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

PRINTED: 09/03/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G224	A. BUILDING _____ B. WING _____	08/20/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO	505 1/2 57TH STREET NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS An recertification survey was conducted from August 18, 2010, through August 20, 2010, utilizing the fundamental survey process. A random sampling of four clients was selected from a population of seven males with various levels of mental retardation and disabilities. The findings of the survey were based on observations at the group home and two day programs, interviews with clients, staff, and the review of clinical and administrative records, including incident reports.	W 000		
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 facility failed to ensure the qualified mental retardation professional (QMRP) coordinated, integrated, and monitored services, for two of four clients included in the sample. (Clients #1 and #2) The findings include: 1. The QMRP failed to coordinate services to ensure that Client #1's sippy cup was used as recommended in his feeding protocol, as evidenced below: Client # 2 was observed eating dinner on August 18, 2010 at 6:05 p.m., and lunch on August 19, 2010 at 12:37 p.m. His beverages appeared to	W 159	GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002 SEP 23 2010 1. The QMRP will report the concern that thickened liquids do not flow through the sippy cup allowing the client to drink. The QMRP will request the SLP to observe how staff thicken liquids and use the cup, and will then provide training on proper use of both the thickener and the sippy cup, unless the SLP, upon observation, determines that the recommendation must be revised. If so, the SLP will complete the revised protocol, provide it in writing to the QMRP, and will train the staff on the new protocol. QA will monitor for three months to ensure compliance.	10/3/2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Marsha A. Thompson	Director of Disability Services	9/23/2010

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 159	Continued From page 1 include a food thickener. During these meals staff was observed to hold the client's beverages and to verbally prompt him and to hold his cup to control how fast he drank his beverages. Interview with the staff on August 18, 2010 at revealed that Client #1 was required to have all of his beverages, including water, thickened to a honey consistency to ensure his safety during swallowing. Further interview with the residential director (RD) on August 20, 2010 at 9:47 a.m. indicated the sippy cup which had been recommended for the client was no longer being used because the beverages was too thick to flow through the spout of the cup. On August 20, 2010 at 9:40 a.m., the review of Client #1's mealtime protocol dated April 10, 2010 which was developed by the speech and language pathologist (SLP) revealed his adaptive feeding supports included a sippy cup for thickened liquids. The feeding protocol also noted , "Independence: Hand over hand support to control rate of self feeding". At no time during the survey was the client observed to drink from a sippy cup. There was no evidence that the aforementioned concern reported by the direct care staff had been communicated to the SLP for follow-up. 2. The QMRP failed to ensure staff implemented Client #2's ambulation protocol as recommended by the physical therapist as evidenced below: On August 18, 2010, at 3:33 p.m., Client #2 was observed to walk to the bathroom with physical assistance and repeated verbal prompts from his 1:1 staff. At 4:34 p.m., Client #2's 1:1 staff was	W 159	2. The QMRP will ensure that the client has the appropriate shoes as recommended by the physical therapist. The QMRP will train all staff on the client's ambulation protocols, as set forth by the physical therapist. QA will monitor for three months to ensure compliance.	10/23/10

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W 159	Continued From page 2 observed to take off his shoes while he sat in the chair located in the living. The shoes remained off until Client #2 was escorted from the living room to the dining room for dinner at approximately 6:00 p.m. During the transition, the 1:1 staff was observed to have some difficulty in helping Client #2 maintain his balance while ambulating. Interview with the Client #2's 1:1 staff at the day program on August 19, 2010, at 12:07 p.m., revealed the client required total assistance while ambulating. Further interview revealed Client #2 used a wheelchair for long distance due to his unsteady gait. When asked, the 1:1 staff person stated that Client #2 should never been transported without the use of his comfortable tennis shoes. Review of Client #2's medical records on August 19, 2010, at approximately 1:20 p.m., revealed the client had a diagnosis of cerebral palsy with left hemiplegia. Further review revealed an ambulation protocol dated June 4, 2009. According to the protocol, Client #2 should always have on comfortable shoes while ambulating. On August 20, 2010, at approximately 4:15 p.m., interview with the 1:1 staff who was observed assisting Client #2 with ambulating on August 18, 2010, acknowledged that he should have put the client's shoes back on before escorting him to the dining table. 3. The QMRP failed to coordinate services to ensure the Client #1's behavior support plan specified how 1:1 supervision was to be provided by staff, as evidenced below:	W 159	3. The QMRP will request the Behavior Specialist to specify the distance between the 1:1 staff and the client while the staff is providing supervision.	10/3/10

