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

PRINTED: 06/29/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	09G125		06/21/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 04	1004 URELL PLACE, NE WASHINGTON, DC 20017

(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	W 000		
	A recertification survey was conducted from June 19, 2007 through June 21, 2007 utilizing the fundamental survey process. A random sampling of three clients was selected from a residential population of five males with various degrees of mental retardation and other disabilities. The findings of the survey were based on observations, interviews, and the review of client and administrative records, including unusual incident reports.			
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.	W 104		
	This STANDARD is not met as evidenced by: Based on observation, interviews and record review, the governing body failed to provide operating direction over the facility as evidenced below.			
	1. The governing body failed to effectively implement it's door chimes protocol to ensure the system was maintained in good repair. The review of the Human Rights Committee (HRC) minutes on June 20, 2007 revealed that on June 22, 2006 the HRC reviewed the practice of sensor alarms being installed on each exit doors of the facility. Further review of the minutes revealed the chimes were installed to alert staff whenever someone came into or left the facility and to ensure the safety of all residents Observation of the front door on June 20, 2007 revealed the censor was no longer on the door.		The door chimes will be repaired to work as intended.	8/10/2007

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Theresa H. Thompson — Director of Disability Services — 7/11/07

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 104	Continued From page 1 Interview with home manager (HM) on June 21, 2007 indicated that no staff had reported that the censor had become detached from the door. It also should be noted that inspection the basement exit door on June 21, 2007 revealed that the chimes activated intermittently when the door was opened. 2. The the governing body failed to ensure timely implementation of measures to assist Client 2 in the resolution of day placement concerns and to facilitate Community Based Transitional Employment to maximize his personal growth. [See W159]	W 104	The Governing Body will continue to work closely with DDS to ensure timely referrals and acceptance into appropriate authorized programs.	8/10/07
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 each client and/or their legal guardian to be informed the client's rights to refuse behavioral intervention for two of three clients (Clients #1 and #2) included in the sample. The findings include: 1. Observation of the evening medication administration on June 19, 2007 beginning at	W 124	The QMRP will ensure that written explanation of risks and benefits of proposed treatments are provided to the clients and their decision makers, and that clients and their decision makers also have the opportunity to ask questions and receive further clarification as needed. The informed consent for treatment letters will be signed by the client or his decision maker and kept with the clients' records. Clients who are able to understand the risks and benefits of their treatments and give consent for themselves will continue to do so, with support from family members or other authorized representatives. The QMRP will ensure that the Human Rights Committee has evidence of written informed consent for use of Behavior Support Plans.	8/10/07

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NAME OF PROVIDER OR SUPPLIER: CARECO 04

STREET ADDRESS, CITY, STATE, ZIP CODE: 1004 URELL PLACE, NE WASHINGTON, DC 20017

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W 124	Continued From page 2 4:37 PM revealed Client #1 received Depakote 1000 mg (for explosive behavior), Haloperidol 5 mg (for aggression) and Xanax XR 2 mg (for explosive behavior). Interview with the medication nurse revealed that the aforementioned medications were prescribed for behaviors. Interview with the house manager on June 19, 2007 at 8:37 AM revealed Client #1 received 1:1 staffing supports 24 hours a day. Subsequent interview with the Qualified Mental Retardation Professional (QMRP) on June 19, 2007 at 12:50 PM revealed Client #2 had a Behavior Support Plan (BSP that addressed verbal and physical aggression, elopement, property destruction, and noncompliance. Continued interview with the QMRP revealed that Client #1 did not have a guardian or the capacity to give informed consent for the use of his medications, habilitation services, treatments and financial matters. This was verified through review of Client #1's Psychological Evaluation dated January 30, 2007 on June 20, 2007. The Psychological Assessment did however reveal the client was able to provide limited input in these matters, which should be considered when appropriate during decision-making. At the time of the survey, the facility failed to provide evidence that Client #1's had a legally authorized representative to whom his treatment needs, including the benefits and potential side effects associated with the medications, and the right to refuse treatment, had been explained. 2. Observation of the evening medication administration on June 19, 2007 beginning at 4:43 PM revealed Client #2 received Depakote	W 124		

