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

PRINTED: 04/14/2010
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		03/26/2010

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 000	INITIAL COMMENTS	W 000	Received 4/27/10	
	A recertification survey was conducted from March 24, 2010 through March 26, 2010. The survey was initiated using the fundamental survey process. A random sample of three clients was selected from a population of six female clients with various levels of mental retardation and disabilities.		GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
	The findings of the survey was based on observations at the group home and three day programs, interviews with clients, staff, family members and the review of clinical and administrative records including incident reports.			
W 114	483.410(c)(4) CLIENT RECORDS	W 114		
	Any individual who makes an entry in a client's record must make it legibly, date it, and sign it.			
	This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all physician orders (PO) in clients' records were signed and dated by the primary care physician (PCP), for two of the three clients included in the sample. (Clients #1 and #3)			
	The findings include:			
	1. Review of Client #1's PO sheet on March 25, 2010, at 10:14 a.m., revealed a telephone order dated February 26, 2010, for Risperdal 0.5 mg, by mouth twice a day (in the morning and at bedtime)."		The Registered Nurse will delegate the LPN Coordinator the responsibility for acquiring the PCP signature on telephone orders to be in compliance with the standard.	5/10/10
	2. Review of Client #3's PO sheet on March 26, 2010, at 9:10 a.m., revealed a telephone order dated September 22, 2009 for a thyroid scan per		The Registered Nurse will delegate the LPN Coordinator the responsibility for acquiring the PCP signature on telephone orders to be in compliance with the standard.	5/10/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marsha H. Thompson
TITLE: Director of Disability Services
(X6) DATE: 4/26/10

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that er safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing 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 s following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued gram participation.

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W 114	Continued From page 1 ENT recommendation. Interview with the Register Nurse on March 26, 2010, at approximately 11:00 a.m., failed to provide an explanation as to why the PCP did not sign or date the orders.	W 114		
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to establish a system that would ensure clients, guardians were informed of their risks and benefits of clients restrictive measures, for two of three clients included in the sample. (Clients #1 and #3) The findings include: 1. The facility failed to ensure that informed consent was obtained from Client #1's family member prior to the administration of her psychotropic medications. During the entrance conference on March 24, 2010, beginning at 4:30 p.m., the Qualified Mental Retardation Professional (QMRP) indicated that Client #1 received psychotropic medications to address her maladaptive behaviors. Further interview revealed the client did not have the	W 124	1. The Director of Disability Services will retrain the QMRP on the process for gaining written informed consent from medical decision-makers prior to restrictive or invasive health or mental/behavioral health treatments.	5/10/10

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W 124	Continued From page 2 capacity to give informed consent for the use of medications and habilitation services. Review of the Client #1's March 2010, physician orders on March 25, 2010, at 10:14 a.m., revealed an order of Risperdal 0.5 mg, twice a day (in the morning and at bedtime). Interview with the Licensed Practical Nurse (LPN) on March 25, 2010, at approximately 11:00 a.m., revealed that the client "just" started Risperdal. The QMRP's statement was verified on March 25, 2010, at 1:25 p.m., through review of Client #1's psychological assessment dated July 16, 2009. According to the assessment, the client "does not evidence the capacity to make decisions on her own behalf in treatment, habilitation, residential placement, and financial matters." Further interview with the QMRP during the survey, revealed that the client had a family member that was involved in her habilitation planning and decision making process. Record verification on March 25, 2010, at 1:45 p.m., revealed that Client #1's family member had given informed consent for the use of Carbatrol 200 mg, twice a day and Depakote 125 mg, three times a day, both for seizure disorder. There was no evidence that informed consent had been obtained for client's current Risperdal 0.5 mg, twice a day. 2. The facility failed to ensure that informed consent was obtained from Client #3's family member prior to the administration of her psychotropic medications. During the entrance conference on March 24, 2010, beginning at 4:30 p.m., the Qualified Mental	W 124	2. See response to n#1 above.	5/10/10

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W 124	Continued From page 3 Retardation Professional (QMRP) indicated that Client #3 received psychotropic medications to address her maladaptive behaviors. Further interview revealed the client did not have the capacity to give informed consent for the use of medications and habilitation services. Observations during the medication administration on March 24, 2010, at 5:35 p.m., revealed Client #3 was observed taking her Depakote, Buspar, Cogentin, Neurontin and Risperdal. Review of Client #3's March 2010, physician order dated on March 26, 2010, beginning at 9:10 a.m., revealed an order of Xanax 2 mg, twice a day (in the morning and at bedtime), Depakote 500 mg, twice a day (BID), Neurontin 600 mg, three times a day (TID), Cogentin 1 mg, BID, Buspar 30 mg, TID and Risperdal 30 mg, twice a day. The QMRP's statement was verified on March 26, 2010, at 2:00 p.m., through review of Client #3's psychological assessment dated April 16, 2009. According to the assessment, the client "does not evidence the capacity to make decisions on her own behalf in treatment, habilitation, residential placement, and financial matters." Further interview with the QMRP during the survey, revealed that the client had a family member that was involved in her habilitation planning and decision making. Record verification on March 25, 2010, at 2:30 p.m., revealed that Client #3's family member had given informed consent on September 19, 2009, for the use of Xanax 3 mg once a day, Depakote 500 mg, BID, Neurontin 600 mg, TID, Cogentin 1	W 124		