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W 159	Continued From page 3 On August 18, 2010 at approximately 12:30 p.m., Client #1 was observed pulling away from his 1:1 staff who was attempting to provide him ambulation supervision as he left the dining room. On August 19, 2010, at 4:40 p.m., Client #1 was observed walking throughout the facility independently at a rapid pace without difficulty, as his 1:1 staff walked rapidly behind him. Staff indicated that the client's health condition had improved significantly since his transfer to the facility in April 2010, and that he was able to ambulate independently with supervision. Interview with the staff and the QMRP during this time revealed that the client's pulling away appeared to be a behavior exhibited when he was attempting to avoid complying with a request. On August 20, 2010, at approximately 12:30 p.m., review of Client #1's psychological assessment dated April 12, 2010, revealed, "..Despite the client unenergetic disposition and disinterest, when he does not want to do something that is asked of him, he becomes combative, resistive and will wrestle with staff until he is allowed to have his way." On August 20, 2010 at 1:22 p.m., Client #1 grabbed the surveyor by the forearm with both hands above her wrist, as she stood in the hallway of the facility talking with the nurse. After the QMRP verbally prompted the client to release the surveyor's arm several times, the client complied. He was then approached by his assigned direct care staff who prompted him to go with him. At 2:35 p.m., Client #1 very rapidly walked into the dining room as he was pursued by his 1:1 staff. Inquiry of Client #1's 1:1 staff on August 20, 2010	W 159		

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W 159	Continued From page 4 at 2:37 p.m. revealed that he was supposed to be with the client, however "Staff should not be right up on him." The client was noted to attempt to pull away from his 1:1 staff, then reluctantly left the dining room with him. Interview with the QMRP revealed that staff should maintain a distance of "arm's length" from the client. On August 20, 2010 at 2:19 p.m., review of Client #1's psychological assessment dated April 12, 2010, revealed the client should be provided 1:1 staffing assistance 24 hours/7 days a week and nursing care, in view of his current medical needs. On August 20, 2010 at 2:40 p.m., review of the client's ISP dated October 1, 2009 revealed the the client had 1:1 supervision 24 hours a day. On August 20, 2010 at 2:37 p.m., review of Client #1's BSP "Specific Duties for 1:1 Parapaprofessional staff" for Client #1, revealed the following: "Behavior monitoring should entail close supervision by ensuring that the client is within sight of the 1:1 staff person at all times with the exception of bathroom use (unless the client presents with such toileting behaviors as feces smearing and stuffing toilets that require physical supervision in the bathroom. Otherwise, the 1:1 staff person and the client should consistently maintain close physical proximity with other at all times." At the time of the survey, however, the BSP failed to provided specific instructions on the distance staff should remain from the client while providing 1:1 supervision.	W 159		
W 193	483.430(e)(3) STAFF TRAINING PROGRAM	W 193		

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W 193	Continued From page 5 Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure each staff was trained on strategies to effectively manage Client #1's behaviors. The finding includes: The review of unusual incidents on August 18, 2010 at 11:37 a.m., revealed that on July 6, 2010 at 3:30 p.m., Client #1 was exhibiting a behavior inside the house. The incident revealed that his 1:1 staff had escorted him outside to walk around the house. As they were walking, the client saw the residential van and wanted to get inside. Although staff tried to explain to him that the van could not be driven at the time, the client pulled his arm away from the staff escorting him. The momentum from the client's pull caused him to fall and sustain an injury. The nurse was immediately notified. Upon assessment the client was observed to have a right lateral arm bruise near his elbow, and multiple open areas on his right knee. Investigative recommendation included: (a) Continue to follow the Behavior Support Plan (BSP); (b) report incident to the the primary care physician and; (c) Continue 1:1 Safety (health and safety). On August 20, 2010 at 2:21 p.m., review of Client #1's psychological assessment dated April 12, 2010 revealed, despite the client's unenergetic disposition and disinterest, when he does not want to do something that is asked of he, he	W 193	1. The QMRP will request the Behavior Specialist to provide written protocols in the BSP to address the client's combativeness, refusal to remain upright and slouching behaviors when he does not want to compty with a request.	10/3/10

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W 193	Continued From page 6 became combative, resistive and would wrestle with staff until he is allowed to have his way. The review of antecedent-behavior-consequences (abc) data for August 2010 revealed incidents of the client refusing to stay upright and slouching over when he needed to walk continued to occur At the time of the survey, however, there was no evidence BSP included specific intervention to address these behaviors. 2. On 8/18//2010 at 12:30 p.m., interview with the QMRP revealed Client #1 had sustained a fall during the afternoon of 8/17/2010 while on a community walk with his 1:1 staff. According to the unusual incident report dated 8/17/10, while getting out of bed at approximately 3:30 p.m., the client began to exhibit behaviors after he saw glasses owned by a consultant who was visiting the home. He was then escorted outside the home by his 1:1 staff for a community walk to calm down. While walking outside, the client tripped on the sidewalk. The 1:1 staff observed bleeding from the client's knee and escorted him back into the home for assessment by the shift nurse. Nursing assessment revealed bleeding from an abrasion on client's right knee, which measured 3.9 x 2.7 cm. A smaller open area, slightly to the right of the client's knee was also documented, which measured 1.3 cm x 0.6 cm. The client's vital signs were assessed and the R.N. supervisor was notified. On August 19, 2010 at 4:17 p.m., discussion with the 1:1 staff monitoring Client #1 revealed that he had taken the client for a walk with the hope of relieving his agitation. Staff indicated that while walking with the client in the community, the client fell on the sidewalk before he was able to prevent	W 193	2. The QMRP will request the Behavior Specialist to provide training on the client's currently exhibited maladaptive behaviors, and to provide training on any other changes to the BSP resulting from this plan of correction.	10/3/10

