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

PRINTED: 09/14/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G167	A. BUILDING _____ B. WING _____	08/31/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 10	1613 TAYLOR STREET, NW WASHINGTON, DC 20011

(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
W 000	INITIAL COMMENTS This recertification survey was conducted from August 30, 2007 through August 31, 2007. It was determined that a full survey be conducted as a result of the condition level practices cited during the previous survey. A random sample of three individuals was selected from the population of four females and two male clients. One of the individuals in the sample was diagnosed to function in the profound range of mental retardation, one was severe, and the last one functioned in the profound range of mental retardation. One individual in the sample had a diagnosis of blindness and one had diagnosis of visual impairment. The findings of this survey were based on observations at the residence and three day programs, staff interviews at both the group home and day programs, review of clinical and administrative records to include the facility's unusual incident reports and policies.	W 000		
W 100	440.150(c) ICF SERVICES OTHER THAN IN INSTITUTIONS "Intermediate care facility services" may include services in an institution for the mentally retarded (hereafter referred to as intermediate care facilities for persons with mental retardation) or persons with related conditions if: (1) The primary purpose of the institution is to provide health or rehabilitative services for mentally retarded individuals or persons with related conditions; (2) The institution meets the standards in Subpart E of Part 442 of this Chapter; and (3) The mentally retarded recipient for whom payment is requested is receiving active treatment as specified in §483.440.	W 100	See response to W195	10/10/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Martha H. Thompson	Director of Disability Services	10/5/2007

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 100	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation, interviews and record review, the facility failed to ensure that each client received continuous active treatment services. [See W195]	W 100		
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 observations, interviews, and the review of records, the facility's governing body provided general operating directions except for the deficienct practices detailed below. The findings include: 1. The facility failed to provide continous active treatment services. [See W249] 2. The Governing Body failed to establish and/or implement policies that ensured the health and safety of its clients. [See W149]	W 104	See response to W195	10/10/07
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 observations, staff interview, and	W 120	The QMRP will establish and implement a monthly monitoring and technical assistance schedule that will enable the facility to ensure that day programs effectively implement, review, and revise program objectives for all people who live in the facility. The QMRP will establish a quarterly schedule where each person served will have an individualized meeting to review program goals for relevancy and success. The quarterly meeting will yield an updated functional assessment for each reviewed/revised IPPs both at the day program and at home. 167	10/3/07

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W 120	Continued From page 2 record review, the facility failed to effectively monitor each client's day program to assure that the day program met the needs of three of the four clients included in the sample (Clients #3). The findings include: The facility failed to ensure Client #3 ' s new program objectives scheduled to be implemented at his day program was implemented. Observation at Client #3 ' s day program on August 30, 2007 beginning at 12:35 PM revealed the client in the dance studio listening to music and intermittently dancing with staff and his peers. Interview was conducted with the Activities Coordinator to ascertain information regarding some of the things the Client #3 was learning while at the program. According to the coordinator, Client #3 had a new Individual Program Plan (IPP) developed on August 7, 2007. The plan documented program objectives including the following: - Given hand over hand assistance, Client #3 will complete 100% of the steps of three interactive computer games within 12 months. Continued interview with the coordinator and review of Client #3' s data collection record revealed, the client ' s newly developed August 2007 IPP had not been implemented. At the time of the survey, the facility failed to ensure Client #3 ' s was given the opportunity to participate with his new formal program objectives at the day program.	W 120		
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client	W 122		

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W 122	Continued From page 3 protections requirements are met. This CONDITION is not met as evidenced by: The facility failed to implement effective policies and procedures to ensure the implementation of its incident management system [See W149]; failed to ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, were reported and investigated thoroughly [See W153 and 154]; failed to ensure that investigations were reported to the administrator or designated representative within five working days of the incident [See W156]failed to ensure that injuries were assessed timely [See W331]; and failed to ensure that sufficient staffing to prevent neglect and abuse [See W189]. The effects of these systemic practices results in the failure of the facility to protect its clients from harm and to ensure their general safety and well being.	W 122	The Director of Disability Services (DoDS) will provide a retraining to the QMRP, the Incident Management Coordinator, the Residential Director, and all home staff to ensure that the policy on Incident Management is properly implemented per regulations promulgated by the Departments of Health and Disability Services. The DoDS will review internal communication practices for incidents at the home, and will ensure that practices and protocols are revised as needed to meet the requirements for timely assessment of injuries, timely and accurate reporting to the Careco administration, DOH, and all other appropriate parties/entities. The DoDS will also review investigations with the Incident Management Coordinator (IMC) to ensure that each is thorough, complete, and submitted per regulations. The DoDS will review and revise staffing levels and staffing schedules with the QMRP and the Human Resources Department to ensure that the home is adequately staffed at all times with people who are properly trained.	10/10/07
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	W 124	The QMRP will submit a request to the Developmental Disabilities Administration's Case Manager for assignment of a legal guardian.	10/8/07

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W 124	Continued From page 4 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 #2) included in the sample. The findings include: Observation of the evening medication administration on August 30, 2007 beginning at 8:27 PM revealed Client #2 received medications including Lithium Carbonate, Risperdal, and Gabapentin. Interview with the medication nurse during the medication administration revealed the aforementioned medications were used to address the client's behaviors. Interview was conducted with the Qualified Mental Retardation Professional (QMRP) via telephone on August 30, 2007 at 8:10 AM. According the the QMRP, Client #2 was not capable of giving informed consent for the use of medications and habilitation services. Additionally, the QMRP revealed that Client #2 did not have involved family and was in need of a legally appointed guardian. Further interview with the QMRP revealed the client had a behavior support plan and required one to one staffing supports 12 hours daily (4 hours in the morning, 8 hours from 3 -11 PM weekdays, and 11 AM - 7 PM on the weekends) to address her behaviors. Review of Client #2's records on August 30, 2007 verified the clients Behavior Support Plan dated February 10, 2007. The plan incorporated the use of the aforementioned one to one staffing supports. At the time of the survey, however, the facility failed to provide evidence that Client #2's treatment needs, including the benefits and potential side	W 124		

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W 124	Continued From page 5 effects associated with the medications, and the right to refuse treatment, had been explained to her and/or a legally authorized representative.	W 124		
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 establish and/or implement policies that ensured the client's health and safety, for one of the three clients (Client #2) in the sample. The finding includes: 1. The facility failed to ensure its incident management policy was implemented to make certain notifications were made as outlined. Review of unusual incident reports on August 30, 2007 at 9:17 AM revealed the following incidents: a. On August 8, 2007, staff reported that Client #2 became agitated while on the residential van and began to spit, curse, scratch, and hit Client #1. The report further documented that Client #2 bit Client #4 on his left arm. It should be noted that Client #4 was taken to the emergency room, released and prescribed antibiotic medications. Further review of the incident report revealed that only the residential director was notified of the incident. Review of the Department of Health's (DOH) incident management intake documents (pre-survey) revealed DOH was notified of the incident on August 9, 2007.	W 149	1. See response to W122. The QMRP will place a notification protocol sheet, including accurate contact information, in the home's incident book. All staff will be retrained on Careco's incident management policy and protocols.	10/8/07

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W 149	Continued From page 6 b. On June 20, 2007, staff reported a sore on Client #2's left toe. Further review of the incident report revealed that only the licensed practical nurse was notified. There was no evidence this incident was reported to the Department of Health c. On April 3, 2007 at 9:15 AM, an incident report documented an allegation of abuse involving Client #2. According to the report, a phone message was left on April 2, 2007 from a female representative of the clients' primary care physician's office. The female reported that a mailroom personnel observed a woman (later revealed to be the house manager) being "evil" to the clients and was "hitting, beating, and shoving them." It should be noted that initially the report indicated that four clients (Clients #1, #2, #4 and #6) were involved; however, interview with the Qualified Mental Retardation Professional (QMRP) on August 30, 2007 revealed that only Client #2 was involved in the incident. It should be further noted that continued review of the incident report revealed the Department of Health was notified of the incident via fax on April 3, 2007 at 6:00 PM. Interview was conducted with the acting Residential Director (RD) and the Qualified Mental Retardation Professional (QMRP) on August 30, 2007 to ascertain information about the facility's incident management policy. According to the interviews, the Department of Health should be immediately verbally notified of all incidents that document injuries of unknown source, abuse, neglect and mistreatment. Review of the facility's Incident Management Policy on August 30, 2007 verified that serious reportable incidents require staff to immediately	W 149		

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W 149	Continued From page 7 call the Department of Health. At the time of the survey, the facility failed to implement its policy as outlined. 2. The facility failed to ensure implement its incident management policy regarding investigations. (Refer to 1 above) Review of unusual incident reports on August 30, 2007 at 9:17 AM revealed the facility documented two allegations of abuse and one injury of unknown origin. Further review of the incident reports and interview with the QMRP on August 30, 2007 and August 31, 2007 failed to provide evidence that the injury of unknown source (June 20, 2007) and allegation of abuse (August 8, 2007) were investigated. Review of the facility's incident management policy on August 30, 2007, revealed that "all serious reportable incidents will be investigated by [the provider] beginning within 12 hours after the incident was witnessed, discovered or being informed that the incident has occurred." At the time of the survey, the facility failed to ensure its incident management policy regarding conducting investigations had been implemented. 3. The facility failed to ensure its incident management policy had been implemented to ensure investigations were conducted within the specified timeframes. (Refer to 1 above) Review of unusual incident reports on August 30, 2007 at 9:17 AM revealed an allegation of abuse dated April 3, 2007. Review of the corresponding investigation revealed the investigation was dated April 12, 2007. According to review of the facility's incident	W 149	2. See response to #1 above. The DoDS will perform a monthly review to ensure that the QMRP and the Incident Management Coordinator are complying with Careco policy regarding timely notification and thorough investigation of incidents. 3. See response to #1 and #2 above.	10/8/07 10/8/07

