

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

PRINTED: 07/16/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G224	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R 06/29/2009
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NAME OF PROVIDER OR SUPPLIER  CARECO	STREET ADDRESS, CITY, STATE, ZIP CODE 505 1/2 57TH STREET NE WASHINGTON, DC 20019
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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

The Health Regulation Licensing Administration (HRLA) received a report via email on June 1, 2009, from University Legal Services (ULS) monitoring team. Attached to the email was a report dated April 19, 2009 of an onsite visit completed by their team which alleged that "Evans Class" members were at risk, as described below:

- (1) Staff are not implementing a class members dining protocol correctly, placing him at risk of choking;
- (2) Staff have limited knowledge of the class members' significant health risks;
- (3) Staff have limited knowledge of the class members' behavioral support plans;
- (4) Staff are not adequately implementing class members' behavioral support plans;
- (5) Staff are not offering a class member the opportunity to ambulate as recommended;
- (6) A class member is not wearing TED stockings or knee braces as ordered;
- (7) Staff are not offering the class member activities;
- (8) Staff are placing the residents in bed in the afternoon for extended periods of time;
- (9) The provider is not providing the class members with an adequate number of community outings;

{W 000}

Received 7/27/09

GOVERNMENT OF THE DISTRICT OF COLUMBIA  
DEPARTMENT OF HEALTH  
HEALTH REGULATION ADMINISTRATION  
825 NORTH CAPITOL ST., N.E., 2ND FLOOR  
WASHINGTON, D.C. 20002

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Marta H. Thomas</i>	TITLE Director of Disability Service	(X6) DATE 7/27/09
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting provided 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}	Continued From page 1 (10) Staff interviewed was not adequately familiar with the class members' significant health risks  A follow-up survey was conducted from June 27, 2009 through June 29, 2009 to determine the facility's compliance with the previous standard level deficiencies cited on May 8, 2009, and to verify corrective actions as indicated on the Plan Of Corrections dated June 18, 2009.  A random sample of two original clients and two new clients were selected from a population of seven males with various degrees of disabilities. The findings of the survey were based on observations in the group home, interviews with the facility staff, review of the ULS findings, and review of records, including unusual incident reports, investigations and administrative records.  The June 29, 2009 survey findings revealed the facility met substantial compliance with the May 8, 2009 citations cited however, continued standard level deficiencies were cited. The following two out of the ten concerns identified by ULS were substantiated as follows:  (a) The facility failed to ensure that all staff had received training on Clients #1 and #4 Behavior Support Plan (BSP).  (b) The facility failed to ensure that the direct care staff implemented Client #5's picture communication book as recommended by the Speech and Language Pathologist.	{W 000}			
{W 159}	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL  Each client's active treatment program must be integrated, coordinated and monitored by a	{W 159}			

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CARECO

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WASHINGTON, DC 20019

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{W 159}	<p>Continued From page 2</p> <p>qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by: Based on observations, interview and record review, the facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP), for three of seven clients residing in the facility. (Clients #3, #5 and #6)</p> <p>The finding includes:</p> <p>1. The QMRP failed to ensure that the day program was made aware of Client #3's prescribed plate guard to assist with feeding as evidenced below:</p> <p>The QMRP was cited during the May 8, 2009 survey for failing to ensure that the day program was made aware of Client #3's prescribed plate guard to assist with feeding. The facility forwarded a Plan of Correction (POC) dated June 8, 2009, that reflected the QMRP will make at least a monthly visit to each client's day program, and will assist the Residence Director (RD) to also make at least a monthly visit.</p> <p>On June 29, 2009, at approximately 3:30 PM, interview with the QMRP revealed that she had not visited and/or addressed Client #3's prescribed plate guard concerns with the day program. Further interview with the QMRP revealed that she was waiting for a new assessment to be conducted by another assigned Occupational Therapist.</p> <p>2. The QMRP failed to coordinate services with</p>	{W 159}	<p>1. The QMRP will visit the day program and provide evidence of the visit to the Director of Disability Services. The QMRP will develop and provide a schedule of planned visits to the day program to be completed by both the QMRP and the Residential Director, and will provide a note of such visits in the electronic data management system the facility uses. The QMRP will order the required equipment from the adaptive equipment/assistive technology catalog and provide evidence of the order. The QMRP will ensure that the equipment is approved by the Human Rights Committee prior to use. The Director of Disability Services will request information from the Department on Disability Services and other sources for leads on a new Occupational Therapist.</p>	7/31/09

