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Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G225		03/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO	1776 VERBENA STREET, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 000	INITIAL COMMENTS On November 16, 2009, the State Surveying Agency (SSA) received written notification that Resident #1's one on one staff allegedly physically struck the resident with a belt. According to the report this incident was witnessed by two staff on two separate occasions. According to the report the License Practical Nurse (LPN) assessed the resident. A note in the action section of the incident report revealed the results of the nurses assessment as, "One old scratch on his clavicle bone. No redness or open areas noted, no distress or swelling noted." An on-site investigation was initiated on March 1, 2010, at 9:05 a.m., to follow up and to verify compliance with the local regulatory requirements. The results of this investigation were based on observation at the group home, interviews with the senior management, the Qualified Mental Retardation Professional (QMRP), the facility's nursing staff and direct care staff. Also, findings were based on the review of the resident's habilitation records, medical records, and administrative records, including the review of the facility's incident management reporting system.	I 000	Received 6/1/10 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL STREET, 9TH FLOOR WASHINGTON, D.C. 20002	
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on staff interviews, and record review, the facility's staff failed to ensure scheduled training for all personnel was implemented to protect one of six residents health and safety. (Resident #1)	I 222		

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Maybe A. Thompson TITLE: Director of Disability Services (X6) DATE: 8/26/2010

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I 222	Continued From page 1 The findings include: The facility failed to ensure that staff training on the incident management policies and procedures were implemented to protect Resident #1 from abuse and neglect as evidenced by the following: On November 16, 2009, the State Surveying Agency (SSA) received written notification that Resident #1's one on one staff physically struck the resident with a belt on several occasions. According to the incident report, the incident of abuse occurred on November 14, 2009 and was witnessed by two direct care staff on separate occasions. Interview with the Qualified Mental Retardation Professional (QMRP) on March 1, 2010, at approximately 10:50 a.m., revealed that she interviewed Staff #1 and requested a written statement of her observation. Review of Staff #1 written statement showed evidenced the following sequence of events on the day of the alleged abuse incident: a. Staff #1 observed that the assigned one on one staff for Resident #1 was not in close proximity as established by his one on one protocol. The one on one staff assigned to Resident #1 was observed in the kitchen washing dishes at 9:00 am on the day of the alleged abuse. Resident #1 was left alone in his bedroom with his door ajar. The one on one staff repeatedly walked back and forth from the kitchen to the bedroom. Staff #1 asked the one on one staff why he was leaving the resident alone. The 1:1 replied by stating, "[The resident] will be all right".	I 222	All staff are trained initially and on a continuous on-going schedule as required by regulation and Careco's policy. As noted on page 5 of 8, second paragraph, evidence of training specific to abuse and neglect as well as incident reporting, was provided to the staff on October 22 and 23, 2009, approximately three weeks prior to the incident of abuse, and the staff failed to implement their training by immediately reporting an incident of abuse. As a result, the Residence Director was terminated, the staff person who was accused of the abuse was placed on administrative leave and later terminated, and other staff were disciplined and/or retrained per Careco's policy. Careco will continue to implement our training, quality assurance, abuse/neglect, incident management, and other policies as written. Careco will continue to recruit and hire staff who can demonstrate competency on the written and verbal examinations, thereby reducing the potential of harm to people served.	5/26/10

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I 222	Continued From page 2 Staff #1 encouraged the one on one staff to leave the dishes for later and return to Resident #1's bedroom. b. According to Staff #1 at approximately 9:50 a.m. , while assisting another client in the bathroom near the bedroom of Resident #1, staff heard slapping sounds. Reportedly, the sounds were coming from Resident #1's bedroom and she went to check it out. The staff went into the resident's bedroom and observed the resident in his bed "curled up in fetal position". His bed was pushed against the wall. Staff #1 asked the one on one staff about the slapping sound. The one on one staff reportedly responded, Resident #1 slapped himself. Staff #1 stated that she became very suspicious of the answer he had given her. c. Staff #1 went to discuss her uneasiness about the one on one staff with Staff #2. Staff #1 and Staff #2 agreed to keep an eye on Resident #1. They also agreed to keep a close watch on the one on one to determine if the resident was being abused. According to Staff #1, she was concerned with falsely accusing the one on one when she had not personally witnessed Resident #1 being abused. d. Staff #1 went back into Resident #1's bedroom approximately 10:30 a.m. and the resident was still in his bed. The one on one staff was observed laying on the floor in the corner of the bedroom on a comforter. According to Staff #1 she called the resident by name. Reportedly, Resident #1 responded by saying "Cookie" and raised up to get out of his bed. After hearing the residents' request for a cookie, the one on one stood to his feet and demanded Resident #1 to remain in his bed in a "gruff voice". The one on one further commented, "Lay back in the bed and	I 222		