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W 149	Continued From page 8 management policy on August 30, 2007, "all investigations for serious reportable incidents will be completed within 5 business days and forwarded to the Incident Management Coordinator." At the time of the survey, the facility failed to ensure its implement management policy was implemented as outlined. 4. The facility failed to ensure an incident management policy had been implemented and/or developed to make certain that notifications and investigations of incidents coincided with requirements outlined in the federal regulations. Review of unusual incident reports on August 30, 2007 at 9:17 AM revealed two incidents of alleged abuse and one injury of unknown source had been documented (Refer to 1 above). Further review of the incident reports failed to provide evidence that the administrator had been notified of the aforementioned incidents as required in the federal regulations §483.420(d)(2). Review of the facility's incident management policy on August 30, 2007 failed to provide evidence that reporting the aforementioned incident to the administrator was required. At the time of the survey, the facility failed to provide evidence that its incident management policy had been developed to coincide with federal requirements. (See also W153)	W 149	4. The DoDS will review the Careco Incident Management Policy and propose revisions that meet federal and local regulations as necessary to the Director of Operations. The DoDS will provide training on policy revisions to the IMC, QMRP, and home staff.	10/8/07
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other	W 153	See response to W149	10/8/07

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W 153	Continued From page 9 officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure all injuries of unknown source and allegations of abuse, were immediately reported to the administrator and to other officials in accordance with State Law (DC regulation 22 DCMR Chapter 35 Section 3519.10), for one of the three clients (Client #2) included in the sample. The findings include: Review of unusual incident reports on August 30, 2007 at 9:17 AM revealed the following incidents: a. On August 8, 2007, staff reported that Client #2 begame agitated while on the residential van and began to spit, curse, scratch, and hit Client #1. The report further documented that Client #2 bit Client #4 on his left arm. It should be noted that Client #4 was taken to the emergency room, released and prescribed antibiotic medications. b. On June 20, 2007, staff reported a sore on Client #2's left toe. c. On April 3, 2007, an incident report documented an allegation of abuse involving Client #2. According to the report, a phone message was left on April 2, 2007 from a female representative of the clients' primary care physician's office. The female reported that a mailroom personnel observed a woman (later revealed to be the house manager) being "evil" to the clients and was "hitting, beating, and shoving	W 153		

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W 153	Continued From page 10 them." It should be noted that initially the report indicated that four clients (Clients #1, #2, #4 and #6) were involved; however, interview with the Qualified Mental Retardation Professional (QMRP) on August 30, 2007 revealed that only Client #2 was involved in the incident. Further review of the aforementioned incident reports on August 30, 2007 failed to provide evidence that the incidents were immediately reported to the administrator and the Department of Health as required.	W 153		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide evidence that all allegations of abuse and injuries of unknown source were thoroughly investigated, for three of the three clients (Clients #1, #2, and #4) that resided in the facility The finding includes: 1. The facility failed to ensure required investigations were conducted. (Refer to W149, 1) Review of unusual incident reports on August 30, 2007 at 9:17 AM revealed two allegations of abuse and one injury of unknown origin were reported. Further review of the incident reports and interview with the Qualified Mental Retardation Professional (QMRP) on August 30, 2007 and August 31,	W 154	See response to W122 and W149 1. The DoDS will ensure that incidents, including progress with investigations, are part of the standard agenda for standing program meetings, that the IMC will also attend, thus ensuring that incidents are thoroughly investigated and appropriate follow up is completed. The weekly nursing reports generated for the home will also list follow up for any incidents where people served were assessed for possible injury.	10/8/07 10/8/07

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W 154	Continued From page 11 2007, failed to provide evidence that the allegation of abuse (dated August 8, 2007) and the injury of unknown source (dated June 20, 2007) were investigated. 2. The facility failed to ensure its investigations were thorough. Review of unusual incident reports on August 30, 2007 at 9:17 AM revealed an incident dated April 3, 2007. According to the incident report an allegation of abuse had been reported by a female representative of the clients' primary care physician's office. The message left by the female revealed that a mailroom person had observed a woman (later revealed to be the house manager) being "evil" to the clients and was "hitting, beating, and shoving them." It should be noted that initially the report indicated that four clients (Clients #1, #2, #4 and #6) were involved; however, interview with the Qualified Mental Retardation Professional (QMRP) on August 30, 2007 revealed that only Client #2 was involved in the incident. Review of the corresponding investigation dated April 12, 2007 on August 30, 2007 and August 31, 2007 revealed witness statements were received from staff members involved in the incident. Review of the statements revealed information that was contradictory with the investigative report as evidenced below: a) According to the review of the staff member's statement (the driver) dated April 11, 2007, he/she transported the residential director and "six clients on a medical appointment..). Additionally, the statement revealed that the driver assisted the residential director with	W 154	2. The DoDS, the IMC and the Director of Operations will hold an Incident Management meeting at least twice monthly. During the meeting each incident on the agenda will be thoroughly discussed and the investigations will be reviewed. If additional questions arise, or if additional evidence comes to light during the review meeting, even if the concerns or evidence becomes known after the investigation has been submitted, the IMC will prepare amendments and ensure they are forwarded to all authorized recipients in accordance with Careco's policy.	10/8/07

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W 154	Continued From page 12 transporting four clients off the van and to the hospital doors. Review of the investigative report however, revealed that the driver remained on the van with one client that would not leave the van, while the residential director assisted the four clients to the doctor's office. It should be noted that there was no mention of the sixth client in the investigation. Interview was conducted with the Incident Management Coordinator (IMC) via telephone on September 6, 2007 at approximately 10:30 AM that verified there were in fact six clients on the van, two of which remained on the van with the driver. Additionally, the IMC was interviewed to ascertain information regarding who remained on the van to assist the two clients that remained on the van while the driver and the residential director assisted four clients to the doctor's office. Review of the investigative report failed to provide evidence that the aforementioned issue had been addressed. b) According to the incident report and the corresponding investigation a female called and left a message regarding the alleged abuse. According to the IMC and review of the incident report, the incident was initially reported by a person that was not an eye witness of the abuse. Continued review of the incident investigation and interview with the IMC failed to provide evidence that the initial person that reported the incident had been interviewed. C. According to the interview with the IMC and review of the investigation report, the mailroom person reported the abuse to a representative that worked in the clients' primary care physician's office. Further interview revealed that	W 154		

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W 154	Continued From page 13 the abuse was reported while the clients were in the primary care physician's office. Review of the investigation and interview with the IMC failed to provide evidence that documented whether or not the the alleged injury to Client #2's arm was evaluated by the primary care physician. Additionally, there was no indication that the physician was aware of the abuse or if he/she had been interviewed as a result of the allegation. At the time of survey, the facility failed to ensure a thorough investigation of the aforementioned incident had been conducted.	W 154		
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that investigations were reported to the administrator or designated representative within five working days of the incident, for one of the three clients (Client #2) included in the sample. The finding includes: [Cross Refer W149] Review of unusual incident reports on August 30, 2007 at 9:17 AM revealed an allegation of abuse dated April 3, 2007. Review of the corresponding investigation revealed the investigation was dated April 12, 2007. The Qualified Mental Retardation Professional (QMRP) was interviewed to	W 156	See response to W122, W149, and W154.	10/10/07

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W 156	Continued From page 14 ascertain information about the length of time the provider allows for an investigation. According to the QMRP, investigations were to be completed within five working days. At the time of the survey, the facility failed to ensure that the results of required investigations had been reported to the administrator or designee in accordance with the regulation.	W 156		
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 observations, interviews, and record review, the Qualified Mental Retardation Professional (QMRP) failed to ensure that each client (#1, #3)received the recommended active treatment services to meet their needs. The findings include: 1. The QMRP failed to ensure continuous active treatment services. (See W249) 2. The QMRP failed to ensure Client #1's individual program plan was revised after the client failed to progress with the identified objectives. (See W257) 3. The QMRP failed to that the Client #3's day program met his needs. (See W120) 4. The QMRP failed to provide evidence that the clients' formal program objectives were monitored.	W 159	1. See response to W249 2. See response to W257 3. See response to W120 4. The DoDS will provide technical and clerical support to the QMRP so that monthly notes are completed timely, per Careco's policy. The DoDS will track ISP annual meetings to ensure that the QMRP initiates new programs within 10 days of approval by the IDT.	10/10/07 10/10/07 10/10/07 10/10/07

