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

PRINTED: 11/17/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G010		C 11/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 01	6417 KANSAS AVE, NE WASHINGTON, DC 20001

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W 000	INITIAL COMMENTS I. On October 2, 2008, at approximately 4:23 PM the State Agency (SA) was notified (via telephone) by the Residential Director (RD) that a client alleged being "choked" by a staff member. Additionally, the RD reported that all of the staff that were present at the time of the alleged abuse were placed on administrative leave. On October 17, 2008, the State Agency (SA) received an Unusual Incident Report (UIR) that documented the client' s allegation of abuse. According to the UIR, Client #1 reported to Direct Support Professional (DSP) #1 that "the big guy choked him and another guy held his legs." An onsite investigation was initiated on October 17, 2008, to verify compliance with federal regulatory requirements. During the investigation, the SA substantiated that Client #1 was physically abused by one or more staff persons. The SA determined that the facility failed to ensure systems were designed and implemented to make certain clients (Clients #1, #2, #3, #4, #5 and #6) were not subjected to physical abuse/neglect that posed a serious and immediate threat to their health and safety. The Administrator/Director of Operations was notified of the immediate jeopardy concerns on October 28, 2008, at approximately 9:45 AM. The findings of the investigation were based on observations at the group home and one day program, interviews with clients, group home and day program direct care staff, nursing and administrative staff, and review of client and administrative records; including incident reports. As a result of the findings, a determination was	W 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marsha H. Thompson
TITLE: Director of Disability Services
(X6) DATE: 12/9/08

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	Continued From page 1 made that the facility failed be in compliance with the Conditions of Participation requirements in Governing Body, Client Protections, Facility Staffing and Health Care Services as evidenced by: A) Residential and day program nursing staff failed to report the aforementioned alleged abuse. B) Six employees on duty at the time of the incident, that either committed, witnessed or had knowledge of the abuse, did not report the abuse as required by the facility' s policy and by federal and local regulations. C) Client # 1, Client # 3 and Client # 6's Behavior Support Plans (BSPs) documented requiring physical interventions if the clients ' behaviors placed them and/or others in immediate danger. The plans however, failed to identify specific restrictive techniques (used by staff) for managing physical aggression during a crisis. II. In addition to the on-site investigation, a monitoring survey was conducted on October 17, 2008, to determine the facility's continued compliance with the deficiencies cited during the recertification survey on February 8, 2008. The findings of the survey were based on observations, interviews and record review, as well as a review of client and administrative records, including incident reports. The result of the survey determined the facility failed to maintain compliance with all of the previously cited standard level deficiencies. III. An onsite visit was conducted on November 4,	W 000		

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W 000	Continued From page 2 2008, to ensure the facility implemented systems to remove the immediate jeopardy. These systems included: A) Residential staff were trained on immediately reporting allegations of abuse as required by the facility's policy and by federal and local regulations. B) Residential nursing staff were trained on immediately reporting allegations of abuse as required by the facility's policy and by federal and local regulations. C) Day program nursing and administrative staff were trained on immediately reporting allegations of abuse as required by the facility's policy and by federal and local regulations. D) At least one residential staff on each shift was trained on Non- violent Crisis Prevention Intervention (CPI) techniques for managing physical aggression. A determination was made on November 4, 2008 that sufficient systems had been implemented by the facility to alleviate the immediate threat to client' health and safety identified on October 17, 2008.	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:	W 102	See responses to W104, W122, W127, W147, and W149. The Governing Body will ensure that the facility continues to build upon and strengthen systems that failed to provide sufficient protections to clients in the facility, including ensuring that all nurses follow the incident management policy implementation steps, and by the Director of Disability Services reviewing all Careco policies governing health and safety for clients served, and revising them as needed. The Director of Disability Services will ensure staff are trained on policy revisions as needed. The QMRP will ensure that all staff receive additional training in implementation of behavior support plans, Non-violent Crisis Prevention Intervention, and incident management. The QMRP will establish a 4-hour staff rotation schedule for those clients whose behavioral needs require 1:1 staff supports.	12/10/08

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W 102	Continued From page 3 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 each clien ' s health and safety. [See also W122]	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. 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 and failed to ensure policies were developed to make certain day programs reported all allegations of abuse. 2. Cross Refer to W155. The governing body failed to ensure that systems were developed/implemented to make certain clients were protected from further potential abuse while an allegation of abuse was investigated. 3. Cross Refer to W189. The governing body failed to ensure systems were implemented to make certain each employee was provided with	W 104	1. See response to W149. The Governing Body will ensure that each day program that serves clients receives a copy of the incident management policy. The Governing Body has replaced the QMRP and RD who were responsible for the facility's safe operation (whose duties included selecting staff, monitoring their performance, and providing ongoing support and mentoring in all facility policies). All staff working in the facility have been retrained on incident reporting, and facility policies on the rights of individuals served, including prohibitions against abuse. The Day Program serving Client #1 was immediately trained on reporting and managing incidents per facility policy. 2. See response to W155.	12/10/08 12/10/08

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W 104	Continued From page 4 initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently. 4. Cross Refer to W368. The governing body failed to ensure systems were developed/implemented to make certain that any irregularities in the client' s drug regimens were reported to the prescribing physician. 5. Cross Refer to W381. The governing body failed to ensure systems were developed/implemented to make certain that medications were appropriately stored and secured.	W 104	3. See response to W189. The Governing Body ensured that initial training was provided; formal training was also provided on a periodic basis; staff were given resources for continued study. The Governing Body recruited, trained, and hired new staff and management to ensure that policies are properly implemented in the home. 4. The LPN will be retrained on following the physician's orders on use of medications. 5. See response to W381. The QMRP provided an incorrect answer, in that the facility did have a policy on medication delivery. The Governing Body will ensure that the policy is reviewed and updated if necessary. The Governing Body will ensure that the Pharmacy is made aware of the updated policy, and is also made aware of the inappropriate delivery practice of the PDP. The Governing Body will require the Pharmacy to follow the facility policy as written, per their contract.	12/10/08 12/10/08 12/10/08
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on interview and record review, the facility failed to ensure systems were designed/implemented to make certain clients were not subjected to physical abuse (See W127); failed to ensure that each client was provided with a vacation in vacation (See W147); failed to implement policies and procedures that ensured clients' health and safety (See W149); failed to ensure that all allegations of abuse were reported (See W153); failed to ensure that allegations of abuse were thoroughly investigated (See W154); failed to provide evidence that clients were protected from further potential abuse while an allegation of abuse was investigated (See W155); failed to report the results of all investigations to the administrator or	W 122	See responses to standard deficiencies W127, W147, W149, W153, W154, W155, W156, W189, and W193. The facility will continue to provide training to all staff persons on client rights and protections, and incident management, to ensure that clients are kept free from harm, and to the greatest extent possible, free from the potential for harm. The Governing Body has replaced the previous management of the facility have been with professionals who have been well trained in the facility's policies and requirements, and who will be physically present on various shifts to observe, mentor, and retrain staff as needed. The facility will also institute a policy of rotating 1:1 staff every two hours for people supporting clients with acute behavioral needs to provide relief and reduce the occurrence of "burnout" and frustration for the staff who are so assigned. The new management staff who have been assigned to the facility will set up a vacation for each of the clients who lives there to occur in the next 60 days; the Director of Disability	12/10/08

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W 122	Continued From page 5 designated representative within five working days of the incident (See W156); failed to ensure that each employee was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently (See W189); and failed to demonstrate competency in implementing each client ' s Behavior Support Plan (See W193). The effects of these systemic practices resulted in the failure of the facility to protect its clients and ensure their health and safety.	W 122	Services will review and revise facility policy on vacations as needed; the management staff of the facility will ensure that all clients are able to participate in at least one vacation annually. All staff who were either involved in the incident (See W153) or were aware of it and did not report it, were immediately suspended from client contact when the incident was reported, both for alleged abuse of client rights and for deliberate failure to report incidents, as they had been trained to do, per facility policy. All facility nurses and day program nurses (See W149) who did not either properly report the medical condition of the client to the Administrator or to the Physician will be retrained on facility policy protecting the health and safety of	
W 127	483.420(a)(5) PROTECTION OF CLIENTS RIGHTS 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. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that systems were designed and implemented to make certain clients were not subjected to physical abuse, for six of the six clients that resided in the facility. (Client #1, Client #2, Client #3, Client #4, Client #5 and Client #6) The findings include: On October 2, 2008, at approximately 4:23 PM the State Agency (SA) was notified (via telephone) by the Residential Director (RD) that a client alleged being " choked " by a staff member. Additionally, the RD reported that all of the staff that were present at the time of the alleged abuse were placed on administrative leave.	W 127	clients served. All staff and management in the facility will be retrained on Incident Management. The facility's "Whistle Blower" policy will be redistributed to each staff person in the facility – this policy affords protections to people who report an incident or other violation. The Governing Body has hired a new Incident Management Coordinator (IMC) with professional investigative credentials who will ensure that steps are taken to protect clients from harm or the potential from harm immediately, and that investigations are thorough and completed timely and provided to the Administrator. The Governing Body will ensure that staff are carefully vetted prior to hire, that initial training is provided in a thorough manner, and that facility management staff provide ongoing training to staff to enable them to perform duties effectively, efficiently and competently. The facility staff will ensure that all staff are trained on competently implementing each client's Behavior Support Plan. The Governing Body will ensure that the facility continues to build upon and strengthen systems that failed to provide sufficient protections to clients in the facility, including ensuring that all nurses follow the incident management policy implementation steps, and by the Director of Disability Services	12/10/08

