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

PRINTED: 05/01/2009
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		04/17/2009

NAME OF PROVIDER OR SUPPLIER: CARECO 01

STREET ADDRESS, CITY, STATE, ZIP CODE: 6417 KANSAS AVE, NE, WASHINGTON, DC 20001

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W 000	INITIAL COMMENTS	W 000		

A recertification survey was conducted on April 14, 2009 through April 17, 2009. The survey was initiated as a full survey due to facility's history of condition level deficiencies during the previous survey period. A random sampling of three clients from the residential population of five male was selected for the survey. The results of the survey were based on observations in the home and at three day programs, staff interviews, as well as a review of the client and administrative records, including a review of the unusual incident reports.

During the survey process the review of the facility's unusual incident reports were completed and evidenced that a client (#2), who requires 24 hour staffing supports, seven days a week, had sustained an injury of unknown origin to his right eye. The injury was described as a " black discoloration underneath the right eye, a reddish colored spot on the sclera of the client's right eye, and swelling on the right side of his nose."

Based on the findings of the survey and the review of the facility's April 3, 2009 preliminary investigation, on April 17, 2009 at 3:20 PM, it was determined that Client #2's health and safey was compromised and an immediate jeopardy existed under the Condition of Participation of Client Protections. The Agency's Administrator and facility's Qualified Mental Retardation Professional (QMRP) were informed at 3:20 PM of the immediate jeopardy and at approximately 5:35 PM systems were employed by the facility to alleviate the immediate concern prior to the surveyors exiting the facility.

As a result of the findings during the survey the facility was determined to be in non-compliance

Received May 23, 2009
GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION
825 NORTH CAPITOL ST., N.E., 2ND FLOOR
WASHINGTON, D.C. 20002

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marsha H. Thompson
TITLE: Director of Disability Services
(X6) DATE: 5/22/09

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

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W 000	Continued From page 1 with the Conditions of Participation in the areas of Governing Body, Client Protections and Facility Practices.	W 000		
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: The facility's governing body failed to maintain general operating direction over the facility. [See W104 and W127]. The results of these systemic practices revealed the facility's Governing Body failed to adequately govern the facility in a manner that would ensure each client 's health and safety. [See also W122]	W 102	The Governing Body has created the position of Quality Management Program Director. The new QMPD position includes setting up and implementing the annual training plan for all employees serving clients via DDS in the ICF/MR program and the Medicaid Home and Community Based Waiver. The QMPD is a certified incident investigator, and also manages all incident investigations. The QMPD provides recommendations for corrective action to the Director of Operations and the Director of Disability Services to ensure that client protections, ISP recommendations, facility staffing, and human rights are properly and timely implemented, monitored, and adjusted per each client's individual needs. Also see responses to W104, W127 and W122.	
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	W 104	1. All staff will be retrained in incident management. Staff who are unable or unwilling to abide by the policy and procedures as trained will receive disciplinary actions up to and including termination.	5/22/09 5/22/09

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W 104	Continued From page 2 facility's incident management policy. 2. Cross Refer to W154. The governing body failed to provide administrative oversite to ensure that an injury of unknown origin was thoroughly investigated. 3. Cross Refer to W186. The governing body failed to provide administrative oversight to ensure that a sufficient number of staff was available to monitor client, prevent injuries and to address behavior management needs. 4. Cross Refer to W159. The governing body failed to ensure administrative oversite and support to the Qualified Mental Retardation Professional for the coordination, integration, and monitoring of the clients the active treatment programs. 5. Cross Refer to W189. The governing body failed to ensure systems were implemented to make certain each employee was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently. 6. Cross-refer to W393. The governing body failed provide evidence that certification to conduct glucose testing had been obtained.	W 104	2. The QMPD (IMC) will reopen the investigation and provide an in-depth report with recommendations. 3. The Director of Operations will ensure that the house will be fully staffed in accordance with each client's needs. When client #3 is in the community (away from the private property of his home) as described in the BSP, he will be supported by the proper staffing ratio. 4. The Governing Body hired a new QMRP who will be compliant with policy. The Governing Body has established a system of quality management and supervision to provide required oversight for the QMRP. 5. The Governing Body will direct the QMPD and QMRP to provide appropriate refresher training, and to contact clinicians to provide additional training as needed. Employees who are unable or unwilling to perform in accordance with training will retrained and/or disciplined, up to and including termination. 6. The Director of Operations will submit an application for CLIA.	5/22/09 5/22/09 5/22/09 5/22/09 5/22/09
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, interview and record	W 120		

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W 120	Continued From page 3 review, the facility failed to ensure that contracted nutrition services addressed the needs of for three of three clients in the sample. (Clients #2, #4 and #5) The finding includes: On April 14, 2009 at 7:25 AM, Clients # 2, #4 and #5 were observed eating their breakfast at the dining table. Interview with the staff revealed dietary orders and special notes were available in the kitchen which provided instructions to staff. On April 14, 2009 at 8:20 AM, the review of dietary orders and special notes in the kitchen were observed with staff instructions. Client #2's name and information, however was not available. Additionally, record review on April 14, 2009 at 1:37 PM revealed Client #2 had not been provided a nutritional assessment since he was admitted to the facility in May 2008. Client #2 ' s Annual Medical Assessment dated May 29, 2008 revealed, "Awaiting consult, to determine ideal body weight. Will follow prescribed diet per the Primary Care Physician, pending nutritional consult ". Interview with the Qualified Mental Retardation Professional (QMRP) on April 15, 2009 at 12:45 PM revealed the facility had recently contracted services with a nutritionist to monitor the clients' diets, and to evaluate and monitor the clients' nutritional status. According to the QMRP, the new nutritionist assessed Client #4 and #5 (date unknown), however, had not provided any written assessments. On April 17, 2009 at 2:14 PM, the review of the	W 120	1. The QMRP will contact the Nutritionist to get the completed nutritional assessments. She will also request the Nutritionist to provide training to staff and clients, and provide evidence of a written request to the QMPD. 5/22/09	

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W 120	Continued From page 4 facility's agreement with the nutritionist dated December 19, 2008, revealed, "Nutrition Consultant Services, including assessment" were to be provided. At the time of the survey, there was no evidence the facility had ensured that the contracted nutrition services had been provided to meet the needs of each client. [See W217) 2. On April 15, 2009 at 11:50 AM, interview with the day program case manager revealed that Client #2 becomes agitated and will want to walk around. Day program staff indicated that the client ate everything and speculated that the client may want more food. The review of the Day programs psychological progress note dated February 10, 2009 revealed that during the review of the client data for the renewal of his behavior support plan, it was determined that many of the clients episodes of agitation (23/48)occurred immediately after lunch. The psychologist recommended that the nutritionist evaluate Client #2's diet to determine the feasibility of allowing him to have more food. At the time of the survey, there was no evidence that the recommendation had been addressed.	W 120	2. See response to #1 above. The QMRP will ensure that the recommendations from the Nutritionist and the Behavior Specialist are reviewed and approved by the PCP. If the PCP approves the recommendation it will be implemented. The QMRP will call a meeting of the Interdisciplinary Team to discuss a change of placement to a much smaller setting for client #2 as a possible solution to assist him in presenting with more socially acceptable and safe behavior.	5/22/09
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 that systems were designed and implemented to ensure clients were not subjected to physical abuse (Cross refer to W127); failed to implement policies that ensured each clients'	W 122	The Governing Body has created the position of Quality Program Management Director to oversee and implement incident management and staff training and hired a competent professional in the role. The QPMD will provide consistent planned training and mentoring to ensure staff are able to identify and avoid actual or potential harm to clients. The Director of Disability Services has established an electronic method for tracking staff levels, qualifications, training, and scheduling to ensure that clients receive appropriate and safe staff supports per the ISP. The Director of Disability Services will ensure	5/22/09

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W 122	Continued From page 5 health and safety; (Cross refer to W149); 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	that the QMRP holds scheduled grand rounds to ensure that all medical recommendations are reviewed and approved by the PCP or disapproved with a written justification, and that nursing follows up on all approved recommendations. Follow up must be documented per Careco policies in each client's record. See responses to W102, W104, W124, W127, W149, W154, W159, W185, W186, W191, W220, W322, W323, and W331.	5/22/09
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the rights of each client and/or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment, for one of the three clients (Client #1) included in the sample. The finding includes: The facility failed to ensure that informed consent was obtained from Client #1 and/or her legal guardian prior to the administration of her psychotropic medications and prior to the implementation of her Behavior Support Plan (BSP). Observation of the medication administration on April 14, 2009, at 4:40 PM revealed that Client #1 received medications including Paroxetine.	W 124	Client #1 has a sister who makes his medical decisions. The QMRP will contact the sister to provide written informed consent for his treatments.	5/22/09

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W 124	Continued From page 6 Interview with the Licensed Practical Nurse (LPN) after the medication administration revealed that the aforementioned medication were used to address the client's maladaptive behaviors. An entrance conference with the Qualified Mental Retardation Professional on April 14, 2009 at approximately 10:45 AM revealed that the client did not have the capacity to give informed consent for the use of medications and for habilitation services. The QMRP's statement was verified on April 14, 2009 at 12:19 PM through review of Client #1 psychological assessment dated January 8, 2009. According to the assessment, Client #1 does not evidence the capacity to make independent decisions on his behalf regarding his treatment plan, financial affairs, living arrangements or day placement due to profound mental retardation. Continued interview with the QMRP, revealed that Client #1's sister is available to make medical and habilitation decisions. Further review of Client #1's record on April 14, 2009, at 12:27 AM revealed that in addition to taking a psychotropic medication, the client also had a Behavior Support Plan, dated January 3, 2009 to address self injurious behaviors. At the time of the survey, the facility failed to provide evidence that consent was obtained for the use of the psychotropic medication and a Behavior Support Plan.	W 124		
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	W 127		

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W 127	Continued From page 7 not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure policies and procedures were implement to protect the health and safety of Client #2. The findings include: A . The facility failed to implement timely measures to address Client #2's injury of unknown origin. 1. The facility failed to provide supervision as prescribed in Client #2's Individual Support Plan (ISP) and Behavior support Plan (BSP) to ensure his safety and well being. The review of an unusual incident on April 14, 2009 at 9:20 AM revealed the following information regarding an injury sustained by Client #2 as evidenced below: On March 30, 2009 at approximately 7:10 AM, Client #2's one on one staff (7:00 AM to 3:00 PM) discovered a blackness (discoloration) underneath the client's right eye as soon he arrived at the facility. The incident reported revealed that the staff immediately telephoned the designated Licensed practical nurse at 7:12 AM, then telephoned the Qualified Mental Retardation Professional (QMRP) at 7:15 AM, to inform them of Client #2's injury. Interview with the Qualified Mental Retardation Professiona (QMRP)l on April 14, 2009 at 9:20	W 127	1. The facility staffing plan includes 24-hour 1:1 staffing for Client #2. The assigned staff person was trained in the BSP and in Incident Management. He failed to document a behavior or an incident that could have led to an injury. The staff person was terminated, and new staff trained and assigned. The QMRP will schedule a meeting of the IDT to discuss moving him to a much smaller environment. Also, the previous DDS case manager had determined that Client #2 did not require a 1:1 staff ratio. The current DDS case manager will assist the facility to have an approved 1:1 staff ratio for the client while he remains in the facility. 5/22/09	

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W 127	Continued From page 8 AM, revealed Client #2 was prescribed to have one on one staff supervision, 24 hours a day. The review of Client #2's ISP dated June 28, 2008 and a BSP support plan dated October 8, 2008, on April 14, 2009 at 12:05 PM, revealed the client should be provided one on one supervision. 24 hours a day, seven days a week to ensure his safety and to address his target behaviors of aggression, self-injurious behavior/biting, pica and Bolting behaviors. At the time of the survey, there was no evidence the client had been provided the recommended level of supervision, as evidenced the his injury of unknown origin. See also W186. 2. The facility failed to ensure a thorough investigation of Client #2's injury of unknown origin. Interview with the QMRP on April 14, 2009 revealed that Client #2 had a behavior support plan which required that he be provided one on one staff supervision 24 hours a day, 7 days a week. Further interview with the QMRP revealed that the client was provided one on one supervision during the shifts, beginning March 29, 2009 at 7:00 AM through the overnight shift (11:00 PM to 7:00 AM). The QMRP revealed that none of the staff had observed or reported an injury sustained by Client #2. Through additional interview with the QMRP, it was determined that the 11:00 PM to 7:00 AM staff was the last one on one staff assigned to the client, prior to the shift on which his injury was discovered. The QMRP revealed however, that this staff had not provided shift notes or provided behavioral documentation for Client #2 during his shift. The QMRP also	W 127	2. The QMPD (IMC) will reopen the investigation and include statements and other documentation such as photographs. The IMC will provide a thorough report with recommendations. 5/22/09	

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W 127	Continued From page 9 confirmed that the one on one staff had not been interviewed or provided a written statement concerning Client #2 and the injury of unknown origin. On April 17, 2009, further interview with the QMRP revealed pictures had been taken of the injury. The surveyors observed several telephone camera photographs which the RD revealed he had taken on March 30, 2009 of Client #2's eye injury. The surveyors observed the photos and noted the client to have a black discoloration underneath the right eye, a reddish colored spot on the sclera of the client right eye, and swelling on the right side of his nose. Interview with the RD revealed that the IMC did not have the photographs. According to the facility's preliminary investigative report, the etiology was reported as unknown, though it may be due to one of the client behaviors. Staff was encouraged to maintain one on one supervision/monitoring via being in arm's reach of [the Client] at all times. Although the investigation was being continued, at the time of the survey, the origin of the client's injury remained unknown.	W 127		
	3. The facility failed to implement it's policy which prohibited staff potentially involved in abuse/neglect from having contact with clients as evidenced below: Interview with the Residential Director and the QMRP on April 15, 2009 revealed that on March 29, 2009, Staff #1 was assigned to Client #2 on the overnight shift (11:00 PM to 7:00 AM). Further interview with the QMRP revealed that he was the last staff assigned to provide one on one		3. The QMRP and/or the QMPDD will provide retraining to the Residential Director on Incident Management policy, and supports available to him when he needs to remove staff from the schedule, and how to handle evidence that he gathers (such as the photos he took of the injury that were never mentioned to or shared with the IMC). 5/22/09	

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W 127	Continued From page 10 support to Client #2 prior to the time his injury was discovered by Staff #2 on March 30, 2009 at 7:10 AM. Further interview with the QMRP and the review, the investigation, and statements obtained for the investigation revealed no evidence that any information had been obtained from Staff #1. Addition interview with the QMRP and the RD revealed that Staff #1, a regular weekend staff, had continued to work with Client #2. It should be noted that the facility removed this employee from client contact on April 17, 2009. 4. The facility failed to ensure that Client #2 received prompt medical attention to address his eye injury as evidenced below: Interview with the morning medication nurse on April 15, 2009 at revealed that he received a call from the designated nurse on March 30, 2009 regarding Client #2's eye injury. The review of the medication administration record revealed on March 30, 2009 at 8:10 AM, the morning medication nurse documented, "Observed blackness coloration underneath the right eye and redness on right corner of the eye. Neosporin ointment applied on the blackness coloration. Will continue to assess until healed. Pain assessmet /medication On April 17, 2009, further interview with the QMRP revealed the surveyors observed several telephone camera photographs which the RD revealed he had taken on March 30, 2009 of Client #2's eye injury. The surveyors observed the photos and noted the client to have a black discoloration underneath the right eye, a reddish colored spot on the sclera of the client right eye,	W 127	4. The Director of Disability Services will re-train the Designated Nurse on the requirement to call the PCP immediately when an injury is discovered. 5/22/09	

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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		04/17/2009

NAME OF PROVIDER OR SUPPLIER: CARECO 01

STREET ADDRESS, CITY, STATE, ZIP CODE: 6417 KANSAS AVE, NE WASHINGTON, DC 20001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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and swelling on the right side of his nose.