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W 159	Continued From page 15 Interview with the Qualified Mental Retardation Professional (QMRP) and review of Client #3' s record on August 31, 2007 revealed Client #3 had an Individual Support Plan (ISP) in his record dated August 1, 2006 that was outdated. According to the QMRP, Client #3 had an ISP meeting on August 8, 2007 but the comprehensive document had not been completed. Further interview with the QMRP and record review revealed that the new program objectives recommended at his ISP meeting had not been implemented (See also W249). Continued interview with the QMRP and review of Client #3' s record revealed QMRP monthly notes that documented the client ' s progress with his formal program objectives. Review of the available notes revealed that there were no monthly notes in Client #3 ' s record after March 2007. Interview with the QMRP revealed that according to the facility policy, QMRP monthly notes were to be completed by the 10th of every month. It should be noted that review of Client #2 ' s record also revealed that QMRP monthlies had not been completed after March 2007. Furthermore, review of Client #2's record revealed her ISP was dated April 25, 2007. At the time of the survey, the facility failed to provide evidence of the monitoring of the clients ' formal program objectives.	W 159		
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	W 186	Home staffing schedules will be submitted on a weekly basis to the DoDS, who will coordinate with the QMRP and the Human Resources Department to recruit and train appropriate personnel and ensure the home is properly staffed.	10/10/07

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W 186	Continued From page 16 period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure sufficient staffing was provided to prevent neglect and abuse, for one of six clients (Client #2) in the sample. The finding includes: (Refer to W154, 2) Review of unusual incident reports on August 30, 2007 at 9:17 AM revealed an incident dated April 3, 2007 that documented the alleged abuse of Client #2. Review of the corresponding investigation dated April 12, 2007 on August 30, 2007 and August 31, 2007 revealed witness statements were received from staff members involved in the incident. According to the review of one of the staff member's statement (the driver) dated April 11, 2007, he/she transported the residential director and "six clients on a medical appointment...). Additionally, the statement revealed that the driver assisted the residential director with transporting four clients off the van and to the hospital doors. Review of the investigative report however, revealed that the driver remained on the van with one client that would not leave the van, while the residential director assisted the four clients to the doctor's office. It should be noted that there was no mention of the sixth client in the investigation. Interview was conducted with the Incident Management Coordinator (IMC) via telephone on September 6, 2007 at approximately 10:30 AM that verified there were in fact six clients on the van, two of which remained on the van with the	W 186		

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W 186	Continued From page 17 driver. Additionally, the IMC was interviewed to ascertain information regarding who remained on the van to assist the two clients that remained on the van while the driver and the residential director assisted four clients to the doctor's office. Review of the investigative report failed to provide evidence that the aforementioned issue had been addressed. At the time of the survey, the facility failed to provide evidence that the were staff available to monitor/provide supervision to the clients that remained on the van.	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 interview and record review, the facility 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. The finding includes: (Refer to W154, 2) Review of unusual incident reports on August 30, 2007 at 9:17 AM revealed an incident dated April 3, 2007 that documented the alleged abuse of Client #2. Further review of the incident report and review of the corresponding investigation revealed that the house manager was identified as the alleged abuser. Although interview with the QMRP revealed that staff have been trained on staffing protocol after the incident occurred, there was no evidence that the facility's previous house	W 189	The Director of Operations and the Human Resources Director will recruit and hire an effective Residential Director (RD) who displays an ability to understand training and act in accordance with policy. The QMRP will ensure that the RD is appropriately trained on programming and operations to manage the home.	10/10/07

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W 189	Continued From page 18 manager (who was responsible for staffing) had received effectively trained in the domain of abuse/neglect prior to the incident.	W 189		
W 195	483.440 ACTIVE TREATMENT SERVICES The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure continuous active treatment services (See W249); failed to ensure the accurate and consistent documentation of each client's formal programs (See W252); failed to ensure each clients individual program plan was revised after the client failed to progress with the identified objectives (See W257), failed to ensure that comprehensive functional assessments had been completed and/or updated (See W259), failed to make revisions or to justify the repetition of the objectives from the previous year (See W260), and failed to ensure clients were taught to administer their own medications (See W371). The effects of these systemic practices results in the failure of the facility to ensure the delivery of adequate active treatment services.	W 195	The DoDS will provide guidance and support to the QMRP by reviewing each comprehensive functional assessment for accuracy, thoroughness and timeliness. The DoDS will assist the QMRP to develop active treatment programs over the next 90 days to ensure that the QMRP is producing and capitalizing on learning opportunities for people who live in the home. The DoDS will assist the QMRP to implement a functional assessment for each proposed program to ensure it is appropriate to assist the person in strengthening and/or gaining needed skills for more independent and dignified living. The QMRP will provide evidence to the DoDS of the monthly review and analysis of the success of each program for each person. The DoDS will work with the QMRP to ensure that programs proving to be unsuccessful or non-productive are revised, discontinued, or replaced. The DoDS, the RN Supervisor and the QMRP will ensure each person is assessed for self-medication and that appropriate programming is developed and monitored monthly for progress. See response to W120 and W249.	10/10/07
W 209	483.440(c)(2) INDIVIDUAL PROGRAM PLAN Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate. This STANDARD is not met as evidenced by:	W 209		

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W 209	Continued From page 19 Based on interview and review of meeting attendance records the facility failed to ensure the participation of client #1 and/or her family in the Individual Support Plan (ISP) meetings. The finding includes: A review of client #1's clinical records was conducted on August 31, 2007 at 12:10 PM. Client #1's name was not included as being in attendance at her pre-ISP. Although the ISP did reflect that the client's sister "provides consent for procedures"; there was no evidence that the client's family had been invited to prepare the complete treatment plan for their family member.	W 209	The QMRP will send an invitation to each person's family and/or legal guardian inviting their attendance at the annual pre-ISP and ISP. A reminder notice will be sent 30 days prior to the planned meetings, and will be followed by telephone reminders one week prior to the meeting. As there are legal requirements that the ISP meeting be held by a date certain that has been designated the anniversary, if people's family members or guardians indicate that they will not be able to attend, the QMRP will forward recommendations in writing and request signed approval or disagreement with goals ratified by the rest of the tea, to be included with the person's formal record. If a person cannot attend his or her own meeting due to some emergency situation, the QMRP will inform the team and the presiding judge of Family Court, and the sitting magistrate judge overseeing MR cases and will reschedule the meeting at the earliest possible date.	
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, interview, and record review, the facility failed to ensure that each client received continuous active treatment services, for three of the three clients (Clients #1, #2, and #3) included in the sample. The findings include: A. The facility failed to provide client #1 with continuous opportunities for learning as detailed	W 249		10/10/07

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W 249	Continued From page 20 below. 1. Client #1 was observed at the group home from 3:30 PM to 7:17 PM. 3:30 PM - Client #1 was was observed talking with the staff and complaining of her day and instructor; 3:55 PM - Client #1 left the living room where she had been seated and exited independently stating that she was going to see her show in her bedroom. Client #1 was in her bedroom for approximately five minutes and then was observed going to the closet near the front entrance and retrieving a comb and hair pic. 4:30 PM - Client #1 was observed coming from the bathroom with her robe on. She stated that she had taken a shower. She stated that she did not require assistance. This was confirmed during other staff interviews. Client #1 returned the items that she retrieved from the closet and sat back on the sofa; 5:18 PM - Client #1 was observed conversing and making complaints to others about her day. The staff acknowledged the client's concerns and then offered the client an opportunity to do her laundry. Client #1 stated that she would do laundry later. The client remained seated on the sofa; 6:00 PM - Client #1 was observed eating dinner independently. Following dinner, the client removed her plate and utensils to the kitchen sink; 6:30 PM - Client #1 was observed dancing with the other clients; and	W 249	A1. The DoDS will review the person's active treatment program with the QMRP. The DoDS and QMRP will ensure the program plans are appropriate and timely for the person, and will confirm this by completing individual functional assessments on the programs. The DoDS and QMRP will determine the appropriate frequency for implementation, and will train staff to implement and document the program. The QMRP will monitor the staff's implementation of the programs at least 2 times weekly.	10/10/07

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W 249	Continued From page 21 6:55 PM - Client #1 was observed talking with staff as she continued to make complaints about her day. Although Client #1's individual program plans (IPPs) reflected a frequency of implementation to be daily, these programs were not observed to be implemented at given opportunities. 2. According to Client #1's "individualized" active treatment schedule, the following activities were scheduled: 4:30 PM - Offer walk; if not desired the client may do her laundry or be assisted with her training programs (i.e. identify coins, use telephone); Note: Staff asked Client #1 to do her laundry and she elected not to; however, there were no other options presented at the time; 5:30 PM - To engage client in other activities to keep her busy. Straighten her room, apply activator to her hair etc.; 6-6:30 PM - To eat dinner and to remind the client to use fork, spoon, and knife; 6:45 PM - To clean and remove dishes from the table; 7:00 PM - To assist in choosing activities; may choose to listen to music, play her keyboard, listen to gospel music or books on tape, etc.; 8:00 PM - To get medications and assist in getting her cup of water for medications.	W 249	A2. See response to #1 above	10/10/07

