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

PRINTED: 04/07/2009
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
	09G159		03/19/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 02	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) COMPLETION DATE
W 000	INITIAL COMMENTS	W 000		
	A recertification survey was conducted from March 17, 2009 through March 19, 2009. The survey was initiated using the fundamental survey process. The facility had a resident population of six women with various disabilities. One client had been admitted within the past year; therefore, she was included in the sample. Two additional women were selected randomly for inclusion in the sample. The findings of the survey were based on observations, interviews with clients, interviews with staff in the home and at three day program, as well as a review of client and administrative records, including incident reports.		GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
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 entries in each client's record were dated, for one of the three clients in the sample. (Client #3) The findings include: On March 17, 2009, at 10:27 AM, interview with the Qualified Mental Retardation Professional (QMRP) revealed that Client #3 had been admitted to the facility in early June, 2008. On March 19, 2009, at 12:51 PM, review of Client #3's habilitation record revealed that the psychologist and behavior specialist had signed but not dated her 1st and 2nd quarterly reviews, for the periods of July 16, 2008-October 17, 2009	W 114	The QMRP will contact the Behavior Specialist and Psychologist date the assessments, and in future that assessments and Behavior Support Plans are both signed and dated by the person who completes and/or approves them.	5/1/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marsha H. Thompson
TITLE: Director of Disability Services
(X6) DATE: 4/17/2009

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 114	Continued From page 1 and October 18, 2008-January 30, 2009, respectively.	W 114		
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 interview and record review, the facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP), for two of the three clients in the sample. (Clients #2 and #3) The findings include: 1. Cross-refer to W322 and W340. The QMRP failed to ensure that Client #2's day program was provided with the ProAir (albuterol) inhaler that was prescribed "as needed" for wheezing/ shortness of breath.	W 159	1. The QMRP will ensure that day programs receive medications to administer to clients as prescribed. See responses to W322 and W340.	5/1/09
	2. Cross-refer to W322.3. The QMRP failed to seek clarification from the medical team regarding Client #2's diagnosis of either asthma or bronchitis.		2. The QMRP will meet with the medical team to ensure that the correct diagnoses are listed for all clients.	5/1/09
	3. The QMRP failed to follow-up on a recommendation for further assessment of Client #3's air swallowing behavior, as follows: According to interviews with the QMRP and the Designated Nurse, and verified through record review, Client #3 was admitted to the facility on June 3, 2008. Client #3 was observed in the		3. The QMRP will ensure that recommendations made by specialists are forwarded to the PCP, and that those recommendations are implemented by the medical team per the PCP's approval.	5/1/09

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W 159	Continued From page 2 home on March 17, 2009 from 7:15 AM - 8:35 AM and again from 3:08 PM - 6:23 PM. She was of thin build. Her abdomen, however, protruded noticeably. On March 19, 2009, at 11:59 AM, review of Client #3's medical records revealed that she had been assessed by a gastro-intestinal specialist on September 18, 2008. The purpose of the visit was cited as "Assessment of habitual air swallowing with mild abdominal distention." The GI specialist wrote the following: "mouth breather... increased air in the stomach... recommend speech pathologist evaluated for behavioral therapy but I'm not sure patient will be able to participate. That assessment needs to be made by her psychologist/ psychiatrist/ PCP." He also diagnosed a ventral hernia and recommended Prevacid daily "to protect esophagus." The GI consultant report had not been initialed or signed and dated by a PCP, which was how the nurse indicated the PCP routinely documented his or her review. Subsequent review of Client #3's nursing, primary care physician, QMRP, speech/language, psychological and psychiatric records revealed no evidence that the GI specialist's recommendation had been addressed. At 12:39 PM, the DN acknowledged that the September 18, 2008 recommendation for further assessment had not been brought to the PCP's attention. During the Exit Conference that evening, which began at 6:22 PM, the QMRP acknowledged that to date, the GI specialist's September 18, 2008 recommendation for further assessment had not been brought to the attention of Client #3's PCP, psychologist or the psychiatrist.	W 159		

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W 159	Continued From page 3	W 159		
	4. The QMRP failed to monitor Client #3's sleep pattern and coordinate appropriate interventions to ensure that she received active treatment in accordance with her Individual Support Plan (ISP), as follows:		4. The QMRP will establish a protocol for staff to check and document the client's sleep patterns for a minimum of thirty (30) days across the day and home settings, with approval and input from the IDT. The data will be shared with the PCP and the Psychiatrist so that appropriate interventions, either medical or behavioral, can be developed and approved by the team and the Human Rights Committee. Once such interventions have been developed and approved, the QMRP will implement and document them for effectiveness.	5/1/09
	According to interviews with the QMRP and the Designated Nurse, and verified through record review, Client #3 was admitted to the facility on June 3, 2008.			
	Client #3 was observed in the home on March 17, 2009 from 7:15 AM - 8:35 AM. At 7:23 AM, the client's eyes wandered around the room during an attempted interview. She blinked several times and she appeared to be having trouble focusing on the moment. At 7:35 AM, she was observed with her eyes closed while seated on a sofa. A minute later, her assigned one-on-one staff person awakened her and she sat up. Similar observations were made at 7:47 AM, when the client repeatedly (3 times) appeared to fall asleep on the sofa. After she had finished breakfast, Client #3 sat on the sofa and at approximately 8:16 AM, she closed her eyes for several minutes. Her staff awakened her but she immediately closed her eyes again. At 8:22 AM, her eyes looked very groggy.			
	Later that day, Client #3 slept throughout the observation period at her day program, from 11:30 AM - 12:25 PM. The one-on-one staff said she had been asleep since they had arrived that morning. Some days she reportedly slept all day, while other days she stayed awake. Most often, she fell asleep in the afternoon, after lunch. The day program case manager confirmed what the staff reported, adding that they collected hourly			