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W 127	Continued From page 6 The aforementioned notification to the SA was verified on October 17, 2008, at approximately 11:10 AM through face to face interview with the Residential Director/Driver (RD/D). According to the RD/D, Direct Support Professional (DSP) #1 reported that Client #1 was abused on the 3:00 PM-11:00 PM shift (October 1, 2008). At which time, the RD/D immediately notified the Qualified Mental Retardation Professional (QMRP) about the allegation. The RD/D further revealed that Client #1 sustained a red bruise on the left side and scratches on his back as a result of the incident. Additionally, the RD/D disclosed that DSP #2 informed him that DSP #3 and DSP #4 beat up Client # 1. Interviews with the Residential Director (RD), QMRP, LPN #1, Client #1, DSP #1, and LPN #3 on October 17, 2008 further provided information regarding the previously mentioned allegation of abuse as detailed below: a) Interview with the RD at approximately 11:15 AM revealed that DSP #1 informed him that Client #1 reported he was "choked" by a staff person. Further interview revealed that on October 2, 2008, DSP #2, DSP #3, DSP # 4, DSP #5, DSP #6 and DSP #7 were placed on administrative leave. b) Interview with the QMRP at approximately 11:30 AM revealed that DSP #1 informed her that Client #1 reported he was attacked by three staff persons on October 1, 2008, " the big guy, DSP #4 and DSP #5." Continued discussion with the QMRP revealed she requested DSP #1 to have the client assessed by LPN #1 in order to determine if Client #1 needed to be evaluated at	W 127	reviewing all Careco policies governing health and safety for clients served, and revising them as needed. The Director of Disability Services will ensure staff are trained on policy revisions as needed. The QMRP will ensure that all staff receive additional training in implementation of behavior support plans, Non-violent Crisis Prevention Intervention, and incident management. The QMRP will establish a 4-hour staff rotation schedule for those clients whose behavioral needs require 1:1 staff supports.	12/16/08

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W 127	Continued From page 7 the hospital. Further interview with the QMRP revealed that the RD was requested to place DSP #2, DSP #3, DSP # 4, DSP #5, DSP #6 and DSP #7 on administrative leave on October 2, 2008. Additionally, the QMRP revealed that she made notifications regarding the allegation of abuse to the administrator, RN Supervisor, Adult Protective Services, DC Metropolitan Police Department and the Office of Inspector General (OIG) on that same day. c) Telephone interview with LPN #1 at approximately 11:58 AM revealed that on October 2, 2008, DSP #1 informed him that Client # 1 alleged he was "choked by the big guy." LPN #1 stated that Client #1 was observed to have "redness" on his upper chest and no other injuries. Further interview revealed that LPN #1 did not report the incident to the administrator or PCP. d) Interview with Client #1 at approximately 1:15 PM revealed that "the big guy choked me and pulled me to the floor, [DSP #4] grabbed my legs while the short guy kicked me in the side. I tried to tell him to get off me and not to put their hands on me. The other staff just watched them beat me up. I only told DSP #1 when she came on duty the next day. " e) Interview with DSP #1 on October 17, 2008, at approximately 1:25 PM revealed that Client #1 informed DSP #1 on October 2, 2008 at approximately 6:30 AM that "the big guy choked me on the floor and [DSP #4] held my legs while the short guy kicked me in the side." DSP #1 revealed that Client #1 had a bruise on the left side of his chest, two scratches on his neck and scratches on both sides of his back. Further	W 127		

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W 127	Continued From page 8 interview revealed that DSP #1 immediately informed the RD/D and the RD. f) Interview with the LPN #3 at Client #1' s day program at approximately 2:15 PM revealed that Client #1 and DSP #1 informed her that Client #1 was attacked and restrained by staff at the group home on October 1, 2008. LPN #3 stated that she observed scratches to Client #1's chest, face, neck and upper back. Further interview revealed that LPN #3 did not report the alleged abuse to the administrator because the incident occurred at the group home and not the day program. Review of the facility' s unusual incident reports on October 17, 2008; at approximately 7:00 PM revealed an incident involving Client #1 dated October 2, 2008. According to the report, DSP #1 was informed by Client #1 that " the big guy choked me and another guy held my legs." Additional interviews were conducted regarding the allegation of abuse involving Client #1 reported on October 2, 2008 as detailed below: Interview with the RN Supervisor on October 20, 2008 at approximately 12:25 PM revealed that on October 2, 2008, the QMRP informed her that Client # 1 alleged he was "choked by the big guy, held down on the floor and kicked" on October 1, 2008. Further interview with the RN Supervisor revealed that LPN #1 failed to report the allegation of abuse or injuries to the RN Supervisor. The RN Supervisor additionally stated that the Primary Care Physician (PCP) "would only be notified of an allegation of abuse depending on the level of abuse." The RN Supervisor failed to immediately report Client #1's injuries sustained as a result of an allegation of	W 127		

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W 127	Continued From page 9 abuse to the PCP. Interview the DSP #2 on October 20, 2008 at approximately 1:25 PM revealed that on October 1, 2008 at approximately 7:30 PM, he witnessed DSP #3 grab Client #1 by the front of the neck and pull him to the floor. DSP #4 was witnessed to assist DSP #3 to hold Client #1 down on the floor by his legs while DSP #5 kicked Client #1 five times in the right side. Further interview revealed that DSP#2 did not immediately report the abuse to the administrator. Interview with the Designated Nurse (DN) on October 21, 2008, at approximately 3:50 PM revealed that on October 2, 2008, LPN #1 did not report Client #1's allegation of abuse or injuries to the DN. Further interview revealed that on October 3, 2008, the QMRP informed her and the RN Supervisor that Client # 1 alleged he was "choked by the big guy, held down on the floor and kicked". The DN stated that she never examined or assessed Client #1's injuries. Further interview revealed that the DN did not report the client's injuries or incident to the administrator or the PCP. Cross Refer to W149. Interview with the Director of the day program on October 23, 2008 at approximately 2:25 PM, revealed that the allegation of abuse was not reported because the incident occurred at the group home and not the day program. Review of the day program ' s incident management policy at approximately 2:28 PM revealed that the day program had not developed a policy on reporting external allegations of abuse that occurred outside of their operating hours.	W 127		

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W 127	Continued From page 10 The State Agency (SA) substantiated that Client #1 was physically abused by one or more staff persons. The SA determined that the facility failed to ensure systems were designed and implemented to make certain clients (Clients #1, #2, #3, #4, #5 and #6) were not subjected to physical abuse/neglect that posed a serious and immediate threat to their health and safety. The Administrator/Director of Operations was notified of the immediate jeopardy concerns on October 28, 2008, at approximately 9:45 AM. An onsite visit was conducted on November 4, 2008 to verify that the facility implemented systems to remove the immediate jeopardy. These systems included: A) Residential staff were trained on immediately reporting allegations of abuse as required by the facility's policy and by federal and local regulations. B) Residential nursing staff were trained on immediately reporting allegations of abuse as required by the facility's policy and by federal and local regulations. C) Day program nursing and administrative staff were trained on immediately reporting allegations of abuse as required by the facility's policy and by federal and local regulations. D) At least one residential staff on each shift was trained on Non- violent Crisis Prevention Intervention (CPI) techniques for managing physical aggression.	W 127		

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	A determination was made on November 4, 2008 that sufficient systems had been implemented by the facility to alleviate the immediate threat to clients ' health and safety identified on October 17, 2008.			
W 147	483.420(c)(5) COMMUNICATION WITH CLIENTS, PARENTS &	W 147	The Governing Body has recruited, hired, and trained a new QMRP and RD for the facility. The new management staff in the facility will coordinate and implement a vacation for the clients in the facility within the next 60 days. Evidence of the clients' vacations will be documented in each person's record in the form of pictures and receipts from their expenditures. The Director of Disability Services will ensure that a yearly calendar for vacations and/or other visits and leave away from the facility is developed, published, and implemented.	12/10/08
	The facility must promote frequent and informal leaves from the facility for visits, trips, or vacations.			
	This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure each client was provided an opportunity to participate in a vacation.			
	The finding includes:			
	Interview with the Residential Director (RD) and Qualified Mental Retardation Professional (QMRP) on October 21, 2008 at approximately 11:18 AM failed to provide evidence that clients were given the opportunity to participate in a vacation since 2006. Further interview with the QMRP revealed that in 2007, vacation packages were submitted and approved; however, there was no evidence of any documentation that clients participated in a vacation in 2007. Interview with Client #1 on October 27, 2008 at 10:24 AM revealed that he did not go on vacation last year. Client #1 further revealed that he could not remember the last vacation he went on.			
	Additional interview with the Qualified Mental Retardation Professional (QMRP) on October 27, 2008 at approximately 2:30 PM revealed that the			

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W 147	Continued From page 12 clients were scheduled to go on vacation in October 2008. Review of the financial records conducted on October 22, 2008 at 3:40 PM revealed no evidence that vacation packages were submitted and approved. At the time of the survey, there was no evidence that the clients were afforded the opportunity to participate in an annual vacation.	W 147		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse for six of six clients in the investigation. (Client #1, Client #2, Client #3, Client #4, Client #5 and Client #6) The findings include: 1. The facility's Direct Support Professionals (DSPs) failed to implement the facility's policy on Incident Management as evidenced by: Review of the facility's Incident Management policy on October 20, 2008, at approximately 8:15 AM revealed that " any serious incident which has harmed or may potentially harm an individual's health, safety, or well-being shall be immediately identified, reported, reviewed, investigated and corrected. It is the responsibilty of any staff member who witnesses, discovers or is informed of an incident to complete an incident report".	W 149	1. DSP #2 was placed on administrative leave and later dismissed because he failed to follow policy on protection of client rights, per his training. The Director of Disability Services reviewed and updated the implementation steps for the incident management policy published to all nurses and staff. The IMC provided additional training to all DSPs in the facility.	12/10/08

