PRINTED: 03/20/2008
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	1701 24TH STREET, NE WASHINGTON, DC 20002

(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 A recertification survey was conducted from March 5, 2008 through March 7, 2008 using the fundamental survey process. However due to deficient practices in the Condition of Participation of Active Treatment, the survey was extended to examine this condition. A random sample of three clients was selected from a residential population of two females with mental retardation and other disabilities. The findings of the survey were based on observations at the home and two day programs, interviews with clients and staff, and the review of records, including incident reports.	W 000		
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observations, interview, and record verification, the facility failed to ensure that outside services met the needs for one of three clients included in the sample. (Client #3) The finding includes: On March 5, 2008 at 6:20 PM, Client #3 was observed eating a chopped dinner. On March 6, 2008 at approximately 12:00 PM, the client was observed during lunch at her day program. The client was observed eating a chopped chicken, whole black beans, greens and a whole dinner roll. Interview with the Qualified Mental Retardation Professional (QMRP) and Registered Nurse on March 6, 2008 at approximately 2:30	W 120	The QMRP will review the client's dietary needs with the appropriate staff at the day program.	4/30/08

RECEIVED
DEPARTMENT OF HEALTH
HEALTH REGULATION
ADMINISTRATION
2008 MAR 31 P 5:11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Marsha A. Grayson	Director of Disability Services	3/31/2008

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.

PRINTED: 03/20/2008
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	1701 24TH STREET, NE WASHINGTON, DC 20002

(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 120	Continued From page 1 PM stated that the client received a chopped diet due to her risk of aspiration. Review of the client's current physician's order at 2:00 PM confirmed that the client was required to receive a chopped diet.	W 120		
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, staff interview, and record review, the facility failed to establish a system that would ensure clients that were informed of their risks and benefits of their medication for two of the three clients in the sample. (Clients #1 and #3) The findings include: 1. On March 5, 2008 at 5:23 PM, Client #1 was observed during the evening medication pass being administered Ativan 2 mg and Risperdal 2 mg. Interview with the Licensed Practical Nurse (LPN) at approximately 5:45 PM revealed that client was prescribed these medications for behavioral management. Review of Client #1's current physician's orders confirmed that the client was prescribed the aforementioned medication. Further interview with the LPN revealed that the medications were incorporated into the client's Behavior Support Plan (BSP)	W 124	1. The QMRP will ensure that the client's medical decision-maker is informed in writing of the health benefits and risks of recommended treatments and will obtain written consent for such treatments. 4/30/08	

PRINTED: 03/20/2008
FORM APPROVED
CMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	1701 24TH STREET, NE WASHINGTON, DC 20002

(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 124	Continued From page 2 dated February 5, 2008 to address targeted behaviors that included self-injurious behaviors, physical aggression, property destruction, disrobing and inappropriate touching. Interview with the Registered Nurse during the entrance conference on March 5, 2008 at 3:45 PM revealed that Client #1's mother was very involved in her life but was not the client's legal guardian. Review of the client's, psychological assessment dated July 1, 2007 on March 6, 2008 at revealed that the client did not have the ability to make decisions on his behalf regarding habilitation planning, residential placement, finances, treatment and medical matters. There was no documented evidence that Client #1's mother had been informed of the health benefits and risks associated with the use of her psychotropic medications. Also there was no evidence that the mother had consented to the use of the psychotropic medications and corresponding BSP. 2. On March 5, 2008 at 4:39 PM, Client #3 was observed during the evening medication pass being administered Buspar 15 mg, Depakote 500 mg and Seroquel 100 mg. Interview with the Licensed Practical Nurse (LPN) at approximately 5:45 PM revealed that client was prescribed these medications for behavioral management. Review of Client #3's current physician's orders confirmed that the client was prescribed the aforementioned medication; Further interview with the LPN revealed that the medications were incorporated into the client's Behavior Support Plan (BSP) dated February 5, 2008 to address targeted behaviors that included screaming, self-injurious behaviors, physical aggression, property destruction, disrobing and inappropriate touching.	W 124	2. See response to #1 above.	4/30/08

PRINTED: 03/20/2008
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	1701 24TH STREET, NE WASHINGTON, DC 20002

(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 124	Continued From page 3 Interview with the Registered Nurse during the entrance conference on March 5, 2008 at 3:45 PM revealed that Client #3's mother was very involved in her life but was not the client's legal guardian. Review of the client's, psychological assessment dated July 1, 2007 on March 6, 2008 at revealed that the client does not have the ability to make decisions on his behalf regarding habilitation planning, residential placement, finances, treatment and medical matters. There was no documented evidence that Client #2's mother had been informed of the health benefits and risks associated with the use of her psychotropic medications. Also there was no evidence that the mother had consented to the use of the psychotropic medications and corresponding BSP.	W 124		
W 130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure that clients were provided privacy during care of personal needs for one of the three clients in the sample. (Client #2) The finding includes: On March 5, 2008 at 3:25 PM, staff was observed changing Client #2's adult protective undergarments (APU's) in her bedroom with the door wide opened. The direct care staff did not close the door upon my entry into the hallway.	W 130	The QMRP will provide retraining to staff on each person's right to privacy.	4/30/08

