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

Received 1/4/07

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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
	09G171		C 11/29/2007

NAME OF PROVIDER OR SUPPLIER: CARECO 11

STREET ADDRESS, CITY, STATE, ZIP CODE: 1701 24TH STREET, NE, WASHINGTON, DC 20002

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W 000	INITIAL COMMENTS A monitoring visit was conducted from November 26, 2007 through November 29, 2007. The survey was initiated using the full survey process. A random sample of two clients were selected from a population of four females with various degrees of disabilities. The findings of the survey were based on observations at the home, interviews with clients and staff, and the review of records, including incident reports. The outcome of the survey revealed that the facility failed to be in compliance with the Condition of Participation in Active Treatment.	W 000		
W 114	483.410(c)(4) CLIENT RECORDS Any individual who makes an entry in a client's record must make it legibly, date it, and sign it. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all personnel making entries into the clients records were signed for one of the two clients in the sample. (Client #1) The finding includes: During the entrance conference on November 26, 2007 at 4:10 PM, the direct care staff indicated that Client #1 has one to one support services. Review of the client's psychology assessment dated July 1, 2007 revealed that the assessment was not signed by the person completing the assessment.	W 114	The QMRP will ensure that the assessment is signed by the clinician who completed it.	1/3/08
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS	W 124		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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 The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to establish a system that would ensure clients that were informed of their risks and benefits of their medication for two of the two clients in the sample. (Client #1 and Client #2) The findings include: 1. Client #1 was observed during the morning medication pass on November 26, 2007 at 6:05 PM and was administered Buspar 15 mg, Seroquel 100 mg and Depakote 500 mg. Interview with the Licensed Practical Nurse (LPN) on November 26, 2007 at approximately 6:40 PM revealed that client was prescribed these medications for behavioral management. Review of Client #1's current physician's orders revealed that the client was prescribed the aforementioned medications, twice a day. Further interview with the LPN revealed that the medications were incorporated into the client Behavior Support Plan (BSP) dated February 2, 2007 to address targeted behaviors that included property destruction, disrobing, physical aggression, inappropriate touching self-injurious behaviors and enuresis. Interview with the Qualified Mental Retardation	W 124	1. The QMRP will ensure that the client's mother provides written informed consent, per the District's *Health Care Decisions Act* for therapies in place to assist the client to manage her behaviors.	1/3/08

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W 124	Continued From page 2 Professional (QMRP) on November 27, 2007 at approximately 9:30 AM revealed that Client #1's mother is very involved in his life but are not the client's legal guardians. Review of the client's, psychological assessment on November 27, 2007 at approximately 1:21 PM revealed that the client does not have the ability to make decisions on his behalf regarding habilitation planning, residential placement, finances, treatment and medical matters. There was no documented evidence that the facility obtained consent from Client #2's mother of the health benefits and risks of treatment associated with the use of his psychotropic medications and corresponding BSP. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity. 2. Client #2 was observed during the evening medication pass on November 26, 2007 at approximately 6:25 PM and was administered Paxil 30 mg, Zyprexa 10 mg, and Trazodone 50 mg. Review of the client #2's current physician's orders revealed that the client was prescribed the aforementioned medication and Zyprexa twice a day. Interview with the LPN on November 26, 2007 at approximately 6:40 PM revealed that Client #2 was prescribed these medications for behavioral management. Further interview with the LPN revealed that the medications were incorporated into Client #2's BSP dated March 30, 2007 to address targeted behaviors that included disrobing and masturbation, screaming/crying, physical aggression, property destruction, and self-injurious behaviors. Interview with the QMRP on November 26, 2007 at approximately 9:30 AM revealed that Client	W 124	2. See response to #1 above.	1/3/08

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W 124	Continued From page 3 #2's mother and sister are involved in his life but are not the client's legal guardians. Review of the client #2's, psychological assessment on November 27, 2007 at approximately 1:21 PM revealed that the client does not have the ability to make decisions on his behalf regarding habilitation planning, residential placement, finances, treatment and medical matters. There was no documented evidence that the facility informed Client #2's mother or sister of the health benefits and risks of treatment associated with the use of his psychotropic medications and corresponding BSP. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity.	W 124		
	3. The facility failed to obtain consent prior to the use of sedation for a medical appointments and/or to notify the clients guardian the risks and benefits of treatments for two of the two clients in the sample. (Client #2)		3.a. See response to #1 above.	1/3/08
	a. Review of Client #2's physician orders on November 28, 2007 at approximately 2:00 PM revealed that on July 16, 2007, the client received Xanax 2 mg for an EEG. During the entrance conference on November 26, 2007 at 4:10 PM, the direct care staff indicated that the client has family involvement.			
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 ensure that all staff are trained on privacy issues, and that they support clients to exercise their rights to privacy and personal dignity.	1/3/08

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W 130	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure that clients were provided privacy or taught to exercise privacy throughout the day for one of the four clients in the sample. (Clients #2 and #4) The findings include: During observations conducted throughout the survey on November 26, 2007, Client #2 was observed not using privacy, not encouraged or taught to exercise her right to privacy. The staff failed to provide privacy to clients and their personal issues. On November 26, 2007, the following opportunities to teach privacy to clients was not initiated by the staff at the facility. a. At 6:30 PM Client #2 was sitting in the living room and removed her top. The direct care staff and medication were discussing her afternoon snack before receiving her medication. b. At 6:35 PM the medication nurse was observed administering Client #2 her in the presence of other clients and staff in the living room. c. At 6:45 PM Client #2 stripped her pants below the waist, while sitting in the living room, no staff intervention observed. d. At 6:52 PM direct care staff was observed placing Client #2 on the toilet. The client sat on the toilet with the bathroom door wide opened. The direct care staff was observed going to the clients bedroom to retrieve some clothes. The direct care staff was not encouraged to close the	W 130		

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W 130	Continued From page 5 bathroom door when she was in the bathroom. e. At 7:50 PM direct care staff was observed giving Client #1 a bed bath with the bedroom door wide opened.	W 130		
W 137	483.420(a)(12) 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, staff interview and record review, the facility failed to ensure that clients wore her own personal clothing for one of the four clients in the facility. (Client #3) The finding includes: On November 27, 2007 at approximately 9:40 AM, Client #3 was observed with a pair of socks that had the initials of Client #2. During the environmental inspection on November 30, 2007 at 10:30 AM, observation of Client #3's dresser drawers there three pairs of socks with her initials on them.	W 137	The Residential Director (RD) will train staff to ensure that people are able to use their own personal possessions, and that staff check to make sure that they provide people with their own things.	1/3/08
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 staff interview and record review, the	W 140	The Director of Disability Services will ensure that the QMRP has copies of people's bank statements in their home.	1/3/08