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{W 159}	<p>Continued From page 3</p> <p>the nutritionist and the physician for Client #6 to ensure he received his recommended diet.</p> <p>The QMRP failed to ensure the nutritionist coordinated with the physician to ensure Client #6 received the recommended diet.</p> <p>On June 27, 2009, at 12:02 PM, Client #6 was observed eating a regular diet consisting of a chicken sandwich, chef salad, pineapples and milk. On June 29, 2009 at 5:44 PM, Client #6 was observed eating a regular diet consisting of salmon, rice, mixed vegetables and grape juice.</p> <p>Record review of the Physician's Orders dated June 1, 2009, on June 29, 2009 at 4:00 PM, revealed the Client #6 was prescribed 1500 calorie diet. Review of the nutritional assessment dated April 2, 2009, at 4:10 PM, revealed that Client #6's diet was changed from a 1500 calorie diet to a regular diet.</p> <p>Interview with the QMRP on June 29, 2009, at approximately 4:15 PM confirmed that the physician was not aware of the nutritionist recommendation.</p>	{W 159}	<p>2. The QMRP will provide the Primary Care Physician with a copy of the regular diet recommended by the Nutritionist. If the PCP approves, the diet will be continued. The QMRP will ensure that all clinical recommendations for each person in the home are listed in one document and provided to the Director of Disability Services and to the Primary Care Physician for approval. The Director of Quality Management will ensure that staff are trained to implement approved goals, and that restrictive measures are brought before the Human Rights Committee for approval prior to implementation.</p>	8/15/09
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W 189	<p>3. The QMRP failed to ensure that each employee had been provided with training that enables the employee to perform his or her duties effectively, efficiently and competently. [See W189]</p> <p>483.430(e)(1) STAFF TRAINING PROGRAM</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>	W 189	<p>3. See response to W 189.</p>	7/31/09
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W 189	<p>Continued From page 4</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure each employee was provided initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently for three of four clients in the sample. (Clients #1, #4, and #5)</p> <p>The findings include:</p> <p>1. The facility failed to ensure that all staff had received training on Clients #1 and #4 Behavior Support Plan (BSP) as evidenced below:</p> <p>On June 1, 2009, Health Regulation Licensing Administration (HRLA) received a report dated April 19, 2009 via e-mail from University Legal Services (ULS). The report reflected that staff had limited knowledge of Clients #1 and #4 BSP.</p> <p>a. On June 27, 2009, between 9:17 AM to 9:41 AM, Staff #1 was observed interacting with Client #1 by shaking his hand, encouraging the client to say hi, and talking about the television show. Staff #1 provided verbal praise to Client #1 when he responded with a moaning sound.</p> <p>At 9:51 AM, interview with Staff #1 revealed that he had been working at the facility approximately one month. When asked about Client #1's BSP, Staff #1 stated that he was unsure if the client had one. Staff #1 further stated that he had not seen any behaviors and was not aware of any targeted behaviors (i.e. screaming, hitting self in head) for Client #1. Staff #1 indicated that he had not received training on Client #1's BSP.</p>	W 189	<p>1. The QMRP will ensure that each staff person's orientation includes training on every client's ISP, to include the BSP. The QMRP is to ensure that evidence of the training is recorded in the staff person's personal training record book and is faxed to the administrative office to be included in the staff person's personnel record. The Director of Quality Management will follow up within one week of each general staff orientation to ensure that the in-home orientation is completed and placed in the record. The QMRP will ensure that each staff nurse receives training on the clients' ISPs and BSPs, and that evidence of such training is maintained in the facility's training record book. The Director of Quality Management will review the training record monthly for the next 90 days to ensure that this routine is completed.</p>		