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W 149	Continued From page 13 Interview with DSP #2 on October 20, 2008 at approximately 1:25 PM revealed that on October 1, 2008 at approximately 7:30 PM, he witnessed DSP #3 grab Client #1 by the front of the neck and pull him to the floor. DSP #4 was witnessed to assist DSP #3 and hold Client #1 down on the floor by his legs while DSP #5 kicked Client #1, five times in the right side. Further interview revealed that DSP#2 did not immediately report the abuse or complete an incident report. There was no evidence that on October 1, 2008, staff implemented the facility's Incident Management policy. 2. The facility's DSPs failed to implement the facility's policy on Behavior Supports and Restricted Controls as evidenced by: Review of the facility's Behavior Supports and Restricted Controls policy on October 20, 2008 at approximately 9:00 AM revealed that the following procedures were expressly forbidden " any procedure or action, which is degrading, humiliating, harsh,or abusive; and any form of corporal punishment". Interview the DSP #2 on October 20, 2008 at approximately 1:25 PM revealed that on October 1, 2008 at approximately 7:30 PM, he witnessed DSP #3 grab Client #1 by the front of the neck and pull him to the floor. DSP #4 was witnessed to assist DSP #3 to hold Client #1 down on the floor by his legs while DSP #5 kicked Client #1 five times in the right side. Further interview revealed that the incident lasted approximately ten minutes.	W 149	2. See response to #1 above. Each DSP who was on shift at the time of the incident, and who either participated in the alleged abuse or was aware of the alleged abuse and failed to report it, was placed on administrative leave and later dismissed. Further, the facility ensured that the police, adult protective services, and the Office of the Inspector General were notified and did everything within its power to ensure that law enforcement pursued the abusive DSPs.	12/10/08

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W 149	Continued From page 14 There was no evidence that on October 1, 2008 staff implemented the facility's policy on Behavior Supports and Restricted Controls . 3. The facility's DSPs failed to implement the facility's policy on De-escalation of Assaultive/ Combative Behavior as evidenced by: Review of the facility's De-escalation of Assaultive/ Combative Behavior policy on October 20, 2008 at approximately 9:30 AM revealed that staff were to prevent threatening, aggressive behavior in the following manner," let the individual know the options that are open to him. Offer assistance in modifying his/her goal and handling anger in an acceptable manner; let the individual know that he/she will not be allowed to harm him/herself or other." Interview with DSP #2 on October 20, 2008 at approximately 1:25 PM revealed that on October 1, 2008 at approximately 7:30 PM, he witnessed Client #1 became angry at DSP #4 because DSP #4 would not write down some names for him on a piece of paper. Client #1 walked out of the bedroom behind DSP #4 saying "do you want to fight me?" Further interview revealed that DSP #4 did not say anything to Client #1 as he slammed the front door and walked out the facility, then immediately returned to the facility. DSP #2 revealed that he witnessed DSP #3 come from the basement into the back hallway, grab Client #1 by the front of the neck, and pulled him to the floor. DSP #4 was witnessed to assist DSP #3 to hold Client #1 down on the floor by his legs while DSP #5 kicked Client #1, five times in the right side. There was no evidenced that on October 1, 2008	W 149	3. See responses to #s 1 and 2 above.	12/10/08

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W 149	Continued From page 15 staff implemented facility's policy on De-escalation of Assaultive/ Combative Behavior.	W 149		
	4. The facility's nursing staff and DSPs on duty at the time of the incident, who committed, witnessed or had knowledge of the abuse, did not implement the facility's policy on Abuse and Neglect of Individuals Served as evidenced by: Interview with LPN #1 on October 17, 2008 at approximately 11:58 AM revealed that on October 2, 2008, DSP #1 informed him that Client # 1 alleged that he was "choked by the big guy". LPN #1 stated that Client #1 was observed to have "redness" on his upper chest and no other injuries. Further interview revealed that LPN #1 did not report the incident to his immediate supervisor . Review of the facility's Abuse and Neglect of Individuals Served policy on October 20, 2008 at approximately 9:40 AM revealed that "any employee who commits, witnesses, or has knowledge of any act which may be considered abuse, mistreatment or neglect must report it immediately to his/her immediate supervisor". There was no evidence that on October 1, 2008 staff implemented the facility's policy on Abuse and Neglect of Individuals Served.		4. The Director of Disability Services retrained LPN #1, the LPN Coordinator/Designated Nurse, and the RN Supervisor on the facility's incident management policy and implementation requirements.	12/10/08
	b. Interview with DSP #2 on October 20, 2008 at approximately 1:25 PM revealed that on October 1, 2008 at approximately 7:30 PM, he witnessed DSP #3 grab Client #1 by the front of the neck and pull him to the floor. DSP #4 was witnessed to assist DSP #3 and hold Client #1 down on the floor by his legs while DSP #5 kicked Client #1,		b. See responses to #s 1 and 2 above.	12/10/08

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W 149	Continued From page 16 five times in the right side. Further interview revealed that DSP#2 did not report the abuse to his immediate supervisor. There was no evidenced that on October 1, 2008 staff implemented facility's policy on Abuse and Neglect of Individuals Served. 5. The facility failed to effectively monitor each client's day program to ensure that they had developed a policy on reporting all allegations of abuse as evidenced by: Interview with the Licensed Practical Nurse (LPN #3) at the day program on October 17, 2008 at approximately 2:15 PM revealed that Client #1 and Direct Support Professional (DSP) #1 had informed her that Client #1 was attacked and restrained by staff at the group home. LPN #3 stated that she observed scratches to Client #1's chest, face, neck and upper back. Futher interview revealed that LPN #3 did not report the alleged abuse because the incident occured at the group home and not the day program. Review of a nursing progress note dated October 2, 2008 at approximately 2:20 PM revealed "[Client #1] was presented to nursing as he arrived at the day program at about 9:00 AM with scratches to his chest, face, neck and upper back. The scratches on the back looked like stripes from a whipping with a cane or belt. [Client #1] verbalized having been attacked and restrained by one of his counselors at home". In an interview with the Director of the day program on October 23, 2008 at approximately 2:25 PM, it was acknowledged that the allegation of abuse was not reported because the incident	W 149	5. The RN Supervisor provided training to the Day Program on reporting incidents, allegations of abuse, injuries, etc., per the facility's policy. The facility will also request a copy of the Day Program's incident management policy for review.	12/10/08

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W 149	Continued From page 17 occured at the group home and not the day program. Further interview revealed that the day program did not have a poilcy on reporting external allegations of abuse. Review of the incident management policy at approximately 2:28 PM revealed that the day program had not developed a policy on reporting external allegations of abuse that occured outside of their operating hours. There is no evidence that the day program developed a policy on reporting external allegations of abuse that occured outside of their operating hours.	W 149		
	6. Cross refer to W156. The facility failed to ensure investigations were completed and submitted to their administrator and state agency as required by their policy within five working days.		6. See responses to W104 #2, W122, W127 and W156.	12/10/08
	7. Cross refer to W331. The facility's nursing services failed to implement the facility's policy on Medication Administration.		7. See response to W104 #4 and W331. The RN Supervisor will retrain the LPN on following the physician's orders regarding medication administration.	12/10/08
	8. The facility's nursing services failed to implement the facility's policy on Communication of Medically Related Issues.		8. See responses to W122 and W127, and the response to #4 above.	12/10/08
	a. The facility's medication Licensed Practical Nurse (LPN) failed to immediately report Client #1's injuries, sustained as a result of an allegation of abuse to the Primary Care Physician (PCP) and Designated Nurse (DN). Interview with LPN #1 on October 17, 2008 at approximately 11:58 AM revealed that on October 2, 2008, DSP #1 informed him that Client # 1 alleged he was "choked by the big guy, held down		a. See response to #8 immediately above.	12/10/08

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W 149	Continued From page 18 on the floor and kicked". LPN #1 stated that Client #1 was observed to have "redness" on his upper chest and no other injuries. Further interview revealed that LPN #1 did not report the incident to the Designated Nurse (DN) or Registered Nurse (RN) Supervisor. Review of LPN #1's nursing progress note dated October 2, 2008 at approximately 7:30 AM on October 17, 2008 revealed that LPN #1 observed "redness" on the upper chest of Client #1 and discomfort. Further review verified the administration of the Tylenol 325mg two tablets for pain and neosporin ointment to Client #1's upper chest. Review of the the facility's policy entitled Communication of Medically Related Issues dated July, 2007 on October 20, 2008 at approximately 12:40 PM revealed that "all medical issues not previously identified by the physician are communicated to the physician by the medication nurse". Further review of the policy revealed that when new medical issues are discovered by the medication nurse that were not life threatening they were to be communicated to the DN by verbal notification via telephone. There was no documented evidence that the client's injuries, sustained as a result of an allegation of abuse were reported to the designated nurse or PCP. b. The facility's DN failed to report Client #1's injuries, sustained as a result of alleged physical abuse to PCP. Interview with DN on October 21 , 2008 at approximately 3:50 PM revealed that on October	W 149	b. See response to 8a above. The Director of Disability Services will update the implementation steps for the incident management policy and provide training to the RN Supervisor, DN, and LPN med nurse.	12/10/08

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W 149	Continued From page 19 1, 2008, LPN #1 did not report Client #1's allegation of abuse or injuries to the DN. Further interview revealed that on October 3, 2008, the Qualified Mental Retardation Professional (QMRP) informed her and the RN Supervisor that Client # 1 alleged he was "choked by the big guy, held down on the floor and kicked". The DN stated that she never examined or assessed Client #1's injuries. Further interview revealed that the DN did not report the incident to the PCP. Review of the the facility's policy entitled Communication of Medically Related Issues on October 20, 2008 at approximately 12:42 PM revealed that "all medical issues not previously identified by the physician are communicated to the physician by the DN". Further review revealed that when a DN has discovered new medical issues that were not life threatening she can call the PCP and/or RN Supervisor and that the PCP should be reached as soon as possible to have the PCP provide the course of care for the issue. There was no documented evidence that the DN Supervisor reported the client's injuries, sustained as a result of an allegation of abuse to the PCP. c. The facility's RN Supervisor failed to immediately report Client #1's injuries, sustained as a result of an allegation of abuse to the PCP. Interview with the RN Supervisor on October 20 , 2008 at approximately 12:25 PM revealed that on October 1, 2008, LPN #1 did not report Client #1's allegation of abuse or injuries to the RN Supervisor. Further interview with the RN Supervisor revealed that on October 2, 2008, the	W 149	c. See response to 8b above. The Governing Body had made a determination prior to this incident to move services to a new PCP for various administrative purposes.	12/10/08