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W 159	Continued From page 4 data to see whether they could discern a pattern with her fatigue. Beginning at approximately 11:55 AM, review of the data collection sheets confirmed that there had been days (examples January 7 and February 24, 2009) when she slept all day. There were other days where they had documented after-lunch sleeping. Still other days, there was no data recorded. The day program case manager indicated that they had discussed the issue previously with the home. On March 18, 2009, at 9:17 AM, interview with a direct support staff on the overnight shift revealed that Client #3 often stayed awake until 12:00 AM or 1:00 AM. In the past, the client reportedly played music at night at a volume that disturbed her housemates' sleep. More recently, they had purchased a radio/CD player with headphones. The client listened to whatever music she chose to on her headphones, until she fell asleep. Further interview revealed that she or other staff recorded hourly bedchecks. However, to date, nobody had offered the staff strategies to implement to ensure that Client #3 got a full night's sleep. A few hours later, at 10:12 AM, joint interview with the QMRP and the RN in the facility confirmed that Client #3's drowsiness at day program had been discussed previously. The client had been evaluated by their psychiatrist, who recommended that they discontinue the Melatonin prescribed at bedtime, which she had been taking since before she was admitted to the facility on June 3, 2008. The psychiatrist reportedly did not think Melatonin had any affect. The RN further indicated that the psychiatrist would consider another medication if the client's sleep pattern were to change. At 10:14 AM, both the QMRP	W 159		

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W 159	Continued From page 5 and the RN indicated that neither was aware of Client #3 staying up late. The QMRP stated "no, she sleeps at night." Client #3's medical and habilitation records were reviewed the following day. At 11:36 AM, review of the primary care physician's (PCP's) admission note, dated June 3, 2008, confirmed that she had been prescribed Melatonin 3 mg at bedtime. Further review of her chart revealed that she was last administered Melatonin on October 23, 2008. Beginning at 12:51 PM, review of the psychologist's quarterly report for the period October 18, 2008 - January 30, 2009 revealed no mention of sleep issues. Previously, however, the report for the period July 16, 2008 - October 17, 2008 included the following: "During the review, staff mentioned that <client's name> takes a long time to sleep at night, even after she has been tucked into bed." There was no evidence that the issue had been addressed by the psychologist after October 17, 2008. Beginning at 2:06 PM, review of the hourly data for bedchecks at night confirmed what the staff had reported. Most night, the client remained awake until 12:00 AM or 1:00 AM. On one occasion, staff documented that she was awake at 2:30 AM (March 4 - 5, 2009). It should be noted that on at least 5 nights within the past month (February 16, 18, 19, 28, and March 1, 2009), staff did not record bedchecks or Client #3's sleep pattern. The survey findings revealed several months where Client #3 had not been receiving continuous active treatment (most notably at the day program). During the period of January - March 2009 residential staff had documented	W 159		

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W 159	Continued From page 6 ongoing sleep pattern disturbances. However, review of the client's QMRP monthly reviews, nursing quarterlies and other documentation failed to show evidence that her sleep pattern had been monitored and coordinated with the interdisciplinary team, with appropriate intervention strategies to be determined.	W 159		
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 observation, interview and record review, the facility failed to ensure preventive and general medical care for two of the three clients in the sample. (Clients #2 and #3) The findings include: 1. The facility's medical team failed to develop and implement a plan to ensure that Client #2's ProAir (albuterol) inhaler was available for use as needed, in accordance with physician's orders (POs), as follows: Cross-refer to W340. According to Client #2's Individual Support Plan, dated July 17, 2008, ProAir inhalant was prescribed for "wheezing/ shortness of breath." Her February 2009 POs reflected the following: "ProAir HFA MDI 8.5 mg 2 puffs by mouth as needed up to 4 times daily... <started> July 27, 2007." On March 18, 2009, however, observations and interviews at the client's day program and in the home, at 12:01 PM and 2:18 PM respectively, revealed that there were no ProAir inhalers onsite and available for	W 322	1. The QMRP will ensure that a second inhaler is ordered and delivered to the facility for the client.	5/1/09

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W 322	Continued From page 7 use in either location. There was no documented evidence that the facility had addressed the client's order for PRN ProAir with the her day program, to ensure availability of the treatment during her (approximate) 5 hours spent there every weekday. The DN confirmed this during the March 18, 2009 interview, which began at 1:59 PM. On March 19, 2009, at 5:51 PM, the Designated Nurse (DN) stated that the RN had brought a ProAir inhaler to the facility earlier that day. At 6:01 PM, however, she acknowledged that the facility had not sent one to the day program, stating further "we have had to order another one." 2. The facility's medical team was unable to ensure that Client #2 received ProAir (albuterol) treatment immediately should she develop signs/ symptoms of "wheezing or shortness of breath," as follows: On March 18, 2009, beginning at 1:59 PM, interview with the Designated Nurse (DN) revealed that the inhaler was usually secured under lock and key in a medication cabinet at all times, with keys held only by nursing staff. She acknowledged that nurses only came to the facility to administer morning, evening and bedtime medications and the facility did not employ Trained Medication Employees. She further acknowledged that the ProAir inhaler would not be accessible for at least 30 minutes, perhaps longer, should Client #2 begin experiencing symptoms and there was no nurse in the facility at the time. On March 19, 2009, the Director of Nursing brought a new ProAir inhaler to the facility. At 5:51 PM, the DN indicated the	W 322	2. The QMRP will coordinate with the RN Supervisor to develop and implement a protocol for having TME staff on duty at the home when the client is not at her day program, so that the medication can be administered as indicated for wheezing or shortness of breath.	5/1/09