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W 124	Continued From page 3 500 mg. Interview with the nurse and the review of the MAR revealed that the aforementioned medication was prescribed for maladaptive behaviors along with restrictive behavior management interventions. Interview with the QMRP on June 19, 2007 and review of the client's habilitation records revealed that the client did not have a guardian and was not informed of his of the risks and benefits of his behavioral management treatments. A letter, dated June 28, 2006 addressed to the client's relative, requested the individual to become the client's guardian. At the time of the survey, the facility failed to provide evidence that Client #1's had a legally authorized representative to whom his treatment needs, including the benefits and potential side effects associated with the medications, and the right to refuse treatment, had been explained. [See W263]	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 staff interview and record review, the facility failed to implement established incident management policy to ensure the health and safety of each client that resides in the facility. The finding includes: The facility failed to ensure that it's policy on	W 149	The QMRP will ensure that incidents are reported to DOH per Careco and District policy. The Director of Disability Services and Incident Management Coordinator will retrain the QMRPs and Facility Directors, who will then retrain facility staff. The Incident Management Coordinator will continue to hold scheduled Incident Review Committee Meetings and will address any policy or other discrepancies around incident reporting	8/10/07

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W 149	Continued From page 4 reporting of unusual incidents was effectively implemented. Interview with the facility's Incident Management Coordinator (IMC)on June 20, 2007 at 4:50 PM revealed that emergency room visits should be treated as serious reportable incidents. Further interview with the IMC revealed that all serious reportable incidents should be reported to the Department of Health (DOH) within 24 hours. The review of unusual incidents on June 19, 2007 and June 20, 2007 revealed that several emergency room visits/ hospitalizations had not been reported to DOH in accordance with the agency's protocol for incident management as detailed below: a. March 6, 2007 - Client # 2 had a two to three minutes seizure at 7:15 AM. 911 was telephoned and the client was transported to the ER for evaluation. There was no evidence DOH was notified of the incident. b. July 25, 2007 - When staff required the Client #2 to get off the van at 4:15 PM after he refused, the resident went to his room and slammed the door hard, causing the knob to break. The resident stated he would rather be dead than live at the group home. He proceeded to pick himself with blunt edged arts and craft-type scissors. 911 was telephoned. The police arrived and the client was taken to CPEP. There was no evidence DOH was notified of the incident. c. January 19, 2007- At 6:00 AM Client #1 became verbally abusive and assaulted a staff by violently pushing him. 911 was telephoned and the police arrived. It was determined the client	W 149		

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W 149	Continued From page 5 was at risk and he was transported to CPEP. He was transported from CPEP to a local hospital where he was treated. Resident was discharged back to the group home on January 24, 2007. There was no evidence DOH was not notified of this incident or the resident's hospitalization until January 29, 2007. d. June 30, 2006 - During a fire drill at 6::33 AM, Client #3 kicked another resident. While being redirected by his 1:1 staff, he hit his hand on the concrete wall. Client was taken to the ER for evaluation. There was no evidence DOH was not notified of the incident. f. The review of an unusual incident dated October 7, 2007 revealed that Client #1 was taken to the ER due to profuse sweating and low blood pressure. He was evaluated and admitted to the hospital. There was no evidence that DOH was notified until October 20, 2007. g. The review of an unusual incident dated April 21, 2007 revealed at 6:25 PM Client #4 walked away from the facility when he was left outside unsupervised by staff. The police were notified after staff was unable to locate him. The client returned to the facility at 8:45 PM. The incident was not reported to DOH until April 23, 2007. h. The review of an unusual incident report dated April 12, 2007 revealed that the day program reported that Client #4 was injured by a piece of light wood that fell on the back of his neck. Client was assessed immediately by the day program nurse who indicated that he was alert,oriented and could move. He was taken to the ER for evaluation after returning to the group home. The ER assessment revealed the client had a scalp	W 149		

