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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/24/2009
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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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{W 000}	<p>INITIAL COMMENTS</p> <p>A follow-up survey was conducted on June 24, 2009 to determine the facility's compliance with the previously condition level deficiencies cited on May 28, 2009. A random sample of two clients was selected from a residential population of four males with various disabilities.</p> <p>The findings of the survey were based on observations in the group home, interviews with the facility's management and staff and a review of records, including unusual incident reports, investigations and administrative records.</p> <p>The survey findings determined that the facility remained out of compliance with the Conditions of Participation in Governing Body and Client Protections.</p> <p>During the on-site visit a client was observed to exhibit explosive, unmanageable and unpredictable behavior. As a result of the client's observed behavior a determination was made that a serious and immediate threat to the client, his peers and the facility's staff health and safety existed. The governing body was notified of the immediate jeopardy on June 24, 2009 at approximately 3:45 PM.</p> <p>As a result of the aforementioned observed behavior, the DC Metropolitan Police Department was contacted to assist and the client was escorted to CPEP for emergency psychiatric evaluation and treatment.</p> <p>Post survey, on June 25, 2009, the facility in collaboration with the Department of Disability Services presented a plan to prevent potential harm to individuals residing in this facility. The</p>	{W 000}	<p>7/1/09</p> <p>GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Marsha H. Thompson</i>	TITLE <i>Director of Disability Services</i>	(X6) DATE <i>7/14/09</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{W 000}	<p>Continued From page 1 safety strategies were as follows:</p> <p>a. The agency would seek permission from the Department of Disability Service (DDS) to move the remaining three vulnerable individuals to other vacant placements. The selected placements are to be appropriate to meet each client's needs and would occur quickly.</p> <p>b. None of Client #2's previous housemates will be present upon his return to the group home until the situation is resolved.</p> <p>c. The Qualified Mental Retardation Professional (QMRP) would lock away all sharp objects in the kitchen, bathroom, recreation and administrative areas.</p> <p>d. The QMRP will remove all heavy items that could be used as a weapon, such as hole punchers, staplers, telephones, picture frames, pots/pans, brooms, mops, small chairs, etc., either by locking them away or storing them in an inaccessible area.</p> <p>e. The QMRP would bring in additional male staff who have experience in managing people with mental illness who manifest physically aggressive behavior. The staff will be immediately trained in Client #2's Behavior Support Plan (BSP).</p> <p>f. The treating Psychiatrist will meet with Client #2 on Friday, June 24, 2009. Client #2 will be accompanied by the facility's nurse and the QMRP in order to provide pertinent information to ensure an accurate picture of the client presenting problems.</p> <p>g. The agency's nursing staff will immediately</p>	{W 000}		
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{W 000}	Continued From page 2 establish a protocol with the treating Psychiatrist and Primary Care Physician for telephone orders. The purpose of the protocol is to ensure that if Client #2's behavior escalates and cannot be re-directed per his BSP, appropriate medications can be provided as needed.	{W 000}		
{W 102}	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.	{W 102}	The Governing Body has attempted numerous strategies to provide safe care for client #2. His IDT determined that his Axis I diagnoses are so serious that he cannot be maintained safely in the community. The Governing Body sent the QMRP to the annual commitment review for the client in the Family Court Division of the District of Columbia Superior Court. The QMRP represented to the Court that the client's behaviors make his current living situation unsafe for himself, others living in the home, staff, and people who live in his neighborhood. The Court reminded the Department on Disability Services (DDS) that previous reviews indicated that the client would be better served in a more restrictive environment than an ICF/MR. The Governing Body also provided a letter to the Chief Operating Officer of the Developmental Disabilities Administration outlining the concerns around the placement of client #2 in the home, and agreeing to accept him at discharge from a temporary stay at an acute psychiatric intervention facility on the condition that he be rapidly outplaced. The Governing Body also requested adequate resources to properly support the client until discharge; the DDS sent a letter to state that the Department would support such a request with the Department on Health Care Finance. The letter was received on July 14, and the DDS has agreed to remove the client on July 17, 2009.	
	This CONDITION is not met as evidenced by: Based on observations, interviews, and record review, the facility's governing body failed to maintain general operating direction over the facility to ensure each client's health and safety [See W104 and W127].			