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W 322	Continued From page 8 inhaler was with Client #2's other medications in the medicine cabinet. 3. The facility's medical team failed to obtain and document a clear and accurate diagnostic profile regarding Client #2's history of asthma and/or bronchitis, as follows: a. On March 18, 2009, at approximately 11:40 AM, Client #2's day program IPP, dated August 1, 2008, reflected a diagnosis of asthma. At approximately 2:38 PM, the Qualified Mental Retardation Professional (QMRP) stated that she did not recall Client #2 having a history of asthma. b. At 3:34 PM, review of Client #2's Individual Support Plan (ISP), dated July 17, 2008 revealed the following: "There was an ER visit, during which she was diagnosed with asthma. However, after follow-up with a pulmonary specialist, it was determined that she had a case of bronchitis, which was resolved. She continued to have a PRN order for an inhaler to treat wheezing if it occurs..." At approximately 4:05 PM, review of a November 7, 2007 consultation report revealed that the pulmonary specialist wrote "history of asthma... complains of shortness of breath with climbing...uses inhaler rarely... findings: treated asthma stable... recommend continue prn albuterol, exercise, low calorie diet/weight loss." There was no indication, however, that the pulmonary specialist had changed the diagnosis to bronchitis. On March 19, 2009, at 11:50 AM, the DN looked at the consultation report and stated that the pulmonary specialist wrote "history of asthma." She then pointed to the words "status post asthma" on Client #2's January 20, 2009 Nursing quarterly. [Note: A post-survey	W 322	3. The QMRP will provide medical history to the client's current PCP, and seek referrals as needed from the PCP, to confirm the client's diagnoses (current and/or historical) of bronchitis and/or asthma.	5/1/09

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W 322	Continued From page 9 review of incident reports confirmed a June 20, 2007 ER visit. However, the report indicated that Client #2 left the ER with diagnoses of both asthma and bronchitis. This did not correspond with what had been written in her ISP by the former QMRP.] c. At 2:20 PM, Client #2's Health Management Care Plan (HMCP), dated June 10, 2008 (revised most recently on February 22, 2009), failed to reflect a diagnosis of either asthma or bronchitis, past or present. Instead, the HMCP indicated the ProAir (albuterol) was used to treat her history of persistent allergic rhinitis. The DN stated that "it makes sense" for use of ProAir to treat allergies. d. At 3:55 PM, review of Client #2's Annual Physical Examination report, dated July 8, 2008, revealed that it failed to reflect a diagnosis of either asthma or bronchitis, past or present. The client had since been assigned a new primary care physician (PCP) in October 2008. The PCP's progress notes, however, failed to reflect a diagnosis of either asthma or bronchitis, past or present. The PCP's notes also showed no evidence that the question of current or accurate pulmonary diagnosis had been identified since she had been assigned. e. At 4:11 PM, review of Client #2's Annual Nursing Assessment, dated June 10, 2008, as well as quarterly nursing reports dated September 16, 2008 and January 20, 2009 revealed that all 3 documents showed ProAir "as needed for asthma." However, further review of the Annual Nursing Assessment revealed "status post asthma" was listed as a diagnosis. None of the nurse reports made reference to bronchitis, which had been written in her ISP by the former QMRP.	W 322		

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W 322	Continued From page 10	W 322		
	f. Although Client #2's February 2009 POs included the following: "ProAir HFA MDI 8.5 mg 2 puffs by mouth as needed up to 4 times daily... <started> July 27, 2007," the POs did not indicate the reason why the ProAir (albuterol) was prescribed. The listed diagnoses on her POs also did not reflect a diagnosis of either asthma or bronchitis, past or present.			
	g. There was no evidence that a licensed physician had evaluated Client #2's pulmonary status since November 7, 2007 to clarify the existing diagnosis.			
	4. The facility's medical team failed to follow-up on a recommendation for further assessment of Client #3's air swallowing behavior, as follows:		4. See response to W159 #3.	5/1/09
	According to interviews with the QMRP and the DN, and verified through record review, Client #3 was admitted to the facility on June 3, 2008. Client #3 was observed in the home on March 17, 2009 from 7:15 AM - 8:35 AM and again from 3:08 PM - 6:23 PM. She was of thin build. Her abdomen, however, protruded noticeably.			
	a. On March 19, 2009, at 11:59 AM, review of her HMCP revealed that it had been updated on September 18, 2008, following assessment earlier that same day by a gastro-intestinal specialist. The purpose of the visit was cited as "Assessment of habitual air swallowing with mild abdominal distention." The GI specialist wrote the following: "mouth breather... increased air in the stomach... recommend speech pathologist evaluated for behavioral therapy but I'm not sure patient will be able to participate. That assessment needs to be made by her			

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W 322	Continued From page 11 psychologist/ psychiatrist/ PCP." He also diagnosed a ventral hernia and recommended Prevacid daily "to protect esophagus." The GI consultant report had not been initialed or signed and dated by a PCP, which was how the nurse indicated the PCP routinely documented his or her review. b. At 3:10 PM, review of Client #3's psychological records revealed no evidence that the psychologist had been made aware of the recommendation. Her Nursing Admission Assessment, dated June 3, 2008, as well as a January 10, 2009 Nursing Quarterly both cited "abdominal distention" and included the following: "Swallows air frequently. Passes flatulence very frequently." The January 10, 2009 Nursing Quarterly also cited the September 18, 2008 GI consultation; however, the RN wrote "none" regarding "Recommendations/ Follow-Up Appointment." c. Further review of her HMCP revealed that while it reflected the ventral hernia and newly-prescribed Prevacid, it did not address air swallowing or the recommended follow-up assessment. d. Further review of PCP and nurse progress notes failed to show evidence that the GI specialist's recommendation for further assessment had been brought to the PCP's attention. e. There was no documented evidence of contacts with the Speech Pathologist since the time she conducted Client #3's June 25, 2008 initial assessment (3 months prior to the GI appointment).	W 322		

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	09G159		03/19/2009

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) COMPLETION DATE
W 322	Continued From page 12	W 322		
	f. At 12:39 PM, the DN acknowledged that the September 18, 2008 recommendation for further assessment had not been brought to the PCP's attention.			
	g. At 1:09 PM, review of the QMRP monthly summary report dated October 10, 2008 revealed that while it reflected the September 18, 2008 diagnosis of ventral hernia as well as the newly-prescribed Prevacid, it did not address the GI specialist's recommendation for further assessment of her air swallowing.			
	During the Exit Conference that evening, which began at 6:22 PM, the QMRP acknowledged that to date, she had not been aware of the GI specialist's September 18, 2008 recommendation for further assessment and, therefore, it had not been brought to the attention of Client #3's PCP, psychologist or the psychiatrist.			
W 331	483.460(c) NURSING SERVICES	W 331		
	The facility must provide clients with nursing services in accordance with their needs.			
	This STANDARD is not met as evidenced by: Based on interview and record review, facility nurses failed to ensure that each client's health and medical needs were monitored and coordinated effectively, for two of the three clients in the sample. (Clients #2 and #3)			
	The findings include:			
	1. Cross-refer to W322. Nursing staff failed to ensure that Client #2's home and day program had ProAir (albuterol) inhalers that was		1. See response to W322 #1 and #2.	

