[redacted] 12/18/07

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OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G094	A. BUILDING _____ B. WING _____	R 11/07/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 05	0934 9TH STREET, NW WASHINGTON, DC 20012

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{W 000}	INITIAL COMMENTS A follow-up survey was conducted on November 7, 2007, to determine the facility's compliance with previous condition level deficiencies cited on September 28, 2007. The findings of this survey were based on observations, interviews with direct support and administrative staff and clients, and the review of records, including incident reports and administrative records. The survey findings determined that the facility remained out of compliance with the Condition of Participation in Client Protections.	{W 000}		
{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 observations, staff interviews and record review, the facility's governing body provided general operating direction except in the following areas: The findings include: 1. Cross-refer to W149, W125 and 148. The governing body failed to ensure that all staff recognized and reported allegations of abuse in accordance with policies to ensure the health, safety and due process rights of its clients. 2. Cross-refer to W212 and W225. The governing body failed to ensure that the facility secured timely psychiatric and/or vocational evaluations when indicated.	{W 104}	1. See responses to W149, W125 and W148. 2. See response to W212 and W225.	12/13/07 12/13/07
{W 122}	483.420 CLIENT PROTECTIONS	{W 122}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marsha H. Thompson — TITLE: Director of Disability Services — (X6) DATE: 12/13/07

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 122}	Continued From page 1 The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: The facility failed to develop and implement effective policies and procedures to ensure the implementation of its incident management system [See W149]; failed to ensure that all allegations of neglect or abuse, as well as injuries of unknown source, were reported and investigated thoroughly [See W153 and 154]; and failed to ensure that investigations were reported to the administrator or designated representative within five working days of the incident [See W156]. The effects of these systemic practices results in the failure of the facility to protect its clients from harm and to ensure their general safety and well being.	{W 122}	The DoDS revised agency policy to meet the standards of the Departments of Health and Disability Services. Training was provided to staff at all levels on the requirements of the policy on November 3, 2007. On November 10, 2007 the DoDS convened a meeting of all management staff and provided training on incident reporting and investigation. The Director of Operations convened a meeting of the Nursing Department and the DD Department, where the DoDS trained all QMRPs, Residential Directors (RDs), RN Supervisors, Designated Nurses, and Medication Nurses on November 14, 2007 on the Incident Policy, including notifications and investigations. The Incident Management Coordinator (IMC) attended investigation training with Labor Relations Associates from November 27-30, 2007 that provided her with additional training on thorough, complete, and timely investigative procedures. The DoDS will continue to provide training, mentoring, support and oversight on the incident management system to ensure that staff and professionals providing services comply with the policy and requirements.	12/13/07
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on interview and record review during the revisit on November 7, 2007, the facility failed to ensure each client's right to file a complaint and have his/her complaint fully investigated, for one of the five clients residing in the facility. (Client	W 125	See response to W122. The QMRP has been retrained on documenting, reporting, notifying family, attorney, guardian, administrator, DDS, DOH and investigating incidents.	12/13/07

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W 125	Continued From page 2 #4) The finding includes: Cross-refer to W149. On October 28, 2008, Client #4 informed staff that Client #1 had punched him in the face. Interview with the Qualified Mental Retardation Professional (QMRP) on November 7, 2007, at approximately 6:00 PM, revealed that the allegation of peer-on-peer abuse had not been reported in accordance with facility policies. Although the QMRP indicated that she had interviewed the two clients at the time the client made his allegation, there was no written documentation available for review to verify that the client's complaint had been investigated. In addition, there was no evidence that Client #4's allegation was reported to outside entities, including his mother (she remains involved in his care), in accordance with facility policies, to ensure that his complaint received appropriate review.	W 125		
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on interview and record review during the revisit on November 7, 2007, the facility failed to consistently notify the client's parents of significant incidents, including allegations of physical abuse, for one of the five clients residing in the facility. (Client #4)	W 148	See response to W125.	12/3/07

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W 148	Continued From page 3 The finding includes: Cross-refer to W149. On October 28, 2008, Client #4 informed staff that Client #1 had punched him in the face. Interview with the Qualified Mental Retardation Professional (QMRP) on November 7, 2007, at approximately 6:00 PM, revealed that the allegation of peer-on-peer abuse had not been reported in accordance with facility policies. There was no evidence that Client #4's mother (who remained active in his care) was made aware of her son's allegation. It should be noted, however, that the facility had documented having notified his mother promptly after her son was bitten on the shoulder by Client #1 on September 30, 2007.	W 148		
{W 149}	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on staff interviews, review of Client #4's medical and habilitation records as well as review of the facility's incident management policy, the facility failed to implement written policies that provide the detail necessary to guide staff, to ensure that allegations of abuse were reported and investigated in accordance with federal and state regulations. (Residents #1, #2, #3, #4, #5) The finding includes:	{W 149}	See response to W125. The policies define "incident." The DoDS has held, and will continue to hold, numerous training sessions on Incident Management. The DoDS will ensure that all staff is clear that an individual served is not "charged" with responsibility for incidents when he or she is the aggressor, but that staff are accountable. The DoDS will ensure that staff understand that client-on-client aggression is still a serious reportable incident, and must be managed according to policy. The client may need additional behavioral supports and planning, and the environment must be adjusted as much as possible to prevent the possibility of harm to others through a client's maladaptive behaviors.	12/13/07

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{W 149}	Continued From page 4 On November 7, 2007, at 9:14 AM, interview with the Resident Director (RD) revealed that there had been one incident reported and investigated since the September 28, 2007 recertification survey. The corresponding documentation was reviewed. At 9:20 AM, the RD stated that there had been no other incidents reported. At approximately 1:35 PM, the Qualified Mental Retardation Professional (QMRP) also indicated that no other incidents had occurred since the September 28, 2007 recertification survey. The LPN Designated Nurse, who was present at the time, stated that she was unaware of any other incidents that required nursing care (except for Client #1's medication refusal). Later that day, however, at approximately 5:25 PM, a nursing note was found in Client #4's medical chart that indicated he had made an allegation of physical abuse. On October 28, 2007, at 9:30 PM, a medication nurse documented that a "counselor" reported an altercation between Client #4 and a peer. The progress note further indicated that the nurse had assessed the client and found no sign of injury. He did, however, document having administered Tylenol 650 mg that evening "for pain." At 5:30 PM, the QMRP was asked about the incident. She stated that she had been onsite that evening, working with Client #1 in the dining room. According to the QMRP, Client #4 told the medication nurse that Client #1 had punched him in the face. The nurse promptly came to the dining room and notified the QMRP. She said Client #4 had not told anyone about the alleged attack before the nurse arrived. The QMRP reportedly interviewed the two clients; however, there was no written documentation available to	{W 149}		

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{W 149}	Continued From page 5 verify that an investigation had been initiated. The other staff on duty at that time reportedly had been in the basement with other clients. The QMRP further indicted that she had not viewed this as an incident because she categorized Client #4's allegation as a false accusation. Neither she nor the nurse had documented the allegation of abuse on an incident report. The QMRP and LPN Designated Nurse both stated that making false accusations was not one of Client #4's known target behaviors. At approximately 6:05 PM, the QMRP was asked whether the facility's policy addressed allegations of physical abuse. She replied that she planned to make a reference to Client #4's accusation when she wrote her October QMRP Monthly Note in the client's record. When pressed further about policies on reporting such allegations, at 6:08 PM, she expressed doubt that their policies required an incident report if/when an allegation involved peer on peer allegations: "not individuals..., staff, that's an incident." The facility's Policies and Procedures Manual (manual) was reviewed, beginning at approximately 6:10 PM. At the outset, the manual provided a list of definitions, which included the following: Abuse: "The wrongful treatment of an individual... including, but not limited to, another individual being served, an employee..." Incidents: Included was "Allegation of abuse," which was marked with an asterisk. The list indicated that an asterisk meant this was categorized by the agency as a "Serious Reportable Incident."	{W 149}		