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W 249	Continued From page 22 3. Client #1's program documentation reviewed, on August 31, 2007 at approximately 12:10 PM, revealed that the individual program plans (IPPs) that were established by the interdisciplinary team for the April 2007 individual support plan were continued from the previous ISP held in 2006. The review of the QMRP notes dated back to October 2006 reflected unsuccessful achievements of these objectives. The Qualified Mental Retardation Professional failed to revise these programs that were not successfully achieved by client #1. (Refer to W257) 4. During dinner observation conducted on August 30, 2007, at 6:00 PM, the staff asked Client #1 if she would like her meat cut. The meat was cut in the kitchen by the staff. The facility failed to provide Client #1 the opportunity to learn to cut her meat and subsequently increase independence with her meals. B. The facility failed to ensure clients were given the opportunity to participate in their self medication programs. Observation of the evening medication administration on August 30, 2007 beginning at 8:13 PM revealed Clients #1, #2 and #3 were given medications by the licensed practical nurse on duty. The nurse was observed to punch the medications from the bubble packs and give the medications to the clients. Direct care staff was observed to bring each client a cup of water for the client to drink with their medications. Review of Client #2 ' s record on August 30, 2007 at 7:58 PM revealed a self medication administration assessment dated April 2, 2007. According to the assessment, a recommendation	W 249	A3. See response to A1 above. The DoDS will assist the QMRP to review and revise unsuccessful programs. A4. See responses to A1 and A3 above. B. The QMRP will meet with the Designated Nurse, RN Supervisor, and QMRP will train staff to implement and document their self-medication programming.	10/10/07 10/10/07 10/10/07

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	09G167	A. BUILDING _____ B. WING _____	08/31/2007

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W 249	Continued From page 23 was made for Client #2 to participate in a program that required her to obtain her water with verbal prompts. Review of Client #3' s record on August 31, 2007, at 2:48 PM revealed the client' s nursing assessment dated June 13, 2007. The assessment indicated that Client #3 was to participate in his self medication regimen by obtaining his water and opening the medication cabinet and remove his medication with verbal prompts. Additional review of Client #3' s record on August 30, 2007 at 3:51 PM revealed an Individual Program Plan (IPP) dated August 1, 2006. The plan documented a program for Client #3 to complete the steps for taking his vitamins. It should be further noted that interview with the Qualified Mental Retardation Professional on August 31, 2007, at 1:15 PM, revealed Client #1 was to get her own water in preparation for taking her medications. At the time of the survey, the facility failed to ensure Clients #1, #2 and #3 were given an opportunity to participate with their self medication programs. C. The facility failed to ensure Client #3 was given the opportunity to participate in his newly recommended formal program objectives. (See also W259) D. Interview with the Qualified Mental Retardation Professional (QMRP) and review of Client #3 ' s record on August 31, 2007 revealed Client #3 had an Individual Support Plan (ISP) in his record dated August 1, 2006 that was outdated. According to the QMRP, Client #3 had an ISP meeting on August 8, 2007 but the comprehensive document had not been completed. Further interview with the QMRP revealed the client had the following new program objectives recommended at his ISP:	W 249	C. See responses to A1-4 above. See response to W159 and W209 D. See response to C above	10/10/07 10/10/07

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W 249	Continued From page 24 - Given verbal prompts, Client #3 will complete 1 ADL task daily on 80% of trials for 4 months. - Given touch prompts, Client #3 will complete household chore on 80% of trials per month for 3 months. - Given physical assistance, Client #3 will complete a puzzle on 100 % of attempted trials per month for 6 months. - Given verbal prompts, Client #3 will answer yes/no questions using his communication device. At the time of the survey, the aforementioned programs had not been implemented. E. The facility failed to provide evidence that Client #2's money management program was implemented timely. Review of Client #2's records on August 31, 2007 revealed the client had her annual ISP meeting on April 25, 2007. At that time programs were recommended for the client to participate with for the upcoming year. One of the recommended program objective for Client #2 required her to recognize a one dollar bill and a five dollar bill. Interview with the QMRP and further review of Client #2's record failed to provide evidence that the program had been implemented before August 2007. F. The facility failed to ensure Client #3 ' s new program objectives scheduled to be implemented at his day program was implemented. Observation at Client #3 ' s day program on August 30, 2007 beginning at 12:35 PM revealed the client in the dance studio listening to music	W 249	E. See response to C above F. See response to C above and W120	10/10/07 10/10/07

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W 249	Continued From page 25 and intermittently dancing with staff and his peers. Interview was conducted with the Activities Coordinator to ascertain information regarding some of the things the Client #3 was learning while at the program. According to the coordinator, Client #3 had a new Individual Program Plan (IPP) developed on August 7, 2007. The plan documented program objectives including the following: - Given hand over hand assistance, Client #3 will complete 100% of the steps of three interactive computer games within 12 months. Continued interview with the coordinator and review of Client #3' s data collection record revealed, the client ' s newly developed August 2007 IPP had not been implemented. At the time of the survey, the facility failed to ensure Client #3 ' s was given the opportunity to participate with his new formal program objectives at the day program.	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. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure data relative to the accomplishment of the criteria specified in each client ' s individual program plan objectives were documented in measurable terms, for one of the three clients (Client #3) included in the sample.	W 252	The DoDS will review IPPs and data collection methods with the QMRP. The DoDS will review the data collection bi-weekly at the home for a minimum of three months to ensure that staff understand requirements for data collection, and document data as planned and directed by the QMRP.	10/10/07

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W 252	Continued From page 26 The finding includes: (Cross Refer W249) Review of Client #3's record on August 31, 2007 at 4:04 PM revealed the client had been participating with the following formal program objectives during the past year: - Given physical assistance, Client #3 will mail a card to his father on monthly sessions for six consecutive months. - Given verbal prompts, Client #3 will master the steps of brushing his teeth for three consecutive months. - Given verbal prompts, Client #3 will complete the steps of taking his vitamin on all trials per month for three months. - Given verbal prompts, Client #3 will pass out snacks to named peers on 80 % of the trials for three months. - Client #3 will independently complete the steps of post-toileting skills on 80% of trials per month for three months. - Client #3 will independently clear his place after the dinner meal daily sessions for 30 days. Further review of the client's record revealed there was no data available for review for the months of April, May, and June 2007. The Qualified Mental Retardation Professional (QMRP) was interviewed on August 31, 2007, to ascertain information about the location of the missing data. At the time of survey however, the QMRP failed to provide evidence of the missing data collection records for Client #3.	W 252		

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W 257	483.440(f)(1)(iii) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. This STANDARD is not met as evidenced by: Based on interview and record review, the Qualified Mental Retardation Professional (QMRP) failed to ensure each clients individual program plan was revised after the client failed to progress with the identified objectives, for one of the three clients (Client #1) included in the sample. The finding includes: The QMRP failed to revise client #1's programs as performance measures reflected a lack of progress. Client #1's documentation and individual program plans were reviewed on August 31, 2007 at 12:30 PM and August 30, 2007 at 1:10 PM. 1. According to client #1's IPP that was reviewed on August 30, 2007, at 1:10 PM, the client had an objective that read "Will correctly identify $1 and $5 by touch 80% of the trials. Review of the program data revealed that client #1 performed at 0% with verbal prompting and physical assistance from November 2006 through March 2007. The IPP reflected that the client continued this objective in the April 2007's individual support plan. The objective was reimplemented without revisions. The documentation for the months of	W 257	See responses to W195, W209, W249, and W252	10/10/07

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W 257	Continued From page 28 May 2007 through July 2007 reflected a continued lack of criterion level attainment. 2. Client #1's IPP reflected an objective to "learn to identify by touch, the numbers on a telephone keypad 80% of the trials given verbal prompting and an adaptive telephone." The August data sheet for this program referenced to making a sandwich. The May and July 2007's documentation revealed the client's performance as requiring physical assistance and fading verbal prompts. Review of the QMRP's notes from December 2006 through March 2007 reflected that client #1 performed at 0% of the criterion level. Note that in February 2007, "the telephone was not working". 3. Client #1's IPP reflected an objective to measure water with verbal prompting 80% of the trials. May and July 2007's data reflected that the client performed below criterion at the the fading verbal prompt and physical assistance level. There was no June documentation for this program. According to the notes written by the QMRP, client #1 performed at 0% November 2006 through March 2007.	W 257		
W 259	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that comprehensive functional assessments had been completed and/or updated for one of the three clients (Client	W 259	See responses to W195, and W209, W249 and W252. The DoDS will track the development of the ISP document and IPPs. The ISP document will be submitted to the Department on Disability Services, and the final approved document will be placed in each person's record according to DDS policy. The DoDS will follow up with the QMRP to ensure the new IPPs are implement4ed within 10 days of the ISP team adopting them.	10/10/07

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W 259	Continued From page 29 #3) included in the sample. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of Client #3's record on August 31, 2007 at 3:19 PM revealed Client #3's annual Individual Support Plan (ISP) meeting was held on August 7, 2007. Review of the ISP in the record revealed the plan was dated August 1, 2006. Further interview was conducted to ascertain information about the current ISP (dated August 7, 2007). According to the QMRP, the plan had not been written and new program objectives recommended at the ISP had not been implemented. At the time of the survey, the facility failed to provide evidence that Client #3's ISP had been completed and updated as required.	W 259		
W 260	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on review of clients individual program plans (IPPs), the interdisciplinary team (IDT) failed to make revisions or to justify the repetition of the objectives from the previous year, for one of the three clients (Client #1) included in the sample. The findings include: (Cross refer to W257) Client #1's assessments, IPPs and documentation were reviewed on	W 260	The QMRP will submit new individual functional assessments supporting new IPPs for each person. The DoDS will review the new IPPs, and the QMRP will present the new IPPs to the IDT for the next quarterly once they are formulated. The QMRP will implement the new IPPs within ten days of their formulation.	10/10/07