PRINTED: 03/20/2008
FORM APPROVED
CMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	1701 24TH STREET, NE WASHINGTON, DC 20002

(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 130	Continued From page 4 The surveyor stood in the client's bedroom doorway in clear view of the client being changed. At no time during the observation did the direct care staff attempt to protect Client #2's privacy by closing the door.	W 130		
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must: notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to notify parents and/or guardians of significant incidents, for one of the three clients in the sample. (Client #2) The findings include: Review of the unusual incidents on March 5, 2008, at approximately 2:15 PM revealed an incident dated January 17, 2008. The incident documented that Client #3 hit Client #2 in the face. The Incident failed to indicate that the client's family was made aware of the incident. Interview with the Qualified Mental Retardation Professional on March 7, 2008 at 10:00 AM acknowledged the deficient practice.	W 148	The QMRP will provide refresher training to all staff on incident management, including required notifications.	4/30/08
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported	W 153		

PRINTED: 03/20/2008
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	1701 24TH STREET, NE WASHINGTON, DC 20002

(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 153	Continued From page 5 Immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all unusual incidents including injuries of unknown origin were reported immediately to the administrator and other officials according to district law (22 DCMR, Chapter 35, Section 3519.10) one of the three clients in the facility. (Client #2) The findings include: 1. Review of the unusual incidents on March 5, 2008, at approximately 2:15 PM revealed an incident dated January 17, 2008. The incident documented that Client #3 hit Client #2 in the face. The incident failed to indicate that the State Agency, the clients family or the administrator was made aware of the incident. 2. Review of the unusual incidents on March 5, 2008, at approximately 2:15 PM revealed an incident dated November 15, 2007. The incident documented that Client #3 scratched Client #2 in the face. The incident failed to indicate that the administrator was made aware of the incident. Interview with the Qualified Mental Retardation Professional on March 7, 2008 at 10:00 AM acknowledged the deficient practice.	W 153	1. See response to W148.	4/30/08 4/30/08
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative	W 156	See response to W148.	4/30/08

PRINTED: 03/20/2008
FORM APPROVED
CMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	1701 24TH STREET, NE WASHINGTON, DC 20002

(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 156	Continued From page 6 or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on record review, the facility failed to ensure the results of investigations were reported to the administrator or designee for two of the five clients residing in the facility. (Clients #2 and #5) The findings include: Review of the unusual incidents and investigative reports on March 6, 2008, at approximately 2:15 PM revealed seven unusual incidents dated January 1, 2008, January 17, 2008, February 11, 2008, November 15, 2008, and November 26, 2007. The incidents were investigated, however, there was no evidence that the administrator was made aware of the results of the investigations. Interview with the Qualified Mental Retardation Professional on March 7, 2008 at 10:00 AM acknowledged the deficient practice.	W 156		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL	W 159		

PRINTED: 03/20/2008
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	1701 24TH STREET, NE WASHINGTON, DC 20002

(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 A recertification survey was conducted from March 5, 2008 through March 7, 2008 using the fundamental survey process. However due to deficient practices in the Condition of Participation of Active Treatment, the survey was extended to examine this condition. A random sample of three clients was selected from a residential population of five females with mental retardation and other disabilities. The findings of the survey were based on observations at the home and two day programs, interviews with clients and staff, and the review of records, including incident reports.	W 000		
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observations, interview, and record verification, the facility failed to ensure that outside services met the needs for one of three clients include in the sample. (Client #3) The finding includes: On March 5, 2008 at 6:20 PM, Client #3 was observed eating a chopped dinner. On March 6, 2008 at approximately 12:00 PM, the client was observed during lunch at her day program. The client was observed eating a chopped chicken, whole black beans, greens and a whole dinner roll. Interview with the Qualified Mental Retardation Professional (QMRP) and Registered Nurse on March 6, 2008 at approximately 2:30	W 120	The QMRP will review the client's dietary needs with the appropriate staff at the day program.	4/30/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marsha A. Thompson — TITLE: Director of Disability Services — (X6) DATE: 3/31/2008

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.

