

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-265	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/04/2013
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NAME OF PROVIDER OR SUPPLIER VOLUNTEERS OF AMERICA	STREET ADDRESS, CITY, STATE, ZIP CODE 8520 1ST STREET, NW WASHINGTON, DC 20012
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1231	<p>Continued From page 4</p> <p>records on October 4, 2013, at approximately 5:00 p.m., revealed that a check dated February 1, 2013, for \$31.29 paid towards a hospital bill.</p> <p>When asked about the hospital payments on October 4, 2013, at approximately 5:15 p.m., the facility's director of intellectual disabilities stated that the residents should not have paid for medical bills. Further interview revealed that the residential coordinator (RC) #1 had paid the hospital bills without knowing that the residents were not required to pay medical bills. She further indicated that this had not been discussed during orientation training. The director of intellectual disabilities then stated that the residents would be reimbursed.</p>	1231		
1379	<p>3519.10 EMERGENCIES</p> <p>In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day.</p> <p>This Statute is not met as evidenced by: Based on interview and review of resident records, including incident reports and investigations, the group home for individuals with intellectual disabilities (GHID) failed to ensure that all incidents that present a risk to residents' health and safety were reported immediately to</p>	1379	<p>3519.10</p> <p>VOAC has reviewed the cause of this deficiency and assigned a different investigator to look into the allegations made by the individual to HRLA and the allegation regarding food withholding. The investigation was completed and recommendations made to the</p>	

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1379	<p>Continued From page 5</p> <p>the Department of Health, Health Regulation and Licensing Administration (DOH/HRLA), for one of four residents of the facility. (Resident #1)</p> <p>The findings include:</p> <p>I. On October 2, 2013, beginning at 10:57 a.m., review of an incident report dated September 26, 2013, revealed that Staff #1 had informed the residential coordinator (RC) #1 that on September 24, 2013, she overheard Resident #1 tell a nurse (LPN #1) that Staff #2 "hits her and calls her monkey."</p> <p>On October 2, 2013, at 4:48 p.m., interview with the residential coordinator (RC) #1 confirmed that the incident had not been reported to HRLA.</p> <p>II. On October 4, 2013, at approximately 9:00 a.m., review of Resident #1's behavior data revealed that on April 20, 2013, staff wrote that the resident "called her mother and fed that she was not fed." There was no evidence that her allegation of mistreatment (food withheld) was reported to the facility's administrator or to HRLA.</p> <p>On October 4, 2013, interview with RC #1 at 4:30 p.m. confirmed that the "behavior" had not been reported as an incident and to her knowledge it had not been further investigated.</p> <p>It should be noted that on October 2, 2013, at 12:45 p.m., review of Resident #1's BSP, dated July 1, 2013, had revealed that it addressed a targeted behavior of making false allegations. According to the BSP, the resident should be interviewed immediately and if she insists that the allegation is true and her answers to a list of query questions suggest that the allegation might be true, then an investigation is required and</p>	1379	<p>VOAC administrator. The assigned QIDP will ensure the staff understand the steps to take when an allegation is made that appears to be a part of the individual's target behavior in her BSP. VOAC will ensure through its QA process that staff follows the BSP and asked the questions as outlined in the BSP before making a determination that the issue is one of a behavior rather than an incident. The Program Director via the Incident management Coordinator will ensure the policy for reporting incident and for investigation is followed once the determination is made that the allegation is not a behavior.</p> <p>By 10/30/13</p>	

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1379	Continued From page 6 referrals should be made. There was no documented evidence, however, that Resident #1 was interviewed on the day she made the allegation that staff had not fed her. III. On October 2, 2013, at 11:26 a.m., review of an incident report dated January 16, 2013, revealed that a direct support staff (Staff #4) accused another staff (Staff #5) of yelling at Resident #3 while Staff #5 was assisting the resident with bathing. The allegation was reported to HRLA two days later, via telephone voice mail, on January 18, 2013, at 4:50 p.m. At the time of the survey, the GHID failed to ensure that all allegations of abuse or mistreatment were reported immediately to HRLA.	1379		
1422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for individuals with intellectual disabilities (GHID) staff failed to ensure each resident's behavior support plan (BSP) was implemented consistently for the one resident in the sample with a BSP. (Resident #1) The findings include: 1. Review of incident reports and investigations on October 2, 2013, beginning at 10:57 a.m., revealed an incident dated September 26, 2013. According to the incident report, Staff #1 informed	1422	3521.3 VOAC has already conducted staff training on incident reporting and the BSP to address the staff understanding of the behavior of making false allegations. VOAC will ensure that staff follows the steps in the BSP and ask the list of questions as outlined in the BSP. The assigned Incident Manager will further ensure that staff members that are placed on leave remain on	