{W 104}	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.	{W 104}		
	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 for all clients residing in the facility. (Clients #1, #2, #3, and #4)			7/17/09

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{W 104}	<p>Continued From page 3</p> <p>The findings include:</p> <p>1. The governing body failed to effectively protect four of four clients and staff from potential harm as evidenced below:</p> <p>On June 24, 2009, a revisit was initiated to determine if the facility had employed sufficient safeguards to effectively protect the clients. The revisit revealed Client #2's explosive and unpredictable behaviors continued to place the safety of the client, his peers, and the facility's staff at risk.</p> <p>On June 24, 2009, beginning at 2:35 PM and ending at approximately 3:25 PM the following was observed:</p> <p>At 2:35 PM, Client #2 was observed sitting in the dining room with two of his assigned one on one staff (one male, one female staff). In addition, the Qualified Mental Retardation Professional (QMRP), the Nurse and the House Manager was also seated at the dining room table. At approximately 2:40 PM, Client #2 started using profane language and began to verbally threaten his male one on one staff. He picked up a broom from the kitchen and began to repeatedly threaten to hit the male one on one staff. He opened the front door and stormed out into the front yard. Both one on one staff and the QMRP followed him out into the front yard. He made approximately four attempts to hit the male one on one staff with the broom. As the male one on one re-entered the front door, Client #2 swung the broom toward him and just missed him. The broom hit the threshold of the door and broke into several pieces.</p>	{W 104}	<p>1. See response to W 102.</p>	<p>7/17/09</p>
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{W 104}	<p>Continued From page 4</p> <p>The male one on one entered the facility and entered Client #1's bedroom and shut the door. It should be noted that Client #1, his one on one and the Residential Director were already in his bedroom with the door shut. During that time the QMRP and the female one on one were left alone to handle Client #2's explosive behavior.</p> <p>Client #2 was then observed to enter the kitchen and grabbed a knife from a kitchen drawer and threatened to "Kill" the female one on one staff person. He repeated, "Leave me alone. I don't want to talk to you!" He walked toward Client #1's bedroom door and said, " Come on, Come on Bitch, I am going to kill you! You are not going to hurt me." The female one on one directed the QMRP to contact 911 for assistance. The QMRP picked up the phone and "signaled" to the female one on one that 911 had been contacted.</p> <p>Shortly after, Client #2 walked towards the front door and opened the door. A male was standing in the door way. The QMRP acknowledged that the male at the door was Client #2's one on one relief staff for the second shift. She further commented, "He always arrives to work early". The relief staff immediately attempted to redirect Client #2 back into the group home. Client #2 backed up with the knife in hand and repeated, "Tell that man to leave me alone. I [am] going to kill him! I [am] going stab him!" The relief staff redirected him and ignored his comments. He changed the subject and offered him something to drink with no success. Then he offered Client #2 some jello pudding and he also refused.</p> <p>Again, Client #2 opened the front door and both Clients #3 and #4 with their one on one one staff</p>	{W 104}		
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{W 104}	<p>Continued From page 5</p> <p>entered the facility. As they entered, Client #2 was standing in the doorway holding the knife in his right hand. The one on one seated both clients on the couch in direct line of Client #2. The QMRP immediately intervened and redirected the staff to take Clients #3 and #4 up to the second level for their safety.</p> <p>Client #2 was then observed to exit the facility with the knife in hand and went out to the front yard. The female one on one, the QMRP and the relief one on one followed him out into the front yard. He continued his rampage in the front yard using profanity and exhibiting threatening behaviors with the knife in his hand. He yelled, "You are not going to hurt me. I'll kill you. I'll stab you with this knife." Then he was observed to walk toward the sidewalk near the street out in front of the facility.</p> <p>At approximately 2:45 PM two police cruisers pulled up with lights and sirens blaring. The police officer in the cruiser closest to the client got out of his cruiser first. Client #2 lunged toward the officer with the knife. The police officer pulled out his pistol from the holster and pointed it towards Client #2. The officer then shouted, "Drop the knife sir!, Drop the knife!" The QMRP started yelling repeatedly, "Don't shoot! Don't shoot! He has a disability! He has mental illness!" The officer continued to move toward Client #2. Client #2 began to walk away from the officer and down the sidewalk towards Eastern Avenue. Two additional police cruisers pulled up and one of the officers that exited his cruiser was tall and large in stature. The tall officer waved back the other two officers who were holding their pistols. He introduced himself to Client #2 and asked him to surrender the knife. Client #2 handed over the</p>	{W 104}		