Although the client received first aid treatment from the medication nurse on March 30, 2009, there was no evidence the client received medical observation for his eye injury until March 31, 2009. A medical consult form dated March 31, 2009 revealed, "Patient refused treatment. Patient with right eye redness without discharge. Black and blue under eye right x 2 days....FU with ophthalmology, if no improvement. Tobradex Opth Solution was prescribed. ....." The review of nursing progress noted revealed that the discoloration was resolving after five days. There was no evidence that the client had been further medically assessed for his eye injury.

B. The surveyor remained onsite until the facility addressed the serious and immediate jeopardy. The facility initiated a Corrective Action Plan, effective April 17, 2009 as evidenced below:

1. Staff Discipline
The staff who was assigned to provide one on one support and care for Client #2 during the time when the eye injury occurred was immediately suspended, pending termination, regarding failure to report an injury.

2. Staff Training
Retraining of staff on Client #2 ' s BSP was initiated by the QMRP for all staff who come on duty. Training agenda and training sign-in sheet will be maintained for all staff. Training will be repeated for all staff on duty on April 18, 2008. The QMRP will schedule the behavior specialist/psychologist to provide refresher training on Client #2's BSP for all staff, including the RN Supervisor and Licensed Practical Nurse

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W 127	Continued From page 12 Coordinator by April 22, 2009. 3. Documentation On April 17, 2009 the QMRP will review protocols and requirements with all staff that come on duty on proper completion of documentation for shift/staff progress notes and behavioral data collection. Starting April 18, 2009, the Residential Director (RD) will review the documentation daily and provide retraining and/or disciplinary action for staff who fails to complete documentation per protocol. 4. Incident Management The Incident Management Coordinator (IMC) will acquire a written statement from the staff person who failed to report Client #2 ' s injury. The IMC will amend her completed investigation to include the statement and any new recommendations that emerge. The IMC will also ensure that the QMRP and the Human Resources Director immediately remove staff from duty (contact with persons served) per Careco policy, in cases of suspected or confirmed abuse/neglect and failure to follow incident reporting policy. The IMC will ensure that such actions are documented in the personnel record and the incident investigation report. 5. Staff Scheduling for one on one Supports By April 17, 2009, the QMRP and the Residential Director will ensure that staffing ratios are implemented per the ISP and BSP for Client #2. The QMRP and the RD will bring in staff from the on-call roster and other Careco sources. if needed to ensure that staffing ratios are met with properly trained staff. 6. Overnight Monitoring	W 127		

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W 127	Continued From page 13 The QMRP and RD will train staff to check on the individual in question per the protocol listed in his medical shift log, and to document their observations there. The QMRP and the Residential Director will ensure that there is sufficient staff support in the home for persons who require 24 hour one on one support, without impacting the ability of other staff to check on and document their observations on the other persons living in the home on an hourly basis overnight. On April 17, 2009, at approximately 5:45 PM, systems were employed by the facility to alleviate the immediate concern.	W 127		
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 implement written policies and procedures that prohibit mistreatment, neglect or abuse for five of the five client residing in the facility. (Client #1, Client #2, Client #3, Client #4, and Client #5) The findings include: [Cross Refer to W154] 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 was conducted on April 14, 2009, at	W 149	See response to W127 #3.	5/22/09

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W 149	Continued From page 14 approximately 2:15 AM. The policy 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 responsibility of any staff member who witnesses, discovers or is informed of an incident to complete an incident report". Interview with the QMRP on April 14, 2009 at 9:20 AM revealed that interview had been conducted with several of the staff who were on duty the day before Client #2's injury was discovered, to ascertain a possible origin of the client's injury. Further interview with QMRP revealed that statements had not been obtained from several of the staff, including Client #2's 1:1 staff, during the shift prior to the time the client's injury was discovered. During interview with the QMRP on April 17, 2009 at approximately 2:30 PM, the surveyor was informed that Client #2's 1:1 staff on the shift prior to the discovery of the injury, also still had not been interviewed during the investigation. Further interview with the QMRP revealed that this same staff worked the client after the March 30, 2009 injury was reported. At the time of the survey, there was no evidence the facility had implemented it's policy which stated "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.	W 149		
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 15	W 154		
	This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that an injury of unknown origin was thoroughly investigated, for one of the three clients (Client #2) included in the sample. The findings include: 1. Interview was conducted with the facility's Qualified Mental Retardation Professional (QMRP) on April 14, 2009 at 9:40 AM to obtain information regarding the facility's unusual incidents. The QMRP revealed that on March 30, 2009 at 7:10 AM, Client #2's 1:1 staff observed the client to have a "blackness" under his right eye, when he reported for duty. Further interview the the QMRP revealed that during the preliminary investigation it was concluded that the injury to the client's injury was of unknown origin. The QMRP stated that the investigation remained ongoing. On April 14, 2009, beginning at approximately 10:30 AM, the review of the facility's incidents reports revealed the following: On March 30, 2009 at approximately 7:10 AM, Client #2's 1:1 staff (7:00 AM to 3:00 PM) discovered a blackness (discoloration) underneath the client's right eye. The staff stated that he discovered the discoloration underneath the client's eye immediately upon his arrival at the facility. He telephoned the designated Licensed practical nurse at 7:12 AM, then telephoned the Qualified Mental Retardation Professional (QMRP) at 7:15 AM, to inform them Client #2's injury.		1. See response to W127 #2, #3, and #4. The IMC will reopen the investigation, and provide a thorough report with recommendations. 5/22/09	

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	2. The review of the facility's investigative report dated April 3, 2009 1:00 PM revealed it was submitted by the QMRP and reviewed by the incident Management Coordinator. The agency's findings of the investigation revealed the following details: "..[Client] exhibits target behaviors of bolting, physical aggression, non-compliance, PICA, and biting. The injury's origin is unknown, as it was discovered and reported by the staff on March 3, 2009 at 7:10 AM upon their arrival on shift. The QMRP has initiated investigation to identify etiology, though it may be due to one of his behaviors as he often jumps (bolting) without prior warning. It is encouraged that staff maintain 1:1 supervision/monitoring via being in arm's reach of [the Client] at all times. Investigation is ongoing at this point to attempt to determine etiology of injury." Interview with QMRP on April 14, 2009 at 9:42 AM that statements had been obtained from several of the staff, including Client #2's 1:1 staff, who worked on the shift prior to the time the client's injury was discovered. Further interview with the QMRP revealed that staff should write shift notes daily in each client's program book. The review of behavior data revealed that none were documented between March 27, 2009 at 12:15 PM and March 30, 2009 at 9:08 AM. The record review also reveal there were no shift notes. At the at the time of the survey, there was no		2. The QMRP and/or QMPD will re-train the Residential Director and staff on collecting data and completing progress notes daily. 5/22/09	

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W 154	Continued From page 17 evidence the facility had implemented measures to ensure a thorough investigation of Client #2's injury of unknown origin was conducted.	W 154		
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 active treatment 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	The QMRP was recruited and hired by the Governing Body in early 2009 to replace a poorly performing previous QMRP (released in November 2008). The QMRP has been undergoing training in Careco's policies and procedures, and has demonstrated good judgment, clinical skills, and other requirements to perform successfully in the position. The QMRP will be supported and overseen by the Director of Disability Services as she works to correct previous deficient practices in the facility. The QMPD will provide assistance and support by establishing a training schedule, providing training, and assisting the Director of Disability Services to bring outside expertise to augment staff training to enable employees to perform their duties effectively, efficiently, and competently, including in the implementation of each client's Behavior Support Plan. See responses to W102, W104, W120, W122, W159, W189 and W193. 5/22/09	
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the Qualified Mental Retardation Professional (QMRP) failed to coordinate,	W 159		

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W 159	Continued From page 18 integrated and monitor the active treatment programs for five of the five clients residing in the facility. (Clients #1, #2, #3, #4, and #5) The findings include: 1. The QMRP failed to ensure that the day program was included in the interdisciplinary team review and the development of Client #2's individual support plan. Interview with the QMRP on April 14, 2009 at 10:20 AM revealed that she was employed by the agency in January 2009. Additional interview with the QMRP revealed that Client #2 was admitted to the group home from a youth facility (ICF) on May 28, 2008. According to the QMRP, an interdisciplinary team meeting was held on June 27, 2008 to update the client's Individual Support Plan (ISP) and the ISP was implemented on June 30, 2008. On April 15, 2009 at 11:50 AM, the day program case manager stated that the day program was not informed of the June 27, 2008 ISP meeting which was held at the group home. Further interview with the day program case manager revealed that the Individual Plan of Care (IPC) implemented at the day program until its expiration on March 31, 2009, was the one which was developed while the client resided at his previous facility. The day program case manager revealed that when he telephoned the group home to inquire about the 2009 ISP meeting date, he was informed of the ISP which became effective on June 30, 2008. According to the case manager, at that time, he was provided a copy of the current ISP (dated June 30, 2008) and a copy of the current BSP dated October 8,	W 159	1. The QMRP will call a meeting of the IDT to discuss a discharge and change of placement for the client. The QMRP will ensure that all members of the IDT (including the Day Program) are given written invitations to the meeting. The IDT meeting is chaired by the QMRP and monitored by the DDS case manager, and the Day Program is a member of the IDT. The new QMRP is aware of this policy and will ensure that the Day Program is represented in meetings of the IDT.	5/22/09

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W 159	Continued From page 19 2008. The review of Client #2's June 30, 2008 ISP revealed no evidence that the day program had participated in the meeting and development of the ISP. 2. The QMRP failed to coordinate services to ensure that Client #2 received monitoring for the same targeted behavior at his group home and his day program. Interview with group home and day program staff on April 15, 2009 at --- revealed that Client #2 exhibited behavior of biting and attempted biting (physical aggression). Interview with the case manager revealed that the client's BSP which had been implemented until March 31, 2009, did not include biting self as a targeted behavior. Further interview with the case manager revealed that the client's new BSP (dated October 10, 2008) was not received from the group home until April 2009. Interview with the QMRP on April 15, 2009 revealed she was not aware that the Day Program did not have the current BSP and confirmed that it was sent in April 2009. The review of both the old and new BSPs revealed that Client #2 was supervised at his day program by a 1:1 staff from his group home. The review of the old BSP implemented at the day program prior to April 1, 2009 however, revealed that it only included biting self (self-injurious behavior) as a targeted behavior, and did not include biting others as a targeted behavior. There was no evidence the QMRP had maintained close coordination with Client #2's day to ensure his behavioral needs were consistent monitoring in all settings.	W 159	2. The QMRP will develop a monitoring and coordination schedule for each client's day program, and will ensure that when new assessments and protocols are developed for the home setting, the Day Program receives a copy and provides a receipt.	5/22/09

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3. The QMRP failed to ensure that Client #1's feeding protocol was implement by the Direct Care Aides as evidence below:

During breakfast observation on April 14, 2009, at 7:25 AM, Client #1 was spoonfed a purred meal consisting of sausages, boiled eggs and cream of wheat. After he completed his meal, he was given apple juice with 100% assistance.

Review of the feeding protocol dated February 13, 2009, on April 14, 2009, at approximately 12:00 PM, revealed the following:

a. Client #1 should be parallel with the table (when not using a lap tray) so that he can easily access his plate and utensils.

b. Client #1's plate, drinking container and utensils should always remain in the same place.

c. Staff should take Client #1's hand to his mouth to shape the sign "eat" to announce that the meal activity is starting.

d. After the tactile sign eat, staff should provide light physical assistance to help him with scooping and directing the spoon to his mouth. Staff should immediately release their grasp so that Client #1 can maintain control of the spoon.

e. After [the client] "rakes" the food (usually with his teeth) from the spoon, he will return it to the plate. Staff can provide a light touch to the back of the right hand to indicate "good work."

f. After two or three presentations of solids, [the client] should be instructed to have a drink. His

3. The QMRP will re-train the staff and the Residential Director on the dining protocol, and randomly observe meals to ensure that it is properly and consistently implemented.

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W 159	Continued From page 21 hand should be guided to the container so that he can independently hold his drink by guiding it to his mouth and returning it to the table. He may need light physical assistance. There was no evidence that the QMRP ensured that the feeding protocol was implemented for Client #1. 4. The QMRP failed to ensure Client 1's vibrating pillow was functional. On April 14, 2009, at 6:15 PM, Client #1 was observed holding a pillow. At approximately 6:20 PM, the Direct Care Aid placed the pillow on his shoulder. Interview with the Direct Care aid at 6:24 PM revealed that the pillow vibrates and was used to provide tactile stimulation for the client. Further interview revealed that batteries should be provided to activate the vibrator. The client was therefore only able to squeeze the pillow, without feeling the vibration. Interview with the Qualified Mental Retardation Professional (QMRP) confirmed that Client #1 is "blind and deaf", therefore the client benefits from tactile sensory stimulators. There was no evidence the QMRP coordinated services to ensure batteries were available to maximize the client's benefit from the sensory stimulator. 5. The QMRP failed to ensure coordination of service for implementation of Client #1's individual program plan. See [W249.2] 6. The QMRP failed to coordinate services to ensure adequate staffing in accordance with the	W 159	4. The QMRP will provide tactile-based activities and stimuli for Client #1, including ensuring that his pillow is maintained with live batteries. 5. See response to #4 above. 6. The Residential Director will provide a written schedule for each work week. The IMC will check the payroll for the week in question and obtain statements from staff on duty for the overnight shift of March 29 when she reopens the investigation.	5/22/09 5/22/09 5/22/09

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W 159	Continued From page 22 developed staffing pattern. (five staff on the 3:00 PM to 11:00 PM Shift). During interview with the RD and QMRP on April 14, 2009 at 8:36 AM and 9:20 AM respectively, it was acknowledged that there was no written schedule for the week of March 29, 2009. The review of the written schedule, beginning April 13, 2009 revealed that five direct support staff should be on duty during the 7:00 AM - 3:00 PM and 3:00 PM to 11:00 PM Shifts. The schedule revealed that four direct support staff should be on duty from 11:00 PM to 7:00 AM. At the time of the survey, there was no evidence written statements had been obtained from direct support staff, who worked the overnight shift (11:00 PM to 7:00 AM)on March 29, 2009.	W 159		
W 185	483.430(c)(4) FACILITY STAFFING The facility must provide sufficient support staff so that direct care staff are not required to perform support services to the extent that these duties interfere with the exercise of their primary direct client care duties. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to provide sufficient support staff so that direct care staff were not required to perform support services to the extent that these duties interfered with the exercise of their primary direct client care duties for five of five clients in the residing in the facility. (Clients #1, #2, #3, #4, and #5) The finding includes:	W 185		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G010	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/17/2009
NAME OF PROVIDER OR SUPPLIER CARECO 01		STREET ADDRESS, CITY, STATE, ZIP CODE 6417 KANSAS AVE, NE WASHINGTON, DC 20001	