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1422	<p>Continued From page 7</p> <p>the residential coordinator (RC) #1 that on September 24, 2013, she overheard Resident #1 telling a nurse (LPN) #1 that Staff #2 "hits her and calls her monkey." Continued review of the incident report revealed that LPN #1 was heard telling the resident she would "take care of it."</p> <p>Interview with the interim program director (IPD) #1 on October 2, 2013, at approximately 12:30 p.m., revealed that Resident #1 had a target behavior of making false allegations.</p> <p>On October 2, 2013, at 12:45 p.m., review of Resident #1's BSP, dated July 1, 2013, confirmed that making false allegations was a targeted maladaptive behavior. Continued review of the BSP revealed staff should address allegations by asking the following questions:</p> <p>a. Are you certain what you're saying is true?</p> <p>b. Did anyone else witness the incident you're talking about?</p> <p>c. What is the person's name who witnessed the incident you're talking about?</p> <p>d. Were you injured during the incident?</p> <p>e. Show me where you were injured?</p> <p>f. Show me the place where the incident occurred.</p> <p>Further review of the BSP revealed "if the resident insists that the allegation is true, especially during instances of alleged physical or verbal abuse or other serious allegations and her answers to the query questions suggest that the allegation might be true, then an investigation is</p>	1422	<p>leave until the investigation is complete and findings are given to the VOAC administrator for a decision to be made. VOAC will ensure that there is documentation in the individual's record that shows the staff followed the BSP. This documentation should include asking the questions and getting an answer that confirms that the individual is making a false allegation or not. If no evidence of a behavior, the staff that the allegation is made against will be placed on leave pending the outcome of the investigation.</p> <p>By 10/30/13</p> <p>The Incident Manager will ensure all notification is made for incident, as evidenced by the QIDP or designee verifying the contacts logs, progress notes, phone verification and documentation of such.</p> <p>By 10/30/13</p> <p>VOAC will ensure family members are notified as part of the required notification process evidenced by the QIDP or designee as evidenced by verifying the contacts logs, progress notes, phone verification and documentation of such; also review of the incident in the monthly IRC.</p> <p>By 10/30/13</p>	
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1-422	<p>Continued From page 8.</p> <p>required and referrals should be made.</p> <p>Staff #1 was interviewed in the facility on October 3, 2013, beginning at 10:50 a.m. She reiterated that she had heard Resident #1 make the allegations of abuse on September 24, 2013. When queried about the resident's BSP, Staff #1 indicated that she was unaware of the list of specific questions outlined in the BSP. Twice, she stated staff was expected to document the allegation on the behavior sheets.</p> <p>On October 3, 2013, at 11:14 a.m., review of Resident #1's behavior data failed to show evidence that staff had documented the resident's allegations of being hit or called names by other staff. Continued review of the resident's record failed to show evidence that Resident #1 was asked the list of questions (as per the BSP) on the day that she made the allegations.</p> <p>ii. On October 4, 2013, at approximately 9:00 a.m., review of Resident #1's behavior data revealed that on April 20, 2013, staff wrote that the resident "called her mother and lied that she was not fed." There was no additional information noted on the behavior data sheet that would evidence that her allegation of mistreatment (food withheld) was followed by questioning by staff, in accordance with the resident's BSP.</p> <p>On October 4, 2013, interview with RC #1 at 4:30 p.m. revealed that she knew little about that particular incident. The RC stated that to her knowledge the "behavior" had not been further investigated.</p> <p>There was no documented evidence that Resident #1 was interviewed on the day that she made the allegation that staff had not fed her.</p>	1-422		