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W 140	Continued From page 6 facility failed to maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of two of the two clients in the sample. (Clients #1 and #2) The finding includes: In an attempt to review the financial records for Clients #1 and #2 on November 27, 2007 revealed that there were no bank statements available for review at the group home. Interview with the Qualified Mental Retardation Professional (QMRP) on November 27, 2007 indicated that the bank statements were located in the main office and would be brought to the facility for review. By the end of the survey, the bank statements were not made available for review. It should be noted that the QMRP indicated that the clients received their monthly Social Security Income (SSI).	W 140		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that each client's active treatment program was coordinated, integrated and monitored by the Qualified Mental Retardation Professional (QMRP). The findings include: 1. The facility's QMRP failed to have client's legal	W 159	1. The QMRP will invite the person's guardian or family member via letter to participate in the annual Individual Support Plan meeting.	1/3/08

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W 159	Continued From page 7 guardian or family member participated in her annual Individual Support Plan (ISP) meeting. [See W209] 2. The facility's QMRP failed to ensure that clients who was receiving psychotropic medications had a psychiatric assessment. [See W212] 3. The facility's QMRP failed to ensure that an objectives was developed to address self medication training program need as identified by the interdisciplinary team (IDT) in the comprehensive assessment. [See W227] 4. The facility's QMRP failed to provide continuous active treatment. [See W249] 5. The facility's QMRP failed to ensure that each client's Individual Program Plan (IPP) objectives are documented consistently and accurately. [See W252] 4. The facility's QMRP failed to revise objectives identified in the clients's IPP that had not been achieved. [See W257]	W 159	2. The QMRP will schedule a psychiatric assessment for each person who is receiving psychotropic medications. 3. The RN Supervisor will schedule an assessment to determine whether people are candidates for self-medication. The QMRP will review the results of assessments when they are complete and develop programming if appropriate. 4. The QMRP will review each person's objectives as identified in the IPP and revise them appropriately. 5. The QMRP will retrain all staff to ensure that program activities are accurately and consistently documented. 4. The QMRP will review all IPPs and revise them appropriately.	1/3/08 1/3/08 1/3/08 1/3/08 1/3/08
W 195	483.440 ACTIVE TREATMENT SERVICES The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure continuous active treatment services (See W196 and W249); the facility failed to ensure that clients were provided privacy or taught to exercise privacy	W 195	The Director of Disability Services made a change in personnel to address Active Treatment and any other concerns in the concerns in the home. The new QMRP started on November 28, 2007, and is assigned full time to the home Additionally, a new Residential Director, who is well experienced in active treatment and human rights, and can provide supports to people in the home in accordance with their ISPs and regulatory requirements, was hired and began work on December 27, 2007. The home is also staffed with a new RN Supervisor who started in November 2007. The new team will provide retraining to all facility staff on providing and	

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W 195	Continued From page 8 (See W130); the facility failed to have client's legal guardian or family member participated in her annual Individual Support Plan (ISP) meeting (See W209); the facility failed to ensure that clients who was receiving psychotropic medications had a psychiatric assessment (See W212); the facility failed to ensure that an objectives was developed to address self medication training program need as identified by the interdisciplinary team (IDT) in the comprehensive assessment (See W227); the facility failed to ensure that each client's Individual Program Plan (IPP) objectives are documented consistently and accurately (See W252); and the Qualified Mental Retardation Professional (QMRP) failed to ensure each client's IPP was revised after the client failed to make progress with the identified objectives (See W257). The effects of these systemic practices results in the failure of the facility to adequately provide active treatment services.	W 195	exercising privacy and all aspects of each person's ISP. The QMRP will ensure that people who are receiving psychotropic medications also received a psychiatric assessment. They will ensure that the clients are properly assessed for eligibility for self-medication; that family members are properly notified in writing of team meetings and requested to attend; and that all IPPs are reviewed for client progress and revised appropriately according to the person's progress or lack of progress. The QMRP and RD will ensure that all staff are trained on each person's IPPs and BSP, and that staff document both in accordance with the protocols governing each.	1/3/08
W 196	483.440(a)(1) ACTIVE TREATMENT Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. This STANDARD is not met as evidenced by:	W 196		

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W 196	Continued From page 9 Based on observation, staff interviews, and record review the facility failed to ensure that clients received continuous active treatment program in accordance with recommendations made by the interdisciplinary team (IDT) for two of the two clients included in the sample. (Clients #1 and #2) The findings include: I. The facility failed to ensure that Client #2 received continuous active treatment as outlined in her Individual Habilitation Plan (IHP). A. On November 26, 2007 Client #2's was observed from 4:00 PM to 8:40 PM revealed the following: 1. At 4:00 PM the client was observed sitting in her bedroom, alone. 2. At 4:55 PM the client who remained alone in her bedroom was overheard screaming. After checking on the client, the staff returned to the living room and indicated that the client was hungry. The staff also stated that the client was sitting in a chair listening to music. 3. At 5:00 PM the surveyor entered the client's bedroom and observed the client was banging her head against the wall. The staff was not present and there was no intervention. 4. At 5:02 PM the client pulled her pants down. The direct care staff requested that the client pull her pants up, three times. After multiple request the client complied. 5. At 5:04 PM the client remained in the	W 196	I. The QMRP will review the 24-hour active treatment schedule and revise it as needed. The QMRP will review the IPPs for the person and ensure that they are appropriate, and include programming for personal care and hygiene. The QMRP will train staff on implementation of the active treatment schedule, the BSP, and IPPs and ensure that staff document programs accurately and timely per the established protocols. The QMRP will ensure that the staff are appropriately trained to assist the person to exercise her right to privacy, and assist her to maintain her dignity. The QMRP will ensure that staff engage the client according to her schedule, and refrain from leaving her unattended and alone in her room, other than at sleep time. The QMRP and RD will ensure that the person receives appropriate snacks in appropriate places, in accordance with her dietary plan. See response to W 195.	1/3/08