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{W 104}	<p>Continued From page 6</p> <p>knife without incident and hugged the officer and laughed. Client #2 walked over to another officer and gave him a hug as well. The four police officers escorted Client #2 back into the group home. The officers completed the necessary paper work with the QMRP's assistance. Client #2 was then hand-cuffed without incident and escorted to CPEP for emergency psychiatric treatment.</p> <p>2. The governing body failed to ensure that criminal background checks were obtained for all staff to ensure their 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. The written Plan of Correction, dated May 23, 2009 revealed the completion date for obtaining all police clearances was May 22, 2009.</p> <p>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.</p> <p>During the re-visit on June 24, 2009, review of the personnel records revealed there was no evidence that criminal background checks had been obtained for all the staff currently employed by the agency. During an interview with the QMRP on the same day at approximately 4:30 PM, she stated the records on hand were complete and current.</p> <p>Review of the plan of correction (POC) dated</p>	{W 104}	<p>2. The Director of Disability Services requested the Director of Operations to order a complete audit of the personnel files of all staff working in the DD Department. The Director of Disability Services requested that any background checks that do not meet the regulations be re-run in a thorough manner, using Careco's revised protocol.</p>	<p>7/17/09</p>
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<p>{W 104} Continued From page 7 June 22, 2009 revealed that all staff's criminal background checks were on file in the management office.</p> <p>It should be further noted that at the time of the revisit, seven (7) of the twenty-four (24) staff cited during the previous survey, were still providing direct care services to the clients. Additionally, another 7 staff failed to have background checks that covered each jurisdiction where they previously lived and/or worked.</p>	{W 104}		
<p>{W 122} 483.420 CLIENT PROTECTIONS</p> <p>The facility must ensure that specific client protections requirements are met.</p> <p>This CONDITION is not met as evidenced by: On June 24, 2009, a follow-up survey was conducted to assess the facility's level of compliance with correcting the deficiencies identified during the re-certification survey completed on May 28, 2009.</p> <p>Based on observation, interview, and record review, the governing body failed to exercise general policy and operating direction over the facility [See W104]; the facility failed to ensure the health and safety of all four clients that reside in the facility [See W127].</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 put specific protections in place for the clients served in the home; however, due to the explosive and unpredictable behaviors of client #2, the Governing Body asked the DDS to effectuate a discharge for him, and the Governing Body provided appropriate placements elsewhere for the remaining clients. See responses to <u>CONDITION 102</u>, and deficiency W104.</p>	7/17/09
<p>{W 124} 483.420(a)(2) PROTECTION OF CLIENTS RIGHTS</p>	{W 124}		

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{W 124}	<p>Continued From page 8</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 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 three of four clients residing in the facility. (Clients #3 and #4)</p> <p>The findings include:</p> <p>The facility was cited during the May 28, 2009 survey for failing to ensure informed consent was obtained from Client #1's sister for the use of psychotropic medications and the implementation of his Behavior Support Plan (BSP). On May 23, 2009, the facility forwarded a Plan of Correction (POC) that reflected the Qualified Mental Retardation Professional (QMRP) would "contact Client #1's mother to secure 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).</p> <p>Review of medical records on May 27, 2009 at</p>	{W 124}	<p>The Director of Disability Services will prepare a training for the medical decision makers for the clients served, which will be provided at each person's ISP meeting. The training will encompass the requirement for clients/medical decision-makers to provide written informed consent prior to any new prescriptions for psychotropic medications or new/revised behavior support plans can be implemented. The training will include a process whereby the medical decision-maker can provide signed informed consent through in-person visit to the home, return postage-paid mail, fax, in-person visit to the administrative office, or if acceptable to the decision-maker, a personal visit by facility staff or by use of the electronic data system in use by the facility that provides electronic signatures through internet access.</p>	7/31/09