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W 149	Continued From page 6 contusion. There was no evidence the incident was reported to DOH until April 17, 2007. According to the agency's policy dated March 5, 2007, serious reportable incidents include those wherein emergency personnel (911) was needed and when the Metropolitan Police Department (MPD) was involved. Further review of the aforementioned policy revealed the Incident Management Coordinator shall forward the serious reportable incident reports within 24 hours to the DOH. There was no evidence the policy had been implemented as written.	W 149		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that each client's active treatment program was coordinated, integrated and monitored by the Qualified Mental Retardation Professional (QMRP). The findings include: 1. The QMRP failed to ensure Client #2 received his therapeutic diet as prescribed. [See W460] 2. Client #2 was observed on each day of the survey leaving on the van with his housemates and staff, including his 1:1 staff. Interview with staff indicated that the client worked as a voluteer on some days at a food pantry.	W 159	1. The Nutritionist will provide training to the client and staff on implementing his therapeutic diet. 2. The QMRP will review all programs on at least a monthly basis to determine whether programs are effectively meeting clients' needs.	8/10/07 8/10/07

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W 159	Continued From page 7 Interview with the Qualified Mental Retardation Professional (QMRP) on June 19, 2007 revealed that Client #2 was discharged from his day program due to aggressive behavior and non-compliance. Further interview with the QMRP indicated the client had a 1:1 staff for sixteen hours (8:00 AM to 12:00 AM) a day. The QMRP indicated that the client had an activity schedules which was developed for him to follow between the hours of 9:00 AM and 4:00 PM when he did not go to the day program. Further interview with the QMRP indicated to increased compliance, the client was allowed to select activities of his choice in various categories such as in the areas of chores and leisure/recreation. According to the activity schedule, at 9:00 AM "With independence [Client #2] will complete the steps of doing a chore of his choice for 100% of trials recorded per month for three consecutive months". The client's performance in the objective was scheduled to be monitored by the QMRP. Training program instructions indicated that if needed, the client should be be provided with cleaning supplies and/or broom and dustpan. The task analysis for implementing the objectives stated that the client will do the following: a. Choose the chore b. Participate in the chore c. Complete the activity d. Put away items used for the chore. Interview with the home manager and Client #2's 1:1 staff indicated the client is able to perform some chores with supervision and verbal prompting; however he does not like to follow	W 159		

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W 159	Continued From page 8 instructions. There was no evidence the QMRP had monitor the program to determine if the program was meeting the client needs. 3. The QMRP failed to ensure that revisions in the IPP were considered when Client #2 demonstrated a lack of achievement in attaining the established criterion level. [See W257]	W 159	3. See #2 above. The QMRP will revise programming appropriately based upon the findings in the monthly review.	8/10/07
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 observations, interview, and record review, the facility failed to provide each employee with initial and continuing training that enables the employee to perform his or her duties, effectively, efficiently, and competently for Client #2. The findings include: 1. The facility failed to ensure effective training on therapeutic diets and menu substitutions. Observation of the dinner meal on June 19, 2007 revealed that vegetable lasagna was served as the main entree. Client #2 expressed that he wanted a substitute for the vegetable lasagna. He was provided with a turkey bacon as a substitute. The review of the physician's orders revealed that the client was prescribed a Low Fat, Low cholesterol, Low Salt Diet.	W 189	1. The Nutritionist will retrain all staff on therapeutic diets. The QMRP and Facility Director will ensure that clients are able to participate in food selections within their diet orders, and that substitutions are readily available. The QMRP will ensure that there is a current list for each client on food preferences and dislikes.	8/10/07