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	09G159		03/19/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 02	5613 6TH STREET, NW WASHINGTON, DC 20012

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W 331	Continued From page 13 prescribed "as needed" for wheezing/ shortness of breath. On March 18, 2009, Client #2's day program was without a ProAir inhaler. Similarly, there was no inhaler in the home.	W 331		
	2. Cross-refer to W322.3. The facility's nursing staff failed to seek clatification regarding Client #2's diagnosis of asthma and/or bronchitis.		2. See response to W322 #3.	5/1/09
	3. Cross-refer to W322.4 The facility's nursing staff failed to follow-up on a recommendation for further assessment of Client #3's air swallowing behavior.		3. See response to W159 #3.	5/1/09
W 382	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration.	W 382	The Designated Nurse will ensure that all medication nurses keep the cabinet locked; if she finds that locks need to be replaced she will ensure that the replacement occurs on the same date that the need is discovered.	5/1/09
	This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to keep all drugs locked securely when not being prepared for administration. The finding includes: On March 17, 2009, the medication nurse was already in the facility and administering morning medications when the survey was initiated, at 6:27 AM. The nurse left before breakfast was served. At 8:43 AM, the clients and staff left in the facility van for day programs. At approximately 8:57 AM, it was observed that the combination lock on one of the two medication cabinets had not been clicked shut. At 9:56 AM, the Designated Nurse and the Qualified Mental Retardation Professional looked at the medication			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 382	Continued From page 14 cabinet and confirmed that the lock had not been properly secured. The Designated Nurse locked it, stating that 3 of the 6 clients' medications were kept stored in that cabinet. Note: On March 18, 2009, at 2:00 PM, the Designated Nurse stated that they had replaced the 2 padlocks on the medication cabinets. Both locks were properly secured when examined a few minutes later.	W 382		
W 449	483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with evacuation drills and take corrective action. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to investigate client refusals to cooperate with staff during evacuation drills and take corrective action, for one of the six residents of the facility. (Client #3) The findings include: On March 17, 2009, at 10:27 AM, the Qualified Mental Retardation Professional (QMRP) stated that Client #3 had been admitted to the facility in early June 2008. Beginning at 4:07 PM later that day, review of the facility's fire drill evacuation records revealed that staff had documented Client #3 refused to get out of bed during overnight drills on September 25, 2008, November 25, 2008 and February 26, 2009. On the lower right corner of the form used to document each fire drill were the words "Reviewed by:" followed by a line for Signature/Title/Date. None of the 22 fire drill reports completed during the period April 6, 2008	W 449	The QMRP will review copies of the Careco policies and forms regarding evacuation drills that were updated and forwarded on August 26, 2008. The QMRP will train staff and ensure that they adhere to the policy.	5/1/09

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	09G159		03/19/2009

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W 449	Continued From page 15 - March 17, 2009, including the 3 aforementioned drills, reflected a review signature and title with date. On March 18, 2009, at 9:15 AM, review of the facility's written policy on fire drills (dated 03/00) revealed the following: "The person in charge on the shift evaluates the drill and makes appropriate recommendations." The policy did not, however, specify if, how, when or by whom drill report forms should be reviewed by management. Moments later, at 9:17 AM, interview with a direct support staff person who had participated in the overnight drills confirmed that Client #3 had refused to get out of bed and participate. When asked if management had offered guidance or direction regarding strategies that might be used to elicit the client's cooperation, the staff person replied "no." She further indicated that while she thought that someone higher up reviewed the forms, she wasn't sure who that was. When interviewed on March 18, 2009, at 10:07 AM, the QMRP stated "I look at the fire drills, make notes... talk to staff about it... No one has brought any problems to my attention..." She indicated that she was previously unaware that Client #3 refused to cooperate during overnight drills and acknowledged that to date, no actions had been taken to address the problem. When asked whether facility policies addressed investigating problems with fire drills, she said wasn't sure; however, she agreed to review their policies. On March 19, 2009, at 5:49 PM, the QMRP stated that she had not located a policy regarding administrative review of fire drill records and investigating problems identified by direct support staff.	W 449		

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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 03/19/2009
NAME OF PROVIDER OR SUPPLIER CARECO 02	STREET ADDRESS, CITY, STATE, ZIP CODE 6613 6TH STREET, NW WASHINGTON, DC 20012		

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I 000	INITIAL COMMENTS A licensure survey was conducted from March 17, 2009 through March 19, 2009. The Group Home for Persons with Mental Retardation (GHMRP) had a resident population of six women with various disabilities. One resident had been admitted within the past year; therefore, she was included in the sample. Two additional women were selected randomly for inclusion in the sample. The findings of the survey were based on observations, interviews with residents, interviews with staff in the home and at three day program, as well as a review of resident and administrative records, including incident reports.	I 000		
I 082	3503.10 BEDROOMS AND BATHROOMS Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to equip all bathrooms used by residents with paper cups. The findings include: 1. On March 17, 2009, at 8:45 AM, the paper cup dispenser was empty in the restroom located on the main floor (next to Resident #1's bedroom). The cup holder was empty on March 18, 2009 at 9:30 AM, and on March 19, 2009 at 6:46 PM. 2. On March 19, 2009, at 10:13 AM, the paper	I 082	1. The QMRP will ensure that the paper cup holder has disposable cups loaded. She will review the shopping lists and receipts to ensure that a proper supply of cups is available, and will assign staff to keep the holder properly filled. 2. See response to #1 above.	5/1/09 5/1/09

