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

PRINTED: 11/16/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G225		11/05/2010

NAME OF PROVIDER OR SUPPLIER: CARECO

STREET ADDRESS, CITY, STATE, ZIP CODE: 1778 VERBENA STREET, NW, WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS	W 000		
	A recertification survey was conducted from November 3, 2010 to November 5, 2010 utilizing the fundamental survey process. A random sampling of three residents was selected from a current residential population of two males and four females 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.		GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002 11-29-10	
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to consistently implement policies and procedures that protect the clients' health, safety and welfare, for one of three clients in the sample. (Client #2) The finding includes: On November 4, 2010, at 12:55 p.m., review of an unusual incident report dated August 4, 2010 (7:30 p.m.) revealed that an outside individual alleged that she observed a direct support staff verbally abusing Client #2 while on appointment. On November 4, 2010, at 1:17 p.m., review of the corresponding investigative report revealed that the staff against whom the allegation was made was placed on administrative on August 6, 2010.	W 149	The Incident Management Coordinator (IMC) will review and retrain the QMRP on agency Incident Management Policy. The IMC will provide refresher training to the QMRP and staff at 90-day intervals for six months to ensure compliance.	12/29/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marsha H. Thompson
TITLE: Director of Disability Services
(X6) DATE: 11/29/10

Deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 149	Continued From page 1	W 149		
	A discussion with the qualified mental retardation professional (QMRP) on November 5, 2010, at 4:40 p.m. revealed that on August 4, 2010, at 7:30 p.m., she received a telephone call from Client #2's family. The family member reportedly had been informed by an outside individual that the incident occurred on the afternoon of August 4, 2010. According to the QMRP, the staff returned to work on August 5, 2010 and was placed on administrative leave, beginning on August 6, 2010. Interview with the QMRP revealed that it was the agency policy to place staff on administrative leave immediately upon learning of a possible involvement in any allegation of abuse. According to the QMRP, the failure to place the staff on administrative leave immediately upon learning of the incident was an oversight.			
	Although the outcome of the investigation revealed that the allegation was unsubstantiated, the written agency policy required that staff involved in an allegation of abuse should be placed on administrative leave immediately, pending the outcome of the investigation. At the time of the survey, there was no evidence the facility had implemented its policy.			
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL	W 159		
	Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.			
	This STANDARD is not met as evidenced by: Based on interview, and record review, the facility failed to ensure that the Qualified Mental			

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W 159	Continued From page 2 Retardation Professional (QMRP) coordinated services for four of six clients residing in the facility. (Clients #2, #3, #5, and #6) The findings include: 1. The facility's QMRP failed to ensure each client's individual program plan (IPP) included training in activities of dental hygiene. [See W242] 2. The facility's QMRP failed to ensure clients were provided with opportunities for choice and self-management. [See W247]] 3. The facility's QMRP failed to ensure consistent documentation of progress on the Individual Program Plan (IPP) objective. [See W252] 4. The facility's QMRP failed to ensure continuous active treatment in accordance with the interdisciplinary team (IDT) recommendations. [See W249]	W 159	1. See response to W 242. 2. See response to W 247. 3. See response to W 52. 4. See response to W 249.	12/29/10 12/29/10 12/29/10 12/29/10
W 242	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure each client's individual program plan (IPP) included training in	W 242	The QMRP will develop an IPP to assist the client to learn and implement dental hygiene skills. The QMRP will participate in grand rounds on the periodic schedule to ensure that all medical, clinical, and dental recommendations are incorporated into each client's IPPs. Quality Assurance will monitor for compliance each quarter.	12/29/10

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W 242	Continued From page 3 activities of dental hygiene, for one of the three clients in the sample. (Client #2) The finding includes: Observation of Client #2 on November 3, 2010, at 6:32 p.m. revealed she independently ate her dinner, as staff provided direct supervision and verbal prompts. Interview with staff on November 4, 2010 at 11:10 a.m. revealed that the client required verbal prompts and physical assistance to meet his daily needs in toothbrushing, grooming, dressing, and bathing. On November 4, 2010, at 3:18 p.m. the licensed practical nurse (LPN) indicated that the client had a recent dental visit and that the consultation report would be located. Review of Client #2's medical record on November 5, 2010, at 12:36 p.m. revealed a history of poor oral hygiene and heavy calculus deposits. On March 23, 2010, the dentist noted, "heavy calculus deposits." Interview with qualified mental retardation professional (QMRP) on November 5, 2010, at 1:17 p.m. revealed that Client #2 did not have a training program to increase her independence in toothbrushing. Subsequent record review at that time confirmed that Client #2's IPP did not include training in activities of dental hygiene, to the extent of her capability.	W 242		
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management.	W 247	The QMRP will train the staff on providing support for clients at meal times instead of fully serving them to provide clients with greater opportunities for independence in self-management.	