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W 193	Continued From page 7 it. Interview with the QMRP on August 19, 2010 at 4:30 p.m. revealed that the incident was being investigated. At the time of the survey, it had not been confirmed that the client's fall had not been associated with the behavior exhibited prior to his exiting the facility. Review of training record on August 20, 2010 at 3:19 p.m., revealed the behavioral specialist provided training to staff on Client #1's BSP on May 21, 2010. At the time of the survey, however, there was no evidence the staff had been trained on effective strategies to address Client #1's currently exhibited maladaptive behaviors.	W 193		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that as soon as the interdisciplinary team (IDT) formulated a client's individual program plan (IPP), each client received continuous active treatment services, in sufficient number and frequency to support the achievement of the objectives identified in the IPP, for two of four of the clients included in the sample. (Clients #2 and #4)	W 249		

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W 249	Continued From page 8 The findings include: 1. On August 18, 2010, at 3:33 p.m., Client #2 was observed to walk to the bathroom with physical assistance and repeated verbal prompts from his 1:1 staff. At 3:38 p.m., Client #2 was observed sitting back in a single chair located in the living room. Client #2 remained in the single chair listening to his 1:1 staff play the keyboard until the shift change at approximately 4:13 p.m. At 4:28 p.m., while still sitting in the single chair, Client #2 was provided with a radio to listen too. At 4:34 p.m., Client #2 passed the soccer ball back/forth with his evening 1:1 staff while sitting. At approximately 6:01 p.m., Client #2's 1:1 staff escorted him to the dining table for dinner without his shoes on. The 1:1 staff had some difficulty helping Client #2 maintain his balance while walking to the dining room. Interview with Client #2's 1:1 staff on August 19, 2010, at approximately 5:00 p.m., revealed that one of the client's program objectives were to stand with physical assistance for 2 minutes every 2 hours. Further interview revealed that the objective should be implemented between 4:00 and 6:00 PM in accordance with the physical therapist schedule. Record verification of Client #2's IPP dated May 28, 2010, on August 19, 2010, at approximately 5:20 p.m., revealed the client "will stand with physical assistance for 2 minutes every two hours at 100% accuracy for 3 months." At the time of the observations on August 18, 2010, between 3:38 p.m. and 6:01 p.m., there was no evidence that staff implemented Client	W 249	1. The QMRP will train the staff on the client's IPP, and ensure that the IPP is completed per the schedule and documented by staff. QA will monitor for three months to ensure compliance.	10/31/10

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W 249	Continued From page 9 #2's IPP as recommended. 2. The facility failed to ensure continuous active treatment for Client #4 using the Wii Game recommended by the IDT, as evidenced below: On August 20, 2010 at 11:40 a.m., the residential director (RD) was observed attempting to connect a Wii game to the television as Client #4 sat in the living room with her. At 12:00 p.m., the game was observed to be connected to the television and the RD attempted to get the client to play the bowling game with hand over hand assistance. Although the control dropped on the floor, she continued to encourage the client to play the game. By 12:05 p.m., the client seemed to enjoy the staff as they demonstrated how to play the game. Interview with the RD on August 20, 2010 at 11:42 a.m. revealed that the Wii game belonged to Client #4 and had been recommended by the IDT for his recreation. According to the QMRP, as recommended, the Wii game had been purchased for the client several months prior to the survey, however, for various reasons, had not been set up for implementation of the client's IPP until August 20, 2010. Record review on August 20, 2010 at 1:15 p.m. revealed Client #4's individual program plan dated May 7, 2010 included a goal to improve his recreation . The IPP stated "Given hand over hand assistance from staff, [Client #4] will manipulate the controls of the Wii gaming system 45% of the opportunities provided for 3 out of 4 consecutive trials for 3 consecutive months (daily) At the time of the survey, their was no evidence the facility had ensured the timely implementation	W 249	2. The QMRP will ensure that all IPPs are implemented as soon as they are approved by the IDT, including ensuring that items purchased for programming are properly assembled/installed, etc., for use, and that staff are trained to implement the IPP. QA will monitor for three months to ensure compliance.	10/3/10