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{W 149}	Continued From page 6 Serious Reportable Incident: "A reportable incident which, due to its significance or severity, requires immediate notification to, and investigation by, external authorities, in addition to internal review and investigation by the provider agency..." Review of the Incident Management Policy, revised 10/8/07, revealed that "Allegation of Abuse" was listed as a Serious Reportable Incident on the incident report form that was used for documenting all incidents, regardless of severity, as per the facility's policy. It should be noted that Clients #1 and #4 have a documented history of altercations between the two, some of which led to serious injuries that required treatment at hospital emergency rooms. For example, an incident report dated September 30, 2007 and its corresponding investigation report, described how Client #1 bit Client #4 on the shoulder with little provocation. The bite broke the skin. Client #4 was taken to an emergency room for immediate care and antibiotic treatment. It should be further noted that at approximately 3:05 PM, the QMRP and RD both stated that the agency's Director of Disability Services had reviewed their Incident Management Policies with all nurses, RDs, QMRPs and the Incident Management Coordinator at a "program management" meeting held Thursday, November 1, 2007. **********	{W 149}		

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{W 149}	Continued From page 7 Previously, the September 28, 2007 survey findings included: Based on interview and record review, the facility failed to establish and/or implement policies to ensure the health and safety of four of the six clients residing in the facility. (Clients #1, #2, #4 and #6) The findings include: 1. The facility failed to document the notification of the State agency of significant incidents, in accordance with their incident management policy, as follows: Cross-refer to W153. Review of the facility's incident reports, investigations and client records on September 25-27, 2007 revealed evidence of four incidents of abuse and one injury of unknown source documented to have occurred between January 2007 and September 2007. Continued review of the facility's incident reports and/or interview failed to show evidence that the administrator and the Department of Health were made aware of the five aforementioned incidents. Interview with the Resident Director (RD) and Qualified Mental Retardation Professional (QMRP) was conducted on September 25, 2007 at 3:21 PM and 3:44 PM respectively. They both indicated that staff who witnessed, discovered or were informed of the aforementioned incidents should have documented the incident on an incident report prior to end of his/her shift. The QMRP stated that the Department of Health (DOH) was to be notified of all allegations of abuse/neglect and injuries of unknown source immediately, followed by written notification within	{W 149}	1. See response to W125.	12/13/07

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{W 149}	Continued From page 8 24 hours. Review of the facility's "Incident Management" policy on September 26, 2007 revealed incidents were categorized into both reportable and serious reportable incidents. Allegations of abuse, neglect and injuries of unknown source were identified as serious reportable incidents. According to the policy, staff were required to "immediately call" the case manager, the DOH, and the client's parent or guardian for all serious reportable incidents. Incident report forms were to be completed on "all serious reportable incidents" and the incident report was to be forwarded to the DOH within 24 hours. However, the survey revealed that the facility had not consistently notified the State agency of the incidents, in accordance with its policies. 4. The facility failed to ensure consistent implementation of the "investigation" component of its Incident Management policies, as evidenced by the following: Cross-refer to W153 and W154. Review of incident reports, investigations and client records on September 25, 2007 and September 27, 2007, revealed two allegations of abuse and/or neglect (January 17, 2007 and April 8, 2007) and one allegation of verbal abuse (May 14, 2007). The QMRP was interviewed on September 25, 2007, at 3:44 PM. She stated that all allegations of abuse were to be investigated and completed within five business days. Review of the facility's "Incident Management" policy on September 26, 2007 verified this; "all investigations for serious reportable incidents will be completed within 5 business days ... " Survey findings, however, revealed no evidence that the January 17, 2007	{W 149}	4. The QMRP and Residential Director who staffed the home from January 2007 – May 2007 are no longer employed by the agency. The current QMRP and RD were brought in to replace them, and have been trained thoroughly on incident management. See response to W122.	12/13/07

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{W 149}	Continued From page 9 and April 8, 2007 incidents were investigated; and, the investigation report for the May 14, 2007 allegation of abuse documented that it was submitted for review on May 24, 2007, and the Director of Operations signed it on May 25, 2007.	{W 149}		
{W 153}	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on staff interviews, review of Client #4's medical and habilitation records as well as review of the facility's incident management policy, the facility failed to report all allegations of abuse in accordance with federal and state regulations and facility policies. The finding includes: Cross-refer to W149. According to a nursing progress note in Client #4's medical chart, a "counselor" reported to a medication nurse that there had been an altercation between Client #4 and a peer. On October 28, 2007, at 9:30 PM, Client #4 alleged that Client #1 had punched him in the face. Interview with the QMRP revealed that she thought the client, not a counselor, had first reported the allegation of abuse to the nurse. The nurse then notified the QMRP. The QMRP further indicted that she had not viewed this as an incident because she categorized Client #4's allegation as a false accusation. Neither she nor	{W 153}	See response to W149.	12/13/07

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{W 153}	Continued From page 10 the nurse had documented the allegation of abuse on an incident report, in accordance with agency policies. Further interview and record review revealed no evidence that Client #4's allegation was immediately reported to the Administrator and/or the Department of Health as required. ********** Previously, the September 28, 2007 survey findings included: Based on interview and record review, the facility failed to ensure all injuries of unknown source and allegations of abuse, were immediately reported to the administrator and to other officials in accordance with State law (DC regulation 22 DCMR Chapter 35, Section 3519.10), for three of the six clients residing in the facility. (Clients #1, #2 and #4) The findings include: 1. Review of the facility's incident reports and investigations on September 25, 2007 beginning at 4:22 PM revealed that the facility failed to provide evidence that the following incidents were immediately reported to the administrator and/or the Department of Health as required: a. On January 17, 2007 staff reported that Clients #1 and #4 were in a physical altercation that resulted in Client #1 needing emergency medical services to address an injury to his lower lip. Review of the emergency room consultation form dated January 17, 2007 revealed Client #1 received sutures to his lower lip laceration.	{W 153}	1. a. See response to W149 #4.	12/3/07

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{W 153}	Continued From page 11 b. On April 8, 2007, staff reported that Client #1 was verbally aggressive to his roommate Client #4. According to the incident report, Client #4 was kicked by Client #1 and then Client #4 bit Client #1 on the left side of his wrist.	{W 153}	1.b. See response to W149 #4.	12/13/07
{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 staff interviews, review of Client #4's medical and habilitation records as well as review of the facility's incident management policy, the facility failed to investigate all allegations of abuse in accordance with federal and state regulations. (Residents #1, #2, #3, #4, #5) The finding includes: Cross-refer to W148. According to a nursing progress note in Client #4's medical chart, a "counselor" reported to a medication nurse that there had been an altercation between Client #4 and a peer on October 28, 2007. At 9:30 PM, a medication nurse documented having assessed the client and found no sign of injury. The nurse did, however, administer Tylenol 650 mg that evening "for pain" after the altercation. On November 7, 2007, beginning at approximately 5:30 PM, interview with the QMRP revealed that she had been onsite that evening (October 28, 2007), working with Client #1 in the dining room. According to the QMRP, Client #4 told the medication nurse that Client #1 had	{W 154}	See response to W149	12/13/07

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{W 154}	Continued From page 12 punched him in the face. The nurse promptly came to the dining room and notified the QMRP. She said Client #4 had not told anyone about the alleged attack before the nurse arrived. Careco's Policies and Procedures Manual (manual) was reviewed, beginning at approximately 6:10 PM. "Allegation of abuse" was listed, or categorized as a "Serious Reportable Incident." A Serious Reportable Incident was defined as; "A reportable incident which, due to its significance or severity, requires immediate notification to, and investigation by, external authorities, in addition to internal review and investigation by the provider agency..." The QMRP reportedly interviewed the two clients; however, there was no written documentation available to verify that she had initiated an investigation. She said she had not interviewed the other staff person who was onsite that evening. There was no evidence that Client #4's allegation of physical abuse was thoroughly investigated by the QMRP. Because it was not reported up the chain of command within the agency, there had been no administrative investigation performed by the Incident Management Coordinator in accordance with facility policies, nor were investigation(s) conducted by outside entities as mandated by regulation. It should be noted that Clients #1 and #4 have a documented history of altercations between the two, some of which led to serious injuries that required treatment at hospital emergency rooms. For example, an incident report dated September 30, 2007 and its corresponding investigation report, described how Client #1 bit Client #4 on	{W 154}		