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W 247	Continued From page 4	W 247		
	This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure clients were provided with opportunities for choice and self-management, for four of six clients residing in the facility. (Clients #2, #3, #5 and #6) The finding includes: The facility failed to ensure Clients, #2, #3, #4, and #6 were afforded opportunities for choice and /or self-management during dinner, as evidenced below: On November 3, 2010, at 5:40 p.m., observations of the dinner meal revealed that direct care staff (DCS) #2 was observed to prepare a family style dinner. DCS #2 placed a bowl of BBQ turkey cutlets, a bowl of potato salad, and a bowl of green beans on the table. At 6:07 p.m., DCS #2 was observed to measure each client's portion on to their plates. Although the dining table was set for family style dining, Clients #2, #3, #4, and #6 were not observed to participate in the service of their food. Interview with the DCS #2 and DCS #4 on the same day at approximately 6:17 p.m., revealed that the aforementioned clients were very capable of assisting direct care staff in serving their food with minimal assistance. DCS #2 further revealed that Client #3 could serve herself independently.			
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	W 249	The QMRP will retrain the staff on data collection when goals are attempted and implemented. The Residence Director will monitor the data weekly to ensure staff are recording it in accordance with training and IPP standards. Quality Assurance will monitor for compliance each quarter.	12/27/10

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W 249	Continued From page 5 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 with the interdisciplinary team (IDT) recommendations, for one of three clients in the sample. (Client #2) The finding includes: On November 3, 2010, at 7:26 p.m., Client #2 was observed seated at the dining table with her 1:1 staff who was engaging her in a variety of activities. During this time, the client was asked to sign donut, bacon and cereal with hand over hand assistance from the 1:1 staff, however, failed to cooperate with instructions. The staff then offered the client a choice and stated, "Let's do something else then." Record review on November 4, 2010, at 3:37 p.m. revealed Client #2 had a goal (dated August 2010) to improve her communication skills. The objective required that "Given verbal cues, [Client] will sign 5 healthy food items from colored photos on 75% of trials per month for 12 consecutive months (3 x a week). Although staff was observed to attempt to implement the objective on November 3, 2010, no data was available. Interview with the QMRP on November 5, 2010,	W 249		

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W 249	Continued From page 6 at 4:07 p.m. acknowledged that the IDT had recommended the aforementioned IPP communication objective for Client #2. According to the QMRP, the objective was being implemented, however, the program data was not available. At the time of the survey, the record failed to provide evidence that the program objective identified to improve the client's communication had been implemented, as recommended by the IDT.	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 consistent documentation of progress on the Individual Program Plan (IPP) objective, for one of three clients in the sample. (Client #2) The finding includes: The facility failed to ensure that data identifying the consequences of Client #2's behavior support plan was measurable, as evidenced below: Observation of Client #2 on November 3, 2010 at 3:30 p.m., revealed her walking around with a staff who provided direct supervision and verbally prompted her to discontinue attempted maladaptive behavior. According to the staff, the client required 1:1 supervision due to her targeted behaviors, which included physical aggression	W 252	The QMRP will retrain staff on collecting/recording accurate and complete data in accordance with the person's BSP. See response to W 249.	12/29/10

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W 252	Continued From page 7	W 252		

Continued interview with staff on November 4, 2010, at 11:05 a.m. revealed if Client # 2's exhibited a targeted behavior, staff was required to document the antecedent and consequence of the behavior on the antecedent - behavior - consequences (ABC) data collection form. According to staff, the frequency of the client's behaviors had decreased.

Record review on November 5, 2010 at 1:15 a.m., confirmed that Client #2 had a behavior support plan (BSP) dated August 10, 2010. The BSP addressed targeted behaviors of inappropriate affect, disruptive behavior, screaming, aggression, wetting, and resistive behavior. Further record review revealed that staff was required to document the consequences of all incidents of the targeted behaviors. The data collection form defined the consequences as "Anything and everything that followed the incident; what was said and done by staff in response to the situation, whether the behavior was resolved, and if so, how long it took."

