

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

PRINTED: 06/23/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R 05/28/2009
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NAME OF PROVIDER OR SUPPLIER  CARECO 01	STREET ADDRESS, CITY, STATE, ZIP CODE 6417 KANSAS AVE, NE WASHINGTON, DC 20001
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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{W 000}	INITIAL COMMENTS  A follow-up survey was conducted from May 26, 2009 through May 28, 2009 to determine the facility's compliance with the previously condition level deficiencies cited on April 17, 2009. A random sample of three clients was selected from a residential population of five males with various disabilities. Due to observations of the facility's system for managing client behavior, a fourth client was added as a focus.  The findings of the survey were based on observations in the group home and day program, interviews with the facility and day program staff and a review of records, including unusual incident reports, investigations and administrative records.  The survey findings determined that the facility remained out of compliance with the Conditions of Participation in Governing Body, Facility Staffing and Client Protections.	{W 000}		
{W 102}	483.410 GOVERNING BODY AND MANAGEMENT  The facility must ensure that specific governing body and management requirements are met.  This CONDITION is not met as evidenced by: The facility's governing body failed to maintain general operating direction over the facility. [See W104 and W127].  The results of these systemic practices revealed the facility's Governing Body failed to adequately govern the facility in a manner that would ensure	{W 102}	The Governing Body held a case conference with DDS specialty clinicians who provided a plan for revised supports for the client. The Governing Body also directed the QMRP to hold a discharge conference, and requested an expedited change of placement for the client. The facility will discharge the client to a different residential placement. The Governing Body directed the QMPD to re-train staff on Incident Management, including proper and timely notifications in accordance with regulations. The QMPD was directed to re-open the investigation referenced, and to provided a thorough investigative report, including where possible interviews with staff who were not included in the first investigation. Going forward, staff interviews will be conducted for each person who could have possibly witnessed or been involved in an incident within 24 hours of the occurrence. The QMRP will be directed to provide re-training on the BSPS and regularly observe implementation; the Residential Director is to review data collection at least weekly and provide a written report for review by management which will indicate where additional training or other measures are needed; the QMRP will be directed to provide a written schedule that reflects the proper staffing ratios for each client as outlined in the ISP.	6/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Melinda H. ...* TITLE: *Director of Disability Services* (X6) DATE: 6/22/09

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

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{W 102}	Continued From page 1 each client 's health and safety. [See also W122, and W158]	{W 102}		
{W 104}	483.410(a)(1) GOVERNING BODY  The governing body must exercise general policy, budget, and operating direction over the facility.  This STANDARD is not met as evidenced by: Based on interview and record review, the governing body exercised general policy and operating direction over the facility, except in the following areas.  The findings include:  1. The governing body failed to effectively protect five of five residents and staff from potential harm as evidenced below.  On May 26, 2009 a revisit was initiated to determine if the facility had employed sufficient safeguards to effectively protect the clients. The revisit revealed that Client #2 ' s explosive and unpredictable behaviors continued to place the client, his peers, and staff's safety at risk.  On May 27, 2009, beginning at 3:03 PM to approximately 3:25 PM the following was observed:  Client #2 was served a bowl of hot soup and crackers for lunch. The soup was observed to have steam coming from the bowl. Client #2 ' s 1:1 staff tried to take the bowl of soup to keep him from burning his mouth. Client #2 immediately began to scream loudly. The 1:1 staff tried to explain to him that the soup was too hot. Client	{W 104}	1. See response to W 102.	6/24/09

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{W 104}	<p>Continued From page 2</p> <p>#2 started to scream and ran out of the dining room. Staff redirected him to his bedroom on the second floor. Although the client was redirected away from others, he could be heard forcefully jumping up/down in his bedroom, causing the dining room chandelier to shake at its foundation. At 3:07 PM, Client #2 came downstairs with his 1:1 staff, however, upon entering into the living room area he attempted to bite two staff. At 3:12 PM, Client #2 made an attempt to bite Client #3 who was sitting on the sofa in the living room area. While his 1:1 staff and the House Manager (HM) were in the process of redirecting him away from his peer, he bit the HM on his right forearm.</p> <p>At 3:16 PM, in an attempt to calm Client #2, his 1:1 staff escorted him outside. While outside the client attempted to dart into traffic. His 1:1 staff had to physically restrain him to ensure his safety. Additionally, Client #2 was observed to tightly pinch his 1:1 staff's arms and chest with both hands. The pinch was observed to be of extreme force and intensity that caused Client #2's hands to tremor. Interview with the 1:1 staff at approximately 3:25 PM, revealed that he could not react to the client's physical abuse because it would cause an escalation in aggressive behaviors. The 1:1 staff indicated that these behaviors were not out of character for Client #2.</p> <p>On May 27, 2009 at approximately 3:50 PM, a review of client #2's program record revealed an October 8, 2008 behavior support plan. The plan notated (8 months prior to the April survey), the psychologist's concerns with client #2's current placement at the residential facility. In addition, the psychologist expressed at his 30 day review meeting that staff trained in least restrictive crisis prevention intervention techniques were not</p>	{W 104}			

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{W 104}	<p>Continued From page 3</p> <p>adequately equipped to protect the safety of the remaining peers when client #2 became violent and aggressive.</p> <p>2. The governing body failed to ensure that criminal background checks were obtained for its staff to ensure it ability to protect its clients from potential harm as evidenced below.</p> <p>The facility was cited during the previous survey (April 17, 2009) for not having criminal background checks in all jurisdictions in which staff lived and worked within the past seven (7) years. On May 28, 2009, at approximately 1:00 PM, interview with the Qualified Mental Retardation Professional (QMRP) revealed that all staff had received background checks, but they were not available. The QMRP stated that all the personnel files were present in the group home. The written Plan of Correction, dated May 23, 2009 revealed the completion date for obtaining all police clearances was May 22, 2009. At the time of the re-visit, there was no evidence that criminal background checks had been obtained. It should be further noted that 15 of 27 staff cited during the previous survey, was still providing direct care services to the clients.</p> <p>3. Cross-Refer to W149. The governing body failed to provide sufficient administrative oversight to ensure the effective implementation of the facility's incident management policy.</p> <p>4. Cross-Refer to W154. The governing body failed to provide administrative over-site to ensure that an injury of unknown origin was thoroughly investigated.</p> <p>5. Cross-Refer to W186. The governing body</p>	{W 104}	<p>2. The personnel records for the staff assigned to this home will be properly compiled by the administrative support staff and provided to the QMRP. In future all staff records will be maintained in an electronic data management system that will allow for timely review of complete records.</p> <p>3. The QMPD will provide re-training to the staff on incident management policy; the QMPD will review all incident documentation in the home at least monthly to ensure that staff adhere to policy.</p> <p>4. See response to W 102.</p>	<p>6/22/09</p> <p>6/22/09</p> <p>6/22/09</p>	