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W 124	Continued From page 4 mg, BID, Buspar 30 mg, TID and Risperdal 30 mg, twice a day. There was no evidence that informed consent had been obtained for the client's Xanax 2 mg, twice a day.	W 124		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that injuries of unknown origin were reported to the administrator and to other officials in accordance with District law (22 DCMR, Chapter 35, Section 3519.10), for one of the three clients included in the sample. (Client #1) The finding includes: On March 25, 2010, at 10:10 a.m., review of a nursing note dated March 1, 2010, revealed that Client #1 had a 1/4 inch scratch on her shoulder blade. Interview with the licensed practical nurse (LPN) on March 25, 2010, at approximately 11:00 a.m., indicated that the house manager asked the nurse to assess the client's shoulder due to a scratch noted on her shoulder blade. The nurse assessed the client and provided first aid treatment. Further interview revealed that she did not know what happened to the client's shoulder nor did she complete an incident report. There was no evidence the facility reported the injury of	W 153	The QMRP will retrain the licensed practical nurse and the Residential Director (House Manager) on incident reporting and management.	5/10/10

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W 153	Continued From page 5 unknown origin immediately to the administrator.	W 153		
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 record reveiw and interveiw, the facility's qualified mental retardation profressional (QMRP) failed to coordinate client's medical appointments, for one of the three clients included in the sample. (Cleint #2) The finding includes: Review of Client #2 medical records on March 25, 2010, at 3:00 p.m., revealed a urology consult dated June 15, 2009. The diagnosis included a history of urinary incontinence. The recommendations were to continue the bladder schedule and return in six months. According to the record, the client had an appointment scheduled for January 20, 2010. However, the consult form reflected that the facility did not take her. Interview with the LPN on March 25, 2010, at approximately 4:00 p.m., revealed that an appointment was scheduled for June, 11, 2010. At the time of the survey, the QMRP failed to obtain an urology consult for Client #2 as recommended by the specialist.	W 159	The QMRP will attend grand rounds with the Residential Director and nursing staff so that she is aware of all scheduled appoints, and will ensure that resources are available so that appointments are kept.	5/10/10
W 193	483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions	W 193		

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W 193	Continued From page 6 to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on observations, staff interview and record verification, the facility's staff failed to demonstrate the skills and techniques necessary to implement each client's Behavior Support Plan (BSP), for one of the three clients in the sample. (Client #1) The finding includes: During the medication administration on March 24, 2010, beginning at 6:05 p.m., Client #1 was observed refusing her medications, by turning her head from side to side, after the medication nurse attempted to administer her medication. At 6:07 p.m., the licensed practical nurse (LPN) attempted to spoon fed the client her medications, again. The one to one support staff was observed gently holding the client's head in place and holding the client's hands in her lap, and stated, "Good girl," as the LPN continued the attempts to administer the medications. These attempts went on, continuously until 6:20 p.m. Interview with the LPN after the medication administration, revealed that Client #1 had a BSP to address her maladaptive behaviors. Interview with the qualified mental retardation professional (QMRP) on March 25, 2010, at approximately 10:00 a.m., indicated that the client had a BSP to address her maladaptive behaviors to include non-compliance (refusal to take medications). According to Client #1's Behavior Support Plan (BSP) dated July 16, 2009, the following procedures for non-compliance include:	W 193	The QMRP will request the Psychologist to revise the Behavior Support Plan to include both proactive strategies and interventions, and train staff on these methods, so that if/when the client has difficulty complying with medication administration, staff can properly support her.	5/14/10

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W 193	Continued From page 7 - Request to complete task(s) should be made in a positive and upbeat manner. - When she completes the appropriate tasks, she should be immediately praised. - Staff should help and work with her in completing tasks. - If she refused the first time, the request should be repeated after a while, for the second time. If she does not comply, then she should be approached with the request a third time after a brief 3-5 minute interval. - On the third consecutive occasion, if the client refuses a staff should should document the refusal as one non-compliant incident. - However if the client shows early signs of stubbornness or of resistance, do not pursue further as she might drop herself to the floor in protest. Her one to one support staff should remain alert. - Redirect her attention to an activity she prefers to do. If she responds to this effort shift her focus to a "talk" or activity for a while and she should be praised. - The verbal redirection should only come from her one to one support staff. - Once she is stable and calm repeat the original request that she had refused. The aforementioned interventions were not observed being implemented when Client #1 was	W 193		