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W 249	Continued From page 10 of the training objective recommended to improve the client's recreation.	W 249		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the provision of nursing services in accordance with the needs for two of four of the clients in the sample (Clients #2 and #4) The findings include: 1. The facility's nursing services failed to ensure establish a schedule for the wearing and removal of Client #4's right resting hand splint, as evidenced below: On August 18, 2010 at 10:37 a.m., Client #4 was observed to have bilateral hand contractures, with the right hand contracture greater than the left. On August 20, 2010 at 11:42 a.m., staff indicated that the client had a hand splint which he wore to prevent further contracture. Interview with the licensed practical nurse (LPN) on August 20, 2010 at 12:55 p.m. , revealed the client wore a right hand splint at night only, as recommended by the physical therapist (PT). At that time, the LPN presented a right resting hand splint, which she stated belonged to the client and was applied by the nurse or the staff at night. Record review on August 20, 2010 at 12:50 p.m. confirmed a PT Assessment dated 9/18/09 which	W 331	1. The QMRP will provide a schedule with space for documentation and the nurse will train the staff on placing and removing the splint. QA will monitor for three months to ensure compliance. 10/3/10	

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W 331	Continued From page 11 stated "Wear the splint from 9:00 p.m. to 5:00 a.m. Wear the splint for 2 hours and off for two hours." At the time of the survey, however, there was no evidence a schedule had been established to monitor when the splint was applied and when it was removed. 2. The facility's nursing services failed to ensure day program was made aware of the change in Client #2's medication changes as evidenced below: During an onsite visit to Client #2's day program on August 19, 2010, at approximately at 12:20 p.m., interview with the day program's nurse revealed that the day program had not received current physician's orders (PO's) from Client #2's group home. The nurse stated that the last PO's received was dated March 31, 2010. The nurse further stated that the PO's were good for 90 days. Interview with the facility's Licensed Practical Nurse (LPN) on August 19, 2010, at approximately 1:50 p.m., revealed that there have been several changes in Client #2's medication regimen since March 2010 to include the following: a. discontinue Zyprexa 10 mg and give Zyprexa 15 mg po q hs; b. discontinue Haldol 4 mg; c. Keppra was prescribed due to an influx of seizure activity and; d. Dilantin was increased due to an influx of seizure activity. Further interview with the facility's LPN revealed that she had sent Client #2's current PO's to the	W 331	2. The LPN Coordinator will henceforth request the day program to sign and return a receipt detailing the documents sent and received. The LPN Coordinator will file such receipts in the clients' medical books. QA will monitor for six months to ensure compliance. 10/3/10	

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	09G224	A. BUILDING _____ B. WING _____	08/20/2010

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W 331	Continued From page 12 day program; however, could not produce any evidence.	W 331		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure necessary adaptive equipment was maintained in good repair, for two of four clients in the sample. (Clients #2 and #3) The finding includes: 1. The facility failed to ensure Client #2's wheelchair was maintained in good repair as evidence below: On August 19, 2010, at approximately 11:30 a.m., observation conducted at the day program revealed Client #2 was observed with two different types of wheels located (rear) on both sides of the wheelchair. The rear left wheel was observed to have ridges in the tire while the right rear wheel was observed to have a smooth tire. Interview with 1:1 staff on the same day at approximately 11:35 p.m., revealed that he was unsure of how long Client #2's wheelchair had been with two different wheels. Further interview revealed that it was difficult to transport the client in the wheelchair because of the different tires.	W 436	1. The QMRP will contact the equipment vendor and have the chair repaired. The QMRP will keep a log of contacts with the equipment vendor and set follow-up times to ensure that equipment repairs are effectuated as quickly as possible. QA will monitor for three months to ensure compliance.	10/3/10

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W 436	Continued From page 13 Interview with the qualified mental retardation professional (QMRP) on August 20, 2010, at approximately 3:30 p.m., revealed that she was aware of the issues regarding Client #2's wheelchair. 2. The facility failed to ensure Client #3's wheelchair was maintained in good repair, as evidenced below: On August 18, 2010, at approximately 3:26 p.m., Client #3 was transported to his bedroom in his wheelchair. Staff removed the client from his wheelchair onto his hospital bed. Client #3's right arm rest was observed to have an approximate 2/3 inch tear. The right arm rest was observed to be torn. Interview with the QMRP on August 20, 2010, at approximately 3:50 p.m., revealed that she was aware that Client #3's wheelchair arm rests were damage and needed to be repaired.	W 436	2. See response to #1 above.	
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on interview and the review of fire drill reports, the facility failed to hold evacuation drills at least quarterly for each shift of personnel, on two of three shifts of drills reviewed. (8 AM to 4 PM and 4 PM to 12 PM shifts) The finding includes: Interview with the qualified mental retardation professional (QMRP) on August 20, 2010, at 3:53	W 440	The QMRP will submit her schedule of fire drills to the Director of Disability Services. The QMRP will hold the fire drills per the schedule. QA will monitor for six months to ensure compliance.	10/3/10

