PRINTED: 05/26/2010
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	04/29/2010

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from April 27, 2010 through April 29, 2010. The survey was initiated using the fundamental survey process. A random sample of two clients was selected from a population of four female clients with various levels of mental retardation and disabilities. The findings of the survey were based on observations at the group home and two day programs, interviews with clients and staff and the review of clinical and administrative records including incident reports.	W 000	Received 6/7/10 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
W 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. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure privacy during personal needs, for one of the two clients in the sample. (Client #3) The finding includes: On April 27, 2010, at 6:44 p.m., Client #3 was observed sitting in her wheelchair in front of the bathroom door. The client was observed wearing a towel that covered the front of her torso, however the back of the client was uncovered, leaving her buttocks exposed. Seconds later, her one to one support staff was observed wheeling the client into her bedroom. As the client was wheeled into her bedroom, Client #1 and her one to one direct support staff was	W 130	The QMRP will provide training to the Residence Director and staff on privacy, including providing privacy for people when they share a bedroom. The QMRP will purchase bathrobes for each person to be used whenever the person is in a state of undress or partial dress outside of their bedroom or bathroom.	6/15/2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Marsha W. Thompson	Director of Disability Services	6/7/2010

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.

PRINTED: 05/26/2010
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	04/29/2010

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 130	Continued From page 1 observed in the same bedroom. When interviewed on the same day, at approximately 7:30 p.m., the direct support staff acknowledged that Client #3 was not provided privacy while exiting the bathroom or in her bedroom. Further interview revealed that she did not provide privacy in the bedroom because the client shared a bedroom with Client #1. On April 29, 2010, at 12:57 p.m., interview with the Qualified Mental Retardation Professional (QMRP) revealed that staff was required to ensure privacy during personal needs. If another client is in the bedroom, staff are required to ask them to "please excuse themselves unless their sleeping." At the time of the survey, there was no evidence that staff ensured privacy during Client #3's personal care.	W 130		
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 facility failed to ensure a system had been implemented to maintain a complete accounting of clients' personal funds, for two of the two clients in the sample. (Clients #1 and #2) The findings include: Interview with the qualified mental retardation professional (QMRP), house manager (HM) and	W 140	The Accounting Department will provide copies of the updated re-deposits to the clients' accounts. The QMRP will retrain the Residence Director on the Careco policy of returning unspent funds to the Accounting Department on a timely basis.	6/15/2010

PRINTED: 05/26/2010
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	04/29/2010

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 140	Continued From page 2 review of the client's financial records on April 29, 2010, beginning at 1:00 p.m., revealed that the facility assisted the clients with maintaining their finances. Continued interview and record review revealed that the clients received Supplemental Security Income (SSI) in the amount of $70.00 per month. a. Review of Client #1's bank statement from April 2009, through April 2010 revealed a withdrawal in the amount of $250.00, on October 21, 2009. Additional review revealed receipts totaling $226.44. Interview with the house manager indicated that the money was returned to the office (accounting department). b. Client #2's bank statements were reviewed from April 2009, through April 2010 and revealed the following withdrawals: - On May 7, 2009 $700.00 was withdrawn. Further review revealed receipts totaling $390.27 - On April 8, 2009 $270.00 was withdrawn. Further review revealed receipts totaling $225.41 Interview with the HM indicated that the money was returned to the office (accounting department). At the time of the survey, the facility failed provide evidence to ensure a complete accounting of the clients' personal funds by providing evidence that verified the HM statement (return of funds) and/or receipts to justify the remaining balance of withdrawn funds.	W 140		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL	W 159		

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

PRINTED: 05/26/2010
FORM APPROVED
OMB NO. 0938-0391

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 _____	04/29/2010

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 3 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, staff interview and record review, the facility's qualified mental retardation professional (QMRP) failed to monitor, coordinate, and integrate each client's active treatment program, for one of two sampled clients. (Client #1) The findings include: 1. Cross Ref. W436. The facility's QMRP failed to furnish Client #1's day program with her adaptive feeding equipment. 2. Cross refer to W252. The facility's QMRP failed to ensure that data was collected in the form and required frequency.	W 159	1. The QMRP will purchase adaptive feeding equipment that the client needs and provide it to the day placement. The QMRP will obtain a receipt from the day placement to document that the equipment was provided. The QMRP will ensure that she checks for the presence of the equipment during her regularly scheduled visits to monitor day placement services. 2. See response to W 252. The QMRP will retrain the Residence Director and staff, and coordinate with other clinical disciplines, to ensure that data are properly recorded in form and frequency. The QMRP will check the records weekly for a minimum of four weeks to ensure that the data are properly recorded and provide retraining and mentoring if required.	6/15/2010 6/15/2010
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 was implemented in accordance	W 249	The QMRP will coordinate with the RN Supervisor to retrain the medication nurses on the self-medication IPPs. The QMRP will check the documentation of the program weekly for four weeks to ensure that the program is implemented and documented.	6/15/2010