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W 193	Continued From page 8	W 193		
	observed repeatedly refusing her medication. Further interview with the facility's QMRP on November 25, 2008 at approximately 10:00 a.m., confirmed that the LPN and direct care staff didn't effectively implement the proactive strategies outlined in Client #1's BSP.			
W 212	483.440(c)(3)(i) INDIVIDUAL PROGRAM PLAN	W 212		
	The comprehensive functional assessment must identify the presenting problems and disabilities and where possible, their causes.			
	This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that each clients who were receiving psychotropic medications had a psychiatric assessment, for two of the three clients included in the sample. (Clients #2 and #3)			
	The findings include:			
	1. Observation of the evening medication administration on March 24, 2010, 5:46 p.m., revealed Client #2 received Abilify 30 mg. Interview with the nursing staff after the medication administration, revealed that the medication was prescribed for behavior management. Review of the client's physicians orders on March 25, 2010, at 3:00 p.m., revealed that psychotropic medication was incorporated in a Behavior Support Plan (BSP) dated February 12, 2010, to address behaviors associated with inappropriate sexual provocation, incidents of talk and inappropriate wetting.		1. The facility was court-ordered to find a different psychiatrist for many of the people served. As a result, the facility began taking people to Seton House for psychiatric services. The RN Supervisor has had several meetings with Seton House in company with staff from the DC Health Resources Partnership to establish schedules, assessments, med reviews, etc. The staff at Seton House have agreed to provide the facility with printed copies of their electronic records of psychiatric assessments for each person on their patient panel.	5/14/10
	Review of Client #2's medical evaluation dated January 26, 2010, at 3:00 p.m., revealed that the			

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W 212	Continued From page 9 psychotropic medications were prescribed to address behaviors associated with a diagnosis of Atypical psychosis. Further review of the client's medical record revealed no documented evidence of a psychiatric assessment. 2. Similarity, during medication observations on March 24, 2010, at 5:35 p.m., Client #3 was observed receiving Depakote, Buspar, Cogentin, Neurontin and Risperdal. Interview with the client, during the medication administration, revealed that the medications were prescribed for anxiety and aggression. Review of the client's March 2010, physicians order on March 26, 2010, beginning at 9:10 a.m., revealed that the medications were incorporated in a Behavior Support Plan (BSP) dated April 16, 2009, to address behaviors associated with verbal and physical aggression, self injurious behaviors, non-compliance, screaming/yelling and false accusations. Review of Client #3's medical evaluation dated April 21, 2009, on March 26, 2010, at 9:10 a.m., revealed that the psychotropic medication was prescribed to address behaviors associated with a diagnoses of impulse control disorder and atypical psychosis disorder. Review of Client #3's medical record on March 26, 2010, at approximately 2:00 p.m., revealed no documented evidence of a psychiatric assessment. Interview with the licensed practical nurse on March 26, 2010, at approximately 11:00 a.m., confirmed that the client's did not have psychiatric assessments.	W 212	2. See response to #1 above.	5/14/10
W 220	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN	W 220		

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W 220	Continued From page 10	W 220		

The comprehensive functional assessment must include speech and language development.

This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that clients received speech language assessment to determine the client's communication needs, for one of the three clients included in the sample. (Client #1).

The finding includes:

During the medication administration on March 24, 2010, at 6:05 p.m., Client #1 was overheard speaking in a mumbled voice. During the medication administration on March 24, 2010, beginning at 6:05 p.m., Client #1 was refusing her medications, by turning her head side to side, after the medication nurse attempted to adminster her medications. She was also heard mumbling, "No, No," many times.

Interview with the qualified mental retardation professional (QMRP)on March 25, 2010, at approximately 12:30 p.m., revealed that Client #1 was admitted to the facility in June 2008. Further interview revealed that the QMRP requested that the speech pathologist assess the client, in preparation of her Individual Support Plan meeting (July 2009).

Review of Client #1's Individual Support Plan (ISP) dated July 17, 2009, revealed no evidence of a speech and language evaluation. At the time of the survey, there was no evidence that a speech evaluation had been completed.