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Marsha A. Thompson TITLE Director of Disability Services (X6) DATE 4/17/09

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I 082	Continued From page 1	I 082		
	cup dispenser in the bathroom located on the 2nd floor (adjacent to the steps leading to the office on the top floor) was empty. The cup holder was empty later that day, at 6:46 PM.			
I 090	3504.1 HOUSEKEEPING	I 090		
	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 of the facility in a safe, clean, orderly, and attractive manner.			
	The findings include:			
	First floor bathroom (next to Resident #1's bedroom).			
	1. On March 17, 2009, at 8:45 AM,			
	a. the caulking around the top edge of the bathtub was either missing or cracked;		1. (a) Maintenance will repair the caulking around the top edge of the bathtub.	5/1/09
	b. the picture frame hanging on the wall behind the toilet tank was broken and presented a potential safety hazard. The upper right and lower left corners were split, leaving sharp edges exposed. The frame was hanging loosely and appeared as if it could fall from the wall with only the slightest nudge; and,		1. (b) Maintenance or the QMRP will remove the picture frame from behind the toilet tank.	5/1/09
	c. A tile was broken and missing from the wall directly above/behind the hand sink. The exposed tile edge presented a potential safety		1. (c) Maintenance will replace the broken tile above/behind the hand sink.	5/1/09

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I 090	Continued From page 2 hazard. 2. The conditions cited above (bathtub caulking, broken picture frame and broken wall tile) were observed on March 18, 2009 at 9:30 AM and on March 19, 2009 at 6:46 PM. Upstairs bathroom: 1. the caulking around the top edge of the bathtub was either missing or cracked.	I 090	2. See responses to 1(a), 1(b), and 1(c) above. 1. Maintenance will repair the caulking around the bathtub.	5/1/09 5/1/09
I 097	3504.8 HOUSEKEEPING No cleaning agent, bleach, insecticide or any other poisonous, dangerous, or flammable material shall be accessible to a resident where access to such substance is contraindicated in the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, the GHMRP failed to ensure that cleaning agents were not accessible to the residents. The finding includes: On March 18, 2009, at 9:30 AM, a spray bottle of Clorox "Clean-Up" with bleach was observed in the vanity cabinet beneath the hand sink in the bathroom located on main floor (next to Resident #1's bedroom).	I 097	The QMRP will ensure that all poisonous or dangerous agents are kept locked and inaccessible to residents per Careco's policy.	5/1/09
I 204	3509.4 PERSONNEL POLICIES Each employee shall be given a copy of his or her job description to review and sign at the	I 204	The Human Resources Director will review the QMRP job description with the QMRP, and obtain her signature on it. She will provide the QMRP with a copy of her job description.	5/1/09

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I 204	Continued From page 3 beginning of employment. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to have on file for review current job descriptions for all new employees. The finding include: On March 17, 2009, the Qualified Mental Retardation Professional (QMRP), stated that she began working in that position in early November 2008. Review of the personnel files on March 19, 2008, beginning at 2:15 PM, revealed no evidence that she had been given a QMRP job description to review and sign at the time that she was promoted. During the Exit Conference, which began at 6:22 PM later that day, the QMRP confirmed that she had not been given a copy of her job description.	I 204		
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 GHMRP failed to ensure that each employee provided evidence of a current 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	I 206	The Human Resources Director will ensure that all nurses have updated health inventories on file.	5/1/09

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I 206	Continued From page 4 the required duties, for 5 of the 8 nurses employed by the facility. The findings include: On March 19, 2009, beginning at 4:31 PM, review of the personnel files made available revealed expired health certificates for the following nurses, as follows: N1 - expired December 22, 2007 N2 - none in record N3 - expired November 9, 2008 N5 - expired April 2, 2008 N6 - expired October 15, 2008 During the Exit Conference, which began at 6:22 PM later that day, neither the QMRP nor the Designated Nurse could verify that the 5 nurses identified above had obtained updated health inventories as certified by a licensed physician. This is a repeat deficiency. ********** Previously, the annual licensure deficiency report dated April 25, 2008 included the following: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the GHMRP's personnel files on April 24, 2008 at 2:39 PM revealed the GHMRP failed to provide evidence that current health certificates were on file for one staff, one nurse, and three consultants. It should be noted that interview was conducted with the Director of Disability Services and further record review on April 25, 2008 additionally failed to provide evidence of the required physician's certifications.	I 206		

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I 291	3514.2 RESIDENT RECORDS Each record shall be kept current, dated, and signed by each individual who makes an entry. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure entries in each resident's record were dated and/or maintain accurate physician's orders, for two of the three residents in the sample. (Residents #2 and #3) The findings include:	I 291		
	1. On March 17, 2009, at 10:27 AM, interview with the Qualified Mental Retardation Professional (QMRP) revealed that Resident #3 had been admitted to the facility in early June, 2008. On March 19, 2009, at 12:51 PM, review of Resident #3's habilitation record revealed that the psychologist and behavior specialist had signed but not dated her 1st and 2nd quarterly reviews, for periods July 16, 2008-October 17, 2009 and October 18, 2008-January 30, 2009, respectively.		1. See response to W114.	5/1/09
	2. On March 18, 2009, at approximately 11:40 AM, review of Resident #2's February 2009 physician's orders (POs) revealed that they did not accurately reflect her known diagnoses. Specifically, her POs failed to reflect allergic rhinitis and status post asthma, for which she was prescribed several daily and/or PRN ("as needed") medications.		2. See response to W159.	5/1/09
I 391	3520.2(a) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor	I 391	See responses to federal deficiencies W159, W 322, W331, and W382.	5/1/09