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1422	Continued From page 9 At the time of the survey, there was no evidence that facility staff had implemented Resident #1's BSP as written.	1422		
1500	3523.1 RESIDENTS RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observations, interviews and record review, the group home for individuals with intellectual disabilities (GHID) failed to observe and protect residents' rights in accordance with federal regulations 42 CFR 483 Sub-Part 1 (for Intermediate Care Facilities for Individuals with Intellectual Disabilities) and Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) that governs the care and rights of individuals with intellectual disabilities, for one of four residents of the facility. (Resident #1) The findings include: 1. [483-470(g)(2)] The GHID failed to ensure that all residents were protected from further potential abuse while investigations of abuse were in progress, as follows: A. Review of incident reports and investigations on October 2, 2013, beginning at 10:57 a.m., revealed an incident dated September 26, 2013. According to the incident report, Staff #1 informed	1500	See 3521.3	

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1500	<p>Continued From page 11</p> <p>that the first interviews conducted with Resident #1 and Staff #2 were dated September 30, 2013. On October 2, 2013, at 6:20 p.m., the IPD informed the survey team that Staff #2 "is placed on leave immediately pending the outcome of further investigation." On October 3, 2013, at 12:50 p.m., review of Staff #2's payroll summary records confirmed that she had worked in the facility while the investigation was ongoing (on September 27, 2013, September 30, 2013 and October 1, 2013, the 10:00 p.m. - 6:00 a.m. shift).</p> <p>It should be noted that during an interview on October 2, 2013, at 3:49 p.m., Resident #1 informed the survey team that Staff #2 gets frustrated and shakes her, then tells her to tell her mother. She also described Staff #2 as "mean and aggressive... evil." When asked if anyone had verbally abused her, Resident #1 stated that Staff #2 called "me a monkey."</p> <p>At the time of the survey, there was no evidence that the facility implemented its policy to prevent further potential abuse of its residents, while investigations were being conducted.</p> <p>II. [Title 7, Chapter 13, § 7-1305.10(f), formerly § 6-1970(f)]</p> <p>The GHID failed to demonstrate protection of residents' rights to have their family notified whenever an allegation of abuse is made, as follows:</p> <p>Review of the aforementioned incident report dated September 26, 2013 (Resident #1's allegations of abuse) revealed no evidence that the resident's sister had been notified of the allegations.</p>	1500		
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1500	<p>Continued From page 12</p> <p>On October 2, 2013, at 5:40 p.m., interview with the residential coordinator (RC) #1 confirmed that Resident #1's sister was not notified of the aforementioned incident.</p> <p>In an attempt to interview family members, the surveyor telephoned Resident #1's sister on October 4, 2013, at approximately 12:00 p.m. The sister, however, did not return the message before the survey ended.</p> <p>III. [483.420(b)(1)(i)] The GHID failed to ensure that residents' funds entrusted to the facility for management were spent appropriately, for two of four residents of the facility, as follows:</p> <p>Review of Resident #1's financial records on October 4, 2013, beginning at approximately 4:45 p.m., revealed that the resident had paid \$64.60 for a hospital bill with a check dated February 1, 2013. Similarly, review of Resident #3's financial records on October 4, 2013, at approximately 5:00 p.m., revealed that a check dated February 1, 2013, for \$31.29 paid towards a hospital bill.</p> <p>When asked about the hospital payments on October 4, 2013, at approximately 5:16 p.m., the facility's director of intellectual disability operations stated that the residents should not have paid for medical bills. Further interview revealed that the residential coordinator (RC) #1 had paid the hospital bills without knowing that the residents were not required to pay medical bills. She further indicated that this had not been discussed during orientation training. The director of intellectual disability operations then stated that the residents would be reimbursed.</p>	1500	<p>VOAC reimbursed the individuals for the expenditure from their funds. VOAC will ensure that this doesn't happen again by ensuring the random and periodic quality assurance reviews occur as scheduled. Assistance in this area is also provided by the VOAC finance office.</p> <p>By 10/15/13</p>	

Continued 10/23/13