PRINTED: 05/26/2010
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	04/29/2010

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 4 with the interdisciplinary team (IDT) recommendations for one of two clients in the sample. (Client #1) The finding includes: The facility failed to implement Client #1's self medication program as evidenced below: On April 27, 2010, at 5:31 p.m., the licensed practical nurse (LPN) was observed getting a box from the refrigerator and entering the nurse's station. Minutes later, the LPN was overheard asking staff to bring Client #1 to the nurse's station. After the LPN completed administering Client #1 her medications, the LPN was observed putting the box back into the refrigerator. Interview with LPN #2 on April 28, 2010, at approximately 10:10 a.m., indicated that Client #1 does not participate in a self medication program. Review of the record on April 28, 2010, at approximately 3:00 p.m. revealed a self medication assessment dated March 29, 2010, The assessment indicated that the client was recommended for a self medication program. Review of Client #1's Individual Program Plan (IPP) dated August 11, 2009, on April 28, 2010, at approximately 3:15 p.m., revealed a program objective for the client to receive training in self-medication skills development. Further review indicated Client #1's self- medication program was as follows: a. Get insulin from the refrigerator and get water; b. Go to the nurse's station with insulin box; c. Give box to nurse and take medication from the nurse;	W 249		

PRINTED: 05/26/2010
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	04/29/2010

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 5 d. Swallow medication; e. drink water; and f. Return box to the refrigerator. At the time of the survey, the facility failed to provide evidence that the self medication program was implemented.	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: Based on observation, interview and record review, the facility failed to ensure that data was collected in the form and required frequency, for one of the two clients in the sample. (Client #1) The finding includes: On April 27, 2010, at 5:02 p.m., Client #1 was observed digging her fingernails into her chin and attempting to turn over the dining room table. Staff asked the client to stop and she complied. At 5:21 p.m., Client #1 was observed turning over a chair while sitting at the dining room table. Staff asked the client to stop and she complied. On April 28, 2010, at 9:40 a.m., Client #1 was observed scratching the surveyor and knocking over a chair. Staff asked her stop and she complied. Interview with the one to one support staff on April 27, 2010, at approximately 6:10 p.m., indicated that Client #1 has a behavior support	W 252	The QMRP will ensure that the Residence Director and all staff are trained on the client's BSP and the documentation requirements. The QMRP will monitor staff implementation and documentation at least weekly for a minimum of eight weeks and provide immediate retraining and mentoring if staff fails to implement or document the BSP as written.	6/15/2010

PRINTED: 05/26/2010
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	04/29/2010

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 252	Continued From page 6 plan (BSP) to address physical aggression, property destruction and self-injurious behaviors (SIB). Record verification on April 28, 2010, at 2:30 p.m., revealed Client #1's BSP dated August 9, 2009 that identified maladaptive behaviors of property destruction, SIB and physical aggression. According to the data collection instructions, staff are to record behaviors on the data sheet provided for each occurance. Further review of the data chart on April 29, 2010, at approximately 4:00 p.m. revealed that Client #1 had no behaviors documented of property destruction, physical aggression or SIB on either April 27, 2010 or April 28, 2010. There was no evidence that data had been collected in accordance with the client's BSP, which was necessary for a functional assessment of the client's progress.	W 252		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure preventive health services were implemented as recommended, for two of two clients in the sample. (Client #1 and #2) The findings include: 1. The facility failed to obtain a physician order (POS) for Client #1's glucose testing prior to	W 322	1. The Director of Disability Services and the RN Supervisor will meet with the Pharmacy to ensure that POS are updated and revised appropriately and timely, and that the POS are accurate each month per the PCP.	6/15/2010

PRINTED: 05/26/2010
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	04/29/2010

