PRINTED: 09/12/2008
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: 09G167	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2008
NAME OF PROVIDER OR SUPPLIER CARECO 10		STREET ADDRESS, CITY, STATE, ZIP CODE 1613 TAYLOR STREET, NW WASHINGTON, DC 20011	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF 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 August 18, 2008, through August 21, 2008. The survey was initiated using the full survey process. A random sample of three clients was selected from a residential population of four women and two men with mental retardation and other disabilities. The findings of the survey were based on observations, interviews at the facility and at three day programs, and a review of records, including unusual incident reports.	W 000	Received 9/29/08 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 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the rights of each client and/or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment, for one of the three clients (Client #2) included in the sample. The finding includes: The facility failed to provide evidence that informed consent was obtained from Client #2 and/or her legal guardian for her psychotropic medications and Behavior Support Plan (BSP).	W 124	The QMRP will ensure that informed consent is obtained from the client and/or decision maker for psychotropic medications and behavior support plans.	10/21/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marsha H. Thompson
TITLE: Director of Disability Services
(X6) DATE: 9/29/08

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 124	Continued From page 1 Observation of the evening medication administration on August 19, 2008 at 5:09 PM revealed Client #2 received medication including Benztropine mg. Interview with the medication nurse during the medication administration revealed the aforementioned medications were used to address the client's behaviors. Interview with the Qualified Mental Retardation Professional (QMRP) on August 19, 2008, at 11:36 AM revealed that Client #2 did not have the capacity to give informed consent for the use of medications and habilitation services. The QMRP's statement was verified on August 21, 2008, at 10:12 AM through review of Client #2's psychological assessment dated August 9, 2008. According to the assessment, Client #2 "is not able to make independent decisions concerning her treatment plan; financial affairs, living arrangement or day placement. She lacks the cognitive and academic skills necessary to understand the implications of such decision, and therefore cannot give her informed consent in regards to these matters. She likewise cannot execute a durable of power of attorney." Review of Client #2's medical record on August 20, 2008 at 3:48 PM revealed a written physician's order dated July 2008, that documented the client was also prescribed Abilify 10 mg each morning. Interview with the QMRP during the entrance conference on August 19, 2008, revealed Client #2 did not have a guardian, but a hearing to obtain a legal guardian was pending. The QMRP revealed that the facility had attempted to contact the client's family, but were	W 124		

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W 124	Continued From page 2 unsuccessful Record verification on August 21, 2008, at 10:1 AM revealed a generalized letter sent to Client #2's family dated October 5, 2007. Further review of the letter revealed that the client's family was being notified that the "resident must have on file signed consent forms which must be updated annually or whenever there is a change in medication or dosage." Additionally, continued review of the letter revealed a consent form attached to the letter identifying the prescribed psychotropic medication (Abilify 10 mg once daily) and a copy of client #2's BSP. At the time of the survey, the facility failed to provide evidence that informed consent was obtained from the client and/or legally authorized representative for the psychotropic medications and her BSP	W 124		
W 126	483.420(a)(4 PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure clients were being taught to manage their finances to the best of their abilities, for one of the three clients (Client #3) included in the sample. The findings include: Interview with the Qualified Mental Retardation Professional QMRP) on August 19, 2008, at 11:36 AM revealed that Client #3 was not capable of managing his finances. Further interview with	W 126	The QMRP will assess the clients' ability to manage their own finances and will ensure that appropriate training programs to improve their skill levels are developed and implemented.	10/21/08

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W 126	Continued Fro n page 3 the QMRP on August 21, 2008 at 1:59 PM revealed the f cility was responsible for managing the client's fin nces in collaboration with the Department o Disability Services (DDS). The QMRP additic nally revealed the client received Supplemental Security Income (SSI) in the amount of $1(0.00 monthly. Review of the client's bank s tatements on August 21, 2008 at 4:05 PM verif ed the monthly SSI. On August 21 2008, at 4:05 PM the client's money mana ement skills assessment was reviewed and revealed the following skill needs: - Dependent n identifying the type and number of coins need ed to make a purchase from a vending mach ine. - Dependent n budgeting available money. Additional int rview with the QMRP and further review of the assessment revealed that although the client was capable of carrying cash ($1.00), there was no evidence that the client had been assessed to determine his understanding of the complete val e of the money ($1.00). There was no evidence Client #3 was assessed to determine his understanding of coin denominations and/or combinations. Furthermore, at the time of the survey, the f cility failed to provide evidence that Client #3 was being provided with money managemen training to increase his skills in that domain.	W 126		
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.	W 130	The QMRP will retrain staff on clients' right to privacy.	10/21/08

