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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 A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G171		R 06/13/2007

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 return visit was conducted on June 13, 2007. The focus of the survey was to examine the systemic effect of the facility's governing body to adequately manage and govern the facility and to ensure its compliance with the Conditions of Participation in Health Care Services. Client #1 was transferred to a long term care hospital on May 21, 2007; however, Client #1 has not been discharged from the facility. Four females with varying degrees of disabilities currently reside in this facility. Two of the four residents were selected for the sample. The survey findings were based on observations in the group home, interviews with clients, residential, nursing and administrative staff. Review of records, including investigations of unusual incidents was also conducted. The survey findings determined that the facility failed to substantially comply with the Condition of Participation in Health Care Services.	{W 000}	The client who was admitted to a long term care facility for rehabilitative reasons has recuperated, and has returned to residency in the facility. The Governing Body has decided to discharge all clients from the facility in an effort to fully redesign service delivery under a different funding mechanism. The Governing body has taken extraordinary measures to improve the quality and timeliness of health and other supports in the facility, including moving to a home in a much safer and better integrated neighborhood; hiring a residential director with deep sensitivity and ability to support people living in the facility in her care; discharge of nearly half of the clients previously served in order to better support the intensive needs of those who remained; and removal of staff at all levels who could or would not work within established company policy and procedures.	9/15/2007
{W 104}	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on interviews and review of records, the facility's governing body failed to provide general operating directions over the facility as evidenced by the following and the deficiencies cited throughout this report: 1. [Cross Refer to W149, 192 and W342] The governing body failed to establish effective	{W 104}	1. The Governing Body ensures that health care training, mentoring and support is provided to all direct care staff.	7/31/07

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

Marsha H. Thompson — Director of Disability Services — 7/12/07

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 104}	Continued From page 1	{W 104}		
	polices and procedures to ensure that clients were provided health care monitoring and training.			
	2. [Cross Refer to W153.1] The governing body failed to implement its policy and procedures on incident management.		2. The Governing Body will take measures in training and follow up to ensure that the incident management policy is correctly and consistently implemented by all staff.	7/21/07
	3. [Cross Refer to W192] The governing body failed to implement its policy and procedures on communicating medical concerns to administrative staff.		3. See response to W153.	
{W 114}	483.410(c)(4) CLIENT RECORDS	{W 114}		
	Any individual who makes an entry in a client's record must make it legibly, date it, and sign it.			
	This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that the Director of Nurses (DON) retrained the nursing staff on the facility's policies regarding medication documentation content, style and timeliness; failed to develop a contract with other medical providers for primary care according to the facility's Plan of Correction (POC) dated June 6, 2007.			
	The findings include:			
	1. Interview with the Licensed Practical Nurse on June 13, 2007 at approximately 1:00 PM revealed that she was unable to recall the training that the DON had provided following the incident on April 19, 2007. Interview with the Director of Nurses on June 13, 2007 at approximately 4:30 PM revealed that she did not know what specific training that she had provided the nursing staff.		1. The Governing Body is reassigning nursing staff, and has released a previously hired RN Supervisor. The Governing Body has hired another RN Supervisor. The DON will provide a full orientation and training to the new RN Supervisor, and the DON will implement training on the facility policies on medication administration, including documentation, style and timeliness.	7/31/07

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{W 114}	Continued From page 2 Review of nursing staff training records on June 13, 2007 at approximately 4:35PM revealed no evidence of retraining on the facility's policies regarding medication documentation content, style and timeliness. There was no documented evidence that the DON retrained the nursing staff on the facility's policies regarding medication documentation content, style and timeliness	{W 114}		
	2. Interview with the Director of Disability Services (DODS) on June 14, 2007 at approximately 10:30 AM revealed that the facility has not developed a contract with other medical providers for primary care according to the facility's POC dated June 8, 2007. Further interview revealed that the Primary Care Physician (PCP) on duty at the time of the incident on April 19, 2007 was still the PCP for the clients in the facility. There was no documented evidence that the facility developed a contract with other medical providers to provide primary care.		2. The Director of Disability Services (DoDS) is still negotiating with the Fort Lincoln Family Medical Center. The "Fort" is willing to provide individualized primary care, however has no previous experience with the ICFMR requirement for contracts. This has considerably slowed the process, and has contributed to the Governing Body's decision to discharge clients fro the facility and seek an opportunity to provide services in a less institutionalized environment.	9/1/2007
{W 124}	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure that the Qualified Mental Retardation Professional (QMRP) informed each client, parent, or legally authorized party the	{W 124}		