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{W 124}	<p>Continued From page 9</p> <p>approximately 2:50 PM, revealed current Physician's Orders (PO's) were on file and dated April 2009 for Clients #3 and #4. The PO's revealed Clients #3 and #4 was prescribed psychotropic medications. Further record review revealed the clients' had BSPs to address their maladaptive behaviors.</p> <p>On May 28, 2009, at approximately 1:00 PM, review of Clients #3 and #4's Individual Support Plan (ISP) failed to evidence that Client #3's mother and Client #4's sister had provided informed consent prior to the use of their prescribed psychotropic medications and BSPs.</p> <p>On June 24, 2009 at approximately 12:00 noon, interview with the QMRP revealed attempts were made to secure the informed consent form Client #1's sister, Client #3's mother and Client #4's sister without success.</p> <p>According to the QMRP she may have to make a personal visit to the family member's homes to get the consents signed. At the time of the revisit there was no evidence that the aforementioned client representatives were informed of the risk and benefit of each client's habilitation and treatment.</p>	{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</p>	{W 127}	<p>See response to CONDITION 102.</p>	<p>7/17/09</p>

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{W 127}	<p>Continued From page 10</p> <p>review, the facility failed to ensure the health and safety of all four clients that reside in the facility. (Client's #1, #2, #3, #4)</p> <p>The finding includes:</p> <p>Cross refer to W104. On June 24, 2009, a revisit was initiated to verify that the facility had employed sufficient safeguards to effectively protect the client's health and safety. An immediate jeopardy existed under the Condition of Participation of Client Protections. Observations and interviews during the revisit survey determined that Client #2's explosive behavior continued to pose an immediate safety risk to himself, his housemates and staff.</p>	{W 127}		
{W 159}	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</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> <ol style="list-style-type: none"> 1. The facility failed to ensure staff was effectively trained on implementing Client #1's meal-time protocol. [See W189] 2. The QMRP failed to ensure informed consent 	{W 159}	<ol style="list-style-type: none"> 1. See response to W189. 2. See response to W124. 	<p>7/17/09</p> <p>7/17/09</p>

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{W 159}	Continued From page 11	{W 159}		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM	W 189		
	<p>were obtained for clients #3 and #4 psychotropic medications and Behavior Support Plan. [See W124]</p> <p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that each employee had been provided with adequate training that enabled the employee to perform his or her duties effectively, efficiently and competently.</p> <p>The findings include:</p> <p>1. The facility was previously cited during the May 28, 2009 survey for failing to provide sufficient support staff to manage and supervise residents in accordance with their individual program plans (IPP).</p> <p>The facility's plan of correction (POC) dated June 22, 2009 indicated the QMRP would retrain all staff as needed on the job duties and responsibilities of providing one on one support. In addition, the corrective action provided for "immediate" disciplinary action for "all staff who repeats the behavior of moving beyond the distance outlined in a client's behavior support plan (BSP)".</p> <p>During the re-visit on June 24, 2009, interview with the QMRP and record review of the</p>		<p>1. The facility received the incorrect federal deficiency report; the correct report was received the evening prior to surveyors visiting the facility. Therefore, all of the answers had to be crafted and submitted without time to actually address the new and continuing deficiencies noted. Training was the solution proposed for this deficiency; however there was no time available to provide it. All staff had received training on 1:1 supports prior to being assigned to work in the facility. Evidence of the training is both in their orientation packages and in their working folders that each person had in the house during the survey.</p>	<p>7/17/09</p>