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{W 104}	Continued From page 4 failed to provide administrative oversight to ensure that a sufficient number of staff was available to monitor client, prevent injuries and to address behavior management needs.	{W 104}	5. The Governing Body has directed the QMRP to provide a written prospective schedule reflecting staff supports for each client as required by their ISPs. The schedule will be maintained in the facility's electronic data management system for review by the Director of Disability Services.	6/22/09
{W 120}	6. Cross-Refer to W159. The governing body failed to ensure administrative oversight and support to the Qualified Mental Retardation Professional for the coordination, integration, and monitoring of the clients the active treatment programs. <b>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</b>  The facility must assure that outside services meet the needs of each client.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that contracted nutrition services addressed the needs for one of three clients in the sample. (Client #2)  The finding includes:  1. On May 27, 2009, at approximately 11:30 PM, the surveyor visited Client #2's day program to explore if the nutritionist had addressed the behaviors the client exhibits during mealtime, (as documented in the survey report dated April 17, 2009). Interview with the administrative staff at the day program revealed they had not received a nutritional assessment for Client #2 from the group home.  Interview with the QMRP, on May 27, 2009 at 2:00 PM, revealed that the nutritionist had performed an assessment, however, the facility	{W 120}	6. The Director of Disability Services has installed an electronic data management system that will allow for closer oversight and support of the QMRP's management of coordination, integration, and monitoring of the clients' active treatment programs.  The QMRP will develop a monitoring and coordination schedule for each client's day program, and will ensure that when new assessments and protocols are developed for the home setting, the Day Program receives a copy and provides a receipt.	6/22/09

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{W 120}	<p>Continued From page 5</p> <p>had not received the report. According to the facility's plan of correction dated May 22, 2009, "The QMRP will contact the Nutritionist to get the completed nutritional assessments. She will also request the nutritionist to provide training to staff and clients, and provide evidence of a written request to the QMRP."</p> <p>Review of the facility's agreement with the nutritionist dated December 19, 2008, revealed, "Nutrition Consultant Services, including assessment" were to be provided. At the time of the re-visit, there was no evidence the facility had ensured that the contracted nutrition services had been provided to meet the needs of each client. [See W217)</p> <p>2. Interview with the day program staff on May 27, 2009 at approximately 11:50 PM revealed that most of the clients behaviors occurred around meal time. As noted in the April 17, 2009 survey, The day program's psychologist recommended that the nutritionist evaluate Client #2's diet to determine the feasibility of allowing him to have more food.</p> <p>Interview with the QMRP, on May 27, 2009 at 2:00 PM, revealed that the nutritionist had performed an assessment, however, the facility had not received the report. According to the facility's plan of correction dated May 22, 2009, "The QMRP will contact the Nutritionist to get the completed nutritional assessments. She will also request the nutritionist to provide training to staff and clients, and provide evidence of a written request to the QMRP."</p> <p>At the time of the survey, there was no evidence that the recommendation had been addressed.</p>	{W 120}	<p>2. The QMRP will provide evidence of her requests to the Nutritionist to provide the needed interventions.</p>	6/22/09

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{W 122}	<p><b>483.420 CLIENT PROTECTIONS</b></p> <p>The facility must ensure that specific client protections requirements are met.</p> <p>This CONDITION is not met as evidenced by: On May 26, 2009 through May 28, 2009, a follow-up survey was conducted to assess the facility's level of compliance with correcting the deficiencies identified during the recertification survey completed on April 17, 2009. Based on observation, interview, and record review, the facility failed to ensure the health and safety of all five clients that reside in the facility [See W127]; the facility failed to implement established procedures of reporting all of significant incidents (i.e. client to client abuse) [See W149]; facility failed to ensure that an incident of staff neglect which lead to client to client abuse was reported immediately to the administrator [See W153]; the facility failed to ensure that an injury of unknown origin was thoroughly investigated [W154]; failed to demonstrate competency in implementing each client's Behavior Support Plan [See W193]; and failed to provide 1:1 supervision to ensure clients' health and safety [W249].</p> <p>The effects of these systemic practices resulted in the failure of the facility to protect its clients from harm and to ensure their general safety and well being.</p>	{W 122}	<p>The Governing Body requested the DDS to remove the client from the facility. The client was discharged on June 12. The QMPD will provide evidence of the re-training provided to staff on required notifications whenever an incident occurs, including the requirement to notify the administrator of all incidents per regulation and policy; the QMRP will provide evidence of the new, thorough investigation of the incident of unknown origin referenced in this CONDITION; the QMRP will ensure that all staff are properly able to implement the BSP (see response to W 102); the QMRP will provide a written schedule that reflects the staff supports required by each client's ISP (see response to W 104 #5).</p>		
{W 124}	<p><b>483.420(a)(2) PROTECTION OF CLIENTS RIGHTS</b></p> <p>The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental</p>	{W 124}	<p>The QMRP will provide written information to the clients' decision-makers with a request for their signed consent. When new restrictive treatments are prescribed the QMRP will implement the signed, written informed consent for each client. The QMRP will contact the decision-makers and request a meeting so that these consents can be signed.</p>	6/22/09	