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W 440	Continued From page 14 p.m., revealed the facility had three shifts of direct care personnel. The shifts were identified as weekdays and weekends 8 AM - 4 PM, 4 PM - 12 AM, and 12 PM - 8 AM. Review of the fire drill reports from June 2009 to May 2010 was conducted on August 20, 2010, at approximately 3:55 p.m. Further review of the fire drill reports from June 2009 to August 2009 during the 8 AM to 4 PM shift and September 2009 to November 2009 during the 4 PM to 12 PM shift revealed no fire drills were conducted during the week. Interview with the QMRP on the same day at 4:20 p.m., acknowledged that no fire drills were conducted during the aforementioned shifts. At the time of the survey, there was no documented evidence that fire drills were conducted quarterly as required.	W 440		

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I 000	INITIAL COMMENTS An relicensure survey was conducted from August 18, 2010, through August 20, 2010. A random sampling of four residents was selected from a population of seven males with various levels of mental retardation and disabilities. The findings of the survey were based on observations at the group home and two day programs, interviews with residents and staff, and the review of clinical and administrative records, including incident reports.	I 000		
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 Group Home for the Mentally Retarded Persons (GHMRP) failed to maintained the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner. The findings include: Observation and interview with the facility's house manager (HM) on August 20, 2010, beginning at 2:00 p.m. revealed the following: Exterior: There were tree limbs and branches along the side of the house and in the rear yard.	I 090	The QMRP will request Maintenance to remove fallen limbs and branches.	10/3/10

Marla A. Kemper
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Director of Disability Services
TITLE

9/23/10
(X6) DATE

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I 090	Continued From page 1 All of the deficiencies were acknowledge by the House Manager(HM) at the conclusion of the environmental inspection.	I 090		
I 135	3505.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift. This Statute is not met as evidenced by: Based on interview and the review of fire drill reports, the GHMRP failed to hold evacuation drills at least quarterly for each shift of personnel, on two of three shifts of drills reviewed. (8 AM to 4 PM and 4 PM to 12 PM shifts) The finding includes: Interview with the qualified mental retardation professional (QMRP) on August 20, 2010, at 3:53 p.m., revealed the GHMRP had three shifts of direct care personnel. The shifts were identified as weekdays and weekends 8 AM - 4 PM, 4 PM - 12 AM, and 12 PM - 8 AM. Review of the fire drill reports from June 2009 to May 2010 was conducted on August 20, 2010, at approximately 3:55 p.m. Further review of the fire drill reports from June 2009 to August 2009 during the 8 AM to 4 PM shift and September 2009 to November 2009 during the 4 PM to 12 PM shift revealed no fire drills were conducted during the week. Interview with the QMRP on the same day at 4:20 p.m., acknowledged that no fire drills were conducted during the aforementioned shifts. At the time of the survey, there was no documented evidence that fire drills were conducted quarterly as required.	I 135	See response to federal deficiency W 440.	10/3/10

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I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure the qualified mental retardation professional (QMRP) coordinated, integrated, and monitored services, for two of four residents included in the sample. (Residents #1 and #2) The findings include: 1. The QMRP failed to coordinate services to ensure that Resident #1's sippy cup was used as recommended in his feeding protocol, as evidenced below: Resident # 2 was observed eating dinner on August 18, 2010 at 8:05 p.m., and lunch on August 19, 2010 at 12:37 p.m. His beverages appeared to include a food thickener. During these meals staff was observed to hold the resident's beverages and to verbally prompt him and to hold his cup to control how fast he drank his beverages. Interview with the staff on August 18, 2010 at revealed that Resident #1 was required to have all of his beverages, including water, thickened to a honey consistency to ensure his safety during swallowing. Further interview with the residential director (RD) on August 20, 2010 at 9:47 a.m. indicated the sippy cup which had been recommended for the resident was no longer being used because the beverages was too thick	I 180	1. See response to federal deficiency W 159 #1.	10/3/10

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I 180	Continued From page 3 to flow through the spout of the cup. On August 20, 2010 at 9:40 a.m., the review of Resident #1's mealtime protocol dated April 10, 2010 which was developed by the speech and language pathologist (SLP) revealed his adaptive feeding supports included a sippy cup for thickened liquids. The feeding protocol also noted , "Independence: Hand over hand support to control rate of self feeding". At no time during the survey was the resident observed to drink from a sippy cup. There was no evidence that the aforementioned concern reported by the direct care staff had been communicated to the SLP for follow-up. 2. The QMRP failed to ensure staff implemented Resident #2's ambulation protocol as recommended by the physical therapist as evidenced below: On August 18, 2010, at 3:33 p.m., Resident #2 was observed to walk to the bathroom with physical assistance and repeated verbal prompts from his 1:1 staff. At 4:34 p.m., Resident #2's 1:1 staff was observed to take off his shoes while he sat in the chair located in the living. The shoes remained off until Resident #2 was escorted from the living room to the dining room for dinner at approximately 6:00 p.m. During the transition, the 1:1 staff was observed to have some difficulty in helping Resident #2 maintain his balance while ambulating. Interview with the Resident #2's 1:1 staff at the day program on August 19, 2010, at 12:07 p.m., revealed the resident required total assistance while ambulating. Further interview revealed Resident #2 used a wheelchair for long distance	I 180	2. See response to federal deficiency W 159 #2.	10/3/10