PRINTED: 03/20/2008
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	1701 24TH STREET, NE WASHINGTON, DC 20002

(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 120	Continued From page 1 PM stated that the client received a chopped diet due to her risk of aspiration. Review of the client's current physician's order at 2:00 PM confirmed that the client was required to receive a chopped diet.	W 120		
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, staff interview, and record review, the facility failed to establish a system that would ensure clients that were informed of their risks and benefits of their medication for two of the three clients in the sample. (Clients #1 and #3) The findings include: 1. On March 5, 2008 at 5:23 PM, Client #1 was observed during the evening medication pass being administered Ativan 2 mg and Risperdal 2 mg. Interview with the Licensed Practical Nurse (LPN) at approximately 5:45 PM revealed that client was prescribed these medications for behavioral management. Review of Client #1's current physician's orders confirmed that the client was prescribed the aforementioned medication. Further interview with the LPN revealed that the medications were incorporated into the client's Behavior Support Plan (BSP)	W 124	1. The QMRP will ensure that the client's medical decision-maker is informed in writing of the health benefits and risks of recommended treatments and will obtain written consent for such treatments.	4/30/08

PRINTED: 03/20/2008
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	1701 24TH STREET, NE WASHINGTON, DC 20002

(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 124	Continued From page 2 dated February 5, 2008 to address targeted behaviors that included self-injurious behaviors, physical aggression, property destruction, disrobing and inappropriate touching. Interview with the Registered Nurse during the entrance conference on March 5, 2008 at 3:45 PM revealed that Client #1's mother was very involved in her life but was not the client's legal guardian. Review of the client's, psychological assessment dated July 1, 2007 on March 6, 2008 at revealed that the client did not have the ability to make decisions on his behalf regarding habilitation planning, residential placement, finances, treatment and medical matters. There was no documented evidence that Client #1's mother had been informed of the health benefits and risks associated with the use of her psychotropic medications. Also there was no evidence that the mother had consented to the use of the psychotropic medications and corresponding BSP. 2. On March 5, 2008 at 4:39 PM, Client #3 was observed during the evening medication pass being administered Buspar 15 mg, Depakote 500 mg and Seroquel 100 mg. Interview with the Licensed Practical Nurse (LPN) at approximately 5:45 PM revealed that client was prescribed these medications for behavioral management. Review of Client #3's current physician's orders confirmed that the client was prescribed the aforementioned medication. Further interview with the LPN revealed that the medications were incorporated into the client's Behavior Support Plan (BSP) dated February 5, 2008 to address targeted behaviors that included screaming, self-injurious behaviors, physical aggression, property destruction, disrobing and inappropriate touching.	W 124	2. See response to #1 above.	4/30/08

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

PRINTED: 03/20/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	1701 24TH STREET, NE WASHINGTON, DC 20002

(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 124	Continued From page 3 Interview with the Registered Nurse during the entrance conference on March 5, 2008 at 3:45 PM revealed that Client #3's mother was very involved in her life but was not the client's legal guardian. Review of the client's, psychological assessment dated July 1, 2007 on March 6, 2008 at revealed that the client does not have the ability to make decisions on his behalf regarding habilitation planning, residential placement, finances, treatment and medical matters. There was no documented evidence that Client #2's mother had been informed of the health benefits and risks associated with the use of her psychotropic medications. Also there was no evidence that the mother had consented to the use of the psychotropic medications and corresponding BSP.	W 124		
W 130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure that clients were provided privacy during care of personal needs for one of the three clients in the sample. (Client #2) The finding includes: On March 5, 2008 at 3:25 PM, staff was observed changing Client #2's adult protective undergarments (APU's) in her bedroom with the door wide opened. The direct care staff did not close the door upon my entry into the hallway.	W 130	The QMRP will provide retraining to staff on each person's right to privacy.	4/30/08

PRINTED: 03/20/2008
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	1701 24TH STREET, NE WASHINGTON, DC 20002

(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 130	Continued From page 4 The surveyor stood in the client's bedroom doorway in clear view of the client being changed. At no time during the observation did the direct care staff attempt to protect Client #2's privacy by closing the door.	W 130		
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to notify parents and/or guardians of significant incidents, for one of the three clients in the sample. (Client #2) The findings include: Review of the unusual incidents on March 5, 2008, at approximately 2:15 PM revealed an incident dated January 17, 2008. The incident documented that Client #3 hit Client #2 in the face. The incident failed to indicate that the client's family was made aware of the incident. Interview with the Qualified Mental Retardation Professional on March 7, 2008 at 10:00 AM acknowledged the deficient practice.	W 148	The QMRP will provide refresher training to all staff on incident management, including required notifications.	4/30/08
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported	W 153		

PRINTED: 03/20/2008
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	1701 24TH STREET, NE WASHINGTON, DC 20002

(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 153	Continued From page 6 immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all unusual incidents including injuries of unknown origin were reported immediately to the administrator and other officials according to district law (22 DCMR, Chapter 35, Section 3519.10) one of the three clients in the facility. (Client #2) The findings include: 1. Review of the unusual incidents on March 5, 2008, at approximately 2:15 PM revealed an incident dated January 17, 2008. The incident documented that Client #3 hit Client #2 in the face. The incident failed to indicate that the State Agency, the clients family or the administrator was made aware of the incident. 2. Review of the unusual incidents on March 5, 2008, at approximately 2:15 PM revealed an incident dated November 15, 2007. The incident documented that Client #3 scratched Client #2 in the face. The incident failed to indicate that the administrator was made aware of the incident. Interview with the Qualified Mental Retardation Professional on March 7, 2008 at 10:00 AM acknowledged the deficient practice.	W 153	1. See response to W148. 2. See response to W148.	4/30/08 4/30/08
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative	W 156	See response to W148.	4/30/08