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{W 154}	Continued From page 13 the shoulder with little provocation. The bite broke the skin. Client #4 was taken to an emergency room for immediate care and antibiotic treatment. ********** Previously, the September 28, 2007 survey findings included: Based on interview and record review, the facility failed to ensure that all allegations of abuse or neglect were thoroughly investigated, for two of the six clients residing in the facility. (Clients #1 and #4) The findings include: 2. The facility failed to ensure a thorough investigation was conducted for all allegations of abuse, as follows: Review of the facility's incident reports and investigations on September 25, 2007, beginning at 4:22 PM, revealed that on April 8, 2007, staff reported that Client #1 was verbally aggressive to his roommate Client #4. According to the incident report, Client #1 kicked Client #4 and Client #4 bit Client #1 on the left side of his wrist. An "Incident Summary Report" had been completed for the aforementioned incident. Review of the summary, however, revealed that it documented only two components, a restatement of the actual incident and recommendations. There was no evidence that interviews or statements had been collected and reviewed to investigate the incident. Additionally, there was	{W 154}	2. See response to W122 and W125.	12/13/07

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{W 154}	Continued From page 14 no documentation indicating whether the incident had been substantiated or unsubstantiated. At the time of the survey, the facility failed to show evidence that the aforementioned incident had been thoroughly investigated.	{W 154}		
{W 159}	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the Qualified Mental Retardation Professional (QMRP) failed to respond timely to previously-identified active treatment and/or support needs, for three of the five clients residing in the facility. (Clients #1, #2 and #3) The findings includes: 1. The September 28, 2007 recertification survey had revealed inconsistent implementation of Client #1's recommended cigarette smoking reduction, without evidence of coordination and monitoring by the Qualified Mental Retardation Professional (QMRP). The November 7, 2007 revisit revealed continued inconsistent implementation of the client's recommended smoking plan and continued failure to coordinate and monitor an effective intervention strategy, as follows: a. Even though the QMRP stated that Client #1"can only have three cigarettes per day," as recommended by the cardiologist and agreed to by the primary care physician and the client's	{W 159}	1. a. The QMRP will request the Psychologist, Psychiatrist, and Primary Care Physician to recommend behavioral and medical (if needed) interventions to assist the client in smoking cessation. *Effective* strategies must manage his constant demands and resulting behaviors when he is frustrated by not being able to smoke, and must prevent him from harming himself, others, and property, and must include, but go beyond, setting a smoking schedule.	12/13/07

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{W 159}	Continued From page 15 brother, he was observed smoking his third cigarette before departing for day program on the morning of November 7, 2007 and key staff were without clear instructions on how to address the issue. At 6:54 AM, Client #1 was observed on the front porch smoking a cigarette. At 7:18 AM, the client asked the Resident Director (RD) for a cigarette. The client smiled as he told the RD that he had not yet had a cigarette that morning. The RD said he thought that he had already smoked one. Nevertheless, the RD gave the client another cigarette and he smoked it on the front porch. At approximately 8:02 AM, Client #1 came back to the RD and asked for cigarettes. The RD asked him to wait but then gave him another cigarette after he complied with a request to insert his dentures. The client smoked it (his third that morning) at approximately 8:10 AM. At 8:24 AM, the clients and staff loaded onto the van and left for day program. According to the RD, Client #1 took a cigarette with him to smoke during a break at day program. At approximately 10:04 AM, the QMRP stated that Client #1"can only have three cigarettes per day," as recommended by the cardiologist and agreed to by the primary care physician and the client's brother. b. The QMRP and Client #1 had not established a set schedule. At 10:12 AM, the QMRP indicated that the client normally smoked a cigarette after breakfast, another one after lunch and a third after dinner. Two minutes later, however, she acknowledged that this had "not been outlined in a written schedule." Interview with the RD later, at approximately 1:40 PM, revealed that the client had been taking two cigarettes with him to day program daily, whereas	{W 159}	I.b. See response to I.a. above.	12/13/07

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{W 159}	Continued From page 16 the QMRP expected him to take only one. Conversation between the RD and Client #1 prior to day program departure indicated that the client also expected to take two cigarettes with him to day program. c. Client #1's Behavior Support Plan (BSP), which had expired on September 18, 2007, did not provide direction to staff on how to address the smoking issue. During the revisit, a staff person was observed offering him a cigarette as a reward for complying with a request to insert his dentures as instructed. On November 7, 2007, at approximately 8:02 AM, Client #1 approached the RD and asked for cigarettes. The RD replied he would give them to him when he got on the van to go to day program. He told the client that it was too early and he was trying to help him to curb his smoking. The RD then asked him to insert his dentures. After the client hesitated, the RD said "I'll work with you, work with me" and then offered to give the client another cigarette if he put in the dentures. At 8:09 AM, the client returned to the dining room wearing his dentures and the RD gave him a cigarette. He promptly smoked it outdoors. At approximately 10:14 AM, the QMRP indicated that she had addressed the topic with staff at an October 20, 2007 training session. At 10:15 AM, when asked at what point would it be acceptable for staff to allow him to smoke more than three cigarettes, the QMRP stated that was "not acceptable." When asked if a cigarette could be offered as a reward for complying with a request, she replied "cigarettes are not a reward. No. We reward him in other ways." The QMRP then acknowledged that the BSP had expired. She	{W 159}	1.c. See response to 1.a. above.	12/13/07

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{W 159}	Continued From page 17 expressed an expectation that an updated BSP would be available for review at the client's upcoming annual ISP meeting, scheduled for November 16, 2007. It should be noted that review of the facility's Human Rights Committee minutes for a meeting held on November 30, 2006 revealed that the committee had recommended that Client #1's BSP be updated. The BSP, however, had not been updated since the committee made the recommendation 11 months earlier. d. Facility staff documented at least two recent behavioral outbursts, including one incident that led to client injury, that were cigarette-related, as follows: (1) On November 7, 3007, at 9:14 AM, the RD indicated that Client #1 had bitten Client #4 recently. It had broken the skin therefore they took Client #4 to an emergency room for a tetanus shot. An incident report documented the bite had occurred on September 30, 2007. The corresponding investigation report, dated October 2, 2007, indicated that Client #1 had been angry because he didn't have cigarettes. When his then-roommate Client #4 asked him to be quiet and go to sleep, he came over to Client #4's bed and bit him on the shoulder. The investigation listed four recommendations, including "Make sure <client's name> has required amount of cigarettes as recommended by medical doctor." Observations and interviews during this revisit failed to show evidence that staff were effectively implementing the recommendation. (2) At approximately 10:55 AM, review of Client #1's BSP revealed that it had expired on	{W 159}	1.d. (1) See response to 1.a. above. 1.d.(2) See response to 1.a. above.	12/13/07

