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OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	03/06/2009

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

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W 000	INITIAL COMMENTS A recertification survey was conducted from March 5, 2009 through March 6, 2009. The survey was initiated using the fundamental survey process. A random sample of three clients was selected from a client population of five females with various disabilities. The findings of the survey were based on observations at the group home and three day programs, interviews with day program staff, management and direct care staff in the residence and the review of administrative records, including the facility's incident management system.	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 physician orders were signed by the physician for two of the three clients in the sample. [Clients #2 and #3] The findings include: The facility failed to ensure that physician's orders for Client #2 and #3 were reviewed and signed by the Primary Care Physician (PCP) as evidenced below: a. On March 6, 2009 at 2:30 PM, the most recent physician's orders available (dated February 2, 2009 through February 28, 2008) for Client #2 were reviewed. The orders included a note which	W 114	a. The I.PNC will ensure that the physician orders are signed timely by sending them to the PCP's office for review and signature, instead of waiting for the PCP's scheduled visits to the facility.	4/25/09

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

Marsha H. Thompson — Director of Disability Services — 4/6/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 114	Continued From page 1 stated "Good for 120 days". Interview with the License Practical Nursing Coordinator (LPNC) revealed the primary care physician was scheduled to evaluate the clients at the group home every ninety (90) days and to sign the physician's orders. At the time of the survey, however, there was no evidence that physician's orders for February 2009 had been reviewed and signed by the PCP. b. On March 6, 2009 at 3:30 PM, the most recent physician's orders available (dated February 2, 2009 through February 28, 2008) for Client #3 were reviewed. The orders included a note which stated "Good for 120 days". Interview with the LPNC revealed the primary care physician is scheduled to evaluate the clients at the group home every ninety (90) days and to sign the physician's orders. At the time of the survey, however, there was no evidence that physician's medication orders for February 2009 had been reviewed and signed by the PCP.	W 114	b. See response above.	4/25/09
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 clothing were provided that met the needs of one of the three clients in the sample. (Client #3) The finding includes:	W 137	The QMRP will request the Behavior Specialist to re-evaluate the client's desires around the type of clothing that she may prefer. Once the Behavior Specialist either confirms or revises the recommendation, the QMRP will ensure that the client is taken to select and purchase the kind of clothing that she may be able to tolerate for wear.	4/25/09

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W 137	Continued From page 2 The facility failed to ensure that Client #3 was provided the style of clothing which met her assessed needs. Observation throughout the survey on March 5, 2009, revealed Client #3 to keep her arms positioned underneath her shirt. On several occasions, the client was observed to remove her shirt in the living room. On March 5 and March 6, 2009, Client #3 was observed wearing a pullover-style of shirt that buttoned at the neckline. Interview with the direct care staff on March 5, 2009 at approximately 5:50 PM, revealed that the client had a Behavior Support Plan (BSP) which addressed her disrobing behavior. Interview with the Residential Director at approximately 6:00 PM, confirmed that the client had a BSP which addressed her maladaptive behavior of disrobing. On March 6, 2009 at approximately 10:38 PM, a review of the BSP dated July 8, 2008 confirmed disrobing as one of Client #3's targeted behaviors. Further Review of her behavior support recommendations revealed the following: "Staff are to help [the client] to shop around for and try on tops that are well tailored. Choose poncho or kaftan style tops that feature large and loose sleeves, and may cater to her desire for free arm movement." Review of Client #3's financial records did not evidence that the facility had purchased the recommended style of clothing to allow for free arm movement. At the time of the survey, there was no evidence that Client #3 had received the	W 137		

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W 137	Continued From page 3 style of clothing recommended to the client comfort and free movement.	W 137		
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 integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP) for three of the three clients in the sample. (Clients #1, #2 and #3) The findings include: 1. The QMRP failed to ensure that Client #1's adaptive equipment needs were adequately and timely coordinated as evidenced below: On March 6, 2009 at 8:42 AM, Client #1 was observed to bite a portion from the spout of the flexible plastic cup, from which she drank water after receiving her medications. Interview with the medication nurse on March 5, 2009 at 8:45 AM, revealed the client often firmly grasped the coated spoon and spout of the cup with her mouth when the medications and water were offered. Interview with the Residential Director (RD) revealed the client's use of the spout cup enabled her to independently drink a beverage, after the cup was placed in her hand. Further interview with the RD, however revealed	W 159	1. The QMRP will request the Speech-Language Pathologist (SLP) to evaluate the client's needs concerning a spouted cup, and recommend the specific kind of cup required for her to drink independently, comfortably, and safely.	4/25/09

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W 159	Continued From page 4 that the client should have been provided with a different type of spout cup. On March 5, 2008 at 2:15 PM, the review of a mealtime protocol dated January 2009 revealed the speech and language pathologist (SLP) approved Client #1's use of a "spout cup" for drinking beverages. Further review of the mealtime protocol revealed it did not specify the type of spout cup the client should be provided. There was no evidence the QMRP integrated and coordinated services to ensure the type of cup provided for the client was appropriate for her developmental needs.	W 159		
	2. The QMRP failed to integrate and coordinate services to ensure the IPP objective were implemented in accordance with the individual support plan for Client #1. (See W249)		2. See response to W249.	4/25/09
	3. The QMRP failed to integrate and coordinate services to ensure an effective system for the provision of a training program on self-administration for Client #1. (See W371)		3. See response to W371.	4/25/09
	4. The QMRP failed to coordinate services to ensure comprehensive bed mobility assessments were conducted for Clients #2, #4 and #5. (See W214)		4. See response to W214.	4/25/09
	5. The QMRP failed to ensure that program data was collected in measurable terms for Clients #1, #2, and #3. (See W252)		5. See response to W252.	4/25/09
	6. The QMRP failed ensure the IPP) objectives were incorporated in the individual activity schedules of Clients #1, #2 and #3. (See W250)		6. See response to W250.	4/25/09
W 189	483.430(e)(1) STAFF TRAINING PROGRAM	W 189		

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W 189	Continued From page 5 The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations, staff interview, and record verification, the facility failed to provide each employee with initial and continuing training that enabled the employee to perform his or her duties effectively and competently for three of three clients in the sample. (Clients #1, #2, and #3) The findings include: 1. The facility failed to ensure effective training to direct care staff on documentation of individual program plan objectives for Clients #1, #2 and #3. (See W252) 2. The facility the failed to ensure that direct care staff were trained effectively to implement Client #1's self-medication objective. (See W249) 3. The facility failed to ensure that each staff was trained on the use of a spout cup prescribed for Client #1 to increase her independence in drinking beverages. On March 5, 2009 at 8:42 AM, Client #1 was observed to bite a portion from the spout of the flexible plastic cup, from which she drank water after receiving her medications. The nurse then repeatedly prompted the client to open her mouth. As the client opened her mouth, the bitten off piece of the spout fell to the floor.	W 189	1. See response to W252. 2. See response to W249. 3. The QMRP will ensure that the staff are trained on which spouted cup to purchase for client #1 and ensure that all staff are trained to use it.	4/25/09 4/25/09 4/25/09