PRINTED: 03/20/2008
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	1701 24TH STREET, NE WASHINGTON, DC 20002

(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 156	Continued From page 6 or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on record review, the facility failed to ensure the results of investigations were reported to the administrator or designee for two of the five clients residing in the facility. (Clients #2 and #5) The finding includes: Review of the unusual incidents and investigative reports on March 5, 2008, at approximately 2:15 PM revealed an unusual incidents dated January 1, 2008, January 17, 2008, February 11, 2008, November 15, 2008, and November 26, 2007. The incidents were investigated, however, there was no evidence that the administrator was made aware of the results of the investigations. Interview with the Qualified Mental Retardation Professional on March 7, 2008 at 10:00 AM acknowledged the deficient practice.	W 156		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the facility's Qualified Mental Retardation Professional failed to monitor and coordinate services for the two of the three clients in the sample. (Clients #1 and #2)	W 159		

PRINTED: 03/20/2008
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	1701 24TH STREET, NE WASHINGTON, DC 20002

(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 159	Continued From page 7 The findings include: 1. The QMRP failed to ensure Client #1's day program had a current Individual Support Plan (ISP) as evidenced below: During an interview with Client #1's day program staff on March 6, 2007 at 11:00 AM, it was revealed that there was no current Individual Support Plan in the clients record. Review of the client's record verified the same. When this information was brought to the QMRP, she indicated that she had assumed the responsibility for the client on February 11, 2008. She was not aware that the day program did not have the necessary documents. 2. The QMRP failed to ensure Client #1 was re-assessed by the physical therapist post hospitalization. (See W210)	W 159	1. The QMRP will ensure that the Day Program has a current copy of the client's ISP in the record. 2. The QMRP will arrange for the client to be reassessed by the physical therapist.	4/30/08 4/30/08
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure staff was trained on safe transfer techniques for one of the three clients in the sample. (Client #1) The finding includes: On March 6, 2007 at 8:15 AM, Client #1 was observed being transferred from the couch to her wheelchair by a staff. Interview with the House	W 189	The QMRP will ensure that staff are trained on safe physical transfers.	4/30/08

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

PRINTED: 03/20/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	1701 24TH STREET, NE WASHINGTON, DC 20002

(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 189	Continued From page 8 Manager revealed that the staff was newly hired. Review of Client #1's physical therapy assessment dated May 14, 2007 revealed a recommendation for a two-person transfer for safety. Although the House Manager indicated that she assisted the staff with the transfer, the surveyor could not corroborate the House Manager's account.	W 189		
W 210	483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure clients were re-assessed by the physical therapist after her ability to ambulate decreased post hospitalization for one of the three clients in the sample. (Client #1) The findings include: 1. The facility failed to ensure Client #1 was re-assessed by the physical therapist after being re-admitted to the facility as evidenced below: During the survey conducted March 5, 2008 through March 7, 2008, Client #1 was observed being pushed in a wheelchair by staff. She was also observed being repositioned out of her wheelchair onto the couch. Review of the client's physical therapy assessment dated May 14, 2007 revealed that the consultant recommended that	W 210	1. The QMRP will ensure that client #1 is reassessed by the Physical Therapist.	4/30/08

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

PRINTED: 03/20/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	1701 24TH STREET, NE WASHINGTON, DC 20002

(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 210	Continued From page 9 the client use the wheelchair only for transportation; however, interview with the staff revealed that the client's condition had changed and she required the use of a wheelchair for mobility. Interview with the Qualified Mental retardation Professional (QMRP) on March 7, 2008 at approximately 10:40 AM revealed that the client had not been re-assessed by the Physical Therapist post hospitalization. When asked what the assessment/re-assessment policy was for the facility, the QMRP indicated that the client should have been re-assessed when she was re-admitted from the hospital; and verified that Client #1 had not been re-assessed. 2. The facility failed to ensure that Client #1's feeding skills was assessed after being re-admitted to the facility as evidenced below: During the evening observation on March 5, 2008, at 6:34 PM, staff fed Client #1 her dinner. The staff did not encourage the client to eat independently or with hand over hand assistance. Observations at the day program on March 6, 2008 at 11:50 PM, Client #1 was eating her lunch. She fed herself independently with staff assisting to wipe her mouth. The contrast in observations was brought to the attention of the Qualified Mental Retardation Professional (QMRP). There was no evidence that Client #1's eating skills had been re-assessed.	W 210	2. The QMRP will ensure that the client's eating skills are reassessed.	4/30/08
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the	W 249	The QMRP will review and revise the active treatment program as needed, and provide training to staff and the nurse in implementation and documentation	4/30/08

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

PRINTED: 03/20/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	1701 24TH STREET, NE WASHINGTON, DC 20002