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W 185	Continued From page 23 [Cross Refer to W186.] 1. On each day of the survey, (April 14, 15, and 17, 2009) between the hours of 8:00 AM and 9:00 AM, direct support staff were observed mopping the floors, for approximately twenty minutes. Interview with the staff revealed that the floors needed to be mopped before the clients leave for the day program. Further interview with the QMRP and the Residential Director revealed that each of the day shift staff went to the day program to provided one on one support. The review of the staff schedule revealed evidence that each staff on duty was scheduled to provide one on one coverage for the clients. 2. On April 14, 2009 and April 15, 2009, direct support staff were observed in the kitchen preparing dinner. Interview with the staff preparing the meal revealed that cooking duty was rotated among the staff. Interview with the QMRP revealed that during the times the household chores were being completed by the staff, Client #3 may be with them. If it was another clients 1:1 support staff completing the chore, the RD, QMRP or another client's 1:1 support staff would temporarily monitor the client whose 1:1 staff was performing the chore.	W 185	1. The QMRP will submit a request to the DHCF through DDS for funding for 1:1 staff, as the agency is not reimbursed for this level of support for at least two of the clients in the home. Additional funds will allow the agency to hire support staff. 2. See response to #1 above.	5/22/09 5/22/09
W 186	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by:	W 186		

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W 186	Continued From page 24 Based on observation, interviews, and record verification, the facility failed to maintain a sufficient number of staff to ensure that each client was monitored to prevent injuries and to address behavior management needs of the clients residing in the facility for five of five clients residing in the facility.(Client #1, #2, #3, #4 and #5) The findings include: I. The facility failed to ensure sufficient direct care staff to manage and supervise clients in accordance with their individual program plans (IPP). Interview with the Qualified Mental Retardation Professional (QMRP) on April 14, 2009 at 2006 at 10:10 AM revealed that five clients reside in the facility. According to the QMRP, the following information was conveyed regarding each clients' functional status and their use of behavior modification drugs. A. Client #1- functions within the profound range of mental retardation and is prescribed psychotropic medication (s) in conjunction with other interventions to address inappropriate behaviors. Client #1 is vision and hearing impaired. The BSP requires that the client be provided 1:1 supervision for 16 hour a day. B. Client #2 - functions within the profound range of mental retardation and is prescribed psychotropic medication(s) in conjunction with other interventions to address inappropriate behaviors. The BSP requires that the client be provided 1:1 supervision for 24 hour a day.	W 186	I. The Director of Disability Services will coordinate with the Director of Human Resources to ensure that an appropriate written staffing schedule (weekly or bi-weekly) is produced by the QMRP and the Residential Director thus ensuring that clients in the home have sufficient staff support. See response to W185. 5.22.09	

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C. Client #3 - functions within the profound range of mental retardation and is prescribed psychotropic medication(s) in conjunction with other interventions to address inappropriate behaviors. The BSP requires that the client be provided 1:1 supervision for 24 hour a day.

Interview with the QMRP revealed that the client was being monitored on the overnight shift (11:00 PM to 7:00 AM) by support staff that also provide supervision for Client #4.

D. Client #4 - functions within the profound range of mental retardation and receives psychotropic medication. Client #4 is vision impaired. The review of Client #4's ISP revealed a recommendation for 1:1 staffing ratio 24 hours per day; seven days a week. However, the BSP requires that the client be provided 1:1 supervision for 16 hours a day.

E. Client #5- functions within the profound range of mental retardation and is prescribed psychotropic medication(s) in conjunction with other interventions to address inappropriate behaviors. The BSP requires that the client be provided 1:1 supervision for 16 hour a day.

The review of records on April 15, 2009 at 4:57 PM revealed that the IPPs for Clients #2 and #3, required that they be provided one on one support 24 hours a day. The review of the time schedule for the week of April 13, 2009 through April 19, 2009 revealed that one staff was scheduled to provide supervision to Client # 3 and #5 during the 11:00 PM to 7:00 AM shift. According to the IPPs for Clients #1, #4 and #5, they should be provided one on one support for 16 hours a day. At the time of the survey, there was no evidence

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W 186	Continued From page 26 that the facility had provided staffing for the clients in accordance with their IPPs. II. (Cross-refer to W127) The facility failed to deploy staff to prevent an injury of unknown origin for Client #2. A. On April 14, 2009 at 8:35 AM, the review of an unusual incident report dated March 30, 2009 revealed that at 7:10 AM, Client #2 was discovered to have a right eye injury of unknown origin. During the entrance conference on April 14, 2009 at approximately 9:35 AM, the investigation report of Client #2's injury of unknown origin and the corresponding statements written by staff on duty over the weekend, were requested for review. Interview with the facility's QMRP and Residential Manager Coordinator (RD) on April 14, 2009 at 8:36 AM and 9:20 AM respectively revealed that on March 29, and March 30, 2009, Client #2 should have been provided 1:1 supervision in accordance with his BSP. Interview with the RD concerning the schedule to verify names of the staff who worked on March 29 and March 30, 2009 revealed that no written staff schedule was available. The RD did however,provide a list of the names who worked on March 29, 2009. According to this list, four staff were on duty between the hours of 7:00 AM to 3:00 , three staff between 11:00 PM to 7:00 AM, and three staff on duty from 11:00 PM to 7:00 AM. Further interview with the RD revealed that during the overnight shift one staff should remain on the first floor of the facility with Client #1, and the other two staff should remain on the second level with the other four clients.	W 186	II. See response to I above. Staff will be trained on procedures to notify the Residential Director and QMRP when they cannot report for duty per the schedule. The QMRP and Residential Director will be trained on procedures to provide fill-in duty and assignments for on-call staff, so that clients are properly provided with staff supports per their ISPs. 5/22/09	

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According to the QMRP, an interview and/or statement had not been provided by the overnight staff (11:00 PM, 3/29/09 - 7:00 AM, 3/30/09) who worked with Client #2. Interview with QMRP on April 14, 2009 revealed she interviewed other staff on the overnight shift. The review of statements provided to the surveyor failed to evidence that any staff on the aforementioned shift had provided a written statement for the investigation.

S11's statement completed for the investigation revealed he left the RD a telephone message notifying him that Client #1's one on one support staff for the 3:00 PM to 11:00 PM shift had not arrived to relieve him. S11 further noted that he had worked from 7:00 AM until 11:00 PM on March 29, 2009 and returned to duty on March 29, 2009 at 7:00 AM. S11's investigative statement revealed that another support staff (S21) told him to leave the facility, because he had work 16 hours on Saturday. S11 documented in the interview that S24 arrived as he was leaving duty at 3:30 PM, however stated he was to provide one on one support during the shift to Client #3. According to S11, as he left the facility he observed S21 monitoring Clients #1 and #2 as they sat in the living room. There was no evidence the facility ensured adequate staffing for Client #2's monitoring in accordance with his IPP and to ensure his health and safety were met. At the time of the survey, there was no evidence that adequate staff were on duty to manage the safety and health needs of the clients, including Client #2, between the hours of 3:30 PM on March 29, 2009 and 7:00 AM on March 30, 2009.

B. During the entrance conference on April 14,

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W 186	Continued From page 28 2009 at approximately 9:35 AM, the investigation of the Client #2's injury of unknown origin and the corresponding statements of staff on duty over the weekend of March 28, and March 29, 2009 were requested for review. Further interview with the QMRP revealed that statement, no interview, or written statement had not been provided by the overnight staff (11:00 PM, March 29, 2009 through 7:00 AM, March 30, 2009) who worked with Client #2. The QMRP and the RD also revealed that no written schedule was available for the weekend of March 28, 29, 2009. Interview with the RD however, revealed that there were four staff on duty during the day shift and evening the evening shift. Although interview with the QMRP and the RD revealed that four staff should have been on the overnight shift (11:00 PM to 7:00 AM shift), documentation provided by the RD revealed that only three staff worked the shift on the overnight shift. Interview with the RD on April 14, 2009 at approximately 8:45 AM revealed that Clients #2 and #3 required 1:1 Supervision 24 hours a day. Further interview with the QMRP revealed that Client #1, #4, and #5 require 1:1 supervision for 16 hours a day (from 7:00 AM until 11:00 PM). Continued interview with the RD revealed that Client #2 requires one to one supervision to ensure his safety and due to physical aggression (biting), SIB (biting self), Pica, provoking peers, and inappropriately entering others personal space. Review Client #3's Individual Support Plan (ISP) dated June 30, 2008 on April 15, 2009 at 2:27 PM revealed the following interventions:	W 186		

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	"1:1 staffing ratio 24 hours per day; seven days a week. All injuries should be reported to nursing and documented." At the time of the survey, there was no evidence the facility had deployed staff in a manner to ensure the safety of Client #2.			
	III. The facility failed to ensure that the RD and the QMRP provided monitoring and supervision of direct care staff to ensure that the clients needs were addressed.		III.The Director of Disability Services will coordinate with the Director of Human Resources and the Director of Operations to ensure that both the QMRP and the Residential Director have access to a list of appropriately trained and scheduled on-call employees who can be assigned as substitutes. The Director of Disability Services will ensure that the QMRP and Residential Director develop prospective written staffing schedules based upon the established and approved staffing pattern for the home. The Director of Disability Services and the Quality Management Director will monitor scheduling through an electronic web-based data management tool.	5/22/09
	A. Interview with the QMRP and the Residential Director during the entrance conference on April 17, 2009 revealed the QMRP had been employed by the agency for approximately four months and the RD had been employed for approximately one month. Interview with the RD and QMRP during this time revealed that the RD was responsible for developing the work schedule for the direct support support staff. Further inquiry during the interview revealed no written staff schedule was available for the March 30, 2009. The RD provided the surveyor with a copy of the written schedule for week of 4/13/09 on 4/15/09, however stated that recent schedules for previous three weeks were not available.			
	Record review on April 17, 2009 at 2:38 PM evidence the QMRP responsibilities included the following:			
	1. Ensure adequate staffing in the facility based on the developed staffing pattern 2. Make certain no substitute is located for a late night shift that members from the 3-11 shift take turns filling in. 3. Informing substitutes of caseload, activity			

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W 186	Continued From page 30 schedule of consumers and special consumer needs/concerns. B. Interview with the RD on April 14, 2009, at 8:50 AM revealed he came by the group home on March 29, 2009, to get the time for the week. The clients were observed sleeping and he did not disturb them. The RD stated that on the next day, he was informed by the QMRP that Client #2 had sustained an injury to his eye, possibly on Sunday which was being investigated. The RD revealed that the the injury occurred during his first week of employment at the group home. At the time of the survey there was no evidence that sufficient supervisory staff was provided for the group home to manage the needs of the clients. [See also W159]	W 186		
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 each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently for four of five clients residing in the facility. (Clients #1, #3, #4 and #5) The findings include: The facility failed to ensure staff were provided training on the clients' on nutritional needs, and modified diets, and mealtime protocols for Client #1. (See W159.3)	W 189	See response to W159. The QMRP will contact the Nutritionist to provide training on the dining protocols for all clients; the QMRP will immediately provide training to staff on the protocol for Client #1. 5/22/09	

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W 189	Continued From page 31	W 189		
	Cross refer to meal time observation. Interview with the QMRP on April 15, 2009 at 12:45 PM revealed the nutritionist had visited the facility, however had not provided training to staff.			
	The review of prescribed dietary orders on April 15, 2009 at 4:15 PM revealed that Clients #3 and #4 were prescribed calorie restricted diets. The record review also revealed that Clients #1, #3, #4, and #5 were prescribed modified texture diets. At the time of the survey, there was no evidence that the staff had received recent instructions (within the last 12 months) from a nutritional professional on the client's diets.			
W 191	483.430(e)(2) STAFF TRAINING PROGRAM	W 191	The QMRP will request the DHCF through the DDS case manager to receive funding for 2:1 staffing on a schedule so that the client can safely engage in community-based activities.	5/22/09
	View in-service training as a dynamic growth process. It is predicated on the view that all levels of staff can share competencies which enable the individual to benefit from the consistent, wide-spread application of the interventions required by the individual's particular needs.			
	In the final analysis, the adequacy of the in-service training program is measured in the demonstrated competencies of all levels of staff relevant to the individual's unique needs as well as in terms of the "affective" characteristics of the caregivers and the personal quality of their relationships with the individuals. Observe the staff's knowledge by observing the outcomes of good transdisciplinary staff development (i.e., in the principles of active treatment) in such recommended competencies as:			
	· Respect, dignity, and positive regard for individuals (e.g., how staff refers to individuals,			

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W 191	Continued From page 32 refer to W150);	W 191		
	Use of behavioral principles in training interactions between staff and individuals;			
	· Use of developmental programming principles and techniques, e.g., functional training techniques, task analysis, and effective data keeping procedures;			
	· Use of accurate procedures regarding abuse detection and prevention, restraints, medications, individual safety, emergencies, etc.;			
	· Use of adaptive mobility and augmentative communication devices and systems to help individuals achieve independence in basic self-help skills; and			
	· Use of positive behavior intervention programming.			
	§483.430(e)(2) Probes			
	Does the staff training program reflect the basic needs of the individuals served within the program?			
	Does observation of staff interactions with individuals reveal that staff know how to alter their own behaviors to match needs and learning style of individuals served?			
	For employees who work with clients, training must focus on skills and competencies directed toward clients' behavioral needs.			