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{W 124}	<p>Continued From page 7 and behavioral status, attendant risks of treatment, and of the right to refuse treatment.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the rights of each client and/or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment, for two of three clients included in the sample. (Clients #3 and #4)</p> <p>The findings include:</p> <p>The facility was cited during the previous survey for failing to ensure informed consent was obtained from Client #1's sister for the use of psychotropic medications and the implementation of their Behavior Support Plan (BSP). On May 23, 2009, the facility forwarded a Plan of Correction (POC) that reflected the Qualified Mental Retardation Professional (QMRP) will contact the mother to provide written informed consent for his treatments.</p> <p>On May 27, 2009, at appropriately 2:05 PM, interview with the QMRP revealed that all of the clients surrogate decision makers had signed informed consents for the use of their psychotropic medications and Behavior Support Plans (BSPs), which were located in their Individual Support Plans (ISP) books.</p> <p>Review of medical records on May 27, 2009 at approximately 2:50 PM, revealed current Physician's Orders (PO's) dated April 2009 for Clients #3 and #4. The PO's revealed the Clients</p>	{W 124}		
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{W 124}	Continued From page 8 #3 and #4 was prescribed psychotropic medications. Further record review revealed that the clients had BSPs to address their maladaptive behaviors.	{W 124}		
{W 127}	<p>483.420(a)(5) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the health and safety of all five clients that reside in the facility. (Client's #1, #2, #3, #4 and #5)</p> <p>The finding includes:</p> <p>Cross refer to W104. On April 17, 2009, during the recertification survey, it was determined that Client #2's health and safety was compromised and an immediate jeopardy existed under the Condition of Participation of Client Protections. The Agencies Administrator and facility's Qualified Mental Retardation Professional (QMRP) developed and initiated a Corrective Action Plan to ensure Client #2's safety to include, staff discipline, staff training, proper completion of documentation, incident</p>	{W 127}	The Governing Body will request that the client be discharged from the facility.	6/22/09

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{W 127}	Continued From page 9 management, staff scheduling of one to one supports and overnight monitoring.	{W 127}			
{W 149}	<p>On May 26, 2009, a revisit was initiated to verify that the facility had employed sufficient safeguards to effectively protect the client's health and safety. Observations and interviews during the revisit survey determined that Client #2's behavior posed an immediate safety risk to himself, his housemates and staff.</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to implement established procedures of reporting all of significant incidents (i.e. client to client abuse) to the State Agency for one of three clients in the sample. (Client #2)</p> <p>The finding includes:</p> <p>On May 28, 2009, at approximately 12:00, the Qualified Mental Retardation Professional (QMRP) was asked whether the Incident Management Policy (IMP) was implemented regarding the May 7, 2009 incident that occurred at Client #2's day program. The QMRP stated that the IMP was not implemented as evidence below:</p> <p>On May 27, 2009, at approximately 10:00 AM, review of the facility's incident reports revealed an incident dated May 7, 2009. According to the</p>	{W 149}	See response to W 102 and W 122.	6/22/09	

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{W 149}	Continued From page 10 incident report, Client #2's 1:1 staff left the client while he took the client's lunch dishes to the sink. While unattended, Client #2 ran into a classroom and bit another individual.  Interview with the day program's Activity Coordinator (AC) and review of the day program investigative report on May 27, 2009, at approximately 11:15 AM, revealed that the incident was initially categorized as a reportable incident. However, an outside monitoring entity, the Department of Disability Services (DDS), recognized the day program's failure to identify and classify this incident as client to client abuse.  Further interview with the day program's AC revealed that after further instruction was given from DDS, the incident was reclassified and resubmitted as client to client abuse. This was confirmed through interview with the QMRP on May 28, 2009 at approximately 1:00 PM. There was no evidence that the aforementioned incident of client to client abuse was reported to the facility's administrator or the Department of Health in accordance with their policy and procedures.	{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 interview and record review the facility	W 153	See response to W102 and W 122.	6/22/09	

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NAME OF PROVIDER OR SUPPLIER  <b>CARECO 01</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8417 KANSAS AVE, NE</b> <b>WASHINGTON, DC 20001</b>		
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W 153	Continued From page 11 failed to ensure that an incident of staff neglect which lead to client to client abuse was reported immediately to the administrator for one of three in the sample. (Client #2)  The finding includes:  On May 27, 2009, at approximately 10:00 AM, review of the facility's incident reports revealed an incident dated May 7, 2009 that occurred at the day program. According to the incident, 1:1 staff left Client #2 unattended to take the client's lunch dishes to the sink. While unattended, Client #2, ran into a classroom and bit another individual. Further review of the verbal notification area of the incident report failed to show evidence that the facility's administrator was notified of the incident. This was confirmed through interview with the Qualified Mental Retardation Professional (QMRP) on May 28, 2009 at approximately 1:00 PM. When asked, the QMRP stated that the aforementioned incident was not reported to the administrator in accordance with their policy and procedures.	W 153			
{W 154}	483.420(d)(3) STAFF TREATMENT OF CLIENTS  The facility must have evidence that all alleged violations are thoroughly investigated.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that an injury of unknown origin was thoroughly investigated, for one of the three clients (Client #2 ) included in the sample.  The findings include:	{W 154}	See response to W127 #2, #3, and #4. The QMPD will reopen the investigation, and provide a thorough report with recommendations. For the next 90 days the QMPD will ensure that all incidents are treated at the outset as serious reportables, which require a more intensive investigative protocol.  The staff person referred to in the deficiency was placed on suspension and then terminated as a result of the investigation. The QMPD will modify the report to reflect the recommendations.	6/22/09  6/22/09	

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{W 154}	<p>Continued From page 12</p> <p>The facility was cited during the April 17, 2009 survey for not conducting a thorough investigation into the April 14, 2009 incident involving Client #2. According to the plan of correction submitted on May 23, 2009, the facility's Incident Management Coordinator (IMC) re-opened the April 14, 2009 investigation. The IMC was to provide a thorough report with recommendations. Review of the re-opened investigation dated April 15, 2009, on May 27, 2009 at approximately 3:00 PM revealed that the IMC only interviewed three(3) people during the investigation; the 1:1 staff, the QMRP and the client (who is non verbal). The report further reflected that the determination was made that Client #2 "sustained his eye injury through his activity in the house as he at times bends down to pick up items off the floor and perhaps hit his eye in the table."</p> <p>It should be noted that Client #2 requires 1:1 supervision 24 hours per day. The 1:1 staff is required to be at an arms length proximity to the client at all times.</p> <p>The investigation failed to have documented evidence that all 1:1 staff responsible for the care of Client #2 was interviewed nor was there evidence that any other staff who could have possibly observed the client was interviewed.</p> <p>The re-opened investigation contained recommendations. The recommendations, however did not include any disciplinary actions for any of the 1:1 staff responsible for the clients care. Interview with the QMRP on May 28, 2009 at approximately 1:00 PM revealed that one of the 1:1 staff was put on suspension, however the investigative report did not reflect it.</p>	{W 154}			
{W 158}	483.430 FACILITY STAFFING	{W 158}			