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I 222	Continued From page 3 shut your mouth". At this time the staff attempted to leave Resident #1's bedroom. Staff #1 stopped and look over her shoulder and observed the one on one staff hit Resident #1 with a black belt three times. e. Staff #1 informed Staff #2 of her observations. Staff #1 stated that she would contact the Residential Director, however, failed to do so. According to Staff #1, she felt that she needed to be discreet. Staff #1 was not sure if the one on one staff may overreact to her reporting her observations to management. f. At lunch approximately 12:45 p.m. (2 hours and 15 minutes after the initial abuse observed by Staff #1), Staff #3 came to Staff #1 and stated, "That man is beating the crap of [the resident]". Staff #1 responded by raising her hands to the ceiling and said "Thank you Lord! Some one else has witnessed abuse." Staff #1 communicated her observations to Staff #3. Staff #1 then proceeded to the basement to notify the Residential Director(RD) by telephone. Reportedly, Staff #1 and Staff #2 wrote an incident report at approximately 1:50 p.m. and attempted to faxed it to the corporate office. The fax transmittal did not get through successfully. They both placed the copies inside the staff box in the basement before leaving the shift. The RD did not come to the facility or communicate to the one on one staff after being notified of the abuse. The one on one staff remained on duty until the end of his shift (3:00 PM) and left the facility. Further interview with the QMRP on March 1, 2010, at approximately 11:00 a.m., revealed that the staff failed to notify appropriate management in accordance with the agency's policy and	I 222		

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I 222	Continued From page 4 procedures. The facility failed to ensure that Resident #1 was protected from abuse by his assigned one on one staff. According to the QMRP once the Residential Director was notified, the one on one staff should have been immediately removed from the facility and taken off the schedule in order to protect the resident from further abuse. Review of the in-service training log on March 1, 2010, at approximately 1:50 p.m. revealed that all facility staff were provided training October 22 and 23, 2009 on the reporting of abuse and neglect incidents and the management notification hierarchy. Further review of the sign in sheet for the training revealed that the one on one staff, Staff #1 and #3 as well as the Residential Director all had participated in the training. Although, the above mentioned staff participated in scheduled incident training, the staff failed to implement the incident policy and procedures.	I 222		
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by:	I 379	As noted in the deficiency report on page 6 of 8, paragraph 4, the QMRP made the DOH/HRLA aware of the incident of abuse within 24 hours of it being reported to her. See response to I 222.	5/26/2010

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I 379	Continued From page 5 Based on staff interviews and record review, the facility failed to ensure that all incidents were reported within 24 hours to the Department of Health (DOH) for one of the six residents residing in the facility. (Resident #1) The finding includes: The facility failed to ensure the alleged abuse of Resident #1 was reported to the Department of Health within 24 hours as evidenced below: On November 16, 2009, the State Surveying Agency (SSA) received written notification that Resident #1's one on one staff physically struck the resident with a belt on November 14, 2009. This incident was witnessed by Staff #1. A second incident of abuse was reported by Staff person #3. On March 1, 2010 at approximately 10:45 a.m. interview with the QMRP revealed that the Staff #1 and Staff #3 reported the incident of abuse to the Residence Director (RD) on November 14, 2009. However; further interview with the QMRP revealed that the RD did not make her aware of this incident until late in the afternoon on November 15, 2009 (24 hour later). According to the QMRP the RD failed to communicate the abuse incident on the same day to the next level of management as required by the agency's incident management policy and procedures. It should be noted, that as a result, the one on one staff was not immediately removed from facility to ensure that Resident #1 was protected from ongoing abuse by the 1:1. The agency failed to protect Resident #1's from further abuse. The agency allowed the one on one staff to work his entire shift, however the RD was notified by	I 379		

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I 379	Continued From page 6 the staff on duty but failed to use her management authority to take the 1:1 off the schedule and replace him with another staff. Review of the 1:1 staff's personnel file revealed that he was not formally placed on administrative leave until November 16, 2009 (two days after the reported incident). Additionally, the QMRP stated that that the RD was also placed on administrative leave for failing to implement the incident notification procedures as outlined in the agency's policy on abuse and neglect.	I 379		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observations, interviews and record review, the GHMRP failed to 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 for one of the six residents residing in this facility. (Resident #1) The finding includes: [Chapter 19 - 6-1970] Mistreatment, neglect or abuse prohibited.... (e) Alleged instance of mistreatment, neglect or abuse of any customer shall be reported immediately to the Director.....	I 500		

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I 500	Continued From page 7 On November 16, 2009, the State Surveying Agency (SSA) received written notification that Resident #1's one on one staff physically struck the resident with a belt on November 14, 2009. According to the incident report, two staff witnessed abuse of Resident #1 on separate occasions. On March 1, 2010, at approximately 11:30 a.m., interview with the QMRP revealed that the incident was not reported to the Director or the Department of Health in accordance with the agency incident policy. The facility's staff failed to ensure that Resident #1 was protected from abuse by his assigned one on one staff. According to the QMRP the Residential Director was notified on the same day of the incident (November 14, 2009), however, failed to notify upper level management and to remove the one on one staff from facility to protect the resident from further abuse.	I 500	See responses to I 222 and I 379.	3/26/2010