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W 149	Continued From page 20 QMRP informed her that on October 1, 2008, Client # 1 alleged he was "choked by the big guy, held down on the floor and kicked on". The RN Supervisor additionally stated that the PCP" would only be notified of an allegation of abuse depending on the level of abuse. " Review of RN Supervisor's nursing progress note dated October 3, 2008 on October 17, 2008 at approximately 12:00 PM revealed that she was informed by the QMRP regarding Client #1's injuries. Further review revealed that there were "two resolving scratch marks visible with redness, area not opened. Chest area left upper part with small bruised area resolving". Review of Client #1's PCP 's medical consult dated October 21, 2008 on October 22, 2008 at approximately 1:10 PM revealed "patient noted to be hit by staff in past, 10/2/08 reported. Bruises on back, scratches on neck. Pt. complained of being choked, held down by 3 staff members and kicked. Bruises now cleared up". Review of the the facility's policy entitled Communication of Medically Related Issues on October 20, 2008 at approximately 12:46 PM revealed that "all medical issues not previously identified by the physician are communicated to the physician by the RN Supervisor". There was no documented evidence that the client's injuries, sustained as a result of an allegation of abuse were reported timely to the PCP. [Note: The PCP medical consult dated October 21, 2008 revealed that Client #1 was seen twenty days after the incident by the PCP regarding the injuries that he sustained on October 1, 2008.	W 149		

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W 149	Continued From page 21 The PCP that evaluated Client #1 on October 21, 2008 was not the PCP of record at the time of the incident on October 1, 2008.] 9. Cross refer to W155. The facility failed to provide evidence that clients were protected from further potential abuse while an allegation of abuse was investigated.	W 149	9. See responses to W104 #2 and W122. The Director of Disability Services will consult with the State Agency and the Department on Disability Services, and revise facility policy on how to proceed when there is an allegation that does not name any individual staff person or specific staff group (shift) and clients are in danger of being displaced due to an entire home's staff being placed on administrative leave.	12/10/08
W 150	483.420(d)(1)(i) STAFF TREATMENT OF CLIENTS Staff of the facility must not use physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on observations, staff interview and record review, the facility failed to ensure that systems were implemented to ensure clients were free from physical, verbal and psycholgical abuse for one of the one client in the investigation . (Client #1) The finding includes: Based on observations, staff interview and record review, the facility failed to ensure that systems were implemented to make certain clients were free from physical, verbal and psychological abuse, for one of the one client in the investigation. (Client #1) The finding includes: Cross Refer to W127. On October 2, 2008, at approximately 4:23 PM the State Agency (SA) was notified (via telephone) by the Residential	W 150	See response to W127.	12/10/08

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W 150	Continued From page 22 Director (RD) that a client alleged being " choked " by a staff member. Interviews and record review beginning on October 17, 2008 and throughout the investigation verified the RD ' s notification and further revealed that Client #1 alleged being kicked and held to the floor. As a result of the alleged abuse, the client sustained injuries to his chest, face, neck and upper back. The findings of the investigation revealed that clients ' health and safety were at risk and an immediate jeopardy was identified. A determination was made on November 4, 2008, (through an onsite visit) that sufficient systems had been implemented by the facility to alleviate the immediate threat to clients ' health and safety.	W 150		
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 failed to ensure that all allegations of abuse, neglect, and mistreatment were immediately reported to the administrator or to other officials in accordance with State law. The findings include: 1. Review of the facility's unusual incident reports on October 17, 2008, at approximately	W 153	1. See responses to W102, W104, W122, W127 and W149.	12/10/08

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W 153	Continued From page 23 7:00 PM revealed an incident involving Client #1 dated October 2, 2008. According to the report, DSP #1 was informed by Client #1 that " the big guy choked me and another guy held my legs. " Interview with DSP #2 on October 20, 2008 at approximately 1:25 PM acknowledged being aware of the incident as it occurred on October 1, 2008. According to the DSP #2, on October 1, 2008, at approximately 7:30 PM, he witnessed DSP #3 grab Client #1 by the front of the neck and pull him to the floor. DSP #4 was witnessed to assist DSP #3 by holding Client #1 down on the floor by his legs while DSP #5 kicked the client five times in the right side. Further interview revealed that the incident lasted approximately ten minutes. At the time of the investigation, the facility failed to provide evidence that the incident had been immediately reported to the administrator as required. (See also W149) 2. Review of the facility's incidents reports on October 21, 2008 at 3:53 PM revealed an incident report dated March 30, 2008. According to the report, staff noticed a scratch on Client #4's ear and shoulder. The incident report revealed that Client #4 stated that Client #2 caused the injury. Interview with the Qualified Mental Retardation Professional (QMRP) on the same day at approximately 4:00 PM revealed that she was not aware of the incident. Additionally, at the time of the survey, there was no evidence the facility's administrator was immediately notified of the aforementioned incident.	W 153	2. The IMC and the Director of Disability Services will provide initial and ongoing training on incident reporting and management in accordance with the facility policy. Nurses, facility management staff, and DSPs will have initial and retraining in the policy and implementation.	12/10/08
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.	W 154		

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W 154	Continued From page 24 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that allegations of abuse were thoroughly investigated, for three of six clients (Clients #2, #3, and #4) included in the sample. The findings include: 1. The facility failed to ensure an allegation of abuse involving Clients #2 and #3 was thoroughly investigated. a. On September 10, 2008, the State Agency received an investigation report dated August 25, 2008. According to the report, the facility received an anonymous letter on July 14, 2008, (dated June 6, 2008) that alleged "Client #2 and Client #3 were routinely physically abused whenever they did not comply with demands of the employees. Further review of the investigation report revealed that only 11 of 23 Direct Support Professionals (DSP) were interviewed using the facility "Witness Questionnaire/Statement" form. The form documented open ended questions such as: - How long have you been employed at [provider]? - What is your regular work schedule? - How many individuals reside at the facility? - Do you know (Client #2 and Client #3)? - Are you aware that there has been alleged physical abuse towards the mentioned individual?	W 154	1a. The Governing Body has recruited and hired a qualified IMC who will implement the facility policy regarding incident reporting and investigation in accordance with federal and local regulations.	12/10/08

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W 154	Continued From page 25 Review of all of the available questionnaires revealed staff were only required to answer questions with yes or no and failed to document detailed information as it related to the questions. Interview with the Qualified Mental Retardation Professional (QMRP) and Residential Director (RD) on October 21, 2008 at approximately 2:30 PM acknowledged that 10 DSPs that worked directly with Clients #2 and #3 as an assigned 1:1 staff or overnight staff were not interviewed. Additionally, review of the corresponding investigative summary (submission date August 25, 2008) failed to provide evidence that clients were interviewed regarding the allegation. At the time of the survey, the facility failed to ensure the aforementioned allegation of abuse was thoroughly investigated. b. Continued review of the facility's investigations for the previously mentioned allegation of abuse revealed the facility completed two separate investigations, one for Client #2 (submission date August 25, 2008) and one for Client #3 (submission date August 15, 2008). Further review of the investigative reports revealed evidence that some interviews were conducted for each investigation after the actual submission dates. For example; Review of Client #3's investigation (submission date August 15, 2008) on October 21, 2008 revealed that eleven staff were interviewed on August 25, 2008 (10 days after the submission date) and one staff was interviewed on August 27, 2008 (17 days after the submission date). At the time of the survey, the facility failed to provide evidence that information received from	W 154	b. The IMC will implement the protocols for incident investigations as prescribed by facility policy, which allows for investigations to be updated if/when new information is received.	12/19/08

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W 154	Continued From page 26 interviews conducted after the submission dates were incorporated into the investigations. c. Interview with the Vice President of Operations (pre-survey) on September 10, 2008, revealed that the she was unaware of the aforementioned allegation and further indicated that the investigation was going to be reopened in order to address all of the allegations presented in the letter. At the time of the survey however, there was no evidence that the investigation had been reopened. 2. The facility failed to ensure an a Review of the facility's incident reports on October 21, 2008 at 3:53 PM revealed an incident report dated March 30, 2008. According to the report, staff noticed a scratch on Client #4's ear and shoulder. The incident report further revealed that Client #4 stated that Client #2 caused the injury. Interview with the Qualified Mental Retardation Professional (QMRP) on the same day at approximately 4:00 PM revealed that she was not aware of the incident. Continued review of the facility ' s incident reports and available investigations failed to provide evidence that the incident had been investigated.	W 154	c. The Vice President of Operations (Director of Disability Services) requested the QA department to review the previous investigation and reopen it for a look-behind. For a two-to-three week period the facility was without an IMC, as the previous person joined the Office of the Inspector General and there was a lag time before the current IMC was recruited, her hire and start date approved. The incident that precipitated the immediate jeopardy occurred just as the new IMC started. The results of the investigation of this incident will be incorporated into the previous incident investigation.	12/10/08
			2. See response to W153 #2.	12/10/08
W 155	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must prevent further potential abuse while the investigation is in progress. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide evidence that clients were protected from further potential abuse while an allegation of abuse was investigated for six of six	W 155	See response to W149 #9. The Director of Disability Services will revise the facility policy on how to proceed when there is an allegation that does not name any individual staff person or specific staff group (shift) and clients are in danger of being displaced due to an entire home's staff being placed on administrative leave.	12/10/08