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W 260	Continued From page 30 August 30 and 31, 2007. The IPPs identified in client #1's individual support plan (ISP) dated April 2007 were continued from the previous ISP annual. The written IPPs reflected that these program criterions and objectives were not revised. There was no documentation of interdisciplinary team review to justify continuation of the same objectives during the April 2007 individual support plan meeting.	W 260		
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's Human Rights Committee (HRC) failed to ensure written informed consent had been obtained from the client and/or their legal guardian for the use of behavior support plans, for one of the three clients (Client #2) included in the sample. The findings include: Observation of the evening medication administration on August 30, 2007 beginning at 8:27 PM revealed Client #2 received medications including Lithium Carbonate, Risperdal, and Gabapentin. Interview with the medication nurse during the medication administration revealed the aforementioned medications were used to address the client's behaviors.	W 263	The QMRP will obtain written informed consent from people or their families and present copies to the HRC. The HRC will review the written informed consents as part of the process of approval/disapproval of any restrictive treatments.	10/10/07

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W 263	Continued From page 31 Interview was conducted with the Qualified Mental Retardation Professional (QMRP) via telephone on August 30, 2007 at 8:10 AM. According the the QMRP, Client #2 was not capable of giving informed consent for the use of medications and habilitation services. Additionally, the QMRP revealed that Client #2 did not have involved family and was in need of a legally appointed guardian. Further interview with the QMRP revealed the client had a behavior support plan and required one to one staffing supports 12 hours daily (4 hours in the morning, 8 hours from 3 -11 PM weekdays, and 11 AM - 7 PM on the weekends) to address her behaviors. Review of Client #2's records on August 30, 2007 verified the clients Behavior Support Plan dated February 10, 2007. The plan incorporated the use of the aforementioned one to one staffing supports. At the time of the survey, the facility failed to provide evidence that its Human Rights Committee had obtained written informed consent for the use of Client #2's behavior support plan. [See also W124]	W 263		
W 264	483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. This STANDARD is not met as evidenced by:	W 264	The DoDS will provide the process for the HRC voting members to review and approve changes in restrictive treatments, such as medications. The voting members of the HRC are the parents of adult children with developmental disabilities and behavioral health concerns who live at home, and a retired DD professional who is not associated with Careco.	10/10/07

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W 264	Continued From page 32 Based on observation, interview and record review, the facility failed to provide evidence that its Human Rights Committee (HRC) thoroughly monitored and made suggestions about the facility's practice of increasing and administering clients psychotropic medications prior to the HRC approval, for one of the three clients (Client #2) included in the sample. The finding includes: Observation of the evening medication administration on August 30, 2007 beginning at 8:27 PM revealed Client #2 received medications including Lithium Carbonate, Risperdal, and Gabapentin. Interview with the medication nurse during the medication administration revealed the aforementioned medications were used to address the client's behaviors. Review of the Client #2's record on August 30, 2007 revealed a written order that indicated the client's medication was increased to Risperdal 2 mg on June 20, 2007. Further review of the client's record (Medication Administration Record) revealed that the client received her first dose of the medication on June 23, 2007. The Qualified Mental Retardation Professional (QMRP) was interviewed on August 31, 2007 to ascertain information about the process utilized by the facility to ensure the client's rights were being protected, prior to administering the Risperdal 2 mg. It should be noted that prior interview with the QMRP revealed that the client was not capable of giving informed consent and had no legally appointed guardian to assist her with decision making in that regard (See also W124). According to the QMRP, the HRC would meet to	W 264		

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W 264	Continued From page 33 discuss such matters and make their decision. The QMRP was further queried to ascertain if the HRC had met to discuss Client #2's increase in her psychotropic medication. The QMRP revealed that a telephone approval had been obtained from the HRC to increase the medication. The QMRP further revealed that only two people were a part of the telephone conference, the QMRP and a community representative. Upon the community representatives approval, the medication was increased. Review of the client's records on August 31, 2007 revealed a form entitled, "Human Rights Committee Telephone Approval" dated June 21, 2007. There were two signatures documented on the form, one was the QMRP's and the other belonged to the co-chairperson. There was no evidence that documented the telephone discussion with the community representative. Further interview with the QMRP revealed that a full HRC meeting was held on June 28, 2007. At the time of the survey, the facility failed to provide evidence that the HRC met and reviewed the practice of obtaining telephone approval for Client #2's increase in Risperdal and failed to ensure her rights were protected.	W 264		
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 medical records review and interview with the nurse, the facility failed to assure that client #1 was provided timely preventive and	W 322		

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W 322	Continued From page 34 general medical assessments as recommended. The finding includes: 1. According to the medical record for client #1 that was reviewed on August 30, 2007 at 10:15 AM, the GYN consultation document dated December 7, 2005 indicated that the client was uncooperative; therefore, the evaluation was incomplete. Some abdominal fullness and firmness was documented. The consult document reflected that the "patient needs to have documented Guardian/Medical Decision Maker assigned and IV and an abdominal sonogram should be considered." The nursing quarterly report dated January 31, 2007 reflected that the client needed GYN as soon as possible. On August 31, 2007 at 1:00 PM, the nurse stated during interview that client #1 was being referred to another facility that was felt to handle patients with more sensitivity. At the time of the survey, the GYN appointment had not been scheduled. The Qualified Mental Retardation Professional stated on August 31, 2007, that client #1 did not have a guardian neither a legal decision maker as previously recommended. 2. Client #1's health plan that was included in the medical record was reviewed on August 30, 2007, at 10:15 AM. The plan stated that client #1 had "fall and safety precautions" as a prevention to injury due to her blindness. On August 31, 2007 at 1:30 PM, the nurse and the Qualified Mental Retardation Professional (QMRP) were interviewed and were unable to provide documentation of these written precautions that had been referenced to in the medical plan.	W 322	1. The QMRP will follow up with the Case Manager on assignment of a medical guardian for the person. 2. The RN Supervisor will ensure that fall and safety precautions are attached to the medical record, and that staff are trained to follow these protocols.	10/8/07 10/8/07

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W 322	Continued From page 35 3. Review of client #1's medical record conducted on August 30, 2007, at 10:15 AM, revealed a cardiology report dated August 29, 2007. The report reflected that client #1's blood pressure was controlled and that there was weight loss. It was recommended that client #1 receive Ensure. The nutritional assessment dated June 23, 2007 was reviewed on the same day. This assessment that client #1's ideal body weight was 100-120 lbs and the client was weighed at 127 lbs in May 2007. Weights were not available of the months of June, July, and August 2007 to confirm if there was weight loss. During meal observation on August 30, 2007, client #1 ate all of her meal. 4. According to client #1's nutritional assessment dated June 23, 2007, it was recommended that client #1's diet intake be monitored, increase protein, carbohydrates, potassium rich foods, and protein intake and portion sizes. On August 31, 2007 at 1:55 PM, the nurse stated that the physician would have to approve the recommendations. The Qualified Mental Retardation Professional stated that the recommendations should have been referred to the physician. It could not be determined that the nutritionist's or the cardiologist's recommendations had been reviewed and addressed by the facility's medical staff. 5. Review of Client #2' s record on August 30, 2007 at 8:10 PM revealed Client #2 was seen by an ophthalmologist on July 7, 2006. According to the consultation form, the client was to return for a follow up visit in one year. Interview with the	W 322	3. The Primary Care Physician will review the nutritionist's and the cardiologist's recommendations and determine whether Ensure or other supplements are warranted. 4. See response to #3 above 5. The QMRP and the RD will ensure that all needed appointments are scheduled in a timely fashion. This issue will be addressed at the regularly scheduled grand rounds.	10/10/07 10/10/07 10/10/07

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W 322	Continued From page 36 nurse on August 31, 2007 revealed the appointment was scheduled for October 3, 2007. At the time of the survey, the facility failed to ensure Client #2 received a timely ophthalmology follow up visit. Based on interview and record review, the facility failed to ensure general and preventive care for one of the three clients (Clients #2) included in the sample. The findings include: 1. Review of Client #2' s record on August 30, 2007 at 8:10 PM revealed Client #2 was seen by an ophthalmologist on July 7, 2006. According to the consultation form, the client was to return for a follow up visit in one year. Interview with the nurse on August 31, 2007 revealed the appointment was scheduled for October 3, 2007. At the time of the survey, the facility failed to ensure Client #2 received a timely ophthalmology follow up visit. 2. On April 3, 2007 at 9:15 AM, an incident report documented an allegation of abuse involving Client #2. According to the report, a phone message was left on April 2, 2007 from a female representative of the clients' primary care physician's office. The female reported that a mailroom personnel observed a woman (later revealed to be the house manager) being "evil" to the clients and was "hitting, beating, and shoving them." The investigative report revealed that Client #2 was the only client involved in the incident and reported to have been injuried. According to the report the client complained of her arm hurting and indicated that the house manager was the cause of her injury.	W 322	1. See response to #5 above 2. See response to W153 and W 149	10/10/07 10/10/07

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W 322	Continued From page 37 Reveiw of the nursing notes and other medical records failed to indicated that the client's arm had been assessed. [Also See W153].	W 322		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review, the facility failed to provide nursing services in accordance with the needs of one of the three clients (Client #2) included in the sample. The finding includes: On April 3, 2007 at 9:15 AM, an incident report documented an allegation of abuse involving Client #2. According to the report, a phone message was left on April 2, 2007 from a female representative of the clients' primary care physician's office. The female reported that a mailroom personnel observed a woman (later revealed to be the house manager) being "evil" to the clients and was "hitting, beating, and shoving them." It should be noted that initially the report indicated that four clients (Clients #1, #2, #4 and #6) were involved; however, interview with the Qualified Mental Retardation Professional (QMRP) on August 30, 2007 revealed that only Client #2 was involved in the incident. Further review of the incident report revealed that Client #2 alleged that the staff person that "shoved her in the corner" of the elevator made her "hurt her arm." Additional review of the incident report and corresponding investigation	W 331	See response to W122, W149, W154, W195.	10/10/07

