidents that present a risk to residents' health and well-being were reported through written notification to the Department of Health, Health Regulation and Licensing Administration (DOH/HRLA), for one of the four residents of the facility. (Resident #3) The finding includes: On May 15, 2011, at 1:36 p.m., continued review of the incidents reports revealed that on May 11, 2013, Client #3 was sitting in his wheelchair just after he received his a.m. medications from the nurse. The client immediately began to vomit a	I 379	Incident reports and incident investigation reports are now reviewed during weekly management team meetings on Mondays of each week. The administrator reviews and signs off incidents and investigation reports at that time or if that does not meet the 5 day requirement, the IMC/QIDP ensures that the administrator reviews incident reports and investigations within the required time frames and verifies the review via sign offs and dating in the proper areas...6-30-13	

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I 379	<p>Continued From page 6</p> <p>little bit at first. Then the vomit began to come out like a water faucet. The client was transported to the emergency room via 911 personnel. Further review of the incident report revealed there was no documented evidence that DOH/HLRA had been notified of the incident.</p> <p>On May 15, 2013, at approximately 1:45 p.m., qualified intellectual disabilities professional #1 (QDIP1) who was current acting as the incident management coordinator #1 (IMC1) was interviewed. According to QDIP1, she admitted that she had not notified DOH/HLRA of the aforementioned incident. QDIP1 stated that she would forward the incident report to DOH via facsimile today (May 15, 2013).</p>	I 379		