NAME OF PROVIDER OF COMP CARE I I (X4) ID PREFIX REGULA (X4) ID PREFIX REGULA A recertif Septemb This surve process; of active review the Condition Treatmer was selected various led disabilities. The finding observating guardian/	ENCIES TION R SUPPLIER SUMMARY STA H DEFICIENCY LATORY OR L COMMENT fication sur per 28, 200 Vey was init	,	A. BUILI B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 1320 LONGFELLOW STREET NW WASHINGTON, DC 20011 PROVIDER'S PLAN OF CORRE	OULD BE COMPLETION
(X4) ID PREFIX TAG (EACH REGULE) W 000 INITIAL (EACH REGULE) A recertif September This surveyorcess; of active review the Condition Treatment was selected various led disabilities. The finding observation guardian/	SUMMARY STA H DEFICIENCY LATORY OR L COMMEN' fication sur per 28, 200 Vey was init	ATEMENT OF DEFICIENCIES Of MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) TS	ID PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP CODE 1329 LONGFELLOW STREET NW WASHINGTON, DC 20011 PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	CTION (X5) OULD BE COMPLETION
(X4) ID PREFIX TAG (EACH REGULE) W 000 INITIAL (EACH REGULE) A recertif Septembor This survey process; of active review the Condition Treatmer was selected various led disabilities. The finding observation guardiant	SUMMARY STA H DEFICIENCY LATORY OR L COMMEN' fication sur per 28, 200 Vey was init	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	1329 LONGFELLOW STREET NW WASHINGTON, DC 20011 PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	CTION (X5) OULD BE COMPLETION
W 000 INITIAL (EACH REGULE) A recertif September This survey process; of active review the Condition Treatmen was selected various ledisabilitie. The finding observation guardian/	H DEFICIENCY LATORY OR L COMMENT fication sur per 28, 200 Vey was init	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	OULD BE COMPLETION
A recertification observations of active review the Condition Treatment was selected to the Condition observation	fication sur per 28, 200 vey was init	,	W M		110111111111111111111111111111111111111
client and incident/ir 483.410(c) OUTSIDE The facility meet the incident/ir 483.410(c) OUTSIDE This STAI Based on review, the services in two clients	treatment, the facility's in sof Particular. A rando cted from a evels of meas. Ings of the strongs of the strongs at two from the facility facility fail and the needs of each observation of acility fail net the needs in the san	rices provided with services ach client. not met as evidenced by: n, interviews, and record led to ensure that outside ads of each client, for one of nple. (Client #1)	W 120	GOVERNMENT OF THE DISTRIC DEPARTMENT OF HE. HEALTH REGULATION ADMI 825 NORTH CAPITOL ST., N.E WASHINGTON, D.C. 2	T OF COLUMBIA ALTH NISTRA TION 2ND FLOOR
The facility implement prescribed	ted Client # i.	ensure that the day program 1's behavior support plan as #1's day program on			
DRATORY DIRECTOR'S	an at Anglif				
deficiency statement er		R/SUPPLIER REPRESENTATIVE'S SIGNA	TURE	TITLE	(XIS) DATE

ny ther safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days also disclosable 10 days are disclosable 10 days are following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/15/2009

		I AND HUMAN SERVICES & MEDICAID SERVICES					M APPROVED 0. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	AULTIF ILDING	PLE CONSTRUCTION	(X3) DATE	
		09G153	B. WI	NG_		10/	01/2009
NAME OF F	PROVIDER OR SUPPLIER		· · · · · · · · · · · · · · · · · · ·	STR	EET ADDRESS, CITY, STATE, ZIP CODE		
COMPC	ARE I I			13	29 LONGFELLOW STREET NW ASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	September 29, 200 direct care aid promof a puzzle together placed his hand in	at 12:34 p.m., revealed the opting Client #1 to put pieces At 12:37 p.m., Client #1 his mouth. At 12:47 p.m., bite his wrist. The staff stated, ehaviors". However, the staff 12:54 p.m., Client #1 began in. The staff repeated the electron stopped. At 12:59 p.m., as hite his wrist again, the direct elbow several times and one minute later, Client #1 st. The staff took his wrist out stop. By program staff at 12:58 he is required to ask the client name when he is biting his home, revealed the following essing Client #1 target ing: him a specific verbal prompt name and stating "please win." ds and repeat the verbal combining it with a light are is no risk of staff being	W	120	W 120 The Qualified Mental Retardation (QMRP) an House Manager (HM) w meet with the day progra Interdisciplinary Team (to discuss implementation interventions specified in #1's Behavior Support P (BSP). The residential fa will request the day program to train staff on implementation of client' Behavior Support Plan (I) The QMRP and the HM on a monthly basis visit to day program to monitor counselors implementation client #1's BSP. During th monitoring, discrepancies implementing the BSP wi brought to the attention of day program's Case Man	ill am's (IDT) on of of client lan cility gram 's BSP). will he on of he s in ill be of the	11/30/09

PRINTED: 10/15/2009

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			<u> </u>). 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION (X3) DATE (COMPL	SURVEY
	•	09G153	B. WI	NG_		104	01/2009
NAME OF F	ROVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE 1329 LONGFELLOW STREET NW WASHINGTON, DC 20011		71/2009
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	TOX	PROVIDER'S PLAN OF CORRECTIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 120	Continued From pa	ge 2	w	120			
W 149	that the day program Client #1's BSP.	urvey, there was no evidence m counselor implemented	W 1	149			
	policies and proced mistreatment, negle	velop and implement written ures that prohibit ct or abuse of the client. s not met as evidenced by:		į	·		
	Based on observation review, the facility facestablished policy of mistreatment, to ensure the control of the c	on, interview and record illed to implement its nabuse, neglect and sure the health and safety for in the facility. (Client #3)	·		•		
	On September 30, 2 p.m., interview with 5 p.m., interview with 5 p.m., interview with 5 stated that his class him against the wall interview revealed the practical nurse (LPN with the LPN at 4:34 assessed Client #3 fewere no signs of injuinterview with Staff # they did not complete orderview with the quaprofessional (QMRP) approximately 4:50 prot made aware of the processional (PMRP) approximately 4:50 prot made aware of the processional (PMRP) approximately 4:50 protessional experience of the processional processional (PMRP) approximately 4:50 protessional experience of the processional experience of the procession experience of	2009, at approximately 2:30 Staff #3 revealed that Client eptember 29, 2009, and mate pushed and slammed at his day program. Further at staff informed the license) on the same day. Interview p.m., revealed that he or head injuries and there ry or pain. Additional 3 and the LPN revealed that			W 149 Administrative action was taken against the two staff v failed to report such allegat of abuse. Staff have been trained on t facility's incident management policy and procedure. Staff shall be trained quarte on incident management and reporting.	ion he ent	11/30/09