The facility has engaged a new Speech-Language Pathologist. The QMRP will request the SLP to complete an assessment for this client. 5/14/10

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W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure that each client was provided opportunities to make a choice during snack time, for six of the six clients residing in the facility, (Clients #1, #2, #3, #4, #5 and #6) and failed to ensure clients were given a choice when they refused vegetable offered during dinner, for one of the three clients included in the sample. (Client #3) The findings include: 1. On March 25, 2010, at 3:20 p.m., direct care staff was observed cutting apples. Minutes later, in an interview with the direct care staff indicated that she was preparing the Client #1, #2, #3, #4, #5, and #6's snack. At 3:40 p.m., the staff was observed serving the client's their snack of apples and a cup of water. During the environmental inspection on March 25, 2010, at approximately 11:00 a.m., revealed there were a variety of snacks in the pantry and the refrigerator. Review of the client's Individual Support Plans during the survey revealed that staff should provide each client a variety of choices and participation in all activities. At no time during snack time were the clients given the opportunity to select a snack from the variety of food choices. 2. On March 24, 2010, at 5:20 p.m., direct care staff was observed assisting Client #3 with	W 247	1. The people who live in this facility often do their own shopping and cooking. The QMRP will provide an IPP which encourages the clients to prepare their own snacks from the groceries that they list and purchase.	5/14/10

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G159		03/26/2010

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 247	Continued From page 12 serving dinner family style. The client refused, the offered vegetable (salad and spinach). The only food observed on the client's plate was fish, rice and bread. The direct care staff did not offer the client any additional vegetables. During the environmental inspection on March 25, 2010, at 11:00 a.m., revealed that there were a variety of vegetables in the freezer. At no time during the dinner, did the staff offer Client #3 another choice of vegetables, so the client could receive a nutritional meal.	W 247	2. Everyone who lives in the home has the opportunity for making food choices. People who do not choose to eat a particular "class" of food (in this case, a vegetable) will be offered a snack later in the day in the same class of food (substitutions will be acceptable, such as veggie sticks, in this case, or fruit) to ensure their nutritional needs are met	5/14/10
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on interview and record review, the facility's specially-constituted committee failed to ensure that restrictive programs were used only after written consents had been obtained, for two of the three clients included in the sample. (Clients #1 and #3) The findings include: The facility failed to ensure that written consent was obtained from Client #1's family member prior to the administration of his psychotropic medication. During the entrance conference on March 24, 2010, beginning at 4:30 p.m., the Qualified Mental Retardation Professional (QMRP) indicated that Client #1 received psychotropic medications to	W 263	1. The Director of Disability Services will retrain the members of the Human Rights Committee on the requirement of written informed consent from the individual or his/her medical decision-maker for restrictive or invasive treatments prior to implementation of such treatments.	5/31/10

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

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W 263	Continued From page 13 address her maladaptive behaviors. Further interview revealed the client did not have the capacity to give informed consent for the use of medications and habilitation services. Review of the Client #1's March 2010, physician orders on March 25, 2010, at 10:14 a.m., revealed an order for Risperdal 0.5 mg, twice a day (in the morning and at bedtime). Interview with the Licensed Practical Nurse (LPN) on March 25, 2010, at approximately 11:00 a.m., revealed that the client "just" started Risperdal. The QMRP's statement was verified on March 25, 2010, at 1:25 p.m., through review of Client #1's psychological assessment dated July 16, 2009. According to the assessment, the client "does not evidence the capacity to make decisions on her own behalf in treatment, habilitation, residential placement, and financial matters." Further interview with the QMRP during the survey, revealed that the client had a family member that was involved in her habilitation planning and decision making process. Record verification on March 25, 2010, at 1:45 p.m., revealed that Client #1's family member had given informed consent for the use of Carbatrol 200 mg, twice a day and Depakote 125 mg, three times a day, both for seizure disorder. There was no evidence that written consent had been obtained for client's current Risperdal 0.5 mg, twice a day. 2. The facility failed to ensure that written consent was obtained from Client #3's family member prior to the administration of her psychotropic medications.	W 263	2. See response to #1 above.	5/31/10

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NAME OF PROVIDER OR SUPPLIER
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W 263	Continued From page 14 During the entrance conference on March 24, 2010, beginning at 4:30 p.m., the Qualified Mental Retardation Professional (QMRP) indicated that Client #3 received psychotropic medications to address her maladaptive behaviors. Further interview revealed the client did not have the capacity to give informed consent for the use of medications and habilitation services. Observations during the medication administration on March 24, 2010, at 5:35 p.m., revealed Client #3 was observed taking her Depakote, Buspar, Cogentin, Neurontin and Risperdal. Review of Client #3's March 2010, physician order dated on March 26, 2010, beginning at 9:10 a.m., revealed an order of Xanax 2 mg, twice a day (in the morning and at bedtime), Depakote 500 mg, twice a day (BID), Neurontin 600 mg, three times a day (TID), Cogentin 1 mg, BID, Buspar 30 mg, TID and Risperdal 30 mg, twice a day. The QMRP's statement was verified on March 26, 2010, at 2:00 p.m., through review of Client #3's psychological assessment dated April 16, 2009. According to the assessment, the client "does not evidence the capacity to make decisions on her own behalf in treatment, habilitation, residential placement, and financial matters." Further interview with the QMRP during the survey, revealed that the client had a family member that was involved in her habilitation planning and decision making. Record verification on March 25, 2010, at 2:30 p.m., revealed that Client #3's family member had given informed consent on September 19, 2009,	W 263		