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W 189	Continued From page 6 Interview with the Residential Director (RD) on March 5, 2009 revealed the client should have been drinking from a different type of spout cup. After the morning medication administration observation on March 5, 2009, the RD provided the client with a new and different type of spout cup, which was made of a rigid plastic. At 3:40 PM, the RD was observed instructing an evening staff to be sure that Client #1 used only the new cup. Client #1 was observed holding the new cup and drinking from it at approximately 4:10 PM. At the time of the survey, however, there was no evidence that each staff had been trained on the the use of the new cup.	W 189		
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure each client had a comprehensive bed mobility assessment, for three of the five clients (Client #2, #4 and #5) residing in the facility. The findings include: Observation during an environmental walk-through on March 6, 2009 at approximately 5:45 PM, revealed hospital beds with rails were being used for Client #2, #4, and #5. Interview with the Qualified Mental Retardation Professional (QMRP) and the Residential Director (RD) revealed that Clients #2, #4 and #5 required	W 214	The QMRP will ensure that a bed mobility assessment is completed for clients #2, #4, and #5 and placed in the record.	4/25/09

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W 214	Continued From page 7 bed rails at night to ensure their safety. Further interview with the RD revealed that none of these client were able to independently get in and out of their beds. Interview with the Director of Nursing (DON) revealed that the agency's practice was to complete a bed mobility assessment to determine the clients' need for a hospital bed/rails. Once the determination was made, the result was required to be presented to the Human Rights Committee (HRC) for review and approval. Review of the medical and habilitative records of Clients #2, #4 and #5 did not evidence that a bed mobility assessment had been completed for each client.	W 214		
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, interview and record review, the facility failed to ensure continuous active treatment for one of three clients in the sample. (Client #1) The finding includes: The facility failed to ensure Client #1's	W 249	The QMRP will review and revise the self-medication IPP and train the client, staff, and nurses on how to implement and document the program.	4/25/09

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W 249	Continued From page 8 self-medication program objective was implemented in accordance with the interdisciplinary team recommendation. Observation of the medication administration on March 5, 2009 at approximately 8:42 AM, revealed that direct care staff brought Client #1 into the medication room in her wheelchair. At 8:45 AM, the nurse was observed verbally prompting and physically assisting Client #1 to hold her spout cup containing water in her left hand. On March 6, 2009 at 12:52 PM, interview with the Qualified Mental Retardation Professional (QMRP) and review of the individual program plan (IPP) at approximately 2:30 PM, revealed that the client had a self-medication objective. The objective was written as follows; "Given verbal prompting, [the client] will wash and dry her hands before taking her medication with 60% accuracy for 6 consecutive months." Further interview with the QMRP revealed that she was aware that this self medication objective was not being implemented. Review of the IPP data sheet for this objective failed to evidence that this objective was being implemented. There was no evidence the aforementioned objective for handwashing prior to taking her medication was implemented for Client #1.	W 249		
W 250	483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.	W 250	The QMRP will ensure that the active treatment schedules are completed, and that staff and clients are trained on their purpose and implementation. The QMRP will ensure that the schedules are available for staff in each client's record.	4/25/09

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W 250	Continued From page 9 This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that each client's Individual Program Plan (IPP) objectives were incorporated in their individual activity schedules for three of three clients in the sample. (Clients #1, #2 and #3) The findings include: The facility failed to ensure that the activity schedules for Clients #1, #2 and #3 were available and incorporated IPP objectives as evidenced below: On March 6, 2009 at approximately 1:45 PM, interview with the Qualified Mental Retardation Professional (QMRP) and the review of the Individual Support Plans (ISPs) for Clients #1, #2, and #3 respectively revealed that the activity schedules of Client #1, #2 and #3 was not available. Further interview with the QMRP revealed the activity schedule format had been revised. According to the QMRP, the new schedules would include the day and time, specific activities and IPP objectives. At the time of the survey, however, there was no evidence that the each client's activity schedule had been developed.	W 250		
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.	W 252		

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W 252	Continued From page 10 This STANDARD is not met as evidenced by: Based on interview, and record review, the facility failed to ensure that data was collected in the required form and frequency for three of three clients included in the sample. (Client #1, #2 and 3) The findings include: The facility failed to ensure that data was collected and maintained on Client #1, #2 and #3's individual program plan (IPP) objectives as evidenced below: a. Interview with staff on March 6, 2009 at approximately 10:45 AM, revealed that Client #2 enjoyed going on outings in the community with her day program. Record review at the group home on the same day revealed the client's IPP included an objective to improve the her recreational skills as evidenced below: - Client (#2) "will complete the steps in planning an activity of her choice with 50% independence for 3 consecutive months by August 2009." Review of the Client #2's Individual Support Plan (ISP) dated August 11, 2008 on March 6, 2009 at approximately 4:30 PM, confirmed that the interdisciplinary team recommended the aforementioned IPP objective for Client #2. Interview with the QMRP later that day (4:50 PM) and the subsequent review of the IPP data, however failed to evidence that the aforementioned recreation objective had been implemented for Client #2.	W 252	a. The QMRP will train the Residential Director and Direct Care Professional staff to implement the client's IPP based upon the schedule and to document the IPP per instruction.	4/25/09

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W 252	Continued From page 11 b. The facility failed to ensure that data was collected on Client #1's self-medication objective. (See W249) c. On March 6, 2009 at approximately 2:40 PM, interview with the QMRP and review of Client #3's IPP revealed that the client had a communication objective. The objective was written as follows; "Given verbal assistance, [the client] will respond to tactile voice directives with 60 % of the trials for 3 consecutive months." Interview with the QMRP on the same day revealed that she was aware that this objective was not being implemented. Review of the IPP data form failed to evidence that this communication objective data was being collected. d. On March 6, 2009 at approximately 2:45 PM, interview the QMRP and review of the Client #3's IPP revealed that the client had a money management objective. The objective was written as follows; "Given verbal prompting, [the client] will select and purchase an item by feel and touch with 60 % of the trials for 3 consecutive months." Interview with the QMRP on the same day revealed that she was aware that this objective was not being implemented. Review of the IPP data form failed to evidence that the money management objective data was being collected. e. On March 6, 2009 at approximately 2:55 PM, interview the QMRP and review of Client #3's IPP	W 252	b. See response to W249. c. See response to "a" above. d. See response to "a" above. e. See response to "a" above.	4/25/09 4/25/09 4/25/09 4/25/09