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W 331	Continued From page 38 failed to provide evidence that the nurse was notified and assessed the client's injury.	W 331		
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure timely dental services, for one of the three clients (Client #2) included in the sample. The finding includes: Review of Client #2' s records on August 30, 2007 at 8:04 PM revealed Client #2 was seen by the dentist as documented below: October 5, 2006 - the dental consultant documented that the patient needed scaling. May 17, 2007 - the consultation form documented that the patient refused to leave the van. July 10, 2007 - the dental consultant documented that the patient needed scaling. Interview with the nurse on August 31, 2007 and review of the record failed to provide evidence that the recommended scaling (documented to the October 5, 2006 consultation form) had been conducted.	W 356	The QMRP will ensure that the person is properly supported to cooperate with the scaling recommended by the dentist. The QMRP will consult with the psychologist and the HRC to ensure that every means is explored to successfully manage dental care timely in the least restrictive manner.	10/0/07
W 371	483.460(k)(4) DRUG ADMINISTRATION	W 371	See response to W195 and W249	

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W 371	Continued From page 39 The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure clients were taught to administer their own medications, for two of the three clients (Clients #2 and #3) included in the sample. The finding includes: Observation of the evening medication administration on August 30, 2007 beginning at 8:13 PM revealed Clients #1, #2 and #3 were given medications by the licensed practical nurse on duty. The nurse was observed to punch the medications from the bubble packs and give the medications to the clients. Direct care staff was observed to bring each client a cup of water for the client to drink with their medications. Review of Client #2 ' s record on August 30, 2007 at 7:58 PM revealed a self medication administration assessment dated April 2, 2007. According to the assessment, a recommendation was made for Client #2 to participate in a program that required her to obtain her water with verbal prompts. Review of Client #3' s record on August 31, 2007, at 2:48 PM revealed the client' s nursing assessment dated June 13, 2007. The assessment indicated that Client #3 was to participate in his self medication regimen by	W 371		

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W 371	Continued From page 40 obtaining his water and opening the medication cabinet and remove his medication with verbal prompts. Additional review of Client #3' s record on August 30, 2007 at 3:51 PM revealed an Individual Program Plan (IPP) dated August 1, 2006. The plan documented a program for Client #3 to complete the steps for taking his vitamins. It should be further noted that interview with the Qualified Mental Retardation Professional on August 31, 2007, at 1:15 PM, revealed Client #1 was to get her own water in preparation for taking her medications. At the time of the survey, the facility failed to ensure Clients #1, #2 and #3 were given an opportunity to participate with their self medication programs.	W 371		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure Client #3's communication device was maintained in good repair and failed to make certain the client was being taught to use it. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of Client #3 ' s record on August 31, 2007 revealed Client #3 had program objectives recommended at his	W 436	The QMRP will contact the Speech-Language Pathologist and the manufacturer (if needed) to ensure the device is working and properly programmed. The QMRP will then ensure the person and the staff are trained to properly and effectively use the device.	10/8/07

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W 436	Continued From page 41 Individual Support Plan (ISP) on August 8, 2007 that had not been implemented (See also W249). One of the program objectives required the client to answer yes/no questions using his communication device. The QMRP was interviewed on August 31, 2007 to ascertain information regarding the aforementioned communication device. The QMRP retrieved the device and attempted to demonstrate how the device would be used, but the device was malfunctioning. At the time of the survey, the facility failed to ensure Client #3 was being trained to use his communication device. Additionally, the facility failed to ensure the device was maintained in good repair.	W 436		

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I 000	INITIAL COMMENTS This licensure survey was conducted from August 30, 2007 through August 31, 2007. A random sample of three individuals was selected from the population of four females and two male clients. One of the individuals in the sample was diagnosed to function in the moderate range of mental retardation and the other two had a diagnosis of severe degree of mental retardation. One individual in the sample had a diagnosis of blindness and one had diagnosis of visual impairment. The findings of this survey were based on observations at the residence and three day programs,staff interviews at both the group home and day programs, review of clinical and administrative records to include the facility's unusual incident reports and policies. It was determined that there were repeated deficiencies from the previous survey year.	I 000		
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, the GHMRP failed to ensure the interior of the facility was maintained in a safe, clean, orderly, attractive and sanitary manner. The findings include: 1. Light bulbs were out and needed to be	I 090	1. Light bulbs will be replaced.	10/5/07

Health Regulation Administration

Marsha A. Thompson
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Director of Disability Services
TITLE

10/5/07
(X6) DATE

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I 090	Continued From page 1 replaced throughout the facility. 2. Ceiling light fixtures throughout the facility needed to be cleaned as debris was observed. 3. The main bathroom in the hallway had a door that was in disrepair and a broken drawer on the vanity.	I 090	2. Ceiling light fixtures will be cleaned. 3. The main bathroom door will be repaired or replaced; the broken drawer on the vanity will be repaired or replaced.	10/5/07 10/8/07
I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on record review, the GHMRP failed to provide evidence that the supervisor discussed the contents of job descriptions with each employee at the beginning of their employment and annually thereafter. The findings include: Review of the personnel records was completed on August 30, 2007 at 4:40 PM. Seven of the twelve staff identified on the current staffing schedule did not have current annual signed job descriptions. Four staff identified as substitutes did not have files available for review a the facility and no other options were provided.	I 203	Each staff persons will sign current annual job descriptions. Substitute staff files will be available for review.	10/10/07
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	I 206	Consultants will be contacted and their current health certificates will be obtained.	10/8/07

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I 206	Continued From page 2 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 each employee, prior to employment and annually thereafter, provided evidence of a physician's certification that documented a health inventory had been performed and that the employee's health status would allow him or her to perform the required duties. The finding includes: Interview with the Qualified Mental Retardation Professional and review of the GHMRP's personnel files on August 31, 2007 at 11:57 AM revealed the GHMRP failed to provide evidence that current health certificates were on file for five consultants.	I 206		
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specially areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure staff were effectively	I 229		

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I 229	Continued From page 3 trained on modified diets and behavior support plans. The findings include: 1. Each of the residents had behavioral support plans, however, there was no evidence that the staff had been trained on the target behaviors and the associated plans by the professional. The Qualified Mental Retardation Professional looked for training attendance documents on August 30, 2007 and did not locate them. 2. There was no evidence that staff received training on the resident's modified diets.	I 229	1. The QMRP will ensure that staff are trained on behavioral support plans, and that documentation of the training is available for review. 2. The QMRP will ensure that staff receive training on resident's modified diets.	10/10/07 10/10/07
I 274	3513.1(e) ADMINISTRATIVE RECORDS Each GHMRP shall maintain for each authorized agency ' s inspection, at any time, the following administrative records: (e) Signed agreements or contracts for professional services; This Statute is not met as evidenced by: Based on record review, the Group Home for the Mentally Retarded (GHMRP) failed to provide evidence of contracts with each of their consultants. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the personnel records on August 31, 2007 at 11:57 AM revealed the GHMRP failed to have contracts on file for the four consultants.	I 274	The Director of Disability Services will ensure that consultants have contracts on file.	10/10/07

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I 379	Continued From page 4	I 379		
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure the Department of Health, Health Facilities Division was immediately, followed by written notification within 24 hours, notified of unusual incidents that substantially interfered with a resident's health, for one of the three residents (Resident #4) that resided in the facility. The finding includes: Review of unusual incident reports on August 30, 2007 at 9:17 AM revealed the following incident: On August 8, 2007, staff reported that Resident #2 became agitated while on the residential van and began to spit, curse, scratch, and hit Resident #1. The report further documented that Resident #2 bit Resident #4 on his left arm. It should be noted that Resident #4 was taken to the emergency room, released and prescribed antibiotic medications. Interview with the Qualified Mental Retardation	I 379	The Director of Disability Services will provide refresher training to the QMRP, Residential Director, and the Incident Management Coordinator to ensure that incidents are reported timely to Department of Health, Health Facilities Division.	10/10/07

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I 379	Continued From page 5 Professional and further record review failed to provide evidence that the aforementioned incident had been reported to the Department of Health as required.	I 379		
I 391	3520.2(a) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (a) Medicine; This Statute is not met as evidenced by: The findings include: 1. According to the medical record for client #1 that was reviewed on August 30, 2007 at 10:15 AM, the GYN consultation document dated December 7, 2005 indicated that the client was uncooperative; therefore, the evaluation was incomplete. Some abdominal fullness and firmness was documented. The consult document reflected that the "patient needs to have documented Guardian/Medical Decision Maker assigned and IV and an abdominal sonogram should be considered." The nursing quarterly report dated January 31, 2007 reflected that the client needed GYN as soon as possible. On August 31, 2007 at 1:00 PM, the nurse stated	I 391	(a) 1. The QMRP will follow up with the Case Manager to acquire medical guardians for the person.	10/10/07