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W 189	Continued From page 9	W 189		
	The review of Client #2's annual nutritional assessment dated September 12, 2006 revealed "Provide appropriate substitutions for food that Mr [Client #2] does not tolerate or dislikes." The review of training records on June 21, 2007 revealed staff received instructions on nutrition and the clients' diets on December 9, 2006 and again on May 2, 2007. There was no evidence however that this training was effective to ensure the client received appropriate menu subtitutions and food in accordance with his prescribed Low Fat, Low Cholesterol, Low Salt Diet.			
	2. The facility failed to ensure staff were trained to assist/supervise Client #2 in packing his lunch in accordance with his Low Fat, Low Cholesterol, Low Salt Diet. [See W460]		2. The Facility Director will ensure that staff oversee and assist the clients to pack lunches appropriately and in accordance with therapeutic diets.	8/10/07
W 257	483.440(f)(1)(iii) PROGRAM MONITORING & CHANGE	W 257		
	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.		See responses to W159 1 and #2. The Director of Disability Services and the Quality Assurance staff will review the QMRP's program notes and plans every 90 days to ensure that programming is appropriately revised in accordance with the clients' progress or lack thereof.	8/10/07
	This STANDARD is not met as evidenced by: Based on record review, the interdisciplinary team (IDT) failed to ensure that revisions in the individual program plan (IPP) were considered when Client #2 demonstrated a lack of achievement in attaining the established criterion level.			
	The findings include:			

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W 257	Continued From page 10 On the mornings of June 19, 2007 and June 20, 2007, Client #2 was observed carrying a lunch box and leaving the group home with staff. Interview with the QMRP on June 19, 2007 revealed that Client #2 was discharged from his day program due to aggressive behavior and non-compliance. Further interview with the QMRP indicated the client has a 1:1 staff for 16 hours a day. The QMRP confirmed that the client has an activity schedules which was developed for him to follow between the hours of 9:00 AM and 4:00 PM when he does not go to the day program. Record review revealed a schedule dated June 30, 2006 for 9:00 AM to 4:00 PM which included the two objectives below: a. According to Client #2's Individual Support Plan dated October 25, 2006, the has a goal to improve his interview skills. Review of the scheduled reflected that this objective should be implemented at 1:00 PM. The individual program plan objective stated "With verbal prompt, Mr. [Client #2] will answer interview questions on 100% of trials recorded per month for 3 consecutive months". The following questions were included in the task analysis: a. Tell me a little about yourself? b. Why do you want to work? c. What kind of job are you looking for? d. What are some of you skills? Record review revealed this objective was initiated in July 2006 and that the client performed this objective at the verbal prompt level at that time. Further review of the collected data	W 257		

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W 257	Continued From page 11 revealed the client had not advanced beyond the verbal prompts level during all opportunities from January 2007 through June 2007. There was no evidence this objective was revised when Client #2 failed to show progress. b. According to the activity schedule, at 9:00 AM "With independence [Client #2] will complete the steps of doing a chore of his choice for 100% of trials recorded per month for three consecutive months". The client's performance in the objective was scheduled to be monitored by the QMRP. Interview with staff and the review program data indicated the client had not progressed beyond the verbal prompt in this objective. There was no evidence this objective was revised when Client #2 failed to show progress. [See W159]	W 257		
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 two of the three clients (Clients #1 and #2) included in the sample. The finding includes: 1. Observation of the evening medication	W 263	See response to W124.	8/10/07

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G125		06/21/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 04	1004 URELL PLACE, NE WASHINGTON, DC 20017