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I 391	Continued From page 6	I 391		
	necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (a) Medicine; This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to provide medical services to ensure the health and safety needs of Clients #2 and #3. The findings include: 1. The facility's medical team failed to develop and implement a plan to ensure that Resident #2's ProAir (albuterol) inhaler was available for use as needed, in accordance with physician's orders (POs), as follows: Cross-refer to Federal Deficiency Report - Citation W322. According to Resident #2's Individual Support Plan, dated July 17, 2008, ProAir inhalant was prescribed for "wheezing/ shortness of breath." Her February 2009 POs reflected the following: "ProAir HFA MDI 8.5 mg 2 puffs by mouth as needed up to 4 times daily... <started> July 27, 2007." On March 18, 2009, however, observations and interviews at the resident's day program and in the home, at 12:01 PM and 2:18 PM respectively, revealed that there were no ProAir inhalers onsite and available for use in either location. There was no documented evidence that the facility had addressed the			

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I 391	Continued From page 7	I 391		
	resident's order for PRN ProAir with the her day program, to ensure availability of the treatment during her (approximate) 5 hours spent there every weekday. The Designated Nurse (DN) confirmed this during the March 18, 2009 interview, which began at 1:59 PM. On March 19, 2009, at 5:51 PM, the DN stated that the RN had brought a ProAir inhaler to the facility earlier that day. At 6:01 PM, however, she acknowledged that the facility had not sent one to the day program, stating further "we have had to order another one." 2. The facility's medical team failed to obtain and document a clear and accurate diagnostic profile regarding Resident #2's history of asthma and/or bronchitis, as follows: a. On March 18, 2009, at approximately 11:40 AM, Resident #2's day program IPP, dated August 1, 2008, reflected a diagnosis of asthma. At approximately 2:38 PM, the Qualified Mental Retardation Professional (QMRP) stated that she did not recall Resident #2 having a history of asthma. b. At 3:34 PM, review of Resident #2's Individual Support Plan (ISP), dated July 17, 2008 revealed the following: "There was an ER visit, during which she was diagnosed with asthma. However, after follow-up with a pulmonary specialist, it was determined that she had a case of bronchitis, which was resolved. She continued to have a PRN order for an inhaler to treat wheezing if it occurs..." At approximately 4:05 PM, review of a November 7, 2007 consultation report revealed that the pulmonary specialist wrote "history of asthma... complains of shortness of breath with			

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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 03/19/2009
NAME OF PROVIDER OR SUPPLIER CARECO 02	STREET ADDRESS, CITY, STATE, ZIP CODE 6613 6TH STREET, NW WASHINGTON, DC 20012		

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I 391	Continued From page 8 climbing...uses inhaler rarely... findings: treated asthma stable... recommend continue pm albuterol, exercise, low calorie diet/weight loss." There was no indication, however, that the pulmonary specialist had changed the diagnosis to bronchitis. On March 19, 2009, at 11:50 AM, the DN looked at the consultation report and stated that the pulmonary specialist wrote "history of asthma." She then pointed to the words "status post asthma" on Resident #2's January 20, 2009 Nursing quarterly. [Note: A post-survey review of incident reports confirmed a June 20, 2007 ER visit. However, the report indicated that Resident #2 left the ER with diagnoses of both asthma and bronchitis. This did not correspond with what had been written in her ISP by the former QMRP.] c. At 2:20 PM, Resident #2's Health Management Care Plan (HMCP), dated June 10, 2008 (revised most recently on February 22, 2009), failed to reflect a diagnosis of either asthma or bronchitis, past or present. Instead, the HMCP indicated the ProAir (albuterol) was used to treat her history of persistent allergic rhinitis. The DN stated that "it makes sense" for use of ProAir to treat allergies. d. At 3:55 PM, review of Resident #2's Annual Physical Examination report, dated July 8, 2008, revealed that it failed to reflect a diagnosis of either asthma or bronchitis, past or present. The resident had since been assigned a new primary care physician (PCP) in October 2008. The PCP's progress notes, however, failed to reflect a diagnosis of either asthma or bronchitis, past or present. The PCP's notes also showed no evidence that the question of current or accurate pulmonary diagnosis had been identified since she had been assigned.	I 391		

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I 391	Continued From page 9	I 391		
	e. At 4:11 PM, review of Resident #2's Annual Nursing Assessment, dated June 10, 2008, as well as quarterly nursing reports dated September 16, 2008 and January 20, 2009 revealed that all 3 documents showed ProAir "as needed for asthma." However, further review of the Annual Nursing Assessment revealed "status post asthma" was listed as a diagnosis. None of the nurse reports made reference to bronchitis, which had been written in her ISP by the former QMRP.			
	f. Although Resident #2's February 2009 POs included the following: "ProAir HFA MDI 8.5 mg 2 puffs by mouth as needed up to 4 times daily... <started> July 27, 2007," the POs did not indicate the reason why the ProAir (albuterol) was prescribed. The listed diagnoses on her POs also did not reflect a diagnosis of either asthma or bronchitis, past or present.			
	g. There was no evidence that a licensed physician had evaluated Resident #2's pulmonary status since November 7, 2007 to clarify the existing diagnosis.			
	3. The facility's medical team failed to follow-up on a recommendation for further assessment of Resident #3's air swallowing behavior, as follows:			
	According to interviews with the QMRP and the DN, and verified through record review, Resident #3 was admitted to the facility on June 3, 2008. Resident #3 was observed in the home on March 17, 2009 from 7:15 AM - 8:35 AM and again from 3:08 PM - 6:23 PM. She was of thin build. Her abdomen, however, protruded noticeably.			
	a. On March 19, 2009, at 11:59 AM, review of			