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{W 158}	Continued From page 13  The facility must ensure that specific facility staffing requirements are met.  This CONDITION is not met as evidenced by: On May 26, 2009 through May 28, 2009, a follow-up survey was conducted to assess the facility's level of compliance with correcting the deficiencies identified during the recertification survey completed on April 17, 2009. Based on observation, interview, and record review, the Qualified Mental Retardation Professional (QMRP) failed to adequately monitor, integrate, and coordinate the active treatment health and safety needs of each client [See W159]; the facility failed to provide sufficient support staff to manage and supervise clients in accordance with their individual program plans [W185]; the facility failed to maintain a sufficient number of staff to ensure that each clients were monitored to prevent injuries and to address behavior management needs [W186]; and failed to demonstrate competency in the implementation of each client's Behavior Support Plan [W191 and W193].  The cumulative effects of these systemic practices resulted in the facility's failure to provide adequate staffing and ensure each client's health and safety. [See also W122]	{W 158}	See responses to W 159, W185, W186, W191 and W193. The QMRP will provide a written schedule that reflects staff supports as required in each person's ISP. The schedule will in future be maintained in the facility's electronic data management system where it can be reviewed by the Director of Disability Services as part of quality assurance. The QMRP will provide re-training to staff on implementation of the BSP, and will observe staff performance on a regular basis. The Residential Director will review data collection and provide a weekly written report on data collection, as well as additional staff training needs and implementation.		
{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.	{W 159}			

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{W 159}	<p>Continued From page 14</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the Qualified Mental Retardation Professional (QMRP) failed to coordinate, integrated and monitor the active treatment programs for five of the five clients residing in the facility. (Clients #1, #2, #3 and #4)</p> <p>The findings includes:</p> <p>1. The QMRP failed to ensure Client #1's vibrating pillow was functional as evidence below:</p> <p>On May 26, 2009, 5:05 PM, Client #1's 1:1 staff was observed putting a horseshoe shape pillow around the client's neck and shoulder. Interview with the 1:1 staff revealed that the pillow provided vibration while keeping Client #1 from engaging in his targeted behaviors of hitting himself on the head, in the face and neck. Further interview with the 1:1 staff revealed that the pillow needed batteries to activate the vibrator. At approximately 5:07 PM, the 1:1 staff was observe to search the facility for batteries, however, was not able to retrieve any.</p> <p>On May 26, 2009, at approximately 5:15 PM, interview with the Qualified Mental Retardation Professional (QMRP) confirmed that pillow vibrates and was used to provide tactile stimulation for the Client #1. At 5:20 PM, the QMRP searched the facility for batteries to operate the pillow. The QMRP could not any batteries for the pillow. There was no evidence the QMRP coordinated services to ensure batteries were available to maximize the client's benefit from the sensory stimulator. It should be noted that Client #1 was observed to hit his head when left alone at 4:37 PM and 4:49 PM.</p>	{W 159}	<p>1. The QMRP will ensure that the Residential Director includes batteries for the pillow on the regular shopping list so that the client is consistently provided with his equipment per his ISP.</p> <p>6/22/09</p>	

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{W 159}	<p>Continued From page 15</p> <p>2. The QMRP failed to ensure recommendations made by consultants were addressed as evidenced below:</p> <p>Client #1's medical record was reviewed on May 27, 2009 at 3:30 PM to evaluate any systemic issues surrounding nutritional services provided by the facility. The physician's orders reflected the client was to receive a regular pureed diet; however, review of a nutritional assessment dated February 1, 2009, the consultant recommended that the client receive a pureed diet with increased fiber. The staff was to add pudding or apple sauce to the food for meal palatability. Interview with the QMRP on the same day revealed that she was not aware of the recommendation.</p> <p>3. The QMRP failed to ensure informed consent were obtained for clients #3 and #4 psychotropic medications and Behavior Support Plan. [See W124]</p> <p>The QMRP failed to ensure continuous active was implemented for Client #3 in accordance with the interdisciplinary team recommendations. [See W249]</p> <p>The QMRP failed to ensure staff demonstrated competency in the implementation of client #2 and #3's Behavior Support Plan (BSP). [See W191 and W193]</p> <p>The QMRP failed to ensure that the comprehensive functional assessment included an evaluation of client #2's nutritional status. [See W217]</p>	{W 159}	<p>2. The QMRP will review each client's assessments so that she is aware of the recommendations. The Director of Disability Services will set a protocol for uploading assessments to the electronic data management system so that they can be reviewed by a higher level of management thus ensuring that they are approved and implemented.</p> <p>3. The QMRP will request the medical decision-makers for the clients to come to the facility to review treatments and provide written informed consent. In future when completing the grand rounds, the QMRP will ensure that any new treatments are properly approved by decision-makers, and when new restrictive treatments of any sort are recommended, the QMRP will acquire the consents. Copies of the consent will be provided to the Director of Disability Services and the QMPD. See responses to W 249, W 191, W193, and W217.</p>	6/22/09	
{W 185}	483.430(c)(4) FACILITY STAFFING	{W 185}			