PRINTED: 10/15/2009

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	0. 0938-0391
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) I A. BL		TIPLE CONSTRUCTION	(X3) DATE COMP	
		09G153	B. W	ing		10/	01/2009
NAME OF	PROVIDER OR SUPPLIER CARE 11		·	s	TREET ADDRESS, CITY, STATE, ZIP CODE 1329 LONGFELLOW STREET NW WASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES OF T	ULD BE	(XS) COMPLETION DATE
	report and write an allegations abuse, reported in recipient to approximately 5:30 suspected or actual abuse or neglect by otherwise associate reported immediate the facility staff men witnessing or hearing. There was no evide its established policy and abuse to ensure harm. 483.420(d)(2) STAFCLIENTS The facility must ensure injuries of unknown immediately to the acofficials in accordance established procedure. This STANDARD is Based on interview a failed to ensure that mistreatment, neglections and accordance in the stablished procedure.	incident report for all neglect, and mistreatment. ent management policy dated in September 30, 2009 at p.m., revealed "Any alleged, incident of mistreatment, a person not employed or incident of mistreatment, a person not employed or incident of with the facility, shall be by to the QMRP/Director by inber or other representative ag of the alleged incident". Ince the facility implemented you mistreatment, neglect e all clients were safe from if TREATMENT OF Bure that all allegations of ct or abuse, as well as source, are reported diministrator or to other be with State law through res. Inot met as evidenced by: Ind record review the facility all allegations of ct or abuse, are reported diministrator and the in (DOH), Health Regulation in the of three clients residing in (3)	W 1				
		i		i	•	ı	

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/15/2009

CENT	ERS FOR MEDICARE	& MEDICAID SERVICES		<u> </u>		OMB NO	0. 0938-0391	
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		09G153	B. Wi	NG_				
	PROVIDER OR SUPPLIER			'	REET ADDRESS, CITY, STATE, ZIP CODE 1329 LONGFELLOW STREET NW WASHINGTON, DC 20011	TOMPLETED 10/01/2009 DDE RRECTION (XS) SHOULD BE APPROPRIATE DATE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	JLD BE	(XS) COMPLETION DATE	
	1. On September 3 2:30 p.m., interview Client #1 came horr and stated that his or slammed him again Further interview re- license practical nur Interview with the LI he assessed Client were no signs of injuinterview with Staff at they did not complet Interview with the qualification. Further in staff is required to re- report for all allegation. On September 30, 2009 p.m., there was no e- administrator had be allegation. 483.420(d)(3) STAFI CLIENTS The facility must have violations are thorough This STANDARD is Based on interview af failed to thoroughly in	io, 2009, at approximately with Staff #3 revealed that he on September 29, 2009, class mate pushed and st the wall at his day program, wealed that staff informed the se (LPN) on the same day. On at 4:34 p.m., revealed that #3 for head injury and there arry or pain. Additional #3 and the LPN revealed that the an incident report. Talified mental retardation of at approximately 4:50 p.m., here not made aware of the atterview indicated that the aport and write an incident ons. The inform of the alleged of the evidence that the en inform of the alleged of the evidence that all alleged of the evidence that the evidence that all alleged of the evidence that the evidence that all alleged the evidence that the evidence t			W 153 Cross reference W 149.			
- 1	3	j.				J	ŀ	

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

PRINTED: 10/15/2009 FORM APPROVED

CENTE	RS FOR MEDICAR	E & MEDICAID SERVICES					D. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI	il DIN G	PLE CONSTRUCTION	(X3) DATE	
		09G153	B. WIN	NG_		10/	01/2009
COMP C	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID DOCES	13 W	EET ADDRESS, CITY, STATE, ZIP CODE 129 LONGFELLOW STREET NW ASHINGTON, DC 20011 PROVIDER'S PLAN OF CORRECTS	ION	COMPLETION
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION DATE
	On September 29, p.m., review of an revealed that on the licensed practical revening medication get Client #2 for his observed Client #2 Staff (AS). Further Client #2 destroyed and kicking and brocking and starts was upstairs in the beside Client #2 left hoffice and started a further stated Client downstairs in the killing him. Client #2 left hoffice and started a further stated Client was upstairs in the killing him. Client #2 left hoffice and started a further stated Client was upstairs in the killing him. Client #2 left hoffice and started a further stated Client property destruction and a chair). Law ecalled and transport further review of the evidence an interview of the evidence and interview of the evidence an interview of the evidence and interview of the evidence and interview of the evidence an interview of the evidence an interview of the evidence and interview of the evidence an interview of the evidence and interview of the evid	a 2009, at approximately 2:16 unusual incident report (UIR) ne evening of July 15, 2009, the nurse (LPN) came to administer ons. Staff #1 went upstairs to is evening medications and 2 attacking the Administrative or review of the UIR revealed d property by throwing a chair reaking the dining table. The reaking the dining table. The reaking the dining table as result of his maladaptive 2009, at approximately 10:30 or the qualified mental sional (QMRP) revealed AS administrative office located bedroom. The QMRP stated his bedroom, went into the attacking AS. The QMRP attacking AS. The QMRP attacking AS. The QMRP attacking AS. The QMRP of the surveyor with internal dated July 15, 2009 (three cort revealed that Client #2 t behaviors towards AS by k2's behavior escalated to or (destroyed the dining table enforcement (police) was ted Client #2 to CPEP. e investigation failed to one with Staff #1 who	W 1	154	W 154 The deficient practice of fato include written interviewand statements from witner during an investigation has been corrected through modification of the provide investigation form to include sections of written interviewand statements. Justification of this claim is evident in the provider's investigation report of the incident of September 30, 2009. An investigation repoincluding written interviewand statements was submitted DOH within five (5) working days from the date the incident. Please refer to W149 for details of incident. The administrative office wreview all investigations to ensure that written interviewand statements are included the reports. The administrative will sign all reviewed investigations.	ws sses s er's de ws s ort s ted e of t. till ews d in	11/30/09
		attacked by Client #2. The					