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W 130	Continued From page 4	W 130		
	This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure each client's right to privacy, for one of the three clients (Client #1) included in the sample. The finding includes: Observation on August 19, 2008, at 4:08 PM revealed the direct care staff escorting Client #1 to the facility's bathroom. The staff was observed to assist the client to sit on the toilet with the bathroom door opened. The staff stood in the doorway of the bathroom with the door opened, while Client #1 sat on the toilet. The facility failed to ensure Client #1 was provided privacy.			
W 137	483.420(a)(1) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the right of each client to retain the use of adequate clothing, for one of the three clients (Client #1) included in the sample. The finding includes: Observation of Client #1 on August 19, 2008, at 5:19 PM revealed the client walking to the living room. It should be noted that the client had just arrived to the facility from her day program. She	W 137	The QMRP will retrain staff to assist clients to choose appropriate clothing.	10/21/08

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W 137	Continued From page 5 was observed wearing a pair of sheer pink pants that exposed her undergarments. Interview was conducted with the direct care staff on the aforementioned date revealed the overnight shift was responsible for assisting Client #2 with selecting her clothes. At the time of the survey, the facility failed to ensure the client wore adequate clothing that did not expose the client's undergarments.	W 137		
W 140	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. This STANDARD is not met as evidenced by: Based on interview and the record review, the facility failed to provide evidence that assured a system had been established that maintained a complete accounting of each clients' personal funds, for one of the three clients (Client #3) included in the sample. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) on August 19, 2008, at 11:36 AM revealed that Client #3 was not capable of managing his finances. Further interview with the QMRP on August 21, 2008, at 1:59 PM revealed the facility was responsible for managing the client's finances in collaboration with the Department of Disability Services (DDS). The QMRP additionally revealed the client received Supplemental Security Income (SSI) in the amount of $[illegible]00.00 monthly.	W 140	The QMRP will maintain receipts and other proofs that justify the client's expenditures from his community account.	10/21/08

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W 140	Continued From page 6 Continued interview with the QMRP and review of the facility's financial records on August 21, 2008, at 4:05 PM revealed $114.56 was withdrawn from the client's account on February 7, 2008. The QMRP was interviewed regarding the aforementioned withdrawal and at the time of the survey, failed to provide evidence that justified the withdrawal/expenditure from Client #3's personal account.	W 140		
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 ensure parents/guardians were notified of serious incidents, one of the three clients (Client #1) included in the sample. The finding includes: Review of the facility's incident reports on August 19, 2008, beginning at 9:50 AM revealed the following: On October 15, 2008 a direct care staff discovered a bruise on Client #1's lower lip. According to the report, the client was unable to explain or tell what happened. Interview with the QMRP during the entrance conference on August 19, 2008, at 11:36 AM	W 148	The Director of Disability Services will review incident policy implementation with the QMRP and home staff to ensure that they provide appropriate, timely notice of incidents to family members and others, and that investigations are completed and filed appropriately.	10/21/08

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W 148	Continued From page 7 revealed Client #1 had a sister that was involved in her care. At the time of the survey, however, the facility failed to provide evidence that Client #1's sister had been notified of the aforementioned incident.	W 148		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to implement policies that ensured the client's health and safety, for one of the three clients (Client #1) included in the sample. The finding includes: The facility failed to implement their Incident Management Policy (IMP) as evidenced below: Interview with the facility's Qualified Mental Retardation Professional (QMRP) and review of the facility's incidents reports on August 19, 2008, beginning at 1:11 PM revealed an incident report involving Client #1. Continued review of the incident revealed that on October 15, 2007, staff reported observing a "bruise" on the client's lower lip. Additionally, another incident dated November 15, 2007, revealed the staff discovered a month later that the Client #1 had another "swollen lip." According to the review of the incident dated November 15, 2007, the client was taken to a local emergency room where she was diagnosed with "lip contusion with edema." Both of the aforementioned incidents failed to	W 149	See response to W148.	10/21/08