(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 249	Continued From page 10 objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to provide continuous active treatment for one of the three clients in the sample. (Clients #2) The finding includes: During the medication pass observation on March 5, 2008 at 5:37 PM, Client #2 received her medicine. As the nurse was preparing to pour the liquid lactulose, the client asked the nurse, "do you want me to pour it?" The nurse made an attempt to assist the client in pouring the medication, however due to the clients inability to grasp the bottle, the nurse poured the medication. Review of the clients Individual Program Plan (IPP) revealed that Client #2 has a program to improve her home management skills by learning to pour items of her choice with 50% verbal prompts for three consecutive months. According to the instructions to the staff, they were to assist the client in pouring the liquid item by using hand over hand assistance. Interview with the Qualified Mental Retardation Professional (QMRP) on March 7, 2007 at approximately 10:45 AM revealed that the program was developed as a day program goal, however the QMRP acknowledged the group home staff were documenting the implementation of the program. When asked why the nurse did not implement the program, the QMRP was unable to answer the question.	W 249		

PRINTED: 03/20/2008
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	1701 24TH STREET, NE WASHINGTON, DC 20002

(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 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's Human Rights Committee (HRC) failed to review and approve the use of restrictive measures, for two of the three clients in the sample. (Clients #1 and #3) The finding includes: On March 6, 2008 at approximately 1:00 PM, review of the HRC minutes and interview with the Qualified Mental Retardation Professional (QMRP) revealed that there was no evidence that the HRC had approved the use of restrictive techniques (i.e. behavior support plan and psychotropic medications) to manage behaviors for Clients #1 and #3 behaviors. [See W124]	W 262	The QMRP will ensure that restrictive measures recommended to help the clients manage behaviors are brought to the HRC for review and approval.	4/30/08
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, staff interview and record review, the facility failed to ensure that each client's behavior intervention technique, including	W 263	See response to W124.	4/30/08

PRINTED: 03/20/2008
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	1701 24TH STREET, NE WASHINGTON, DC 20002

(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 263	Continued From page 12 the use of behavior modification drugs was conducted with the written informed consent of the client, parents (if the client is a minor) or legal guardian for two of the three clients in the sample. (Clients #1 and #3) The finding includes: The facility failed to obtain informed consent prior to the use of restrictive measures as described in Client #1 and #3's Behavior Support Plan. [See W124]	W 263		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that clients physician orders were signed, timely for one of the three clients. (Client #3) The finding includes: Review of Client #3's medical record on March 6, 2008 at approximately 12:00 PM, revealed a telephone order transcribed by the Registered Nurse dated November 28, 2007. The order did not have a counter signature by the prescribing physician. [The Director of Nursing stated that the policy required that the primary care physician (PCP) sign telephone orders within 24-48 hours.]	W 322	The RN Supervisor will ensure that all physician orders are appropriately and timely signed by the prescribing physician.	4/30/08
W 325	482.460(a)(3)(iii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum	W 325	The QMRP will ensure that all required lab studies are performed per physician orders.	4/30/08

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

PRINTED: 03/20/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	1701 24TH STREET, NE WASHINGTON, DC 20002

(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 325	Continued From page 13 includes routine screening laboratory examinations as determined necessary by the physician. This STANDARD is not met as evidenced by: Based on observations, staff interview and record verification, the facility failed to ensure recommended laboratory studies were obtained for clients, timely for one of the three clients in the sample, (Client #3) The finding includes: During the evening medication administration on March 5, 2008 at 4:39 PM, Client #3 was observed receiving Depakote 1000 mg. Interview with the medication nurse indicated that the client received the medication for her maladaptive behaviors. Review of the client's physician order dated January 2008 revealed an order for Depakote 500 mg every morning and 1000 mg every evening. The order further required Depakote levels studies 10 days after implementation of new dosage of Depakote. On January 29, 2008, the client's Depakote level was 41.0 (range 50-100). According to the February 20, 2008 Psychotropic medication review, the Psychiatrist recommended to repeat Depakote laboratory study if not within normal limits. At the time of the medical record review on March 6, 2008, the facility failed to repeat the study.	W 325		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by:	W 331	The RN Supervisor will ensure that all medication nurses are aware of and follow physician orders regarding medication administration and surveillance (i.e., monitoring and reporting glucose levels, etc.)	4/30/08

PRINTED: 03/20/2008
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	1701 24TH STREET, NE WASHINGTON, DC 20002

(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 331	Continued From page 14 Based on observation, staff interview and record review, the facility's nurse failed to inform the physician of blood sugar fingerstick values as ordered for one of three clients in the sample. (Client #3) The finding includes: On March 5, 2008 at 4:39 PM, the medication nurse obtained a blood sugar reading via finger stick from Client #3. The reading was 238. The nurse was asked, "when should the physician be notified of a glucose level?" The nurse indicated that the physician should be notified of a blood sugar level of 250 or greater. Review of the current physician's orders on March 6, 2007 at 9:16 AM, revealed that the physician should be notified of blood sugars if the readings are below 60 or greater than 200. Review of the nursing note and interview with the Registered Nurse revealed no evidence that the medication nurse notified the physician of a finger stick reading of 238 as ordered by the physician.	W 331		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation interview and record review, the facility failed to ensure clients were furnished with recommended adaptive equipment for one of the three clients in the sample. (Client	W 436		