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W 155	Continued From page 27 clients residing in the facility. (Clients #1, #2, #3, #4, #5, and #6) The finding includes: On September 10, 2008, the State Agency received an investigation report with a submission date of August 25, 2008. According to the report, the facility received an anonymous letter on July 14, 2008 (dated June 6, 2008) that alleged "Client #2 and Client #3 were routinely physically abused whenever they did not comply with demands of the employees. The letter further documented that the facility's management staff were aware of the alleged abuse but viewed it as a way of correction and not abuse. Interview with the facility's Residential Director (RD) and Qualified Mental Retardation Professional (QMRP) on October 21, 2008 at approximately 11:00 AM revealed that they were not aware that Clients #2 and #3 were abused. Interview with the facility ' s Director of Disability Services on October 22, 2008, at approximately 3:40 PM revealed that she had been made aware of the allegation of abuse on July 14, 2008. The Director of Disability Services further revealed that the facility' s Incident Management Coordinator launched an investigation of the allegation. Review of the corresponding investigation (submission date August 25, 2008) revealed that the allegation was not substantiated. Further review of the investigation failed to document any information regarding systems that had been implemented to prevent further abuse of Clients #2 and #3 while the investigation was in progress. Review of the facility' s incident management	W 155		

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W 155	Continued From page 28 policy on October 22, 2008, at approximately 3:00 PM however, revealed that immediately upon receiving any report of mistreatment, neglect or abuse, the staff person who allegedly committed the act is placed on administrative leave while the incident management coordinator conducts an investigation. At the time of the survey, there was no evidence that the facility implemented their policy to prevent further abuse.	W 155		
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to report the results of all investigations to the administrator or designated representative or to other officials in accordance with State Law within five working days of the incident. The finding includes: The facility failed to ensure the results of investigations were reported to the administrator or designee within five working days as evidenced below: On September 10, 2008, the State Agency received an investigation report with a submission date of August 25, 2008. According to the report, the facility received an anonymous letter on July 14, 2008 (dated June 6, 2008) that alleged "Client #2 and Client #3 were routinely physically abused	W 156	See response to W154.	12/10/08

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W 156	Continued From page 29 whenever they did not comply with demands of the employees. Further review of the facility's internal investigations revealed two investigative reports for the allegation with submission dates of August 15, 2008 (for Client #3) and August 25, 2008 (for Client #2). At the time of the survey, the facility failed to provide evidence that the administrator or designee reviewed the results of the aforementioned investigations within five working days as required.	W 156		
W 158	483.430 FACILITY STAFFING The facility must ensure that specific facility staffing requirements are met. This CONDITION is not met as evidenced by: Based on observations, staff interviews, and record review, the Qualified Mental Retardation Professional (QMRP) failed to adequately monitor, integrate, and coordinate the health and safety needs of each client[See W159]; failed to ensure that each employee was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently [See W189]; and failed to demonstrate competency in the implementation of each client's Behavior Support Plan [W193]. The 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 W102, W122, W159 and W189. The Governing Body determined that a staff change was needed for the QMRP and RD positions, and the personnel change was implemented. An experienced RD was hired to support the new QMRP as she carries out the programs and staff development devised to address monitoring, integration, and coordination of the health and safety needs of each client. The new team will ensure that staff receive initial and continuing training and mentoring in order to carry out their duties effectively.	12/10/08
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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W 159	Continued From page 30 qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on interview, and record review, the Qualified Mental Retardation Professional (QMRP) failed to adequately monitor, integrate, and coordinate the health and safety needs, for six of six clients in the investigation. (Client #1,Client #2, Client 3, Client #4,Client #5, and Client # 6) The findings include: 1. Cross Refer to W189.1. The QMRP failed to ensure that DSPs had received initial and continuing training that included techniques for managing physical aggression and in implementing the BSP's for Client #1,Client #2, Client 3, Client #4,Client #5, and Client # 6.	W 159	1. See response to W158.	12/10/08
	2. Cross refer to W193. The QMRP failed to ensure that staff demonstrated competency in the implementation the Behavior Support Plan (BSP) for one of one client in the investigation. (Client #1)		2. See response to W102, W104, W122 and W127.	12/10/08
W 189	483.430(e)(1) STAFF TRAINING PROGRAM 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. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each employee was provided with initial and continuing	W 189		

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W 189	Continued From page 31 training that enabled the employee to perform his or her duties effectively, efficiently, and competently. The findings include: 1. Cross refer to W193. The facility failed to ensure that DSPs had received initial and continuing training that included techniques for managing physical aggression during a crisis for Client #1,Client #2 and Client # 6 as evidenced by: Interview with the Qualified Mental Retardation Professional (QMRP) on October 24, 2008 at approximately 2:30 PM revealed that only DSP #1 and DSP # 12 had training on the Department on Disability Services' (DDS) approved non-violent crisis prevention techniques. Review of Client # 1, Client # 2 and Client # 6's Behavior Support Plans (BSPs) on October 24, 2008 at approximately 3:00 PM revealed that the BSPs documented that when strategies for addressing physical aggression were not effective, physical intervention techniques of Crisis Prevention and Intervention (CPI) may be used to ensure client safety and that of peers and staff. Review of training records on October 27, 2008 at approximately 11:30 AM verified that only DSP #1 and DSP # 12 had training in the DDS approved non-violent crisis prevention techniques. [Note: At the time of the investigation only two out of twenty-six staff had training in CPI] 2. The facility failed to ensure that staff had received initial and continuing training on Client	W 189	1. See response to W127 and W159.	12/10/08
			2. See response to W127 and W159. The QMRP will schedule training for each staff person on each client's BSP.	12/10/08

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W 189	Continued From page 32 #1,#2, #3, #4,#5, and # 6 BSPs as evidenced by: Interview with the Qualified Mental Retardation Professional (QMRP) on October 24, 2008 at approximately 2:45 PM revealed that each client in the facility had a BSP. Further interview revealed that only DSP #1, DSP #4, DSP #8, DSP #10, DSP #12, DSP #13, DSP #14, DSP #16, DSP #17 ,DSP #20 and the Residential Director/Driver had training in the BSPs for each client. Review of training records on October 27, 2008 at approximately 12:30 PM verified that only DSP #1, DSP #4, DSP #8, DSP #10, DSP #12, DSP #13, DSP #14, DSP #16, DSP #17 ,DSP #20 and the Residential Director/Driver had training in the BSPs for each client. [Note: At the time of the investigation only twelve out of twenty-six staff had training in the clients BSPs] 3. Cross Refer to W149. The facility failed to ensure that the DSPs had received effective training on their incident management policy ensuring that all allegations of abuse/neglect were reported immediately to the administrator. 4. Cross Refer to W149. The facility failed to ensure that the nursing staff had received effective training on their incident management policy ensuring that all allegations of abuse/neglect were reported immediately to their supervisor. 5. Cross Refer to W193. The facility failed to ensure that DSPs received effective training to demonstrate competency in implementing the	W 189	3. See response to W102, W104, W122, W127, W149, W153, W154 and W158. 4. See response to #3 above. 5. See response to #3 above.	12/10/08 12/10/08 12/10/08

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W 189	Continued From page 33 BSP for Client #1.	W 189		
W 193	483.430(e)(3) STAFF TRAINING PROGRAM 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 staff interviews and record verification, the facility staff failed to demonstrate competency in the implementation the Behavior Support Plan (BSP) for one of one client being investigated. (Client #1) The finding includes: Review of an unusual incident report dated October 2, 2008, on October 17 9, 2008 at approximately 7:00 PM revealed that Direct Support Professional (DSP) #1 was informed by Client #1 that a "big guy" choked him while another guy held his legs. Interview with DSP #2 on October 20, 2008 at approximately 1:25PM revealed that on October 1, 2008, DSP #3 was in the basement and Client #1 and DSP #4 were in Client # 5's bedroom on the first floor of the facility. On that same day at approximately 7:30 PM, DSP #2 revealed that he witnessed Client #1 become angry toward DSP #4 because DSP #4 would not write down some names for him on a piece of paper. Client #1 walked out of the bedroom behind DSP #4 saying "do you want to fight me"? Further interview revealed that Client #1 walked out of the front door than returned to the facility. DSP #2 revealed that he witnessed DSP #3 come from the basement into the back hallway and grab	W 193	See response to W102, W127 and W189.	12/10/08

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W 193	Continued From page 34 Client #1 by the front of the neck and pull him to the floor. DSP #4 was witnessed to assist DSP #3 to hold Client #1 down on the floor by his legs while DSP #5 kicked Client #1 five times in the right side. Review of the facility's staff schedule on October 17, 2008 at approximately 11:25 AM, revealed that on October 1, 2008 between 3:00 PM-11:00 PM, DSP #3 was assigned to provide 1:1 supervision for Client #1. Review of Client #1's BSP dated September 2008, on October 23, 2008 at approximately 3:00 PM revealed the client exhibited targeted behaviors that included verbal aggression, physical aggression, non-compliance, making excessive demands on staff to write for him, making false accusations, and inappropriately approaching children. The plan further documented that Client #1 required 1:1 staff supervision. Further review revealed that interventions for making excessive demands included "if [Client #1] continuously asks staff to write or spell names for him request him to write them down himself ... if he takes this instruction well and begins to write the names himself provide verbal praise. If he shows signs of increased irritation and anger at not obtaining the expected response from staff to his demands, follow strategies mentioned under escalating physical aggression. The plan also indicated interventions for physical aggression and verbal aggression that included "staff should make a decision to engage [Client #1] in an alternative task or activity before irritability or agitation sets in and that "if [Client #1] is silent,even for a few moments, let [Client #1]	W 193		

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W 193	Continued From page 35 know that you would be willing to speak with [Client #1] once [Client #1] calms down". There was no evidence that on October 1, 2008 the facility staff demonstrated competency in the implementation of the client's BSP.	W 193		
W 289	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. This STANDARD is not met as evidenced by: Based on interview and record review, the psychologist failed to revise the Behavior Support Plan (BSP) to incorporate all techniques for managing physical aggression during a crisis for four of six clients in the investigation. (Client #1,Client #2 and Client # 6) The findings includes: 1. The facility failed to ensure that Client #1's Behavior Support Plans (BSPs) included techniques for managing physical aggression during a crisis as evidenced by: Review of Client # 1's BSP on October 24, 2008 at approximately 3:00 PM revealed that when strategies for addressing physical aggression were not effective, physical intervention techniques of Crisis Prevention and Intervention (CPI) may be used. The BSP further documented	W 289	1. The QMRP will request the Psychologist to revise clients' behavior management plans to include specific techniques that may be used to address the client's behavior during a crisis that places him and/or others in immediate danger (this includes specifying the techniques for managing physical aggression). The agenda/techniques from CPI training will be kept with the clients' behavior management files. CPI training includes a range of physical intervention techniques to use when behaviors place a client or others in immediate danger.	12/10/08