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{W 159}	Continued From page 18 September 18, 2007. The functional analysis identified seven likely antecedents for his targeted maladaptive behaviors (non-compliance, verbal aggression, verbal threats, crying and using a loud tone of voice indoors), including when he had no cigarettes and when he could not smoke due to task/ activity involvement. (3) At approximately 1:45 PM, the QMRP and the LPM Designated Nurse presented an Incident report, dated October 24, 2007. The nurse documented the client's repeated refusals to take his morning medications. Review of the Incident Summary Report, dated October 25, 2007, revealed that staff had refused to give him a second cigarette and referred him to the nurse. The client then became angry and refused to comply with the nurse's requests (three times) to take his medications. 2. The September 28, 2007 recertification survey had revealed that the QMRP failed to establish a system to ensure clients had batteries available to operate their TV remote controls. Specifically, Client #2's remote was without batteries and the QMRP had been unaware. The November 7, 2007 revisit revealed continued failure to establish a system to address this need, as follows: On November 7, 2007, at 5:16 PM, Client #2 was asked about his television remote. He retrieved the remote (marked with his name) from his bedroom. Inspection revealed that the battery compartment was empty. The QMRP and RD said the remote had been "lost" after the September 28, 2007 survey and they were surprised to see it reappear that afternoon. The RD offered to assist Client #2 with buying new	{W 159}	1.d.(3) See response to 1.a. above. 2. The QMRP will provide an active treatment program for the person where he will budget for purchase of batteries; alert staff when his batteries are low, so that they can be discarded; and he can buy and insert new batteries in the remote.	12/13/07 12/13/07

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{W 159}	Continued From page 19 batteries that evening during a community walk. 3. Cross-refer to W212. The September 28, 2007 recertification survey had revealed that the QMRP failed to ensure comprehensive assessment of Clients #1 and #3's psychiatric conditions/ needs. On November 7, 2007, at 3:27 PM, the QMRP stated that neither client had received an updated psychiatric evaluation. ********** Previously, the September 28, 2007 survey findings included: Based on observation, interview and record review, the Qualified Mental Retardation Professional (QMRP) failed to ensure active treatment services were monitored, coordinated and integrated, for three of the six clients residing in the facility. (Clients #1, #3 and #4) The findings include: 1. Observation of Client #1 throughout the survey revealed the client smoked cigarettes. Review of the client's medical records on September 27, 2007 at 8:34 PM revealed a cardiology consultation report that documented recommendations including decreasing the client's use of tobacco to no more than three cigarettes a day. Interview was conducted with the designated Licensed Practical Nurse (LPN) on September 27, 2007, at 1:58 PM, to ascertain information regarding Client #1's smoking practices. According to the nurse, there was no schedule	{W 159}	3. The QMRP will schedule a comprehensive psychiatric evaluation for the people who need this consult. 1. See response to W159.	12/13/07 12/13/07

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{W 159}	Continued From page 20 Implemented to assist the client with reducing his tobacco intake. The nurse stated that the client was given $5.00 weekly that he used to purchase cigarettes. The nurse further indicated that the client maintained his own cigarettes. On September 26, 3007, at 7:37 AM, Client #1 was seen taking a cigarette outside to smoke. The Resident Direct (RD) was asked if Client #1 was on a schedule. He replied "He should have 4 cigarettes per day, per his physician's orders... 1 after breakfast, 1 after return from day program at 4:00 PM, 1 after his evening hygiene and he takes 1 to day program." The RD further indicated that the client was "really resourceful" and received cigarettes from peers outside of the facility (exact source not known). The client reportedly became upset when told to limit his smokes; he knew they were "his own personal property...he buys them... that makes them his." Interview was conducted with the QMRP on September 27, 2007, seeking further clarity about Client #1's smoking practices. The QMRP stated that no schedule had been implemented to assist Client #1 with a reduction on his tobacco intake. On September 28, 2007, at 6:20 PM, a follow-up interview with the RD indicated that he had sought input from Client #1's brother, in a telephone conversation just minutes earlier. The client and staff were "really struggling with the cigarette issue... he's on a set number of cigarettes a day... we need to do something with his doctor's orders and IHP... he has stolen from staff, pocket books... I know that he smokes at his day program too." At 7:11 PM, a direct support staff person approached the RD and asked about Client #3's cigarettes. The RD	{W 159}		

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{W 159}	Continued From page 21 informed him that Client #3 was out of cigarettes and did not have money to purchase more. He told the staff that Client #1 was free to share some of his with Client #3 if he wanted, "but tell him that he'll run out faster with sharing with his smoke partner." When the staff asked where Client #1's cigarettes were kept, the RD pulled a pack out of his pocket and handed it to the staff, adding "they are now in his possession." At the time of the survey, the QMRP failed to facilitate an interdisciplinary team review of the client's smoking-related needs, to address the cardiologist's recommendation for a reduction in his tobacco intake. 2. The QMRP failed to establish a system to ensure clients had batteries available to operate their TV remote controls, as follows: On September 26, 2007, at approximately 8:40 AM, Client #2 openly declared that "my TV broke." The RD replied "you have lost your remote." This surveyor asked the client to show him the TV. Once in the bedroom, a direct support staff person presented a remote control. It was quickly determined that there were no batteries in the remote. Client #2 confirmed that this was his remote. He then demonstrated how he had been using his roommate's remote to change channels (both of their TVs responded to the same brand of remote control). The RD then informed the client that it was a matter of "budgeting... you buy your own batteries." Review of Client #2's record on September 28, 2007 revealed no evidence that he received assistance with budgeting for such purchases. When interviewed later that day, the QMRP indicated that she was previously unaware that the client	{W 159}	2. See response to #2 above. (p.19)	12/13/0

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{W 159}	Continued From page 22 was out of batteries for his remote. She also acknowledged that there had been no budget developed to assist the client with planning for such purchases. 3. Cross-refer to W212. The QMRP failed to ensure comprehensive assessment of Clients #1 and #3's psychiatric conditions/ needs.	{W 169}	3. See response to #3 above. (p. 30)	12/13/07
{W 212}	483.440(c)(3)(i) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the presenting problems and disabilities and where possible, their causes. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure a comprehensive psychiatric assessment had been conducted for both of the two clients (out of three sampled clients) in the sample who were prescribed psychotropic medications for behavior management. (Clients #1 and #3) The findings include: The September 28, 2007 recertification survey had revealed that the QMRP failed to ensure comprehensive assessment of Clients #1 and #3's psychiatric conditions/ needs. On November 7, 2007, at 3:27 PM, the QMRP stated that neither client had received an updated psychiatric evaluation. The consulting psychiatrist reportedly was attending an out of town conference. She further indicated that a November 21, 2007 meeting was scheduled with the psychiatrist to "review all individuals on psychotropic medications." It should be noted, however, that Client #1's interdisciplinary team was scheduled	{W 212}	See response to #3 above.	12/13/07

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{W 212}	Continued From page 23 to meet before then, on November 16, 2007, to review an update his annual plan. ********** Previously, the September 28, 2007 survey findings included: Based on interview and record review, the facility failed to ensure a comprehensive psychiatric assessment had been conducted for both of the two clients (out of three sampled clients) in the sample who were prescribed psychotropic medications for behavior management. (Clients #1 and #3) The finding includes: Interview with the Resident Director on September 25, 2007, at 2:33 PM, revealed that both Clients #1 and #3 received psychotropic medications to address maladaptive behaviors. This was verified through observation of the evening medication administration on September 25, 2007. Client #1's Annual Medical Evaluation, dated September 25, 2007, reflected a diagnosis of Intermittent Explosive Disorder (source and date of diagnosis not indicated). Interview with the Qualified Mental Retardation Professional (QMRP) and review of Clients #1's and #3's records on September 27, 2007 failed to provide evidence of a comprehensive psychiatric assessment that documented each client's Axis I diagnosis and justified the use of the prescribed psychotropic medications.	{W 212}		
{W 225}	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must	{W 225}	The QMRP and DoDS will provide the comprehensive vocational assessment.	12/13/07