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W 252	Continued From page 12 revealed that the client had a home management objective. The objective was written as follows; "Given hand over hand assistance, [the client] will sweep her bedroom floor with 50% accuracy for 6 consecutive months." Interview with the QMRP on the same day revealed that she was aware that this objective was not being implemented. Further interview revealed that this home management goal was not an appropriate objective for Client #3, who is blind. Review of the IPP data sheet failed to evidence that the home management objective data was being collected.	W 252		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure programs that incorporated restrictive techniques had been reviewed, approved and monitored by the specially constituted committee prior to implementation, for three of five clients residing in the facility. (Client #2, #3 and #5) The findings include: The facility failed to ensure the results of bed mobility assessments for Client #2, #3 and #5 were reviewed by the Human Rights Committee	W 262	See response to W214. The QMRP will ensure that new bed mobility assessments and recommendations are presented to the Human Rights Committee for review and approval.	4/25/09

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W 262	Continued From page 13 (HRC) and the use of bedrails was approved for the clients. (See W214)	W 262		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure its physician services conducted a timely review of medical orders, the results of prescribed medical consultations and laboratory tests for two of three clients in the sample. (Clients #2 and #3) The findings include: The facility failed to ensure the primary care physician conducted a timely review of the medical and laboratory results prescribed for Clients #2 and #3 as evidenced by: a. Interview with the Licensed Practical Nurse Coordinator (LPNC) on March 5, 2009 at 3:05 PM, revealed that the most current results of prescribed medical consultations and laboratory studies were maintained in a special notebook for the physician. The nurse revealed that Client #2 had medical screening to rule out health concerns as a possible cause of her weight loss in 2008. The results of the Client's hepatic evaluation (January 13, 2009) and gall bladder series (January 26, 2009) would be filed in the client's medical record after the studies were reviewed and acknowledged by the primary care physician (PCP). The LPNC reported that the usual procedure was to notify the PCP by telephone,	W 322	a. The Director of Operations will amend the PCP's contract via a supplemental letter outlining the timeframes for the PCP to review and acknowledge the results of medial referrals.	4/25/09

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W 322	Continued From page 14 and to fax the results to the primary care physician for review. The physician special notebook was reviewed on March 5, 2009 at 3:38 PM. There was no evidence that the results of consultations and medical procedures that were conducted after January 6, 2009 had not been reviewed and signed by the PCP. The review of the facility's contractual agreement with the PCP (dated October 8, 2008) revealed it failed to establish time frames in which the PCP was required to review the results of medical referrals. b. The review of the physician's special notebook on March 5, 2009 at 3:50 PM revealed Client #3's hematology report dated January 13, 2009. The following elevated laboratory values were documented in the report: [AST 116 U/L (reference range: 10 - 42 U/L) and ALT 144 U/L(reference range: 13 -51 U/L)]. At the time of the survey, there was no evidence that these abnormal laboratory findings had been forwarded to the PCP for review and approval.	W 322	b. The QMRP will ensure that laboratory findings are forwarded to the PCP for review and approval as soon as they are available.	4/25/09
W 371	483.460(k)(4) DRUG ADMINISTRATION The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to establish an effective system to provide a training program for self-administration for one of the three clients in	W 371	The QMRP will ensure that the client is reassessed for self-medication administration. The assessment will be reviewed by the IDT at the next quarterly meeting. If the IDT (the IDT includes the PCP) approves the client for self-medication administration programming, the QMRP will develop the program and train the client, staff, and nurses on implementing and documenting the program.	4/25/09

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W 371	Continued From page 15 the sample. (Client #1) The finding includes: The facility failed to ensure Client #1 had been assessed for a self-medication objective prior to its inclusion in the individual program plan (IPP). Observation of the medication pass on March 5, 2009 at approximately 8:40 AM, revealed that Client #1 did not participate in a self-medication objective. Interview with the License Practical Nurse and the Director of Nursing at approximately 11:00 AM, revealed that Client #1 was assessed, however was not approved to participates in a self-medication objective. Interview with the Qualified Mental Retardation Professional (QMRP), on the same day at approximately 3:30 PM, revealed that if the client had been approved to participate in a self-medication objective, the medication nurse would be the responsible person for implementing the objective. Additionally, the LPN would be responsible for documenting the data in the Medication Administration Record (MAR). Review of the IPP, however on the same day at 3:40 PM, however did revealed a self-medication objective that stated, "Given verbal prompting, [the client] will wash and dry her hands before she takes her medication with 60% accuracy for 6 consecutive months". Further review of the IPP book did not evidence that this objective was being implemented by the designated medication nurse or that data was being documented as outlined. Review of the client physician orders dated September 30, 2008 did not evidence an order for the client to participate in the	W 371		

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W 371	Continued From page 16 aforemention self-medication objective which had been discovered in the IPP. Review of the MAR for the month of March 2009 failed to evidence that Client #2 self-medication objective had been implemented as recommended by the IDT.	W 371		
W 390	483.460(m)(2)(i) DRUG LABELING The facility must remove from use outdated drugs. This STANDARD is not met as evidenced by: Based on observation, the facility failed to remove from use, an out dated medication for one of five clients residing in the facility. (Client #5) The finding includes: The facility's nursing staff failed to ensure that an expired topical medication was destroyed as evidenced below: During an environmental walk-through on March 6, 2009 at approximately 5:35 PM, the surveyor observed an expired topical medication (Sensi Care Body Cream) container prescribed for Client #5, which was in her ADL basket. The expiration date on the container read December 4, 2008. Interview with the Licensed Practical Nurse Coordinator (LPNC) revealed that she monitored the topical medication. According to the LPNC, the direct care staff apply the topical medications and document in the medication treatment administration records. At the time of the survey, there was no evidence that the facility's nursing staff ensured that expired medication was removed from the client's supplies after its expiration date.	W 390	The LPNC will abide by Careco's policy and ensure that expired unused medications are appropriately destroyed.	4/25/09

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W 393	483.460(n)(1) LABORATORY SERVICES If a facility chooses to provide laboratory services, the laboratory must meet the requirements specified in part 493 of this chapter. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure it met the requirements for performing glucose testing for one of three clients in the sample. (Client #2) The finding includes: On March 5, 2009 at approximately 9:48 AM, observation of the medication administration revealed that the Licensed Practical Nurse (LPN) used the finger stick method to test Client #2's blood glucose level. Interview with the LPN revealed that Client #2 had a diagnosis of Diabetes Mellitus, Type II. Further interview with the LPN revealed that blood glucose levels were to be monitored, using a Glucometer in the morning and evening. Interview with the Qualified Mental Retardation Professional(QMRP) on March 5 ,2009 at approximately 11:00 AM, revealed that the facility did not have the required certification to conduct blood glucose testing as identified by Part 493 of the Clinical Laboratory Improvement Act (CLIA). Review of the physician's orders dated February 1, 2009, revealed that Client #2's blood glucose level should be tested every morning and evening at the group home. At the time of the survey, there was no evidence that the CLIA certification had been obtained.	W 393	The facility did have an *unexpired* CLIA certification at the time of the survey, and since the survey, the renewal application has been submitted. A copy of the CLIA certification was forwarded to the facility.	4/25/09
W 418	483.470(b)(4)(ii) CLIENT BEDROOMS	W 418		