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W 289	Continued From page 36 that "staff certified and trained in Department on Disability Services (DDS) approved non-violent crisis prevention techniques may use only those techniques that are necessary to ensure [Client] safety and that of peers and staff". The BSP however failed to document the specfic techniques that may be used to address the client's behavior during a crisis that places him and/or others in immediate danger. There was no evidence that the techniques for managing physical aggression during a crisis was included in the BSP. 2. The facility failed to ensure that Client #2's BSP included techniques for managing physical aggression during a crisis, as evidenced by: Review of Client # 2's BSP on October 24, 2008 at approximately 3:10 PM revealed that the BSP include a notation that " if physicial aggression escalates to a point where the strategies for addressing physical aggression are not effective, physical intervention techniques of Crisis Prevention and Intervention (CPI) may be used, beginning with the least restrictive and progressing to the most restrictive as behaviors warrent. Further review revealed that Client #2's BSP failed to include techniques for managing physical aggression during a crisis, although the plan requires physical interventions if the client's behavior places him and/or others in immediate danger. There was no evidence that the techniques for managing physical aggression during a crisis was included in the BSP. 3. The facility failed to ensure that Client #6's BSP	W 289	2. See response to #1 above. 3. See response to #1 above.	12/10/08 12/10/08

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W 289	Continued From page 37 included techniques for managing physical aggression during a crisis, as evidenced by: Review of Client # 6's BSP on October 24, 2008 at approximately 3:10 PM revealed that the BSP included a notation that " if [Client] behavior worsens, staff certified and trained in DDS approved non-violent crisis prevention techniques may use only those techniques that are necessary to ensure [Client] safety and that of peers and staff. Further review revealed that Client #6's BSP failed to include techniques for managing physical aggression during a crisis, although the plan requires physical interventions if the client's behavior placed him and/or others in immediate danger. There was no evidence that the techniques for managing physical aggression during a crisis was included in the BSP.	W 289		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interviews and record verification, the facility's nursing services failed to establish systems to provide health care monitoring and identify services in accordance with clients' needs for one of one client in the investigation. (Client #1) The findings include: 1. The facility's nurses failed to transcribe medication orders and document the administration of medications as evidenced	W 331	1. The Director of Disability Services, or the RN Supervisor, or the DN will retrain LPN #1 on transcribing medications and initialing the MAR when PRN medications are administered.	12/10/08

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	09G010		C 11/04/2008

NAME OF PROVIDER OR SUPPLIER: CARECO 01

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W 331	Continued From page 38 below: Interview with LPN #1 on October 17, 2008 at approximately 11:58 AM revealed that on October 2, 2008, Client #1 was administered Tylenol 325 mg, two tablets for discomfort and neosporin ointment was applied on Client #1's upper chest. Review of the nursing progress note dated October 2, 2008 at approximately 7:30 AM revealed that LPN #1 observed "redness on the upper chest" of Client #1. Further review verified the administration of Tylenol 325 mg, two tablets for discomfort and the neosporin ointment on Client #1's upper chest. Interview with the DN on October 21, 2008 at approximately 3:40 PM revealed that all PRN (as needed) medications were to be documented on the back of the MAR. Review of the Medication Administration Policy dated July 23, 2007 on October 22, 2008 at approximately 2:40 PM revealed that the licensed nurse was to initial the MAR to indicated the administration of the medication. There was no evidence that the medications were transcribed or initialed by the nurse on the MAR. 2. Cross refer to W368. The facility's nursing services failed to ensure that all drugs were administered in compliance with the physician's orders.	W 331	2. See response to W368.	12/10/08
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.	W 368	See response to W104 #4.	12/10/08

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W 368	Continued From page 39 This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that all drugs are administered in compliance with the physician's orders for one of one client in the investigation. (Client #1) The finding includes: Interview with LPN #1 on October 17, 2008 at approximately 11:58AM revealed that on October 2, 2008, Client #1 was observed to have " redness" on his upper chest. Further interview revealed neosporin ointment was applied on Client #1's upper chest. Review of a nursing progress note dated October 2, 2008 at approximately 7:30AM verified that LPN #1 observed "redness on the upper chest" of Client #1 and neosporin ointment was applied on Client #1's upper chest. Review of the physician 's standing orders dated 2007- 2008 on October 21, 2008 at approximately 3:45PM revealed an order that stated "with swelling, redness and/or irritation clean with hydrogen peroxide twice a day whenever necessary" There was no evidence that the medication administered was given in compliance with the physician's orders.	W 368		
W 381	483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that	W 381	See response to W104 #5.	12/10/08

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W 381	Continued From page 40 medications were appropriately stored and secured. The finding includes: On October 21, 2008 at 10:09 AM, the Pharmacy Deliver Person (PDP) was observed to ring and knock on the front door of the facility to deliver two bags of medications. After no one answered, the PDP was observed to leave the two bags of medications at the side door which was located on the left side of the facility. The PDP stated "that sometimes he leaves the medications at the side door when no one is home." At 10:11 AM, the PDP left the facility with the medications unattended. The medications were left unattended until the facility's Residential Director (RD) arrived to the facility and retrieved the medications at 10:24 AM. Interview with the Qualified Mental Retardation Professional (QMRP) on the same day at approximately 11:45 AM revealed that PDP should have never left the medications unattended. Further interview with the QMRP revealed the facility did not have a policy on delivering medication. Interview with the facility's designated Licensed Practical Nurse (LPN) on October 23, 2008 at approximately 1:00 PM revealed that she was not sure if the facility had a pharmacy policy on delivering medications to the facility. Review of the Delivery and Transportation of Medications policy and procedures on November 3, 2008 at approximately 2:30 PM revealed that the person accepting the medications from the pharmacy will sign for the medications at the time of delivery. At the time of the survey, the facility	W 381		

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W 381	Continued From page 41 failed to ensure that medications were supervised and secured in accordance with the agency's policy.	W 381		

Health Regulation Administration

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I 000	INITIAL COMMENTS I. On October 2, 2008, at approximately 4:23 PM the State Agency (SA) was notified (via telephone) by the Residential Director (RD) that a resident alleged being " choked " by a staff member. Additionally, the RD reported that all of the staff that were present at the time of the alleged abuse were placed on administrative leave. On October 17, 2008, the State Agency (SA) received an Unusual Incident Report (UIR) that documented the client ' s allegation of abuse. According to the UIR, Resident #1 reported to Direct Support Professional (DSP) #1 that "the big guy choked him and another guy held his legs." An onsite investigation was initiated on October 17, 2008, to verify compliance with federal regulatory requirements. During the investigation, the SA substantiated that Resident #1 was physically abused by one or more staff persons. The SA determined that the facility failed to ensure systems were designed and implemented to ensure that clients (Residents #1, #2, #3, #4, #5 and #6) were not subjected to physical abuse/neglect that posed a serious and immediate threat to their health and safety. The Administrator/Director of Operations was notified of the immediate jeopardy concerns on October 28, 2008 at approximately 9:45 AM. The findings of the investigation were based on observations at the group home and one day program, interviews with clients, group home and day program direct care staff, nursing and administrative staff, and review of resident and administrative records; including incident reports. As a result of the findings, a determination was	I 000		

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I 000	Continued From page 1 made that the facility failed be in compliance with the Conditions of Participation requirements in Governing Body, Client Protections and Health Care Services as evidenced by: A) Residential and day program nursing staff failed to report the aforementioned alleged abuse. B) Six employees on duty at the time of the incident, that either committed, witnessed or had knowledge of the abuse, did not report the abuse as required by facility ' s policy and by federal and local regulations. C) Resident #1, Resident #3 and Resident # 6's Behavior Support Plans (BSPs) documented requiring physical interventions if the residents' behaviors placed them and/or others in immediate danger. The plans however, failed to identify specific restrictive techniques (used by staff) for managing physical aggression during a crisis. II. In addition to the on-site investigation a monitoring survey was conducted on October 17, 2008, to determine the facility's continued compliance with the deficiencies cited during the recertification survey on February 8, 2008. The findings of the survey were based on observations, interviews and record review, as well as a review of client and administrative records, including incident reports. The result of the survey determined the facility failed to maintain compliance with all of the previously cited standard level deficiencies. III. An onsite visit was conducted on November 4, 2008 to verify that the facility implemented systems to remove the immediate jeopardy.	I 000		

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I 000	Continued From page 2 These systems included: A) Residential staff were trained on immediately reporting allegations of abuse as required by the facility's policy and by federal and local regulations. B) Residential nursing staff were trained on immediately reporting allegations of abuse as required by the facility's policy and by federal and local regulations. C) Day program nursing and administrative staff were trained on immediately reporting allegations of abuse as required by the facility's policy and by federal and local regulations. D) At least one residential staff on each shift was trained on Non- violent Crisis Prevention Intervention (CPI) techniques for managing physical aggression. A determination was made on November 4, 2008 that sufficient systems had been implemented by the facility to alleviate the immediate threat to residents ' health and safety identified on October 17, 2008.	I 000		
I 091	3504.2 HOUSEKEEPING Housekeeping and maintenance equipment shall be well constructed, properly maintained and appropriate to the function for which it is to be used. This Statute is not met as evidenced by: Based on observations and interview, the GHMRP failed to maintain the interior and exterior of the facility in a in a safe, clean, orderly, attractive, and sanitary manner. The finding includes:	I 091	The Director of Operations will ensure that the Maintenance staff repair any holes in the bathroom ceiling.	12/10/08