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W 189	<p>Continued From page 12</p> <p>personnel files at 11:32 AM revealed the facility failed to ensure eight (8) out of twenty-four (24) staff (Staffs #1, #2, #4, #13, #20, #21, #23, and #24) received training on the job duties for one on one support.</p> <p>2. The facility was previously cited during the May 28, 2009 survey for failing to provide sufficient administrative oversight to ensure the effective implementation of the facility's Incident Management Policy (IMP).</p> <p>The facility's plan of correction (POC) dated June 22, 2009 indicated the QMRP would retrain all staff on the incident management policy and procedures.</p> <p>Interview with the QMRP and review of the in-service training log on 6/24/2009 at 11:21 AM revealed the facility failed to ensure nine (9) out of twenty-four (24) staff (Staffs #1, #2, #18, #19, #20, #21, #22, #23, and #24) received training on the Incident Management Policy and Procedures.</p> <p>3. The facility was previously cited during the May 28, 2009 survey for failing to ensure staff was able to demonstrate competency in implementing a client's behavior management plan.</p> <p>The facility's plan of correction (POC) dated June 22, 2009 detailed the QMRP would retrain all staff on each client's behavior support plans (BSP). According to the POC, this corrective action should have been addressed by June 22, 2009.</p> <p>Interview with the QMRP and review of the in-service training log on June 24, 2009 at approximately 11:15 AM revealed, the facility</p>	W 189	<p>2. See response to #1 above.</p> <p>3. See response to #1 above. There was no time available to implement the correction due to the late receipt of the correct deficiency report.</p>	<p>7/17/09</p> <p>7/17/09</p>
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W 189	<p>Continued From page 13</p> <p>failed to ensure five (5) out of twenty-four (24) staff (Staffs #2, #3, #20, #21, and #22) received training on the BSPs.</p> <p>4. The facility was previously cited during the May 28, 2009 survey for failing to ensure staff was able to demonstrate competency in implementing a nutrition recommendations for Client #1.</p> <p>The facility's plan of correction (POC) dated June 22, 2009 detailed the QMRP would retrain all staff on Client #1's nutritional recommendation to receive a pureed diet with increased fiber. The staff was to add pudding or apple sauce to the food for meal palatability. According to the POC, this corrective action should have been addressed by June 22, 2009.</p> <p>Interview with the QMRP and review of the in-service training log on June 24, 2009 at approximately 11:15 AM revealed, the facility failed to ensure five (5) out of twenty-four (24) staff (Staffs #2, #3, #20, #21, and #22) received training on Client #1 nutritional recommendations.</p> <p>{W 263} 483.440(f)(3)(ii) PROGRAM MONITORING & 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>	W 189	<p>4. See response to #3 above.</p> <p>See response to W 124.</p>	<p>7/17/09</p> <p>7/17/09</p>
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{W 263}	<p>Continued From page 14</p> <p>The findings include:</p> <p>The facility was cited during the previous survey (May 28, 2009) for failing to ensure informed consent were obtained prior to the use of psychotropic medications and the implementation of Behavior Support Plans. On June 22, 2009, the facility forwarded a Plan of Correction (POC) that reflected the Qualified Mental Retardation Professional (QMRP) would "contact the mother to provide written informed consent for his treatments".</p> <p>During the re-visit on June 24, 2009, the facility's system for obtaining informed consents was evaluated. Clients #3 and #4's records were reviewed. The clients were noted to receive psychotropic medications and had BSPs which included restrictive measures. On June 24, 2009, at approximately 12:05 PM, interview with the QMRP revealed that attempts were made to secure signed informed consents for the use of Client #3 and #4's psychotropic medications and Behavior Support Plans (BSPs). 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]</p> <p>W 473 483.480(b)(2)(ii) MEAL SERVICES</p> <p>Food must be served at appropriate temperature.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that food was served at the appropriate temperature for one of two clients in the sample. (Clients #1)</p>	{W 263}	<p>Staff who provide inappropriate food service will be disciplined and retrained.</p>	<p>7/17/09</p>
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W 473	<p>Continued From page 15</p> <p>The finding includes:</p> <p>On June 24, 2009 upon entering the group home at 7:03 AM, several plates of food were observed on the table. At approximately 7:18 AM, the food on the table remained. At 7:54 AM, (51 minutes later), the direct care staff was observed to wheel Client #1 out of his bedroom to the dining room table. The food items on the plate included pureed scrambled eggs, grits and whole wheat bread. Further observation revealed the staff begin to feed Client #3 with hand over hand assistance with his breakfast. At no time prior to the client eating his breakfast was the staff observed to reheat the client's meal.</p>	W 473		
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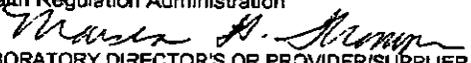
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{R 000}	<p>INITIAL COMMENTS</p> <p>A follow-up survey was conducted on June 24, 2009 to determine the facility's compliance with the previously condition level deficiencies cited on May 28, 2009. A random sample of two clients was selected from a residential population of four males with various disabilities.</p> <p>The findings of the survey were based on observations in the group home, interviews with the facility's management and staff and a review of records, including unusual incident reports, investigations and administrative records.</p>	{R 000}		