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W 263	Continued From page 12 administration on June 19, 2007 beginning at 4:37 PM revealed Client #1 received Depakote 1000 mg (for explosive behavior), Haloperidol 5 mg (for aggression) and Xanax XR 2 mg (for explosive behavior). Interview with the nurse revealed that the aforementioned medications were prescribed to address behaviors. Interview with the Qualified Mental Retardation Professional (QMRP) and the record review revealed the client has a behavior support plan (BSP) that addressed verbal and physical aggression, elopement, property destruction, and noncompliance. Interview with the Qualified Mental Retardation Professional (QMRP) on June 19, 2007 at 12:50 PM revealed Client #3 also received 1:1 staffing supports 24 hours a day. Continued interview with the QMRP revealed that Client #1 did not have a legal guardian and did not have the capacity to give informed consent for the use of his medications, habilitation services, treatments and financial matters. The review of the Human Rights Committee (HRC) minutes revealed the restrictive measures were approved by the HRC. At the time of the survey, however, the facility failed to provide evidence that its HRC had obtained written informed consent for the use of Client #1's behavior support plan. (See also W124) 2. Observation of the evening medication administration on June 19, 2007 beginning at 4:43 PM revealed Client #2 received Depakote 500 mg (for behavior). Interview with the nurse revealed that the aforementioned medications were prescribed to address maladaptive behaviors. Interview with the QMRP and the record review	W 263		

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W 263	Continued From page 13 revealed the client has a behavior support plan (BSP) that elopement physical and verbal aggression, making excessive demands of staff, noncompliance, suicidal threats, and teasing peers. Interview with the Qualified Mental Retardation Professional (QMRP) on June 19, 2007 at 12:50 PM revealed Client #2 also received 1:1 staffing supports 16 hours a day. Continued interview with the QMRP revealed that Client #2 did not have a legal guardian and did not have the capacity to give informed consent for the use of his medications, habilitation services, treatments and financial matters. The review of the Human Rights Committee (HRC) minutes revealed the restrictive measures were approved by the HRC. At the time of the survey, however, the facility failed to provide evidence that its HRC had obtained written informed consent for the use of Client #2's behavior support plan.	W 263		
W 362	483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. This STANDARD is not met as evidenced by: Based on interview and record, the facility failed to ensure that quarterly reviews of drug regimens were conducted timely for three of three clients in the sample. (Clients #1, #2, and #3) The findings include: Interview with the primary LPN for the facility on June 20, 2007 revealed the pharmacist reviews the clients' prescribed medications quarterly. The review of the Drug Regimen Review forms in the medical records of Clients #1, #2, and #3	W 362	The Director of Disability Services will ensure that the Pharmacist's contract specifies the requirement for quarterly reviews of the clients' prescribed medications. The QMRP and the DON will ensure that these reviews occur in accordance with the contract and the facility policy, and the Director of Disability Services and the Quality Assurance staff will review quarterly to ensure compliance.	8/10/07

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W 362	Continued From page 14 revealed the the pharmacist conducted reviews of the clients' medication regimens on July 7, 2006 and again on October 10, 2006. The review of the agency's Medication Policy revealed a record of each resident's drug regimen review shall be kept in the resident's medical chart. There was no evidence the clients' drug regimens were reviewed at least quarterly.	W 362		
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each medications were administered as prescribed for one of three clients in the sample. (Client #2). The findings include: Based on observation, interview and record review, the facility failed to ensure that each drug was administered as ordered. The finding includes: Medication administration observations were conducted on June 19, 2007 beginning at 4:37 PM. Client #2 was observed to participate in a self medication program. The client was offered the opportunity to self administer his eye drops. He was observed and put one drop of the medication into his own left eye. Observation of the medication container confirmed that this medication was Cosoft. Instructions on the label revealed "Instill 1 drop twice daily to both eyes for	W 369	The DON will retrain the Primary LPN and the medication nurses to ensure that medication administration is accurately documented. The QMRP will coordinate training for the DON, LPN and Medication nurses on client Behavior Support Plans.	8/10/07