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{W 124}	Continued From page 3 client's medical conditions, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment for two of two clients in the sample (Client #2 and Client #3). The findings include: 1. Interview with the Residential Director (RD) on June 13, 2007 at approximately 9:15AM revealed that the RD did not know if the QMRP informed Client # 2 of her medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. Further interview revealed that the client did not have a legally authorized guardian or decision maker. Review of Client #2's Psychological Assessment dated April 21, 2007 on June 13, 2007 at approximately 9:20AM indicated that the client did not evidence the capacity to make independent decisions on her behalf regarding her habilitation planning, placement, treatment, financial and medical matters and could not give informed consent. Review of the medical and habilitation records on June 13, 2007 at approximately 9:25AM revealed no documented evidence the QMRP informed Client #2 of her medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.	{W 124}	1. The QMRP will provide evidence of written information concerning the benefits and risks of proposed treatments. The client's decision maker gives informed consent. The client has an active and involved family member who gives consent for treatment.	7/21/07
	2. Interview with the Residential Director (RD) on June 13, 2007 at approximately 10:20AM revealed that the RD did not know if the QMRP informed Client # 3 of her medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. Further interview revealed that the client did not have a legally authorized guardian or decision maker. Review of Client #3's		2. See response to #1 above.	7/21/07

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{W 124}	Continued From page 4 Psychological Assessment dated April 21, 2007 on June 13, 2007 at approximately 10:25AM indicated that the client did not evidence the capacity to make independent decisions on her behalf regarding her habilitation planning, placement, treatment, financial and medical matters and could not give informed consent. Review of the medical and habilitation records on June 13, 2007 at approximately 10:30AM revealed no documented evidence the QMRP informed the client of her medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.	{W 124}		
{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 interviews and record review, the facility failed to employ its Plan of Correction (PoC) to ensure that nursing staff were trained on the implementation of its policy/procedure on the use of sedation to prevent abuse/misuse. Additionally, the facility failed to ensure an effective policy/procedure on identifing those clients in need of sedation for two of two clients in the sample (Client #2 and Client #3). The findings include: 1. Interview with the Residential Director (RD) on June 13, 2007 at approximately 3:00PM revealed that RD did not know if the Psychologist assessed Client #2 for least restrictive interventions	{W 149}	1. The Psychologist will assess clients for the least restrictive interventions required to successfully complete medical appointments and will revise the desensitization plan if required.	7/31/07

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{W 149}	Continued From page 5 required to successfully complete medical appointments. Review of a Gyn consult dated March 28, 2007 on June 13, 2007 at approximately 3:10PM revealed that Client #2 was administered Ativan 3 mg by mouth at 12:00 PM. Review of Client #2's psychological assessment dated April 21, 2007 at approximately 3:15PM revealed no documented evidence that the client was assessed for least restrictive interventions required to successfully complete medical appointments and procedures.	{W 149}		
	2. Interview with the Residential Director (RD) on June 13, 2007 at approximately 3:20 PM revealed that RD did not know if the Psychologist assessed Client #3 for least restrictive interventions required to successfully complete medical appointments. Review of an audiology consult dated March 15, 2007 on June 13, 2007 at approximately 3:25PM revealed that Client #3 was administered Ativan 5mg by mouth. Review of Client#3's psychological assessment dated April 21, 2007 at approximately 3:27 PM revealed that Client #3's desensitization plan was revised.		2. See response to #2 above.	7/31/07
	3. Interview with the Licensed Practical Nurse (LPN) on June 13, 2007 at approximately 1:10 PM revealed that she was unable to recall the training that the DON had provided following the incident on April 19, 2007. Interview with the Director of Nurses on June 13, 2007 at approximately 4:30 PM revealed that she did not know what specific training that she had provided the nursing staff. Review of nursing staff training records on June 13, 2007 at approximately 4:30PM revealed a training on Scheduled II substances on April 17, 2007. There was no documented evidence of retraining on the facility's policy on Controlled Scheduled II Substances		3. The nursing assignments at the facility have been revised. The DON will provide retraining on Controlled Schedule II substances and all agency policies on medication administration.	7/31/07