{R 125}	<p>4701.5 BACKGROUND CHECK REQUIREMENT</p> <p>The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check.</p> <p>This Statute is not met as evidenced by: Based on interview and review of personnel records, the GHMRP failed to ensure criminal background checks for all jurisdictions where the employee resided or was employed within the seven (7) years prior to the background check for seven (7) of the twenty-four (24) direct care staff.</p> <p>The finding includes:</p> <p>The GHMRP was previously cited during the May 28, 2009 survey for not ensuring all staff received criminal background checks based on all the jurisdictions where they previously lived and worked within the past seven (7) years. The GHMRP's written Plan of Correction indicated the</p>	{R 125}	See response to federal deficiency W104 #2.	7/17/09

Health Regulation Administration  LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE Director of Disability Fees	(X6) DATE 7/14/09
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(R 125)	<p>Continued From page 1</p> <p>deficient practice would be corrected by June 22, 2009.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) and a review of the personnel files on June 24, 2009, at approximately 5:00 PM revealed, the criminal background checks for fourteen (14) out of twenty-four (24) staff (Staff #6, #7, #9, #10, #11, #14, #13, #17, #18, #19, #20, # 21, and #24) did not reflect a full review of the jurisdictions in the state(s) where they currently reside or work on file.</p>	(R 125)		
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{I 000}	<p>INITIAL COMMENTS</p> <p>A follow-up licensure survey was conducted on June 24, 2009 to determine the facility's compliance with the previously condition level deficiencies cited on May 28, 2009. A random sample of two residents was selected from a residential population of four males with various disabilities.</p> <p>The findings of the survey were based on observations in the group home, interviews with the facility's management and staff and a review of records, including unusual incident reports, investigations and administrative records.</p>	{I 000}		
{I 206}	<p>3509.6 PERSONNEL POLICIES</p> <p>Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that each employee, prior to employment and annually thereafter, provided evidence of a physician's certification that documented a health inventory had been performed and that the employee's health status would allow him or her to perform the required duties, for eight (8) of the twenty-four (24) staff records reviewed. (Staff #2, #7, #8, #11, #12, #13, #14, #15, #17, #18, #19 and #23)</p> <p>The findings include:</p>	{I 206}	<p>See response to federal deficiency W104 #2. The audit will reveal which staff do not have required health certificates. The facility is entering this personnel data into an electronic data management system that will flag management prior to the expiration of documents required for staff to provide direct services to clients. Staff will be notified that they must complete the requirements or be removed from the work schedule until they are in compliance.</p>	7/31/09

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{I 206}	<p>Continued From page 1</p> <p>The GHMRP was previously cited during the May 28, 2009 revisit for failing to ensure all active staff received an updated annual health certificate.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) and review of the personnel records on June 24, 2009 at approximately 11:50 AM revealed no current health certificate was on file for twelve (12) of twenty-four (24) staff. (Staff #2, #7, #8, #11, #12, #13, #14, #15, #17, #18, #19 and #23).</p>	{I 206}		
I 223	<p>3510.4 STAFF TRAINING</p> <p>Each training program agenda and record of staff participation shall be maintained in the GHMRP and available for review by regulatory agencies.</p> <p>This Statute is not met as evidenced by: Based on staff interview and record review, the GHMRP failed to ensure all staff received training in the areas of Behavior and Incident Management to ensure the health and safety of all residents residing in the GHMRP. [Residents #1, #2, #3, and #4]</p> <p>The findings include:</p> <p>1. The facility was previously cited during the May 28, 2009 survey for failing to provide sufficient support staff to manage and supervise residents in accordance with their individual program plans (IPP).</p> <p>The facility's plan of correction (POC) dated June 22, 2009 indicated the QMRP would retrain all staff as needed on the job duties and responsibilities of providing one on one support. In addition, the corrective action provided for</p>	I 223	<p>See response to federal deficiency W189.</p>	<p>7/17/09</p>