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WASHINGTON, DC 20012

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W 263	Continued From page 15 for the use of Xanax 3 mg once a day, Depakote 500 mg, BID, Neurontin 600 mg, TID, Cogentin 1 mg, BID, Buspar 30 mg, TID and Risperdal 30 mg, twice a day. There was no evidence that informed consent had been obtained for the client's Xanax 2 mg, twice a day. At the time of the survey, the facility failed to provide evidence that written consent was obtained from the client and/or family member prior to implementing Client #1's psychotropic medications.	W 263		

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	HFD03-0143		03/26/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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I 000	INITIAL COMMENTS A licensure survey was conducted from March 24, 2010 through March 26, 2010. The survey was initiated using the fundamental survey process. A random sample of three residents was selected from a population of six female residentswith various levels of mental retardation and disabilities. The findings of the survey was based on observations at the group home and three day programs, interviews with residents, staff, family members and the review of clinical and administrative records including incident reports.	I 000		
I 058	3502.16 MEAL SERVICE / DINING AREAS A review and consultation by a dietitian or nutritionist shall be conducted at least quarterly to ensure that each resident who has been prescribed a modified diet receives adequate nutrition according to his or her Individual Habilitation Plan. This Statute is not met as evidenced by: Based on record review, the Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure that residents with modified diets had been reviewed at least quarterly by the consulting dietitian, for two of the three residents included in the sample. (Residents #2 and #3) The findings include: 1. Review of Resident #2's current physician orders (POS) dated March 2010, on March 25, 2010, at 3:00 p.m., revealed a diet order of 1200 low fat, low cholesterol, low sodium, high fiber diet with salad at lunch and dinner. Further	I 058	1. The QMRP will provide the Nutritionist with a quarterly schedule for review of the diets, and will follow up with the Nutritionist to ensure that the reviews take place and are documented in the record.	5/10/10

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

TITLE: Director of Disability Services

(X6) DATE: 4/26/10

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I 058	Continued From page 1	I 058		
	review of the medical records revealed a Nutrition assessment dated February 17, 2009. The record failed to show evidence that the resident's modified diet had been reviewed by the dietitian, quarterly.			
	2. Review of Resident #3's current POS dated March 2010, on March 26, 2010 at 9:10 a.m., revealed a diet order of 1500 low fat, low cholesterol, low sodium diet. Further review of the medical records revealed a Nutrition assessment dated May 9, 2009. The record failed to show evidence that the resident's modified diet had been reviewed by the dietitian, quarterly.		2.See response to #1 above.	5/10/10
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 Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure the interior and exterior of the GHMRP were maintained in a safe, clean, orderly, attractive, and sanitary manner for seven of the seven residents in the facility			
	The findings include:			
	Observation and interview with the facility's QMRP on March 25, 2010, at approximately 11:00 a.m., the following concerns were identified:			

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I 090	Continued From page 2	I 090		
	a. Kitchen			
	1. A frying pan that was currently being used evidenced a broken handle.		1. The Residential Director will replace broken pans, and will check at least weekly to ensure that pots and pans are clean and in good repair.	5/10/10
	2. Several pots had excessive grease on them.		2. The Residence Director will retrain staff on their assignments and the expectations for maintaining cookware, dishes, and appliances clean and in good working order. See response to #1 above.	5/10/10
	3. The toaster oven had grease on the inside of and in need of cleaning		3. See response to #2 above.	
	4. The refrigerator light was inoperable.		4. The Residence Director will change the refrigerator light bulb. In future, when the bulb is inoperable the Residence Director will change it immediately.	5/10/10
	5 The kitchen floor tiles were discolored in the center of the floor.		5. The Residence Director will request the Maintenance Contractor to repair or replace the tiles.	5/10/10
	b. Dining Room			
	1. The dining room chair cushions were soiled. In addition, the chairs were not sturdy to touch.		1. The Residence Director will have the chair cushions cleaned, and will have the furniture repaired or replaced.	5/10/10
	2. The first floor hall closet was dirty. In addition cleaning materials were being stored inside the closet.		2. Cleaning materials will be kept in a locked area for safety. The Residence Director will retrain staff on their assignments to assist people living in the facility to keep it clean and neat. The Residence Director will check at least weekly to ensure that the home is kept clean and in good order.	5/10/10
	c. Bathrooms			
	1. Second floor bathroom soap dispenser was broken.		1. The Residence Director will have the soap dispenser repaired or replaced.	5/10/10
	2. The bathroom walls evidenced peeling paint.		2. The Residence Director will request the Maintenance Contractor to repaint the bathroom.	5/31/10
	d. Bedrooms			
	1. Client #1's Wardrobe door does not close properly.			
	2. Client #2 s room ceiling evidenced peeling paint.			