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I 091	Continued From page 3 On October 21, 2008 at 10:33 AM, a whole was observed in the ceiling just above the shower head in the bathroom located on the first floor. Interview with the Residential Director revealed that maintenance was aware of the whole in the ceiling. At 12:16 PM, maintenance was observed to fix a leak in the kitchen ceiling; however, failed to fix the whole in the bathroom ceiling.	I 091		
I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure adequate administrative support had been provided to efficiently meet the needs of the residents as required by their habilitation plans, for six of the six residents in the investigation. (Resident #1, Resident #2, Resident # 3, Resident #4, Resident #5, and Resident # 6) The findings include: 1. Cross Refer to W189.1. The QMRP failed to ensure that DSPs had received initial and continuing training that included techniques for managing physical aggression and in implementing the BSP's for Resident #1, Resident #2, Resident # 3, Resident #4, Resident #5, and Resident # 6. 2. Cross refer to W193. The QMRP failed to ensure that staff demonstrated competency in the implementation the Behavior Support Plan (BSP)	I 180	1. See response to federal deficiency W189. 2. See response to federal deficiency W193.	12/10/08 12/10/08

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I 180	Continued From page 4 for one of one resident in the investigation. (Resident #1)	I 180		
I 228	3510.5(e) STAFF TRAINING Each training program shall include, but not be limited to, the following: (e) Resident ' s rights; This Statute is not met as evidenced by: Based on interview, and record review, the GHMRP failed to ensure staff were effectively trained in maintaining residents' rights for one of six residents in the investigation. (Resident #1) The finding includes: Cross Refer to W127 and W149. The facility failed to ensure that the DSPs had received effective training on their incident management policy ensuring that all allegations of abuse/neglect were reported immediately to the administrator.	I 228	See responses to federal deficiency W127 and W149.	12/10/08
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on staff interviews and record verification, the GHMRP staff failed to demonstrate	I 229		

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I 229	Continued From page 5 competency in implementation the Behavior Support Plan for six of six residents being investigated. (Resident #1,Resident #2, Resident # 3, Resident #4, Resident #5, and Resident # 6) The findings include: 1. Cross refer to W193. The facility failed to ensure that DSPs had received initial and continuing training that included techniques for managing physical aggression during a crisis for Resident #1, Resident #2 and Resident # 6 as evidenced by: Interview with the Qualified Mental Retardation Professional (QMRP) on October 24, 2008 at approximately 2:30 PM revealed that only DSP #1 and DSP # 12 had training had training in the Department on Disability Services (DDS) approved non-violent crisis prevention techniques. Review of Resident # 1, Resident # 2 and Resident # 6's Behavior Support Plans (BSPs) on October 24, 2008 at approximately 3:00 PM revealed that the BSPs documented that when strategies for addressing physical aggression were not effective, physical intervention techniques of Crisis Prevention and Intervention (CPI) may be used to ensure client safety and that of peers and staff. Review of training records on October 27, 2008 at approximately 11:30 AM verified that only DSP #1 and DSP # 12 had training in the DDS approved non-violent crisis prevention techniques. [Note: At the time of the investigation only two out of twenty-six staff had training in CPI] 2. The facility failed to ensure that staff had	I 229	1. See response to federal deficiency W158, W193 and W289.	12/10/08
			2. See response to federal deficiency W189.	12/10/08

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I 229	Continued From page 6 received initial and continuing training on Residents #1,#2, #3, #4,#5, and # 6 BSPs as evidenced by: Interview with the Qualified Mental Retardation Professional (QMRP) on October 24, 2008 at approximately 2:45 PM revealed that each client in the facility had a BSP. Further interview revealed that only DSP #1, DSP #4, DSP #8, DSP #10, DSP #12, DSP #13, DSP #14, DSP #16, DSP #17 ,DSP #20 and the Residential Director/Driver had training in the BSPs for each client. Review of training records on October 27, 2008 at approximately 12:30 PM verified that only DSP #1, DSP #4, DSP #8, DSP #10, DSP #12, DSP #13, DSP #14, DSP #16, DSP #17,DSP #20 and the Residential Director/Driver had training in the BSPs for each client. [Note: At the time of the investigation only twelve out of twenty-six staff had training in the clients BSPs] 2. Review of an unusual incident report dated October 2, 2008, on October 17 9, 2008 at approximately 7:00 PM revealed that Direct Support Professional (DSP) #1 was informed by Client #1 that a "big guy" choked him while another guy held his legs. Interview with DSP #2 on October 20, 2008 at approximately 1:25PM revealed that on October 1, 2008, DSP #3 was in the basement and Client #1 and DSP #4 were in Client # 5's bedroom on the first floor of the facility. On that same day at approximately 7:30 PM, DSP #2 revealed that he witnessed Client #1 become angry toward DSP #4 because DSP #4 would not write down some	I 229	2. See response to W193.	12/16/08

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I 229	Continued From page 7 names for him on a piece of paper. Client #1 walked out of the bedroom behind DSP #4 saying "do you want to fight me"? Further interview revealed that Client #1 walked out of the front door than returned to the facility. DSP #2 revealed that he witnessed DSP #3 come from the basement into the back hallway and grab Client #1 by the front of the neck and pull him to the floor. DSP #4 was witnessed to assist DSP #3 to hold Client #1 down on the floor by his legs while DSP #5 kicked Client #1 five times in the right side. Review of the facility's staff schedule on October 17, 2008 at approximately 11:25 AM, revealed that on October 1, 2008 between 3:00 PM-11:00 PM, DSP #3 was assigned to provide 1:1 supervision for Client #1. Review of Client #1's BSP dated September 2008, on October 23, 2008 at approximately 3:00 PM revealed the client exhibited targeted behaviors that included verbal aggression, physical aggression, non-compliance, making excessive demands on staff to write for him, making false accusations, and inappropriately approaching children. The plan further documented that Client #1 required 1:1 staff supervision. Further review revealed that interventions for making excessive demands included "if [Client #1] continuously asks staff to write or spell names for him request him to write them down himself ... if he takes this instruction well and begins to write the names himself provide verbal praise. If he shows signs of increased irritation and anger at not obtaining the expected response from staff to his demands, follow strategies mentioned under escalating physical aggression. The plan also	I 229		

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I 229	Continued From page 8 indicated interventions for physical aggression and verbal aggression that included "staff should make a decision to engage [Client #1] in an alternative task or activity before irritability or agitation sets in and that "if [Client #1] is silent,even for a few moments, let [Client #1] know that you would be willing to speak with [Client #1] once [Client #1] calms down". There was no evidence that on October 1, 2008 the facility staff demonstrated competency in the implementation of the client's BSP.	I 229		
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: Based on interview and record review, the GHMRP failed to notify the Department of Health (DOH), 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.	I 379		

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I 379	Continued From page 9 The findings include: The GHMRP failed to ensure that the DOH was notified of allegations of abuse within 24 hours as evidenced below: 1. Review of the facility's incidents reports on October 21, 2008 at 3:53 PM revealed an incident report dated March 30, 2008. According to the report, staff noticed a scratch on Client #4's ear and shoulder. The incident report revealed that Client #4 stated that Client #2 caused the injury. Interview with the Qualified Mental Retardation Professional (QMRP) on the same day at approximately 4:00 PM revealed that she was not aware of the incident. Additionally, at the time of the survey, there was no evidence the facility's notified the DOH as required.	I 379	1. See response to federal deficiency W153, #2.	12/10/08
	2. On September 10, 2008, the State Agency received an investigation report with a submission date of August 25, 2008. According to the report, the GHMRP received an anonymous letter on July 14, 2008 (dated June 6, 2008) that alleged "Resident #2 and Resident #3 were routinely physically abused whenever they did not comply with demands of the employees. At the time of the survey, the GHMRP failed to provide evidence that the DOH was notified of the incident within 24 hours as required. Also See federal deficiencies report W153		2. See response to federal deficiency W122 and W154.	12/10/08
I 473	3522.4 MEDICATIONS The Residence Director shall report any irregularities in the resident ' s drug regimens to the prescribing physician. This Statute is not met as evidenced by:	I 473	See response to federal deficiency W104 #4.	12/10/08

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I 473	Continued From page 10 Based on staff interview and record review, the facility failed to ensure that any irregularities in the drug regimen for one resident in the investigation was reported to the prescribing physician. (Resident #1) The finding includes: Interview with LPN #1 on October 17, 2008 at approximately 11:55AM revealed that on October 2, 2008, Resident #1 was observed to have " redness" on his upper chest. Further interview revealed neosporin ointment was applied on Resident #1's upper chest. Review of a nursing progress note dated October 2, 2008 at approximately 7:30AM verified that LPN #1 observed "redness on the upper chest" of Resident #1 and neosporin ointment was applied on Resident #1's upper chest. Review of the physician 's standing orders dated 2007- 2008 on October 21, 2008 at approximately 3:45PM revealed an order that stated "with swelling, redness and/or irritation clean with hydrogen peroxide twice a day whenever necessary" There was no evidence that the medication administered was given in compliance with the physician's orders.	I 473		
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:	I 500		

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I 500	Continued From page 11 Based on interview and record review, the facility failed to ensure that systems were designed and implemented to ensure clients were not subjected to physical abuse, for six of the six resident that resided in the facility. (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5 and Resident #6) The findings include: 1. On October 2, 2008, at approximately 4:23 PM the State Agency (SA) was notified (via telephone) by the Residential Director (RD) that a client alleged being " choked " by a staff member. Additionally, the RD reported that all of the staff that were present at the time of the alleged abuse were placed on administrative leave. The aforementioned notification to the SA was verified on October 17, 2008, at approximately 11:10 AM through face to face interview with the Residential Director/Driver (RD/D). According to the RD/D, Direct Support Professional (DSP) #1 reported that Resident #1 was abused on the 3:00 PM-11:00 PM shift (October 1, 2008). The RD/D further revealed that Resident #1 sustained a red bruise on the left side and scratches on his back as a result of the incident. Additionally, the RD/D disclosed that DSP #2 informed him that DSP #3 and DSP #4 beat up Resident #1. Further discussion with the RD/D revealed that he immediately notified the Qualified Mental Retardation Professional (QMRP) about the allegation. Interviews with the Residential Director (RD), QMRP, LPN #1, Resident #1, DSP #1, and LPN #3 on October 17, 2008 further provided information regarding the previously mentioned allegation of abuse as detailed below:	I 500	1. See response to federal deficiency W127.	12/10/08