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{W 225}	Continued From page 24 include, as applicable, vocational skills. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that clients received comprehensive vocational assessments as indicated, for one of the three clients in the sample. (Client #3) The findings include: The September 28, 2007 recertification survey had revealed that the QMRP failed to ensure a comprehensive vocational assessment for Client #2. On November 7, 2007, at approximately 7:15 AM, Client #3 told this surveyor that he was not going to day program that day; he was "going shopping" instead. At 7:37 AM, while seated in the nurse's office, Client #3 stated "I want another job." Minutes later, the client sat at the dining room table and began eating breakfast. At approximately 7:46 PM, he repeated the comment "I want another job." Then at 7:49 AM, he said "I want a new job." At 3:30 PM, the Qualified Mental Retardation Professional (QMRP) was asked about Client #3's day placement. She said his vocational program had "moved him" to another location two days per week. On Tuesdays and Wednesdays, he was performing janitorial duties at a community gym. She and the Resident Director both said the client had not complained to them about wanting a new job. However, the QMRP acknowledged that Client #3 had not received a comprehensive vocational assessment. Record review confirmed this and indicated that he had been in the "Work Activity Program" (vocational)	{W 225}		

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{W 225}	Continued From page 25 since at least 1999. There was no evidence that the facility had sought a comprehensive vocational assessment, describing the client's current interests, strengths and needs. [Note: In follow-up to the last survey, the QMRP stated that Client #2's interdisciplinary team was scheduled to meet November 15, 2007 for a case conference to discuss his day placement.] ********** Previously, the September 28, 2007 survey findings included: Based on observation, interview and record review, the facility failed to ensure that clients received comprehensive vocational assessments as indicated, for one of the three clients in the sample. (Client #2) The findings include: On September 27, 2007, at approximately 8:15 AM, the Resident Director (RD) stated that Client #2 performed volunteer work in the dining area of a nursing home. The RD indicated that he had just been informed by Client #2's job coach that the client had done so well during the "trial period" that the nursing home wanted him to continue there on a permanent basis. The job coach reportedly planned to inform the client's government case worker of his work performance and recommend that he remain at that location. Client #2 was observed at his day placement on September 27, 2007, beginning at 9:57 AM. The client placed eating utensils in individual plastic	{W 225}		

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{W 225}	Continued From page 26 bags. He did so without any assistance from his job coach or his peers. His job coach stated that he and three other volunteers with disabilities placed the eating utensils, along with napkins and ice water, at the residents' place settings before lunch. The coach described the client as "one of my best workers." According to the coach, Client #2 had been volunteering there for approximately 1 month, "preparing him for employment." She stated that the client was "well-mannered and polite." The job coach indicated that Client #2's trial period was scheduled to end in 3 months (December), however, she would "try to get him to stay because he is very good." He and his peers did not earn a stipend or receive a wage for their work. They volunteered at this work site Monday-Friday, between 9:00 AM - 2:00 PM. At 10:16 AM, Client #2 approached the job coach and asked "I'm going to make more money, right?" After the client walked away, the coach acknowledged that money meant something to him. She said that while he was already motivated, she thought that he "would be even more motivated if he got a check in hand." At the time, there was only one paid staff in the dining area, the nursing home's dining room supervisor. This was verified a few minutes later through interview with the supervisor. She was the sole paid employee. She also confirmed that Client #2 "enjoys his work and is doing well." At approximately 10:30 AM, the coach indicated that to date, she had not met either the Qualified Mental Retardation Professional (QMRP) or RD; neither individual had visited the current setting. When asked about Client #2's strengths, the	{W 225}		

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{W 225}	Continued From page 27 coach said she "he catches on very well... can perform most tasks after one demonstration... is independent in silver ware, wiping tables, pretty much everything." However, she described the client as distractible. When asked if he was currently employable, she responded "yes." Later that day, the RD and QMRP were asked about Client #2's day placement. At 5:24 PM, the RD confirmed that he had not observed the client performing work tasks at the current location. At approximately 5:29 PM, the QMRP also acknowledged that she had not visited the current work site. She did, however, report having received a telephone call from the job coach on the previous day. The coach reported that the client was "doing well." She confirmed that while the other clients were leaving the work site in December, they wanted "to keep him" at the nursing home and a case conference was planned for within the coming month (October) to discuss the proposal. When asked about a vocational assessment, the QMRP stated that she did not know whether an assessment had been performed. On September 28, 2007, beginning at 9:53 AM, review of Client #2's record failed to show evidence that he had received a comprehensive vocational assessment to determine his interests, skills and training needs. There was, however, an annual report (dated April 30, 2007) that was prepared by the client's current day program. The report indicated that while he was a "very hard worker," he required "verbal prompts throughout the day to remain on task." The day program plan for the coming year included a recommendation to "explore community based employment opportunities" by exposing the client	{W 225}		

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{W 225}	Continued From page 28 to "at least 2 community-based employment opportunities per quarter." It should be noted that further interviews with Client #2 and residential staff confirmed that money was important to the client and that he enjoyed making purchases. According to the RD, the client was responsible for purchasing batteries for such items as his TV remote control. At the time of the survey, there was no evidence that Client #2's interdisciplinary team had a comprehensive vocational assessment, describing the client's current interests, strengths and needs, available for discussion at the upcoming case conference. It was proposed to keep the client placed in a volunteer position with no opportunity for advancement to a paid position of employment. It should be further noted that on September 28, 2007, at 4:51 PM, Client #2 enthusiastically declared to that he had received a paycheck that day. Payment was for "contract work" that he had performed during a recent period he spent working at a sheltered workshop, and not at the volunteer work site.	{W 225}		

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{I 000}	INITIAL COMMENTS A follow-up survey was conducted on November 7, 2007 to determine the facility's compliance with previous deficiencies cited on September 28, 2007. The findings of this survey were based on observations, interviews with direct support and administrative staff and clients, and the review of records, including incident reports and administrative records.	{I 000}		
{I 042}	3502.2(b) MEAL SERVICE / DINING AREAS Modified diets shall be as follows: (b) Planned, prepared, and served by individuals who have received instruction from a dietitian; and... This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all persons working with residents were trained to effectively meet the residents' dietary needs, for 4 of the 6 residents residing in the facility. (Clients #1, #3, #4 and #5) The finding includes: The GHMRP submitted a written Plan of Correction, signed October 25, 2007, in which the provider indicated that the Nutritionist would provide "appropriate dietary management training to all facility staff" by November 2, 2007. However, review of staff in-service training records and interviews with the Qualified Mental Retardation Professional on November 7, 2007 revealed that training had not yet been provided. The QMRP stated that the Nutritionist was scheduled to provide additional training on November 11, 2007.	{I 042}		

Health Regulation Administration
Marsha H. Thompson
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE Director of Disability Services

(X6) DATE 12/13/2007

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{I 042}	Continued From page 1 ********** Previously, the September 28, 2007 survey findings included: Based on observation, interview and record review, the facility failed to ensure that all persons working with residents were trained to effectively meet the residents' dietary needs, for 4 of the 6 residents residing in the facility. (Clients #1, #3, #4 and #5) The findings include: 1. Dinner was observed in the facility on September 25, 2007 and breakfast was observed on September 26, 2007. At both meals, all six residents were served 2% milk. Residents #1, #3, #4 and #5 were all prescribed low cholesterol diets. In addition, Residents #1, #3 and #5 were prescribed reduced calorie (1800, 1800 and 1500, respectively) diets. On September 28, 2007, review of the menu revealed that residents who were prescribed low cholesterol and/or reduced calorie (1500, 1800) diets were to have skim milk. On September 26, 2007, review of staff in-service training records revealed no evidence of recent training on Nutrition, menus and/or prescribed diet plans. The most recent documented training had been provided on February 18, 2006 and only one of the employees who attended that session (19 months earlier) was still employed by the GHMRP. There was no evidence that the Residence Director, who was responsible for overseeing the purchase of menu items, had received training by the Nutritionist. 2. Resident #1's diet plan was changed on August 23, 2007, to reflect a restriction on daily	{I 042}	1. The Nutritionist will provide training to facility staff, including the Residential Director (RD).	12/13/07