8/15/09

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W 189	<p>Continued From page 5</p> <p>On June 29, 2009 at 4:58 PM, review of the staff in service training book confirmed that Staff #1 had not received training Client #1's BSP.</p> <p>b. On June 17, 2009, at approximately 10:30 AM, interview with the Qualified Mental Retardation Professional (QMRP) revealed that Staff #1 was assigned to work with Client #4 as his 1:1 for approximately three hours (time not specified). At 3:57 PM, additional interview with Staff #1 revealed that Client #4 had a BSP. When asked about his maladaptive behaviors, Staff #1 stated that he had only observed Client #4 fall to the floor during behaviors. Staff #1 stated that he had not received any formal training on Client #4's BSP prior to working with him. Review of the staff in service training records on June 29, 2009 at 5:00 PM, confirmed that Staff #1 had not received training on Client #4's BSP.</p> <p>c. Similarly, interview with Licensed Practical Nurse (LPN) at 12:02 PM, revealed that she had been working every other weekend at the facility for approximately eight (8) months. Further interview with the LPN revealed that she had not received formal/informal training on Client #1's BSP. Review of the staff in service training book on June 29, 2009 at 5:02 PM, confirmed that the LPN had not received training Client #1's BSP.</p> <p>2. The facility failed to ensure that the direct care staff received training on implementing Client #5's picture communication book as recommended by the Speech and Language Pathologist as evidenced below:</p> <p>On June 27, 2009, at 9:15 AM, Staff #2 was observed asking questions and conversing with Client #5 while putting a puzzle together. Further</p>	W 189			
			2. See response to deficiency W 159 #2 and W 189 #1.	8/15/09	

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W 189	<p>Continued From page 6</p> <p>observation at 10:30 AM revealed Staff #2 asking questions and conversing with Client #5 as they played connect four. Client #5 was not given the choice or opportunity to answer Staff #2's questions during the aforementioned activities.</p> <p>Record review conducted on June 29, 2009, at 12:50 PM, revealed a Speech and Language Assessment dated December 12, 2008. The evaluation recommended that staff provide Client #5 with "ongoing opportunities for choice making, exposure to a picture communication book and a voice output device to enhance his oral communication skills."</p> <p>On June 29, 2009, at approximately 3:00 PM, interview with the House Manager (HM) revealed that training was conducted on Client #5's picture communication book on June 4, 2009. Further interview with the HM revealed that Staff #2 did not attend the training on Client #5's picture communication book.</p>	W 189			

Health Regulation Administration

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{1 000}	<p><b>INITIAL COMMENTS</b></p> <p>The Health Regulation Licensing Administration (HRLA) received a report via email on June 1, 2009, from University Legal Services (ULS) monitoring team. Attached to the email was a report dated April 19, 2009 of an onsite visit completed by their team which alleged that "Evans Class" members were at risk, as described below:</p> <ul style="list-style-type: none"> <li>(1) Staff are not implementing a class members dining protocol correctly, placing him at risk of choking;</li> <li>(2) Staff have limited knowledge of the class members' significant health risks;</li> <li>(3) Staff have limited knowledge of the class members' behavioral support plans;</li> <li>(4) Staff are not adequately implementing class members' behavioral support plans;</li> <li>(5) Staff are not offering a class member the opportunity to ambulate as recommended;</li> <li>(6) A class member is not wearing TED stockings or knee braces as ordered;</li> <li>(7) Staff are not offering the class member activities;</li> <li>(8) Staff are placing the residents in bed in the afternoon for extended periods of time;</li> <li>(9) The provider is not providing the class members with an adequate number of community outings;</li> <li>(10) Staff interviewed was not adequately familiar</li> </ul>	{1 000}		

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *March A. Stump* TITLE *Director of Disability Services* (X6) DATE *7/27/09*

STATE FORM 6888 SROV12 If continuation sheet 1 of 7

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## Health Regulation Administration