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I 223	<p>Continued From page 2</p> <p>"immediate" disciplinary action for "all staff who repeats the behavior of moving beyond the distance outlined in a resident's behavior support plan (BSP)".</p> <p>During the re-visit on June 24, 2009, interview with the QMRP and record review of the personnel files at 11:32 AM revealed the facility failed to ensure eight (8) out of twenty-four (24) staff (Staff #1, #2, #4, #13, #20, #21, #23, and #24) received training on the job duties for one on one support.</p> <p>2. The facility was previously cited during the May 28, 2009 survey for failing to provide sufficient administrative oversight to ensure the effective implementation of the facility's Incident Management Policy (IMP).</p> <p>The facility's plan of correction (POC) dated June 22, 2009 indicated the QMRP would retrain all staff on the incident management policy and procedures.</p> <p>Interview with the QMRP and review of the inservice training log on 6/24/2009 at 11:21 AM revealed the facility failed to ensure nine (9) out of twenty-four (24) staff (Staff #1, #2, #18, #19, #20, #21, #22, #23, and #24) received training on the Incident Management Policy and Procedures.</p> <p>3. The facility was previously cited during the May 28, 2009 survey for failing to ensure staff was able to demonstrate competency in implementing a resident's behavior management plan.</p> <p>The facility's plan of correction (POC) dated June 22, 2009 detailed the QMRP would retrain all staff on each resident's behavior support plans (BSP).</p>	I 223		
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I 223	<p>Continued From page 3</p> <p>According to the POC, this corrective action should have been addressed by June 22, 2009. Interview with the QMRP and review of the in-service training log on June 24, 2009 at approximately 11:15 AM revealed, the facility failed to ensure five (5) out of twenty-four (24) staff (Staffs #2, #3, #20, #21, and #22) received training on the BSPs.</p> <p>4. The facility was previously cited during the May 28, 2009 survey for failing to ensure staff was able to demonstrate competency in implementing a nutrition recommendations for resident #1.</p> <p>The facility's plan of correction (POC) dated June 22, 2009 detailed the QMRP would retrain all staff on resident #1's nutritional recommendation to receive a pureed diet with increased fiber. The staff was to add pudding or apple sauce to the food for meal palatability. According to the POC, this corrective action should have been addressed by June 22, 2009.</p> <p>Interview with the QMRP and review of the in-service training log on June 24, 2009 at approximately 11:15 AM revealed, the facility failed to ensure five (5) out of twenty-four (24) staff (Staff #2, #3, #20, #21, and #22) received training on resident #1 nutritional recommendations.</p>	I 223		
{ 1500}	<p>3523.1 RESIDENT'S RIGHTS</p> <p>Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws.</p>	{ 1500}	<p>See response to federal CONDITION 102 and federal deficiency W104.</p>	7/17/09

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0230	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/24/2009
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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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{1 500}	<p>Continued From page 4</p> <p>This Statute is not met as evidenced by: Based on observations, interviews and record review, the GHMRP failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) that governs the care and rights of persons with mental retardation.</p> <p>The findings include:</p> <p>1. The governing body failed to effectively protect four of four residents and staff from potential harm as evidenced below:</p> <p>On June 24, 2009, a revisit was initiated to determine if the facility had employed sufficient safeguards to effectively protect the residents. The revisit revealed Resident #2's explosive and unpredictable behaviors continued to place the safety of the resident, his peers, and the facility's staff at risk.</p> <p>On June 24, 2009, beginning at 2:35 PM and ending at approximately 3:25 PM the following was observed:</p> <p>At 2:35 PM, Resident #2 was observed sitting in the dining room with two of his assigned one on one staff (one male, one female staff). In addition, the Qualified Mental Retardation Professional (QMRP), the Nurse and the House Manager was also seated at the dining room table. At approximately 2:40 PM, Resident #2 started using profane language and began to verbally threaten his male one on one staff. He picked up a broom from the kitchen and began to repeatedly threaten to hit the male one on one staff. He opened the front door and stormed out into the front yard. Both one on one staff and the</p>	{1 500}		