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 322	Continued From page 7 implementation as evidenced below: On April 28, 2010, at approximately 9:20 a.m., Licensed Practical Nurse #1 (LPN #1) was observed to use a glucometer and perform a finger stick on Client #1. Further observation revealed the blood glucose reading was 74 mg/dl. During a face to face interview with LPN #1 on April 28, 2010, at approximately 9:30 a.m., revealed that the finger sticks were performed on Client #1 twice a day. Review of the March and April, 2010, daily blood sugar records on April 28, 2010, at approximately 9:40 a.m., confirmed finger sticks were performed on Client #1 twice a day. Review of the POS dated April 2010, revealed Client #1 had a diagnosis of Diabetes Mellitus. Further review revealed Client #1 did not have a physician's order for finger sticks twice a day. During a face to face interview with the Registered Nurse #1 (RN) on April 28, 2010, at approximately 10:15 a.m., it was acknowledged Client #1 did not have a POS for finger sticks twice a day nor had parameters been established. There was no evidence the facility's nursing staff had obtained clarification from the physician as to how Client #1's glucose monitoring should occur. 2. The facility failed to ensure the primary care physician addressed Client #2's radiology report. On April 29, 2010, at approximately 10:00 a.m., review of Client #2's radiology report dated April 5, 2010, revealed impressions of multiple small	W 322	2. When specialty consults are completed the RN Supervisor will ensure that they are communicated to the PCP via telephone and fax. The RN Supervisor will ensure that a nursing note is placed in the record detailing when the PCP is notified and any orders that the PCP may issue regarding the specialty consult. A fax receipt and cover will be placed in the record behind the specialty consult as additional evidence that the PCP is notified.	6/5/2010

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 _____	04/29/2010

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 322	Continued From page 8 cysts on the client's right breast. Further review revealed a recommendation for routine screening. Interview with the license practical nurse (LPN) on the same day at 12:40 p.m., indicated that primary care physician was aware of the report, however, it was not noted because she is scheduled in the facility every thirty days. There was no evidence the facility made the primary care physician aware of Client #2's ultrasound. 3. The QMRP failed to ensure Client #2 wore her compression stockings as prescribed. On April 27, 2010, at 7:31 p.m., Client #2 was observed sitting in her wheelchair wearing white cotton crew socks. The next day at her day program at 12:15 p.m., the client was observed wearing white cotton crew socks. Later that day at the facility, Client #2 was observed wearing compression stockings. Interview with the license practical nurse at 4:50 p.m., revealed Client #2 is required to wear compression stockings during waking hours. On April 29, 2010, at 11:10 p.m., review of the Client #2's medical vascular report dated July 10, 2009, revealed a recommendation for the client to wear compression stockings due to mild edema in her knees. There was no evidence that the facility ensured Client #2 wore her compression stockings as recommended.	W 322	3. The RN Supervisor will request the PCP to review the need for compression stockings and the protocols on when they should be used. The RN Supervisor will then update the Health Management Care Plan and Health Passport, and train the QMRP and staff on the use of the stockings and documentation on their use.	6/15/2010
W 381	483.460(l)(1) DRUG STORAGE AND RECORDKEEPING	W 381		

PRINTED: 05/26/2010
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	04/29/2010

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 381	Continued From page 9 The facility must store drugs under proper conditions of security. This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to ensure all medications were properly secured, for one of the four clients residing in the facility. (Client #1) The finding includes: On April 28, 2010, at approximately at 10:25 a.m., a tool like box was observed in the facility's refrigerator. The box contained a vial of Lantus insulin for Client #1 and a tube of Tubersol, labeled house stock. Immediately, the licensed practical nurse (LPN) was informed that the box of medications were stored in the refrigerator unsecured. The LPN acknowledged the unsecured vials of medications. Interview with the LPN on April 28, 2010, at 10:45 a.m., indicated that the lock broke approximately 2-3 weeks, ago. The house manager indicated that she purchased a new box, however, it was the incorrect type of box. The LPN instructed the HM to purchase another type. Further interview with the LPN acknowledged that all medications should be secured with a lock.	W 381	The LPN Coordinator will advise the medication nurses in writing to immediately report both verbally and in writing if a lock for any medication storage device or area is broken. As soon as such a report is made repairs and/or equipment purchases will be made.	4/15/2010
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.	W 436		