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W 369	Continued From page 15 glaucoma". The review of the MAR revealed documentation that the client instilled 1 drop of the Cosoft into both eyes. Interview with interview with the licensed practical nurse (LPN) supervising the self medication the med nurse confirmed that the client did not place the eye drop in his right eye. Further interview with med nurse revealed the client was sometimes non-compliant for receiving his eye drops. Both the med nurse and the primary LPN acknowledged the client had a behavior support plan to address his non-compliance for taking medication. There was no evidence however that the nurse accurately documented the administration of the Cosoft to the client's right eye.	W 369		
W 441	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on interview and record review of the fire drill records, the facility failed to conduct emergency evacuation drills during different times of the day and night. The finding includes: Interview with the home manager on June 20, 2007 revealed fire evacuation drills are held monthly on each shifts. The review of fire drill records on June 21, 2007 at for the period June 1, 2006 through May 31, 2007 confirmed that the aforementioned drills had been conducted. Further review of the fire evacuation drill however revealed that there was no evidence that drills	W 441	The QMRP and Facility Manager will ensure that fire drills are held between the hours of 7:30 p.m. and 5:30 a.m. at least once each quarter. The Director of Disability Services and the Quality Assurance staff will monitor quarterly to ensure compliance.	8/10/07

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W 441	Continued From page 16 had been conducted between the hours of 7:30 PM and 5:30 AM during this period. Interview with the QMRP failed to reveal that additional fire drill records were available for the hours in question.	W 441		
W 460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: The facility failed to ensure t hat Client #2 received a well balanced diet. The findings include: On 6/19/07 at 8:20 AM a staff arrived at the facility to escort clients to their respective day programs. The staff indicated Client #2 volunteers at a food pantry, where he assists in packaging and distributing free food. upon departing from the facility the client was observed with a large lunch box. The surveyor asked the client what he had for lunch. The client opened his lunch box to show the surveyor several small cans of vienna sausage and potted meat, a can of soda and a bottle of Gatorade. On 6/20/07 the client was observed to have cans of potted meat and vienna sausages, packages of crackers, a box of orange juice in his lunch box. The client was also observed to have serveral pieces of cooked turkey bacon in his lunch box. Interview with the home manager revealed that he was not aware of how many cans of meat the	W 460	See responses to W159 and W189.	8/10/07

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W 460	Continued From page 17 client had in his lunch box. Interview with the QMRP indicated that she was not aware the client was carrying canned meats for his lunch. Interview with staff preparing dinner on June 19, 2007 as well as the physician's orders revealed the client was prescribed a Low Fat, Low Cholesterol, Low Salt Diet. According to the client's annual nutritional assessment dated September 12, 2006, the client should be provided needed supports that allow him to participate in meal preparation and other activities. There was no evidence the client was assisted with lunch preparation to ensure he packed foods that met the nutritional requirements of his prescribed diet and reflect the prescribed menu.	W 460		
W 466	483.480(a)(6) FOOD AND NUTRITION SERVICES Unless otherwise specified by medical needs, the diet must be prepared at least in accordance with the latest edition of the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences, adjusted for age, sex, disability and activity. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each diet was prepared in accordance with the latest edition of the recommended dietary allowances for three of three clients in the sample. (Clients #1, #2 and #3) The findings include: 1. On the evening of June 20, 2007 Clients #1,	W 466	The OMRP and the Director of Disability Services will require the Nutritionist to prepare menus in accordance with the U.S. Department of Agriculture Human Nutrition Information Services guidelines. The Nutritionist will provide training on the revised menus.	8/10/07

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W 466	Continued From page 18 #2 and #3 were observed during dinner. The Clients were served the following: circular pieces of meat in gravy, which was identified as turkey; dark green vegetable, which was identified as spinach; biscuits; fruit cocktail; and sodas. Record review revealed a regular diet menu that prescibed roast turkey breast (3 - 4 ounces), spinach (1/2 cup), fruit cocktail (1/2 cup), dinner roll (1), margarine beverage (8 ounce), and a beverage. The review of the 1200 calorie menu revealed 2 ounce of turkey, 1/2 cup spinach, 12 cup fruit cocktail, 1 teaspoon margarine and sugar free beverage should be served. Inquiry of the staff concerning any additional food being served at the meal indicated the meal was served in accordance with the menu. According to the menu for June 20, 2007 (Spring/Summer Menu , Week 2, Wednesday) spinach was the only vegetable scheduled to be served all day. There was no evidence that menu had been planned in accordance with U.S. Department of Agriculture Human Nutrition Information Services guidelines for the inclusion of three to five servings of vegetables in the diet daily. 2. [Cross refer to W460]	W 466		