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W 418	Continued From page 18 The facility must provide each client with a clean, comfortable mattress. This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure that a comfortable mattress support was provided for one of the three clients in the sample. (Client #5) The finding includes: The facility failed to provide Client #5 with a supportive mattress pad in good condition. During the environmental walk through on March 6, 2009, at approximately 5:15 PM, a supportive mattress pad was observed on the top of Client #5's regular mattress. The mattress pad which was approximately 3 inches thick, was observed to have a deep indention through-out the middle section. Interview with the Residential Director (RD) revealed that the mattress pad provided Client #3 with additional support when lying in her bed. Further interview with the RD revealed that the mattress pad was fairly new. At the time of the survey, that was no evidence that the group home had maintained Client #5's support mattress to ensure her comfort.	W 418	The Director of Operations will ensure that a new mattress pad is purchased for the client. The Residential Director will ensure that staff are trained to properly maintain the mattress pad, and to notify both the Residential Director and the QMRP when the mattress pad needs to be cleaned or replaced.	4/25/09
W 420	483.470(b)(4)(iv) CLIENT BEDROOMS The facility must provide each client with functional furniture, appropriate to the clients needs.	W 420	The Residential Director will ensure that the client's chest of drawers is either repaired or replaced.	4/25/09

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W 420	Continued From page 19 This STANDARD is not met as evidenced by: Based on observation and record review, the facility failed to provide functional furniture, appropriate to the clients' needs of one of the three clients in the sample. (Client #3) The finding includes: The facility failed to ensure that Client #3 was provided with the use of a chest of drawers appropriate for her personal clothing. During the environmental walk through on March 6, 2009, at approximately 5:15 PM, Client #3's top chest of drawer was missing the face panel and the drawer was broken. Further observation revealed that the remaining drawers were broken and off track. Interview with the Residential Director (RD) revealed that Client #3 had a behavior support plan which addressed property destruction. Further interview with the RD revealed that the chest of drawers may have been damaged during Client #3's behavioral outbursts. Review of the behavior support plan dated July 17, 2008 on March 6, 2009 at approximately 3:30 PM, confirmed that property destruction was one of the client's targeted behaviors. At the time of the survey, there was no evidence that the facility provided Client #3 with a chest of drawers from which she could access personal clothing safely.	W 420		
W 421	483.470(b)(4)(iv) CLIENT BEDROOMS The facility must provide each client with individual closet space in the client's bedroom with clothes racks and shelves accessible to the client.	W 421	The Residential Director will hang a divider in the closet to ensure that the two clients' clothing is identified and separated.	4/25/09

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W 421	Continued From page 20 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide individual closet space appropriate for two of the five clients residing in the facility. (Clients #2 and #5). The finding includes: The facility failed to ensure that each client was provided with appropriate and identifiable closet space for their personal clothing. During the environmental walk through on March 6, 2009, at approximately 5:22 PM, it was observed that Client #2 and #5 shared a small closet in their bedroom. Observation of the closet revealed it failed to have a system to identify and separate each client's personal clothing. According to the Residential Director (RD), Client #2's clothing were to the left of the closet and Client #5's clothing were to the right closet. At the time of the survey, there no evidence that the facility had established a system to clearly identify each client's personal clothing.	W 421		
W 426	483.470(d)(3) CLIENT BATHROOMS The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit. This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to maintain water temperatures that did not	W 426	The Residential Director will ensure that water temperatures are checked and documented daily per Careco's policy. If the temperature deviates from the acceptable reading then the Residential Director will ensure that Maintenance staff are called in immediately to adjust the settings. The Residential Director and Maintenance staff will then test the water temperature on a frequent basis (approx every two hours), making necessary adjustments, until the water temperature is at an acceptable reading.	4/25/09

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W 426	Continued From page 21 exceed 110 degrees Fahrenheit. The finding include: During observation of the environment on March 6, 2009 at approximately 5:45 PM, the hot water was turn on in the bathroom on the main level of the facility. The Licensed Practical Nurse Coordinator (LPNC) entered the bathroom and placed her hands under the running water. The LPNC yelled loudly , "The water is too hot". The surveyor used a thermometer to check the hot water temperature and discovered the temperature read 125 degrees Farenheit in bathroom. The water temperature was then checked in the kitchen and the thermometer read 138 degrees Fahrenheit. Interview with the Qualified Mental Retardation Professional (QMRP) at 5:49 PM, revealed that the hot water was monitored frequently and adjusted when needed. Further interview with the QMRP indicated that the direct care staff usually checked the water temperature prior to bathing the clients and no clients bathed independently. At the time of the walk through, the clients were out of the facility participating in a community outing. A maintenance staff was observed on site at the time of the temperature readings and was instructed by the QMRP to adjust the hot water heater. It should be noted that at 6:00 PM the facility's QMRP developed a 72 hour plan to monitor the hot water temperature. The plan was to be implemented immediately to ensure the clients' safety throughout the weekend. The surveyor re-tested the hot water temperature	W 426		

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W 426	Continued From page 22 at approximately 6:25 PM, prior to exiting the facility. The thermometer temperature read 124 degrees Fahrenheit the bathroom and 125 degrees Fahrenheit in the kitchen. On March 9, 2009 at approximately 4:10 PM, a post survey was conducted to verify water temperatures. The temperature read 114 degrees Fahrenheit in the bathroom and 116 degrees Fahrenheit in the kitchen.	W 426		
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on interview and the review of fire drill reports, the facility failed to hold evacuation drills at least quarterly for each shift of personnel, on two of three shifts. The findings include: Interview with the Residential Director (RD) on March 5, 2009 at 9:30 AM, revealed the group home had three shifts of direct care personnel. The shifts were identified as: 7:00 AM - 3:00 PM, 3:00 PM - 11:00 PM, and 11:00 PM - 7:00 AM seven days a week. On March 5, 2009 at 10:55 AM, a review of fire drills records provided for April 1, 2008 through February 2009 was conducted. The review of the drills provided the following information: a. There were no documented fire drill on the 7:00 AM - 3:00 PM (day shift).	W 440	The QMRP will ensure that the Residential Director and Direct Support Professional staff are trained on Careco's policy concerning evacuation drills. The QMRP will ensure that drills are conducted on each shift at least quarterly, and that such drills are accurately documented.	4/25/09

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W 440	Continued From page 23 b. There were no documented fire drill on the 3:00 PM - 11:00 PM shift (evening shift) after October 27, 2008. During a follow-up interview on March 5, 2009 at approximately 1:00 PM, the RD and the Qualified Mental Retardation Professional acknowledged the drills had not been conducted at the frequency required by this regulation.	W 440		
W 473	483.480(b)(2)(ii) MEAL SERVICES Food must be served at appropriate temperature. This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure that food was served at the appropriate temperature for two of the five client residing in the facility. (Client #2 and #5) The finding includes: The facility staff failed to serve food at the appropriate temperature during breakfast as evidenced below: At 7:05 AM five covered plates were observed on the dining table in the kitchen. At approximately 8:08 AM, Client #3's assigned staff assisted her to the dining table in the kitchen. The staff removed the cover from her plate and began to feed the client breakfast. At no time prior to feeding the client was the staff observed to reheat her scrambled eggs. At approximately 8:14 AM, Client #5's assigned staff was observed to assist her to the dining table in the kitchen. The staff removed the cover	W 473	The Residential Director will ensure that Direct Support Professional staff are trained on serving clients their meals at the appropriate temperature.	4/25/09