PRINTED: 10/15/2009 FORM APPROVED

		AND HUMAN SERVICES & MEDICAID SERVICES		•		FOR	D: 10/15/2009 M APPROVED D. 0938-0391
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) A A. BU		TPLE CONSTRUCTION NG	(X3) DATE	
		09G153	B. WI	NG_		10/	01/2009
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
COMP	CAREII				1329 LONGFELLOW STREET NW WASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	COMPLETION DATE
W 154			w	154			
W 156	and statements from licensed practical no through interview wi	to include written interviews in the witnesses including the urse. This was confirmed ith the facility's QMRP on approximately 10:35 a.m. F TREATMENT OF	W	156			
	to the administrator	restigations must be reported or designated representative in accordance with State law lays of the incident.					
	Based on interview a failed to ensure requ reviewed by the adm	not met as evidenced by: and record review, the facility ired investigations were ninistrator within five working clients included in the					
	The finding includes:	:					
	mental retardation preview of the facility's corresponding invest 2009, at approximate incident dated July 19 revealed that Client a	Interview with the qualified ofessional (QMRP) and incidents reports and igative reports on October 1, ely 10:35 a.m., revealed an 5, 2009. The incident 12 was transported to CPEP (police) for attacking staffing property.			W 156 Cross reference W 154.		
W 159	revealed that the QM investigation. There	was no writtenn evidence investigation was reviewed ministrator.	W 15	59			

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	0. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION IG	(X3) DATE : COMPL	
		09G153	B. WW	NG_		104	01/2009
NAME OF F	PROVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE 329 LONGFELLOW STREET NW WASHINGTON, DC 20011	100	0 112009
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETION DATE
	RETARDATION PREACTION PRODUCT PREACTION PREACTION PRODUCT PREACTION PRODUCT PREACTION PRODUCT PREACTION PRODUCT PREACTION PRODUCT PREACTION PRODUCT PRODUCT PREACTION PRODUCT PR	treatment program must be ated and monitored by a sardation professional. It is not met as evidenced by: ons, interview and record ailed to ensure that each ment program was integrated, onitored by the qualified professional (QMRP), for three ling in the facility. (Clients #1, it is: 120. The QMRP failed to program implemented Client at plan as prescribed. 3. The QMRP failed to strated competency in the le behavior support plans. 247. The facility's QMRP Client #3 client was provided e a choice during snack time.	W 1	159	W 159 1. Cross reference V 2. Cross reference V 3. Cross reference V 4. Cross reference V 5. Cross reference V 6. Cross reference V	V 193 V 247 V 249 V 252	

PRINTED: 10/15/2009

		H AND HUMAN SERVICES	•		FOR	D: 10/15/2009 M APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE), 0938-0391 SURVEY LETED
		09G153	B. WING_	•	1 10	01/2009
NAME OF I	PROVIDER OR SUPPLIER CARE I I		1 1	REET ADDRESS, CITY, STATE, ZIP 1329 LONGFELLOW STREET NO WASHINGTON, DC 20011	CODE	01/2009
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TO DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
W 159	Continued From pa	age 8	W 159			
W 193	ensure that fire eva quarterly on all shif	V440. The QMRP failed to alluation drills were conducted ts. FF TRAINING PROGRAM	W 193			
17 133	Staff must be able techniques necessi	to demonstrate the skills and ary to administer interventions propriate behavior of clients.	W 193			
	Based on observati record review, the fi demonstrate compo of behavior support	s not met as evidenced by: ons, staff interviews and acility staff failed to etency in the implementation plans (BSPs), for two of two ne sample. (Clients #1 and				
	The findings include	:				
	Client #1 was obser occasions. Record 2009, at 10:40 a.m., dated June 1, 2009, screaming as a targ	9. On September 28, 2009, ved biting his wrist on several review on September 29, confirmed Client #1's BSP, included hand biting and et behavior. Further record following procedures for hand g:				
	to engage in self-inju prompt him to stop a involving manipulation hands." "Staff should hands and initiate tho while, till he begins to					
	b. Screaming - If Cli	ent #1 begins to scream,				

PRINTED: 10/15/2009

		1 AND HUMAN SERVICES 8 MEDICAID SERVICES					APPROVED . 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		AULTI ILDIN	PLE CONSTRUCTION G	(X3) DATE S COMPLI	URVEY
		09G153	B. WI	NG_		10/0	1/2009
NAME OF	PROVIDER OR SUPPLIER			1:	REET ADDRESS, CITY, STATE, ZIP CODE 329 LONGFELLOW STREET NW VASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	"attempt first to detr him to do so. Ask h Address these need There was no evide these intervention s the psychologist. 2. Cross-refer to W ensure that Client # competency in imple remaining in physical below: Upon entering the fa at 4:35 p.m., to start process, Client #2 w walked over from the to greet the surveyor want you her. You re observations at approvent and the that time, immediate Client #2 to another identified 1:1 staff re during this time. Interview with the Qiff at approximately 3:00 received 1:1 staffing a.m., to address his physical aggression a absconding, self-injufalse allegations. Review of Client #2's dated June 2, 2009, of	ermine what may be causing im to show you what he wants.	W	193	W 193, 1a, b & 2 Staff will be in-serviced of implementation of interventions specified in #1's and client #2's BSPs. During the in-service, emphasis will be placed of staff being at physical arrilength of client #2 at all tiduring waking hours. The House Manager (HM QMRP will on a weekly be monitor staff implementate of interventions specified client #1's and client #2's	client n ns mes) and asis tion in	11/30/09

PRINTED: 10/15/2009

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 09G153 10/01/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1329 LONGFELLOW STREET NW COMP CARE I I WASHINGTON, DC 20011 **SUMMARY STATEMENT OF DEFICIENCIES** (X4) ID PROVIDER'S PLAN OF CORRECTION D (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) W 193 Continued From page 10 W 193 interview of the aforementioned maladaptive behaviors. Further review of Client #2's BSP revealed that one of the 1:1 staff duties and responsibilities was "being physically present arm's length" from Client #2 during waking hours (from time he is awake till he goes to sleep), while at the day program, while on community outings and while in the community to ensure prevention of physical aggression against others, injury against himself and absconding. At the time of the survey, there was no evidence that on September 28, 2009, the facility staff demonstrated competency in the implementation of the client's BSP. W 247 483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN W 247 The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that each client was provided opportunities for choice, encouraged and taught to make choices for one of three clients residing in the facility. (Client #3) The finding includes: On September 29, 2009, at 3:13 p.m., Staff #3 was observed to retrieve a bag of white cheddar popcorn from the kitchen to bring to Client #3 who was sitting at the dining table talking with the surveyors. Staff opened the bag of popcorn and gave it to Client #3. Interview with Staff #3 on

September 30, 2009, at approximately 2:30 p.m., confirmed that she did not provide and/or offer