PRINTED: 05/26/2010
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	04/29/2010

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 436	Continued From page 10 This STANDARD is not met as evidenced by: Based on observation, interview and the record review, the facility failed to ensure a wheelchair was maintained in good repair, for one of the two clients in the sample (Clients #2) and failed to ensure that clients were furnished with the recommended adaptive feeding equipment, for one of two clients in the sample. (Client #1) The findings includes: On April 28, 2010, at 11:58 p.m., Client #2 was observed at her day program sitting in her wheelchair wearing a chest harness. Further observation revealed the harness straps were worn and torn. On April 29, 2010, at 9:55 a.m., review of the occupational therapy assessment dated September 5, 2009, revealed a recommendation that documented, "A wheelchair evaluation should be performed to replace wheelchair." The occupational therapist also noted that as a temporary fix, the caregivers should place a towel over the back head cushion where a hole has formed. On April 30, 2010, at approximately 4:00 p.m., the direct support staff was asked to remove the client's towel if possible. Upon removal of the towel, the headrest was observed to be worn and had formed a hole. On April 29, 2010, at 10:12 a.m., review of Client #2's physical therapy assessment dated June 11, 2009, indicated that the client's wheelchair required repairs, please see wheelchair evaluation form. Moments later, review of the wheelchair evaluation form dated April 8, 2010, revealed the	W 436	1. The QMRP will review all clinical assessments as soon as they are made and ensure that recommendations are addressed. In the case of the wheelchair, which is durable medical equipment, the QMRP will complete a prior authorization form and ensure it is signed by the PCP and provided to the equipment vendor so that the equipment can be obtained or repaired so that it is in good condition.	6/15/2010

PRINTED: 05/26/2010
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	04/29/2010

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 436	Continued From page 11 following recommendations: a. Consider a new wheelchair, seating system, and accessories; b. Repair male end of waist belt; c. New wheels; d. Secure the lower straps for the chest harness to the seat back; e. Install wheelchair seat and back cushion covers; Interview with the license practical nurse (LPN) and the QMRP on the April 29, 2010 at approximately 3:00 p.m., indicated that several repairs were made in the past. Further interview revealed that a 719A form and the physical therapist's recommendations were faxed in April 2010, to start the process for a new wheelchair. The QMRP also stated that she plans to fax the aforementioned information to a second vendor to speed up the process. There was no evidence that the facility addressed Client #2's recommendations timely to maintain her wheelchair in good repair. 2. During meal observations on April 27, 2010, at 5:02 p.m., Client #1 was observed eating dinner using a regular teaspoon, regular plate and regular cup, requiring verbal prompts. The client was further observed dropping the spoon on the floor. The client had difficulty putting and keeping the food on the spoon. As the client consumed her meal, liquid was observed running down her chin. The client consumed a soft chopped diet	W 436	2. See the response to #1 above. The QMRP will obtain the equipment as recommended and ensure that staff are trained to support the client in using it as intended.	6/15/2010

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 _____	04/29/2010

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 436	Continued From page 12 texture. On April 28, 2010, at 9:20 a.m., Client #1 was observed eating breakfast. The one to one support staff was observed feeding the client the entire meal which consisted of a soft chopped diet. At 12:30 p.m., during day program observations, the client was observed eating lunch. The lunch consisted of peaches (cut into quarters), bite size (quarter sized) chicken, mashed potatoes and mixed vegetables. The client was observed consuming one quarter portion of the meal. The one to one support staff offered the client, a half of a peanut butter and jelly sandwich. The one to one support staff was observed feeding the client the sandwich, which was cut into quarters. Review of the Client #1's occupational therapy assessment dated September 5, 2009, on April 29, 2010, at 9:11 a.m., indicated that the client should use a built up spoon, hi/low plate and cup with handles. Further record review on April 29, 2010, at 9:30 a.m., revealed a Feeding Protocol dated February 13, 2010. According to the protocol the client required adaptive feeding supports including, a built up handle spoon, a hi-low pate and a cup with handles. Interview with the QMRP on April 29, 2010, at 10:30 a.m., revealed that Client #1 does not require any adaptive feeding equipment. Furthermore, the QMRP revealed she was unaware of any recommended edaptive feeding equipment. At the time of the survey, the facility failed to ensure Client #1 was provided with the recommended adaptive feeding equipment.	W 436		
W 455	463.470(l)(1) INFECTION CONTROL	W 455		