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I 180	Continued From page 4 due to his unsteady gait. When asked, the 1:1 staff person stated that Resident #2 should never been transported without the use of his comfortable tennis shoes. Review of Resident #2's medical records on August 19, 2010, at approximately 1:20 p.m., revealed the resident had a diagnosis of cerebral palsy with left hemiplegia. Further review revealed an ambulation protocol dated June 4, 2009. According to the protocol, Resident #2 should always have on comfortable shoes while ambulating. On August 20, 2010, at approximately 4:15 p.m., interview with the 1:1 staff who was observed assisting Resident #2 with ambulating on August 18, 2010, acknowledged that he should have put the resident's shoes back on before escorting him to the dining table. 3. The QMRP failed to coordinate services to ensure the Resident #1's behavior support plan specified how 1:1 supervision was to be provided by staff, as evidenced below: On August 18, 2010 at approximately 12:30 p.m., Resident #1 was observed pulling away from his 1:1 staff who was attempting to provide him ambulation supervision as he left the dining room. On August 19, 2010, at 4:40 p.m., Resident #1 was observed walking throughout the GHMRP independently at a rapid pace without difficulty, as his 1:1 staff walked rapidly behind him. Staff indicated that the resident's health condition had improved significantly since his transfer to the GHMRP in April 2010, and that he was able to ambulate independently with supervision. Interview with the staff and the QMRP during this time revealed that the resident's pulling away	I 180	3. See response to federal deficiency W 159 #3.	10/3/10

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I 180	Continued From page 5 appeared to be a behavior exhibited when he was attempting to avoid complying with a request. On August 20, 2010, at approximately 12:30 p.m., review of Resident #1's psychological assessment dated April 12, 2010, revealed, "..Despite the resident unenergetic disposition and disinterest, when he does not want to do something that is asked of him, he becomes combative, resistive and will wrestle with staff until he is allowed to have his way." On August 20, 2010 at 1:22 p.m., Resident #1 grabbed the surveyor by the forearm with both hands above her wrist, as she stood in the hallway of the GHMRP talking with the nurse. After the QMRP verbally prompted the resident to release the surveyor's arm several times, the resident complied. He was then approached by his assigned direct care staff who prompted him to go with him. At 2:35 p.m., resident #1 very rapidly walked into the dining room as he was pursued by his 1:1 staff. Resident #1's 1:1 staff on August 20, 2010 at 2:37 p.m. revealed that he was supposed to be with the resident, however "Staff should not be right up on him." The resident was noted to attempt to pull away from his 1:1 staff, then reluctantly left the dining room with him. Interview with the QMRP revealed that staff should maintain a distance of "arm's length" from the resident. On August 20, 2010 at 2:19 p.m., review of Resident #1's psychological assessment dated April 12, 2010, revealed the resident should be provided 1:1 staffing assistance 24 hours/7 days a week and nursing care, in view of his current medical needs. On August 20, 2010 at 2:40 p.m.,	I 180		

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I 180	Continued From page 6 review of the resident's ISP dated October 1, 2009 revealed the the resident had 1:1 supervision 24 hours a day. Resident #1's BSP "Specific Duties for 1:1 Parapaprofessional staff" for Resident #1, revealed the following: "Behavior monitoring should entail close supervision by ensuring that the resident is within sight of the 1:1 staff person at all times with the exception of bathroom use (unless the resident presents with such toileting behaviors as feces smearing and stuffing toilets that require physical supervision in the bathroom. Otherwise, the 1:1 staff person and the resident should consistently maintain close physical proximity with other at all times." At the time of the survey, however, the BSP failed to provided specific instructions on the distance staff should remain from the resident while providing 1:1 supervision.	I 180		
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure each staff was trained on strategies to effectively manage Resident #1's behaviors. The finding includes: The review of unusual incidents on August 18, 2010 at 11:37 a.m., revealed that on July 6, 2010 at 3:30 p.m., Resident #1 was exhibiting a behavior inside the house. The incident revealed that his 1:1 staff had escorted him outside to walk	I 222	See response to federal deficiency W 193.	10/3/10

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I 222	Continued From page 7 around the house. As they were walking, the resident saw the residential van and wanted to get inside. Although staff tried to explain to him that the van could not be driven at the time, the resident pulled his arm away from the staff escorting him. The momentum from the resident's pull caused him to fall and sustain an injury. The nurse was immediately notified. Upon assessment the resident was observed to heve a right lateral arm bruise near his elbow, and multiple open areas on his right knee. Investigative recommendation included: (a) Continue to follow the Behavior Support Plan (BSP); (b) report incident to the the primary care physician and; (c) Continue 1:1 Safety (health and safety). On August 20, 2010 at 2:21 p.m., review of Resident #1's psychological assessment dated April 12, 2010 revealed, despite the resident's unenergetic disposition and disinterest, when he does not want to do something that is asked of he, he became combative, resistive and would wrestle with staff until he is allowed to have his way. The review of antecedent-behavior-consequences (abc) data for August 2010 revealed incidents of the resident refusing to stay upright and slouching over when he needed to walk continued to occur At the time of the survey, however, there was no evidence BSP included specific intervention to address these behaviors. 2. On 8/18//2010 at 12:30 p.m., interview with the QMRP revealed Resident #1 had sustained a fall during the afternoon of 8/17/2010 while on a community walk with his 1:1 staff. According to the unusual incident report dated 8/17/10, while getting out of bed at approximately	I 222	2. See response to federal deficiency W 193 #2.	10/3/10