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W 473	Continued From page 24 from her plate and prompted the client to eat breakfast. The staff fed her two spoonfuls and placed the spoon on the edge of the plate. Client #2 then picked up the spoon and began to eat her food independently. At approximately 8:18 AM, the client finished eating the mini blueberry muffin and bowl of cheerios with milk. The client was offered the cold scrambled eggs and the client initially refused to eat them, however after drinking her beverage, began to eat her cold scrambled eggs. At no time prior to Client #2 consuming the eggs did the direct care staff reheat her eggs. Interview with the Residential Director (RD) at approximately 8:52 AM revealed the the overnight shift prepared the breakfast before departing the facility.	W 473		
W 477	483.480(c)(1)(i) MENUS Menus must be prepared in advance. This STANDARD is not met as evidenced by: Based on observation, staff interview and record, the facility failed to ensure that lunch menus were prepared in advance for five of 5 clients residing in the facility. (Clients #1, #2, #3, #4 and #5) The findings include: 1. Observation on March 5, 2009 at 8:04 AM, revealed Client #2 assisting staff in the preparation of a bag lunch. The lunch consisted of a jelly sandwich, applesauce, Glucerna (nutritional supplement) and a bottle of water. Interview with Residential Director (RD) on March 5, 2009 at 3:20 PM, revealed that Client #2 takes	W 477	1. The QMRP will request the Nutritionist to provide weekday lunch menus for the client.	4/25/09

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	09G171	A. BUILDING _____ B. WING _____	03/06/2009

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W 477	Continued From page 25 her lunch to her day program because she is a picky eater. On March 6, 2009 at 10:15 AM, interview with Client #2's 1:1 staff indicated that the client brought her lunch with her. The lunch consisted of a peanut butter and jelly sandwich, mandarin orange sections, Glucerna and a bottle of water. The 1:1 staff also revealed that the client brought her lunch to the day program because she was a "picky eater". Interview with the Qualified Mental Retardation Professional (QMRP) on March 6, 2009 at 1:45 PM revealed the lunch menus were planned by the guidelines on the menus. The review of available menus in the facility, however, revealed there were no planned weekday lunch menus for the client. 2. Interview with the RD on March 5, 2009 at 7:10 AM revealed all clients (#1, #2, #3, #4, and #5) living in the group home attended a day program from approximately 9:00 AM to 3:00 PM on Monday through Friday. Further interview with the RD on March 5, 2008 at approximately 1:45 PM, revealed that all clients, except Client #2, were provided lunch by their day programs. According to the RD, no weekday lunch menus had been planned by the nutritionist because usually no clients were in the group home for lunch. The review of the cycle menus on the same day confirmed that there were no planned lunch menus for Monday through Fridays.	W 477	2. See response to #1 above.	4/25/09
W 483	483.460(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	The QMRP will ensure that clients are able to eat at the table in shifts, so that table service is provided for everyone.	4/25/09

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W 483	Continued From page 26 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that its direct care staff allowed two of the five clients who reside in the facility an opportunity to eat at the dining room table. (Clients #1 and #4) The finding includes: Observation on March 5, 2009 at 7:27 AM, revealed Client #1 being fed breakfast as she sat in her wheelchair in the living room. Observation on the same morning at 7:53 AM, revealed Client #4 also being fed in the living room while seated in her wheelchair. Follow-up observation after the meal, revealed a table located in the kitchen/dining room. The dining table was noted to be pushed against the wall, rendering three sides accessible for seating. There was no evidence the facility provided table service for all residents.	W 483		
W 488	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. This STANDARD is not met as evidenced by: Based on observation, staff interview, the facility failed to ensure that one of three clients in the sample ate a manner consistent with her developmental level. (Client #3) The finding includes: During breakfast on March 5, 2009 at	W 488	The QMRP will ensure that staff are trained to use proper supports such as placemats and napkins to assist clients to eat without soiling their clothes, in a manner consistent with adult dignity.	4/25/09

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W 488	Continued From page 27 approximately 8:00 AM, Client #3 was observed wearing a protective bed pad for a bib which was tied around her neck. Further observation revealed that the direct care staff placed the bottom portion of the pad underneath the client's plate and used it as a placement. Interview with staff revealed that the protective bed pad was used as a bib to prevent the client from soiling her clothing. There was no evidence there the client was trained to use a napkin or was provided with appropriate covering to protect her clothing.	W 488		

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R 000	INITIAL COMMENTS A licensure survey was conducted from March 5, 2009 through March 6, 2009. The survey was initiated using the fundamental survey process. A random sample of three residents was selected from a resident population of five women with various disabilities. The findings of the survey were based on observations, interviews with residents, interviews with staff in the home and at two day programs, as well as a review of resident 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 the review of personnel records, the GHMRP failed to ensure criminal background checks for all jurisdictions in which the employees had worked or resided within the seven (7) years prior to the check. The findings include: On March 5, 2009 at approximately 8:45 AM, the Qualified Mental Retardation Professional (QMRP) was requested to provide documentation to show evidence that criminal background checks had been conducted for all staff employed in the facility. On March 5, 2009, beginning at 3:35 PM, review of the personnel records	R 125	The Human Resources Director will ensure that all staff have evidence of a comprehensive criminal background check in their records.	4/25/09

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

Director of Disability Services
TITLE

4/6/09
(X6) DATE

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R 125	Continued From page 1 presented for 4 (S4, S5, S13 and S14) of 12 direct care staff revealed no evidence of comprehensive criminal backgrounds checks.	R 125		

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I 000	INITIAL COMMENTS A licensure survey was conducted from March 5, 2009 through March 6, 2009. The survey was initiated using the fundamental survey process. A random sample of three residents was selected from a resident population of five females with various disabilities. The findings of the survey were based on observations at the group home and three day programs, interviews with day program staff, management and direct care staff in the residence and the review of administrative records, including the facility's incident management system.	I 000		
I 049	3502.7 MEAL SERVICE / DINING AREAS Each GHMRP shall serve meals at proper temperatures. This Statute is not met as evidenced by: Based on observation, the facility failed to ensure that food was served at the appropriate temperature for two of the five resident in the facility. (Resident #2 and #5) The finding includes: The facility staff failed to serve food at the appropriate temperature during breakfast as evidenced below: At 7:05 AM five covered plates were observed on the dining table in the kitchen. At approximately 8:08 AM, Resident #3's assigned staff assisted her to the dining table in the kitchen. The staff removed the cover from	I 049	See response to federal deficiency W 473.	4/25/09