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{W 149}	Continued From page 6 after the April 19, 2007 incident.	{W 149}		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to consistently document the reporting of client injuries of unknown origin to the designated administrator, and to report incidents that pose a risk to client health or safety to governmental agencies, as required by DC regulation (22 DCMR Chapter 35 Section 3519.10). The findings include: 1. Review of an unusual incident report dated June 5, 2007 on June 13, 2007 at approximately 8:30 AM revealed that Client # 2 sustained a cut (involved body part not identified) while being shaved. Interview with the Residential Director (RD) on June 13, 2007 at approximately 9:15 AM revealed she was unaware of the incident and that Direct Staff #1 did not inform her of the alteration in Client #2's health care status. There was no documented evidence that this incident had been reported to governmental agencies as required. 2. Review of an unusual incident report dated June 5, 2007 on June 13, 2007 at approximately 8:40 AM revealed that Client #3 was treated and	W 153	Staff will be retrained on incident reporting requirements and documentation in appropriate logs and client records. Staff who refuse to comply with the required protocols after being trained will be disciplined up to and including termination of employment with the agency.	7/21/07

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W 153	Continued From page 7 released from the emergency room for bi-lateral swollen ankles. Interview with the Residential Director (RD) on June 13, 2007 at approximately 9:20 AM revealed that Direct Staff #2 did not inform her of the alteration in Client #3's health care status. There was no documented evidence that this incident had been reported to governmental agencies as required.	W 153		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on interview, and record review, the Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination of services for two of two clients in the sample. (Client #2 and Client #3) The findings include: 1. Cross Refer to W153. The QMRP failed to ensure that the facility's incident managment system had been implemented. 2. The QMRP failed to coordinate services with the Nutritionist to ensure that Client #2's consumption of foods and that reduction client behaviors that could be potentially harmful was assessed, monitored, and addressed as evidenced by: Interview with the Residential Director (RD) on June 13, 2007 at approximately 6:40 PM revealed that Client #2 did have a mealtime protoco.	W 159	1. The QMRP will ensure that dining protocols are trained and posted for staff to follow. 2. The survey of the facility took place as the clients and staff were moving into the new home. Staff were still in the process of unpacking files, equipment, clothing, etc., and had not had the opportunity to post the protocols on which they had been trained. The RD will ensure that dining protocols are posted for staff to follow.	7/21/07 7/21/07

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W 159	Continued From page 8 Review of the Nutritional Assessment Evaluation dated April 7, 2007 on June 13, 2007 at approximately 6:45 PM revealed that Client #2 had a mealtime protocol for staff to follow as a guide when feeding. There was no evidence of a current mealtime protocol for the direct staff to follow regarding the client's need for supervision and safe strategies during mealtime.	W 159		
	3. The QMRP failed to coordinate services with the Nutritionist to ensure that Client #2's consumption of foods and that reduction client behaviors that could be potentially harmful was assessed, monitored, and addressed as evidenced by:		3. See response to #2 above.	7/21/07
	Interview with the Residential Director (RD) on June 13, 2007 at approximately 6:50 PM revealed that Client #3 did have a mealtime protoco. Review of the Nutritional Assessment Evaluation dated April 7, 2007 on June 13, 2007 at approximately 6:55 PM revealed that Client #3 had a mealtime protocol for staff to follow as a guide when feeding. There was no documented evidence of a current mealtime protocol for the direct staff to follow regarding the client's need for supervision and safe strategies during mealtime.			
	4. Cross Refer to W192.3 The QMRP failed to ensure that all staff had been effectively trained to implement emergency measures for four of four clients in the facility as evidenced by:		4. The CPR Instructor is scheduled to provide training on this issue in July 2007.	7/31/07
	Interview with the RD and review of staff training records dated on June 13, 2007 at approximately 6:00 PM revealed no documented evidence of training on procedures for clearing clients airways of food or foreign objects following the incident on			