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/15/2009

		I AND HUMAN SERVICES 8 MEDICAID SERVICES					APPROVED 0.0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) A A. BU		LTIPLE CONSTRUCTION DING	(X3) DATE S COMPLI	SURVEY
		09G153	B. WI	NG		10/0	01/2009
NAME OF I	PROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE 1329 LONGFELLOW STREET NW WASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDS OF THE APPROPRIES OF THE	JLD BE	(X5) COMPLETION DATE
W 249	Client #3 a choice Staff #3 stated that talkative mood; thei because she knew Review of Client #3 September 30, 200 stated "provide me choice and participato me" At the time of the suensure Client #3 was choice and/or self-ntime. 483.440(d)(1) PROOF As soon as the interformulated a client's each client must rectreatment program of interventions and seand frequency to sure objectives identified plan. This STANDARD is Based on observation review, facility staff fimplementation of clients wood of two clients (Clients #1 and #2) The findings include: 1. On September 28	of snack during snack time. Client #3 was not in a refore, she gave him popcom he like it. 's Individual Support Plan on 9, at approximately 4:30 p.m., [Client #3] with freedom of ation in all activities pertaining arvey, the facility failed to as afforded opportunities for nanagement during snack. GRAM IMPLEMENTATION redisciplinary team has a individual program plan, seive a continuous active consisting of needed ervices in sufficient number apport the achievement of the in the individual program. In not met as evidenced by: on, interviews and record failed to ensure continuous ients' behavior support plans, included in the sample.	W 2		Staff will be trained on provision of choices, promotion of self-management, and rights. The House Manager will oweekly basis observe staff ensure compliance with provision of choices, promotion of self-management, and implementation of clients'	to	11/30/09
	#1 was observed sitt	ing in the living room on the				ľ	

PRINTED: 10/15/2009

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE					FORM): 10/15/2009 MAPPROVED): 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) A A. BU		TIPLE CONSTRUCTION NG	(X3) DATE (COMPL	SURVEY
	09G153	B. WI	NG_		104	01/2009
NAME OF PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
COMP CARE I I				1329 LONGFELLOW STREET NW WASHINGTON, DC 20011		·
PREFIX (EACH DEFICIENCY)	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREF TAG	X	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	COMPLETION DATE
making a loud noise p.m., Staff #1 assists room to eat. After C to yell then proceeds room. Staff #1 took (living room and offer Staff #1 assisted the Once Staff #1 placed neck, he began to ye p.m., Staff #1 took C 6:58 p.m., Client #1 began to yell and bits Client #1 was observed #1 asked him to stop Interview with the Quebrofessional (QMRP approximately 4:50 phad a Behavior Supphis maladaptive behavior maladaptive behavior december 29, 2009, revealed the client has hand biting, screaming of the BSP revealed scaled that Client #1 to 4:07 p.m. and from Further review of the revealed that the Client #1 to 4:07 p.m. and from Further review of the revealed that the Client #1 to 4:01 p.m. and	ration revealed Client #1 and biting his hands. At 6:43 ad Client #1 into the dining lient #1 sat down, he began ad to walk back into the living Client #1's ice tea into the ad it to him. At 6:49 p.m., client into the dining room. I Client#1's bib around his all and bite his wrist. At 6:54 lient #1 for a walk outside. At returned from his walk and a his hand. At 7:02 p.m., red biting his wrist and Staff bit. alified Mental Retardation on September 28, 2009, at m., revealed that Client #1 ort Plan (BSP) to address aviors. Client #1's BSP dated June er 29, 2009 at 10:40 a.m., ad maladaptive behaviors of ag and pica. Further review staff were to record Consequence (ABC) on the a daily.	W	249	W 249.1 Staff will be trained on implementation of interve strategies in client#1's BS and accurate data collection. The House Manager and QMRP will once monthly shift conduct monitoring of staff implementation of client#1's BSP and behavi data collection to ensure compliance.	Pon. per	11/30/09

CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES				OMB NO). 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE (COMPL	
		09G153	B. WIN	IG_		10/01/2009	
NAME OF F	PROVIDER OR SUPPLIER			13	REET ADDRESS, CITY, STATE, ZIP CODE 329 LONGFELLOW STREET NW VASHINGTON, DC 20011	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
W 249	Continued From pa	age 13	W 2	:49			
	these intervention the psychologist.	strategies as recommended by					
	2. Observations On September 28, 2009, beginning at 4:35 p.m. to 6:48 p.m., revealed staff failed to implement Client #1's BSP as follows:						
	- At 4:35 p.m., Upon entering the facility to start the annual recertification process, Client #2 was observed to immediately walked over from the dining area to the front door to greet the surveyors by saying "get out, I don't want you here. You need to leave now."						
	not indentified as C immediately interve another area of the	4:36 p.m., Staff #1 who was lient #2's 1:1 staff at that time, ened by redirecting Client #2 to home. Client #2's identified in the dining area during this					
	professional (QMRI Client #2 on a comi (assigned to Client	qualified mental retardation P) was observed to transport munity walk. Staff #2 #2) was observed to transport munity walk during this time.					
	his bedroom while a	nt #2 was observed upstairs in assigned different 1:1 staff rved in the kitchen preparing			•		
		t #2 was upstairs in his					

PRINTED: 10/15/2009

CENTE	CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0391	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1	AULTIP ILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G153	B. Wi	NG		104	01/2009
COMP C	PROVIDER OR SUPPLIER			13	ET ADDRESS, CITY, STATE, ZIP CO 29 LONGFELLOW STREET NW ASHINGTON, DC 20011		112000
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOW TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)		SHOULD BE	(X5) COMPLETION DATE
W 249	Continued From page 14			249			
	living room looking out the window.						
	- At 6:06 p.m., Staff #1 was observed to go upstairs to Client #2's bedroom to ask him if he wanted to assist with dinner preparation. The client stated, maybe next time. Staff #1 returned back to the kitchen/dining area.						
	- At 6:08 p.m., the QMRP was observed in Client #2's bedroom encouraging him to come down to the dining area to eat dinner. Client #2 stated that he would eat after the surveyors leave. Shortly afterwards, Client #2 was observed to come to the dining to eat his dinner.						
		nt #2 finished his dinner and the dishwasher after rinsing					
	- At 6:21 p.m., Clien bedroom alone.	t #2 returned back to his					
	upstairs to sit with C	MRP stated to Staff #1 to go lient #2. Staff #1 was seat outside of Client #2's					
	5:16 p.m., revealed of called off and that Staff for today. Furth revealed that Staff #	#1 on September 28, 2009, at Client #2's second shift 1:1 baff #2 was his assigned 1:1 her interview with Staff #1 2 had worked with Client #2 as not an assigned staff for					
	Interview with the QMRP on the same day at approximately 5:53 p.m., revealed Staff #1 was the assigned 1:1 staff for Client #2 for the evening of September 28, 2009. The QMRP further						