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I 222	Continued From page 8 3:30 p.m., the resident began to exhibit behaviors after he saw glasses owned by a consultant who was visiting the home. He was then escorted outside the home by his 1:1 staff for a community walk to calm down. While walking outside, the resident tripped on the sidewalk. The 1:1 staff observed bleeding from the resident's knee and escorted him back into the home for assessment by the shift nurse. Nursing assessment revealed bleeding from an abrasion on resident's right knee, which measured 3.9 x 2.7 cm. A smaller open area, slightly to the right of the resident's knee was also documented, which measured 1.3 cm x 0.6 cm. The resident's vital signs were assessed and the R.N. supervisor was notified. On August 19, 2010 at 4:17 p.m., discussion with the 1:1 staff monitoring Resident #1 revealed that he had taken the resident for a walk with the hope of relieving his agitation. Staff indicated that while walking with the resident in the community, the resident fell on the sidewalk before he was able to prevent it. Interview with the QMRP on August 19, 2010 at 4: 30 p.m. revealed that the incident was being investigated. At the time of the survey, it had not been confirmed that the resident's fall had not been associated with the behavior exhibited prior to his exiting the GHMRP. Review of training record on August 20, 2010 at 3:19 p.m., revealed the behavioral specialist provided training to staff on Resident #1's BSP on May 21, 2010. At the time of the survey, however, there was no evidence the staff had been trained on effective strategies to address Resident #1's currently exhibited maladaptive behaviors.	I 222		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO	505 1/2 57TH STREET NE WASHINGTON, DC 20019

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I 401	Continued From page 9	I 401		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure the provision of nursing services in accordance with the needs for two of four of the residents in the sample (Residents #2 and #4) The findings include: 1. The GHMRP's nursing services failed to ensure establish a schedule for the wearing and removal of Resident #4's right resting hand splint, as evidenced below: On August 18, 2010 at 10:37 a.m., Resident #4 was observed to have bilateral hand contractures, with the right hand contracture greater than the left. On August 20, 2010 at 11:42 a.m., staff indicated that the client had a hand splint which he wore to prevent further contracture. Interview with the licensed practical nurse (LPN) on August 20, 2010 at 12:55 p.m., revealed the client wore a right hand splint at night only, as recommended by the physical therapist (PT). At that time, the LPN presented a right resting hand splint, which she stated belonged to the client and was applied by the nurse or the staff at night.	I 401	1. See response to federal deficiency W 331 #1.	10/3/10

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I 401	Continued From page 10 Record review on August 20, 2010 at 12:50 p.m. confirmed a PT Assessment dated 9/18/09 which stated "Wear the splint from 9:00 p.m. to 5:00 a.m. Wear the splint for 2 hours and off for two hours." At the time of the survey, however, there was no evidence a schedule had been established to monitor when the splint was applied and when it was removed. 2. The GHMRP's nursing services failed to ensure day program was made aware of the change in Resident #2's medication changes as evidenced below: During an onsite visit to Resident #2's day program on August 19, 2010, at approximately at 12:20 p.m., interview with the day program's nurse revealed that the day program had not received current physician's orders (PO's) from Resident #2's group home. The nurse stated that the last PO's received was dated March 31, 2010. The nurse further stated that the PO's were good for 90 days. Interview with the GHMRP's Licensed Practical Nurse (LPN) on August 19, 2010, at approximately 1:50 p.m., revealed that there have been several changes in Resident #2's medication regimen since March 2010 to include the following: a. discontinue Zyprexa 10 mg and give Zyprexa 15 mg po q hs; b. discontinue Haldol 4 mg; c. Keppra was prescribed due to an influx of seizure activity and; d. Dilantin was increased due to an influx of seizure activity. Further interview with the GHMRP's LPN	I 401	2. See response to federal deficiency W 331 #2.	10/3/10