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

PRINTED: 03/20/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	1701 24TH STREET, NE WASHINGTON, DC 20002

(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 436	Continued From page 15 #2) The findings include: 1. During the survey conducted from March 5, 2008 through March 7, 2008, Client #2 was observed without any adaptive equipment(i.e. glasses etc.). Review of the client's record on March 6, 2008 at 1:00 PM revealed the ophthalmologist evaluated the client on August 13, 2007. At that time she was prescribed glasses. Interview with the facility's nurse on March 7, 2008 at approximately 10:00 AM revealed Client #2 has glasses but refuses to wear them. When asked if there was a program in place to encourage the client to tolerate her glasses, the nurse and Qualified Mental Retardation Professional (QMRP) indicated that there was no program in place to encourage Client #2 to wear her glasses. 2. On March 5, 2008 during evening observations, Client #2 was observed with her fist closed tight. Further review of the client's medical record on March 6, 2008 at 10:47 AM, revealed a Physical Therapist assessment dated April 19, 2007. The assessment recommended Swanson cones for the client's hands. At no time during the survey was Swanson cones obsered in the client's hands. Interview with the QMRP on March 7, 2008 at approximately 9:30 AM verified that the client did not have the recommended adaptive equipment.	W 436	1. The QMRP will develop a program to help the client understand the need for her eyeglasses and wear them; the QMRP will train staff to implement and document the program. 2. The QMRP will obtain Swanson Cones and ensure staff are trained to assist the client to use them.	4/30/08 4/30/08

PRINTED: 03/20/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	1701 24TH STREET, NE WASHINGTON, DC 20002

(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 000	INITIAL COMMENTS A re-licensure survey was conducted from March 5, 2008 through March 7, 2008 using the fundamental survey process. However due to deficient practices in the Condition of Participation of Active Treatment, the survey was extended to examine this condition. A random sample of three residents was selected from a residential population of five females with mental retardation and other disabilities. The findings of the survey were based on observations at the home and two day programs, interviews with clients and staff, and the review of records, including incident reports.	I 000		
I 043	3602.2(c) MEAL SERVICE / DINING AREAS Modified diets shall be as follows: (c) Reviewed at least quarterly by a dietitian. This Statute is not met as evidenced by: Based on record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that the modified diet for one out of four residents in the sample had been reviewed at least quarterly by the consulting dietitian for one of the three residents in the sample. (Resident #1) The finding includes: Review of Resident #1's nutritional assessment dated May 22, 2007 on March 6, 2007 at 9:56 AM revealed that the resident was recommended a 1500 calorie soft bite sized textured diet. Further review failed to show evidence that the facility's Nutritionist had reviewed Resident #1's diet on a	I 043	See response to federal deficiency W120.	4/30/08

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Director of Disability Services TITLE 3/31/08 (X6) DATE

STATE FORM 6899 HDMO11 If continuation sheet 1 of 10

PRINTED: 03/20/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	090171	A. BUILDING _____ B. WING _____	03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	1701 24TH STREET, NE WASHINGTON, DC 20002

(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 043	Continued From page 1 quarterly basis. It should be noted that the resident was admitted to the hospital on November 24, 2007 through December 5, 2007 due to seizure activity. During the hospitalization, a PEG tube was inserted for feeding while in the hospital. Interview with Qualified Mental Retardation Professional (QMRP) acknowledged that the residents nutritional status had not been reviewed quarterly.	I 043		
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that all staff had current health certificates on file. The finding includes: Review of the personnel files on March 7, 2008, revealed that one of the nine charts presented for review failed to show evidence of a current annual health assessment. It should be noted that two staff records was not presented for review therefore it could not be determined if they had the required health inventory.	I 206	The Human Resource Director will ensure that all staff assigned to work at the facility have a current annual health assessment on file.	4/30/08

PRINTED: 03/20/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	090171	A. BUILDING _____ B. WING _____	03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	1701 24TH STREET, NE WASHINGTON, DC 20002

(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 379	Continued From page 2	I 379		
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that the Administrator, was notified of unusual incidents or events that substantially interfered with each resident's health and welfare within twenty-four hours or the next work day. The findings include: 1. Review of the unusual incidents on March 5, 2008, at approximately 2:15 PM revealed an incident dated January 17, 2008. The incident documented that Resident #3 hit Resident #2 in the face. The incident failed to indicate that the State Agency, the residents family or the administrator was made aware of the incident. 2. Review of the unusual incidents on March 5, 2008, at approximately 2:15 PM revealed an incident dated November 16, 2007. The incident documented that Resident #3 scratched Resident #2 in the face. The incident failed to indicate that the administrator was made aware of the	I 379	See response to federal deficiencies W148.	4/30/08

PRINTED: 03/20/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	1701 24TH STREET, NE WASHINGTON, DC 20002