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W 191	Continued From page 33 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide evidence that employees working with the clients received required behavior management training that enabled them to implement approved interventions for one of the five clients residing in the facility. (Client #3) The finding includes: The facility failed to ensure that Client #3's one to one support staff was effectively trained on his one on one protocol (for a 2:1 staff while in the community). (See W249.1)	W 191		
W 217	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include nutritional status. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that the comprehensive functional assessment included evaluation on clients' nutritional status for one of three clients in the sample. (Client 2). The finding includes: The facility failed to ensure Client #2 received a nutritional assessment to determine the adequacy of his diet and feeding skills. On April 15, 2009 at 5:30 PM, Client #2 was observed to appear drowsy as he ate his dinner. The QMRP revealed that it was unsual for the client to be sleepy at the table. Further interview	W 217	The QMRP will contact the Nutritionist to request the assessment for Client #2 to ensure he has adequate food to meet his nutritional needs, and that his ideal body weight information can be placed in his record and shared with his primary care physician.	5/22/09

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W 217	Continued From page 34 with the QMRP regarding the client's nutritional assessment revealed he had not received one since his admission to the group home May 28, 2008. Staff revealed that the client was on a regular, with chopped food. The review of the list of prescribed diets in the kitchen revealed that it was dated April 19, 2008 and that it did not include Client #2's name or diet order. The review of the Annual Medical Assessment dated May 29, 2008 revealed "Awaiting Consult to determine ideal body weight. Will follow prescribed diet per the PCP pending nutritional consult. Further review Client #2's records revealed he had no nutritional assessment since he was admitted to the facility in May 28, 2008. The review of the client's individual support plan (ISP) dated June 30, 2008 revealed "Nutritional assessment by dietitian annually with quarterly reviews of dietary needs and compliance". At the time of the survey, there was no evidence the client had received any nutritional assessment since his admission to the group home.	W 217		
W 220	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include speech and language development. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to fully assess Client #2's speech and language needs, to determine if he might benefit from professional intervention. The findings include:	W 220	The QMRP will schedule a meeting of the IDT to propose and approve clinical interventions needed, including specialty Speech-Language services. The QMRP will also ask the IDT to determine the best residential setting for the client, and prepare an official discharge plan for him. 5/22/09	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G010	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/17/2009
NAME OF PROVIDER OR SUPPLIER CARECO 01		STREET ADDRESS, CITY, STATE, ZIP CODE 6417 KANSAS AVE, NE WASHINGTON, DC 20001	

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On April 14, 2009, at 8:20 AM, Client #2 's one on one staff was observed to follow him everywhere, keeping him at arms distance. Interview with the staff revealed he was the client's one on one staff and that the client required constant supervision . Later that evening, screaming was heard coming from the lower first floor of the facility. Interview with the Qualified Mental Retardation Professional revealed that it was Client #2 screaming. When questioned why the client was screaming, the QMRP indicated that it was one of the client's targeted behavior which he frequently exhibited. Further interview with the QMRP revealed the screaming behavior was being monitored by the psychologist. The QMRP revealed however, that client had not received a Speech and language Evaluation since the client was admitted to the facility on May 28, 2008. The QMRP stated that the client had a Speech and Language Evaluation at his previous group home.

The review of the annual nursing assessment dated June 27, 2008 on April 14, 2009 at 2:22 PM revealed "Screeching - will also attempt to bite. All staff in house have been trained on CPI used as a last resort...CPI technique is to stand to side or remain out of reach. " The review of a PCP note dated October 24, 2008 on April 14, 2009 at 12:35 PM revealed "Schreech a lot and bites people. Seroquel increased yesterday."

The review of the aforementioned Speech and Language Evaluation on April 15, 2009 at 4:10 PM revealed that it was dated July 5, 2005. The Speech and Language Pathologist (SLP) assessed Client #2 's oral mechanism to be grossly adequate for speech production purposes. The SLP recommended that this area

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W 220	Continued From page 36 be further assessed once the client was more cooperative. The SLP recommended that the client be evaluated by a neuro-psychologist for a behavioral profile. Additionally, the SLP recommended that the client be enrolled in an individual trial speech and language treatment program to develop his ability to sustain attention and increase his tolerance for structured learning. There was no evidence that the facility had ensured that Client #2's Speech and language needs had been evaluated or addressed by the interdisciplinary Team (IDT).	W 220		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure continuous active was implemented in accordance with the interdisciplinary team recommendations for two of the three clients in the sample. (Clients #1, and #3) The finding includes: 1. The facility failed to ensure that Client #3 was provided staff support in accordance with his individual support plan and and his behavior support plan.	W 249	1. See response to W191.	5/22/09

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W 249	Continued From page 37	W 249		
	On April 15, 2009, at approximately 8:30 AM, Client #3 was observed walking in his community with his 1:1 staff.			
	Review of the behavior support plan dated September 2008, on April 15, 2009, at 3:30 PM revealed that Client #3 requires 2:1 staff supervision when out in the community to prevent him from approaching children. Review of the social work assessment dated October 2, 2008, on April 15, 2009, at 3:40 PM, confirmed that Client #3 requires 2:1 staff supervision when out in the community .			
	Interview with the Qualified Mental Retardation Professional (QMRP) on April 15, 2009 at approximately 7:00 PM indicated that Client #3 only has a 2:1 on the weekends.			
	At the time of survey, there was no evidence that Client #3 was provided with a 2:1 staff while in the community.			
	3. The facility failed to ensure that Client #1 IPP objectives were implemented.		3. See response to W159 #4. The QMRP will provide training to staff and materials for use in tactile-stimulatory activities. 5/22/09	
	On April 14, 2009, at 6:15 PM, Client #1 was observed holding a pillow. At approximately 6:20 PM, the Direct Care Aid placed the pillow on his shoulder.			
	Interview with the Direct Care aid at 6:24 PM revealed that the pillow was to vibrate and was not equipped with batteries, therefore the client was only able to squeeze without feeling the vibration. Interview with the Qualified Mental Retardation Professional (QMRP) confirmed that Client #1 is blind and deaf, therefore he benefits			

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W 249	Continued From page 38 from tactile sensory stimulators. Interview with Client #1's 1:1 staff on April 15, 2009, at 4:30 PM revealed that the staff teaches activities of daily living skills, choice and decision making skills. Further interview revealed tactile stimulation is also provided with assistance. Review of the IPP dated January 14, 2009, at approximately 5:30 PM, revealed the following goals: a. Will tolerate lotion applied to his arms for a minimum of 5 minutes, three times a week for three consecutive months. b. Will identify (by touching) personal care items (lotion, deodorant, etc) after showering, 75% of the time, three times a week for six consecutive months. c. Will tolerate textured mitts for a minimum of 10 minutes, twice a week for three consecutive months. d. Will choose ands participate in at least two activities daily for 12 consecutive months. Further interview with Client #1's 1:1 staff on April 15, 2009, at 4:30 PM and subsequent interview with the QMRP, followed by record review, revealed no evidence that the above IPP objectives had been implemented since January 2009.	W 249		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.	W 252		

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W 252	Continued From page 39	W 252		

This STANDARD is not met as evidenced by:
Based on interview and record review, the facility failed to ensure accurate documentation of progress on the individual program plan (IPP) objectives, for two of the three clients included in the sample. (Client #1 and #2)

The findings include:

1. The facility failed to maintain data as required by Client #2's behavior support plan (BSP).

On April 14, 2009 at 7:20 AM, a staff was observed providing direct supervision to Client #1 as he walked around in the group home. Interview with the staff revealed that he was Client #2's 1:1 staff for the 7:00 AM to 3:00 PM shift on Monday through Friday. Further interview with the 1:1 staff revealed that a behavior support plan (BSP) was being implemented for the client at the group home and at his day program. Additional interview with client's 1:1 staff revealed that data was being maintained on the client's targeted behaviors when he exhibited them. Interview with the QMRP revealed that she had provided recent training to staff because they had failed to document the client's progress on some days.

The review of an investigative report for an unusual incident dated 3/30/09 revealed that at 7:10 AM, Client #2 was observed to have an injury of unknown origin to his right eye. The investigative report documented that the client's injury may have occurred during a targeted behavior. The review of the client's recent

1. The QMRP and the Residential Director will review data collection at least weekly. If data collection is found to be inadequate, the QMRP and RD will re-train the staff and mentor them in collection. If the inadequacy continues and staff do not or cannot respond sufficiently to training provided, progressive discipline up to and including termination will be instituted. 5/27/09

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W 252	Continued From page 40 behavioral data revealed that none were documented between March 27, 2009 at 12:15 PM and March 30, 2009 at 9:08 AM. Additionally, no behavioral data was available for April 1, 3, 4, 5, 8, 2009. The client also had no shifts notes for the above periods. Record review revealed that data on the client targeted behaviors had been collected on 9 of 25 days the during the weekends between December 1, 2008 and February 28, 2009. The review of Client #2's BSP revealed he was being monitored for target behaviors which included Self Injurious Behavior (SIB - Biting self); Physical Aggression, Pica, and Bolting. According to the documentation procedures included in the BSP, "All incidents of the targeted behaviors should be documented on the data sheets provided. Documentation should occur on every shift and every day. If no incidents of the behavior have occurred on a particular shift, this should be noted as well." Further review of the documentation instructions revealed all possible antecedents of the behavior, and the consequences of the behavior should be documented. At the time of the survey, there was no evidence staff had consistently documented the client's behaviors to facilitate accurate monitoring of the client's progress. [Note: Interview with the QMRP revealed that a psychotropic medication review was held for Client #2 on 4/15/09. The review of the Psychotropic Medication Review revealed that the team agreed to increase Client #2 Risperdal from .5 mg BID to 3 mg/day and to increase the clients evening dosage of Depakote from 500 mg to 1000 mg. Record review on 4/17/09 revealed a	W 252		

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W 252	Continued From page 41 physician's order dated 4/15/09 for the aforementioned medications.]	W 252		
	2. Interview with Client #2's 1:1 staff on April 14, 2009 at approximately 6:32 PM revealed he was being taught to bathe himself. Staff revealed that after the water was adjusted for the client ,he does most of the bathing himself, with verbal prompts. The review of the IPP on April 15, 2009 revealed a goal to improve Client #2's activity of daily living skills - Bathing. According to the objective, the client "will shower with physical assistance with 80% accuracy for 6 consecutive months." Review of program data for April 2009 revealed that the data had been entered for the entire month of April 2009. At the time of the survey, there was no evidence accurate documentation had been maintained on Client #2's bathing objective.		2. See response to #1 above.	5/22/09
	3. On April 14, 2009, at approximately 8:08 AM, Client #3 was observed putting dishes into the dishwasher. Interview with the Qualified Mental Retardation Professional at approximately 5:45 PM revealed that Client #3's IPP was implemented daily. Review of the IPP dated October 3, 2008, at approximately 6:30 PM, revealed the following goals: a. Will plan and engage others in a board game with a peer for 40 minutes with 100% accuracy on 3 out of 4 trials for 6 consecutive months.		3. See response to #1 above.	5/22/09

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W 252	Continued From page 42 b. Will clean his dentures with 100% accuracy for 6 consecutive months. There was no evidence that the data had been collected in accordance with the IPP for the client, which was necessary for a functional assessment of the client's progress.	W 252		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that restrictive programs were used only after written consents had been obtained, for one of the three clients in the sample. (Client #1) The finding includes: Observation of the medication administration on April 14, 2009, at 4:40 PM revealed that Client #1 received medications including Paroxetine. Interview with the Licensed Practical Nurse (LPN) after the medication administration revealed that the aforementioned medication were used to address the client's maladaptive behaviors. An entrance conference with the Qualified Mental Retardation Professional on April 14, 2009 at approximately 10:45 AM revealed that the client did not have the capacity to give informed consent for the use of medications and for habilitation services.	W 263	The QMRP will ensure that written informed consent is provided by the medical decision-maker for the treatments provided to the client. 5/22/09	

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The QMRP's statement was verified on April 14, 2009 at 12:19 PM through review of Client #1 psychological assessment dated January 8, 2009. According to the assessment, Client #1 does not evidence the capacity to make independent decisions on his behalf regarding his treatment plan, financial affairs, living arrangements or day placement due to profound mental retardation. Continued interview with the QMRP, revealed that Client #1's sister is available to make medical and habilitation decisions.

Further review of Client #1's record on April 14, 2009, at 12:27 AM revealed that in addition to taking a psychotropic medication, the client also had a Behavior Support Plan, dated January 3, 2009 to address self injurious behaviors.

At the time of the survey, the facility failed to provide evidence that consent was obtained for the use of the psychotropic medication and a Behavior Support Plan.

W 322 483.460(a)(3) PHYSICIAN SERVICES

The facility must provide or obtain preventive and general medical care.

This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to provide preventive and general care, for one of three clients in the sample. (Client #2)

The finding includes:

The facility failed to ensure that Client #2 received

W 322 The Director of Disability Services will re-train the facility designated nurse on the protocol for ensuring that the PCP is contacted when an injury is discovered or reported, and that if the PCP directs the client to be brought in for examination or sent to a hospital, nursing staff ensures that this occurs. 5/22/09

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W 322	Continued From page 44 a prompt medical evaluation for his right eye injury.	W 322		

Interview with the the QMRP on April 14, 2009 at 9:20 AM Client #2's direct support staff discovered him to have an eye injury of unknown origin upon his arrival on duty on March 30, 2009. According to the unusual incident dated March 30, 2009 at 7:10 AM, Client #2's 1:1 direct care staff (7:00 AM - 3:00 PM) discovered him to have "blackness of his right eye". Interview with the designated LPN on April 14, 2009 revealed that the blackness underneath Client #2's right eye was resolving after about 5 days.

The review of the incident report revealed on March 30, 2009 at 8:10 AM, the morning medication nurse documented that he assessed and treated the, "Observed blackness coloration underneath the right eye and redness on right corner of the eye and applied Neosporin ointment applied on the blackness coloration. The review of nursing progress notes also revealed that he administered Ibuprophen for pain.

The review of a Medical consultation form dated March 31, 2009, revealed "Patient refused treatment. Patient with right eye redness without discharge. Black and blue under eye x 2 days....FU with ophthalmology if no improvement. Tobradex Opth Solution was prescribed....."

At the time of the survey, there was no evidence that Client #2 had received prompt medical evaluation after possible trauma, to his right eye to determine the extent of his injury.

[Note: On April 17, 2000 at PM, pictures of Client #2 which were taken by the RD on March

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30, 2009, revealed a red spot on the right sclera (eyeball) on the side close to his nose. nose. The facial area underneath the client's eye was observed to be dark ("blackness"), and there was facial swelling on right side of the client's nose.]

Further record review revealed a medical consult form noted dated March 31, 2009 which stated, "Patient refused treatment. Patient with right eye redness without discharge. Black and blue under eye x 2 days....FU with ophthalmology if no improvement. Tobradex Opth Solution was prescribed....."

At the time of the survey, there was no evidence that Client #2 had received prompt medical evaluation after possible trauma, to his right to determine the extent of his injury.

[Note: On April 17, 2000 at PM, pictures of Client #2 which were taken by the RD on March 30, 2009, revealed a red spot on the right sclera (eyeball) on the side close to his nose. nose. The facial area underneath the client's eye was observed to be dark ("blackness"), and there was facial swelling on right side of the client's nose.]

Further record review revealed a medical consult form noted dated March 31, 2009 which stated, "Patient refused treatment. Patient with right eye redness without discharge. Black and blue under eye x 2 days....FU with ophthalmology if no improvement. Tobradex Opth Solution was prescribed....."