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I 500	Continued From page 12 a) Interview with the RD at approximately 11:15 AM revealed that DSP #1 informed him that Resident #1 reported he was "choked" by a staff person. Further interview revealed that on October 2, 2008, DSP #2, DSP #3, DSP # 4, DSP #5, DSP #6 and DSP #7 were placed on administrative leave. b) Interview with the QMRP at approximately 11:30 AM revealed that DSP #1 informed her that Resident #1 reported he was attacked by three staff persons on October 1, 2008, " the big guy, DSP #4 and DSP #5." Continued discussion with the QMRP revealed she requested DSP #1 to have the client assessed by LPN #1 in order to determine if Resident #1 needed to be evaluated at the hospital. Further interview with the QMRP revealed that the RD was requested to place DSP #2, DSP #3, DSP # 4, DSP #5, DSP #6 and DSP #7 on administrative leave. Additionally the QMRP revealed that notifications regarding the allegation of abuse were made to the administrator, RN Supervisor, Adult Protective Services and the Office of Inspector General (OIG). c) Telephone interview with LPN #1 at approximately 11:58 AM revealed that on October 2, 2008, DSP #1 informed him that Resident #1 alleged he was "choked by the big guy." LPN #1 stated that Resident #1 was observed to have "redness" on his upper chest and no other injuries. Further interview revealed that LPN #1 did not report the incident to the administrator or PCP. d) Interview with Resident #1 at approximately 1:15 PM revealed that "the big guy choked me and pulled me to the floor, [DSP #4] grabbed my	I 500		

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I 500	Continued From page 13 legs while the short guy kicked me in the side. I tried to tell him to get off me and not to put their hands on me. The other staff just watched them beat me up. I only told DSP #1 when she came on duty the next day. " e) Interview with DSP #1 on October 17, 2008, at approximately 1:25 PM revealed that Resident #1informed DSP #1 on October 2, 2008 at approximately 6:30 AM that "the big guy choked me on the floor and [DSP #4] held my legs while the short guy kicked me in the side". DSP#1 revealed that Resident #1 had a bruise on the left side of his chest and two scratches on his neck and scratches on both sides of his back. Further interview revealed that DSP#1 immediately informed the RD/D and the RD. f) Interview with the LPN #3 at Resident #1's day program at approximately 2:15 PM revealed that Resident #1 and DSP #1 informed her that Resident #1 was attacked and restrained by staff at the group home on October 1, 2008. LPN #3 stated that she observed scratches to Resident #1's chest, face, neck and upper back. Further interview revealed that LPN #3 did not report the alleged abuse to the administrator because the incident occurred at the group home and not the day program. Review of the facility' s unusual incident reports on October 17, 2008, at approximately 7:00 PM revealed an incident involving Client #1 dated October 2, 2008. According to the report, DSP #1 was informed by Resident #1 that " the big guy choked me and another guy held my legs. " Additional interviews were conducted regarding the allegation of abuse involving Resident #1 reported on October 2, 2008 as detailed below:	I 500		

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I 500	Continued From page 14 · Interview with the RN Supervisor on October 20, 2008 at approximately 12:25 PM revealed that on October 2, 2008, the QMRP informed her that on October 1, 2008, Resident #1 alleged he was "choked by the big guy, held down on the floor and kicked". Further interview with the RN Supervisor revealed that LPN #1 failed to report the allegation of abuse or injuries to the RN Supervisor. The RN Supervisor additionally stated that the Primary Care Physician (PCP) "would only be notified of an allegation of abuse depending on the level of abuse." The RN Supervisor failed to immediately report Resident #1's injuries sustained as a result of an allegation of abuse to the PCP. · Interview the DSP #2 on October 20, 2008 at approximately 1:25 PM revealed that on October 1, 2008 at approximately 7:30 PM, he witnessed DSP #3 grab Resident #1 by the front of the neck and pull him to the floor. DSP #4 was witnessed to assist DSP #3 to hold Resident #1 down on the floor by his legs while DSP #5 kicked Resident #1 five times in the right side. Further interview revealed that DSP#2 did not immediately report the abuse to the administrator. · Interview with the Designated Nurse (DN) on October 21, 2008, at approximately 3:50 PM revealed that on October 2, 2008, LPN #1 did not report Client #1's allegation of abuse or injuries to the DN. Further interview revealed that on October 3, 2008, the QMRP informed her and the RN Supervisor that Resident #1 alleged he was "choked by the big guy, held down on the floor and kicked". The DN stated that she never examined or assessed Resident #1's injuries. Further interview revealed that the DN did not report the client's injuries or incident to the	I 500		

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I 500	Continued From page 15 administrator or the PCP. Cross Refer to W149. Interview with the Director of the day program on October 23, 2008 at approximately 2:25 PM, revealed that the allegation of abuse was not reported because the incident occurred at the group home and not the day program. Review of the day program ' s incident management policy at approximately 2:28 PM revealed that the day program had not developed a policy on reporting external allegations of abuse that occurred outside of their operating hours. The State Agency (SA) substantiated that Resident #1 was physically abused by one or more staff persons. The SA determined that the facility failed to ensure systems were designed and implemented to make certain clients (Residents #1, #2, #3, #4, #5 and #6) were not subjected to physical abuse/neglect that posed a serious and immediate threat to their health and safety. The Administrator/Director of Operations was notified of the immediate jeopardy concerns on October 28, 2008, at approximately 9:45 AM. An onsite visit was conducted on November 4, 2008 to verify that the facility implemented systems to remove the immediate jeopardy. These systems included: 2. Review of the facility's incidents reports on October 21, 2008 at 3:53 PM revealed an incident report dated March 30, 2008. According to the report, staff noticed a scratch on Client #4's ear and shoulder. The incident report revealed that Client #4 stated that Client #2 caused the injury.	I 500	2. See response to federal deficiency W153 #2 and W154 #s 1a and b.	12/1/08

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I 500	Continued From page 16 Interview with the Qualified Mental Retardation Professional (QMRP) on the same day at approximately 4:00 PM revealed that she was not aware of the incident. Additionally, at the time of the survey, there was no evidence the facility's administrator was immediately notified of the aforementioned incident. 3. The facility failed to ensure an allegation of abuse involving Clients #2 and #3 was thoroughly investigated. a. On September 10, 2008, the State Agency received an investigation report dated August 25, 2008. According to the report, the facility received an anonymous letter on July 14, 2008, (dated June 6, 2008) that alleged "Client #2 and Client #3 were routinely physically abused whenever they did not comply with demands of the employees. Further review of the investigation report revealed that only 11 of 23 Direct Support Professionals (DSP) were interviewed using the facility "Witness Questionnaire/Statement" form. The form documented open ended questions such as: - How long have you been employed at [provider]? - What is your regular work schedule? - How many individuals reside at the facility? - Do you know (Client #2 and Client #3)? - Are you aware that there has been alleged physical abuse towards the mentioned individual? Review of all of the available questionnaires revealed staff were only required to answer	I 500	3a. See response to federal deficiency W154 #s 1a and b.	12/10/08

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I 500	Continued From page 17 questions with yes or no and failed to document detailed information as it related to the questions. Interview with the Qualified Mental Retardation Professional (QMRP) and Residential Director (RD) on October 21, 2008 at approximately 2:30 PM acknowledged that 10 DSPs that worked directly with Clients #2 and #3 as an assigned 1:1 staff or overnight staff were not interviewed. Additionally, review of the corresponding investigative summary (submission date August 25, 2008) failed to provide evidence that clients were interviewed regarding the allegation. At the time of the survey, the facility failed to ensure the aforementioned allegation of abuse was thoroughly investigated.	I 500		
	b. Continued review of the facility's investigations for the previously mentioned allegation of abuse revealed the facility completed two separate investigations, one for Client #2 (submission date August 25, 2008) and one for Client #3 (submission date August 15, 2008). Further review of the investigative reports revealed evidence that some interviews were conducted for each investigation after the actual submission dates. For example; Review of Client #3's investigation (submission date August 15, 2008) on October 21, 2008 revealed that eleven staff were interviewed on August 25, 2008 (10 days after the submission date) and one staff was interviewed on August 27, 2008 (17 days after the submission date). At the time of the survey, the facility failed to provide evidence that information received from interviews conducted after the submission dates were incorporated into the investigations.		b. See response to federal deficiency W154 #s 1a and b.	12/10/08
	c. Interview with the Vice President of		c. See response to federal deficiency W154 c.	12/10/08

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I 500	Continued From page 18 Operations (pre-survey) on September 10, 2008, revealed that the she was unaware of the aforementioned allegation and further indicated that the investigation was going to be reopened in order to address all of the allegations presented in the letter. At the time of the survey however, there was no evidence that the investigation had been reopened. 4. The facility failed to ensure an a Review of the facility's incident reports on October 21, 2008 at 3:53 PM revealed an incident report dated March 30, 2008. According to the report, staff noticed a scratch on Client #4's ear and shoulder. The incident report further revealed that Client #4 stated that Client #2 caused the injury. Interview with the Qualified Mental Retardation Professional (QMRP) on the same day at approximately 4:00 PM revealed that she was not aware of the incident. Continued review of the facility ' s incident reports and available investigations failed to provide evidence that the incident had been investigated.	I 500	4. See response to federal deficiency W153 #2 ad W154 #s 1a and b.	12/1/08