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W 196	Continued From page 10 bedroom alone. The the direct care staff entered the bedroom with a bag of potato chips and water. The direct care staff was observed feeding the client potato chips and water. The client held onto the direct care staff's leg during the entire feeding. After the potato chips were finished the client grabbed both of the staff's legs and slightly lifting him from the floor. 6. At 5:08 PM, the client banged her head on the wall, four times. 7. At 5:12 PM, the client pulled her pants down and removed her soiled adult protective undergarments (APU). 8. At 5:20 PM the client came into the living room and sat in a chair. 9. At 6:20 PM the medication nurse was attempting to feed the client her dinner while the client was seated in the living room chair. The client consumed two spoonfuls of food. The nurse mixed 1/4 teaspoon of the client's crushed medications into her food. The client refused the food and medication. Several minutes later the nurse was observed putting the remained medications into a jelly sandwich. The client consumed the medication sandwich. 10. At 6:30 PM, the client removed her top, exposing her sports bra. 11. At 6:45 PM, the client pulled her pants down below the waist. 12. At 6:52 PM, the direct care staff took the client to the bathroom. The client sat on the toilet with the door wide opened.	W 196		

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W 196	Continued From page 11 13. At 7:15 PM, the client was escorted back to her bedroom to complete evening personal hygiene. B. Interview with direct care staff on November 27, 2007 revealed that Client #2 was dependent on staff for basic personal needs On November 26, 2007, the client was observed wearing an adult protective under garments and dependent on staff for toileting. Also on the morning of November 27, 2007, the staff was observed assisting the client with her jacket. The staff confirmed that the client needs assistance with bathing, dressing and toileting. Review of the client's habilitation record on November 28, 2007 revealed no documented evidence of training programs in these domains. Further review of the client's habilitation records failed to reveal that the client's personal care skills had been identified/assessed. C. Review of the Client #2's IPP revealed objectives to enhance money management, communication and identify activities of daily living skills. At no time during the observations did the direct care staff encourage the client to participate in any of the aforementioned program objectives as identified below: 1. Given verbal assistance, [the client] will perform an action with an object upon request with 70% accuracy per sessions for three consecutive months. 2. Given verbal assistance, [the client] will identify two items needed to complete ADL task	W 196		

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W 196	Continued From page 12 (by touch) with 70% accuracy for three consecutive months. 3. Given verbal prompts, [the client] will rinse her toothbrush on 50% of the trials recorded per month for three consecutive months by 10/07. 4. Given verbal prompts and hand over hand assistance, [the client] will identify coins with 75% accuracy per session as measure by the record trials per month for six consecutive months. Interview with the QMRP and review of the IPP data book revealed no documentation on any of the program objective since June 2007. There was no evidence that these program objective had been implemented since June 2007. D. Interview with the direct care staff indicated that the client preferred to stay in her bedroom. Review of Client #2's Behavior Support Plan (BSP) dated March 30, 2007 indicated proactive strategies to include: 1. The client should be engaged in a task as often as possible to alleviate boredom. 2. The client should be closely supervised to prevent disrobing. 3. The client should wear an additional one or two layers of clothing to prevent or delay clothes stripping. In the event that clothes stripping occurs, direct care staff should cover the client with a towel prior to escorting her to the bedroom or bathroom to redress. 4. Staff should provide frequent verbal praise throughout the day, every day.	W 196		

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W 196	Continued From page 13 There was no evidence that the direct care staff implemented the BSP as written. E. Review of the activity schedule for Client #2 on November 29, 2007 at approximately 10:00 AM revealed the following: - 5 AM wake up and person hygiene; - 7 AM Help in setting the take; - 7:30 AM medication; - 8 AM sign breakfast; - 8:30 AM cleaning the table hold dish cloth and wipe table with staff assistance. Afterward brush teeth (rinse toothbrush); - 9 AM- 4 PM Day Program; - 5 PM communication goal (follow directions); - 6 PM Dinner; - 6:30 PM Household chores; - 7 PM Money Management; - 7:30 PM Bath/shower (OT objective); - 7:45 PM Relaxation; - 8 PM Snack; and - 8:30 Bedtime. The facility failed to implement Client #2's activity schedule as written. II. The facility failed to ensure that Client #1 received active treatment in accordance with her ISP. A. Observations on November 26, 2007 from 4:00 PM through 8:40 PM revealed the following: 1. At 3:55 PM - Upon entry into the facility, Client #1 was observed sleeping in her bed until 5:45 PM;	W 196	II. See response to I above. The QMRP will ensure that staff are fully trained to competently implement and document the person's BSP	1/3/08

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W 196	Continued From page 14 2. At 6:05 PM - the medication nurse administered the client's medication in the medication room; 3. At 6:30 PM - the client had dinner; 4. At 6:47 PM - the client threw a direct care staff's cellular phone on the floor; 5. At 7:00 PM - the client was observed on writing on a pad at the kitchen table for 20 minutes; 6. At 7:25 PM - the client was observed sleeping in a chair at the dining room table for nearly one hour (8:20 PM). The client's 1:1 support staff was observed assisting Client #3 in her activities of daily living skills; and 7. At 8:28 PM - the client's 1:1 support staff was observed escorting the client to her bedroom to assist with evening personal hygiene. B. Interview with the direct care staff on November 27, 2007 at approximately 1:00 PM indicated that the Client #1 required 1:1 staff support to prevent behavior incidents and to ensure the implementation of the following programs: 1. When asked, [the client] will get her things for day program independently 100% for three consecutive months; 2. Given a written telephone number, [the client] will dial the number correctly with verbal prompts 90% of the time during the trials conducted during the month for three consecutive months;	W 196		

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W 196	Continued From page 15 3. Given a pattern of coins and bills, [the client] will pick out the value of money to match the price of the item shown 60% of the trials per month for three consecutive months; 4. Given verbal prompts, [the client] will prepare a simple meal with 100% independence for three consecutive months; 5. When presented with arts and crafts of choice, [the client] will stay on task for up to 30 minutes independently 100% of the tails within a month for three consecutive months; and 6. [The client] will participate in physical fitness exercises for 30 minutes for 12 consecutive months. Review of Client #1's IPP dated September 13, 2007, there was no evidence that the facility implemented the aforementioned program objective since at least June 2007. Interview with the QMRP confirmed that the program objective had no documentation since at least June 2007. C. The 1:1 support staff failed to implement and document Client #1's Behavior Support Plan (BSP) as written. On November 26, 2007 at 6:47 PM, Client #1 was observed throwing a direct care staff's cellular phone on the floor, while sitting idle after her dinner. Review of the BSP dated 2/7/07 revealed a target behavior of property destruction (throwing items). The proactive strategies of the BSP include: engagement in a task as often as possible to alleviate boredom, provide 1:1 support staffing;	W 196		