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I 090	Continued From page 3	I 090	1. The Residence Director will request the Maintenance Contractor to repair or replace the wardrobe door.	5/31/10
	3. Client #5's bedroom ceiling evidenced cracks.		2. The Residence Director will request the Maintenance Contractor to repaint the client's bedroom.	5/31/10
	e. Basement		3. The Residence Director will request the Maintenance Contractor to repair the ceiling cracks.	5/31/10
	Carpet leading to basement on steps is soiled		The Residence Director will request the Maintenance Contractor to clean the carpet on the stairs;	5/31/10
	Laundry room ceiling tiles are water stain need on the right side		replace ceiling tiles where needed;	5/31/10
	In the bathroom over the sink there is chipping and peeling paint on the window ledge.		repaint the window ledge;	5/31/10
	Beside the freezer in the basement the wall is blistering		repair the basement wall where there is blistering;	5/31/10
	The wall behind the washing machine evidenced peeling paint.		repaint the wall behind the washing machine;	5/31/10
	The drain outside the rear basement door had standing water.		clear the drain outside the rear basement door.	5/31/10
	f. Other		1. The Residence Director will request the Maintenance Contractor to tighten the banister.	5/31/10
	1. The third floor banister located near the office was loose.			
I 203	3509.3 PERSONNEL POLICIES	I 203		
	Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter.			
	This Statute is not met as evidenced by: Based on record review and staff interview, the group home for the mentally retarded person (GHMRP) failed to ensure five out of twenty three staff was provided the opportunity to annually review their written job descriptions as required by this section. (Staff #3, #4, #5, #6 and #7)			

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I 203	Continued From page 4	I 203		
	The finding includes: Interview with the qualified mental retardation professional (QMRP) and review of the GHMRP's personnel files conducted on March 25, 2010, beginning at 2:00 p.m., revealed the GHMRP failed to provide evidence that the facility discussed the contents of job descriptions, for five out of twenty three staff. (Staff #3, #4, #5, #6 and #7)		The QMRP will discuss job descriptions with each employee upon initial employment and annually thereafter per Careco's policy.	5/10/10
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.	I 206	The Human Resources Director will ensure that current health certificates are on file for each employee and consultant.	5/10/10
	This Statute is not met as evidenced by: Based on record review and staff interview, the Group Home For The Mentally Retarded Person (GHMRP) failed to ensure all contracted staff secured an annual health inventory as required by this section, for one of the twenty staff and two of the nine consultants. The finding includes: Review of the personnel records and interview with the GHMRP's qualified mental retardation professional (QMRP) on March 25, 2010, at 2:00 p.m., revealed the GHMRP failed to provide evidence that current health certificates were on file, for Staff #8 the pharmacist and behavior			

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I 206	Continued From page 5 therapist.	I 206		
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for the Mentally Retarded Persons (GHMRP)'s nursing staff failed to demonstrate competency in the implementation of the Behavior Support Plan (BSP), for one of three residents included in the sample. (Resident #1) The finding includes: During the medication administration on March 24, 2010, beginning at 6:05 p.m., Resident #1 was observed refusing her medications, by turning her head from side to side, after the medication nurse attempted to administer her medication. At 6:07 p.m., the licensed practical nurse (LPN) attempted to spoon fed the resident her medications, again. The one to one support staff was observed gently holding the resident's head in place and holding the resident's hands in her lap, and stated, "Good girl," as the LPN continued the attempts to administer the medications. These attempts went on, continuously until 6:20 p.m. Interview with the LPN after the medication	I 229	See response to federal deficiency W 193.	5/14/10