At the time of the survey, there was no evidence that Client #2 had received prompt medical evaluation after possible trauma, to his right to

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W 322	Continued From page 46 determine the extent of his injury. [Note: On April 17, 2000 at 4:00 PM, pictures of Client #2 which were taken by the RD on March 30, 2009, revealed a red spot on the right sclera (eyeball) on the side close to his nose. The facial area underneath the client's eye was observed to be dark ("blackness"), and there was facial swelling on right side of the client's nose.]	W 322		
W 323	483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide an annual hearing examination for one of the three clients in the sample. (Client #1). The finding includes: Interview with the Residential Director on April 14, 2009, at approximately 10:00 AM, indicated that Client #1 was "deaf and blind". Review of the Hearing and Speech Center progress notes dated January 29, 2008 on April 15, 2009, at approximately 9:30 AM, revealed that Client #1 will benefit from an annual reevaluation of the middle ear. Interview with the Qualified Mental Retardation Professional at approximately 10:00 AM confirmed that the Client did not received an annual reevaluation of the middle ear as recommended.	W 323	The Director of Disability Services will institute a process for review of each medical consult through a grand round, to ensure that all specialty recommendations are provided to the PCP for review and approval, and if disapproved, that the PCP provides a justification for such. The grand round will also be used to ensure that nursing follows up timely with each approved medical recommendation. 5/22/09	
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing	W 331		

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W 331	Continued From page 47 services in accordance with their needs.	W 331		
	This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that Client #2 received nursing services in accordance with his needs for an eye injury.			
	The findings include:			
	1. Cross refer to W322. The facility failed to ensure that Client #2 was referred for a timely medical evaluation for his right eye injury.		1. See response to W322.	5/22/09
	Interview with direct care staff on April 14, 2009 at 2:47 PM revealed that on March 30, 2009, Client #2 was observed to have a right black eye and that he would not allow the staff to touch his cheek.			
	Interview with the designted nurse on April 14, 2009 at approximately 11:00 AM reveiled that Client #2 was evaluated by the medication nurse upon his arrival at the group home on March 30, 2009 at 8:10 AM. Further interview with the designated nurse and the record review no evidence that the client was referred for medical evaluation of his injury until March 31, 2009.			
	2. Interview with the morning medication nurse on April 15, 2009 at approximately 8:30 AM revealed that he observed Client #2 to have a blackish area underneath his eye and a reddish area on the white of his right eye. Further interview with the nurse revealed that the client did not appear to be in acute distress and allowed him to apply Neosporin to the area. The nurse revealed that Client #2 was non-verbal and that		2. The Director of Disability Services will re-train the Designated Nurse on documentation protocols.	5/22/09

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

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W 331	Continued From page 48	W 331		

he administered Ibuprophen for pain that may occur as a result of the client's injury. According to the nurse, he then wrote a progress note after assessing and treating the client.

The review of the nursing progress note dated March 30, 3009 revealed at 8:10 AM the morning medication nurse "Observed redness on right side of the right eye. Black discoloration underneath the right eye. Neosporin Ointment applied on black sidcoloration of right eye. Ibupropen 400 mg administered for pain. Will assess until healed." Further record review revealed no further documentation of the progress or care of the clients right eye by the morning nurse or the designated nurse.

On the afternoon of April 15, 2009 at approximately 1:30 PM, the designated nurse presented the surveyors with additonal progress notes dated April 1, 3, and 5, 2009 which were written by the evening medication nurse. According to the April 5, 2009, progress note, the red spot on the client's right eye was clearing well, and no discharge or drainage was noted. At the time of the survey, there was no evidence the record failed to document when thd dark area and redness on the sclera of the client's was completely resolved.

(Note: The review of the unusual incident dated March 30, 2009 on April 14, 2009 revealed that the section completed by the morning medication nurse failed to document that Client #2 was administered medication for pain.)

At the time of the survey, there was no evidence that Client #2 had received prompt medical evaluation after possible trauma, to his right to

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W 331	Continued From page 49 determine the extent of his injury. [Note: On April 17, 2000 at PM, pictures of Client #2 which were taken by the RD on March 30, 2009, revealed a red spot on the right sclera (eyeball) on the side close to his nose. nose. The facial area underneath the client's eye was observed to be dark ("blackness"), and there was facial swelling on right side of the client's nose. The review of the nursing progress notes failed to identify when the swelling on Client #2's face occurred and was resolved.]	W 331		
W 393	483.460(n)(1) LABORATORY SERVICES If a facility chooses to provide laboratory services, the laboratory must meet the requirements specified in part 493 of this chapter. This STANDARD is not met as evidenced by: Based on interview, and record review, the facility failed to ensure it met the requirement for performing glucose testing for one of three clients in the sample. (Client #1) The finding includes: Review of Client #1's record on April 15, 2009, at approximately 10:30 AM, revealed that the client had a hematology appointment on March 23, 2009, due to possible hemolytic anemia. Further review of the record revealed that the hematologist recommended blood sugar Accu checks before meals and at bed time while taking Prednisone. Interview with the Licensed Practical Nurse (LPN) on April 15, 2009 at approximately 5:00 PM, confirmed that Client #1's blood sugar Accu	W 393	The Director of Operations will submit the application for CLIA at the facility. 5/22/09	

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W 393	Continued From page 50 checks were performed at the home. Interview was conducted with the Registered Nurse on April 15, 2009, at approximately 1:00 PM to ascertain if the facility had been certified to perform the aforementioned blood sugar Accu checks, as required by part 493 of the Clinical Laboratory Improvement Act (CLIA) revealed that the CLIA certification had not been obtained. At the time of the survey, there was no evidence that the CLIA certification had been obtained.	W 393		
W 418	483.470(b)(4)(ii) CLIENT BEDROOMS The facility must provide each client with a clean, comfortable mattress. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that one of two clients in the facility was provided with a comfortable mattress for two of the five clients residing in the facility. (Client #4 and #5) The findings include: Observation of the environment was conducted with the Qualified Mental Retardation Professional and the residential manager on April 15, 2009 beginning at at approximately 4:15 PM. Client #4's and Client #5 bed mattresses was observed to have palpable springs. Interview with the QMRP indicated that the facility was not aware that the springs in the two mattresses could be felt. At the time of the survey, there was no evidence that Clients #4 and #5 were provided with mattress in a condition to ensure their comfort to ensure his comfort when in bed.	W 418	The Director of Operations will ensure that the mattresses are replaced. 5/12/09	
W 426	483.470(d)(3) CLIENT BATHROOMS	W 426		

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W 426	Continued From page 51	W 426		

The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.

This STANDARD is not met as evidenced by:
Based on observations, interview and record review, the facility failed to ensure water temperatures did not to exceed 110 degrees Fahrenheit.

The findings include:

1. Interview with the Qualified Mental Retardation Professional (QMRP) on April 14, 2009 ar 10:32 AM revealed that staff should monitor the hot water temperature with a thermometer during each shift. Interview with the Residential Director on April 15, 2009 at PM revealed that the thermometer for measuring the water temperature was broken. Later that evening, the RD was observed with a new thermometer for measuring water temperatures.

Later that evening, 4:30 PM the facility was observed with a new thermometer for measuring water temperatures. During the environmental walk-through on April 15, 2009 at approximately 4:40 PM, the hot water temperature measured of 120 degrees Farenheit in the bathroom located across the hall from the nursing office. The water temperature in the other bathroom located on the second floor measured 121 degrees Fahrenheit. The thermometer reading for the hot water in the bathroom located on the first floor was 121degrees Fahrenheit. The thermometer

1. The Residential Director will ensure that the water temperature is measured and properly regulated to remain not higher than 110 degrees Farenheit per Careco's policy. The Residential Director will check the temperature log daily to ensure that water temperatures are checked and recorded. 5/22/09

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W 426	Continued From page 52 reading for the hot water temperature in the bathroom in the basement was 122 degrees Fahrenheit. Upon notification of the water temperatures, the QMRP turned down the setting on the hot water heater. At approximately 5:30 PM, hot water temperatures were retested at all of the previously identified installations. The temperatures ranged from 95 to 100 degrees Fahrenheit. There was no evidence however, that the facility had consistently ensured that the hot water temperatures did not exceed 110 degrees Fahrenheit. 2. The review of the hot water temperature log on April 15, 2009 6:18 PM revealed, "Hot water temperature must not exceed 110 degrees Fahrenheit in all ICF Homes. The temperature should be tested daily and recorded. Record the temperature and report it to maintenance if the reading is outside the acceptable range." The review of the hot water temperature log revealed no water temperatures were recorded for April 11 and April 12, 2009. Additionally, no temperatures were recorded for the day and the evening shift on April 13, 2009. At the time of the survey, there was no evidence the facility had ensured that the water temperature did not exceed 110 degrees Fahrenheit in areas of the facility that were used by individual who had not been trained to regulate water temperature.	W 426	2. See response to #1 above.	5/22/09
W 463	483.480(a)(4) FOOD AND NUTRITION SERVICES The client's interdisciplinary team, including a qualified dietitian and physician must prescribe all modified and special diets.	W 463		

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W 463	Continued From page 53	W 463		

This STANDARD is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure that a qualified dietitian was included in the prescribing of modified and special diets for two of the five clients residing in the facility (Clients #1 and #5)

The findings include:

1. The facility failed to ensure that Client #5's modified was reviewed by the qualified dietitian.

On April 15, 2009 at 5:55 PM, Client #5 was observed raking chopped food into his mouth, as he held his mouth close to the plate guard. Interview with the food preparation staff during the meal revealed the client was prescribed a chopped textured diet. Interview with the QMRP on April 15, 2009 at 6:25 PM revealed that the nutritionist had recently been at the group home however, had not assessed Client #5.

On April 15, 2009 at 6:17 PM, the review of the facility's diet list (dated April 19, 2008) revealed the client was to receive an 1800 Calorie, Low Fat, Low Cholesterol, Chopped Diet. A review of the April 1, 2009 physician's orders revealed an 1800 Calorie, Low Fat, Low Cholesterol, Chopped Diet was prescribed for the client.

Further record review however, revealed a Nutrition Quarterly Review (dated February 8, 2008) documented that a Quarterly nutritional assessment were recommended to be provided every ninety days. At the time of the survey, there was no evidence that Client #5's modified diet had been reviewed by the dietitian during the last fourteen months.

1. See response to W120. The QMRP will follow up with the Nutritionist to ensure that each client receives services in accordance with the ISP. If the current Nutritionist is unable to respond timely and adequately, the Director of Disability Services will engage the services of a different Nutritionist. 5/22/09

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W 463	Continued From page 54	W 463		
	2. The QMRP failed to ensure that Client #1 feeding protocol was implement by the Direct Care Aids as evidence below:		2. See response to #1 above.	
	During breakfast observation on April 14, 2009, at 7:25 AM, Client #1 was spoonfed a pureed meal consisting of sausages, boiled eggs and cream of wheat.			
	On April 14, 2009 at approximately 12:15 PM, the review of Client #1's Individual Support Plan (ISP) dated January 14, 2009, revealed a recommendation for "Nutritional assessments annually with quarterly reviews of dietary needs and compliance". Further record review revealed an annual nutritional assessment dated February 1, 2009.			
	The review of Client #1's record revealed that prior to the February 1, 2009 annual nutritional assessment, the client's diet had not been monitored for the appropriateness and effectiveness of his diet since the first nutritional quarterly, which was dated March 8, 2008.			
W 474	483.480(b)(2)(iii) MEAL SERVICES	W 474		
	Food must be served in a form consistent with the developmental level of the client.		See responses to W120 and W 463. The QMRP will ensure that staff are trained, and/or re-trained, on proper meal preparation and service in accordance with the clients' ISPs. 5/22/09	
	This STANDARD is not met as evidenced by: Based on observation, and staff interview, and record review the facility failed to provide food in the prescribed texture for one of the three clients in the facility. (Client #3)			
	The finding includes:			

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W 474	Continued From page 55 On April 14, 2009 at 8:04 AM, Client #3 was observed eating his breakfast which consisted of a hard boiled egg, a biscuit, sausages and cream of wheat. The feeding protocol dated April 19, 2008 on April 14, 2009 at approximately 12:00 PM, revealed that Client #3 was prescribed a regular, finely chopped diet. Further review of the protocol indicated that finely chopped foods are the size of rice pellets. Interview with the Qualified Mental Retardation Professional (QMRP) confirmed the client was prescribed a regular finely chopped diet. At the time of the survey, there was no evidence that Client #3 received the regular diet, finely chopped as prescribed.	W 474		
W 484	483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure dining supplies were provided to meet the developmental needs of clients, for one of the three clients included in the sample. (Client #1) The finding includes: On April 14, 2009, at 7:23 AM, Client #1 was observed eating a meal which consisted of pureed sausages, biscuits and boiled eggs from a high sided divided plate. Client #1 also ate cream of wheat from a bowl.	W 484	The QMRP will acquire the appropriate adaptive equipment for the client per his ISP. Also see response to W474.	5/22/09

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W 484	Continued From page 56	W 484		
	Review of Client #1's feeding protocol dated February 13, 2008 on April 14, 2009, at 12:00 PM revealed that the client's mealtime adaptive equipment consisted of "a plate guard or a hi-low plate, a medium to large built-up handle spoon, and large bowl to the spoon". Interview with the Qualified Mental Retardation Professional (QMRP) and the Direct Care Aide on April 14, 2009, at approximately 4:30 PM indicated that Client #1 was provided with a high sided divided plate for each meal.			
	At the time of the survey, there was no evidence that the facility ensured that a plate guard or hi-low plate was provided for Client #1 in accordance with his feeding protocol.			
W 489	483.480(d)(5) DINING AREAS AND SERVICE	W 489		
	The facility must ensure that each client eats in an upright position, unless otherwise specified by the interdisciplinary team or a physician.		See response to W474.	5/22/09
	This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each client sat in an upright position while eating for one of the five clients residing in the facility. (Client #5)			
	The finding includes:			
	On April 14, 2009 at 8:17 AM, Client #5 was observed sitting upright in an arm chair as his 1:1 staff interacted `continuously with him.			
	On April 15, 2009 at 5:55 PM, Client #5 was observed feeding himself from a regular plate, to which a plate guard was attached at the front and			

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W 489	Continued From page 57 sides. The client fed himself with a tablespoon as he leaned forward and with his mouth against the edge of the plate guard. After loading each spoonful of food, the client then raked the food into his mouth. During this time, several staff were observed at the table with the clients. Interview with staff on April 14, 2009 at 8:17 AM revealed that Client #5 had a severe vision deficit, however was able to sit upright and to reposition himself independently. Interview with the Qualified Mental Retardation Professional (QMRP) on April 17, 2009 at 5:40 PM revealed the client was able to feed himself using the plate guard and that he did not have a feeding protocol. On April 17, 2009 at 5:42 PM, the review of the individual support Plan (ISP) dated December 9, 2008, revealed the interdisciplinary team (IDT) recommended that Client #5 used a plate guard to keep food on his plate. The April 1, 2009 physician's orders revealed a plate guard was prescribed for the client. At the time of the survey, however, there was no evidence the facility had addressed Client #5's failure to sit in an upright position while eating his meal.	W 489		