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W 196	Continued From page 16 provide frequent, casual verbal praise, and pats on the client's shoulder. After the incident occurred the 1:1 support staff failed to document the episode of property destruction as required by the BSP.	W 196		
W 209	483.440(c)(2) INDIVIDUAL PROGRAM PLAN Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate. This STANDARD is not met as evidenced by: Based on record review, it could not be determined that client's legal guardian or family member participated in her annual Individual Support Plan (ISP) meeting for two of the two clients in the sample. (Clients #1 and #2) The findings include: 1. During the entrance conference on November 26, 2007 at 4:00 PM, revealed that Client #1's mother is very involved in her habilitation and care. Review of Client #1's ISP revealed the meeting was held on July 19, 2007. Further review of the ISP's signature attendance sheet revealed several members of the client's interdisciplinary team were present, however, there was no evidence that the client's mother was present at the meeting.	W 209	1. See response to W 124.	1/3/08
	2. During the entrance conference on November 26, 2007 at 4:00 PM, revealed that Client #2's mother and sister are involved in her habilitation and care. Review of Client #2's ISP revealed the meeting was held on August 11, 2007. Further		2. See response to W 124.	1/3/08

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W 209	Continued From page 17 review of the SP's signature attendance sheet revealed several members of the client's interdisciplinary team were present, however, there was no evidence that the client's family member were present at the meeting.	W 209		
W 212	483.440(c)(3) (i) INDIVIDUAL PROGRAM PLAN 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 clients who was receiving psychotropic medications had a psychiatric assessment for two of the two clients in the sample. (Clients #1 and #2) The findings include: 1. Observation of the evening medication administration on November 26, 2007, at 6:05 PM, revealed Client #1 received Buspar 15 mg and Seroquel 100 mg and Depakote 500 mg by mouth. Interview with the nursing staff on November 26, 2007, at approximately 6:20 PM, revealed that the medication was prescribed for behavior management. Review of the client's current physicians orders, on November 27, 2007 at approximately 10:00 AM, revealed that Buspar 15 mg and Seroquel 100 mg and Depakote 500 mg by mouth twice a day was incorporated in a Behavior Support Plan (BSP) dated February 2, 2007, to address behaviors associated with property destruction, disrobing, physical aggression, inappropriate touching, self-injurious behaviors and enuresis.	W 212	See response to W 159 #2.	1/3/08

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W 212	Continued From page 18 Review of Client #1's medical evaluation dated September 18, 2007, on November 27, 2007 at approximately 10:00 AM, revealed that the psychotropic medications were prescribed to address behaviors associated with a diagnosis of Atypical Psychosis. Interview with the medication nurse on November 26, 2007, at approximately 6:20 PM, revealed that the medication was prescribed for behavior management. Review of the client's current physicians orders, on November 27, 2007 at approximately 10:00 AM, revealed that Buspar 15 mg, Seroquel 100 mg and Depakote 500 mg by mouth twice a day and was incorporated in a Behavior Support Plan (BSP) dated February 2, 2007, to address behaviors associated with property destruction, disrobing, physical aggression, inappropriate touching, self-injurious behaviors and enuresis. 2. Observation of the evening medication administration on November 26, 2007, at 6:05 PM, revealed Client #2 received Paxil 30 mg, Zyprexa 10 mg, and Trazodone 50 mg by mouth. Interview with the medication nurse on November 26, 2007, at approximately 6:20 PM, revealed that the medication was prescribed for behavior management. Review of the client's current physicians orders, on November 27, 2007 at approximately 10:00 AM, revealed that the client also receives Zyprexa 10 mg in the evening and was incorporated in a BSP dated March 30, 2007, to address behaviors associated with disrobing and masturbation, screaming/crying, physical aggression, property destruction, and self-injurious behaviors. Review of Client #2's medical evaluation dated July 13, 2007, on November 27, 2007 at approximately 10:00 AM, revealed that the	W 212		

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W 212	Continued From page 19 psychotropic medications were prescribed to address behaviors associated with a diagnosis of Schizoaffective Disorder (Bipolar type). Further review of the client's medical record revealed no documented evidence of a psychiatric assessment.	W 212		
W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on interview with the observation, staff interview and record review, the facility failed to ensure that a objectives was developed to address self medication training program need as identified by the interdisciplinary team (IDT) in the comprehensive assessment for one of the two clients in the sample. (Client #1) The finding includes: On November 26, 2007 at 6:05 PM, Client #1 was observed being administered his medications. The Licensed Practical Nurse (LPN) prepared the client's medications, poured a cup of water and spoon fed the client's medication in applesauce and the nurse poured the water into the client's mouth. The nurse The nurse also took the client's blood sugar. Interview with the LPN indicated that the client does not participate in a self medication program. Review of the self medication assessment dated August 8, 2007 indicated that the client would benefit from a modified version of a self medication program.	W 227	See response to W 159 #3.	1/3/08

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W 227	Continued From page 20 Review of the Individual Program Plan (IPP) dated September 7, 2007 revealed no program goal or objective for the client to receive training in self medication. A data sheet was in the Medication Administration Record (MARs) book which included steps in which the client should perform during the medication administration. The IPP failed to identified program objective in this area.	W 227		
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 observation, staff interview and record verification, the facility failed to provide continuous active treatment for one of the two clients in the sample. (Client #2) The findings include: 1. Evening observations conducted on November 26, 2007 from 4:00 PM until approximately 8:40 PM revealed the following observations for Client #2: a. At 4:00 PM the client was observed sitting in her bedroom, alone.	W 249	See response to W 196 #1.	1/3/08