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{1 000}	Continued From page 1  with the class members' significant health risks  A follow-up survey was conducted from June 27, 2009 through June 29, 2009 to determine the facility's compliance with the previous standard level deficiency cited on May 8, 2009, and to verify corrective actions as indicated on the Plan Of Corrections dated June 18, 2009.  A random sample of two original residents and two new residents were selected from a population of seven males with various degrees of disabilities. The findings of the survey were based on observations in the group home, interviews with the facility staff, review of the ULS findings, and review of records, including unusual incident reports, investigations and administrative records.  The June 29, 2009 survey findings revealed the facility met substantial compliance with the May 8, 2009 citations cited however, continued standard level deficiencies were cited. The following two out of the ten concerns identified by ULS were substantiated as follows:  (a) The facility failed to ensure that all staff had received training on Residents #1 and #4 Behavior Support Plan (BSP).  (b) The facility failed to ensure that the direct care staff implemented Resident #5's picture communication book as recommended by the Speech and Language Pathologist.	{1 000}			
{1 091}	<b>3504.2 HOUSEKEEPING</b>  Housekeeping and maintenance equipment shall be well constructed, properly maintained and appropriate to the function for which it is to be	{1 091}			

Health Regulation Administration

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{1091}	<p>Continued From page 2 used.</p> <p>This Statute is not met as evidenced by: Based on observations and interview, the GHRMP failed to maintain the interior and exterior of the GHMRP in a safe, clean, orderly, attractive, and sanitary manner.</p> <p>The findings include:</p> <p>The GHMRP was cited during the May 8, 2009 survey for the carpet in the living room area located near the sofa nearest the front door, to have a two and half foot tear. The tear presented a potential trip hazard. On June 8, 2009, the facility forwarded a Plan of Correction (POC) that reflected that maintenance will replace the damage carpet.</p> <p>Observation and interview with the Qualified Mental Retardation Professional (QMRP) on June 29, 2009, acknowledged that the carpet had not been replaced.</p>	{1091}	<p>The Director of Operations will follow up with the maintenance team to ensure the carpet is repaired or replaced. The Director of Disability Services will follow up with the QMRP and the Director of Operations to ensure that the repair or replacement is completed.</p>	8/15/09
1222	<p><b>3510.3 STAFF TRAINING</b></p> <p>There shall be continuous, ongoing in-service training programs scheduled for all personnel.</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview and record review, the GHRMP failed to ensure that each employee had been provided with training that enables the employee to perform his or her duties effectively, efficiently and competently for three of four clients in the sample. (Residents #1, #4, and #5)</p> <p>The findings include:</p>	1222		

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I 222	Continued Form page 3  1. The GHRP failed to ensure that all staff had received training on Residents #1 and #4 Behavior Support Plan (BSP) as evidenced below:  On June 1, 2009, Health Regulation Licensing Administration (HRLA) received a report dated April 19, 2009 via e-mail from University Legal Services (ULS). The report reflected that staff had limited knowledge of Clients #1 and #4 BSP.  a. On June 27, 2009, between 9:17 AM to 9:41 AM, Staff #1 was observed interacting with Resident #1 by shaking his hand, encouraging the client to say hi, and talking about the television show. Staff #1 provided verbal praise to Resident #1 when he responded with a moaning sound.  At 9:51 AM, interview with Staff #1 revealed that he had been working at the facility approximately one month. When asked about Client #1's BSP, Staff #1 stated that he was unsure if the client had one. Staff #1 further stated that he had not seen any behaviors and was not aware of any targeted behaviors (i.e screaming, hitting self in head) for Client #1. Staff #1 indicated that he had not received training on Client #1's BSP.  On June 29, 2009 at 4:58 PM, review of the staff in service training book confirmed that Staff #1 had not received training Resident #1's BSP.  b. On June 27, 2009, at approximately 10:30 AM, interview with the Qualified Mental Retardation Professional (QMRP) revealed that Staff #1 was assigned to work with Resident #4 as his 1:1 for approximately three hours (time not specified). At 3:57 PM, additional interview with Staff #1 revealed that Resident #4 had a BSP. When	I 222	1. See response to federal deficiency W189.	8/15/09