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I 000	INITIAL COMMENTS	I 000		
	A licensure survey was conducted on April 14, 2009 through April 17, 2009. A random sample of three residents was selected from a residential population of five males with mental retardation and other disabilities. The survey findings were based on observations in the group home and day programs. In addition, the findings were based on interviews with direct care, administrative, nursing, and day program staff. A review of the GHMRP's records, including the unusual incident reports was also conducted.			
I 055	3502.13 MEAL SERVICE / DINING AREAS	I 055		
	Each GHMRP shall train the staff in the use of proper feeding techniques and monitor their appropriate use to assist residents who require special feeding procedures or utensils.		See response to federal deficiency W463.	5/22/09
	This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure staff were trained on proper feeding/eating techniques for one of the five residents in the GHMRP. (Resident #5)			
	The finding includes:			
	The GHMRP failed to ensure that staff provided supervision and assistance to Resident #5 to encourage him to sit upright while eating his meal.			
	On April 15, 2009 at 5:53 PM, Resident #5 was observed seated upright at the dining table as staff placed his plate containing food on the table in front of him. Staff was observed to attach a plateguard to the front and sides of the Resident			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marsha H. Thompson TITLE: Director of Disability Services (X6) DATE: 5/22/09

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I 055	Continued From page 1	I 055		
	#5's plate. The resident then leaned forward and placed his mouth against the edge of the plateguard. After loading each spoonful of food, the resident then raked the food into his mouth. During this time, several staff were observed at the table with the residents.			
	Interview with staff on April 14, 2009 at 8:17 AM revealed that Resident #5 had a severe vision impairment, however was able to sit upright and to reposition himself independently. Interview with the Qualified Mental Retardation Professional (QMRP) on April 17, 2009 at 5:40 PM revealed the resident was able to feed himself using the plateguard and that he did not have a feeding protocol. Further interview with the QMRP revealed that the should be provided one on one supervision 16 hours a day.			
	On April 17, 2009 at 5:42 PM, the review of the individual support Plan (ISP) dated December 9, 2009, revealed the interdisciplinary team recommended that Resident #5 use a plate guard to keep food on his plate. The April 1, 2009 physician's orders revealed a plate guard was prescribed for the resident.			
	At the time of the survey, however, there was no evidence the GHMRP had addressed Resident #5's leaning posture while eating his food.			
I 058	3502.16 MEAL SERVICE / DINING AREAS	I 058		
	A review and consultation by a dietitian or nutritionist shall be conducted at least quarterly to ensure that each resident who has been prescribed a modified diet receives adequate nutrition according to his or her Individual Habilitation Plan.			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0230	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/17/2009
NAME OF PROVIDER OR SUPPLIER CARECO 01	STREET ADDRESS, CITY, STATE, ZIP CODE 6417 KANSAS AVE, NE WASHINGTON, DC 20001		

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I 058	Continued From page 2	I 058		
	This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that modified diets were reviewed at least quarterly by the consulting dietitian for two of the five residents residing in the facility. (Residents #1 and #5)			
	The findings include:			
	1. Interview with the Qualified Mental Retardation Professional on April 14, 2009 at approximately 9:45 AM, revealed that a nutritionist had been obtained to provide services for the clients.		1. See response to federal deficiency W120.	5/22/09
	The review of Resident #1's nutritional assessment dated January 9, 2008 on April 14, 2009, at approximately 12:15 PM, revealed that the resident was prescribed a regular, pureed diet. Further record review revealed a first nutritional quarterly dated March 8, 2008 in which it was recommended that Resident #1's prescribed diet be continued. There were no further evidence that Resident #1's modified diet had been reviewed at least quarterly by a dietitian.			
	2. On April 15, 2009 at 5:55 PM, Resident #5 was observed raking chopped food from his plate into his mouth, as he held his mouth close to the plate guard. Interview with the food preparation staff during this time revealed the resident was prescribed a chopped textured diet.		2. See response to federal deficiency W463.	5/22/09
	On April 15, 2009 at 6:17 PM, the review of the facility's most recent diet list (dated April 19, 2008) revealed the resident was to receive an 1800 Calorie, Low Fat, Low Cholesterol, Chopped Diet. A review of the April 1, 2009 physician's orders revealed an 1800 Calorie, Low			

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I 058	Continued From page 3 Fat, Low Cholesterol, Chopped Diet was prescribed for the resident. The Nutrition Quarterly Review dated February 8, 2008 revealed that a quarterly nutritional assessment was recommended to be provided every ninety days. At the time of the survey, there was no evidence that Resident #5's modified diet had been reviewed by the dietitian during the last fourteen months.	I 058		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview the GHMRP failed to maintain the interior of the GHMRP in a safe, clean, orderly, and attractive manner . The findings include: A. The GHMRP failed to maintain the environment clean, orderly, and attractive as evidenced below: 1. On April 15, 2009 at approximately 8:30 AM, Resident #1 was observed seated in his wheelchair. Interview with staff revealed that Resident #1 was not ambulatory and required the use of a wheelchair for mobility. Observation of the wheelchair access revealed that it was located outside the back door. Part of the adjacent driveway in the backyard was observed to be paved with gravel. The section of the yard	I 090	1. The Director of Operations will direct the maintenance team to smooth out the pathway and level it. This may be accomplished by several methods.	5/22/09

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I 090	Continued From page 4	I 090		
	directly beside the paved was dirt covered and not level with the pavement. The GHMRP vehicle was observed parked on the street in front of the house.			
	Interview with the staff revealed the wheelchair was pushed down the driveway to the street by staff to load the resident onto the van.			
	At the time of the survey, there was no evidence the aforementioned condition in the back yard would consistently promote safety for the residents during mobility when in the back yard.			
	2. On April 15, 2009 at approximately 10:30 AM, the beige carpet installed in the hallway of the second floor was observed to be heavily soiled.		2. The Director of Operations will direct the maintenance team to clean the carpet.	5/22/09
	3. On April 17, 2009 the following observations were made:			
	a. The top section of a down spout was noted to be missing from the edge of the roof. This condition would allow water coming from the roof to run to the ground at the foundation of the house.		3. a. The Director of Operations will direct the maintenance team to repair the downspout.	5/22/09
	b. Several cans full of trash and debris were observed placed at the side of the GHMRP.		b. The Director of Operations will direct the maintenance team to remove the debris.	5/22/09
	B. The GHMRP failed to ensure water temperatures did not to exceed 110 degrees Fahrenheit.		B. See response to federal deficiency W426.	5/23/09
	a. Interview with the Qualified Mental Retardation Professional (QMRP) on April 14, 2009 ar 10:32 AM revealed that staff should monitor the hot water temperature with a thermometer during each shift. Interview with the Residential Director (RD) on April 15, 2009 at approximately 3:15 PM			

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I 090	Continued From page 5 revealed that the thermometer for measuring the water temperature was broken. Interview with the RD at approximately 4:30 PM revealed he had obtained another thermometer. During the environmental walk-through on April 15, 2009 at approximately 4:40 PM, the hot water temperature measured of 120 degrees Farenheit in the bathroom located across the hall from the nursing office. The water temperature in the other bathroom located on the second floor measured 121 degrees Fahrenheit. The thermometer reading for the hot water in the bathroom located on the first floor was 121 degrees Fahrenheit. The thermometer reading for the hot water temperature in the bathroom located in the basement was 122 degrees Fahrenheit. Upon notification of the water temperatures, the QMRP turned down the setting on the hot water heater. At approximately 5:30 PM, hot water temperatures were retested at all of the previously identified installations. The temperatures ranged from 95 to 100 degrees Fahrenheit. There was no evidence however, that the GHMRP had consistently ensured that the hot water temperatures did not exceed 110 degrees Fahrenheit. b. The review of the hot water temperature log on April 15, 2009 6:18 PM revealed, "Hot water temperature must not exceed 110 degrees Fahrenheit in all ICF Homes. The temperature should be tested daily and recorded. Record the temperature and report it to maintenance if the reading is outside the acceptable range." The review of the hot water temperature log revealed no water temperatures were recorded for April 11 and April 12, 2009. Additionally, no temperatures	I 090		

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I 090	Continued From page 6 were recorded for the day and the evening shift on April 13, 2009. At the time of the survey, there was no evidence the GHMRP had ensured that the water temperature did not exceed 110 degrees Fahrenheit in areas of the GHMRP that were used by individuals who had not been trained to regulate water temperature.	I 090		
I 097	3504.8 HOUSEKEEPING No cleaning agent, bleach, insecticide or any other poisonous, dangerous, or flammable material shall be accessible to a resident where access to such substance is contraindicated in the resident's Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure a cleaning agent was not accessible to residents who required close supervision for their safety for two of the five residents residing in the GHMRP. (Residents #2 and #5) The finding includes: On April 14, and April 15, 2009, a cleaning agent was observed in a spray bottle in a container on the shelf, located at the bottom of the basement stairs. Interview with the Qualified Mental Retardation Professional (QMRP) on April 15, 2009 indicated the cleaning agent was stored unlocked to ensure that it was available to staff. Further interview with the QMRP revealed that all of the resident's were provided 1:1 supervision for at least 16 hours to ensure their personal safety.	I 097	The QMRP will train staff to lock the cleaning agents away after use.	5/22/09

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I 097	Continued From page 7	I 097		
	During the evening of April 14, and April 15, 2009 respectively, Residents #5 and #2 were observed in the basement while being supervised by their one to one staff. There was no evidence, however, the GHMRP ensure that cleaning agents were not potentially accessible to the residents.			
I 180	3508.1 ADMINISTRATIVE SUPPORT	I 180		
	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 provide adequate administrative support to ensure that the needs of five of five residents in the GHMRP were met. (Residents #1, #2, #3, #4, and #5)			
	The findings include:			
	I. The GHMRP failed to ensure sufficient direct care staff to manage and supervise residents in accordance with their individual program plans (IPP).		I. See response to federal CONDITION W158.	5/22/09
	Resident #5 functions within the profound range of mental retardation and is prescribed psychotropic medication(s) in conjunction with other interventions to address inappropriate behaviors. The BSP requires that the resident be provided 1:1 supervision for 16 hour a day.			
	The review of records on April 15, 2009 at 4:57 PM revealed that the IPPs for Residents #2 and #3, required that they be provided one on one support 24 hours a day. The review of the time			

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	schedule for the week of April 13, 2009 through April 19, 2009 revealed that one staff was scheduled to provide supervision to Resident # 3 and #5 during the 11:00 PM to 7:00 AM shift. According to the IPPs for Residents #1, #4 and #5, they should be provided one on one support for 16 hours a day. At the time of the survey, there was no evidence that the GHMRP had provided staffing for the residents in accordance with their IPPs.			
	II. (Cross-refer to I500 - 3523.1) The GHMRP failed to deploy staff to prevent an injury of unknown origin for Resident #2.		II. See response to federal deficiency W104 #3, federal CONDITION 102, and federal CONDITION 158.	5/22/09
	A. On April 14, 2009 at 8:35 AM, the review of an unusual incident report dated March 30, 2009 revealed that at 7:10 AM, Resident #2 was discovered to have a right eye injury of unknown origin.			
	During the entrance conference on April 14, 2009 at approximately 9:35 AM, the investigation report of Resident #2's injury of unknown origin and the corresponding statements written by staff on duty over the weekend, were requested for review.			
	Interview with the GHMRP's QMRP and Residential Manager Coordinator (RD) on April 14, 2009 at 8:36 AM and 9:20 AM respectively revealed that on March 29, and March 30, 2009, Resident #2 should have been provided 1:1 supervision in accordance with his BSP. Interview with the RD concerning the schedule to verify names of the staff who worked on March 29 and March 30, 2009 revealed that no written staff schedule was available. The RD did however, provide a list of the names of staff reported to have worked on March 29, 2009. According to this list, four staff were on duty between the hours			

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of 7:00 AM to 3:00, three staff between 11:00 PM to 7:00 AM, and three staff on duty from 11:00 PM to 7:00 AM. Further interview with the RD revealed that during the overnight shift, one staff should remain on the first floor of the GHMRP with Resident #1, and the other two staff should remain on the second level with the other four residents.

According to the QMRP, an interview and/or statement had not been provided by the overnight staff (11:00 PM, 3/29/09 - 7:00 AM, 3/30/09) who worked with Resident #2. Interview with QMRP on April 14, 2009 revealed she interviewed other staff on the overnight shift. The review of statements provided to the surveyor failed to evidence that any staff on the aforementioned shift had provided a written statement for the investigation.

S11's statement completed for the investigation revealed he left the RD a telephone message notifying him that Resident #2's one on one support staff for the 3:00 PM to 11:00 PM shift had not arrived to relieve him. S11 further noted that he had worked from 7:00 AM until 11:00 PM on March 29, 2009 and returned to duty on March 29, 2009 at 7:00 AM. S11's investigative statement revealed that another support staff (S21) told him to leave the GHMRP, because he had work 16 hours on Saturday. S11 documented in his statement that S24 arrived as he was leaving duty at 3:30 PM, however stated he was to provide one on one support during the shift to Resident #3. According to S11, as he left the GHMRP he observed S21 monitoring Residents #1 and #2 as they sat in the living room. There was no evidence the GHMRP ensured one on one staffing for Resident #2's monitoring in accordance with his IPP, and to

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I 180	Continued From page 10	I 180		
	ensure his health and safety. At the time of the survey, there was no evidence that adequate staff were on duty to manage the safety and health needs of the residents, including Resident #2, between the hours of 3:30 PM on March 29, 2009 and 7:00 AM on March 30, 2009.			
	B. During the entrance conference on April 14, 2009 at approximately 9:35 AM, the investigation of the Resident #2's injury of unknown origin and the corresponding statements of staff on duty over the weekend of March 28, and March 29, 2009 were requested for review. Interview with the QMRP revealed that no interview or written statement had not been provided by the overnight staff (11:00 PM, March 29, 2009 through 7:00 AM, March 30, 2009) who worked with Resident #2.			
	The QMRP and the RD also revealed that no written schedule was available for the weekend of March 28 - 29, 2009. Interview with the RD however, revealed that there were four staff on duty during the day shift. Although interview with the QMRP and the RD revealed that four staff should have been on the overnight shift (11:00 PM to 7:00 AM shift), documentation provided by the RD revealed that only three staff worked the shift on the overnight shift.			
	C. Interview with the RD on April 14, 2009 at approximately 8:45 AM revealed that Residents #2 and #3 required 1:1 Supervision 24 hours a day. Further interview with the QMRP revealed that Resident #1, #4, and #5 required 1:1 supervision for 16 hours a day (from 7:00 AM until 11:00 PM). Continued interview with the RD revealed that Resident #2 required one to one supervision to ensure his safety and due to physical aggression (biting), SIB (biting self),			

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I 180	Continued From page 11 Pica, provoking peers, and inappropriately entering others personal space. Review of Resident #3's Individual Support Plan (ISP) dated June 30, 2008 on April 15, 2009 at 2:27 PM revealed the following interventions: "1:1 staffing ratio 24 hours per day; seven days a week. All injuries should be reported to nursing and documented." At the time of the survey, there was no evidence the GHMRP had deployed staff in a manner to ensure the safety of Resident #2. III. The GHMRP failed to ensure that the Residential Director and the QMRP provided monitoring and supervision of direct care staff to ensure that the residents' needs were addressed. A. Interview with the QMRP and the Residential Director during the entrance conference on April 17, 2009 revealed the QMRP had been employed by the agency for approximately four months and the RD had been employed for approximately one month. Interview with the RD and QMRP during this time revealed that the RD was responsible for developing the work schedule for the direct support support staff. Further inquiry during the interview revealed no written staff schedule was available for the March 30, 2009. The RD provided the surveyor with a copy of the written schedule for week of 4/13/09 on 4/15/09, however stated that recent schedules for previous three weeks were not available. Record review on April 17, 2009 at 2:38 PM evidence the QMRP responsibilities included the following: 1. Ensure adequate staffing in the GHMRP based	I 180	III. See responses to I and II above. 5/22/09	