(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 379	Continued From page 3 incident. Interview with the Qualified Mental Retardation Professional on March 7, 2008 at 10:00 AM acknowledged the deficient practice.	I 379		
I 394	3520.2(d) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (d) Nutrition; This Statute is not met as evidenced by: Based on record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to provide nutritional monitoring to direct care staff to carry out the resident's prescribed diet, as determined to be necessary by the interdisciplinary team. The finding includes: Review of the personnel files on March 7, 2008 at 10:30 AM, revealed that the GHMRP failed to provide a license for the nutritionist.	I 394	1. The Human Resources Director will ensure that a current license for the nutritionist is on file.	4/30/08
I 397	3520.2(g) PROFESSION SERVICES: GENERAL PROVISIONS	I 397	The Human Resources Director will ensure that a current license for the psychologist is on file.	4/30/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	1701 24TH STREET, NE WASHINGTON, DC 20002

(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 397	Continued From page 4 Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (g) Psychology; This Statute is not met as evidenced by: Based on record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that the licenses of all consultants were current and approved by District of Columbia Licensing Board. The finding includes: Review of the personnel files on March 7, 2008 at 10:30 AM, revealed that the GHMRP failed to provide a license for the psychologist.	I 397		
I 399	3520.2(i) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by	I 399	The Human Resources Director will ensure that a license for the Speech Pathologist is on file.	4/30/08

PRINTED: 03/20/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	1701 24TH STREET, NE WASHINGTON, DC 20002

(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 399	Continued From page 6 District of Columbia law in the following disciplines or areas of services: (i) Speech and language therapy; and... This Statute is not met as evidenced by: Based on record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that the licenses of all consultants were current and approved by District of Columbia Licensing Board. The finding includes: Review of the personnel files on March 7, 2008 at 10:30 AM, revealed that the GHMRP failed to provide a license for the Speech pathologist.	I 399		
I 400	3520.2(j) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (j) Recreation This Statute is not met as evidenced by: Based on record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that the licenses of all consultants were current and approved by District of Columbia	I 400	The facility no longer engages the recreation specialist.	4/30/08

PRINTED: 03/20/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	1701 24TH STREET, NE WASHINGTON, DC 20002

(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 400	Continued From page 6 Licensing Board. The finding includes: Review of the personnel files on March 7, 2008 at 10:30 AM, revealed that the GHMRP failed to provide a license for the recreation specialist.	I 400		
I 405	3520.7 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall be provided by programs operated by the GHMRP or personnel employed by the GHMRP or by arrangements between the GHMRP and other service providers, including both public and private agencies and individual practitioners. This Statute is not met as evidenced by: Based on observations, interview, and record verification, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that outside services met the needs for one of three residents include in the sample. (Resident #3) The finding includes: On March 5, 2008 at 6:20 PM, Resident #3 was observed eating a chopped dinner. On March 6, 2008 at approximately 12:00 PM, the resident was observed during lunch at her day program. The resident was observed eating a chopped chicken, whole black beans, greens and a whole dinner roll. Interview with the Qualified Mental Retardation Professional (QMRP) and Registered Nurse on March 6, 2008 at approximately 2:30 PM stated that the resident received a chopped diet due to her risk of aspiration. Review of the resident's current physician's order at 2:00 PM confirmed that the resident was required to	I 405	See response to federal deficiency W120.	4/30/08

PRINTED: 03/20/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	1701 24TH STREET, NE WASHINGTON, DC 20002

(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 405	Continued From page 7 receive a chopped diet.	I 405		
I 428	3521.5(e) HABILITATION AND TRAINING Each GHMRP shall make modifications to the resident ' s program at least every six (6) months or when the client: (e) As indicated by a change in his or her health status. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure Resident #1 received a re-evaluation by a physical therapist after her ability to ambulate decreased. The findings include: 1. The facility failed to ensure Resident #1 was re-assessed by the physical therapist after being re-admitted to the facility as evidenced below: During the survey conducted March 5, 2008 through March 7, 2008, Resident #1 was observed being pushed in a wheelchair by staff. She was also observed being repositioned out of her wheelchair onto the couch. Review of the resident's physical therapy assessment dated May 14, 2007 revealed that the consultant recommended that the resident use the wheelchair only for transportation; however, interview with the staff revealed that the resident's condition had changed and she required the use of a wheelchair for mobility. Interview with the Qualified Mental retardation Professional (QMRP) on March 7, 2008 at approximately 10:40 AM revealed that the resident had not been re-assessed by the	I 428	See response to federal deficiency W210.	4/30/08

PRINTED: 03/20/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	1701 24TH STREET, NE WASHINGTON, DC 20002