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/15/2009

		AND HUMAN SERVICES		·		FOR	D: 10/15/2009 M APPROVED O. 0938-0391
STATEMENT OF DEFICIES AND PLAN OF CORRECTS	ICIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI	JLTIPLE CONSTI	RUCTION	(X3) DATE	
		09G153	B. WIN	G		10/01/2009	
NAME OF PROVIDER OR	SUPPLIER			STREET ADDRE	SS, CITY, STATE, ZIP COD	E	
COMP CARE ! !			·		ELLOW STREET NW ON, DC 20011		
PREFIX (EACH	DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	· · · · · · · · · · · · · · · · · · ·		(X5) COMPLETION DATE	
1:1 staff vabsent. Additional 29, 2009, Client #2's 12:00 a.m of physica abscondint false alleg Review of dated June approximatinterview obehaviors. revealed the were as for a. Being "p. Client #2 dawake till it program, with a communaggression and abscorb. Always ethree arms c. Providing visitor/s not the time that Client is recommend.	interview at approximate approximate approximate approximate approximate approximations. Client #2'e 2, 2009 at a 2, 2009 at a 3:40 of the aformation approximate	ge 15 was identified as the assigned of #2's original 1:1 staff was with the QMRP on September imately 3:00 p.m., revealed 1:1 staffing from 8:00 a.m. to ess his maladaptive behaviors ion (mainly toward women), urious behaviors, and making s behavior support plan (BSP) on September 29 p.m., confirmed the QMRP's ementioned maladaptive review of Client #2's BSP ementioned maladaptive for time he is a sleep), while at the day ommunity outings and while in its present arm's length from cling hours (from time he is a sleep), while at the day ommunity outings and while in its prevention of physical others, injury against himself that Client #2 remains at least of distance from visitors. Indicate the cues to the with back turn to Client #2. The complete that the BSP also of that the BSP also	W 2	W 24 The r make client staff a client The fa imple strate #2's B empha 1:1 sta client will be client away f The Q on a m staff in		are that nale cified in aff on vention lient will nce of ength of so, staff e that istance	11/30/09

		I AND HUMAN SERVICES			FOR	D: 10/15/200 M APPROVEI D: 0938-039	
TATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILI	*	(X3) DATE COMPI	SURVEY	
		09G153	B. WING		10/	01/2009	
COMP C	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1329 LONGFELLOW STREET NW WASHINGTON, DC 20011	ADDRESS, CITY, STATE, ZIP CODE LONGFELLOW STREET NW		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE	
W 252	recommended that 1:1 staff person who physical stature as matching his height interview on Septemapproximately 3:30 (female) revealed the Client #2's 1:1 staff weekly. It should be surveyors was a fer showed verbal aggrithe facility. 483.440(e)(1) PROCEED at a relative to accesspecified in client in	Client #2 be assigned a male o is of equal (or greater) Client #2 (i.e. at least and weight). During an	W 24				
	Based on observation review, the facility facollected in the form one of the two client. The finding includes. On September 28, 2 was observed sitting floor. Further observating a loud noise p.m., Staff #1 assistation to eat. After C to yell then proceeds	inot met as evidenced by: on, interview, and record iled to ensure that data was and frequency required for in the sample. (Client #1) 009, at 6:37 p.m., Client #1 in the living room on the vation revealed Client #1 and biting his hands. At 6:43 ad Client #1 into the dining lient #1 sat down, he began ad to walk back into the living Client #1's ice tea into the					

living room and offered it to him. At 6:49 p.m., Staff #1 assisted the client into the dining room.

		1 AND HUMAN SERVICES E & MEDICAID SERVICES			FORM): 10/15/2009 I APPROVED): 0938-0391	
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL	ULTIPLE CONSTRUCTION LDING	(X3) DATE S COMPL	SURVEY	
		09G153	B. WIN	G	10/0	01/2009	
(X4) ID PREFIX TAG	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE COMP			
W 325	neck, he began to yp.m., Staff #1 took 6:58 p.m., Client #1 began to yell and began to stee #1 asked him to stolent #1 asked him to stolent professional (QMR approximately 4:50 had a Behavior Suphis maladaptive belong the BSP revealed the client hand biting, scream of the BSP revealed Antecedent Behavior data collection sheet Review of the data collect	ed Client#1's bib around his yell and bite his wrist. At 6:54 Client #1 for a walk outside. At returned from his walk and ite his hand. At 7:02 p.m., rved biting his wrist and Staff op. Rualified Mental Retardation P) on September 28, 2009, at p.m., revealed that Client #1 port Plan (BSP) to address naviors. of Client #1's BSP dated June iber 29, 2009 at 10:40 a.m., had maladaptive behaviors of ing and pica. Further review I staff were to record or Consequence (ABC) on the its daily. collection sheets on 9, at approximately 3:00 PM, #1 bit his hand from 4:00 p.m. m 7:30 p.m. to 7:30 p.m. e data collections sheets ent #1 screamed from 4:00 d from 8 p.m. to 8:10 p.m. #1 on September 30, 2009, at o.m., confirmed that all the document. There was no had been collected in	W 32	W 252 Staff will be trained on accurate collection of bedata. The HM will on a weekl review behavior data shensure consistent documentation of behave pisodes.	y basis eets to	11/30/09	

examinations of each client that at a minimum

		I AND HUMAN SERVICES	•			FOR	D: 10/15/2009 M APPROVED D. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) I A. BU		LTIPLE CONSTRUCTION DING	(X3) DATE	
		09G153	B. WI	ING		10	01/2009
NAME OF	PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
COMP	AREII				1329 LONGFELLOW STREET NW WASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(XS) COMPLETION DATE
	includes routine scr examinations as de physician. This STANDARD is Based on observation, the faciliprovide routine labor necessary by the professory by the physical lender professory by the physical lender professory by the physical recomplessory by the professory by the physical recomplessory by the professory by the physical recomplessory by the professory by the pr	eening laboratory termined necessary by the sonot met as evidenced by: on, staff interview and record ity's nursing staff failed to ratory testing as determined imary care physician (PCP), sincluded in the sample. The medication administration 30, 2009, at 7:42 a.m., ras administered administered administered and the sample outh. The ian orders dated February refer to obtain quarterly further review of the red revealed that the last the aforementioned ducted on January 10, 2009. The practical nurse (LPN) at 1:00 p.m., confirmed receive his quarterly shenobarbital as		32	W 325.1 & 2 The facility's Registered (RN) and the QMRP wil quarterly basis conduct internal audits of medica records to ensure compli with physician's orders, other recommendations.	l on a al ance	11/30/09
ł		, 2009, at 7:06 a.m., nedication administration #2 was administered Haldol			·		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		09G153	B. Wi	NG_		10/01/2009	
COMP C	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1329 LONGFELLOW STREET NW WASHINGTON, DC 20011			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	TX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	2 mg, Cogentin 1 m Depakote 500 mg I Review of Client #2 September 30, 200 Physician's Orders The POs revealed seizure disorder, in and schizophrenia the aforementioned of the POs revealed labs to be tested million to b	ng, Risperdal 2 mg, and by mouth. Is medical record on 9, at 3:06 p.m., revealed (POs) dated October 2009. Client #2 had diagnoses of termittent explosive disorder, paranoid and was prescribed medications. Further review d an order for folic acid serum onthly. In the same day at p.m., revealed the most rum laboratory study was ember 2009. The next rum laboratory study was ember 2009 (six months earlier) in within normal limits. Icility's licensed practical tember 30, 2009, at p.m., acknowledged that serum labs were not tested ed by the primary care. IG SERVICES Inot met as evidenced by: on, interview and record ty's nursing services failed to	W 3	325	W 331.1 The RN will in-service the Licensed Practical Nurse (LPN) on adherence to Physician's Orders (PO). Quarterly audits will be conducted by the RN to e that the LPN is complying orders.	ensure	11/30/09