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I 180	Continued From page 12 on the developed staffing pattern 2. Make certain no substitute is located for a late night shift that members from the 3-11 shift take turns filling in. 3. Inform substitutes of caseload, activity schedule of consumers and special consumer needs/concerns. B. Interview with the RD on April 14, 2009, at 8:50 AM revealed he came by the group home on March 29, 2009, to get the time for the week. The residents were observed sleeping and he did not disturb them. The RD stated that on the next day, he was informed by the QMRP that Resident #2 had sustained an injury to his eye, possibly on Sunday, which was being investigated. The RD revealed that the the injury occurred during his first week of employment at the group home. At the time of the survey there was no evidence that sufficient supervisory staff was provided for the group home to manage the needs of the residents. IV.The GHMRP failed to failed to provide administrative support to ensure coordination, integration and monitoring of the active treatment programs of five of five residents residing in the GHMRP. (Residents #1, #2, #3, #4, and #5) A. The QMRP failed to ensure that the day program was included in the interdisciplinary team review and the development of Resident #2's individual support plan. Interview with the QMRP on April 14, 2009 at 10:20 AM revealed that she was employed by the agency in January 2009. Additional interview with the QMRP revealed that Resident #2 was admitted to the group home from a youth GHMRP (ICF) on May 28, 2008. According to the	I 180	IV. See responses to federal deficiencies W120, and W159, and federal CONDITIONS 102, 122 and 158.	5/22/09

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I 180	Continued From page 13 QMRP, an interdisciplinary team meeting was held on June 27, 2008 to update the resident's Individual Support Plan (ISP) and the ISP was implemented on June 30, 2008. On April 15, 2009 at 11:50 AM, the day program case manager stated that the day program was not informed of the June 27, 2008 ISP meeting which was held at the group home. Further interview with the day program case manager revealed that the Individual Plan of Care (IPC) implemented at the day program until its expiration on March 31, 2009, was the one developed by the resident's previous group home. The day program case manager revealed that when he telephoned the group home to inquire about the 2009 ISP meeting date, he was informed of the ISP which became effective on June 30, 2008. According to the case manager, at that time, he was provided a copy of the current ISP (dated June 30, 2008) and a copy of the current BSP dated October 8, 2008. The review of Resident #2's June 30, 2008 ISP revealed no evidence that the day program had participated in the meeting and development of the ISP. B. The QMRP failed to coordinate services to ensure that Resident #2 received monitoring for the same targeted behavior at his group home and his day program. Interview with group home and day program staff on April 15, 2009 revealed that Resident #2 exhibited behavior of biting self and attempted biting of others (physical aggression). Interview with the case manager revealed that the resident's BSP and ISP from his previous group home had been implemented until March 31,	I 180		

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	2009. Further interview with the case manager revealed that the resident's new BSP (dated October 10, 2008) was not received from the group home until April 2009. Interview with the QMRP on April 15, 2009 revealed she was not aware that the Day Program did not have the current BSP and confirmed that it was sent in April 2009.			
	The review of both the old and new BSPs revealed that Resident #2 was supervised at his day program by a 1:1 staff from his group home. The review of the old BSP implemented at the day program prior to April 1, 2009 however, revealed that it identified physical aggression, bolting, biting self (self-injurious behavior), screaming and agitation as a targeted behaviors. There was no evidence the QMRP had maintained close coordination with Resident #2's day to ensure his behavioral needs received consistent interventions in all settings.			
	C. The QMRP failed to ensure that Resident #1's feeding protocol was implement by the Direct Care Aides as evidence below:			
	During breakfast observation on April 14, 2009, at 7:25 AM, Resident #1 was spoonfed a pureed meal consisting of sausages, boiled eggs and cream of wheat. After he completed his meal, he was given apple juice with 100% assistance.			
	Review of the feeding protocol dated February 13, 2009, on April 14, 2009, at approximately 12:00 PM, revealed the following:			
	1. Resident #1 should be parallel with the table (when not using a lap tray) so that he can easily access his plate and utensils.			

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I 180	Continued From page 15	I 180		
	2. Resident #1's plate, drinking container and utensils should always remain in the same place.			
	3. Staff should take Resident #1's hand to his mouth to shape the sign "eat" to announce that the meal activity is starting.			
	4. After the tactile sign eat, staff should provide light physical assistance to help him with scooping and directing the spoon to his mouth. Staff should immediately release their grasp so that Resident #1 can maintain control of the spoon.			
	5. After [the resident] "rakes" the food (usually with his teeth) from the spoon, he will return it to the plate. Staff can provide a light touch to the back of the right hand to indicate "good work."			
	6. After two or three presentations of solids, [the resident] should be instructed to have a drink. His hand should be guided to the container so that he can independently hold his drink by guiding it to his mouth and returning it to the table. He may need light physical assistance.			
	There was no evidence that the QMRP ensured that the feeding protocol was implemented for Resident #1.			
	D. The QMRP failed to ensure Resident 1's vibrating pillow was functional.			
	On April 14, 2009, at 6:15 PM, Resident #1 was observed holding a pillow. At approximately 6:20 PM, the Direct Care Aid placed the pillow on his shoulder.			
	Interview with the Direct Care aid at 6:24 PM revealed that the pillow vibrates and was used to			

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I 180	Continued From page 16 provide tactile stimulation for the resident. Further interview revealed that batteries should be provided to activate the vibrator. The resident was therefore only able to squeeze the pillow, without feeling the vibration. Interview with the Qualified Mental Retardation Professional (QMRP) confirmed that Resident #1 is "blind and deaf", therefore the resident benefits from tactile sensory stimulators. There was no evidence the QMRP coordinated services to ensure batteries were available to maximize the resident's benefit from the sensory stimulator. E. The QMRP failed to ensure coordination of services for implementation of Resident #1's individual program plan. See [W3521.3] F. The QMRP failed to coordinate services to ensure adequate staffing in accordance with the Individual Program Plan (IPP)developed staffing pattern. (five staff on the 3:00 PM to 11:00 PM Shift). During interview with the RD and QMRP on April 14, 2009 at 8:36 AM and 9:20 AM respectively, it was acknowledged that there was no written schedule for the week of March 29, 2009. The review of the written schedule, beginning April 13, 2009 revealed that five direct support staff should be on duty during the 7:00 AM - 3:00 PM and 3:00 PM to 11:00 PM Shifts. The schedule revealed that four direct support staff should be on duty from 11:00 PM to 7:00 AM. IV. The GHMRP exercised general policy and operating direction over the GHMRP, except in the following areas.	I 180	IV see responses to federal Conditions 102, 122, and 158.	5/22/09

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I 180	Continued From page 17 The findings include: 1. The governing body failed to provide administrative oversight to ensure the effective implementation of the GHMRP's incident management policy as evidenced below: Review of the GHMRP's Incident Management policy was conducted on April 14, 2009, at approximately 2:15 AM. The policy 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 responsibility of any staff member who witnesses, discovers or is informed of an incident to complete an incident report". Interview with the QMRP on April 14, 2009 at 9:20 AM revealed that interview had been conducted with several of the staff who were on duty the day before Resident #2's injury was discovered, to ascertain a possible origin of the resident's injury. During interview with the QMRP on April 17, 2009 at approximately 2:30 PM, the surveyor was informed that Resident #2's 1:1 staff on the shift prior to the discovery of the injury, had not provided a written statement or been interviewed during the investigation. Further interview with the QMRP revealed that this same staff worked with the resident after the March 30, 2009 injury was reported. At the time of the survey, there was no evidence the GHMRP had implemented it's policy which stated "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.	I 180		

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I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that annual health certificates/ inventories was obtained for eleven (11) of twenty-seven (27) staff working in the facility. The findings include: Interview with the Qualified Mental Retardation Professional (QMRP) during the entrance conference on April 14, 2009 at approximately 9:35 AM, revealed that several direct care staff had been recently hired to work at the group home. At this time, the QMRP was requested to obtain the the health certificates of all for staff working in the facility, and who had worked in the facility during the weekend of March 29, 2009 through March 30, 2009. Review of the provided records on April 17, 2009 at approximately 3:45 PM, revealed there was no health certificate available for S5, S7, S10, S13, S15, S16, S17, S18, S21, S24, and S26.	I 206	The Director of Human Resources will ensure that new staff do not begin work in the facility until they have submitted an acceptable health certificate.	5/22/09
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be	I 227		

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I 227	Continued From page 19 limited to, the following: (d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans; This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure staff were trained to implement emergency measures for five of five residents residing in the facility. (Residents #1, #2, #3, #4, and #5) The findings include: During the entrance conference on April 14, 2009 at 9:30 AM, the Qualified Mental Retardation Professional (QMRP) was requested to obtain the training records for staff working in the facility, and who had worked in the facility during the weekend of March 29, 2009 through March 30, 2009. a. The facility failed to provide evidence of certification in Cardiopulmonary Resuscitation (CPR) for thirteen (13) of twenty-seven (27) staff as evidenced below: On April 17, 2009, review of staff records at approximately 4:15 PM, revealed no documentation of current CPR certification was provided for S4, S7, S9, S10, S11, S12 ,S15, S16, S18, S21, S22, S24, and S26. b. The facility failed to provide evidence of current First Aid certification for eight (8) of 27 staff as evidenced below:	I 227	The Director of Human Resources will ensure that all staff have evidence of training and current certification (where appropriate) in first aid, CPR, and the Heimlich maneuver. The Director of Human Resources will ensure that all staff are trained in disaster plans, and fire evacuation.	5/22/09

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I 227	Continued From page 20 On April 17, 2009, review of staff records at approximately 4:15 PM, revealed no documentation of current First Aid certification was provided for S7, S10, S12, S13, S16, S18, S24, and S26.	I 227		
I 271	3513.1(b) ADMINISTRATIVE RECORDS Each GHMRP shall maintain for each authorized agency ' s inspection, at any time, the following administrative records: (b) Personnel records for all staff including job descriptions either at the GHMRP or in a central office and made available upon request; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure personnel records were provided for review for six (6) of twenty-seven (27) staff who worked in the GHMRP. The finding includes: During the entrance conference on April 14, 2009 at 9:30 AM, the (Qualified Mental Retardation Professional QMRP) was requested to obtain the personnel files for staff working in the facility, and who had worked in the facility during the weekend of March 29, 2009 through March 30, 2009. Review of the the personal records on April 17, 2009 at approximately 3:45 PM, revealed there were none available for review for S7, S10, S16, S18, S24, and S26. There was no evidence that the administrative office ensured requested personnel records were available for review during the survey.	I 271	The Director of Operations will coordinate with the Director of Human Resources to ensure there is a method in place to provide complete confidential personnel records on a timely basis for review during a survey.	5/22/09

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I 401	Continued From page 21	I 401		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure medical and nursing services were provided in accordance with the needs of Resident #2 after his eye injury of unknown origin. The findings include: 1. The GHMRP failed to ensure a prompt medical evaluation was provided for Resident #2 after his right eye injury of unknown origin. Interview with the the Qualified Mental Retardation Professional (QMRP) on April 14, 2009 at 9:20 AM revealed that Resident #2's direct support staff discovered him to have an eye injury of unknown origin upon his arrival on duty on March 30, 2009. According to the unusual incident report dated March 30, 2009, at 7:10 AM, Resident #2's 1:1 direct care staff (7:00 AM - 3:00 PM) discovered him to have "blackness of his right eye". Interview with the designated Licensed Practical Nurse (LPN) on April 14, 2009 revealed that the blackness underneath Resident #2's right eye was resolving after about 5 days. The review of the incident report revealed on March 30, 2009 at 8:10 AM, the morning	I 401	1. See response to federal deficiencies W322, W323, and W331.	5/22/09

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I 401	Continued From page 22	I 401		
	medication nurse documented that he assessed and treated the, "Observed blackness coloration underneath the right eye and redness on right corner of the eye and applied Neosporin ointment applied on the blackness coloration." The review of nursing progress notes revealed that the medication nurse also administered Ibuprofen for pain.			
	The review of a Medical consultation form dated March 31, 2009, revealed "Patient refused treatment. Patient with right eye redness without discharge. Black and blue under eye x 2 days....FU with ophthalmology if no improvement. Tobradex Opth Solution was prescribed....."			
	[Note: On April 17, 2000 at approximately 1:00 PM, pictures of Resident #2 taken by the Residential Director (RD)on March 30, 2009, were observed. There was a red spot on the right sclera (eyeball), a dark area ("blackness") underneath the the right eye, and facial swelling on right side of the resident's nose.]			
	At the time of the survey, there was no evidence that Resident #2 had received a prompt medical evaluation, after possible trauma to his right eye/face, to determine the extent of his injury.			
	2. The GHMRP failed to ensure that Resident #2 received nursing services for an eye injury in accordance with his needs.		2. See response to federal deficiency W331.	5/22/09
	a. Interview with direct care staff on April 14, 2009 at 2:47 PM revealed that on March 30, 2009, Resident #2 was observed to have a right black eye and that he would not allow the staff to touch his cheek.			
	b. Interview with the designated nurse on April			

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I 401	Continued From page 23 14, 2009 at approximately 11:00 AM revealed that Resident #2 was evaluated by the medication nurse upon his arrival at the group home on March 30, 2009 at 8:10 AM. Further interview with the designated nurse and the record review revealed no evidence that the resident was referred for medical evaluation of his injury until March 31, 2009. c. Interview with the morning medication nurse on April 15, 2009 at approximately 8:30 AM revealed that he observed Resident #2 to have a blackish area underneath his eye and a reddish area on the white of his right eye. Further interview with the medication nurse revealed that the resident did not appear to be in acute distress and allowed him to apply Neosporin to the area. The nurse revealed that Resident #2 was non-verbal and that he administered Ibuprofen for pain that may occur as a result of the resident's injury. According to the nurse, he then wrote a progress note, after assessing and treating the resident. The review of the nursing progress note dated March 30, 3009 revealed at 8:10 AM, the morning medication nurse "Observed redness on right side of the right eye. Black discoloration underneath the right eye. Neosporin Ointment applied on black coloration of right eye. Ibuprofen 400 mg administered for pain. Will assess until healed." Further record review revealed no other documentation of eye care by the morning medication nurse or the designated nurse. d. On the afternoon of April 15, 2009 at approximately 1:30 PM, the designated nurse presented the surveyors with additional progress notes dated April 1, 3, and 5, 2009, which were written by the evening medication nurse.	I 401		