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W 149	Continued From page 8 provide evidence that they had been investigated. Interview with the QMRP on August 19, 2008, at 3:09 PM revealed that the facility's Incident Management protocol requires the staff to fax the incident reports within twenty-four hours to their Incident Management Coordinator (IMC). Further interview with the QMRP revealed if the incident was regarded as a "serious reportable" incident the IMC would conduct an investigation. Review of the facility's Incident Management Policy and Procedure on August 20, 2008, revealed "all incidents will be investigated by [Provider] within 12 hours after the incident was witnessed, discovered or being informed that the incident has occurred." At the time of the survey, the facility failed to provide evidence that injuries of unknown origin was investigated.	W 149		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all injuries of unknown origin were thoroughly investigated, for one of the three clients (Clients #1) included in the sample. The findings include: Interview with the facility's Qualified Mental Retardation Professional (QMRP) and review of the facility's incidents reports on August 19, 2008,	W 154	See response to W 148.	10/21/08

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W 154	Continued From page 9 beginning at 9:50 AM revealed the following: a. On October 15, 2007, staff reported observing a "bruise" on Client #1's] lower lip. Further interview with the QMRP on August 19, 2008, revealed that she was not certain if the incident reported on October 15, 2008, had been investigated. b. On November 15, 2007, staff discovered Client #1's "lip was swollen." The client was taken to a local emergency room where she was diagnosed with "lip contusion with edema." According to the QMRP the incident reported on November 15, 2008, had not been investigated. At the time of the survey, the facility failed to provide evidence that the aforementioned incidents had been investigated.	W 154		
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative 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 interview and record review, the facility failed to ensure required investigations were reviewed by the administrator or designee within five working days, for one of the six clients (Client # #5) that resided in the facility. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the facility's	W 156	See response to W148.	10/21/08

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W 156	Continued From page 10 incidents reports and corresponding investigation reports on August 19, 2008, at 1:01 PM revealed the following: On October 2., 2007, staff reported discovering Client #5 with a bruise on her right shoulder and chest. According to the report, the client revealed that she fell. Review of the corresponding incident summary report investigation dated October 25, 2007, revealed the client indicated she "fell out back with another staff." The staff member referred to was the client's one to one support staff. Continued review of the incident summary report investigation revealed that staff were interviewed and no staff could substatiate the client's claim of falling or any such occurence that would have caused the client's injury. Further review of the summary report documented that Client #5 revealed the cause of the injury occurred from allegedly being removed off of the van. It was later determined, after Client #5 was seen by her primary care physician, that the injuries were consistent with that of "rug burns." The final results of the investigation revealed that the injuries were potentially caused by a mastabatory incident. Additional review of the incident summary report investigation dated October 25, 2007 revealed the report was completed by the Qualified Mental Retardation Professional (QMRP). Interview with the QMRP on August 19, 2008 beginning at 3:09 PM revealed the administrator was responsible for reviewing incident investigations within five days. At the time of the survey, the facility failed to provide evidence that the results of the aforementioned investigations were reviewed as	W 156		

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W 156	Continued From page 11	W 156		
	required.			
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL	W 159		
	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).			
	The findings include:			
	1. The QMRP failed to ensure Client #3 received a re-evaluation from the Speech Pathologist.		1. The QMRP will ensure that the Speech Language Therapist evaluates the client's training needs on the communication device, and provides recommendations, instruction, and technical assistance as required in order to implement such training.	10/21/08
	Observation of Client #3 on August 19, 2008 at 2:53 PM revealed the client plugging in his communication device after returning home from the day program. Interview with a staff member at 4:00 PM revealed that the client used the communication device to indicate he wanted a shave.			
	Review of Client #3's habilitation records on August 20, 2008, at 4:25 PM revealed the client had an Individual Support Plan (ISP) and corresponding Individual Program Plans (IPP) dated April 2, 2008. Further review of Client #3's IPP's revealed the client had a program that required him to use his communication device to answer a simple question. Interview with the Qualified Mental Retardation Professional (QMRP) and additional review of Client #3's			