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{I 042}	Continued From page 2 fluid intake. As per orders from the nephrologist and primary care physician, his total fluid intake was not to exceed 1200 cc's daily. A newly-established schedule indicated that he should receive 6 oz with his afternoon snack, after return home from the day program. On September 26, 2007, at 4:21 PM, Resident #1 was observed drinking a 16.9 oz bottle of spring water with his snack. He finished the bottle in less than one hour. Subsequent review of staff in-service training revealed no documented evidence of applicable staff training. It should be noted that later that evening, at 6:16 PM, review of the resident's fluid intake chart revealed the Designated Nurse had documented 6 oz for the afternoon snack. When asked, she said the resident had been given 6 oz of juice. Subsequent interview revealed that neither the nurse, nor the Residence Director was previously aware that Resident #1 had taken a bottle of spring water. It remained unclear whether he drank the 16.9 oz of water and 6 oz of juice.	{I 042}	2. The Director of Disability Services (DoDS) will provide training to the Designated Nurse (DN), QMRP, and RD on ensuring that communication and documentation is coordinated and accurate, thereby providing better compliance with recommended health service delivery.	12/13/07
{I 071}	3503.2 BEDROOMS AND BATHROOMS Each bed shall be placed at least three feet (3 ft.) from any other bed and at least three feet (3 ft.) from any unprotected radiator. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure that two residents' beds were at least 36 inches apart. (Residents #4 and #6) The finding includes: The GHMRP submitted a written Plan of Correction, signed October 25, 2007, in which the	{I 071}	The RD will move the bed to meet the distance requirement.	12/13/07

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{I 071}	Continued From page 3 provider indicated that administrators would "review the physical setting and determine how to manage the space requirements." However, observation of the bedroom on November 7, 2007, at approximately 9:20 AM, revealed that the two beds remained in the same position. [Note: At 9:13 AM, the Resident Director stated that Residents #5 and #1 had switched bedrooms since the last survey.] ********** Previously, the September 28, 2007 survey findings included: On September 26, 2007, at 8:00 AM, Resident #1's bed was observed placed only 22.5 inches away from Resident #4's bed. The beds remained in their same position on September 28, 2007, at 7:00 PM.	{I 071}		
{I 090}	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to maintain the interior and exterior of the facility in a clean, orderly, and attractive manner. The findings include: The GHMRP submitted a written Plan of Correction, signed October 25, 2007, in which the	{I 090}		

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(I 090)	Continued From page 4 provider indicated that all environmental deficiencies would be corrected by November 2, 2007. However, inspection of the facility on November 7, 2007, beginning at approximately 9:30 AM, revealed that several previously-cited deficiencies remained, as follows: Backyard and porch: Paint around the windows and window sills inside the back porch was peeling, chipped and dirty. It appeared that numerous coats of paint had been applied over the years and the resultant build-up was notably unattractive. Kitchen: 1. The handle on the upper left cabinet door above the stove was missing a screw and was not secured properly. 2. Cabinetry throughout the kitchen was notably unattractive, presumably due to age and wear. Basement: There was a strip of molding (approx. 3 ft. in length) missing at the base of the wall in the front right corner. Living room: There were 3 burn marks in the carpet that by their shape, appeared to have been caused by an iron. Resident bedrooms. 1. Both Resident #2 and Resident #3 had loose dresser drawers, filled with personal clothing	(I 090)	1. The handle will be properly secured. 2. Cabinetry will be maintained in good repair and kept clean. Missing molding will be replaced. The area rug will be replaced.	12/13/07 12/13/07 12/13/07 12/13/07

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{I 090}	Continued From page 5 items, that were placed directly on the floor underneath their beds. Each resident had a bed, nightstand and wardrobe; the 2 drawers placed on the floor were their only dresser drawers. 2. There was a significant accumulation of dust in the bedroom shared by Residents #1 and #4, especially on the carpet in the corners, along the molding/ walls and on their window curtains. This is a repeat deficiency. See Federal Deficiency Report dated 10/12/06. 3. There was a burn mark in the carpet just inside the door to the bedroom shared by Residents #1 and #4. Judging by its shape, the burn appeared to have been caused by an iron.	{I 090}	1. The residents have "captain's beds" that are built for efficient use of space. The drawers are part of the framework of the bed, and therefore may appear to be "on the floor" but actually slide in and out of the frame the way dresser drawers slide in and out of the dresser's frame. 2. The RD has specifically assigned staff members with duties for dusting and laundering assistance for the people who live in the home, thus increasing accountability for cleanliness and follow up. The room will be dusted and the curtains laundered regularly. 3. The area rug will be replaced.	12/13/07 12/13/07 12/13/07
{I 108}	3504.15 HOUSEKEEPING Each GHMRP shall assure that each resident has at least seven (7) changes of clothing appropriate to his or her daily activities. This Statute is not met as evidenced by: Based on interviews with staff in supervisory positions, the GHMRP failed to secure for each resident at least seven changes of clothing. The finding includes: The GHMRP submitted a written Plan of Correction, signed October 25, 2007, in which the provider indicated that the Resident Director would replace the damaged/ discarded clothing items identified in the September 28, 2007 Deficiency report by November 2, 2007, the follow-up survey on November 7, 2007 revealed that the residents remained without an adequate	{I 108}		

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{I 108}	Continued From page 6 supply of socks and undergarments. According to the Resident Director, at 8:40 AM, (and corroborated later by the Qualified Mental Retardation Professional) no new undergarments had been purchased since the last survey. Reportedly, there had been a delay in securing the necessary funds from the corporate office. ********** Previously, the September 28, 2007 survey findings included: 1. On September 26, 2007, at approximately 7:58 AM, Resident #1 was asked why he was wearing a pair of dress socks while he wore casual shorts and sneakers. He complained that his athletic socks all had holes in them. During the next half hour, the Resident Director, Resident #1 and this surveyor examined the resident's clothing inventory. Ten of the resident's 12 athletic socks had holes in them. (Note: The 2 drawers contained dozens of undershirts and briefs with holes in them and the drawers were in general disarray.) There were 2 socks without holes found in the drawers that morning. Resident #1 put them on before leaving for day program. 2. On September 28, 2007, at approximately 7:00 PM, inspection of Resident #6's clothing inventory revealed 1 pair of white athletic socks and no dress socks. 3. On September 28, 2007, at approximately 7:05 PM, Resident #5's dresser drawers contained 1 pair of underbriefs. On September 28, 2007, at approximately 7:07	{I 108}	1. The RD will ensure that damaged socks and underclothing are replaced. 2. The RD will ensure needed garments are purchased, labeled, and provided to each person. 3. See answer to #2 above.	12/13/07 12/13/07 12/13/07

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{I 108}	Continued From page 7 PM, the Resident Director acknowledged that the residents did not have at least 7 pairs of socks appropriate to his daily activities.	{I 108}		
{I 187}	3508.5(d) ADMINISTRATIVE SUPPORT Each GHMRP shall have an organization chart that shows the following: (d) The lines of authority. This Statute is not met as evidenced by: Based on interview with the Qualified Mental Retardation Professional (QMRP), the GHMRP failed to maintain an organizational chart that showed the lines of authority within the nursing department. The finding includes: The GHMRP submitted a written Plan of Correction, signed October 25, 2007, in which the provider indicated that the organizational chart would be updated by November 2, 2007. However, interview with the QMRP on November 7, 2007, at 4:42 PM, revealed that she had not seen a new chart and there was no revised chart available for review in the facility. On November 8, 2007, subsequent review of materials submitted by the QMRP revealed no additional information. ********** Previously, the September 28, 2007 survey findings included; The organizational chart (dated September 2007) that was made available for review on September	{I 187}	The new organization chart will be posted in the house.	12/3/07