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I 401	Continued From page 24 According to the April 5, 2009, progress note, the red spot on the resident's right eye was clearing well, and no discharge or drainage was noted. At the time of the survey, however the record failed to document when the dark area and redness on the sclera of the resident's was completely resolved. 3. The GHMRP failed to ensure Resident #2 received a nutritional assessment to determine the adequacy of his diet and feeding skills. On April 15, 2009 at 5:30 PM, Resident #2 was observed to appear drowsy as he ate his dinner. The QMRP revealed that it was unusual for the resident to be sleepy at the table. Further interview with the QMRP regarding the resident's nutritional status revealed he had not received a nutritional assessment since his admission to the group home on May 28, 2008. Staff revealed that the resident was on a regular diet, with chopped food. The review of the list of prescribed diets in the kitchen revealed that it was dated April 19, 2008 and that it did not include Resident #2's name or diet order. The review of the Annual Medical Assessment dated May 29, 2008 revealed "Awaiting consult to determine ideal body weight. Will follow prescribed diet per the PCP pending nutritional consult. Further review Resident #2's records revealed he had no nutritional assessment since he was admitted to the GHMRP on May 28, 2008. The review of the resident's individual support plan (ISP) dated June 30, 2008 revealed "Nutritional assessment by dietitian annually with quarterly reviews of dietary needs and	I 401	3. See response to federal deficiency W217.	5/22/09

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I 401	Continued From page 25 compliance". At the time of the survey, there was no evidence the resident had received any nutritional assessment.	I 401		
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview, and record review, the GHMRP failed to ensure continuous active was implemented in accordance with the interdisciplinary team recommendations for two of the three residents in the sample. (Residents #1 and #3) The finding includes: 1. The GHMRP failed to ensure that Resident #3 was provided staff support in accordance with his individual support plan and his behavior support plan. On April 15, 2009, at approximately 8:30 AM, Resident #3 was observed walking in his community with his 1:1 staff. Review of the behavior support plan dated September 2008, on April 15, 2009, at 3:30 PM revealed that Resident #3 requires 2:1 staff supervision when out in the community to prevent him from approaching children. Review of the social work assessment dated October 2, 2008, on April 15, 2009, at 3:40 PM, confirmed that Resident #3 requires 2:1 staff supervision when out in the community . Interview with the Qualified Mental Retardation	I 422	1. See responses to federal deficiency W186 and W249 #2. 5/22/09	

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I 422	Continued From page 26 Professional (QMRP) on April 15, 2009 at approximately 7:00 PM indicated that Resident #3 only has a 2:1 on the weekends. At the time of survey, there was no evidence that Resident #3 was consistently provided with a 2:1 staff while in the community. 2. The GHMRP failed to ensure that Resident #1 individual program plan (IPP) objectives were implemented. On April 14, 2009, at 6:15 PM, Resident #1 was observed holding a pillow. At approximately 6:20 PM, the Direct Care Aid placed the pillow on his shoulder. Interview with the Direct Care aid at 6:24 PM revealed that the pillow was to vibrate however, was not equipped with the batteries. The resident was therefore only able to squeeze the pillow, without feeling the vibration. Interview with the Qualified Mental Retardation Professional (QMRP) revealed that Resident #1 is blind and deaf, therefore he benefits from tactile sensory stimulators. Interview with Resident #1's 1:1 staff on April 15, 2009, at 4:30 PM revealed that the staff teaches activities of daily living skills, choice and decision making skills. Further interview revealed tactile stimulation is also provided with assistance. Review of the IPP dated January 14, 2009, at approximately 5:30 PM, revealed the following goals: a. Will tolerate lotion applied to his arms for a minimum of 5 minutes, three times a week for three consecutive months.	I 422	2. See responses to federal deficiency W159 #4 and W249 #3.	5/22/09

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I 422	Continued From page 27 b. Will identify (by touching) personal care items (lotion, deodorant, etc) after showering, 75% of the time, three times a week for six consecutive months. c. Will tolerate textured mitts for a minimum of 10 minutes, twice a week for three consecutive months. d. Will choose ands participate in at least two activities daily for 12 consecutive months. Further interview with Resident #1's 1:1 staff on April 15, 2009, at 4:30 PM and subsequent interview with the QMRP, followed by record review, revealed no evidence that the above IPP objectives had been implemented since January 2009.	I 422		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observations, interviews and record review, the GHMRP failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) that governs the care and rights of persons with mental retardation. The finding includes: The GHMRP failed to ensure policies and	I 500		

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	procedures were implemented to protect the health and safety of Resident #2. A . The GHMRP failed to implement timely measures to address Resident #2's injury of unknown origin. 1. The GHMRP failed to provide supervision as prescribed in Resident #2's Individual Support Plan (ISP) and Behavior support Plan (BSP) to ensure his safety and well being. The review of an unusual incident on April 14, 2009 at 9:20 AM revealed the following information regarding an injury sustained by Resident #2 as evidenced below: On March 30, 2009 at approximately 7:10 AM, Resident #2's one on one staff (7:00 AM to 3:00 PM) discovered a blackness (discoloration) underneath the resident's right eye as soon he arrived at the GHMRP. The incident reported revealed that the staff immediately telephoned the designated Licensed practical nurse at 7:12 AM. then telephoned the Qualified Mental Retardation Professional (QMRP) at 7:15 AM, to inform them of Resident #2's injury. Interview with the Qualified Mental Retardation Professional (QMRP) on April 14, 2009 at 9:20 AM, revealed Resident #2 was prescribed to have one on one staff supervision, 24 hours a day. The review of Resident #2's ISP dated June 28, 2008 and a BSP support plan dated October 8, 2008, on April 14, 2009 at 12:05 PM, revealed the resident should be provided one on one supervision, 24 hours a day, seven days a week to ensure his safety and to address his target behaviors of aggression, self-injurious		1. See response to federal CONDITIONS 102, 122, and 158.	5/22/09

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I 500	Continued From page 29	I 500		
	behavior/biting, pica and Bolting behaviors. At the time of the survey, there was no evidence the resident had been provided the recommended level of supervision, as evidenced the his injury of unknown origin.			
	[See also 3508.1]			
	2. The GHMRP failed to ensure a thorough investigation of Resident #2's injury of unknown origin.		2. See response to #1 above.	5/22/09
	Interview with the QMRP on April 14, 2009 revealed that Resident #2 had a behavior support plan which required that he be provided one on one staff supervision 24 hours a day, 7 days a week. Further interview with the QMRP revealed that the resident was provided one on one supervision during the shifts, beginning March 29, 2009 at 7:00 AM through the overnight shift (11:00 PM to 7:00 AM). The QMRP revealed that none of the staff had observed or reported an injury sustained by Resident #2. Through additional interview with the QMRP, it was determined that the 11:00 PM to 7:00 AM staff was the last one on one staff assigned to the resident, prior to the shift on which his injury was discovered. The QMRP revealed however, that this staff had not provided shift notes or provided behavioral documentation for Resident #2 during his shift. The QMRP also confirmed that the one on one staff had not been interviewed or provided a written statement concerning Resident #2 and the injury of unknown origin.			
	On April 17, 2009, further interview with the QMRP revealed pictures had been taken of the injury. The surveyors observed several telephone camera photographs which the RD revealed he had taken on March 30, 2009 of			

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I 500	Continued From page 30	I 500		
	Resident #2's eye injury. The surveyors observed the photos and noted the resident to have a black discoloration underneath the right eye, a reddish colored spot on the sclera of the resident right eye, and swelling on the right side of his nose. Interview with the RD revealed that the IMC did not have the photographs.			
	According to the GHMRP's preliminary investigative report, the etiology was reported as unknown, though it may be due to one of the resident behaviors. Staff was encouraged to maintain one on one supervision/monitoring via being in arm's reach of [the Resident] at all times. Although the investigation was being continued, at the time of the survey, the origin of the resident's injury remained unknown.			
	3. The GHMRP failed to implement it's policy which prohibited staff potentially involved in abuse/neglect from having contact with residents as evidenced below:		3. See response to #1 above.	5/22/09
	Interview with the Residential Director and the QMRP on April 15, 2009 revealed that on March 29, 2009, Staff #1 was assigned to Resident #2 on the overnight shift (11:00 PM to 7:00 AM). Further interview with the QMRP revealed that he was the last staff assigned to provide one on one support to Resident #2 prior to the time his injury was discovered by Staff #2 on March 30, 2009 at 7:10 AM.			
	Further interview with the QMRP and the review, the investigation, and statements obtained for the investigation revealed no evidence that any information had been obtained from Staff #1. Addition interview with the QMRP and the RD revealed that Staff #1, a regular weekend staff, had continued to work with Resident #2. It should			

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	be noted that the GHMRP removed this employee from resident contact on April 17, 2009.			
	4. The GHMRP failed to ensure that Resident #2 received prompt medical attention to address his eye injury as evidenced below:		4. See responses to federal deficiencies W322, W323, and W331.	5/22/09
	Interview with the morning medication nurse on April 15, 2009 at revealed that he received a call from the designated nurse on March 30, 2009 regarding Resident #2's eye injury. The review of the medication administration record revealed on March 30, 2009 at 8:10 AM, the morning medication nurse documented, "Observed blackness coloration underneath the right eye and redness on right corner of the eye. Neosporin ointment applied on the blackness coloration. Will continue to assess until healed. Pain assessment /medication			
	On April 17, 2009, further interview with the QMRP revealed the surveyors observed several telephone camera photographs which the RD revealed he had taken on March 30, 2009 of Resident #2's eye injury. The surveyors observed the photos and noted the resident to have a black discoloration underneath the right eye, a reddish colored spot on the sclera of the resident right eye, and swelling on the right side of his nose.			
	Although the resident received first aid treatment from the medication nurse on March 30, 2009, there was no evidence the resident received medical observation for his eye injury until March 31, 2009. A medical consult form dated March 31, 2009 revealed, "Patient refused treatment. Patient with right eye redness without discharge. Black and blue under eye right x 2 days....FU			

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	with ophthalmology, if no improvement. Tobradex Opth Solution was prescribed. ....." The review of nursing progress noted revealed that the discoloration was resolving after five days. There was no evidence that the resident had been further medically assessed for his eye injury.			
	B. The surveyor remained onsite until the GHMRP addressed the serious and immediate jeopardy. The GHMRP initiated a Corrective Action Plan, effective April 17, 2009 as evidenced below:			
	1. Staff Discipline The staff who was assigned to provide one on one support and care for Resident #2 during the time when the eye injury occurred was immediately suspended, pending termination, regarding failure to report an injury.			
	2. Staff Training Retraining of staff on Resident #2 ' s BSP was initiated by the QMRP for all staff who come on duty. Training agenda and training sign-in sheet will be maintained for all staff. Training will be repeated for all staff on duty on April 18, 2008. The QMRP will schedule the behavior specialist/psychologist to provide refresher training on Resident #2's BSP for all staff, including the RN Supervisor and Licensed Practical Nurse Coordinator by April 22, 2009.			
	3. Documentation On April 17, 2009 the QMRP will review protocols and requirements with all staff that come on duty on proper completion of documentation for shift/staff progress notes and behavioral data collection. Starting April 18, 2009, the Residential Director (RD) will review the documentation daily			

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I 500	Continued From page 33 and provide retraining and/or disciplinary action for staff who fails to complete documentation per protocol. 4. Incident Management The Incident Management Coordinator (IMC) will acquire a written statement from the staff person who failed to report Resident #2's injury. The IMC will amend her completed investigation to include the statement and any new recommendations that emerge. The IMC will also ensure that the QMRP and the Human Resources Director immediately remove staff from duty (contact with persons served) per Careco policy, in cases of suspected or confirmed abuse/neglect and failure to follow incident reporting policy. The IMC will ensure that such actions are documented in the personnel record and the incident investigation report. 5. Staff Scheduling for one on one Supports By April 17, 2009, the QMRP and the Residential Director will ensure that staffing ratios are implemented per the ISP and BSP for Resident #2. The QMRP and the RD will bring in staff from the on-call roster and other Careco sources, if needed to ensure that staffing ratios are met with properly trained staff. 6. Overnight Monitoring The QMRP and RD will train staff to check on the individual in question per the protocol listed in his medical shift log, and to document their observations there. The QMRP and the Residential Director will ensure that there is sufficient staff support in the home for persons who require 24 hour one on one support, without impacting the ability of other staff to check on and document their observations on the other persons living in the home on an hourly basis overnight.	I 500		

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I 500	Continued From page 34 On April 17, 2009, at approximately 5:45 PM, systems were employed by the GHMRP to alleviate the immediate concern.	I 500		

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R 000	INITIAL COMMENTS A licensure survey was conducted on April 14, 2009 through April 17, 2009. A random sample of three residents was selected from a residential population of five males with mental retardation and other disabilities. The survey findings were based on observations in the group home and day programs. In addition, the findings were based on interviews with direct care, administrative, nursing, and day program staff. A review of the facility's records, including the unusual incident reports was also conducted.	R 000		
R 124	4701.4 BACKGROUND CHECK REQUIREMENT The facility shall obtain a criminal background check from the Metropolitan Police Department, from the U.S. Department of Justice, or from a private agency. This Statute is not met as evidenced by: Based on interview and review of the records, the GHMRP failed to provide verification that all direct care staff had obtained a criminal background check from the Metropolitan Police Department, from the U.S. Department of Justice, or from a private agency. The finding includes: During the entrance conference on April 14, 2009 at 9:30 AM, the Qualified Mental Retardation Professional (QMRP) was requested to obtain the criminal background checks for all staff working in the GHMRP, and who had worked in the GHMRP during the weekend of March 28, 2009 through March 29, 2009. Review of the the personnel records on April 17, 2009 at approximately 3:45 PM, revealed the	R 124	See responses to state deficiencies I 201 and I 271.	5/22/09

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	administrative office failed to provide the files of S7, S10, S16, S18, S24, and S26. At the time of the survey, there was no evidence that the GHMRP provided verification that each of the aforementioned staff had provided a criminal background check prior to employment.			
R 125	4701.5 BACKGROUND CHECK REQUIREMENT	R 125	See response to R 124.	5/22/09
	The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check.			
	This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure criminal background checks disclosed the criminal history of any prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker had worked or resided within the seven (7) years prior to the check for fifteen (15)of twenty-seven (27) employees.			
	The findings include:			
	a. On April 14, 2009 at 9:40 AM, an entrance conference was conducted with the Qualified Mental Retardation Professional (QMRP) to request documents needed during the survey process. During this time, evidence of criminal background checks for staff who worked at the group home during the weekend of March 28, 2009 and March 29, 2009 was requested. Additionally, the criminal background checks were requested for all staff			

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R 125	Continued From page 2 who work with the residents at the group home. Interview with the QMRP revealed that the requested documents would be provided. On April 17, 2009, beginning at 3:45 PM, the review of the provided personnel records revealed that the GHMRP failed to provide evidence that an employee criminal background check was provided for each jurisdiction where the employees had lived and/or had worked during the last seven years for nine staff (S2, S3, S4, S12, S13, S14, S21, S22, and S23). b. The GHMRP failed to provide evidence that a criminal background check was conducted and disclosed the required information for an additional six staff (S7, S10, S16, S18, S24, and S26) for whom no personnel records were provided. [See also 4701.4]	R 125		