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I 401	Continued From page 11 revealed that she had sent Resident #2's current PO's to the day program; however, could not produce any evidence.	I 401		
I 420	3521.1 HABILITATION AND TRAINING Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure that as soon as the interdisciplinary team (IDT) formulated a resident's individual program plan (IPP), each resident received continuous active treatment services, in sufficient number and frequency to support the achievement of the objectives identified in the IPP, for two of four of the residents included in the sample. (Residents #2 and #4) The findings include: 1. On August 18, 2010, at 3:33 p.m., Resident #2 was observed to walk to the bathroom with physical assistance and repeated verbal prompts from his 1:1 staff. At 3:38 p.m., Resident #2 was observed sitting back in a single chair located in the living room. Resident #2 remained in the single chair listening to his 1:1 staff play the keyboard until the shift change at approximately 4:13 p.m. At 4:28 p.m., while still sitting in the single chair, Resident #2 was provided with a radio to listen too. At 4:34 p.m., Resident #2 passed the soccer ball back/forth with his evening 1:1 staff while sitting. At approximately 6:01 p.m.,	I 420	1. See response to federal deficiency W 249 #1.	10/3/10

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I 420	Continued From page 12 Resident #2's 1:1 staff escorted him to the dining table for dinner without his shoes on. The 1:1 staff had some difficulty helping Resident #2 maintain his balance while walking to the dining room. Interview with Resident #2's 1:1 staff on August 19, 2010, at approximately 5:00 p.m., revealed that one of the resident's program objectives were to stand with physical assistance for 2 minutes every 2 hours. Further interview revealed that the objective should be implemented between 4:00 and 6:00 PM in accordance with the physical therapist schedule. Record verification of Resident #2's IPP dated May 28, 2010, on August 19, 2010, at approximately 5:20 p.m., revealed the resident "will stand with physical assistance for 2 minutes every two hours at 100% accuracy for 3 months." At the time of the observations on August 18, 2010, between 3:38 p.m. and 6:01 p.m., there was no evidence that staff implemented Resident #2's IPP as recommended. 2. The GHMRP failed to ensure continuous active treatment for Resident #4 using the Wii Game as recommended by the IDT, as evidenced below: On August 20, 2010 at 11:40 a.m., the home manager (home manager) was observed attempting to connect a Wii game to the television as Resident #4 sat in the living room with her. At 12:00 p.m., the game was observed to be connected to the television and the residential director (RD) attempted to to get the resident to play the bowling game with hand over hand assistance. Although the control dropped on the floor, she continued to encourage the	I 420	2. See response to federal deficiency W 249 #2.	10/3/10

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I 420	Continued From page 13 resident to play the game. By 12:05 p.m., the resident seemed to enjoy the staff as they demonstrated how to play the game. Interview with the RD on August 20, 2010, at 11:42 a.m. revealed that the Wii game belonged to Resident #4 and had been recommended for his recreation. According to the QMRP, as recommended, the Wii game had been purchased for the resident several months earlier, however, for various reasons, had not been set up for the resident until August 20, 2010. Record review on August 20, 2010 at 1:15 p.m. revealed Resident #4's individual program plan dated May 7, 2010 included a goal to improve his recreation . The IPP stated "Given hand over hand assistance from staff, [Resident #4] will manipulate the controls of the Wii gaming system 45% of the opportunities provided for 3 out of 4 consecutive trials for 3 consecutive months (daily) At the time of the survey, their was no evidence the GHMRP had ensured the timely implementation of the training objective recommended to improve the resident's recreation.	I 420		
I 422	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 GHMRP failed to ensure that as soon as the interdisciplinary team (IDT) formulated a Resident's individual program plan (IPP), each Resident received continuous active treatment services, in sufficient number and frequency to	I 422		

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I 422	Continued From page 14 support the achievement of the objectives identified in the IPP, for one of two of the two Residents included in the sample. (Resident #2) The findings include: 1. On August 18, 2010, at 3:33 p.m., Resident #2 was observed to walk to the bathroom with physical assistance and repeated verbal prompts from his 1:1 staff. At 3:38 p.m., Resident #2 was observed sitting back in a single chair located in the living room. Resident #2 remained in the single chair listening to his 1:1 staff play the keyboard until the shift change at approximately 4:13 p.m. At 4:28 p.m., while still sitting in the single chair, Resident #2 was provided with a radio to listen too. At 4:34 p.m., Resident #2 passed the soccer ball back/forth with his evening 1:1 staff while sitting. At approximately 6:01 p.m., Resident #2's 1:1 staff escorted him to the dining table for dinner without his shoes on. The 1:1 staff had some difficulty helping Resident #2 maintain his balance while walking to the dining room. Interview with Resident #2's 1:1 staff on August 19, 2010, at approximately 5:00 p.m., revealed that one of the Resident's program objectives were to stand with physical assistance for 2 minutes every 2 hours. Further interview revealed that the objective should be implemented between 4:00 and 6:00 PM in accordance with the physical therapist schedule. Record verification of Resident #2's individual program plan (IPP) dated May 28, 2010, on August 19, 2010, at approximately 5:20 p.m., revealed the Resident "will stand with physical assistance for 2 minutes every two hours at 100% accuracy for 3 months."	I 422	(. See response to federal deficiency W 249 #1.	10/3/10

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I 422	Continued From page 15 At the time of the observations on August 18, 2010, between 3:38 p.m. and 6:01 p.m., there was no evidence that staff implemented Resident #2's IPP as recommended.	I 422		