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W 159	Continued From page 9 April 19, 2007.	W 159		
{W 192}	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure adequate training to provide complete and timely verbal and written reports of signs and symptoms of illness; and failed to ensure adequate training in the procedures for clearing clients airways of food or foreign objects according to the facility's Plan of Correction (POC) dated June 8, 2007 for two of two clients in the sample. (Client #2 and Client #3) The findings include: 1. Review of an unusual incident report dated June 5, 2007 on June 13, 2007 at approximately 8:30 AM revealed that Client # 2 sustained a cut ((body part not identified) while being shaved. Interview with the Residential Director (RD) on June 13, 2007 at approximately 9:15 AM revealed she was unaware of the incident and that Direct Staff #1 did not inform her of the alteration in Client #2's health care status. Review of the facility's policy on "Communication of Medically Related Issues" on June 13, 2007 at approximately 9:17 AM revealed that medical incidents were to be documented in the client's medical log. Review of Client #2's medical log on June 13, 2007 at approximately 8:18 AM revealed no documented evidence of the incident. 2. Review of an unusual incident report dated	{W 192}	1. See response to W153. 2. See response to W153.	7/21/07 7/21/07

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{W 192}	Continued From page 10 June 5, 2007 on June 13, 2007 at approximately 8:40 AM revealed that Client #3 was treated and released from the emergency room for bi-lateral swollen ankles. Interview with the Residential Director (RD) on June 13, 2007 at approximately 8:20 AM revealed that Direct Staff #2 did not inform her of the alteration in Client #3's health care status. Review of the facility's policy on "Communication of Medically Related Issues" on June 13, 2007 at approximately 8:25 AM revealed that medical incidents were to be documented in the client's medical log. Review of Client #3's medical log on June 13, 2007 at approximately 8:50 AM revealed no documented evidence of the signs and symptoms of Client #3's illness. [Note: Direct Staff #2 was placed on administrative leave on June 6, 2007.] 3. Interview with the RD and review of staff training records dated on June 13, 2007 at approximately 6:00 PM revealed no documented evidence of training on procedures for clearing clients airways of food or foreign objects following the incident on April 19, 2007.	{W 192}	3. See response to W159 #4.	7/31/07
{W 263}	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on interview and record review, the facility's specially-constituted committee (Human Rights Committee) failed to ensure that restrictive programs were used only with written consents,	{W 263}	The HRC minutes will be made available for review. At the time of the request the HRC book was still in a packing box, possibly at the old facility.	7/21/07

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(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 263}	Continued From page 11 for two of two clients included in the sample. (Client #2 and Client #3) The finding includes: The Human Rights Committee (HRC) minutes were requested on June 13, 2007 at approximately 2:00 PM from the Licensed Practical Nurse (LPN); however, the HRC minutes were not provided at the time of the survey.	{W 263}		
{W 318}	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on staff interview, and record review, the facility failed to develop and implement an effective system to provide general and preventive medical care (See W322); failed to provide nursing services in accordance with each client's needs (See W331); the facility failed to hire and maintain a new Registered Nurse to oversee day to day health care issues (See W342) and failed to train direct care staff on preventative health care (See W192). The effects of these systemic practices results in the failure of the facility to provide adequate health care services.	{W 318}	The agency did hire and then subsequently terminate an RN to oversee the assigned LPN and to oversee the provision of general and preventive medical care, and nursing services in accordance with each client's needs. The RN proved to be unreliable, contrary to her presentation and commitments during the screening and interview process prior to hire, and contrary to the job description, hours, training and expectations that she understood and committed to after hire. The agency released the RN when she did not keep these commitments, and aggressively sought another RN, comparably qualified, who demonstrated a willingness to keep commitments made. The Director of Operations has negotiated an employment arrangement with the new RN as an RN Supervisor. The DON will provide orientation and training on all policies and expectations; the DoDS will provide further training and mentoring. The new RN Supervisor is slated to begin work within the next two weeks.	7/31/07
{W 322}	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care.	{W 322}		