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W 159	Continued From page 12 record (QMRP Monthly Notes) on August 20, 2008 at 5:20 PM revealed the client had achieved the aforementioned program in May 2008. Review of the June 2008 QMRP monthly note on August 20, 2008 revealed documentation that indicated that Client #3's usage of the communication device was to be re-evaluated by the Speech Pathologist to "determine the best training technique" for him. Continued interview was conducted with the QMRP to ascertain if the re-evaluation had been conducted. At the time of the survey, the facility failed to provide evidence that the Speech re-evaluation had been conducted. It should be additionally noted that the facility failed to provide evidence of any comprehensive Speech evaluation/assessment for Client #3.	W 159		
	2. The QMRP failed to ensure each client received continuous active treatment services. (See W249)		2. See response to W249.	10/21/08
	3. The QMRP failed to ensure that data was collected in the form and frequency required. (See W252)		3. See response to W252.	10/21/08
	4. The QMRP failed to ensure an exercise video was secured for Client #1.		4. The QMRP will obtain the exercise video for the client.	10/21/08
	Observation on Client #1 on August 19, 2008, at 4:49 PM revealed the client on the floor in the living room performing floor exercises with staff (stretches and sit-ups). The client was observed to perform the exercises independently with verbal prompts from the staff. Review of Client #1's habilitation records on August 21, 2008, at 1:39 PM revealed the client			

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W 159	Continued From page 13 had an Individual Support Plan (ISP) and corresponding Individual Program Plans (IPP) dated April 23, 2008. Further review of Client #1's IPP's revealed the client had a program that required her to use an exercise video to participate in exercises. Review of Client #1's available QMRP monthly notes for April 2008 to June 2008 or August 21, 2008, at 3:04 PM documented that video had not been secured. The QMRP was interviewed on August 21, 2008, at 3:09 PM to ascertain if the client had the specified video. The QMRP revealed the video had not been obtained. At the time of the survey, the facility failed to Client #1 was provided with the necessary video to complete her aforementioned exercise program.	W 159		
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 objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure each client received continuous active treatment services, including needed interventions for one of the three clients (Client #2) included in the sample. The findings include: Review of Client #2's habilitation record on	W 249	Henceforth the QMRP will ensure that as soon as the IDT accepts recommendations for active treatment, programming will be formulated and implemented.	10/21/08

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W 249	Continued From page 14 August 21, 2008, at 12:05 PM revealed an Individual Support Plan (ISP) dated August 15, 2008. Further review of the client's record revealed that at the time of the ISP meeting, the interdisciplinary team recommended a program objective for the client to independently get a cup of water to take her medication on 75% of trials per month for three months. Another program objective recommended was that Client #2 would prepare her lunch with verbal prompts on all sessions per month for three months, fives times a week. Continued review of the record revealed the Speech Therapist assessed Client #2 on June 25, 2008, and recommended that the client be encouraged to use signing in as many communication situations as possible. Additionally, the Speech Therapist also made a recommendation for the client to be encouraged to use auditory as well as sign language when engaging her in ADL activities. Client #2 was also assessed by the Physical Therapist on August 7, 2008. The Physical Therapist recommended that the client be engaged in physical activity, ball play, dancing and walking at a faster pace to increase her energy expenditure." Review of Client #2's program record revealed that the aforementioned recommendations had not been implemented. Interview with the Qualified Mental Retardation Professional (QMRP) was conducted on August 21, 2008, at :59 PM. The QMRP verified that the program objectives had not been implemented but that they would be implemented on the day of the survey (August 21, 2008). At the time of the survey, the facility failed to	W 249		