PRINTED: 05/26/2010
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G171	A. BUILDING _____ B. WING _____	04/29/2010

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 455	Continued From page 13 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: Based on observation and interview, the facility failed to provide an active program for the prevention and control of infection and communicable diseases, for one of four clients residing at the home. (Client #1) The finding includes: On April 28, 2010, at approximately 7:20 a.m., Licensed Practical Nurse #1 (LPN #1) was observed to use sanitizer to cleanse his hands prior to administering medications to Client #4. However, LPN #1 touched the Medication Administration Records (MAR's), pill crusher and then touched the rim of Client #4's medication cup. During a face to face interview with LPN #1 on April 28, 2010, at approximately 7:25 a.m., it was acknowledged after using hand sanitizer to cleanse his hands, he touched the MAR's, pill crusher and then touched the rim of Client #4's medication cup. There was no evidence the facility's nursing staff provided an active program for the prevention and control of infection.	W 455	The RN Supervisor will provide refresher training on infection control to the medication nurses, and will provide the schedule for required refresher training.	6/15/2010

PRINTED: 05/26/2010
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0233	A. BUILDING _____ B. WING _____	04/29/2010

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 000	INITIAL COMMENTS A recertification survey was conducted from April 27, 2010, through April 29, 2010. The survey was initiated using the fundamental survey process. A random sample of two residents were selected from a population of four female residents with various levels of mental retardation and disabilities. The findings of the survey were based on observations at the group home and two day programs, interviews with residenta and staff and the review of clinical and administrative records including incidant reports.	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 observation, record review and interview, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that the modified diet for resident's had been reviewed at least quarterly by dietitian, for one of the two residents in the sample. (Resident #2) The finding includes: On April 27, 2010, at 5:40 p.m., Resident #2 was observed eating pureed lasagna, spinach, Italian bread and peaches in a sectional plate with a built up spoon. The resident was also observed drinking water from a sippy cup. Review of Resident #2's nutritional assessment dated May 29, 2009, on April 28, 2010, at 4:48 p.m., revealed that the resident was prescribed a	I 043	The QMRP will track each client's clinical plans to ensure that reviews and updates occur per each person's needs and per regulation. The Quality Assurance staff will track progress every 90 days.	6/15/2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Marilyn A. Thompson TITLE Director of Disability Services (X6) DATE 6/7/2010

PRINTED: 05/26/2010
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0233	A. BUILDING _____ B. WING _____	04/29/2010

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 043	Continued From page 1 regular pureed diet and four ounces of prune juice on Mondays, Wednesdays, and Fridays. Further review failed to show evidence that the facility's nutritionist had reviewed Resident #2's diet on a quarterly basis. On April 29, 2010, at approximately 4:30 p.m., interview with the qualified mental retardation professional confirmed that there was no evidence that a second quarterly was conducted. At the time of the survey, the GHMRP failed to have a nutrition review for the second quarter.	I 043		
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 Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure the interior of the GHMRP is maintained in a safe, clean, orderly, attractive, and sanitary manner The findings include: During an environmental inspection of the facility on April 28, 2010, beginning at 2:30 p.m., the following concerns were identified: Interior 1. The washing machine in the laundry room was leaking water from the bottom.	I 090	1. Maintenance will repair the leaking washing machine.	6/15/2010

PRINTED: 05/26/2010
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0233	A. BUILDING _____ B. WING _____	04/29/2010

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 090	Continued From page 2 2. The left arm on one of the dinning room chairs was broken.	I 090	2. The dining chair will be replaced or repaired.	6/15/2010
I 189	3508.7 ADMINISTRATIVE SUPPORT Each GHMRP shall maintain records of residents ' funds received and disbursed. This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure a system had been implemented to maintain a complete accounting of clients' personal funds, for two of the two clients in the sample. (Clients #1 and #2) The findings include: Interview with the qualified mental retardation professional (QMRP), house manager (HM) and review of the client's financial records on April 29, 2010, beginning at 1:00 p.m., revealed that the facility assisted the clients with maintaining their finances. Continued interview and record review revealed that the clients received Supplemental Security Income (SSI) in the amount of $70.00 per month. a. Review of Client #1's bank statement from April 2009, through April 2010 revealed a withdrawal in the amount of $250.00, on October 21, 2009. Additional review revealed receipts totaling $226.44. Interview with the house manager indicated that the money was returned to the office (accounting department). b. Client #2's bank statements were reviewed from April 2009, through April 2010 and revealed the following withdrawals:	I 189	See response to federal deficiency W 140.	6/15/2010