Health Regulation Administration  
STATE FORM

6888

SROV12

If continuation sheet 4 of 7

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FORM APPROVED

## Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0248	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R 06/29/2009
NAME OF PROVIDER OR SUPPLIER  CARECO		STREET ADDRESS, CITY, STATE, ZIP CODE 505 1/2 57TH STREET NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 222	<p>Continued From page 4</p> <p>asked about his maladaptive behaviors, Staff #1 stated that he had only observed Resident #4 fallen to the floor during behaviors. Staff #1 stated that he had not received any formal training on Resident #4's BSP prior to working with him.</p> <p>c. Similarly, interview with Licensed Practical Nurse (LPN) at 12:02 PM, revealed that she had been working every other weekend at the facility for approximately eight (8) months. Further interview with the LPN revealed that she had not had formal/informal training on Resident #1's BSP. Review of the staff in service training book on June 29, 2009 at 5:00 PM, confirmed that the LPN had not received training Resident #1's BSP.</p> <p>2. The facility failed to ensure that the direct care staff received training on implementing Resident #5's picture communication book as recommended by the Speech and Language Pathologist is evidenced below:</p> <p>On June 27, 2009, at 9:15 AM, Staff #2 was observed asking questions and conversing with Resident #5 while putting a puzzle together. Further observation at 10:30 AM revealed the Staff #2 asking questions and conversing with Resident #5 as they played connect four. Resident #5 was not given the choice or opportunity to answer Staff #2's questions during the aforementioned activities.</p> <p>Record review conducted on June 29, 2009, at 12:50 PM, revealed a Speech and Language Assessment dated December 12, 2008. The evaluation recommended that staff provide Resident #5 with "ongoing opportunities for choice making, exposure to a picture communication book and a voice output device to</p>	I 222	<p>2. See response to federal deficiency W189.</p>	8/15/09

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1222	Continued From page 5 enhance his oral communication skills."  On June 29, 2009, at approximately 3:00 PM, interview with the House Manager (HM) revealed that training was conducted on Resident #5's picture communication book on June 4, 2009. Further interview with the HM revealed that Staff #2 did not attend the training on Resident #5's picture communication book.	1222		
{1379}	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 arrangements, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day.  This Statute is not met as evidenced by: Based on interview and review of incident reports and resident records, the GHMRP failed to ensure that all incidents that presented a risk to residents' health or safety were reported immediately to the Department of Health (DOH), Health Regulation Administration, for one of the four residents in the sample. (Resident #6)  The finding includes:  The survey completed on May 8, 2009, outlined systemic issue for reporting significant incidents to DOH timely. The written Plan of Correction (POC) dated June 8, 2009 alleged that the	{1379}	Interview with the IMC indicates that she reported the incident via telephone to DOH within the timeframe approved within regulation.	7/31/09

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(I 379)	<p>Continued From page 6</p> <p>Quality Management Director will ensure that all incidents are reported to DOH per regulations. On June 27, 2009, at 9:25 AM, review of the GHRMP unusual incident report log book revealed no incidents had occurred since the last survey date: May 8, 2009.</p> <p>At approximately 2:31 PM, interview with the Qualified Mental Retardation Professional (QMRP) and Licensed Practical Nurse (LPN) revealed Resident #8 was transported via the GHMRP van to the hospital emergency room on June 12, 2009 due to being lethargic and walking with an unsteady gait. Further interview with the QMRP revealed that the resident was admitted June 12, 2009 and discharged on June 15, 2009. On June 29, 2009, at approximately 10:00 AM, review of the nursing notes and review of the hospital discharge transfer summary dated June 15, 2009, revealed Resident #8 discharge diagnoses included drowsiness, most likely related to medication (Ambien), which is resolved, Ataxia, improve gait now, and acute encephalopathy, resolved.</p> <p>Further interview with the QMRP revealed that the incidents reports were forwarded to the GHMRP Incident Management Coordinator (IMC). The QMRP stated that the IMC was responsible for forwarding all significant incidents to DOH. There was no evidence that the aforementioned ER visit and hospitalization had been reported to DOH/HRA.</p> <p>This is a repeat deficiency.</p>	(I 379)		