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/15/2009

OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED	
		09 G153	B. WIN		104	01/2009	
NAME OF	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, 1329 LONGFELLOW STREET WASHINGTON, DC 20011	ZIP CODE F NW		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
	in the sample. (Clic The findings include 1. Observation on p.m., revealed dark and arms. Interview the blotches were at Review of the derm dated June 26, 200; 4:25 p.m., revealed Lidex ointment to the daily and cover area biting." There was a wore an ace bandar recommended. Interview with the querofessional (QMRF approximately 11:00; #1 was not wearing interview revealed the (LPN) was required during the morning of the commended. 2. Cross Refer to Westaff failed to provide determined necessary physician (PCP), for 483.460(n)(1) LABO If a facility chooses the laboratory must is specified in part 493.	September 30, 2009, at 4:55 blotches on Client #2's wrist with Staff #1 indicated that result of client biting his arms. atologist recommendation 9, on September 29, 2009, at that staff is required to "apply ick plaques on arms twice with ace bandage to prevent no evidence that Client #1 ge to prevent biting as salified mental retardation e) on October 1, 2009, at o a.m., confirmed that Client an ace bandage. Further nat the license practical nurse to put the ace bandage on medication administration. #325. The facility's nursing for routine laboratory testing as my by the primary care Client #2. RATORY SERVICES o provide laboratory services, meet the requirements of this chapter. not met as evidenced by: n, and interview, the facility	W 39	W 331.2 Cross reference W	V 325.		

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/15/2009

OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		09Q153	B. WING)	10/01/200	09
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1329 LONGFELLOW STREET NW WASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COM	(X5) PLETION DATE
	failed to ensure it in performing glucose the two clients (Clie The finding include: Observation of the administration on Sa.m., revealed Clie checked (via finger: Licensed Practical aforementioned datif the facility had be blood glucose testing the Clinical Laborat According to the LP facility had a CLIA conting to the LP facility had a CLIA conting to the LP facility had a CLIA continued the certification administration administration administration administration the CLIA certification administration the CLIA certification administration administratio	met the requirements for monitoring testing, for one of ent #4) residing in the facility. s: morning medication september 30, 2009, at 7:42 at #4 had a blood glucose level stick). Interview with the Nurse (LPN) on the se was conducted to ascertain en certified to conduct the ag as required by part 493 of ory Improvement Act (CLIA). No, he had no knowledge if the certification. scility's Registered Nurse, had not obtained the CLIA surveyor provided the information to the provider to on. At the time of the tration, there was no evidence cation had been obtained. UATION DRILLS Id evacuation drills at least hift of personnel. In not met as evidenced by: and the review of fire drill siled to hold evacuation drills reach shift of personnel, on drills reviewed.	W 44	W 393 The facility has contact source provided by the surveyor in obtaining t certification. The facility has started process of obtaining certification for perfordaboratory procedure.	the ming	30/09
ORM CMS-256	37(02-99) Previous Versione (Obsolete Event ID: ABD811	F	acility ID: 09G153 if conf	inuation sheet Page 2	2 of 23

OMB 140: 0920-0281

STATEMEN	T OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G153	(X2) MULTIF A. BUILDING B. WING		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
NAME OF	PROVIDER OR SUPPLIER	090133	13	EET ADDRESS, CITY, STATE, ZIP CODE 29 LONGFELLOW STREET NW ASHINGTON, DC 20011	<u> 10/</u>	01/2009
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETION DATE
W 440	September 29, 2009 facility had five shifts. The shifts were ider PM, 3 PM - 10 PM, PM on the weekend. Review of the fire dr 2008 to October 2009 September 29, 2009 of the fire drill report September 2009 revicenducted during the week. Interview 30, 2009, at 10:05 p. drills were not in the period. At the time of	ouse manager (HM) on 9, at 2:30 p.m., revealed the s of direct care personnel. hitiled as weekdays 8 AM - 4 10 PM - 8 AM and 10 AM - 10 ill reports from November 10 was conducted on 9, at 2:32 p.m. Further review is from February 2009 to realed that no fire drills were a 8 AM to 4 PM shifts during with the HM on Septemberm. acknowledged that fire fire drill log book for this of the survey, the facility failed of fire drills conducted	W 440	W 440 The QMRP will restructuthe fire drill book into five partitions in accordance withe five shifts. Monthly reviews of the findrill book will be conduct the QMRP and HM to enthat all shifts conduct a findrill at least once quarter. Staff will be in-serviced or conducting and recording fire drills.	e with re ed by sure re ly.	11/30/09

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	MBER: A BUI	IULTIPLE CONSTRUCTION ILDING NG	COMPL	(X3) DATE SURVEY COMPLETED			
ME OF D	ROVIDER OR SUPPLIER		STREET ADORESS C	ITY, STATE, ZIP CODE	1 10/0	01/2009			
OMP C			1329 LONGFELLO	ONGFELLOW STREET NW INGTON, DC 20011					
X4) ID REFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SCIDENTIFYING INFORMA	FULL PREFI		TION SHOULD BE THE APPROPRIATE	COMPL DAT			
I 091	September 28, 200: This survey was init process; however, of active treatment, review the facility's I Conditions of Partic Treatment. A rando was selected from a various levels of medisabilities.	was conducted from 9 through October 1, iated utilizing the fundue to concerns in the the process was extevel of compliance in ipation (CoP) for Actorn sampling of two managements are tardation and survey were based or day programs, interver, interviews with start program, as well an administrative record vestigation reports. PING maintenance equipments properly maintained inction for which it is a sand interview, the intain the interior and Programs and interview, the intain the interior and Programs are safe, clean, or manner for four of	damental e areas ended to n the ive esidents nen with ff in the s a ds, l 091 ent shall and to be						
- 1	he findings include:								
	Observation and inter	rview with the house							
	on Administration		1	i	i				