PRINTED: 05/26/2010
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0233	A. BUILDING _____ B. WING _____	04/29/2010

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 189	Continued From page 3 - On May 7, 2009 $700.00 was withdrawn. Further review revealed receipts totaling $390.27 - On April 8, 2009 $270.00 was withdrawn. Further review revealed receipts totaling $225.41 Interview with the HM indicated that the money was returned to the office (accounting department). At the time of the survey, the facility failed provide evidence to ensure a complete accounting of the clients' personal funds by providing evidence that verified the HM statement (return of funds) and/or receipts to justify the remaining balance of withdrawn funds.	I 189		
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 personnel record review and staff interview, the group home for the mentally retarded person (GHMRP) failed to ensure current health screening for one of twenty employees. (Medical Nurse). The finding includes: Record review and interview with the House Manager on April 28, 2010, at approximately 2:30	I 206	The Human Resources Department will implement policies for removing staff from the schedule when they have not submitted required documentation such as health certificates, licenses, etc.	6/15/2010

PRINTED: 05/26/2010
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0233	A. BUILDING _____ B. WING _____	04/29/2010

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 206	Continued From page 4 p.m. revealed that the medication nurse did not have a current health screening on file.	I 206		
I 226	3510.5(c) 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: Based on observation and interview, the Group Home for the Mentally Retarded (GHMRP) failed to ensure effective training on infection control, for four of four residents residing at the home. (Residents #1, #2, #3 and #4) The finding includes: On April 28, 2010, at approximately 7:20 a.m., Licensed Practical Nurse #1 (LPN #1) was observed to use sanitizer to cleanse his hands prior to administering medications to Client #4. However, LPN #1 touched the Medication Administration Records (MAR's), pill crusher and then touched the rim of Client #4's medication cup. During a face to face interview with LPN #1 on April 28, 2010, at approximately 7:25 a.m., it was acknowledged after using hand sanitizer to cleanse his hands, he touched the MAR's, pill crusher and then touched the rim of Client #4's medication cup. There was no evidence the facility's nursing staff provided an active program for the prevention and control of infection.	I 226	See response to federal deficiency W 455.	6/15/2010

PRINTED: 05/26/2010
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0233	A. BUILDING _____ B. WING _____	04/29/2010

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 291	Continued From page 5	I 291		
I 291	3514.2 RESIDENT RECORDS Each record shall be kept current, dated, and signed by each individual who makes an entry. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that nursing quarterly reviews in the residents' medical records were signed, for two of the two residents in the sample. (Residents #1 and #2) The findings include: 1. Review of Resident #1's medical record on April 28, 2010, at 9:30 a.m., revealed nursing quarterly assessments dated November 2009 and February 2010. Further review revealed that the assessment were not signed. Interview with the facility's licensed practical nurse (LPN) on April 28, 2010, at approximately 9:45 a.m., revealed that the registered nurse (RN) completed quarterly nursing reviews. The findings were brought to the attention of the LPN; who acknowledged that the nursing quarterly assessments were not signed. 2. Review of Resident #2's medical record on April 28, 2010, at 3:00 p.m., revealed nursing quarterly assessments dated October 1, 2009 and February 1, 2010. Interview with the facility's licensed practical nurse (LPN) on April 29, 2010, at 12:09 p.m., revealed that the registered nurse (RN) completed quarterly nursing reviews. The findings were brought to the attention of the LPN; who acknowledged that the nursing quarterly assessments were not signed.	I 291	1. The RN Supervisor will ensure that all nursing documentation is properly signed. The Quality Assurance Department will review quarterly to ensure compliance. 2. See response to #1 above.	6/15/2010 6/15/2010

PRINTED: 05/26/2010
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0233	A. BUILDING _____ B. WING _____	04/29/2010