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{W 185}	<p>Continued From page 16</p> <p>The facility must provide sufficient support staff so that direct care staff are not required to perform support services to the extent that these duties interfere with the exercise of their primary direct client care duties.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide sufficient support staff to manage and supervise clients in accordance with their individual program plans for one of the three clients included in the sample. (Client #1)</p> <p>The findings includes:</p> <p>The facility was cited during the previous survey for not having sufficient support staff to manage and supervise clients. On May 23, 2009, the facility forwarded a Plan of Correction that alleged the Qualified Mental Retardation Professional (QMRP) would submit a request to the Department of Health Care Finance (DHCF) through Department on Disability Services (DDS) for funding for 1:1 staff.</p> <p>On May 26, 2009, beginning at 4:37 PM, evening observations revealed Client #1 was left alone in his bedroom while his 1:1 staff went outside for approximately 2 minutes. At 4:42 PM, Client #1 was left alone in his bedroom while his 1:1 staff gathering food from the pantry in preparation for dinner. At 4:46 PM, Client #1's 1:1 staff was observed in the kitchen looking through the refrigerator as he was left alone in his bedroom room. At 4:52 PM through 4:58 PM, the client was in his bedroom alone while his 1:1 staff was</p>	{W 185}	<p>The QMRP will provide re-training as needed for staff on the duties of a 1:1, and additionally will effect immediate discipline for staff who repeat the behavior of moving beyond the distance defined in the clients' ISPs. The Director of Operations will review the current facility budget and determine how to fund additional staffing as needed.</p> <p>6/22/09</p>		

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{W 185}	Continued From page 17 in the kitchen preparing dinner. At 5:12 PM, two staff were observed transporting Client #5 from his hospital bed to his wheelchair. At 5:17 PM, Client #5 was transported to the living room area with other peers while his 1:1 staff remained in the kitchen cooking dinner until approximately 6:15 PM.  At 4:34 PM, interview with the 1:1 staff revealed that she provided 1:1 services for Client #1 five days a week from 3 PM to 11 PM. Interview with the Qualified Mental Retardation Professional (QMRP) at approximately 5:34 PM, revealed that Client #1 received 1:1 services 16 hours (8 AM to 12 AM) a day seven days a weeks. Further interview with the QMRP revealed that during the times the Client #1's 1:1 staff is preparing dinner or completing other household duties, the RD, QMRP or another client's 1:1 support staff would temporarily monitor the client whose 1:1 staff was performing the cooking duties. The QMRP stated that Client #1's 1:1 staff should remain within arms lengths at all times.  Review of Client #1's Behavior Support Plan (BSP) dated January 3, 2009 on May 28, 2009 at 2:21 PM confirmed that "1:1 staff should be at arm's length from the client in his seated position." Review of the current staff schedule at approximately 3:00 PM, revealed that each staff on duty was scheduled to provide 1:1 coverage for their clients. There was no evidence that the facility had addressed the deficiency in the April 17, 2009 federal report.	{W 185}			
{W 186}	483.430(d)(1-2) DIRECT CARE STAFF  The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.	{W 186}			

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{W 186}	<p>Continued From page 18</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interviews, and record verification, the facility failed to maintain a sufficient number of staff to ensure that each clients were monitored to prevent injuries and to address behavior management needs for one of three sampled clients. (Client #3)</p> <p>The finding includes:</p> <p>The facility was cited during the April 17, 2009 survey for not providing 2:1 staff support for Client #3 while out in the community. The written Plan of Correction, dated May 23, 2009 alleged the Director of Disability Services would coordinate with the Director of Human Resources to ensure that an appropriate written staff schedule (weekly or bi-weekly) was produced by the QMRP and the Residential Director thus ensuring that clients in the home have sufficient staff support. On May 28, 2009, at approximately 10:45 AM, interview with the QMRP and review of the current staff schedule failed to evidence 2:1 staff support for Client #3 while out in the community. The following observations were made during the revisit:</p> <p>a. On May 26, 2009, at 5:24 PM, Client #3 was observed getting into his 1:1 staff's personal vehicle. The 1:1 staff transported Client #3 on a community outing. At 6:04 PM, the client arrived back to the facility with his 1:1 staff.</p>	{W 186}	<p>The QMRP will produce a written schedule that reflects the staff supports required by each client's ISP and BSP. The Department of Health Care Finance does not have a mechanism to reimburse provision of 2:1 staff patterns for clients who have need of this intensive support.</p> <p><i>6/22/09</i></p>		

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{W 186}	<p>Continued From page 19</p> <p>On May 27, 2009, at approximately 4:00 PM, interview QMRP revealed that Client #3's 1:1 staff should have never transported the client on a community outing in his personal vehicle and without an additional support staff. The QMRP stated that all 1:1 support staffs were made of the required 2:1 staff for Client #3 due to his maladaptive behaviors. (i.e. inappropriately approaching children and making sexually inappropriate comments to them)</p> <p>On May 28, 2009, at approximately 10:00 PM, review of Client #3's Behavior Support Plan (BSP) dated September 30, 2009, revealed the client received 1:1 staffing 24 hours a day to manage maladaptive behaviors. (i.e. verbal aggression, physically aggressive, non-compliance, making excessive demands to staff, making false accusations, and inappropriately approaching children). Further review of the BSP revealed Client #3 required 2:1 staff supervision while out in the community. There was no evidence that the administrator and/or governing body had addressed the deficiency as identified in the April 17, 2009 federal deficiency report.</p> <p>b. Similar observations on May 27, 2009, at approximately 4:30 PM, revealed Client #3 was observed walking in his community with his 1:1 staff. This observation was reported to the QMRP on May 28, 2009 at approximately 3:30 PM. The QMRP acknowledged that the client should have been provided 2:1 staff supervision while in the community. At the time of the revisit, there was no evidence that Client #3 was provided with 2:1 staff supervision while in the community as indicated the the client's BSP.</p>	{W 186}			
{W 191}	483.430(e)(2) STAFF TRAINING PROGRAM	{W 191}	See response to W 186.		