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W 249	Continued From page 15 ensure Client #2's new program objectives were implemented timely as required.	W 249		
W 252	483.440(e)(1 PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in current individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure data relative to the accomplishment of the criteria specified in each client's Individual Program Plan (IPP) objective was documented in measurable terms, for one of the three clients (Client #3) included in the sample. The findings include: 1. Observation of Client #3 on August 19, 2008 at 2:53 PM revealed the client plugging in his communication device after returning home from the day program. Interview with a staff member at 4:00 PM revealed that the client used the communication device to indicate he wanted a shave. Review of Client #3's habilitation records on August 20, 2008, at 4:25 PM revealed the client had an Individual Support Plan (FISP) and corresponding Individual Program Plans (IPP) dated April 2, 2008. Further review of Client #3's IPP's revealed the client had a program that required him to shave his face three times per week with verbal prompts. Review of the corresponding data collection record on August	W 252	1. The QMRP will ensure that data collection is monitored at least weekly, and will retrain staff on the requirement to collect data.	10/21/08

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W 252	Continued Fr m page 16 20, 2008 how ver, failed to provide evidence that data was beir g collected on the aforementioned program. Interview with the Qualified Mental Retardation Professional (QMRP) and additional review of Client #3's re ord (QMRP Monthly Notes date July 10, 2008 on August 20, 2008 at 5:20 PM revealed that here was no data for the shaving program for t e months of May 2008 and June 2008. The Q MRP was further queried to ascertain if th program was being implemented and she indic ated that the program was being conducted. A t the time of the survey, however, there was no documented evidence that the program was being conducted and data was being collect d. 2. Observati n on August 19, 2008, at 5:13 PM revealed the direct care staff assisting Client #2 in the kitcher The staff verbally prompted the client to sele t one of the cups from the countertop. The client was observed to select and pick up one of the cups independently. Client #2 was obse ved to turn on the water independentl and filled her cup. The client was observed to pour the water in the sink. The staff would encou age the client to hold the cup of water, but sh would continuously fill the cup with water and pc ur it out in the sink. The client refused to hc d the cup of water until it was time for her to rec ive her medication. Review of Cl ent #2's habilitation record on August 21, 2 08, at 12:05 PM revealed an Individual Su port Plan (ISP) dated August 15, 2008. Furth r review of the client's record revealed tha at the time of the ISP meeting, the interdisciplin ry team recommended a program	W 252	2. See response to W249 and W252 #1.	10/21/08

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W 252	Continued From page 17 objective for the client to independently get a cup of water to take her medication on 75% of trials per month for three months. Another program objective recommended was that Client #2 would prepare her lunch with verbal prompts on all sessions per month for three months, five times a week. Continued review of the record revealed the Speech Therapist assessed Client #2 on June 25, 2008, and recommended that the client be encouraged to use signing in as many communication situations as possible. Additionally, the Speech Therapist also made a recommendation for the client to be encouraged to use auditory as well as sign language when engaging her in ADL activities. Client #2 was also assessed by the Physical Therapist on August 7, 2008. The Physical Therapist recommended that the client be engaged in physical activity, ball play, dancing and walking at a faster pace to increase her energy expenditure." Interview with the Qualified Mental Retardation Professional (QMRP) was conducted on August 21, 2008, at :59 PM. The QMRP verified that the program objectives had not been implemented but that they would be implemented on the day of the survey (August 21, 2008). At the time of the survey, there was no documented evidence that the program was being conducted and data was being collected.	W 252		
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	W 263	See response to W124.	10/21/08

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W 263	Continued From page 18 minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's Human Rights Committee (HRC) failed to ensure written informed consent had been obtained from the client and/or their legal guardian for the use of behavior support plans, for one of the three clients (Client #2) included in the sample. The finding includes: Observation of the evening medication administration on August 19, 2008, at 5:09 PM revealed Client #2 received medication including Benztropine mg. Interview with the medication nurse during the medication administration revealed the aforementioned medications were used to address the client's behaviors. There was no evidence that written informed consents were obtained to use the above behavior medication as part of a behavior management program.	W 263		
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure evacuation drills were held quarterly on all shifts. The finding includes: Interview with the Qualified Mental Retardation	W 440	The QMRP will ensure that evacuation drills are held for each shift at least quarterly.	10/21/08