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{I 187}	Continued From page 8 27, 2007, at 2:49 PM, did not reflect the current lines of authority within the nursing department, to include the recently-hired RN Supervisor.	{I 187}		
{I 206}	3509.6 PERSONNEL POLICIES 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. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that each employee, prior to employment and annually thereafter, provided evidence of a physician's certification that documented a health inventory had been performed and that the employee's health status would allow him or her to perform the required duties. The September 28, 2007 licensure survey had revealed no evidence of annual health inventories for one nurse and four consultants. A staff identifier was included with the deficiency report that was sent to the facility's administrative office. The GHMRP submitted a written Plan of Correction, signed October 25, 2007, in which the provider wrote: "The Human Resources Department will acquire the health certificates and place copies in the file at the home," with a completion date of November 2, 2007. On November 7, 2007, however, there was no evidence of current health certificates in the	{I 206}		

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{I 206}	Continued From page 9 facility. At approximately 4:50 PM, the Qualified Mental Retardation Professional (QMRP) stated that she would seek documentation from the corporate office and forward them to the regulatory agency. On November 8, 2007, review of the documentation submitted by the QMRP revealed the following: 1. The health inventory for the nurse cited in the previous survey (S5) had expired; it was dated September 16, 2006; and, 2. There were no updated health inventories submitted for the four consultants cited in the previous survey (C1, C3, C6 and C7). ********** Previously, the September 28, 2007 survey findings included: Interview with the Qualified Mental Retardation Professional and review of the GHMRP's personnel files on September 27, 2007 revealed the GHMRP failed to provide evidence that current health certificates were on file for one nurse and four consultants. This is a repeat deficiency. See Federal Deficiency Report dated 10/12/06.	{I 206}	1. The Human Resources Director will provide the required documentation for the nurse and consultants. 2. See response to #2 above.	12/13/07 12/13/07
{I 223}	3510.4 STAFF TRAINING Each training program agenda and record of staff participation shall be maintained in the GHMRP and available for review by regulatory agencies. This Statute is not met as evidenced by: Based on interview and record review, the	{I 223}	The DoDS will provide the agendas used.	12/13/07

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{I 223}	Continued From page 10 GHMRP failed to ensure that agendas were maintained in the group home and made available for review. The September 28, 2007 licensure survey had revealed no evidence of agendas for eight staff in-service training sessions. The GHMRP submitted a written Plan of Correction, signed October 25, 2007, in which the provider wrote: "The QMRP will provide copies of the standard agendas that were used for for trainings," with a completion date of November 2, 2007. Staff in-service training records were reviewed in the GHMRP on November 7, 2007, beginning at 9:56 AM. There was a staff signature sheet for training conducted by the QMRP and the RD on October 20, 2007 on the topics "Staff Supervision" and "Documentation." There was no corresponding agenda, however, available for review. At approximately 4:56 PM, the QMRP and RD acknowledged that there was no agenda available to verify the information that had been conveyed. In addition, the QMRP did not offer documentation or copies of "the standard agendas" for trainings cited in the previous survey. ********** Previously, the September 28, 2007 survey findings included: On September 26, 2007, beginning at 3:24 PM, review of the GHMRP's staff in-service training records revealed that there were no agendas available for training sessions that were indicated by staff signature sheets. For example, there were no agendas or handouts to indicate the	{I 223}		

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{I 223}	Continued From page 11 subject matter discussed at the following: - September 6, 2007 "Fire Safety, Cooking Safety, Electrical Safety;" - July 23, 2007 and August 11, 2007 "Sexuality;" - August 8, 2007 "ISPs/Active Treatment;" - July 19, 2007 "Rights of Persons with MR/DD Most Integrated Setting;" - August 8, 12 and 13, 2007 "Role of The Professional Counselor," and other recent training on such topics as "Ethics in The Workplace," "Securing Medical and Dental Care" and "Sign Language." For the most part, the only agendas available for review were those that were brought by DDS personnel when they presented training on DDS policies.	{I 223}		
{I 229}	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that agendas were maintained in the group home and made available for review.	{I 229}		

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{I 229}	Continued From page 12 The findings include: 1. Cross-refer to I042. The September 28, 2007 survey revealed that the most recent documented training by the Nutritionist had been provided on February 18, 2006. Only one of the employees who attended that session (19 months earlier) was still employed by the GHMRP. The GHMRP's Plan of Correction, signed October 25, 2007, stated that training would be provided by November 2, 2007. Staff in-service training records were reviewed in the GHMRP on November 7, 2007, beginning at 9:56 AM. There was no documented evidence that the Nutritionist had provided in-service training. The Qualified Mental Retardation Professional (QMRP) acknowledged that the Nutritionist had not conducted the training to date; however, she reportedly was scheduled to provide additional training on November 11, 2007. 2. The September 28, 2007 survey revealed that Resident #4 (who was not in the sample for that survey), had a diagnosis of seizure disorder. Review of the staff in-service training records, beginning at 9:56 AM, revealed that the most recent documented training on seizures had been provided on January 30, 2006 (20 months earlier). The GHMRP's Plan of Correction stated that training regarding seizure disorder would be provided by November 2, 2007. However, review of the staff in-service training records on November 7, 2007, beginning at 9:56 AM, revealed no evidence of training on seizures. At 5:08 PM, the QMRP acknowledged that the training had not yet occurred; however, she further stated that the Registered Nurse had scheduled seizure training for November 12, 2007.	{I 229}	1. The Nutritionist training will be rescheduled. 2. The RN Supervisor will ensure that seizure training is provided and documented.	12/13/07 12/13/07

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(I 274)	3513.1(e) ADMINISTRATIVE RECORDS Each GHMRP shall maintain for each authorized agency ' s inspection, at any time, the following administrative records: (e) Signed agreements or contracts for professional services; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to document signed written agreements or contracts with professional consultants. The September 28, 2007 licensure survey had revealed no evidence of signed agreements or contracts with three consultants. A staff identifier was included with the deficiency report that was sent to the facility's administrative office. The GHMRP submitted a written Plan of Correction, signed October 25, 2007, in which the provider wrote: "The Human Resources Department will ensure signed contracts are on file in the home," with a completion date of November 2, 2007. On November 7, 2007, however, there was no evidence of written agreements or contracts in the facility. At approximately 4:57 PM, the Qualified Mental Retardation Professional (QMRP) stated that she would seek documentation from the corporate office and forward them to the regulatory agency. On November 8, 2007, review of the documentation submitted by the QMRP revealed no evidence of written agreements or contracts with the three consultants identified in the previous survey (C2, C4 and C5). **********	(I 274)	The HR Director will provide the signed consultant contracts.	12/13/07

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{I 274}	Continued From page 14 Previously, the September 28, 2007 survey findings included: Interview with the Qualified Mental Retardation Professional and review of personnel records on September 27, 2007 revealed the GHMRP failed to have a contract or written agreement on file for three consultants.	{I 274}		
{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 GHMRP failed to ensure that the Department of Health, Health Regulation Administration, was notified of all allegations of physical abuse, immediately by phone then followed up by written notification, for two of the five residents of the facility. (Residents #1 and #4) Cross-refer to Federal Deficiency Report - Citation W149. According to a nursing progress note in Resident #4's medical chart, a "counselor" reported to a medication nurse that there had been an altercation between Resident #4 and a peer. On October 28, 2007, at 9:30 PM,	{I 379}	See response to federal deficiency W149.	12/13/07