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	her HMCP revealed that it had been updated on September 18, 2008, following assessment earlier that same day by a gastro-intestinal specialist. The purpose of the visit was cited as "Assessment of habitual air swallowing with mild abdominal distention." The GI specialist wrote the following: "mouth breather... increased air in the stomach... recommend speech pathologist evaluated for behavioral therapy but I'm not sure patient will be able to participate. That assessment needs to be made by her psychologist/ psychiatrist/ PCP." He also diagnosed a ventral hernia and recommended Prevacid daily "to protect esophagus." The GI consultant report had not been initialed or signed and dated by a PCP, which was how the nurse indicated the PCP routinely documented his or her review.			
	b. At 3:10 PM, review of Resident #3's psychological records revealed no evidence that the psychologist had been made aware of the recommendation. Her Nursing Admission Assessment, dated June 3, 2008, as well as a January 10, 2009 Nursing Quarterly both cited "abdominal distention" and included the following: "Swallows air frequently. Passes flatulence very frequently." The January 10, 2009 Nursing Quarterly also cited the September 18, 2008 GI consultation; however, the RN wrote "none" regarding "Recommendations/ Follow-Up Appointment."			
	c. Further review of her HMCP revealed that while it reflected the ventral hernia and newly-prescribed Prevacid, it did not address air swallowing or the recommended follow-up assessment.			
	d. Further review of PCP and nurse progress			

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I 391	Continued From page 11 notes failed to show evidence that the GI specialist's recommendation for further assessment had been brought to the PCP's attention. e. There was no documented evidence of contacts with the Speech Pathologist since the time she conducted Resident #3's June 25, 2008 initial assessment (3 months prior to the GI appointment). f. At 12:39 PM, the DN acknowledged that the September 18, 2008 recommendation for further assessment had not been brought to the PCP's attention. g. At 1:09 PM, review of the QMRP monthly summary report dated October 10, 2008 revealed that while it reflected the September 18, 2008 diagnosis of ventral hernia as well as the newly-prescribed Prevacid, it did not address the GI specialist's recommendation for further assessment of her air swallowing. During the Exit Conference that evening, which began at 6:22 PM, the QMRP acknowledged that to date, she had not been aware of the GI specialist's September 18, 2008 recommendation for further assessment and, therefore, it had not been brought to the attention of Resident #3's PCP, psychologist or the psychiatrist.	I 391		
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.	I 500		

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I 500	Continued From page 12	I 500		
	This Statute is not met as evidenced by: Based on observations, interviews and record review, the GHMRP failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) that governs the care and rights of persons with mental retardation. The findings include: 1. The facility failed to demonstrate protection of 5 of the 6 residents' right to be free from unnecessary or excessive medication; specifically, psychotropic medications. [Title 7, Chapter 13, § 7-1305.05(h), formerly § 6-1965(h)], as follows: a. On March 18, 2009, at 11:34 AM, review of Resident #2's physician's orders (POs) revealed that they were dated February 1, 2009. There were no POs for the month of March. Further review revealed previous POs dated July 1, 2008 and October 1, 2008. All 3 POs included the statement "All orders in effect for 90 days." Resident #2's prescribed medication regimen included the psychotropic medications Abilify, 10 mg every evening, Divalproex DR 250 mg twice daily, Paroxetine 20 mg every evening, and Clonazepam 0.5 mg three times daily. b. On March 19, 2009, at approximately 3:46 PM, review of Resident #1's POs revealed similar findings (July 2008, October 2008 and February 2009 "in effect for 90 days"). Resident #1's regimen included Alprazol ER 2 mg every night, Gabapentin 600 mg three times daily, Buspirone 30 mg three times daily, Risperidone 3 mg twice daily and Divalproex DR 500 mg twice daily.		1. The facility psychiatrist renews psychotropic medication prescriptions (other than those for seizure control) every month, per Careco and District policy and regulation. The PCP may order medications (other than psychotropics prescribed to support an Axis 1 diagnosis) for longer than 30 days, thus the note regarding the 90-day life of the orders. This notation will be clarified on the physician orders.	5/1/09

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I 500	Continued From page 13 c. During the March 17, 2009 Entrance Conference, at approximately 10:00 AM, the facility's Qualified Mental Retardation Professional (QMRP) and the Designated Nurse (DN) had indicated that all 6 residents were prescribed psychotropic medications. The survey findings revealed that 5 of the 6 residents received psychotropics. (Resident #3's Depakote was prescribed for seizure control.) On March 19, 2009, at approximately 5:52 PM, further interview with the QMRP and the Designated Nurse revealed that neither was aware of a May 2008 notification letter that was sent to every licensed residential facility from the Health Regulation Administration reminding them of the requirement to set a termination date not to exceed 30 days for all prescribed psychotropic medications. 2. The facility failed to demonstrate protection of residents' rights to receive prompt and adequate medical attention. [Title 7, Chapter 13, § 7-1305.05(g), formerly § 6-1965(g)] as follows: a. The facility's medical team failed to develop and implement a plan to ensure that Resident #2's ProAir (albuterol) inhaler was available for use as needed, in accordance with physician's orders (POs), as follows: Cross-refer to I391.1. According to Resident #2's Individual Support Plan, dated July 17, 2008, ProAir inhalant was prescribed for "wheezing/ shortness of breath." Her February 2009 POs reflected the following: "ProAir HFA MDI 8.5 mg 2 puffs by mouth as needed up to 4 times daily... <started> July 27, 2007." On March 18, 2009, however, observations and interviews at the	I 500	2. See response to federal deficiencies W159, W322, W331 and W382.	5/1/09

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I 500	Continued From page 14	I 500		
	resident's day program and in the home, at 12:01 PM and 2:18 PM respectively, revealed that there were no ProAir inhalers onsite and available for use in either location. There was no documented evidence that the facility had addressed the resident's order for PRN ProAir with the her day program, to ensure availability of the treatment during her (approximate) 5 hours spent there every weekday. The DN confirmed this during the March 18, 2009 interview, which began at 1:59 PM.			
	b. The facility's medical team was unable to ensure that Resident #2 received ProAir (albuterol) treatment immediately should she develop signs/ symptoms of "wheezing or shortness of breath," as follows:			
	On March 18, 2009, beginning at 1:59 PM, interview with the Designated Nurse (DN) revealed that the inhaler was usually secured under lock and key in a medication cabinet at all times, with keys held only by nursing staff. She acknowledged that nurses only came to the facility to administer morning, evening and bedtime medications and the facility did not employ Trained Medication Employees. She further acknowledged that the ProAir inhaler would not be accessible for at least 30 minutes, perhaps longer, should Resident #2 begin experiencing symptoms and there was no nurse in the facility at the time.			
	c. Cross-refer to I391.2. The facility's medical team failed to obtain and document a clear and accurate diagnostic profile regarding Resident #2's diagnosis of asthma and/or bronchitis.			
	d. The facility's medical team failed to follow-up on a recommendation for further assessment of			