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I 049	Continued From page 1 her plate and began to feed the resident breakfast. At no time prior to feeding the resident was the staff observed to reheat her scrambled eggs. At approximately 8:14 AM, Resident #5's assigned staff was observed to assist her to the dining table in the kitchen. The staff removed the cover from her plate and prompted the resident to eat breakfast. The staff fed her two spoonfulsl and placed the spoon on the edge of the plate. Resident #2 then picked up the spoon and began to eat her food independently. At approximately 8:18 AM, the resident finished eating the mini blueberry muffin and bowl of cheerios with milk. The resident was offered the cold scrambled eggs and the resident initially refused to eat them, however after drinking her beverage, began to eat her cold scrambled eggs. At no time prior to Resident #2 consuming the eggs did the direct care staff reheat her eggs. Interview with the Residential Director (RD) at approximately 8:52 AM revealed the the overnight shift prepared the breakfast before departing the facility.	I 049		
I 051	3502.9 MEAL SERVICE / DINING AREAS Each GHMRP shall provide table service for all residents who can and will eat at a table, including residents in wheelchairs. This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that its direct care staff allowed two of the five residents who reside in the facility an opportunity to eat at the dining room table.	I 051	See response to federal deficiency W 483.	4/25/09

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I 051	Continued From page 2 (Residents #1 and #4) The finding includes: Observation on March 5, 2009 at 7:27 AM, revealed Resident #1 being fed breakfast as she sat in her wheelchair in the living room. Observation on the same morning at 7:53 AM, revealed Resident #4 also being fed in the living room while seated in her wheelchair. Follow-up observation after the meal, revealed a table located in the kitchen/dining room. The dining table was noted to be pushed against the wall, rendering three sides accessible for seating. There was no evidence the facility provided table service for all residents.	I 051		
I 057	3502.15 MEAL SERVICE / DINING AREAS Menus shall be written on a weekly basis, shall provide a variety of foods at each meal, and be varied from week to week and adjusted for seasonal changes. This Statute is not met as evidenced by: Based on observation, staff interview and record, the facility failed to ensure that lunch menus were prepared in advance for five of 5 residents residing in the facility. (Residents #1, #2, #3, #4 and #5) The findings include: 1. Observation on March 5, 2009 at 8:04 AM, revealed Resident #2 assisting staff in the preparation of a bag lunch. The lunch consisted of a jelly sandwich, applesauce, Glucerna (nutritional supplement) and a bottle of water.	I 057	See response to federal deficiency W 477.	4/25/09

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I 057	Continued From page 3 Interview with Residential Director (RD) on March 5, 2009 at 3:20 PM, revealed that Resident #2 takes her lunch to her day program because she is a picky eater. On March 6, 2009 at 10:15 AM, interview with Resident #2's 1:1 staff indicated that the resident brought her lunch with her. The lunch consisted of a peanut butter and jelly sandwich, mandarin orange sections, Glucerna and a bottle of water. The 1:1 staff also revealed that the resident brought her lunch to the day program because she was a "picky eater". Interview with the Qualified Mental Retardation Professional (QMRP) on March 6, 2009 at 1:45 PM revealed the lunch menus were planned by the guidelines on the menus. The review of available menus in the facility, however, revealed there were no planned weekday lunch menus for the resident. 2. Interview with the RD on March 5, 2009 at 7:10 AM revealed all residents (#1, #2, #3, #4, and #5) living in the group home attended a day program from approximately 9:00 AM to 3:00 PM on Monday through Friday. Further interview with the RD on March 5, 2008 at approximately 1:45 PM, revealed that all residents, except Resident #2, were provided lunch by their day programs. According to the RD, no weekday lunch menus had been planned by the nutritionist because usually no residents were in the group home for lunch. The review of the cycle menus on the same day confirmed that there were no planned lunch menus for Monday through Fridays.	I 057		
I 058	3502.16 MEAL SERVICE / DINING AREAS A review and consultation by a dietitian or nutritionist shall be conducted at least quarterly to	I 058	See response to federal deficiency W393. The QMRP will request the Nutritionist to complete annual and/or quarterly nutritional assessment for the resident.	4/25/09

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I 058	Continued From page 4 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 interview and record review, the GHMRP failed to ensure that a dietitian or nutritionist conducted at least a quarterly review and consultation for Resident #2, who was prescribed a modified diet. The findings include: [Cross refer to 3502.15] On March 5, 2009 at 3:20 PM, Interview with the Residential Director (RD) and the review of cycle menus being used to prepare meals for the residents revealed that no written lunch menus were available for weekdays (Monday through Friday). At 9:48 AM, Resident #2's blood sugar was monitored by the nurse via finger stick. The nurse revealed the test was performed each morning and evening. At 9:51 AM the resident was administered Megace 40 mg, which was to prescribed to stimulate the resident's appetite. The nurse stated that the resident also was prescribed nutritional supplement (Glucerna) three times daily to maintain her weight. Subsequent record review on March 5, 2009 at 10:30 AM, revealed a physician's order dated February 1, 2009 for a "Mechanical soft, 1500 calories, low sodium, high fiber diet" to manage the resident's diagnosed Diabetes Mellitus, Type II. Interview with the Qualified mental Retardation	I 058		

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I 058	Continued From page 5 Professional on March 6, 2009 at 4:40 PM revealed that the consultant nutritionist should have completed a nutritional assessment for Resident #2 to be included in her annual Individual Support Plan (ISP), which was held on August 9, 2008. Review of the ISP revealed that the resident was prescribed a Mechanical Soft, 1500 Calorie- low sodium diet; however revealed no evidence that an annual and/or quarterly nutritional assessments was completed for Resident #2.	I 058		
I 077	3503.5 BEDROOMS AND BATHROOMS Each bedroom shall contain sufficient storage space for each resident ' s seasonal, personal clothing and personal effects. This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to provide individual closet space adequate for two of the five residents residing in the facility. (Resident #2 and #5). The finding includes: The facility failed to ensure that each resident was provided with appropriate and identifiable closet space for their personal clothing. During the environmental walk through on March 6, 2009, at approximately 5:22 PM, it was observed that Resident #2 and #5 shared a small closet in their bedroom. Observation of the closet revealed it failed to have a system to identify and separate each resident's personal clothing. According to the Residential Director (RD),	I 077	See response to federal deficiency W 421.	4/25/09

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I 077	Continued From page 6 Resident #2's clothing were to the left of the closet and Resident #5's clothing were to the right closet. At the time of the survey, there no evidence that the facility had established a system to clearly identify each resident's personal clothing.	I 077		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to maintain the interior of the facility in a safe, clean, orderly, and attractive manner. The findings include: On March 6, 2009, beginning at 5:15 PM, observation of the environment revealed the following concerns: Interior: 1. The facility failed to ensure that Client #3's bedroom wall was repaired. During the environmental walk-through on March 6, 2009 at approximately 5:25 PM, a large hole was observed on the right wall of Client #3's bedroom. Interview with the RD revealed that Client #3 had a behavior support plan which addressed her property destruction. Further interview with the RD revealed that the hole in the wall might have been created during a behavioral	I 090	1. Maintenance will repair the hole in the wall.	4/25/09