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I 000	INITIAL COMMENTS A licensure survey was conducted from June 19, 2007 through June 21, 2007. A random sampling of three residents was selected from a residential population of five males with various degrees of mental retardation and other disabilities. The findings of the survey were based on observations, interviews, and the review of resident and administrative records including incident reports.	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 and interview, the GHMRP failed to maintain the interior and exterior of the facility in good repair. The findings include: An environmental walk through of the facility was conducted on June 21, 2007 beginning at 9:55 AM.	I 090		
	1. The front porch light was observed to be not operable. Interview with the home manager indicated the reason the light was not working had not been identified.		1. The front porch light will be diagnosed and repaired as needed to make it operable.	8/10/07
	2. The drain at the basement exit was nearly clogged with dirt. The drain cover was observed to not fit securely over the drain and to move out position when touched.		2. The drain will be cleaned and the cover secured.	8/10/07

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Marsha H. Simpson
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Director of Disability Services
TITLE

7/11/07
(X6) DATE

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I 090	Continued From page 1	I 090		
	3. Heavily scaling paint was observed above the right window and on the window sill at the rear of house.		3. The old paint will be scraped and the window will be freshly painted.	8/10/07
	4. The walkway at the rear of the facility had an area of broken pavement, which prevented the section from being properly aligned. This created a potential trip hazard.		4. The broken pavement will be repaired.	8/10/07
	5. The bottom of the bath cabinet located above the sink in the first floor bathroom was rusted.		5. The bath cabinet/cabinet door will be replaced.	8/10/07
	6. There was no source of ventilation in the first floor bathroom. Additionally, the ceiling fan in the first floor bathroom was not operable.		6. The ceiling fan in the first floor bathroom will be repaired.	8/10/07
	7. The strike plate on the rear exit door was not properly aligned. This prevented locking of the door.		7. The strike plate on the rear exit door will be repaired/realigned.	8/10/07
	8. The back of the sitting chair was broken in the right front bedroom.		8. The broken chair will be replaced/repaired.	8/10/07
	9. The springs were palpable in the mattress on Resident #1's bed.		9. The mattress will be replaced.	8/10/07
	10. The door of the closet in the bathroom located on the second floor would not close completely.		10. The door will be shaved/replaced/rehung as needed.	8/10/07
	11. The board placed underneath the air conditioner in the window in the right front bedroom had a gagged left edge.		11. The board will be replaced.	8/10/07
	12. Heavily soiled carpet was observed on the floor in Resident #1's bedroom.		12. The carpet will be cleaned, or if too damaged will be replaced.	8/10/07
I 206	3509.6 PERSONNEL POLICIES	I 206		

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I 206	Continued From page 2 Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that 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 the review of the personnel files on June 21, 2007 at 4:30 PM revealed the GHMRP failed to provide evidence of a current health certificate for the consultant pharmacist.	I 206	The Pharmacist will submit a current health certificate as required by policy and by his contract.	8/10/07
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.	I 379	The QMRP will ensure that incidents are reported to DOH per Careco policy and District regulations. The Director of Disability Services and Incident Management Coordinator will retrain the QMRPs and Facility Directors, who will then retrain facility staff. The Incident Management Coordinator will continue to hold scheduled Incident Review Committee Meetings and will address any policy or other discrepancies around incident reporting	8/10/07