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I 500	Continued From page 15 Resident #3's air swallowing behavior. Cross-refer to I391.3. On March 19, 2009, at 11:59 AM, review of Resident #3's HMCP revealed that it had been updated on September 18, 2008, following assessment earlier that same day by a gastro-intestinal specialist. The purpose of the visit was cited as "Assessment of habitual air swallowing with mild abdominal distention." The GI specialist wrote the following: "mouth breather... increased air in the stomach... recommend speech pathologist evaluated for behavioral therapy but I'm not sure patient will be able to participate. That assessment needs to be made by her psychologist/ psychiatrist/ PCP." He also diagnosed a ventral hernia and recommended Prevacid daily "to protect esophagus." The GI consultant report had not been initialed or signed and dated by a PCP, which was how the nurse indicated the PCP routinely documented his or her review. Subsequent review of Resident #3's medical, psychological records or habilitation records revealed no evidence that the psychologist, speech pathologist, psychiatrist or PCP had been made aware of the recommendation. At 12:39 PM, the DN acknowledged that the September 18, 2008 recommendation for further assessment had not been brought to the PCP's attention. During the Exit Conference that evening, which began at 6:22 PM, the QMRP acknowledged that to date, she had not been aware of the GI specialist's September 18, 2008 recommendation for further assessment and, therefore, it had not been brought to the attention of Resident #3's PCP, psychologist or the psychiatrist.	I 500		

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R 000	INITIAL COMMENTS A licensure survey was conducted from March 17, 2009 through March 19, 2009. The Group Home for Persons with Mental Retardation (GHMRP) had a resident population of six women with various disabilities. One resident had been admitted within the past year; therefore, she was included in the sample. Two additional women were selected randomly for inclusion in the sample. The findings of the survey were based on observations, interviews with residents, interviews with staff in the home and at three day program, as well as a review of resident and administrative records, including incident reports.	R 000		
R 122	4701.2 BACKGROUND CHECK REQUIREMENT Except as provided in section 4701.6, each facility shall obtain a criminal background check, and shall either obtain or conduct a check of the District of Columbia Nurse Aide Abuse Registry, before employing or using the contract services of an unlicensed person. This Statute is not met as evidenced by: Based on interview and review of personnel records, the GHMRP failed to ensure criminal background checks had been obtained before employing or using the contract services of an unlicensed person, for 1 out of 18 direct support staff employed. (S7) The findings include: On March 17, 2009, at 10:15 AM, the Qualified Mental Retardation Professional agreed to provide documentation needed to show evidence of criminal background checks for all staff	R 122	The Human Resources Director will ensure that a criminal background check is completed per regulation for each employee prior to start of employment.	5/1/09

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Director of Disability Services — (X6) DATE: 4/17/2009

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R 122	Continued From page 1 employed in the facility. On March 19, 2009, beginning at 2:15 PM, review of one direct support staff person's personnel record (S7) revealed no documentation available to verify that a background check had been obtained prior to employment. Note: The file contained a job description which the staff person had signed on March 17, 2008. It should be noted that there were 5 other direct support staff (S5, S12, S14, S15 and S16) for which there was no evidence of comprehensive criminal background checks, to include all jurisdictions in which he/she lived or worked (see R125).	R 122		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on the review of personnel records, the GHMRP failed to ensure criminal background checks for all jurisdictions in which the employees had worked or resided within the seven (7) years prior to the check. The findings include: On March 17, 2009, at 10:15 AM, the Qualified Mental Retardation Professional agreed to provide documentation needed to show evidence of criminal background checks for all staff employed in the facility. On March 19, 2009,	R 125	The Human Resources Director will ensure that a criminal background check is completed for each prospective employee or contract worker per this statute.	5/1/09

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R 125	Continued From page 2	R 125		
	beginning at 2:15 PM, review of the materials presented revealed the following: 1. A background check for Prince Georges County, MD had been documented for S5. However, her personnel records indicated that she had worked in Montgomery County, MD from July 19, 2004 up until she applied for employment on July 18, 2008. There was no evidence, however, that a background check had been obtained in that jurisdiction. 2. A District of Columbia background check had been documented for S12. However, his personnel records indicated that he had lived and worked in Houston, Texas from January 12, 2008 until December 8, 2008. There was no evidence, however, that a background check had been obtained in that jurisdiction. 3. A District of Columbia background check had been documented for S14. However, her personnel records indicated that she had worked in Chantilly, Virginia from November 2005 until May 2006. There was no evidence, however, that a background check had been obtained in that jurisdiction. 4. Background checks for Prince Georges and Montgomery Counties in MD, as well as Nebraska and North Dakota had been documented for S15. However, her personnel records indicated that she had worked in the District of Columbia from February 2005 until May 2007. There was no evidence, however, that a background check had been obtained in the District of Columbia. 5. A background check had been documented for S16 in Prince Georges County, MD. Her			

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R 125	Continued From page 3 personnel records indicated that she had been employed by a GHMRP in the District of Columbia from 2001 until she applied with this facility on April 24, 2008. There was no evidence, however, that a background check had been obtained in the District of Columbia. This is a repeat deficiency. ********** Previously, the annual licensure deficiency report dated April 25, 2008 included the following: Interview with the Director of Disability Services and review of the GHMRP's personnel records on April 25, 2008, at approximately 7:35 PM revealed that the GHMRP failed to provide evidence that criminal background checks were on file and disclosed a seven year history of all the jurisdictions where the employee resided and worked for three staff.	R 125		