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I 090	Continued From page 7 outburst by the client. 2. During the environmental walk through on March 6, 2009, at approximately 5:15 PM, Resident #3's top drawer of the chest was observed to have a missing face panel. The top drawer was also broken. Further observation revealed that the remaining drawers were broken and off track. 3. The front panel of the hot water heater was observed loose and leaning on the floor. 4. The rear basement exit leading into the back yard had trash, debris, leaves which covered the drainage at the base of the stairs 5. A rear window was missing a window screen. 6. The window over the ramp was missing a window screen. 7. The rear of the facility was observed to have old broken furniture, old discarded brooms and mop handles. 8. The basement bathroom window was without blinds or curtains for privacy.	I 090	2. Maintenance will repair or replace the chest of drawers. 3. Maintenance will repair the font panel of the hot water heater. 4. Staff will clean the back staircase and ensure that the drain is kept clear. 5. Maintenance will replace the rear window screen. 6. Maintenance will replace the screen for the window over the ramp. 7. Maintenance will remove debris from the rear of the facility. 8. The RD will hang a curtain in the window in the basement bathroom.	4/25/09 4/25/09 4/25/09 4/25/09 4/25/09 4/25/09
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: Based on observation, the GHMRP failed to ensure that caustic agents were stored in a locked area.	I 095	The Residential Director will remain staff to ensure that all caustic agents or poisons are kept locked when not in use by staff, or by residents who are being supervised.	4/25/09

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	HFD03-0233	A. BUILDING _____ B. WING _____	03/06/2009

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CARECO 11	1701 24TH STREET, NE WASHINGTON, DC 20002

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I 095	Continued From page 8 The finding includes: Observation during the environmental walk-through on March 6, 2009 at 5:15 PM revealed the following: The basement laundry room had laundry detergent opened on the floor and was unlocked.	I 095		
I 108	3504.15 HOUSEKEEPING Each GHMRP shall assure that each resident has at least seven (7) changes of clothing appropriate to his or her daily activities. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the GHMRP failed to provide an adequate amount of undergarments for one of the five residents residing in this facility. (Resident #3) The findings include: During the environmental inspection on March 6, 2009 at approximately 5:15 PM, Resident #3 was observed to have limited undergarments in her Chester drawers. According to interview with the direct care staff, the resident's undergarments were in the laundry in the basement of the group home. Review of the records did not evidence a personal property inventory was available to verify clothing purchases and supply for Resident #3. At the time of the survey, there was no evidence that Resident #3 had seven changes of undergarments.	I 108	The Residential Director will complete a personal inventory for each resident, and ensure that it is kept in the residents' records with evidence of purchases.	4/25/09

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I 135	Continued From page 9	I 135		
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 the review of fire drill reports, the facility failed to hold evacuation drills at least quarterly for each shift of personnel, on two of three shifts. The findings include: Interview with the Residential Director (RD) on March 5, 2009 at 9:30 AM, revealed the group home had three shifts of direct care personnel. The shifts were identified as: 7:00 AM - 3:00 PM, 3:00 PM - 11:00 PM, and 11:00 PM - 7:00 AM seven days a week. On March 5, 2009 at 10:55 AM, a review of fire drills records provided for April 1, 2008 through February 2009 was conducted. The review of the drills provided the following information: a. There were no documented fire drill on the 7:00 AM - 3:00 PM (day shift). b. There were no documented fire drill on the 3:00 PM - 11:00 PM shift (evening shift) after October 27, 2008. During a follow-up interview on March 5, 2009 at approximately 1:00 PM, the RD and the Qualified Mental Retardation Professional acknowledged the drills had not been conducted at the frequency required by this regulation.	I 135	See response to federal deficiency W 440.	4/25/09

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I 206	Continued From page 10	I 206		
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that a current health certificate was obtained and maintained on file. The findings include: On March 5, 2009, interview with the Qualified Mental Retardation Professional and review of the personnel files, three of 14 direct care staff (S1, S2 and S4) failed to have current health certificates. Review of the consultant health records revealed that Dietitian/Nutritionist, the Physician, the Podiatrist, the Social Worker, and one License Practical Nurse also did not have a current health certification on file.	I 206	The Human Resources Director will ensure that each staff person has a current health certificate on file.	4/25/09
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on observations, interview and record verification, the GHMRP failed to ensure continuous, ongoing in-service training programs	I 222	See responses to federal deficiencies W 252 and W249.	4/25/09

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I 222	Continued From page 11 were conducted for all personnel. The findings include: 1. The facility failed to ensure effective training to direct care staff on documentation of individual program plan objectives for Resident's #1, #2 and #3. (See W252) 2. The facility the failed to ensure that direct care staff were trained effectively to implement Resident #1's self-medication objective. (See W249) 3. The facility failed to ensure that each staff was trained on the use of a spout cup prescribed for Resident #1 to increase her independence in drinking beverages. On March 5, 2009 at 8:42 AM, Resident #1 was observed to bite a portion from the spout of the flexible plastic cup, from which she drank water after receiving her medications. Interview with the Residential Director (RD) on March 5, 2009 revealed the resident should have been drinking from a different type of spout cup. After the morning medication administration observations on March 5, 2009, the RD provided the resident a different new spout cup, which was made of a rigid plastic. At 3:40 PM, the RD was observed instructing an evening staff to be sure that Resident #1 used only the new cup. Resident #1 was observed holding the new cup and drinking from it at approximately 4:10 PM. At the time of the survey, however, there was no evidence that each staff had been trained on the the use of the new cup.	I 222		

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I 227	Continued From page 12	I 227		
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure three of fourteen direct care staff were certified to provide cardiopulmonary (CPR) to five of five residents residing in the GHMRP. (Residents #1, #2, #3, #4, and #5) The finding includes: On March 5, 2009 at 9:10 AM, evidence of staff training focused on skills and competencies necessary to address the residents' health needs was requested for review. The review of personnel and training records on March 5, beginning at 3:00 PM, failed to provide evidence that three direct care staff (S1, S8 and S13) had current CPR certification. Interview with the Qualified Mental Retardation Professional (QMRP) on March 6, 2008 at approximately 3:10 PM confirmed there was no documented evidence that S1, S8 and S13 had current CPR training and certification.	I 227	The Human Resources Director will ensure that each staff person has evidence of CPR training and certification in their files.	4/25/09
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS	I 401		