On November 5, 2010 at 11:29 a.m., review of Client #2's ABC data collection form for September 21, 2010 to October 4, 2010, revealed she exhibited nine incidents of hitting staff and her peers. Staff noted the consequences of these behaviors as, " BSP applied ." Although the form noted what time the incidents ended, it failed to document "Anything and everything that followed the incident and what was said and done by staff in response to the situation... "

On November 5, 2010 at 12:17 p.m., the qualified mental retardation professional (QMRP) acknowledged that staff had not documented how

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W 252	Continued From page 8 the BSP was applied, as required by the ABC data collection instructions. At the time of the survey, there was no evidence that the facility ensured Client #2's BSP data was accurately maintained for effective monitoring of her progress in the objective.	W 252		
W 378	483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of temperature. This STANDARD is not met as evidenced by: Based on observation, the facility failed to store all drugs under proper conditions of temperature for one of the six clients residing in the facility. (Client #6) The finding includes: During the evening medication administration observation on November 4, 2010, at approximately 5:14 p.m., the Licensed Practical Nurse (LPN) was observed removing Client #6's bottle of Xalatan 0.005% eye drops from the medication cabinet. Further observation of the blue pharmacy label attached to the container revealed Xalatan 0.005% eye drops should be refrigerated. During a face to face interview with the LPN on November 4, 2010, at approximately 5:15 p.m., the LPN acknowledged Client #6's Xalatan 0.005% eye drops should be refrigerated. Review of the November 2010 physician's orders (POS) on November 4, 2010, at approximately 7:35 p.m., revealed Client #6 was prescribed Xalatan 0.005% one (1) eye drop in each eye every evening for glaucoma.	W 378	The RN supervisor will review medication storage protocols with the LPN Coordinator to ensure that medications are checked for storage requirements when they are delivered or picked up from a pharmacy. Quality Assurance will monitor for three months to ensure compliance. 12/04/10	

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W 378	Continued From page 9 There was no evidence an effective system to store all drugs under proper conditions of temperature was implemented.	W 378		

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I 000	INITIAL COMMENTS A licensure survey was conducted from November 3, 2010 to November 5, 2010. A random sampling of three residents was selected from a current residential population of two males and four females with various levels of mental retardation and disabilities. The findings of the survey were based on observations at the group home and one day programs, interviews with residents and staff, and the review of clinical and administrative records, including incident reports.	I 000		
I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based observation, interview, and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure the Qualified Mental Retardation Professional (QMRP) coordinated, integrated, and monitored services, for four of the six residents in the GHMRP. (Residents #2, #3, #5, and #6) The findings include: 1. The GHMRP's QMRP failed to ensure each resident's individual program plan (IPP) included training in activities of dental hygiene. [See I0420.1] 2. The GHMRP's QMRP failed to ensure residents were provided with opportunities for choice and self-management. [See I0420.2]	I 180	See response to federal deficiency W 159.	12/29/10

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I 180	Continued From page 1	I 180		
	3. The GHMRP's QMRP failed to ensure consistent documentation of progress on the Individual Program Plan (IPP) objective. [See I0420.3]			
	4. The GHMRP's QMRP failed to ensure continuous active treatment as recommended by the interdisciplinary team. [See I0420.4]			
I 420	3521.1 HABILITATION AND TRAINING	I 420		
	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 and interview, the Group Home for Mentally Retarded Persons (GHMRP) failed to 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, for four of the six residents. (Residents #2, #3, #5, and #6)			
	The findings include:			
	1. The GHMRP failed to ensure that Residents #2, #3, #5, and #6) were afforded opportunities for choice and/or self-management during dinner, as evidenced below:		1. See response to federal deficiency W 247.	12/29/10
	On November 3, 2010, at 5:40 p.m., observations of the dinner meal revealed that direct care staff (DCS) #2 was observed to prepare a family style			

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I 420	Continued From page 2 dinner. DCS #2 placed a bowl of BBQ turkey cutlets, a bowl of potato salad, and a bowl of green beans on the table. At 6:07 p.m., DCS #2 was observed to measure each resident's portion on to their plates. Although the dining table was set for family style dining, Residents #2, #3, #4, and #6 were not observed to participate in the service of their food. Interview with the DCS #2 and DCS #4 on the same day at approximately 6:17 p.m., revealed that the aforementioned residents were very capable of assisting direct care staff in serving their food with minimal assistance. DCS #2 further revealed that Resident #3 could serve herself independently. 2. The GHMRP failed to ensure each resident's individual program plan (IPP) included training in activities of dental hygiene for Resident #2, as evidenced below: Observation of Resident #2 on November 3, 2010, at 6:32 p.m. revealed she independently ate her dinner, as staff provided direct supervision and verbal prompts. Interview with staff on November 4, 2010 at 11:10 a.m. revealed that the resident required verbal prompts and physical assistance to meet his daily needs in toothbrushing, grooming, dressing, and bathing. On November 4, 2010, at 3:18 p.m. the licensed practical nurse (LPN) indicated that the resident had a recent dental visit and that the consultation report would be located. Review of Resident #2's medical record on November 5, 2010, at 12:36 p.m. revealed a history of poor oral hygiene and heavy calculus deposits. On March 23, 2010, the dentist noted,	I 420	2. See response to federal deficiency W 242.	12/29/10