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I 229	Continued From page 6 administration, revealed that Resident #1 had a BSP to address her maladaptive behaviors. Interview with the qualified mental retardation professional (QMRP) on March 25, 2010, at approximately 10:00 a.m., indicated that the resident had a BSP to address her maladaptive behaviors to include non-compliance (refusal to take medications). According to Resident #2's Behavior Support Plan (BSP) dated July 16, 2009, the following procedures for non-compliance include: - Request to complete tasks should be made in a positive and upbeat manner. - When she completes the appropriate tasks, she should be immediately praised. - Staff should help and work with her in completing tasks. - If she refused the first time, the request should be repeated after a while, for the second time. If she does not comply, then she should be approached with the request a third time after a brief 3-5 minute interval. - On the third consecutive occasion, if the resident refused a staff should should document the refusal as one non-compliant incident. - However if the resident shows early signs of stubbornness or of resistance, do not pursue further as she might drop herself to the floor in protest. Her one to one support staff should remain alert. - Redirect her attention to an activity she prefers to do. If she responds to this effort shift her focus	I 229		

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I 229	Continued From page 7 to a "talk" or activity for a while and she should be praised. - The verbal redirection should only come from her one to one support staff. - Once she is stable and calm repeat the original request that she had refused. The aforementioned interventions were not observed being implemented when Resident #1 was observed repeatedly refusing her medication. Further interview with the facility's QMRP on November 25, 2008 at approximately 10:00 a.m., confirmed that the LPN and direct care staff didn't effectively implement the proactive strategies outlined in Resident #1's BSP.	I 229		
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 Group Home for the Mentally Retarded Persons (GHMRP), failed to ensure entries in each resident's record were signed, for two of the three residents in the sample. (Residents #1 and #3) The findings include: 1. Review of Resident #1's PO sheet on March 25, 2010, at 10:14 a.m., revealed a telephone order dated February 26, 2010, for Risperdal 0.5 mg, by mouth twice a day (in the morning and at bedtime)." 2. Review of Resident #3's PO sheet on March 26, 2010, at 9:10 a.m., revealed a telephone	I 291	See response to federal deficiency W 114.	5/10/10

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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 291	Continued From page 8	I 291		
	order dated September 22, 2009 for a thyroid scan per ENT recommendation.			
	Interview with the Register Nurse on March 26, 2010, at approximately 11:00 a.m., failed to provide an explanation as to why the PCP did not sign or date the orders.			
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS	I 401		
	Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident.			
	This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure that each clients who were receiving psychotropic medications had a psychiatric assessment, for two of the three residents included in the sample. (Residents #2 and #3)			
	The findings include:			
	1. Observation of the evening medication administration on March 24, 2010, 5:46 p.m., revealed Resident #2 received Abilify 30 mg. Interview with the nursing staff after the medication administration, revealed that the medication was prescribed for behavior management. Review of the resident's physicians orders on March 25, 2010, at 3:00 p.m., revealed that psychotropic medication was incorporated in a Behavior Support Plan (BSP)		1. See response to federal deficiency W 212.	5/11/10

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I 401	Continued From page 9 dated February 12, 2010, to address behaviors associated with inappropriate sexual provocation, incidents of talk and inappropriate wetting. Review of Resident #2's medical evaluation dated January 26, 2010, at 3:00 p.m., revealed that the psychotropic medications were prescribed to address behaviors associated with a diagnosis of Atypical psychosis. Further review of the resident's medical record revealed no documented evidence of a psychiatric assessment. 2. Similarity, during medication observations on March 24, 2010, at 5:35 p.m., Resident #3 was observed receiving Depakote, Buspar, Cogentin, Neurontin and Risperdal. Interview with the resident, during the medication administration, revealed that the medications were prescribed for anxiety and aggression. Review of the resident's March 2010, physicians order on March 26, 2010, beginning at 9:10 a.m., revealed that the medications were incorporated in a Behavior Support Plan (BSP) dated April 16, 2009, to address behaviors associated with verbal and physical aggression, self injurious behaviors, non-compliance, screaming/yelling and false accusations. Review of Resident #3's medical evaluation dated April 21, 2009, on March 26, 2010, at 9:10 a.m., revealed that the psychotropic medication was prescribed to address behaviors associated with a diagnoses of impulse control disorder and atypical psychosis disorder. Review of Client #3's medical record on March 26, 2010, at approximately 2:00 p.m., revealed no documented evidence of a psychiatric assessment.	I 401	2. To clarify, the LPN who was interviewed should have stated that the clients in the sample had no copies of their psychiatric assessments in the record at the home, and that arrangements were being made to get copies of the electronic records from Seton House to file in the home record. See response to federal deficiency W 212.	5/14/10