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I 401	Continued From page 13 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 interview and record review, the GHMRP failed to provide diagnosis, evaluation, treatment services and necessary follow up services to prevent deterioration or further loss of functioning for five of the five resident in the GHMRP. (Residents #1, #2, #3, #4 and #5) The finding includes: 1. The GHMRP failed to ensure the primary care physician conducted a timely review of the medical and laboratory results prescribed for Residents #2 and #3 as evidenced by: a. Interview with the License Practical Nurse Coordinator (LPNC) on March 5, 2009 at 3:05 PM, revealed that the most current results of prescribed medical consultations and laboratory studies were maintained in a special notebook. The nurse revealed that Resident #2's had received medical screening to rule out health concerns as a possible cause of her weight loss in 2008. Further interview with the LPNC revealed that the results of the hepatic evaluation (January 13, 2009) and the gall bladder series (January 26, 2009) would be filed in the resident's medical record after they had been reviewed and signed by the primary care physician (PCP). The LPNC reported that the usual procedure was to notify the PCP by telephone, and to fax the results to the primary care physician for review.	I 401	1. See response to federal deficiency W 322.	4/25/09

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I 401	Continued From page 14 The physician special notebook was reviewed on March 5, 2009 at 3:38 PM. At the time of the survey, there was no evidence that the results of consultations and medical procedures, conducted after January 6, 2009, had not been reviewed and signed by the PCP. b. The review of the physician's special notebook on March 5, 2009 at 3:50 PM revealed Resident #3's hematology report dated January 13, 2009. Further review of this report revealed elevated laboratory values documented as follows: AST 116 U/L (reference range: 10 - 42 U/L) and ALT 144 U/L(reference range: 13 -51 U/L). At the time of the survey, there was no evidence that these abnormal laboratory findings had been reviewed and approved by the PCP. 2. The GHMRP's nursing staff failed to ensure that the GHMRP met the requirements for performing glucose monitoring testing for Resident #2. On March 5, 2009 at approximately 9:48 AM, observation of the medication administration revealed that the Licensed Practical Nurse (LPN) used the finger stick method to test Resident #2's blood glucose level. Interview with the LPN revealed that Resident #2 had a diagnosis of Diabetes Mellitus, Type II. Further interview with the LPN revealed that blood glucose levels were to be monitored, using a Glucometer in the morning and evening. Interview with the Qualified Mental Retardation Professional(QMRP) on March 5 ,2009 at approximately 11:00 AM, revealed that the facility did not have the required certification to conduct blood glucose testing as identified by Part 493 of the Clinical Laboratory Improvement Act (CLIA).	I 401	2. See response to federal deficiency W 393.	4/25/09

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I 401	Continued From page 15 Review of the physician's orders dated February 1, 2009, revealed that Resident #2's blood glucose level shall be tested every morning and evening at the group home. At the time of the survey, there was no evidence that the CLIA certification had been obtained. 3. The facility failed to ensure that the Human Rights Committee (HRC) reviewed and approved the use of bed rails for each client. Observation during an environmental walk-through on March 6, 2009 at approximately 5:45 PM, revealed hospital beds with rails were being used for Client #2, #4, and #5. Interview with the Qualified Mental Retardation Professional (QMRP) and the Residential Director (RD) revealed that Client #2, #4 and #5 required bed rails at night to ensure their safety. Further interview with the RD revealed that these clients are not able to Independently get in and out of their beds. Interview with the Director of Nursing (DON) revealed that the agency's practice was to complete a bed mobility assessment to determine the clients' need for a hospital bed/rails. Once the determination was made, the result was required to be presented to the Human Rights Committee (HRC) for review and approval. Review of the medical and habilitative records of Client's #2, #4 and #5 did not evidence that bed mobility assessment had been completed for each client.	I 401	3. See responses to federal deficiencies W 214 and W 262.	4/25/09
I 420	3521.1 HABILITATION AND TRAINING	I 420	See response to federal deficiency W 252.	4/25/09

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I 420	Continued From page 16 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 environments and to achieve their optimum levels of physical, mental and social functioning. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to provide training to acquire and maintain skills needed to achieve optimum level of social functioning for one of three residents in the sample. (Resident #2) The findings include: Interview with staff on March 6, 2009 at approximately 10:45 A PM revealed that Resident #2 enjoyed going on outings in the community with her day program Review of the resident's individual support plan (ISP) dated August 11, 2008 on March 6, 2009 at approximately 4:30 PM, revealed the interdisciplinary team (IDT) included a training objective in the individual program plan (IPP) to improve Resident #2's recreation skills. The written goal/objective, to improve the resident's skills in this area included the following: ... ... To improve her recreational skills... Resident (#2) will "complete the steps in planning an activity of her choice with 50% independence for 3 consecutive months by August 2009. Interview with direct care staff on March 6, 2009 at approximately 10:37 AM failed to disclose the objective was one of the IPP objectives being implemented. Interview with the QMRP later that day (4:50 PM), and the subsequent review of the	I 420		

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I 420	Continued From page 17 documented IPP failed to evidence that the aforementioned recreation objective had been implemented.	I 420		
I 458	3521.11 HABILITATION AND TRAINING Each resident ' s activity schedule shall be available to direct care staff and be carried out daily. This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that each resident's Individual Program Plan (IPP) objectives were incorporated in their individual activity schedules for three of three residents in the sample. (Residents #1, #2 and #3) The findings include: The facility failed to ensure that the activity schedules for Residents #1, #2 and #3 were available and incorporated IPP objectives as evidenced below: On March 6, 2009 at approximately 1:45 PM, interview with the Qualified Mental Retardation Professional (QMRP) and the review of the Individual Support Plans (ISPs) for Residents #1, #2, and #3 respectively revealed that the activity schedules of Resident #1, #2 and #3 was not available. Further interview with the QMRP revealed the activity schedule format had been revised. According to the QMRP, the new schedules would include the day and time, specified activities and IPP objectives. At the time of the survey, there was no evidence that the each resident's activity schedule had been developed.	I 458	See response to federal deficiency W 250.	4/25/09

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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, interviews and record review, the GHMRP failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) that governs the care and rights of persons with mental retardation for one of three residents in the sample. (Resident #3) The findings include: The facility failed to ensure that Resident #3 was provided the style of clothing which met her assessed needs. Observation through-out the survey on March 5, 2009, revealed Resident #3 to keep her arms positioned underneath her shirt and on several occasion was observed to remove her shirt in the living room. On March 5 and March 6, 2009, Resident #3 was observation wearing a pullover style of shirt that buttoned at the neckline. Interview with the direct care staff on March 5, 2009 at approximately 5:50 PM, revealed that the resident has a Behavior Support Plan (BSP) which address her disrobing behavior. Interview with the Residential Director at approximately 6:00 PM, confirmed that the resident has a BSP which addresses her maladaptive behaviors of	I 500	See response to federal deficiency 137.	4/25/09

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I 500	Continued From page 19 disrobing. On March 6, 2009 at approximately 10:38 PM, a review of the BSP dated July 8, 2008 confirmed disrobing as one of her target behaviors. Further Review of her behavior support recommendation revealed the following: "Staff were to help [the resident] to shop around for and try on tops that are well tailored. Choose poncho or Kaftan style tops that feature large and loose sleeves and may cater to her desire for free arm movement." Review of Resident #3's financial records did not evidence that the facility had purchased the recommended style of clothing to allow for free arm movement. At the time of the survey, there was no evidence that Resident #3 had received the style of clothing recommended to the resident comfort and free movement.	I 500		