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G225	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/05/2010
NAME OF PROVIDER OR SUPPLIER CARECO	STREET ADDRESS, CITY, STATE, ZIP CODE 1776 VERBENA STREET, NW WASHINGTON, DC 20012		

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I 420	Continued From page 3 "heavy calculus deposits." Interview with qualified mental retardation professional (QMRP) on November 5, 2010, at 1:17 p.m. revealed that Resident #2 did not have a training program to increase her independence in toothbrushing. Subsequent record review at that time confirmed that Resident #2's IPP did not include training in activities of dental hygiene, to the extent of her capability. 3. The GHMRP failed to ensure continuous active treatment was implemented in accordance with the interdisciplinary team (IDT) recommendations for Resident #2, as evidenced below: On November 3, 2010, at 7:26 p.m., Resident #2 was observed seated at the dining table with her 1:1 staff who was engaging her in a variety of activities. During this time, the resident was asked to sign donut, bacon and cereal with hand over hand assistance from the 1:1 staff, however, failed to cooperate with instructions. The staff then offered the resident a choice and stated, "Let's do something else then." Record review on November 4, 2010, at 3:37 p.m. revealed Resident #2 had a goal (dated August 2010) to improve her communication skills. The objective required that "Given verbal cues, [Resident] will sign 5 healthy food items from colored photos on 75% of trials per month for 12 consecutive months (3 x a week). Although staff was observed to attempt to implement the objective on November 3, 2010, no data was available. Interview with the QMRP on November 5, 2010, at 4:07 p.m. acknowledged that the IDT had recommended the aforementioned IPP	I 420	3. See response to federal deficiency W 249.	12/20/10

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I 420	Continued From page 4 communication objective for Resident #2. According to the QMRP, the objective was being implemented, however, the program data was not available. At the time of the survey, the record failed to provide evidence that the program objective identified to improve the resident's communication had been implemented, as recommended by the IDT. 4. The GHMRP failed to ensure that data identifying the consequences of Resident #2's behavior support plan was measurable, as evidenced below: Observation of Resident #2 on November 3, 2010 at 3:30 p.m., revealed her walking around with a staff who provided direct supervision and verbally prompted her to discontinue attempted maladaptive behavior. According to the staff, the resident required 1:1 supervision due to her targeted behaviors, which included physical aggression Continued interview with staff on November 4, 2010, at 11:05 a.m. revealed if Resident # 2's exhibited a targeted behavior, staff was required to document the antecedent and consequence of the behavior on the antecedent - behavior - consequences (ABC) data collection form. According to staff, the frequency of the resident's behaviors had decreased. Record review on November 5, 2010 at 1:15 a.m., confirmed that Resident #2 had a behavior support plan (BSP) dated August 10, 2010. The BSP addressed targeted behaviors of inappropriate affect, disruptive behavior, screaming, aggression, wetting, and resistive behavior. Further record review revealed that staff was required to document the	I 420	4. See response to federal deficiency W 252. 12/29/10	

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I 420	Continued From page 5 consequences of all incidents of the targeted behaviors. The data collection form defined the consequences as "Anything and everything that followed the incident; what was said and done by staff in response to the situation, whether the behavior was resolved, and if so, how long it took." On November 5, 2010 at 11:29 a.m., review of Resident #2's ABC data collection form for September 21, 2010 to October 4, 2010, revealed she exhibited nine incidents of hitting staff and her peers. Staff noted the consequences of these behaviors as, " BSP applied ." Although the form noted what time the incidents ended, it failed to document "Anything and everything that followed the incident and what was said and done by staff in response to the situation... " On November 5, 2010 at 12:17 p.m., the QMRP acknowledged that staff had not documented how the BSP was applied, as required by the ABC data collection instructions. At the time of the survey, there was no evidence that the GHMRP ensured Resident #2's BSP data was accurately maintained for effective monitoring of her progress in the objective.	I 420		
I 483	3522.10 MEDICATIONS Each medication shall be stored under proper conditions of light and temperature as indicated on its label. This Statute is not met as evidenced by: Based on observation, the Group Home for Mentally Retarded Persons(GHMRP), failed to store all drugs under proper conditions of temperature as indicated on its label for one of	I 483	See response to federal deficiency 378.	12/29/10