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{I 379}	Continued From page 15 Resident #4 alleged that Resident #1 had punched him in the face. Interview with the QMRP revealed that she thought the resident, not a counselor, had first reported the allegation of abuse to the nurse. The nurse then notified the QMRP. The QMRP further indicted that she had not viewed this as an incident because she categorized Resident #4's allegation as a false accusation. Neither she nor the nurse had documented the allegation of abuse on an incident report, in accordance with agency policies. Further interview and record review revealed no evidence that Resident #4's allegation was immediately reported to the Administrator and/or the Department of Health as required. It should be noted that the GHMRP failed to document having investigated Resident #4's allegation. ********** Previously, the September 28, 2007 survey findings included: Based on interview and record review, the GHMRP failed to ensure that the Department of Health, Health Regulation Administration, was notified of incidents or events that substantially interfered with a resident ' s health, welfare, living arrangements, well being or in any other way placed the individual at risk, immediately by phone then followed up by written notification, for two of the six residents of the facility. (Residents #1 and #4) The findings include: Review of incident reports and investigations on September 25, 2007, beginning at 4:22 PM, revealed the GHMRP failed to provide evidence that the following incidents had been reported to the Department of Health:	{I 379}		

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{I 379}	Continued From page 16 a. On January 17, 2007, staff reported that Resident #1 and #4 were in a physical altercation that resulted in Resident #1 needing emergency medical services to address an injury to his lower lip (laceration). b. On April 10, 2007, staff reported that Resident #1 needed to be picked up from the day program due to knee pain. The resident was subsequently seen at the emergency room and diagnosed with a knee sprain c. On April 18, 2007, staff reported that Resident #1 was verbally aggressive to his roommate Resident #4. According to the incident report, Resident #1 kicked Resident #4 who in turn, bit Resident #1 on the left side of his wrist. d. On July 7, 2007, staff reported that Resident #4 eloped while staff were packing the van to return from the resident ' s vacation in Ocean City, Maryland. This is a repeat deficiency. See Federal Deficiency Report dated 10/12/06.	{I 379}		
{I 474}	3522.5 MEDICATIONS Each GHMRP shall maintain an individual medication administration record for each resident. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that nursing staff maintained Medication Administration Records (MARs), as follows: On November 7, 2007, at approximately 5:25 PM, a nursing note was found in Resident #4's medical chart that indicated on October 28, 2007, the resident had made an allegation of physical abuse. Resident #1 allegedly hit him in his face. The progress note indicated that the nurse	{I 474}	The Director of Operations, the DoDS, and the RN Supervisor will hold a meeting of all nurses to review documentation to ensure that MARs and progress notes, and incident reports are properly and accurately completed.	12/13/07

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{I 474}	Continued From page 17 assessed Resident #4, found no sign of injury, and administered Tylenol 650 mg that evening "for pain." At approximately 5:43 PM, review of Resident #4's October 2007 MARs revealed no evidence that the nurse had properly documented having administered the Tylenol on the MAR. At 5:50 PM, after reviewing the MAR herself, the facility's LPN Designated Nurse acknowledged that she did not see it documented on Resident #4's MAR. ~~~~~ Previously, the September 28, 2007 survey findings included: Nursing staff failed to consistently implement the GHMRP's policies on maintaining Medication Administration Record (MARs), as follows: The evening medication pass was observed on September 25, 2007. At 5:38 PM, Resident #5 was given his medications. The nurse stated that the pharmacy had not delivered a new supply of Constulose (prescribed to address Resident #5's history of constipation) and the resident, therefore had been without Constulose for 2 days. At approximately 6:30 PM, review of the resident's MAR revealed the following: * September 23, 2007, 5 PM - A trained medication employee (TME) circled her initials and documented "don't see" on the back of the MAR sheet. * September 24, 2007, 7 AM - A nurse initialed the MAR, documenting having administered the Constulose as ordered.	{I 474}		

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{I 474}	Continued From page 18 * September 24, 2007, 5 PM - A nurse circled her initials and documented "on order"on the back of the MAR sheet. * September 25, 2007, 7 AM - A nurse left the space blank, with no other documentation evidenced. At 6:45 PM, Interview with the Designated Nurse confirmed that the resident's supply of Constulose had run out on September 23, 2007. She could not, therefore explain why a nurse had documented administering it the next morning.	{I 474}		
{I 500}	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on interview and record review during the revisit on November 7, 2007, the facility failed to ensure each resident's right to file a complaint and have his/her complaint fully investigated, for one of the five residents of the facility. (Resident #4) The finding includes: On November 7, 2007, at 9:14 AM, interview with the Resident Director (RD) revealed that there had been one incident reported and investigated since the September 28, 2007 recertification survey. The corresponding documentation was reviewed. At 9:20 AM, the RD stated that there	{I 500}	The Director of Operations and the DoDS and RN Supervisor will hold a meeting of all nurses and program management staff to ensure that they each understand and implement Careco's policy on incident reporting and investigation.	12/13/

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{I 500}	Continued From page 19 had been no other incidents reported. At approximately 1:35 PM, the Qualified Mental Retardation Professional (QMRP) also indicated that no other incidents had occurred since the September 28, 2007 recertification survey. The LPN Designated Nurse, who was present at the time, stated that she was unaware of any other incidents that required nursing care (except for Resident #1's medication refusal). Later that day, however, at approximately 5:26 PM, a nursing note was found in Resident #4's medical chart that indicated he had made an allegation of physical abuse. On October 28, 2008, Resident #4 informed staff that Resident #1 had punched him in the face. Interview with the Qualified Mental Retardation Professional (QMRP) on November 7, 2007, at approximately 6:00 PM, revealed that the allegation of peer-on-peer abuse had not been reported in accordance with facility policies. Although the QMRP indicated that she had interviewed the two residents at the time the resident made his allegation, there was no written documentation available for review to verify that the resident's complaint had been investigated. In addition, there was no evidence that Resident #4's allegation was reported to outside entities, including his mother (she remains involved in his care), in accordance with facility policies, to ensure that his complaint received appropriate review.	{I 500}		

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{R 000}	INITIAL COMMENTS A licensure survey was conducted from September 25, 2007 through September 28, 2007. A random sample of three residents was selected from a resident population of six men with various degrees of disabilities. The findings of this survey were based on observations at the group home and two day programs, interviews with residents and staff and one resident's guardian, as well as the review of clinical and administrative records, including incident reports.	{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 interview and record review, the facility failed to document criminal background checks disclosed the criminal history of any prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker had worked or resided within the seven (7) years prior to the check. The finding includes: The September 28, 2007 licensure survey had revealed no evidence of comprehensive background checks for two direct care staff. A staff identifier was included with the deficiency report that was sent to Careco. On November 7, 2007, at 4:45 PM, the Qualified Mental	{R 125}		

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TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G094	A. BUILDING _____ B. WING _____	R 11/07/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 05	6934 9TH STREET, 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) COMPLETE DATE
{R 125}	Continued From page 1 Retardation Professional (QMRP) stated that she thought the agency had run "global" background checks, to include all jurisdictions in the United States, for every employee. She agreed to provide evidence of background checks for the two previously-identified employees, as well as for two newly-hired employees. On November 8, 2007, review of the documentation submitted by the QMRP revealed the following: 1. There was no documentation available to verify compliance for the two employees cited in the previous report (S1 and S2); 2. Instead of "global" background checks, the criminal court records searches that were documented for the two newly-hired employees (S14 and S15) were limited to the jurisdictions in which they had lived during the previous seven years. The GHMRP failed to disclose a seven year history of all the jurisdictions where the employees had worked and/or alleged having included that factor when securing the background checks; therefore, verification could not be achieved. Previously, the September 28, 2007 survey findings included: Interview with the Qualified Mental Retardation Professional and review of the personnel records on September 27, 2007, at 7:21 PM, revealed that the GHMRP failed to provide evidence that criminal background checks were on file and disclosed a seven year history of all the jurisdictions where the employee resided and worked for two direct care staff.	{R 125}	1. The HR Director will ensure background checks for the two employees are completed and are in compliance with regulations. 2. The HR Director will ensure that the 7-year history of all the jurisdictions where the two employees had lived and worked will be completed per regulations.	12/13/07 12/13/07

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{R 125}	Continued From page 2 This is a repeat deficiency. See Federal Deficiency Report dated 10/12/06.	{R 125}		