(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 428	Continued From page 8 Physical Therapist post hospitalization. When asked what the assessment/re-assessment policy was for the facility, the QMRP indicated that the resident should have been re-assessed when she was re-admitted from the hospital; and verified that Resident #1 had not been re-assessed. 2. The facility failed to ensure that Resident #1's feeding skills was assessed after being re-admitted to the facility as evidenced below: During the evening observation on March 6, 2008, at 6:34 PM, staff fed Resident #1 her dinner. The staff did not encourage the client to eat independently or with hand over hand assistance. Observations at the day program on March 6, 2008 at 11:50 PM, Resident #1 was eating her lunch. She fed herself independently with staff assisting to wipe her mouth. The contrast in observations was brought to the attention of the Qualified Mental Retardation Professional (QMRP). There was no evidence that Resident #1's eating skills had been re-assessed.	I 428		
I 430	3521.7(a) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (a) Eating and drinking (including table manners, use of adaptive equipment, and use of appropriate utensils); This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to train residents to use	I 430	See response to federal deficiency W436.	4/30/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09Q171	A. BUILDING _____ B. WING _____	03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	1701 24TH STREET, NE WASHINGTON, DC 20002

(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 430	Continued From page 9 adaptive equipment for one of the three residents in the sample. (Resident #2) The findings include: 1. During the survey conducted from March 5, 2008 through March 7, 2008, Resident #2 was observed without any adaptive equipment(i.e. glasses etc.). Review of the resident's record on March 6, 2008 at 1:00 PM revealed the ophthalmologist evaluated the resident on August 13, 2007. At that time, the client was prescribed glasses. Interview with the facility's nurse on March 7, 2008 at approximately 10:00 AM revealed Resident #2 has glasses but refuses to wear them. When asked if there was a program in place to encourage the resident to tolerate her glasses, the nurse and Qualified Mental Retardation Professional (QMRP) indicated that there was no program in place to encourage Resident #2 to wear her glasses. 2. On March 5, 2008 during evening observations, Resident #2 was observed with her fist closed tight. Further review of the resident's medical record on March 6, 2008 at 10:47 AM, revealed a Physical Therapist assessment dated April 19, 2007. The assessment recommended Swanson cones for the resident's hands. At no time during the survey was Swanson cones observed in the resident's hands. Interview with the QMRP on March 7, 2008 at approximately 9:30 AM verified that the resident did not have the recommended adaptive equipment.	I 430		
I 436	3521.7(f) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas:	I 436	- - - - - - See response to federal deficiency W249.	4/30/08

PRINTED: 03/20/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	1701 24TH STREET, NE WASHINGTON, DC 20002

(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 436	Continued From page 10 (f) Health care (including skills related to nutrition, use and self-administration of medication, first aid, care and use of prosthetic and orthotic devices, preventive health care, and safety); This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure the habilitation and training to residents in the domain of self medication for one of the three residents in the sample. (Resident #2) The finding includes: During the medication pass observation on March 5, 2008 at 5:37 PM, Resident #2 received her medicine. As the nurse was preparing to pour the liquid lactulose, the resident asked the nurse, "do you want me to pour it?" The nurse made an attempt to assist the resident in pouring the medication, however due to the residents inability to grasp the bottle, the nurse poured the medication. Review of the residents Individual Program Plan (IPP) revealed that Resident #2 has a program to improve her home management skills by learning to pour items of her choice with 50% verbal prompts for three consecutive months. According to the instructions to the staff, they were to assist the resident in pouring the liquid item by using hand over hand assistance. Interview with the Qualified Mental Retardation Professional (QMRP) on March 7, 2007 at approximately 10:45 AM revealed that the program was developed as a day program goal, however the QMRP acknowledged the group home staff were documenting the implementation	I 436		

PRINTED: 03/20/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	1701 24TH STREET, NE WASHINGTON, DC 20002

(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 436	Continued From page 11 of the program. When asked why the nurse did not implement the program, the QMRP was unable to answer the question.	I 436		
I 441	3521.7(k) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (k) Mobility (including ambulation, transportation, mapping and orientation, and use of mobility equipment); This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure the habilitation of its residents included training in the area of mobility for one of the three residents in the facility. (Resident #2) The finding includes: On March 6, 2007 at 8:15 AM, Resident #1 was observed being transferred from the couch to her wheelchair by a staff. Interview with the House Manager revealed that the staff was newly hired. Review of Resident #1's physical therapy assessment dated May 14, 2007 revealed a recommendation for a two-person transfer for safety. Although the House Manager indicated that she assisted the staff with the transfer, the surveyor could not corroborate the House Manager's account.	I 441	See response to federal deficiency W189.	4/30/08
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure	I 500		

PRINTED: 03/20/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	1701 24TH STREET, NE WASHINGTON, DC 20002

(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 500	Continued From page 12 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, staff interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure 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. The findings include: 1. The GHMRP failed to establish a system that would ensure residents that were informed of the risks and benefits of their medications. [See Federal Deficiency Citation W124] 2. The GHMRP failed to ensure its Human Rights Committee (HRC) reviewed and approved the use of restrictive measures. [See Federal Deficiency Citation W262]	I 500	See response to federal deficiency W124. See response to federal deficiency W262.	4/30/08 4/30/08