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{W 191}	<p>Continued From page 20</p> <p>View in-service training as a dynamic growth process. It is predicated on the view that all levels of staff can share competencies which enable the individual to benefit from the consistent, wide-spread application of the interventions required by the individual's particular needs.</p> <p>In the final analysis, the adequacy of the in-service training program is measured in the demonstrated competencies of all levels of staff relevant to the individual's unique needs as well as in terms of the "affective" characteristics of the caregivers and the personal quality of their relationships with the individuals. Observe the staff's knowledge by observing the outcomes of good transdisciplinary staff development (i.e., in the principles of active treatment) in such recommended competencies as:</p> <ul style="list-style-type: none"> <li>· Respect, dignity, and positive regard for individuals (e.g., how staff refers to individuals, refer to W150);</li> <li>Use of behavioral principles in training interactions between staff and individuals;</li> <li>· Use of developmental programming principles and techniques, e.g., functional training techniques, task analysis, and effective data keeping procedures;</li> <li>· Use of accurate procedures regarding abuse detection and prevention, restraints, medications, individual safety, emergencies, etc.;</li> <li>· Use of adaptive mobility and augmentative communication devices and systems to help individuals achieve independence in basic</li> </ul>	{W 191}			

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NAME OF PROVIDER OR SUPPLIER  <b>CARECO 01</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>6417 KANSAS AVE, NE</b> <b>WASHINGTON, DC 20001</b>	
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{W 191}	<p>Continued From page 21 self-help skills; and</p> <p>Use of positive behavior intervention programming.</p> <p>§483.430(e)(2) Probes</p> <p>Does the staff training program reflect the basic needs of the individuals served within the program?</p> <p>Does observation of staff interactions with individuals reveal that staff know how to alter their own behaviors to match needs and learning style of individuals served?</p> <p>For employees who work with clients, training must focus on skills and competencies directed toward clients' behavioral needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide evidence that employees working with the clients received required behavior management training that enabled them to implement approved interventions for one of three sampled clients. (Client #3)</p> <p>The finding includes:</p> <p>Cross-refer to W249. The facility was cited during the April 17, 2009 survey for not providing 2:1 staff support for Client #3 while out in the community. The written Plan of Correction, dated May 23, 2009 alleged that the Qualified Mental Retardation Professional (QMRP) would request</p>	{W 191}		

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{W 191}	Continued From page 22 the DHCF through the DDS case manager to receive funding for 2:1 staffing on a schedule so that the client can safely engage in community-based activities. On May 28, 2009, at approximately 10:45 AM, interview with the QMRP revealed that she had not requested funding for Client #3 to receive 2:1 staffing while on community outings. <b>W 193 483.430(e)(3) STAFF TRAINING PROGRAM</b>  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 observations, interviews, and record review the facility staff failed to demonstrate competency in the implementation of clients Behavior Support Plan (BSP) for two of three clients included in the sample. (Clients #2 and #3)  The findings include:  1. The facility failed to ensure that Clients #2's 1:1 staff remained in close proximity in accordance with his BSP as evidence below:  a. On May 27, 2009, at approximately 10:00 AM, review of the facility's incident reports revealed an incident dated May 7, 2009 that occurred at the day program. According to the incident, 1:1 staff left Client #2 unattended to take the client's lunch dishes to the sink. While unattended, Client #2, ran into a classroom and bit another individual.  On May 27, 2009, at approximately 2:15 PM, interview with the Qualified Mental Retardation	{W 191}			
		W 193	1. Client #2 will be discharged from the facility on June 12.	6/22/09	

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W 193	<p>Continued From page 23</p> <p>Professional (QMRP) revealed Client #2 received 1:1 staffing 24 hours a day to manage maladaptive behaviors. (i.e. Self-injurious behavior, physical aggression, pica, and botting). Further interview with the QMRP revealed that one of the primary duties of the 1:1 staff person was to remain within eyesight and/or arms length of Client #2 at all times.</p> <p>On May 28, 2009, at approximately 10:00 AM, review of Client 2's BSP dated October 8, 2008 confirmed the QMRP's interview. There was no evidence that on May 7, 2009 the facility staff demonstrated competency in the implementation of the client's BSP.</p> <p>b. A similar observation was made at the facility on May 27, 2009. At approximately 3:25 PM to approximately 4:15 PM, Client #2 was observed on a playground located across the street with his 1:1 staff and another staff person. Both staff trailed the client by several feet as he walked around the playground.</p> <p>2. The facility failed to ensure that Client #3's 1:1 staff remained in close proximity in accordance with his BSP.</p> <p>a. On May 26, 2009, at 5:01 PM, Client #3 was observed walking upstairs to his bedroom while his 1:1 staff was located in the basement. Two minutes later, 1:1 staff met with Client #3 upstairs. At 5:20 PM, Client #3 was observed downstairs in the dining area while his 1:1 was observed upstairs for approximately one minute. At 6:40 PM, Client #1 was seated in the living room area while his 1:1 staff was observed in the kitchen for approximately two minutes.</p>	W 193	2. See response to W 185.	6/22/09
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W 193	<p>Continued From page 24</p> <p>At approximately 6:45 PM, interview with the Client #3's 1:1 staff revealed that he was to remain within arms length of the client at all times. Further interview with the 1:1 staff revealed that he had received training on Client #3's BSP and on 1:1 duties and responsibilities.</p> <p>On May 27, 2009, at approximately 2:15 PM, interview with the Qualified Mental Retardation Professional (QMRP) revealed Client #3 received 1:1 staffing 24 hours a day to manage maladaptive behaviors. (i.e. verbal aggression, physically aggressive, non-compliance, making excessive demands to staff, making false accusations, and inappropriately approaching children). Further interview with the QMRP revealed that one of the primary duties of the 1:1 staff person was to remain within eyesight and/or arms length of Client #3 at all times.</p> <p>On May 28, 2009, at approximately 10:30 AM, review of Client #3's BSP dated September 30, 2008 confirmed the QMRP's interview. There was no evidence that staff demonstrated competency in the implementation of the client's BSP.</p> <p>3. The facility failed to ensure that Client #3's 1:1 staff implemented his BSP as written as evidenced below:</p> <p>On May 28, 2009 at approximately 4:00 PM, Client #3 was observed with his 1:1 staff at the facility. Client #3 was very agitated and spoke in a loud threatening tone to the staff. As he was speaking to the surveyor he moved very close to the surveyor's face, invading the surveyors personal space. He continued to speak loud and use profanity as he spoke. He continuously</p>	W 193	<p>3. The QMRP will provide re-training to the staff on the BSP.</p>	6/22/09	