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I 379	Continued From page 3 This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure the Department of Health (DOH) , Health Facilities Division was notified of unusual incidents that substantially interfered with the health for four of five residents (Residents #1, #2, #3, and #4) residing in the GHMRP. The findings include: Review of the GHMRP's incident reports and/or summaries on June 19, 2007 and June 20, 2007 revealed the following incidents: 1. The facility failed to ensure that the DOH was informed of changes the residents' health status as detailed below: a. March 6, 2007 - Resident # 2 had a two to three minutes seizure at 7:15 AM. 911 was telephoned and the resident was transported to the ER for evaluation. There was no evidence DOH was notified of the incident. b. February 10, 2007 - Review of an unusal incident report revealed while on an outing at 7:55 PM, Resident #2 was hit by a male individual from the community while fighting with him. There was no evidence DOH was notified of the incident. c. July 25, 2007 - When staff required Resident #2 to get off the van at 4:15 PM after he refused, he went to his room and slammed the door hard, causing the knob to break. The resident stated he would rather be dead than live at the group	I 379		

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I 379	Continued From page 4 home. He proceeded to pick himself with blunt edged arts and craft-type scissors. 911 was telephoned. The police arrived and the resident was taken to CPEP. There was no evidence DOH was notified of the incident. d. January 19, 2007- At 6:00 AM Resident #1 became verbally abusive and assaulted a staff by violently pushing him. 911 was telephoned and the police arrived. It was determined the resident was at risk and he was transported to CPEP. He was transported from CPEP to a local hospital wher he was treated. Resident was discharged back to the group home on January 24, 2007. There was no evidence DOH was not notified of this incident or the resident's hospitalization until January 29, 2007. e. June 30, 2006 - During a fire drill at 6::33 AM, Resident #3 kicked another resident. While being redirected by his 1:1 staff, he hit his hand on the concrete wall. Resident was taken to the ER for evaluation. There was no evidence DOH was not notified of the incident. 2. The facility failed to ensure that the Department of Health received notification within 24 hours or the next work day as detailed below: a. The review of an unusual incident dated October 7, 2006 revealed that Resident #1 was taken to the ER due to profuse sweating and low blood pressure. He was evaluated and admitted to the hospital. There was no evidence that DOH was notified until October 20, 2006. b. The review of an unusual incident dated April 21, 2007 revealed at 6:25 PM Resident #4 walked away from the facility when he was left outside unsupervised by staff. The police were	I 379		

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I 379	Continued From page 5 notified after staff was unable to locate him. The resident returned to the facility at 8:45 PM. The incident was not reported to DOH until April 23, 2007. c. The review of an unusual incident report dated April 12, 2007 revealed that the day program reported that Resident #4 was injured by a piece of light wood that fell on the back of his neck. The resident was assessed immediately by the day program nurse who documented that he was alert,oriented and able to move. After returning to this group home, the resident was taken to the ER for evaluation. The ER assessment revealed he had a scalp contusion. There was no evidence the incident was reported to DOH until April 17, 2007.	I 379		
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 for Resident #2. The findings include: (See Federal Deficiency Report - Citations W159 and W369)	I 401	See responses to federal deficiencies W159 and W369.	8/10/07

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G125	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/21/2007
NAME OF PROVIDER OR SUPPLIER CARECO 04	STREET ADDRESS, CITY, STATE, ZIP CODE 1004 URELL PLACE, NE WASHINGTON, DC 20017		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 420	Continued From page 6	I 420		
I 420	3521.1 HABILITATION AND TRAINING Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide habilitation and training to Resident #2 that would enable him to acquire and maintain life skills needed to cope with his environment and achieve an optimum level of physical, mental and social functioning. The findings include: (See Federal Deficiency Report - Citations W159 and W257)	I 420	See responses to federal deficiencies W159 and W257.	8/10/07
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 GHMRP failed to ensure the protection of each resident's rights. The findings include: (See Federal Deficiency Report Citations - W124, W149, W159 and W263)	I 500	See responses to federal deficiencies W124, W149, W159 and W263	8/10/07

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G125	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 06/21/2007
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