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 401	Continued From page 6	I 401		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to provide professional services that included 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, for one of two residents included in the sample. (Resident #1) The finding includes: 1. The facility failed to obtain a physician order (POS) for Client #1's glucose testing prior to implementation as evidenced below: On April 28, 2010, at approximately 9:20 a.m., Licensed Practical Nurse #1 (LPN #1) was observed to use a glucometer and perform a finger stick on Client #1. Further observation revealed the blood glucose reading was 74 mg/dl. During a face to face interview with LPN #1 on April 28, 2010, at approximately 9:30 a.m., revealed that the finger sticks were performed on Client #1 twice a day. Review of the March and April, 2010, daily blood	I 401	1. See response to federal deficiency W 322.	6/15/2010

PRINTED: 05/26/2010
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0233	A. BUILDING _____ B. WING _____	04/29/2010

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 401	Continued From page 7 sugar records on April 28, 2010, at approximately 9:40 a.m., confirmed finger sticks were performed on Client #1 twice a day. Review of the POS dated April 2010, revealed Client #1 had a diagnosis of Diabetes Mellitus. Further review revealed Client #1 did not have a physician's order for finger sticks twice a day. During a face to face interview with the Registered Nurse #1 (RN) on April 28, 2010, at approximately 10:15 a.m., it was acknowledged Client #1 did not have a POS for finger sticks twice a day, nor had parameters been established. There was no evidence the facility's nursing staff had obtained clarification from the physician as to how Client #1's glucose monitoring should occur. 2. The facility failed to ensure the primary care physician addressed Client #2's radiology report. On April 29, 2010, at approximately 10:00 a.m., review of Client #2's radiology report dated April 5, 2010, revealed impressions of multiple small cysts on the client's right breast. Further review revealed a recommendation for routine screening. Interview with the license practical nurse (LPN) on the same day at 12:40 p.m., indicated that primary care physician was aware of the report, however, it was not noted because she is scheduled in the facility every thirty days. There was no evidence the facility made the primary care physician aware of Client #2's ultrasound.	I 401	2. See response to federal deficiency W 322.	6/15/2010

PRINTED: 05/26/2010
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0233	A. BUILDING _____ B. WING _____	04/29/2010

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 401	Continued From page 8 3. The QMRP failed to ensure Client #2 wore her compression stockings as prescribed. On April 27, 2010, at 7:31 p.m., Client #2 was observed sitting in her wheelchair wearing white cotton crew socks. The next day at her day program at 12:15 p.m., the client was observed wearing white cotton crew socks. Later that day at the facility, Client #2 was observed wearing compression stockings. Interview with the license practical nurse at 4:50 p.m., revealed Client #2 is required to wear compression stockings during waking hours. On April 29, 2010, at 11:10 p.m., review of the Client #2's medical vascular report dated July 10, 2009, revealed a recommendation for the client to wear compression stockings due to mild edema in her knees. There was no evidence that the facility ensured Client #2 wore her compression stockings as recommended.	I 401	3. See response to federal deficiency W 322.	6/15/2010
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 observations, interviews and the review of records, the facility failed to implement an	I 436	See response to federal deficiency W 249.	6/15/2010

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0233	A. BUILDING _____ B. WING _____	04/29/2010

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 436	Continued From page 9 effective system to ensure that each resident participated in a self-medication training program, for one of the three residents in the sample. (Resident #1) The finding includes: On April 27, 2010, at 5:31 p.m., the licensed practical nurse (LPN) was observed getting a box from the refrigerator and entering the nurse's station. Minutes later, the LPN was overheard asking staff to bring Resident #1 to the nurse's station. After the LPN completed administering Resident #1 her medications, the LPN was observed putting the box back into the refrigerator. Interview with the LPN on April 28, 2010, at approximately 10:10 a.m., indicated that Resident #1 does not participate in a self medication program. Review of the record revealed a self medication assessment dated March 29, 2010, on April 28, 2010, at approximately 3:00 p.m. The assessment indicated that the resident was recommended for a self medication program. Review of Resident #1's Individual Program Plan (IPP) dated August 11, 2009, on April 28, 2010, at approximately 3:15 p.m., revealed a program objective for the resident to receive training in self-medication skills development. Further review indicated Resident #1's self- medication program was as follows: a. Get insulin from the refrigerator and get water; b. Go to the nurse;s station with insulin box; c. Give box to nurse and take medication from the nurse; d. Swallow medication; e. Drink water; and	I 436		

PRINTED: 05/26/2010
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0233	A. BUILDING _____ B. WING _____	04/29/2010

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 436	Continued From page 10 f. Return box to the refrigerator.	I 436		