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W 249	Continued From page 21 b. At 4:55 PM, the client was overhead screaming from her bedroom. The client was sitting in her chair, alone listening to music, according to staff. c. At 5:00 PM the client was banging her head on the wall. d. At 5:02 PM the client pulled her pants down. The direct care staff requested that the client pull her pants up, three times. After multiple request the client complied. e. At 5:04 PM the direct care staff retrieved a bag of potato chips and water. The direct care staff was observed feeding the client potato chips and water. The client held onto the direct care staff's leg the entire time of feeding. After the potato chips were finished the client grabbed both the staff's legs slightly lifting him from the floor. f. At 5:08 PM, the client banged her head on the wall four times. g. At 5:12 PM the client pulled her pants down and removed her adult protective undergarments (APU). h. At 5:20 PM the client came into the living room and sat in a chair. i. At 6:30 PM, the client removed her top, exposing her sports bra. j. At 6:45 PM, the client pulled her pants down below the waist. k. At 6:52 PM the client was observed sitting on	W 249		

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W 249	Continued From page 22 the toilet with the door wide opened. I. At 7:15 PM the client was escorted back to her bedroom to complete evening personal hygiene. 2. Interview with the direct care staff indicated that the client likes to stay in her bedroom. Review of the Client #2's Behavior Support Plan (BSP) dated March 30, 2007 indicated proactive strategies to include: a. The client should be engaged in a task as often as possible to alleviate boredom. b. The client should be closely supervised to prevent disrobing. c. The client should wear an additional one or two layers of clothing to prevent or delay clothes stripping. In the event that clothes stripping occurs, direct care staff should cover the client with a towel prior to escorting her to the bedroom or bathroom to redress. d. Staff should provide frequent verbal praise throughout the day, every day. There was no evidence that the direct staff implemented Client #2's BSP as written.	W 249		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by:	W 252	See response to W 196 #1.	1/3/08

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W 252	Continued From page 24 the entire feeding. After the potato chips were finished the client grabbed both of the staff's legs and slightly lifting him from the floor. f. At 5:08 PM the client banged her head on the wall, four times. g. At 5:12 PM, the client pulled her pants down and removed her soiled adult protective undergarments (APU). h. At 5:20 PM the client came into the living room and sat in a chair. i. At 6:20 PM, the medication nurse was attempting to feed the client her dinner while the client was seated in the living room chair. The client consumed two spoonfuls of food. The nurse mixed 1/4 teaspoon of the client's crushed medications into her food. The client refused the food and medication. Several minutes later the nurse was observed putting the remained medications into a jelly sandwich. The client consumed the medication sandwich. j. At 6:30 PM, the client removed her top, exposing her sports bra. k. At 6:45 PM the client pulled her pants down below the waist. l. At 6:52 PM, the direct care staff took the client to the bathroom. The client sat on the toilet with the door wide opened. m. At 7:15 PM the client was escorted back to her bedroom to complete evening personal hygiene.	W 252		

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W 252	Continued From page 25 Review of Client #2's Behavior Support Plan (BSP) dated March 20, 2007, on November 27, 2007 at approximately 10:00 AM revealed that staff were to record maladaptive behaviors on the Antecedent Behavior Consequence (ABC) charts. On November 27, 2007 at 3:00 PM, review of the data chart revealed that the client #1 had no maladaptive behaviors. Review of the behavior data failed to reflect the behavior observed on November 26, 2007. There was no evidence that the data had been collected in accordance with the BSP for the client, which was necessary for a functional assessment of the client's progress.	W 252		
W 257	483.440(f)(1)(i) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. This STANDARD is not met as evidenced by: Based on interview and record review, the Qualified Mental Retardation Professional (QMRP) failed to ensure each clients Individual Program Plan (IPP) was revised after the client failed to make progress with the identified objectives, for one of the two clients included in the sample. (Client #1) The findings include: The QMRP failed to revise Client #1's programs as performance measures reflected a lack of progress. The client's documentation and IPP were reviewed on November 28, 2007 at 12:30	W 257	See response to W 195 and W 196.	1/3/08

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	09G171		C 11/29/2007

NAME OF PROVIDER OR SUPPLIER: CARECO 11

STREET ADDRESS, CITY, STATE, ZIP CODE: 1701 24TH STREET, NE WASHINGTON, DC 20002

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W 257	Continued From page 26 PM. 1. According to Client #1's IPP that was reviewed on November 28, 2007, 12:30 PM reflected the following objectives: a. The client had an objective which stated "Given a written telephone number, [the client] will dial the number correctly with verbal prompts 90% of the time during the trials conducted during the month for three consecutive months". Review of the program data documentation revealed no documentation since March 2007. The IPP reflected that the client continued this objective in the 2007 Individual Support Plan (ISP). The objective was rewritten from the previous ISP. The objective was reimplemented without revisions. b. The client had an objective which stated "Given a pattern of coins and bills, [the client] will pick out the value of money to math the price of the items shown 80% of trials per month for three consecutive months". Review of the program data documentation revealed no documentation since June 22, 2007. The IPP reflected that the client continued this objective in the 2007 ISP. The objective was rewritten from the previous ISP. The objective was reimplemented without revisions. c. The client had an objective which stated "Given verbal prompts, [the client] will prepare a simple meal with 100% independence for three consecutive months". Review of the program data documentation revealed no documentation since June 2007. The IPP reflected that the client continued this objective in the 2007 ISP. The objective was rewritten from the previous ISP.	W 257		

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W 257	Continued From page 27 The objective was reimplemented without revisions. d. The client had an objective which stated "When presented with arts and crafts of choice, [the client] will stay on task for up to 30 minutes independently 100% of the trials within a month for three consecutive months". Review of the program data documentation revealed no documentation since June 2007. The IPP reflected that the client continued this objective in the 2007 ISP. The objective was rewritten from the previous ISP. The objective was reimplemented without revisions. e. The client had an objective which stated "[The client] will participate in physical fitness exercises for 30 minutes for 12 consecutive months". Review of the program data documentation revealed no documentation since June 2007. The IPP reflected that the client continued this objective in the 2007 ISP. The objective was rewritten from the previous ISP. The objective was reimplemented without revisions. Interview with the QMRP confirmed that there was evidence of documentation for the aforementioned programs.	W 257		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by:	W 262	The Human Rights Committee is scheduled to meet on January 11/19 and will review the use of restrictive measures for both people in the sample.	1/3/08