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I 391	Continued From page 6 during interview that client #1 was being referred to another facility that was felt to handle patients with more sensitivity. At the time of the survey, the GYN appointment had not been scheduled. The Qualified Mental Retardation Professional stated on August 31, 2007, that client #1 did not have a guardian neither a legal decision maker as previously recommended. 2. Client #1's health plan that was included in the medical record was reviewed on August 30, 2007, at 10:15 AM. The plan stated that client #1 had "fall and safety precautions" as a prevention to injury due to her blindness. On August 31, 2007 at 1:30 PM, the nurse and the Qualified Mental Retardation Professional (QMRP) were interviewed and were unable to provide documentation of these written precautions that had been referenced to in the medical plan. 3. Review of client #1's medical record conducted on August 30, 2007, at 10:15 AM, revealed a cardiology report dated August 29, 2007. The report reflected that client #1's blood pressure was controlled and that there was weight loss. It was recommended that client #1 receive Ensure. The nutritional assessment dated June 23, 2007 was reviewed on the same day. This assessment that client #1's ideal body weight was 100-120 lbs and the client was weighed at 127 lbs in May 2007. Weights were not available of the months of June, July, and August 2007 to confirm if there was weight loss. During meal observation on August 30, 2007, client #1 ate all of her meal. 4. According to client #1's nutritional assessment dated June 23, 2007, it was recommended that client #1's diet intake be monitored, increase	I 391	(a) 2. The QMRP and RN will provide the fall and safety precautions and the QMRP will ensure staff are trained on the precautions. (a) 3. The QMRP will refer the cardiologist's and the nutritionist's recommendations to the Primary Care Physician for a determination on her dietary needs. (a) 4. See response to (a) 3 above	10/10/07 10/10/07 10/10/07

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I 391	Continued From page 7 protein, carbohydrates, potassium rich foods, and protein intake and portion sizes. On August 31, 2007 at 1:55 PM, the nurse stated that the physician would have to approve the recommendations. The Qualified Mental Retardation Professional stated that the recommendations should have been referred to the physician. It could not be determined that the nutritionist's or the cardiologist's recommendations had been reviewed and addressed by the facility's medical staff.	I 391		
I 394	3520.2(d) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (d) Nutrition; This Statute is not met as evidenced by: The finding includes: According to client #1's nutritional assessment dated June 23, 2007, it was recommended that client #1's diet intake be monitored, increase protein, carbohydrates, potassium rich foods, and protein intake and portion sizes. On August 31, 2007 at 1:55 PM, the nurse stated that the	I 394	The QMRP will refer the nutritionist's recommendations to the Primary Care Physician for approval or change. The QMRP will inform the nutritionist of any changes from the PCP, and request the nutritionist to follow up as needed.	10/10/07

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I 394	Continued From page 8 physician would have to approve the recommendations. The Qualified Mental Retardation Professional stated that the recommendations should have been referred to the physician. At the time of the survey on August 30, 2007, the nutritionist had not demonstrated any follow up to the recommendations.	I 394		
I 398	3520.2(h) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (h) Social Work; This Statute is not met as evidenced by: Based on interview and record review the GHMRP failed to provide evidence of a valid license on file for the social worker. The finding includes: Interview with the Qualified Mental Retardation Professional and review of the personnel files on August 31, 2007 at 11:57 AM revealed the facility failed to have a license on file for the social worker.	I 398	The Director of Disability Services will request a copy of the Social Worker's current, valid license.	10/10/07

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I 401	Continued From page 9	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 professional services were received in a timely manner. The finding includes: 1. Review of Resident #2' s record on August 30, 2007 at 8:10 PM revealed Resident #2 was seen by an ophthalmologist on July 7, 2006. According to the consultation form, the resident was to return for a follow up visit in one year. Interview with the nurse on August 31, 2007 revealed the appointment was scheduled for October 3, 2007. At the time of the survey, the facility failed to ensure Resident #2 received a timely ophthalmology follow up visit. 2. Review of Resident #2' s records on August 30, 2007 at 8:04 PM revealed Resident #2 was seen by the dentist as documented below: October 5, 2006 - the dental consultant documented that the patient needed scaling. May 17, 2007 - the consultation form documented that the patient refused to leave the van. July 10, 2007 - the dental consultant documented that the patient needed scaling.	I 401	1. See response to federal deficiency W322 #5. 2. See response to federal deficiency W356	10/10/07 10/10/07

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I 401	Continued From page 10 Interview with the nurse on August 31, 2007 and review of the record failed to provide evidence that the recommended scaling (documented to the October 5, 2006 consultation form) had been conducted.	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 interview and record review, the GHMRP failed to ensure habilitation, training and assistance was provided to its residents in accordance with their Individual Habilitation Plan(s), for three of three residents (Residents #1, #2, and #3) included in the sample. The findings include: A. The facility failed to provide client #1 with continuous opportunities for learning as detailed below. 1. Client #1 was observed at the group home from 3:30 PM to 7:17 PM. 3:30 PM - Client #1 was was observed talking with the staff and complaining of her day and instructor; 3:55 PM - Client #1 left the living room where she had been seated and exited independently stating that she was going to see her show in her bedroom. Client #1 was in her bedroom for approximately five minutes and then was observed going to the closet near the front	I 422	See response to federal deficiencies W120, W159, W195, W209, W249, W252, W259	10/10/07

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I 422	Continued From page 11 entrance and retrieving a comb and hair pic. 4:30 PM - Client #1 was observed coming from the bathroom with her robe on. She stated that she had taken a shower. She stated that she did not require assistance. This was confirmed during other staff interviews. Client #1 returned the items that she retrieved from the closet and sat back on the sofa; 5:18 PM - Client #1 was observed conversing and making complaints to others about her day. The staff acknowledged the client's concerns and then offered the client an opportunity to do her laundry. Client #1 stated that she would do laundry later. The client remained seated on the sofa; 6:00 PM - Client #1 was observed eating dinner independently. Following dinner, the client removed her plate and utensils to the kitchen sink; 6:30 PM - Client #1 was observed dancing with the other clients; and 6:55 PM - Client #1 was observed talking with staff as she continued to make complaints about her day. Although Client #1's individual program plans (IPPs) reflected a frequency of implementation to be daily, these programs were not observed to be implemented at given opportunities. 2. According to Client #1's "individualized" active treatment schedule, the following activities were scheduled: 4:30 PM - Offer walk; if not desired the client may	I 422		

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I 422	Continued From page 12 do her laundry or be assisted with her training programs (i.e. identify coins, use telephone); Note: Staff asked Client #1 to do her laundry and she elected not to; however, there were no other options presented at the time; 5:30 PM - To engage client in other activities to keep her busy. Straighten her room, apply activator to her hair etc.; 6-6:30 PM - To eat dinner and to remind the client to use fork, spoon, and knife; 6:45 PM - To clean and remove dishes from the table; 7:00 PM - To assist in choosing activities; may choose to listen to music, play her keyboard, listen to gospel music or books on tape, etc.; 8:00 PM - To get medications and assist in getting her cup of water for medications. 3. Client #1's program documentation reviewed, on August 31, 2007 at approximately 12:10 PM, revealed that the individual program plans (IPPs) that were established by the interdisciplinary team for the April 2007 individual support plan were continued from the previous ISP held in 2006. The review of the QMRP notes dated back to October 2006 reflected unsuccessful achievements of these objectives. The Qualified Mental Retardation Professional failed to revise these programs that were not successfully achieved by client #1. (Refer to W257) 4. During dinner observation conducted on August 30, 2007, at 6:00 PM, the staff asked Client #1 if she would like her meat cut. The	I 422		

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I 422	Continued From page 13 meat was cut in the kitchen by the staff. The facility failed to provide Client #1 the opportunity to learn to cut her meat and subsequently increase independence with her meals. B. The facility failed to ensure clients were given the opportunity to participate in their self medication programs. Observation of the evening medication administration on August 30, 2007 beginning at 8:13 PM revealed Clients #1, #2 and #3 were given medications by the licensed practical nurse on duty. The nurse was observed to punch the medications from the bubble packs and give the medications to the clients. Direct care staff was observed to bring each client a cup of water for the client to drink with their medications. Review of Client #2 ' s record on August 30, 2007 at 7:58 PM revealed a self medication administration assessment dated April 2, 2007. According to the assessment, a recommendation was made for Client #2 to participate in a program that required her to obtain her water with verbal prompts. Review of Client #3' s record on August 31, 2007, at 2:48 PM revealed the client' s nursing assessment dated June 13, 2007. The assessment indicated that Client #3 was to participate in his self medication regimen by obtaining his water and opening the medication cabinet and remove his medication with verbal prompts. Additional review of Client #3' s record on August 30, 2007 at 3:51 PM revealed an Individual Program Plan (IPP) dated August 1, 2006. The plan documented a program for Client #3 to complete the steps for taking his vitamins. It should be further noted that interview with the Qualified Mental Retardation Professional on August 31, 2007, at 1:15 PM, revealed Client #1	I 422		

