

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0143	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/22/2008
NAME OF PROVIDER OR SUPPLIER CARECO 02		STREET ADDRESS, CITY, STATE, ZIP CODE 6613 6TH STREET, NW WASHINGTON, DC 20012		
(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
1000	INITIAL COMMENTS A monitoring survey was conducted on August 22, 2008, to determine the GHMRP's continued compliance with the deficiencies cited during the recertification survey on April 25, 2008. The client population included six female residents with varying degrees of mental retardation. The findings of the survey were based on interview and record review, including incident reports. At the time of this monitoring visit standard level deficiencies were cited in this report.	1000	<p><i>Received on 11/19/08</i></p> <p>GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002</p> <p>The QMRP will ensure that the Nutritionist reviews the clients' nutritional status quarterly.</p> <p><i>10/19/08</i></p>	
1058	3502.16 MEDICAL SERVICE / DINING AREAS A review and consultation by a dietitian or nutritionist shall be conducted at least quarterly to ensure that each resident who has been prescribed a modified diet receives adequate nutrition according to his or her Individual Habilitation Plan. This Statute is not met as evidenced by: Based on interview and record review the GHMRP failed to ensure modified diets had been reviewed at least quarterly by the consulting dietitian to ensure the each resident received adequate nutrition in accordance with their needs, for four of the six residents (Residents #2, #3, #4, and #6) residing in the facility. The findings include: There was no evidence that Residents #2, #3, #4, and #6's nutritional status was reviewed quarterly	1058		

Health Regulation Administration

Maria St. Thompson
LABORATORY DIRECTOR'S SIGNATURE

PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: *Director of Disability Services* (X6) DATE: *10/5/08*

STATE FORM

6899

G12E11

If continuation sheet 1 of 1

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

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FORM APPROVED
OMB NO. 0938-0391

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W 000	INITIAL COMMENTS A monitoring survey was conducted on August 22, 2008, to determine the facility's continued compliance with the deficiencies cited during the recertification survey on April 25, 2008. The client population included six female clients with varying degrees of mental retardation. The findings of the survey were based on interview and record review, including incident reports. At the time of this monitoring visit standard level deficiencies were cited in this report.	W 000		
W 114	483.410(c)(4) CLIENT RECORDS Any individual who makes an entry in a client's record must make it legibly, date it, and sign it. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that "Community & Home Life Assessments" was signed by the designated person for one of the three clients in the sample (Client #2) The finding includes: The plan of correction dated May 16, 2008 reflected that the Community Life Assessments would be signed by the qualified mental retardation professional. Review of Client #2's record failed to have evidence that the form was signed by the QMRP. The house manager was present and acknowledged the lack of signature on the form. It should be noted that the assessment had a designated line at the bottom of the form requiring a signature and date.	W 114	The QMRP will ensure that the community life assessment is signed.	10/10/08
W 124	483.420(a)(2) PROTECTION OF CLIENTS	W 124		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Marilyn H. ...</i>	TITLE <i>Director of Disability Svcs</i>	(X8) DATE <i>10/5/08</i>
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with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days after 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 124	<p>Continued From page 1</p> <p>RIGHTS</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the rights of each client and/or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment, for one of the three clients (Client #2) included in the sample.</p> <p>The findings include:</p> <p>During the survey completed April 25, 2008, Client #2 received psychotropic medications. The Residential Director (RD) indicated that the client did not have the capacity to give informed consent for the use of her medications and habilitation services. The RD's statement was verified on April 25, 2008 at 4:37 PM through review of Client #2's psychological assessment dated June 30, 2007. According to the assessment, Client #2 "does not evidence the capacity to make independent decisions on her behalf regarding her habilitation planning, placement, treatment, financial and medical matters due to profound mental retardation. She can not execute a durable power of attorney." Continued interview with the RD on April 24, 2008, further revealed that Client #2 did not have</p>	W 124	<p>The QMRP will ensure that the guardian receives written information on the client's treatment, and provides signed informed consent.</p>	10/10/08

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W 124 Continued From page 2
a legal guardian. The RD revealed that Client #2 had a guardianship hearing next week (week of April 28, 2008).

W 124

The record reflected that Client #2 was appointed a limited health care guardian on May 22, 2008. The plan of correction dated May 16, 2008 reflected that Client #2's guardian would be provided with written information on her medical treatment plans and the QMRP will request written consent for such treatments. The client's record, however, failed to have evidence that the guardian was informed of the client's treatment plan and gave consent.

W 189 483.430(e) STAFF TRAINING PROGRAM

W 189

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.

The Director of Disability Services will ensure that the QMRP and staff are retrained on incident notification.

8/21/08

This STANDARD is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility failed to ensure that each employee had been provided with adequate training that enables the employee to perform his or her duties effectively, efficiently and competently

The findings include:

During the April 25, 2008 survey, the facility was cited for failing to report all allegations of abuse and injuries of unknown source immediately to the administrator and to other officials in accordance with State law, to investigate those injuries and to report the findings of the investigation.

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W 189	Continued From page 3 The plan of correction dated May 16, 2008 reflected that the QMRP and the staff were to be retrained on the incident management and reporting policy and protocol, specifically the policies on reporting incidents to the administrator and state officials among others. The house manager presented the surveyor with the facility's training manual however there was no evidence that the staff had been trained on incident management.	W 189		
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 specially-constituted committee failed to ensure that restrictive programs were used only after written consents had been obtained, for one of the three clients (Client #2) included in the sample. The finding includes: Review of Client #2's physician orders, on August 22, 2008 revealed that she is prescribed Clonidine. Interview with the Licensed practical Nurse on the same day revealed the aforementioned medication was used to address the client's behaviors. The plan of correction dated May 16, 2008 reflected that Client #2's guardian would be	W 263	See response to W124. The QMRP will ensure that the Human Rights Committee reviews the informed written consent provided by the guardian	10/10/08

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W 263	Continued From page 4 provided with written information on her medical treatment plans and the QMRP will request written consent for treatment. The client's record reflected that she was appointed a limited health care guardian on May 22, 2008. However, the record failed to have evidence that the guardian was informed of the client's treatment plan and gave consent. The record further failed to have documented evidence that the Human Right's Committee ensured that the consent was obtained by the court appointed guardian.	W 263		