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I 401	Continued From page 10	I 401		
	Interview with the licensed practical nurse on March 26, 2010, at approximately 11:00 a.m., confirmed that the resident's did not have psychiatric assessments.			
I 437	3521.7(g) HABILITATION AND TRAINING	I 437		
	The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas:		See response to federal deficiency W 220.	5/4/10
	(g) Communication (including language development and usage, signing, use of the telephone, letter writing, and availability and utilization of communications media, such as books, newspapers, magazines, radio, television, telephone, and such specialized equipment as may be required);			
	This Statute Is not met as evidenced by: Based on observation, staff interview and record review, the Group Home for the Mentally Retarded Persons (GHMRP) failed to provide habilitation and training, for one of the three residents included in the sample. (Resident #1)			
	The finding includes:			
	During the medication administration on March 24, 2010, at 6:05 p.m., Resident #1 was overheard speaking in a mumbled voice. During the medication administration on March 24, 2010, beginning at 6:05 p.m., Resident #1 was refusing her medications, by turning her head side to side, after the medication nurse attempted to adminster her medications. She was also heard mumbling, "No, No," many times.			
	Interview with the qualified mental retardation professional (QMRP)on March 25, 2010, at			

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I 437	Continued From page 11	I 437		
	approximately 12:30 p.m., revealed that Resident #1 was admitted to the facility in June 2008. Further interview revealed that the QMRP requested that the speech pathologist assess the client, in preparation of her Individual Support Plan (ISP) meeting (July 2009).			
	Review of Resident #1's ISP dated July 17, 2009, revealed no evidence of a speech and language evaluation. At the time of the survey, there was no evidence that a speech evaluation had been completed.			
I 500	3523.1 RESIDENT'S RIGHTS	I 500		
	Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws.			
	This Statute is not met as evidenced by: Based on observations, interviews and record review, the the Group Home for the Mentally Retardated Persons (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) and other District and federal laws that govern the care and rights of persons with mental retardation, for two of the three residents included in the sample. (Resident #1 and #3)			
	The findings include:			
	1. The facility failed to ensure that informed consent was obtained from Resident #1's family member prior to the administration of her psychotropic medications.		1. See response to federal deficiency W 124.	5/10/10

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I 500	Continued From page 13	I 500		
	2. The facility failed to ensure that informed consent was obtained from Resident #3's family member prior to the administration of her psychotropic medications.		2. See response to #1 above.	5/10/10
	During the entrance conference on March 24, 2010, beginning at 4:30 p.m., the Qualified Mental Retardation Professional (QMRP) indicated that Resident #3 received psychotropic medications to address her maladaptive behaviors. Further interview revealed the resident did not have the capacity to give informed consent for the use of medications and habilitation services.			
	Observations during the medication administration on March 24, 2010, at 5:35 p.m., revealed Resident #3 was observed taking her Depakote, Buspar, Cogentin, Neurontin and Risperdal.			
	Review of Resident #3's March 2010, physician order dated on March 26, 2010, beginning at 9:10 a.m., revealed an order of Xanax 2 mg, twice a day (in the morning and at bedtime), Depakote 500 mg, twice a day (BID), Neurontin 600 mg, three times a day (TID), Cogentin 1 mg, BID, Buspar 30 mg, TID and Risperdal 30 mg, twice a day.			
	The QMRP's statement was verified on March 26, 2010, at 2:00 p.m., through review of Resident #3's psychological assessment dated April 16, 2009. According to the assessment, the resident "does not evidence the capacity to make decisions on her own behalf in treatment, habilitation, residential placement, and financial matters." Further interview with the QMRP during the survey, revealed that the resident had a			

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I 500	Continued From page 14 family member that was involved in her habilitation planning and decision making. Record verification on March 25, 2010, at 2:30 p.m., revealed that Resident #3's family member had given informed consent on September 19, 2009, for the use of Xanax 3 mg once a day, Depakote 500 mg, BID, Neurontin 600 mg, TID, Cogentin 1 mg, BID, Buspar 30 mg, TID and Risperdal 30 mg, twice a day. There was no evidence that informed consent had been obtained for the resident 's Xanax 2 mg, twice a day.	I 500		

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R 000	INITIAL COMMENTS A licensure survey was conducted from March 24, 2010 through March 26, 2010. The survey was initiated using the fundamental survey process. A random sample of three residents was selected from a population of six female residentswith various levels of mental retardation and disabilities. The findings of the survey was based on observations at the group home and three day programs, interviews with residents, staff, family members and the review of clinical and administrative records including incident reports.	R 000		
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 interview and review of personnel records, the Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure criminal background checks for all jurisdictions in which the employees had worked or resided within the 7 years prior to the check, for 2 out of 23 direct support staff and the Speech and Language Pathologist whose background check documentation was not made available for review. (Staff#1, # 6). The finding includes: Review of the personnel files on March 25, 2010,	R 125	The Human Resources Director will ensure that all employees and consultants have a background check on file per regulations.	5/10/10

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Marsha H. Thompson

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Director of Disability Services — (X6) DATE: 4/26/10