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W 262	Continued From page 28 Based on observation, staff interview and record review, the facility's Human Rights Committee (HRC) failed to review and approve the use of restrictive measures, for two of the two clients in the sample. (Clients #1 and #2) The finding includes: On November 28, 2007 at approximately 1:00 PM, review of the HRC minutes and interview with the Qualified Mental Retardation Professional (QMRP) revealed the there was no evidence that the HRC had approved the use of restrictive techniques (i.e. behavior support plan and psychotropic medications) to manage behaviors for Clients #1 and #2. [See W124]	W 262		
W 263	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that each client's behavior intervention technique, including the use of behavior modification drugs was conducted with the written informed consent of the client, parents (if the client is a minor) or legal guardian for two of the two clients in the sample. (Clients #1 and #2) The finding includes: The facility failed to obtain informed consent prior to the use of restrictive measures as described in	W 263	See response to W 124.	1/3/08

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W 263	Continued From page 29 Clients #1 and #2's Behavior Support Plan and sedation. [See W124]	W 263		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide nursing services in accordance with the needs of two of the two clients included in the sample. (Clients #1, and #2) The findings include: 1. The facility's nurse failed to schedule medical consultation appointments for Client #1, timely. a. Review of Client #2's medical record on November 28, 2007 at approximately 12:30 PM revealed that the client had a gynecology consultation on April 26, 2007. The recommendation from the consultation indicated a normal vaginal examination and to follow-up in two years if the pap smear is normal. However there were no results of the pap smear in the record. b. Review of Client #2's medical record on November 28, 2007 at approximately 12:30 PM revealed that the client had a mammogram on January 12, 2007. The examination was unsuccessful. Interview with the Registered Nurse on November 29, 2007 at 2:20 PM, indicated the she would speak with the Primary Care Physician a week later to request a breast sonogram. At the time of the survey, there was	W 331	1. See response to W 195. The new RN Supervisor will hold scheduled grand rounds at least monthly with the Primary Care Physician and the QMRP to ensure people's medical needs are addressed completely and timely.	1/3/08

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W 331	Continued From page 30 no mammogram or an appointment scheduled. 2. The facility failed to ensure comprehensive treatment services for the maintenance of dental health. [See W356] 3. The facility failed to ensure that only authorized persons have access to the drug storage area. [See W383]	W 331	2. See response to #1 above. The RD will schedule another dental appointment and ensure that staff take the required records. Dental recommendations will be completed once written informed consent is acquired. 3. The Director of Disability Services will provide training to the QMRP, RD and staff on authorized access to the drug storage area. The lock combination to the drug storage area will be changed.	1/3/08 1/3/08
W 336	483.460(c)(3) iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that a health status was reviewed by the nursing staff on a quarterly or more frequent basis for one of the two clients in the sample. (Client #1) The finding includes: Review of Client #1's medical record on November 27, 2007 at approximately 12:00 PM revealed that an annual nursing assessment was completed on August 8, 2007. Further review of the medical record revealed that the first quarter assessment had not been completed. Interview with the Registered Nurse confirmed that the quarterly assessment had not been completed.	W 336	The new RN Supervisor will complete the quarterly assessment.	1/3/08
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental	W 356	See response to W 331 #1 and #2.	1/3/08

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W 356	Continued From page 31 treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure comprehensive treatment services for the maintenance of dental health for one of the two clients in the sample. (Client #2) The finding includes: On November 28, 2007, Client #2 was observed with many missing teeth. Review of the dental consultation dated December 6, 2006 revealed that the client needs to have additional seven teeth removed. The client had a dental appointment scheduled on March 20, 2007 with a dental surgeon. The direct care staff did not take the medical book, therefore, the dental surgeon could not assess the client laboratory values. At the time of the survey, there was no appointment scheduled. There was no evidence that the client received the recommended dental care since December 6, 2006.	W 356		
W 383	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that only authorized persons have access to the drug storage area.	W 383	See response to W 331 #3.	1/3/08

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W 383	Continued From page 32 The finding includes: On November 25, 2007 at approximately 4:15 PM, a request of the Medication Administration Record (MARs) was made to the direct care staff. He indicated that the MARs were locked in the nurse's station. At 4:30 PM, the direct care staff was observed to unlock the nurse's station door and retrieve the MARs. Interview with the Qualified Mental Retardation Professional (QMRP) on November 29, 2007 revealed that the direct care staff received the combination numbers from the QMRP. Review of the personnel records on November 28, 2007 at approximately 2:00 PM revealed no evidence that the direct care staff or the QMRP were trained medication employee.	W 383		
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 staff interview and record review, the facility failed to hold evacuation drills quarterly on all shifts. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the staffing pattern on November 29, 2007 at approximately 12:30 PM revealed the scheduled shifts are as follows: Weekdays 1st Shift 7 AM to 3 PM 2nd Shift 3 PM to 11 PM	W 440	The new RD and the QMRP will ensure that fire drills are completed and documented in accordance with the schedule and regulations.	1/3/08

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W 440	Continued From page 33 3rd Shift 11 PM to 7 AM Weekends 1st 7 AM to 7 PM 2nd 7 PM to 7 AM Further interview with the QMRP revealed that the staff was required to conduct a drill once per month on each shift. Review of the fire drill log book revealed that the facility failed to hold fire evacuation drills since their move into the facility (April 2007). There was no evidence that fire drills were conducted quarterly on all shifts.	W 440		
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: The facility's staff failed to implement infection control techniques. The finding includes: On November 26, 2007 at 5:12 PM, Client #2 was observed pulling her pants down and tearing off her soiled adult protective undergarments (APU's), while in her bedroom. The client put the APU on the floor. The direct care staff was observed picking up the soiledAPU's, with no gloves on.	W 455	The RN Supervisor will provide training on infection control.	1/3/08
W 483	483.480(d)(2) DINING AREAS AND SERVICE The facility must provide table service for all clients who can and will eat at a table, including clients in wheelchairs.	W 483		