ABD811

TATE FORM

A CONTRACTOR OF THE CONTRACTOR

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING HFD03-0127 10/01/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1329 LONGFELLOW STREET NW** COMP CARE II WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 1091 Continued From page 1 1091 I 091.1 manager (HM) during the environmental walk The window has been repaired. through on October 1, 2009, beginning at 10:44 a.m., revealed the following: I 091, 2 1. The window in the kitchen where the air The air condition area has been 10/15/09 condition sat in, was observed to be detached painted. from its foundation. The facility will on a quarterly 2. There was severe paint chipping observed basis conduct internal around the window frame located on the outside where the air condition sat. environmental audits to ensure that all maintenance issues are 1 135 3505.5 FIRE SAFETY 1135 resolved. Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift. This Statute is not met as evidenced by: Based on interview and the review of fire drill reports, the GHMRP failed to hold evacuation drills at least quarterly for each shift of personnel. on one of five shifts of drills reviewed. The finding includes: Interview with the house manager (HM) on I 135 September 29, 2009, at 2:30 p.m., revealed the GHMRP had five shifts of direct care personnel. Cross reference W 440. The shifts were identified as weekdays 8 AM - 4 PM. 3 PM - 10 PM, 10 PM - 8 AM and 10 AM - 10 PM on the weekend. Review of the fire drill reports from November 2008 to October 2009 was conducted on September 29, 2009, at 2:32 p.m. Further review of the fire drill reports from February 2009 to September 2009 revealed that no fire drills were conducted during the 8 AM to 4 PM shifts during

Health Regulation Administration

Health (Regulation Administra	ation				FORM APPRO	VED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU HFD03-0127		(X2) MULT A. BUILDI B. WING	NG	3) DATE SURVEY COMPLETED	
NAME OF	PROVIDER OR SUPPLIER	200 0123	STREET AD	DDESS CITY	STATE, ZIP CODE	10/01/2009	
COMP		·	1329 LON		STREET NW		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPI	LETE
l 135	the week. Interview with the HM on September 30, 2009, at 10:05 p.m. acknowledged that fire drills were not in the fire drill log book for this period. At the time of the survey, the GHMRP failed to provide evidence of fire drills conducted quarterly as required.			l 135			
1206	annually thereafter, certification that a he performed and that	EL POLICIES or to employment an shall provide a physiealth inventory has been to perform the received.	cian 's een ilth status	1206			
	This Statute is not represent to employment provided evidence of that documented a horizontal allow him or houses, for one of that the finding includes: Interview with the quiprofessional (QMRP) records on October 16 GHMRP failed to prohealth certificates we nurses. (Nurse #1)	sure that each empk and annually thereat f a physician's certific realth inventory had I the employee's health er to perform the rece see nurses. alified mental retards and review of the particles 1, 2009, revealed the revide evidence that co	e byee, iter, cation been n status juired ation ersonnel		I 206 Nurse #1 has completed an annual physical. The administrator will on a monthly basis review person records to ensure that requir documents are current. A thirty-day notice will be provided to employees prior the expiration of a document documents.	to	9

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLM IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		HFD03-0127		B. WING		10/	01/2009
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY	, STATE, ZIP CODE	<u> </u>	<u> </u>
COMPC	ARE I I			GFELLOW TON, DC	/ STREET NW 20011	-	
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPRIDENCE)	(X5) COMPLETE DATE	
	<u>-</u>	continued From page 3					
	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		I 379	I 379 The incident of July 15, 20 was reported to the Depart of Health (DOH) in a timel manner. This was specified the incident report. The QI followed-up with verbal notification the day after the incident. This issue was abated during exit meeting on October 1, 2 tober 1,	ment y d on MRP se	10/01/09	

Health Regulation Administration

ABD811

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
HFD03-0127			B. WING			10/	01/2009	
COMP CARE II			DORESS, CITY, STATE, ZIP CODE NGFELLOW STREET NW GTON, 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 O (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	E ACTION SHOULD BE CONTROPRIATE		
1 379	Continued From page 4			1379			 	
	that the incident was reported to the Department of Health timely as required.							
l 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS			l 401				
	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 observation, staff interview and record verification, the Group Home for the Mentally Retarded (GHMRP) failed to provide professional services that included 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, for two of two residents included in the sample. (Residents #1 and #2)							
	pass on September revealed Resident# Phenobarbital 15mg,	e medication adminis 30, 2009, at 7:42 a.m	1., 1.					
	2009, revealed an or phenobarbital levels. plient's medical recor aboratory study for t	ian orders dated Feb der to obtain quarter Further review of th rd revealed that the la he aforementioned lucted on January 10	iy ie ast					

Health Regulation Administration

Health	Regulation Administra	ation							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:				(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED			
HFD03-0127				DDECC OTV	STATE TO COOP	10/0	1/2009		
COMP CAPE II					DDRESS, CITY, STATE, ZIP CODE NGFELLOW STREET NW GTON, 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 COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLET			
I 401	Interview with the like on September 30, 2 that Resident #1 did laboratory study for recommended. 2. On September 3 observations of the pass revealed Resident Haldol 2 mg, Cogen Depakote 500 mg b Review of Resident September 30, 2009 Physician's Orders (The POs revealed February September 30, 2009 Physician's Orders (The POs revealed February September 30, 2009 Physician's Orders (The POs revealed February September 30, 2009 Physician's Orders (The POs revealed labs to be tested more reconducted on September 2009 Physician's Orders (The POs revealed labs to be tested more reconducted on September 2009 Physician's Orders (The POs revealed labs to be tested more reconducted on September 2009 Physician's Orders (The POs revealed labs were within the factories (The POs revealed labs to be tested more reconducted on September 2009 Physician's Orders (The POs revealed labs were within the factories (The POs revealed labs to be tested more reconducted on September 2009 Physician's Orders (The POs revealed labs to be tested more reconducted on September 2009 Physician's Orders (The POs revealed labs to be tested more reconducted on September 2009 Physician's Orders (The POs revealed labs to be tested more reconducted on September 2009 Physician's Orders (The POs revealed labs to be tested more reconducted on September 2009 Physician's Orders (The POs revealed labs to be tested more reconducted on September 2009 Physician's Orders (The POs revealed labs to be tested more reconducted on September 2009 Physician's Orders (The POs revealed labs to be tested more reconducted on September 2009 Physician's Orders (The POs revealed labs to be tested more reconducted on September 2009 Physician's Orders (The POs revealed labs to be tested more reconducted on September 2009 Physician Physici	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 Interview with the license practical nurse (LPN) on September 30, 2009 at 1:00 p.m., confirmed that Resident #1 did not receive his quarterly laboratory study for phenobarbital as		1401	I 401. 1 & 2 Cross reference W 325				
	3521.3 HABILITATIC Each GHMRP shall p	•		1 422	•				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION N			A. BUILDIN	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
HFD03-0127				B. WING_		10/0	01/2009	
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE			
COMPC	AREII			NGFELLOW STON, DC 2	STREET NW 0011			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	(EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
	Continued From parand assistance to rethe resident 's India. This Statute is not a Based on observation review, facility staff implementation of continued (Resident's #1 and in the findings include 1. On September 2: Resident #1 was observed in the floor. From the floor. From the floor of the floor of the floor of the floor of the floor. From the floor of the floor	esidents in accordantidual Habilitation Planet as evidenced by on, interviews and refailed to ensure contilients' behavior supply included in the same sure successive strains in the latest of the same successive strains in the latest successive successi	cord inuous port plans, aple. iving evealed ing his lient #1 sat to walk lesident ed it to client into client into client #1 and Client and bite ted him clation 2009, at esident eddress dated 10:40	1422	I 422.1 Cross reference W24	9.1		