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W 193	Continued From page 25 demanded the surveyor to tell the staff person (or repeat) what he had just said. The 1:1 staff, although in close proximity to the client, failed to redirect the client in attempt to deescalate the behavior.  Review of the client's BSP dated September 30, 2008, revealed that the client's 1:1 staff was to give him a clear prompt to go to his room or a less restrictive area of the home when engaged in the aforementioned behaviors. If he did not comply staff was not to discuss it further. The staff was to calmly suggest that he accompany them to a place where he could relax and where he would find it more peaceful.  At the time of the revisit, the 1:1 staff failed to implement Client #3's BSP as written.	W 193			
{W 217}	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN  The comprehensive functional assessment must include nutritional status.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that the comprehensive functional assessment included an evaluation of clients' nutritional status for one of three clients in the sample. (Client #2).  The finding includes:  The facility was cited during the April 17, 2009 survey for not ensuring that Client #2 received a nutritional assessment. According to his April 2009 physician's orders, the client was to receive a regular diet with no seconds. Observations at the facility on May 27, 2009, revealed Client #2	{W 217}	The QMRP held a discharge meeting for the client. The receiving provider was advised of the client's clinical needs that were still outstanding. See response to W 159.	6/22/09	

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{W 217}	<p>Continued From page 26</p> <p>had received a late lunch which consisted of soup and crackers. Shortly after an explosive behavioral episode and the client had finally calmed down, he was observed to go into the kitchen and come out with more crackers.</p> <p>As indicated in the April 2009 survey report, the client was to have a nutritional assessment to determine his nutritional needs. Further review of Client #2's record revealed a recommendation by the day program's psychologist to have the nutritionist evaluate the client to determine the feasibility of allowing him to have more food.</p> <p>Interview with the QMRP, on May 27, 2009 at 2:00 PM, revealed that the nutritionist had performed an assessment (date unknown), however, the facility had not received the report. According to the facility's plan of correction dated May 23, 2009, the QMRP was to contact the Nutritionist by May 22, 2009 to request that an assessment of #2 be completed to ensure he had adequate foods to meet his nutritional needs and that his ideal body weight information could be placed in his record and shared with his primary care physician.</p> <p>At the time of the re-visit, the facility failed to provide evidence of a nutritional evaluation for Client #2.</p>	{W 217}		
{W 220}	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN</p> <p>The comprehensive functional assessment must include speech and language development.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to fully assess Client #2's</p>	{W 220}	<p>A specialized clinical meeting was held concerning client #2. The Director of Disability Services will provide evidence of the meeting.</p>	6/22/09

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{W 220}	Continued From page 27 speech and language needs, to determine if he might benefit from professional intervention.  The findings include:  The facility was cited during the April 17, 2009 survey for not ensuring that Client #2 had his speech and language needs assessed. The written Plan of Corrections (POC) dated May 23, 2009 alleged that QMRP would schedule a meeting of the Interdisciplinary Team to propose and approve clinical interventions needed including speech and language services.  On May 28, 2009, at approximately 3:30 PM, interview with the QMRP revealed that the meeting had not be scheduled as stated in the POC.	{W 220}		
{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, record review and interview, the facility failed to ensure continuous active was implemented in accordance with the interdisciplinary team recommendations for one of the three clients in the sample. (Clients #3)  The findings include:	{W 249}	See response to W 185 and W 186	6/22/09

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{W 249}	<p>Continued From page 28</p> <p>The facility was cited during the April 17, 2009 survey for not providing 2:1 staff support for Client #3 while out in the community. The written Plan of Correction, dated May 23, 2009 alleged that the Qualified Mental Retardation Professional (QMRP) would request the DHCF through the DDS case manager to receive funding for 2:1 staffing on a schedule so that the client can safely engage in community-based activities. On May 28, 2009, at approximately 10:45 AM, interview with the QMRP revealed that she had not requested funding for Client #3 to receive 2:1 staffing while on community outings. The following observations were made during the revisit:</p> <p>a. On May 26, 2009, at 5:24 PM, Client #3 was observed getting into his 1:1 staff's personal vehicle. The 1:1 staff transported Client #3 on a community outing. At 6:04 PM, Client arrived back to the facility with his 1:1 staff.</p> <p>On May 27, 2009, at approximately 4:00 PM, interview with the QMRP revealed that Client #3's 1:1 staff should have never transported the client on a community outing in his personal vehicle and without additional support staff. The QMRP stated that all 1:1 support staff were made aware of Client #3's 2:1 staffing pattern while in the community due to his maladaptive behaviors. (i.e. inappropriately approaching children and making sexually inappropriate comments to them)</p> <p>On May 28, 2009, at approximately 10:00 AM, review of Client #3's Behavior Support Plan (BSP) dated September 30, 2009, revealed the client received 1:1 staffing 24 hours a day to manage maladaptive behaviors. (i.e. verbal aggression,</p>	{W 249}		
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{W 249}	<p>Continued From page 29</p> <p>physically aggressive, non-compliance, making excessive demands to staff, making false accusations, and inappropriately approaching children). Further review of the BSP revealed Client #3 required 2:1 staff supervision while out in the community. There was no evidence that the administrator and/or governing body had addressed the deficiency as identified in the April 17, 2009 federal report.</p> <p>b. Similar observations on May 27, 2009, at approximately 4:30 PM, revealed Client #3 was observed walking in his community with his 1:1 staff. This observation was reported to the QMRP on May 28, 2009 at approximately 3:30 PM. The QMRP acknowledged that the client should have been provided 2:1 staff supervision while in the community. At the time of the revisit, there was no evidence that Client #3 was provided with 2:1 staff supervision while in the community as indicated the the client's BSP.</p> <p>c. On May 27, 2009, at approximately 4:45 PM, Client #3 was observed telling the House Manager (HM) to write down his statement on a piece of paper. The HM was compliant with the client's request and wrote as the client dictated.</p> <p>Review of Client #3's Behavior Support Plan (BSP) dated September 30, 2008, revealed if the client continuously asks staff (or his 1:1) to write down or spell names for him, request him to write them down himself. At no time during the observation did the 1:1 staff direct the client to write for himself as indicated in his BSP. The observation was reported to the Qualified Mental Retardation Professional on May 28, 2009 at approximately 3:00 PM. She acknowledged that the HM should not have written the information for</p>	{W 249}			