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W 483	Continued From page 34 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide enough table room for five of five clients residing in the facility. The finding includes: At 5:04 PM, the client remained in the bedroom alone. The three direct care staff entered the bedroom with a bag of potato chips and water. The direct care staff was observed feeding the client potato chips and water. The client held onto the direct care staff's leg during the entire feeding. After the potato chips were finished the client grabbed both of the staff's legs and slightly lifting him from the floor. At 6:20 PM, the medication nurse was attempting to fed the client her dinner while the client was seated in the living room chair. The client consumed two spoonfuls of food. The nurse mixed 1/4 teaspoon of the client's crushed medications into her food. The client refused the food and medication. Several minutes later, the medication nurse was observed putting the remained medications into a jelly sandwich. The client consumed the medication sandwich.	W 483	The QMRP will ensure that people who eat and will eat the table have adequate comfortable space to do so.	1/5/08

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I 000	INITIAL COMMENTS A licensure survey was conducted from November 26, 2007 through November 29, 2007. The survey was initiated using the full survey process. A random sample of two residents were selected from a population of four females with various degrees of disabilities. The findings of the survey were based on observations at the home, interviews with clients and staff, and the review of records, including incident reports. The outcome of the survey revealed that the facility failed to be in compliance with the Condition of Participation in Active Treatment.	I 000		
I 043	3502.2(c) MEAL SERVICE / DINING AREAS Modified diets shall be as follows: (c) Reviewed at least quarterly by a dietitian. This Statute is not met as evidenced by: Based on record review, the facility failed to ensure that one of the three residents with modified diets had been reviewed at least quarterly by the consulting dietitian. The findings include: Review of Resident #1's medical records on November 27, 2007, failed to show evidence that the resident's modified diet had been assessed/reviewed by the dietitian at least every three months. The most recent quarterly nutrition review for Resident #1 had been documented on August 8, 2007.	I 043	The client's diet will be reviewed by the registered dietitian.	1/3/08

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Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Director of Disability Services — (X6) DATE: 1/3/08

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I 058	Continued From page 1	I 058		
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 facility failed to ensure that one of the three residents with modified diet had been reviewed at least quarterly by the consulting dietitian. The findings include: Review of Resident #1's medical records on November 27, 2007, failed to show evidence that the resident's modified diet had been assessed/reviewed by the dietitian at least every three months. The most recent quarterly nutrition review for Resident #1 had been documented on August 8, 2007.	I 058		
I 082	3503.10 BEDROOMS AND BATHROOMS Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting. This Statute is not met as evidenced by: Based on observation, the GHMRP failed to properly equip each bathroom with the appropriate items to meet each resident's needs. The findings includes:	I 082	The Residential Director (RD) will ensure that soap and paper towels are always available in the bathroom. The RD will ensure that a mirror is available in the bathroom.	1/3/08

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I 082	Continued From page 2 On November 29, 2007, at approximately 11:00 AM, no soap for hand washing, paper towels or mirror were available in the first bathroom in the hallway for residents and staff usage use.	I 082		
I 095	3504.6 HOUSEKEEPING Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach of each resident. This Statute is not met as evidenced by: Observation and interview revealed that the GHMRP failed to ensure that caustic agents were stored in the food preparation and serviced area. The finding includes: During the environmental inspection on November 29, 2007 at approximately 11:00 AM, caustic agents were observed stored in a food preparation area in a cabinet underneath the kitchen sink.	I 095	The RD will ensure that caustic agents are not stored in the food preparation area.	1/3/08
I 096	3504.7 HOUSEKEEPING No poisonous or hazardous agent shall be stored in a food preparation, storage or serving area. This Statute is not met as evidenced by: Observation and interview revealed that the GHMRP failed to ensure that caustic agents were not stored in the food preparation and serviced area The finding includes:	I 096	See response above.	1/3/08

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I 096	Continued From page 3 During the environmental inspection on November 29, 2007 at approximately 11:00 AM, caustic agents were observed stored in a food preparation area in a cabinet underneath the kitchen.	I 096		
I 135	3505.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift. This Statute is not met as evidenced by: Based on interview and record review the GHMRP failed to ensure that each shift conducted a fire drill four times a year. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the staffing pattern on November 29, 2007 at approximately 12:30 PM revealed the scheduled shifts are as follows: Weekdays 1st Shift 7 AM to 3 PM 2nd Shift 3 PM to 11 PM 3rd Shift 11 PM to 7 AM Weekends 1st 7 AM to 7 PM 2nd 7 PM to 7 AM Further interview with the QMRP revealed that the staff was required to conduct a drill once per month on each shift. Review of the fire drill log	I 135	The move to the facility took place in June 2007. The QMRP and RD will ensure that fire drills take place as scheduled quarterly on all shifts, and that the drills are properly documented in the log.	1/3/08

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I 135	Continued From page 4 book revealed that the facility failed to hold fire evacuation drills since their move into the facility (April 2007). There was no evidence that fire drills were conducted quarterly on all shifts.	I 135		
I 167	3507.4(e) POLICIES AND PROCEDURES The manual shall incorporate policies and procedures for at least the following: (e) Personnel which covers job descriptions and qualifications, staff/resident ratios, training and staff development, health inventory; This Statute is not met as evidenced by: Based on review of records the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that their Policies and Procedures' Manual included a policy to address personnel, job descriptions and qualifications, staff/resident ratios, training and staff development, and health inventory. The finding includes: Review of the policies and procedures on November 28, 2007, failed to provide evidence of a policy that addressed personnel, job descriptions and qualifications, staff/resident ratios, training and staff development, and health inventory.	I 167		
I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter.	I 203	The job descriptions will be reviewed with the staff annually. Those who were not reviewed timely will be completed.	1/3/08

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I 203	Continued From page 5 This Statute is not met as evidenced by: Based on record review, the GHMRP failed to provide evidence that the supervisor discussed the contents of job descriptions with each employee at the beginning of their employment and annually thereafter. The finding includes: Review of the personnel files on November 29, 2007 failed to provide evidence that five direct care staff (#8, #9, #10, #13 and #14) job descriptions had been reviewed.	I 203		
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been performed and that the employee's health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interviews and record review, the facility failed to achieve compliance with State regulations pertaining to health (22 DCMR Chapter 35, Section 3509.6). The finding includes: The State regulatory agency conducted a review of personnel records on November 29, 2007, at which time there was no evidence that six direct care staff (Staff #3, #9, #10, #11, #13, and #14), one medication nurse (Nurse #2), Podiatrist, Speech Pathologist and Occupational Therapist	I 206	The Human Resources Director will ensure that staff and consultants have current health certificates signed by a physician on file.	1/3/08