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I 422	Continued From page 14 was to get her own water in preparation for taking her medications. At the time of the survey, the facility failed to ensure Clients #1, #2 and #3 were given an opportunity to participate with their self medication programs. C. The facility failed to ensure Client #3 was given the opportunity to participate in his newly recommended formal program objectives. (See also W259) D. Interview with the Qualified Mental Retardation Professional (QMRP) and review of Client #3 ' s record on August 31, 2007 revealed Client #3 had an Individual Support Plan (ISP) in his record dated August 1, 2006 that was outdated. According to the QMRP, Client #3 had an ISP meeting on August 8, 2007 but the comprehensive document had not been completed. Further interview with the QMRP revealed the client had the following new program objectives recommended at his ISP: - Given verbal prompts, Client #3 will complete 1 ADL task daily on 80% of trials for 4 months. - Given touch prompts, Client #3 will complete household chore on 80% of trials per month for 3 months. - Given physical assistance, Client #3 will complete a puzzle on 100 % of attempted trials per month for 6 months. - Given verbal prompts, Client #3 will answer yes/no questions using his communication device. At the time of the survey, the aforementioned programs had not been implemented. E. The facility failed to provide evidence that Client #2's money management program was	I 422		

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I 422	Continued From page 15 implemented timely. Review of Client #2's records on August 31, 2007 revealed the client had her annual ISP meeting on April 25, 2007. At that time programs were recommended for the client to participate with for the upcoming year. One of the recommended program objective for Client #2 required her to recognize a one dollar bill and a five dollar bill. Interview with the QMRP and further review of Client #2's record failed to provide evidence that the program had been implemented before August 2007. F. The facility failed to ensure Client #3 ' s new program objectives scheduled to be implemented at his day program was implemented. Observation at Client #3 ' s day program on August 30, 2007 beginning at 12:35 PM revealed the client in the dance studio listening to music and intermittently dancing with staff and his peers. Interview was conducted with the Activities Coordinator to ascertain information regarding some of the things the Client #3 was learning while at the program. According to the coordinator, Client #3 had a new Individual Program Plan (IPP) developed on August 7, 2007. The plan documented program objectives including the following: - Given hand over hand assistance, Client #3 will complete 100% of the steps of three interactive computer games within 12 months. Continued interview with the coordinator and review of Client #3' s data collection record revealed, the client ' s newly developed August 2007 IPP had not been implemented. At the time of the survey, the facility failed to ensure Client #3	I 422		

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I 422	Continued From page 16 ' s was given the opportunity to participate with his new formal program objectives at the day program.	I 422		
I 423	3521.4 HABILITATION AND TRAINING Each GHMRP shall monitor and review each resident ' s Individual Habilitation Plan on an ongoing basis to ensure participation of the resident and appropriate GHMRP staff in revision of such Plans whenever necessary. The schedule for the reviews shall be documented within each IHP. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure each resident's Individual Habilitation Plan had been monitored to make certain each resident participated and the plans were revised as needed. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of Resident #3's record on August 31, 2007 at 3:19 PM revealed, Resident #3's annual Individual Support Plan (ISP) meeting was held on August 7, 2007. Review of the ISP in the record revealed the plan was dated August 1, 2006. Further interview was conducted to ascertain information about the current ISP (dated August 7, 2007). According to the QMRP, the plan had not been written and new program objectives recommended at the ISP had not been implemented. At the time of the survey, the facility failed to provide evidence that Resident #3's ISP had been completed and updated as required.	I 423	See response to I422	10/10/07

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I 426	Continued From page 17	I 426		
I 426	3521.5(c) HABILITATION AND TRAINING Each GHMRP shall make modifications to the resident ' s program at least every six (6) months or when the client: (c) Is failing to progress toward identified objectives after reasonable efforts have been made; This Statute is not met as evidenced by: Based on interview and record review, the Qualified Mental Retardation Professional (QMRP) failed to ensure that revisions were considered when residents' demonstrated a lack of achievement in attaining the established criterion levels, for one of three residents (Resident #1) included in the sample. The finding includes: The QMRP failed to revise client #1's programs as performance measures reflected a lack of progress. Client #1's documentation and individual program plans were reviewed on August 31, 2007 at 12:30 PM and August 30, 2007 at 1:10 PM. 1. According to client #1's IPP that was reviewed on August 30, 2007, at 1:10 PM, the client had an objective that read "Will correctly identify $1 and $5 by touch 80% of the trials. Review of the program data revealed that client #1 performed at 0% with verbal prompting and physical assistance from November 2006 through March 2007. The IPP reflected that the client continued this objective in the April 2007's individual support plan. The objective was reimplemented without revisions. The documentation for the months of May 2007 through July 2007 reflected a	I 426	See response to I422	10/10/07

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I 426	Continued From page 18 continued lack of criterion level attainment. 2. Client #1's IPP reflected an objective to "learn to identify by touch, the numbers on a telephone keypad 80% of the trials given verbal prompting and an adaptive telephone." The August data sheet for this program referenced to making a sandwich. The May and July 2007's documentation revealed the client's performance as requiring physical assistance and fading verbal prompts. Review of the QMRP's notes from December 2006 through March 2007 reflected that client #1 performed at 0% of the criterion level. Note that in February 2007, "the telephone was not working". 3. Client #1's IPP reflected an objective to measure water with verbal prompting 80% of the trials. May and July 2007's data reflected that the client performed below criterion at the the fading verbal prompt and physical assistance level. There was no June documentation for this program. According to the notes written by the QMRP, client #1 performed at 0% November 2006 through March 2007.	I 426		
I 458	3521.11 HABILITATION AND TRAINING Each resident ' s activity schedule shall be available to direct care staff and be carried out daily. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure each resident's activity schedule was carried out daily, for one of the three residents (Resident #1) included in the sample. The finding includes:	I 458	See response to 1422	10/10/07

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I 458	Continued From page 19 The facility's staff failed to implement client #1's activity schedule. A. Client #1 was observed at the group home from 3:30 PM to 7:17 PM. 3:30 PM - #1 talking with the staff and complaining of her day and instructor, 3:55 PM - #1 left the living room where she had been seated and exited independently stating that she was going to see her show in her bedroom. Client #1 was in her bedroom for approximately five minutes and then was observed going to the closet near the front entrance and retrieving a comb and hair pic. 4:30 PM - #1 was observed coming from the bathroom with her robe on. She stated that she had taken a shower. She stated that she did not require assistance. This was confirmed during other staff interviews. Client #1 returned the items that she retrieved from the closet and sat back on the sofa. 5:18 PM - one of the staff arrived and client #1 began to converse and make complaints of others and her day. The staff acknowledged the client's issues and then offered the client to do her laundry. Client #1 stated that she would do laundry later. The client remained sitting of the sofa 6:00 PM - dinner was served and client #1 ate independently. Following dinner, client #1 removed her plate and utensils to the kitchen sink. 6:30 PM - client #1 danced as all of the clients in the facility participated as a leisure activity. 6:55 PM - client #1 engaged in talking with staff and making her complaints as she did earlier. Although client #1's individual program plans	I 458		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G167	A. BUILDING _____ B. WING _____	08/31/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 10	1613 TAYLOR STREET, NW WASHINGTON, DC 20011

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I 458	Continued From page 20 (IPPs) reflected a frequency of implementation to be daily, these programs were not observed to be implemented at given opportunities. B. According to client #1's "individualized" active treatment schedule, the following activities were scheduled: 4:30 PM - offer walk; if not desired the client may do her laundry or be assisted with her training programs (i.e. identify coins, use telephone). Note: The staff did offer client #1 to do her laundry and she elected not to; however, there were no other options presented at the time. 5:30 PM - engage client in other activities to keep her busy. Straighten her room, apply activator to her hair etc. 6-6:30 PM - have dinner and remind the client to use fork, spoon, and knife; 6:45 PM - clean and remove dishes from the table 7:00 PM - assist in choosing activities; may choose to listen to music, play her keyboard, listen to gospel music or books on tape, etc. 8:00 PM - prompt to get her medications; assist her in getting her cup of water for medications	I 458		
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 observation, interview and record review, the facility failed to ensure the rights of each resident and/or their legal guardian to be	I 500	See response to federal deficiency W124. The QMRP will prepare an informed consent letter for the person, detailing the proposed treatments, their benefits and risks. The person and/or the legal guardian/medical decision maker will review and sign the document, providing or withholding consent to the proposed treatments. The QMRP will provide the person and the legal guardian/family members with Careco's policies on rights, admissions, and discharges.	10/10/07

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I 500	Continued From page 21 informed of the resident's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment, for one of the three residents (Resident #2) included in the sample. The findings include: Observation of the evening medication administration on August 30, 2007 beginning at 8:27 PM revealed Resident #2 received medications including Lithium Carbonate, Risperdal, and Gabapentin. Interview with the medication nurse during the medication administration revealed the aforementioned medications were used to address the resident's behaviors. Interview was conducted with the Qualified Mental Retardation Professional (QMRP) via telephone on August 30, 2007 at 8:10 AM. According the the QMRP, Resident #2 was not capable of giving informed consent for the use of medications and habilitation services. Additionally, the QMRP revealed that Resident #2 did not have involved family and was in need of a legally appointed guardian. Further interview with the QMRP revealed the resident had a behavior support plan and required one to one staffing supports 12 hours daily (4 hours in the morning, 8 hours from 3 -11 PM weekdays, and 11 AM - 7 PM on the weekends) to address her behaviors. Review of Resident #2's records on August 30, 2007 verified the residents Behavior Support Plan dated February 10, 2007. The plan incorporated the use of the aforementioned one to one staffing supports. At the time of the survey, however, the facility failed to provide evidence that Resident #2's treatment needs, including the benefits and potential side effects	I 500		

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I 500	Continued From page 22 associated with the medications, and the right to refuse treatment, had been explained to her and/or a legally authorized representative.	I 500		