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<p>{1 500} Continued From page 5</p> <p>QMRP followed him out into the front yard. He made approximately four attempts to hit the male one on one staff with the broom. As the male one on one re-entered the front door, Resident #2 swung the broom toward him and just missed him. The broom hit the threshold of the door and broke into several pieces.</p> <p>The male one on one entered the facility and entered Resident #1's bedroom and shut the door. It should be noted that Resident #1, his one on one and the Residential Director were already in his bedroom with the door shut. During that time the QMRP and the female one on one were left alone to handle Resident #2's explosive behavior.</p> <p>Resident #2 was then observed to enter the kitchen and grabbed a knife from a kitchen drawer and threatened to "Kill" the female one on one staff person. He repeated, "Leave me alone. I don't want to talk to you!" He walked toward Resident #1's bedroom door and said, "Come on, Come on Bitch, I am going to kill you! You are not going to hurt me." The female one on one directed the QMRP to contact 911 for assistance. The QMRP picked up the phone and "signaled" to the female one on one that 911 had been contacted.</p> <p>Shortly after, Resident #2 walked towards the front door and opened the door. A male was standing in the door way. The QMRP acknowledged that the male at the door was Resident #2's one on one relief staff for the second shift. She further commented, "He always arrives to work early". The relief staff immediately attempted to redirect Resident #2 back into the group home. Resident #2 backed up with the knife in hand and repeated, "Tell that</p>	<p>{1 500}</p>		
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{I 500}	<p>Continued From page 6</p> <p>man to leave me alone. I [am] going to kill him! I [am] going stab him!" The relief staff redirected him and ignored his comments. He changed the subject and offered him something to drink with no success. Then he offered Resident #2 some jello pudding and he also refused.</p> <p>Again, Resident #2 opened the front door and both Residents #3 and #4 with their one on one staff entered the facility. As they entered, Resident #2 was standing in the doorway holding the knife in his right hand. The one on one seated both residents on the couch in direct line of Resident #2. The QMRP immediately intervened and redirected the staff to take Residents #3 and #4 up to the second level for their safety.</p> <p>Resident #2 was then observed to exit the facility with the knife in hand and went out to the front yard. The female one on one, the QMRP and the relief one on one followed him out into the front yard. He continued his rampage in the front yard using profanity and exhibiting threatening behaviors with the knife in his hand. He yelled, "You are not going to hurt me. I'll kill you. I'll stab you with this knife." Then he was observed to walk toward the sidewalk near the street out in front of the facility.</p> <p>At approximately 2:45 PM two police cruisers pulled up with lights and sirens blaring. The police officer in the cruiser closest to the resident got out of his cruiser first. Resident #2 lunged toward the officer with the knife. The police officer pulled out his pistol from the holster and pointed it towards Resident #2. The officer then shouted, "Drop the knife sir!, Drop the knife!" The QMRP started yelling repeatedly, "Don't shoot! Don't shoot! He has a disability! He has</p>	{I 500}		
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{I 500}	<p>Continued From page 7</p> <p>mental illness!" The officer continued to move toward Resident #2. Resident #2 began to walk away from the officer and down the sidewalk towards Eastern Avenue. Two additional police cruisers pulled up and one of the officers that exited his cruiser was tall and large in stature. The tall officer waved back the other two officers who were holding their pistols. He introduced himself to Resident #2 and asked him to surrender the knife. Resident #2 handed over the knife without incident and hugged the officer and laughed. Resident #2 walked over to another officer and gave him a hug as well. The four police officers escorted Resident #2 back into the group home. The officers completed the necessary paper work with the QMRP's assistance. Resident #2 was then hand-cuffed without incident and escorted to CPEP for emergency psychiatric treatment.</p> <p>2. The governing body failed to ensure that criminal background checks were obtained for all staff to ensure their ability to protect its residents 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. The written Plan of Correction, dated May 23, 2009 revealed the completion date for obtaining all police clearances was May 22, 2009.</p> <p>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.</p> <p>During the re-visit on June 24, 2009, review of the</p>	{I 500}		
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{I-500}	Continued From page 8 personnel records revealed there was no evidence that criminal background checks had been obtained for all the staff currently employed by the agency. During an interview with the QMRP on the same day at approximately 4:30 PM, she stated the records on hand were complete and current. Review of the plan of correction (POC) dated June 22, 2009 revealed that all staff's criminal background checks were on file in the management office. It should be further noted that at the time of the revisit, seven (7) of the twenty-four (24) staff cited during the previous survey, were still providing direct care services to the residents. Additionally, another 7 staff failed to have background checks that covered each jurisdiction where they previously lived and/or worked.	{I 500}			