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

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	09G171		R 06/13/2007

NAME OF PROVIDER OR SUPPLIER: CARECO 11

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{W 322}	Continued From page 12	{W 322}		
	This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to failed to provide preventive and general care and failed to implement medical protocols for two of three clients in the sample (Client #2 and #3)			
	The findings include:			
	1. The facility failed to provide adequate nursing training on the facility 's policies and procedures as evidenced by:		1. See response to W149 #3.	7/31/07
	Interview with the Licensed Practical Nurse on June 13, 2007 at approximately 1:00 PM revealed that she was unable to recall the training that the DON had provided following the incident on April 19, 2007. Interview with the Director of Nurses on June 13, 2007 at approximately 4:30 PM revealed that she did not know what specific training that she had provided the nursing staff. Review of nursing staff training records on June 13, 2007 at approximately 4:35PM revealed no evidence of retraining on the facility's policies regarding medication documentation content, style and timeliness.			
	2. Cross Refer to W331. The facility's nursing services failed to obtain an annual ophthalmology for Client # 2.		2. The DON will ensure that the client receives all annual assessments.	7/31/07
	3. Cross Refer to W331. The facility's nursing services failed to obtain an annual ophthalmology for Client # 3.		3. See response to #2 above.	7/31/07
	4. Cross Refer to W331. The facility's nursing services failed to obtain timely laboratory studies for Client # 2.		4. The DON will ensure that clients receive timely laboratory studies and study results.	7/31/07

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{W 322}	Continued From page 13	{W 322}		
	5. Cross Refer to W331. The facility's nursing services failed to obtain timely laboratory studies for Client # 3.		5. See response to #4 above.	7/31/07
	6. Cross Refer to W331. The facility's nursing services failed to obtain the results of Client # 2's pap smear.		6. The DON will ensure that all test results are timely obtained for each client served.	7/31/07
	7. Cross Refer to W331. The facility's nursing services failed to obtain the results of Client # 3's pap smear.		7. See response to #6 above.	7/31/07
W 331	483.460(c) NURSING SERVICES	W 331		
	The facility must provide clients with nursing services in accordance with their needs.			
	This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to ensure nursing services in accordance with the needs of two of two clients in the sample. (Client #2 and Client # 3)			
	The findings include:			
	1. The facility's nursing services failed to obtain an annual ophthalmology for Client # 2 as evidenced by:		1. See response to W322 #2.	7/31/07
	Review of an ophthalmology consult dated April 28, 2006 on June 13, 2007 at approximately 3:05 PM revealed a recommendation for Client # 2 to return to the ophthalmology clinic in one year. In an interview with the Licensed Practical Nurse (LPN) on June 13, 2007 at approximately 3:06 PM it was acknowledged that Client # 2 had not returned to the ophthalmology clinic. There was no documented evidence that Client # 2 returned			

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

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W 331	Continued From page 14 to the ophthalmology clinic as recommended. 2. The facility's nursing services failed to obtain an annual ophthalmology for Client # 3 as evidenced by: Review of an ophthalmology consult dated April 18, 2006 on June 13, 2007 at approximately 3:07 PM revealed a recommendation for Client # 3 to return to the ophthalmology clinic in one year. In an interview with the LPN on June 13, 2007 at approximately 3:08 PM it was acknowledged that Client # 3 had not returned to the ophthalmology clinic. There was no documented evidence that Client #3 returned to the ophthalmology clinic as recommended.	W 331	2. See response to W322 #2.	7/31/07
	3. The facility's nursing services failed to ensure Client #2's laboratory studies were conducted timely as evidenced by: Review of the Primary Care Physician's orders dated May, 2007 on June 13, 2007 at approximately 1:13PM revealed recommendation for Client #2 to have a urinalysis yearly. Interview with the LPN on June 13, 2007 at approximately 1:14 PM revealed that the laboratory study had not been performed or scheduled. Review of the medical record on June 13, 2007 at approximately 1:15 PM revealed no documented evidence of that laboratory studies for urinalysis. There was no evidence that the laboratory study was obtained as recommended.		3. See response to W322 #4.	7/31/07
	4. The facility's nursing services failed to ensure Client #3's laboratory studies were conducted timely as evidenced by: Review of the Primary Care Physician's orders		4. See response to W322 #4.	7/31/07