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W 440	Continued From page 19 Professional (QMRP) on August 19, 2008 at 2:45 PM revealed the direct care staff were assigned the following shifts of duty: Weekdays and Weekends 7:00 AM - 3:00 PM 3:00 PM - 11:00 PM 11:00 PM - 7:00 AM Review of the evacuation drill records on August 19, 2008 at 2:47 PM revealed the last evacuation drill for the morning shift (7:00 AM - 3:00 PM) was held on August 17, 2007 at 7:30 AM. Continued review of the evacuation drill records revealed the last evacuation drill for the evening shift (3:00 PM - 11:00 PM) was held on February 19, 2008 at 6:00 PM. Further interview was conducted with the QMRP that verified the aforementioned information and revealed that there were no other evacuation drill records. At the time of the survey, the facility failed to provide evidence that evacuation drills were conducted quarterly for each shift of personnel.	W 440		
W 448	483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with evacuation drills, including accidents. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed provide evidence that ensured problems with evacuation drills were investigated and addressed. The finding includes: Review of the evacuation drill records on August 19, 2008 at 2:47 PM revealed the design of the	W 448	The QMRP will review and sign drill records per policy, and when a Residential Director is hired for the facility, the QMRP will ensure that she/he is trained to manage the evacuation drill, and review the drill records. The QMRP will ensure that incidents, accidents, or needed repairs arise during the evacuation drills, they are investigated and addressed.	10/21/08

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W 448	Continued From page 20 evacuation drill records included a place for the signature of the person that completed the drill and required the signature of the person that reviewed the drill record. Continued review of the evacuation drills (from August 2007 through August 2008 failed to provide evidence that the drills records were reviewed. The Qualified Mental Retardation Professional (QMRP) was interviewed on August 19, 2008 to ascertain information regarding the person responsible for reviewing the evacuation drill records. The QMRP revealed that it was the role of the House Manager (HM) to review the records, but since the facility currently had no HM, the QMRP would be the responsible person. It should be noted that there was no evidence the evacuation drill records were reviewed for August 2007 through August 2008 Further review of the records revealed an evacuation drill dated November 19, 2007. According to the drill record, the staff documented that one of the lights was inoperable. Interview was conducted with the QMRP to ascertain if the light was repaired. The QMRP revealed that based on what was documented on the drill record, she was unaware of what light was in need or repair. When further queried to ascertain if the problem had been investigated the QMRP failed to be able to provide information and/or evidence that the issue had been addressed. At the time of the survey, the facility failed to provide evidence that problems associated with evacuation drills were addressed.	W 448		

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	HFD03-0160		08/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 10	1613 TAYLOR STREET, NW WASHINGTON, DC 20011

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I 000	INITIAL COMMENTS A relicensure survey was conducted from August 19, 2008, through August 21, 2008. A random sample of three residents was selected from a residential population of four females and two males with mental retardation and other disabilities. The survey findings were based on observations in the group home and at three day programs, interviews, and a review of records, including unusual incident reports.	I 000	Received 9/29/08 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to maintain the the facility in a clean, orderly, and attractive manner. The findings include: On August 21, 2008, interview with the Qualified Mental Retardation Professional and observation of the the environment beginning at 4:18 PM revealed the following: 1. The picnic table located in the backyard was observed to have a broken plank on the top of the table. The table also had an inoperable microwave oven resting on top of it. 2. There were three garbage cans observed at the top of the stairs in the backyard that were not covered. One can was observed to have a large	I 090	1. The QMRP will have the picnic table repaired or removed. The QMRP will have the micro wave oven removed. 2. The QMRP will ensure that trashcans are in good repair, and are covered with appropriate lids.	10/21/08 10/21/08