ealth Regulation Administration TATE FORM

Health Regulation Administration

Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING HFD03-0127 10/01/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1329 LONGFELLOW STREET NW** COMP CARE !! WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 1422 Continued From page 7 1422 behaviors of hand biting, screaming and pica. Further review of the BSP revealed staff were to record Antecedent Behavior Consequence (ABC) on the data collection sheets daily. Review of the data collection sheets on September 29, 2009, at approximately 3:00 PM. revealed that Client #1 bit his hand from 4:00 p.m. to 4:07 p.m. and from 7:30 p.m. to 7:30 p.m. Further review of the data collections sheets revealed that the Resident #1 screamed from 4:00 p.m. to 4:01 p.m. and from 8 p.m. to 8:10 p.m. There was no evidence that staff implemented these intervention strategies as recommended by the psychologist. Observations On September 28, 2009. beginning at 4:35 p.m. to 6:48 p.m., revealed staff failed to implement Resident #1's BSP as follows: - At 4:35 p.m., Upon entering the facility to start the annual recertification process, Resident #2 was observed to immediately walked over from the dining area to the front door to greet the surveyors by saying "get out, I don't want you her. You need to leave now." - At approximately 4:36 p.m., Staff #1 who was not indentified as Resident #2's 1:1 staff at that time, immediately intervened by redirecting Client #2 to another area of the home. Client #2's I 422.2 identified 1:1 staff remained in the dining area Cross reference W249.2 during this time. At 5:07 p.m., the qualified mental retardation professional (QMRP) was observed to transport Resident #2 on a community walk. Staff #2 (assigned to Resident #2) was observed to

ealth Regulation Administration

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING HFD03-0127 10/01/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE ZIP CODE **1329 LONGFELLOW STREET NW** COMP CARE II WASHINGTON, DC 20011 **SUMMARY STATEMENT OF DEFICIENCIES** (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) 1422 Continued From page 8 1 422 transport Resident #1 on a community walk during this time. At 5:52 p.m., Resident #2 returned back from his community walk. He was observed to go upstairs to wash his hands without a 1:1 staff accompanying him. - At 5:56 p.m., Resident #2 was observed upstairs in his bedroom while an assigned different 1:1 staff (Staff #1) was observed in the kitchen preparing dinner. - At 6:04 p.m., Resident #2 was upstairs in his bedroom while his Staff #1 was observed in the living room looking out the window. - At 6:06 p.m., Staff #1 was observed to go upstairs to Resident #2's bedroom to ask him if he wanted to assist with dinner preparation. The client stated, maybe next time. Staff #1 returned back to the kitchen/dining area. - At 6:08 p.m., the QMRP was observed in Resident#2's bedroom encouraging him to come down to the dining area to eat dinner. Resident #2 stated that he would eat after the surveyors leave. Shortly afterwards, Resident #2 was observed to come to the dining to eat his dinner. - At 6:20 p.m., Resident #2 finished his dinner and placed his dishes in the dishwasher after rinsing them off. - At 6:21 p.m., Resident #2 returned back to his bedroom alone. - At 6:23 p.m., the QMRP stated to Staff #1 to go upstairs to sit with Resident #2. Staff #1 was observed to place a seat outside of Resident #2's

Health Regulation Administration

ABD811

STATEMENT OF DEFICIENCIES (X1) PROMDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING HFD03-0127 10/01/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1329 LONGFELLOW STREET NW COMP CARE II WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) 1422 Continued From page 9 1422 bedroom door. Interview with Staff #1 on September 28, 2009, at 5:16 p.m., revealed Resident #2's second shift 1:1 called off and that Staff #2 was his assigned 1:1 staff for today. Further interview with Staff #1 revealed that Staff #2 had worked with Resident #2 several times, but was not an assigned staff for this facility. Interview with the QMRP on the same day at approximately 5:53 p.m., revealed Staff #1 was the assigned 1:1 staff for Resident#2 for the evening of September 28, 2009. The QMRP further stated that Staff #1 was identified as the assigned 1:1 staff when Resident#2's original 1:1 staff was absent. Additional interview with the QMRP on September 29, 2009, at approximately 3:00 p.m., revealed Resident #2's received 1:1 staffing from 8:00 a.m. to 12:00 a.m., to address his maladaptive behaviors of physical aggression (mainly toward women), absconding, self-injurious behaviors, and making false allegations. Review of Resident #2's behavior support plan (BSP) dated June 2, 2009, on September 29 approximately 3:40 p.m., confirmed the QMRP's interview of the aforementioned maladaptive behaviors. Further review of Resident #2's BSP revealed the 1:1 staff duties and responsibilities were as follows: a. Being "physically present arm's length" from Resident #2 during waking hours (from time he is awake till he goes to sleep), while at the day program, while on community outings and while in the community to ensure prevention of physical

Health Regulation Administration

Health Regulation Administration STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING HFD03-0127 10/01/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1329 LONGFELLOW STREET NW **COMP CARE!!** WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (205) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX **PREFIX** COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG DEFICIENCY) 1 422 Continued From page 10 1422 aggression against others, injury against himself and absconding. b. Always ensuring that Resident #2 remains at least three arms lengths of distance from visitors. c. Providing timely and discreet cues to the visitor/s not to stand with back turn to Resident #2. At the time of the survey, there was no evidence that Resident #2's 1:1 staff implemented his BSP as recommended. Note: it should be noted that the BSP also recommended that Resident#2 be assigned a male 1:1 staff person who is of equal (or greater) physical stature as Resident#2 (i.e. at least matching his height and weight). During an interview on September 29, 2009, at approximately 3:30 p.m., interview with Staff #3 (female) revealed that she sometimes serves as Resident #2's 1:1 staff during the second shift weekly. It should be further noted that one of the surveyors was a female in which Resident#2 showed aggression toward while entering the facility.

lealth Regulation Administration

TATE FORM