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W 331	Continued From page 15 dated May, 2007 on June 13, 2007 at approximately 1:10PM revealed recommendations for Client #3 to have a SMA 12, hepatitis screening and urinalysis yearly. Interview with the LPN on June 13, 2007 at approximately 1:11 PM revealed that the laboratory studies had not been performed or scheduled. Review of the medical record on June 13, 2007 at approximately 1:12 PM revealed that the last laboratory studies were dated May 28, 2007. There was no evidence that the laboratory studies was obtained as recommended.	W 331		
	5. The facility's nursing services failed to obtain the results of Client # 2's pap smear as evidenced by: Review of a Gyn consult dated March 28, 2006 on June 13, 2007 at approximately 12:00 PM revealed that Client #2 had a pap smear performed on March 28, 2007. In an interview with the LPN on June 13, 2007 at approximately 12:05 PM it was acknowledged that Client #2's pap smear results had not been obtained by the facility. There was no documented evidence that Client #2's pap smear results had not been obtained by the facility.		5. See response to W322 #6.	7/31/07
	6. The facility's nursing services failed to obtain the results of Client # 3's pap smear as evidenced by: Review of a Gyn consult dated July 19, 2006 on June 13, 2007 at approximately 12:10 PM revealed that Client #3 had a pap smear performed on July 19, 2006. In an interview with the LPN on June 13, 2007 at approximately		6. See response to W322 #6.	7/31/07

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{W 342}	Continued From page 17 clients in the faculty. (Client #2, Client #3, Client #3 and Client #4) The finding includes: Interview with the Director of Nurses (DON) on June 13, 2007 at approximately 4:45PM revealed that a new RN had been hired but that she was terminated. Interview with the Residential Director (RD) on June 13, 2007 at approximately 7:30PM revealed that the DON was only working part-time for the facility. Review of personnel records provided by the facility on June 14, 2007 at approximately 11:06 AM revealed that the RN was terminated on May 25, 2007. There was no documented evidence that the facility hired a new Registered Nurse to oversee day to day health care issues at the facility after May 25, 2007.	{W 342}		

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{I 000}	INITIAL COMMENTS A return visit was conducted on June 13, 2007. The focus of the survey was to examine the systemic effect of the facility's governing body to adequately manage and govern the facility and to ensure its compliance with the Conditions of Participation in Health Care Services. Five females with varying degrees of disabilities reside in this facility. Resident #1 has been transferred to a long term care hospital on May 21, 2007, however Resident #1 has not been discharged from the facility. The survey sample was derived from a random sampling of two of the four clients residing in the facility. The survey findings were based on observations in the group home, interviews with clients, residential, nursing and administrative staff. Review of records, including investigations of unusual incidents was also conducted. The facility failed to substantially comply with the Condition of Participation in Health Care Services.	{I 000}		
{I 229}	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on interviews and record review, the facility failed to ensure adequate training to provide complete and timely verbal and written reports of signs and symptoms of illness; and failed to ensure adequate training in the procedures for clearing clients airways of food or	{I 229}	See response to federal deficiencies W104, W153 and W159 #4.	7/31/07

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Marsha H. Thompson — Director of Disability Services — 7/12/07

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

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{I 229}	Continued From page 1 foreign objects according to the facility's Plan of Correction (POC) dated June 8, 2007 for two of two residents in the sample. (Resident #2 and Resident #3) The findings include: 1. Review of an unusual Incident report dated June 5, 2007 on June 13, 2007 at approximately 8:30 AM revealed that Resident # 2 sustained a cut (body part not identified) while being shaved. Interview with the Residential Director (RD) on June 13, 2007 at approximately 9:15 AM revealed she was unaware of the incident and that Direct Staff #1 did not inform her of the alteration in Resident #2's health care status. Review of the facility's policy on "Communication of Medically Related Issues" on June 13, 2007 at approximately 9:17 AM revealed that medical incidents were to be documented in the resident's medical log. Review of Resident #2's medical log on June 13, 2007 at approximately 8:18 AM revealed no documented evidence of the incident. 2. Review of an unusual incident report dated June 5, 2007 on June 13, 2007 at approximately 8:40 AM revealed that Resident #3 was treated and released from the emergency room for bi-lateral swollen ankles. Interview with the Residential Director (RD) on June 13, 2007 at approximately 8:20 AM revealed that Direct Staff #2 did not inform her of the alteration in Resident #3's health care status. Review of the facility's policy on "Communication of Medically Related Issues" on June 13, 2007 at approximately 8:25 AM revealed that medical incidents were to be documented in the resident's medical log. Review of Resident #3's medical log on June 13, 2007 at approximately 8:50 AM revealed no	{I 229}		