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I 206	Continued From page 6 had current health certificates.	I 206		
I 224	3510.5(a) STAFF TRAINING Each training program shall include, but not be limited to, the following: (a) Overview of mental retardation including, but not limited to, definition, causes of mental retardation, associated health implications, and frequently used medications, the history of care of individuals with mental retardation, and daily living skills; This Statute is not met as evidenced by: Based on observation, staff interview and record review, the GHMRP failed to ensure effective training was provide to each staff. The finding include: Review of the training records on November 29, 2007, revealed that the GHMRP failed to provide training in overview of mental retardation.	I 224	The QMRP will provide training to staff on an Overview of Mental Retardation.	1/3/08
I 225	3510.5(b) STAFF TRAINING Each training program shall include, but not be limited to, the following: (b) Human development through the life cycle (birth to death); This Statute is not met as evidenced by: Based on record review, the GHMRP failed to ensure effective training was provide to each staff. The finding includes:	I 225	The QMRP will provide training to staff on Human Development.	1/3/08

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I 225	Continued From page 7 Review of the training records on November 29, 2007 revealed that the GHMRP failed to provide training in Human Development.	I 225		
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (c) Infection control for staff and residents; This Statute is not met as evidenced by:	I 227	The RN Supervisor will provide training to staff on infection control.	1/3/08
I 228	3510.5(e) STAFF TRAINING Each training program shall include, but not be limited to, the following: (e) Resident's rights; This Statute is not met as evidenced by: Based on record review, the GHMRP failed to ensure effective training was provide to each staff. The finding includes: Review of the training records on November 29, 2007 revealed that the GHMRP failed to provide training in Resident's Rights.	I 228	The QMRP will provide training to staff on Resident's Rights.	1/3/08
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following:	I 229	The QMRP will provide training to staff on each resident's needs in behavior supports, assistive technology and sexuality.	1/3/08

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I 229	Continued From page 8 (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 review of training documents, the GHMRP failed to provide evidence to validate staff training as indicated by residents' need. The finding includes: Review of the training records on November 9, 2007, the GHMRP failed to provide training on behavior management, assistive technologies and sexuality	I 229		
I 230	3510.5(g) STAFF TRAINING Each training program shall include, but not be limited to, the following: (g) Habilitation planning and implementation; This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each employee was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently. The finding includes: The facility failed to ensure that staff was capable of demonstrating understanding of Clients #1 and #2 need for Active Habilitation and their Individual Support Plans (ISP). (See W196 and W249)	I 230	The QMRP will ensure that staff are trained on clients' individual Support Plans and Active Habilitation.	1/3/08

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I 232	Continued From page 9	I 232		
I 232	3510.5(i) STAFF TRAINING Each training program shall include, but not be limited to, the following: (i) Training of the residents in the maintenance of oral health and hygiene. This Statute is not met as evidenced by: Based on record review, the GHMRP failed to ensure effective training was provide to each staff. The finding includes: Review of the training records on November 29, 2007 revealed that the GHMRP failed to provide training in oral health and hygiene.	I 232	The QMRP will ensure that the staff are trained on health and hygiene.	1/3/08
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 record review the GHMRP failed to ensure each residents records were dated and signed by the individual completing the protocol. The finding includes: See Federal Deficiency Report - Citation W114	I 291	See response to federal deficiency W114.	1/3/08
I 420	3521.1 HABILITATION AND TRAINING Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their	I 420	See response to federal deficiency W221.	1/3/08

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I 420	Continued From page 10 environments and to achieve their optimum levels of physical, mental and social functioning. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the GHMRP failed to ensure habilitation and training was provided to its residents that would enable them to acquire and maintain life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning for one of the two residents in the sample. (Resident #1) The finding includes: See Federal Deficiency Report - Citations W227	I 420		
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 residents in accordance with their Individual Habilitation Plan for two of two residents in the sample. (Residents #1 and #3) The finding includes: See Federal Deficiency Report Citation W196	I 422	See response to federal deficiency W196	1/3/08
I 429	3521.6 HABILITATION AND TRAINING Each GHMRP Director shall arrange for each	I 429	See response to federal deficiency W259	1/3/08

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I 429	Continued From page 11 resident to be reevaluated and to receive an Individual Habilitation Plan, which is updated appropriately at least annually. This Statute is not met as evidenced by: Based on staff interview and record review, the GHMRP failed to provide evidence that each resident had been reevaluated and received an Individual Habilitation Plan that was updated at least annually for one of the two residents included in the sample. (Resident #1) The finding includes: See Federal Deficiency Report - Citation W259	I 429		
I 436	3521.7(f) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (f) Health care (including skills related to nutrition, use and self-administration of medication, first aid, care and use of prosthetic and orthotic devices, preventive health care, and safety); This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure the habilitation and training of residents in the domain of self medication. The finding includes: See Federal Deficiency Report - Citations WW196	I 436	See response to federal deficiency W196.	1/3/08

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I 437	Continued From page 12	I 437		
I 437	3521.7(g) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (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 facility failed to provide habilitation and training for two of the two residents included in the sample (Residents #1 and #2) The finding includes: See Federal Deficiency Report - Citations W196	I 437	See response to federal deficiency W196	1/3/08
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure the protections of each clients rights. The finding includes:	I 500	See responses to federal deficiencies W124, W130, W137, W140, W159, W195, W196, W209, W212, W227, W252, W257, W262, and W263.	1/3/08

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I 500	Continued From page 13 See Federal Deficiency Report - Citations W124, W130, W137, W140, W159, W195, W196, W209, W212, W227, W252, W257, W262 and W263.	I 500		

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R 000	INITIAL COMMENTS A licensure survey was conducted from November 26, 2007 through November 29, 2007. The survey was initiated using the full survey process. A random sample of two residents were selected from a population of four females with various degrees of disabilities. The findings of the survey were based on observations at the home, interviews with clients and staff, and the review of records, including incident reports. The outcome of the survey revealed that the facility failed to be in compliance with the Condition of Participation in Active Treatment.	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 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 finding includes: Review of the personnel files on November 29, 2007 revealed the GHMRP failed to provide	R 125	The Director of Human Resources will ensure that all direct care staff have criminal background checks completed and in their files.	1/3/08

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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R 125	Continued From page 1 evidence of criminal background checks for four direct care staff (Staff #4, #9, #13 and #14).	R 125		