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{W 249}  {W 263}	<p>Continued From page 30 the client as it was not in compliance with his BSP.</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING &amp; CHANGE</p> <p>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that restrictive programs were used only after written consents had been obtained, for two of the three clients in the sample. (Clients #3 and #4)</p> <p>The finding includes:</p> <p>The facility was cited during the previous survey for failing to ensure informed consent were obtained prior to the use of psychotropic medications and the implementation of Behavior Support Plans. On May 23, 2009, the facility forwarded a Plan of Correction (POC) that reflected the Qualified Mental Retardation Professional (QMRP) will contact the mother to provide written informed consent for his treatments.</p> <p>During the re-visit on May 26, 2009 through May 28, 2009, the facility's system for obtaining informed consents was evaluated. Clients #3 and #4 records were reviewed. The clients were noted to receive psychotropic medications and had BSPs which included restrictive measures. On May 27, 2009, at appropriately 2:05 PM, interview with the QMRP revealed that all of the</p>	{W 249}  {W 263}	<p>The QMRP will ensure that written informed consent is provided by the medical decision-maker for the treatments provided to the client. The QMRP will contact the decision-makers to come to the facility to review treatment and sign consents.</p>	6/22/09

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{W 263}	Continued From page 31 clients surrogate decision makers had signed informed consents for the use of their psychotropic medications and Behavior Support Plans (BSPs), which were located in their Individual Support Plans (ISP) books. However, there was no evidence that Client #3's mother and Client #4's sister had provided informed consent prior to use of their prescribed psychotropic medications and BSPs. [See W124]	{W 263}		
{W 474}	483.480(b)(2)(iii) MEAL SERVICES  Food must be served in a form consistent with the developmental level of the client.  This STANDARD is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide food in the prescribed texture for one of the three clients in the facility. (Client #3)  The finding includes:  The survey completed on April 17, 2009 outlined systemic mealtime issues, as it relates Client #3's diet texture during mealtime. The written Plan of Correction (POC) alleged that the Qualified Mental Retardation Professional (QMRP) will ensure that staff are trained, and/or re-trained, on proper meal preparation and service in accordance with the clients' Individual Support Plan (ISP).  On May 26, 2009, at approximately 4:37 PM, Client #3 was observed to be edentulous. Later that evening at 6:18 PM, Client #3 was served baked fish, mixed vegetables, and pasta salad during dinner time. The client's baked fish was not chopped. At approximately 6:35 PM, Client	{W 474}	The QMRP will ensure that staff are trained, and/or re-trained, on proper meal preparation and service in accordance with the clients' ISPs.	6/22/09

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{W 474}	<p>Continued From page 32</p> <p>#s 1:1 staff confirmed that he did not chop the client's baked fish up. On May 28, 2009 at approximately 3:30 PM, interview with the staff who prepared Client #3's dinner on May 26, 2009, revealed that she did not chop the client's fish up as prescribed. The staff stated that Client #3's 1:1 staff normally chops his meats up.</p> <p>Review of the medical records on May 27, 2009 at approximately 1:17 PM revealed current Physician's Orders (PO's) dated April 2009. The PO's revealed Client #3 was prescribed a regular diet with meats cut in "very small pieces." There was no evidence that Client #3's baked fish was chopped into very small pieces as prescribed.</p>	{W 474}		
{W 489}	<p>483.480(d)(5) DINING AREAS AND SERVICE</p> <p>The facility must ensure that each client eats in an upright position, unless otherwise specified by the interdisciplinary team or a physician.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each client sat in an upright position while eating for one of the five clients residing in the facility. (Client #5)</p> <p>The finding includes:</p> <p>As described in the April 17, 2009 federal deficiency report, Client #5 was observed feeding himself with a tablespoon as he leaned forward and with his mouth against the edge of the plate guard. After loading each spoonful of food, the client then raked the food into his mouth. The written Plan of Correction (POC) alleged that the</p>	{W 489}	See response to W 474.	6/22/09

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G010</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R <b>05/28/2009</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CARECO 01</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6417 KANSAS AVE, NE WASHINGTON, DC 20001</b>
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{W 489}	<p>Continued From page 33</p> <p>Qualified Mental Retardation Professional (QMRP) will ensure that staff are trained, and/or re-trained, on proper meal preparation and service in accordance with the clients' Individual Support Plan (ISP).</p> <p>On May 26, 2009, at approximately 6:16 PM, Client #5 was observed sitting at the dining table in an upright position waiting for his dinner. At 6:18 PM, Client #1 was observed to receive baked fish, mixed vegetables, and pasta salad in a regular plate with a plate guard attached to the front side. The client fed himself independently while leaning over into his plate while consuming his food. After retrieving the food with the spoon, the client then raked the food into his mouth with the support of the plate guard. Client #5's 1:1 staff was present beside him during the entire dinner along with other peers and staff and was never observed to prompt him to sit up while eating.</p> <p>Interview with the 1:1 staff revealed that Client #5 has been consuming his food by leaning forward over his plate approximately one year. Further interview with the 1:1 staff after dinner revealed that Client #5 refuses to sit upright while feeding himself during dinner time. On May 28, 2009, at approximately 1:00 PM, interview with the Qualified Mental Retardation Professional (QMRP) revealed that Client #5 had not been assessed by facility's consultants and/or have been discussed by the Interdisciplinary Team (IDT). Further interview with the QMRP revealed that the nutritionist had not trained staff on the client's mealtime protocols.</p> <p>On May 28, 2009, at approximately 1:30 AM, review of Client #5's Individual Support Plan (ISP)</p>	{W 489}		
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NAME OF PROVIDER OR SUPPLIER  <b>CARECO 01</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>6417 KANSAS AVE, NE</b> <b>WASHINGTON, DC 20001</b>		
(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 489}	Continued From page 34 dated December 9, 2008 confirmed that the IDT had not reviewed and or evaluated the client's posture during mealtime to deem it appropriate for the client to consume his food safely. At approximately 1:35 PM, review of the staff training records failed to evidence that the nutritionist had provided training on the client's mealtime protocols.	{W 489}		