Health Regulation Administration

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

TITLE: Director of Disability Svcs

(X6) DATE: 9/29/08

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I 090	Continued From page 1 hole located at the top of the can. 3. There was a brick protruding from above the exterior rear exit doorway. 4. There were one inoperable television on the floor in the basement in the activity room.	I 090	3. The QMRP will ensure that the brick is removed or properly set in place. 4. The inoperable TV will be repaired or disposed.	10/21/08 10/21/08
I 189	3508.7 ADMINISTRATIVE SUPPORT Each GHMRF shall maintain records of residents' funds received and disbursed. This Statute is not met as evidenced by: Based on interview and the record review, the facility failed to provide evidence that assured a system had been established that maintained a complete accounting of each resident's personal funds, for one of the three residents (Resident #3) included in the sample. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) on August 19, 2008, at 11:36 AM revealed that Resident #3 was not capable of managing his finances. Further interview with the QMRP on August 21, 2008, at 1:59 PM revealed the facility was responsible for managing the resident's finances in collaboration with the Department of Disability Services (DDS). The QMRP additionally revealed the client received Supplemental Security Income (SSI) in the amount of $100.00 monthly. Continued interview with the QMRP and review of the facility's financial records on August 21, 2008, at 4:05 PM revealed $114.56 was withdrawn from the resident's account on February 7, 2008. The QMRP was interviewed regarding the	I 189	See response to federal deficiency W126.	10/21/08

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I 189	Continued From page 2 aforementioned withdrawal and at the time of the survey, failed to provide evidence that justified the withdrawal/expenditure from Resident #3's personal account.	I 189		
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure habilitation, training and assistance was provided to its residents in accordance with their Individual Habilitation Plan(s), for one of the three Residents (Resident #2) included in the sample. The finding includes: Review of Resident #2's habilitation record on August 21, 2008, at 12:05 PM revealed an Individual Support Plan (ISP) dated August 15, 2008. Further review of the Resident's record revealed that at the time of the ISP meeting, the interdisciplinary team recommended a program objective for the resident to independently get a cup of water to take her medication on 75% of trials per month for three months. Another program objective recommended was that Resident #2 would prepare her lunch with verbal prompts on all sessions per month for three months, five times a week. Continued review of the record revealed the Speech Therapist assessed Resident #2 on June 25, 2008, and recommended that the Resident be encouraged to use signing in as many communication situations as possible.	I 422	See response to federal deficiency W252	10/21/08

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I 422	Continued From page 3 Additionally, the Speech Therapist also made a recommendation for the resident to be encouraged to use auditory as well as sign language when engaging her in ADL activities. Resident #2 was also assessed by the Physical Therapist on August 7, 2008. The Physical Therapist recommended that the Resident be "engaged in physical activity, ball play, dancing, and walking at a faster pace to increase her energy expenditure." Review of Resident #2's program record revealed that the aforementioned recommendations had not been implemented. Interview with the Qualified Mental Retardation Professional (QMRP) was conducted on August 21, 2008, at 2:59 PM. The QMRP verified that the program objectives had not been implemented but that they would be implemented on the day of the survey (August 21, 2008). At the time of the survey, the GHMRP failed to ensure Resident #2's new program objectives were implemented timely as required.	I 422		

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Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0044	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/05/2008
NAME OF PROVIDER OR SUPPLIER: CMS	STREET ADDRESS, CITY, STATE, ZIP CODE: 5610 FIRST STREET NW WASHINGTON, DC 20011		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This licensure survey was conducted from September 3 2008 through September 4, 2008. Four male clients with varying degrees of disabilities reside in this facility. Two of the four clients were randomly selected for the sample. The findings of the survey were based on observations at the group home and two day programs, interviews with management and direct care staff in the residence and the review of the administrative records including the facility's incident management system.	R 000	Received 9/29/08 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
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 records, the GHMRP failed to ensure criminal background checks disclosed the criminal history of any 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. The findings include: Review of the personnel records on 9/5/08 at 1:30 PM revealed that the GHMRP failed to provide evidence that ensured criminal background checks were on file for one direct	R 125	The Director of Human Resources will ensure that criminal background checks are completed per regulations.	10/21/08

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

TITLE: Director of Disability Svcs

(X6) DATE: 9/29/08

PRINTED: 09/12/2008
FORM APPROVED

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R 125	Continued From page 1 care staff (#1 and the Qualified Mental Retardation Professional.	R 125		