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{I 229}	Continued From page 2 documented evidence of the signs and symptoms of Resident #3's illness. [Note: Direct Staff #2 was placed on administrative leave on June 6, 2007.] 3. Interview with the RD and review of staff training records dated on June 13, 2007 at approximately 6:00 PM revealed no documented evidence of training on procedures for clearing clients airways of food or foreign objects following the incident on April 19, 2007.	{I 229}		
{I 291}	3514.2 RESIDENT RECORDS Each record shall be kept current, dated, and signed by each individual who makes an entry. This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that the Director of Nurses (DON) retrained the nursing staff on the facility's policies regarding documentation content, style and timeliness; the facility failed to develop a contract with other medical providers for primary care according to the facility's Plan of Correction (POC) dated June 8, 2007. The findings include: 1. Interview with the Licensed Practical Nurse (LPN) on June 13, 2007 at approximately 1:00 PM revealed that she was unable to recall the training that the DON had provided following the incident on April 19, 2007. Interview with the DON on June 13, 2007 at approximately 4:30 PM revealed that she did not know what specific training that she had provided the nursing staff. Review of nursing staff training records on June 13, 2007 at approximately 4:35 PM revealed no	{I 291}	See response to federal deficiencies W114 and W318 HEALTH CARE CONDITION.	7/31/07

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

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{I 291}	Continued From page 3 evidence of retraining on the facility's policies regarding documentation content, style and timeliness. 2. Interview with the Director of Disability Services (DODS) on June 14, 2007 at approximately 10:30 AM revealed that the facility has not developed a contract with other medical providers for primary care according to the facility's POC dated June 8, 2007. Further interview revealed that the Primary Care Physician (PCP) on duty at the time of the incident on April 19, 2007 was still the PCP for the residents in the facility.	{I 291}		
I 370	3519.1 EMERGENCIES Each GHMRP shall maintain written policies and procedures which address emergency situations, including fire or general disaster, missing persons, serious illness or trauma, and death. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to consistently document the reporting of client injuries of unknown origin to the designated administrator, and to report incidents that pose a risk to client health or safety to governmental agencies, as required by DC regulation (22 DCMR Chapter 35 Section 3519.10). The findings include: 1. Review of an unusual incident report dated June 5, 2007 on June 13, 2007 at approximately 8:30 AM revealed that Resident # 2 sustained a cut (involved body part not identified) while being shaved. Interview with the Residential Director (RD) on June 13, 2007 at approximately 9:15 AM revealed she was unaware of the incident and	I 370	See response to federal deficiency W104 #2 and W153.	7/21/07

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I 370	Continued From page 4 that Direct Staff #1 did not inform her of the alteration in Resident #2's health care status. There was no documented evidence that this incident had been reported to governmental agencies as required. 2. Review of an unusual incident report dated June 5, 2007 on June 13, 2007 at approximately 8:40 AM revealed that Resident #3 was treated and released from the emergency room for bi-lateral swollen ankles. Interview with the Residential Director (RD) on June 13, 2007 at approximately 9:20 AM revealed that Direct Staff #2 did not inform her of the alteration in Resident #3's health care status. There was no documented evidence that this incident had been reported to governmental agencies as required.	I 370		
{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 interviews and record review, the facility failed to ensure that the Qualified Mental Retardation Professional (QMRP) informed each client, parent, or legally authorized party the client's medical conditions, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment according to the facility's Plan of Correction (POC) dated June 8, 2007 for two of two residents in the sample. (Resident #2 and Resident #3) The findings include:	{I 500}	See response to federal deficiency W124.	7/31/07

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{I 500}	Continued From page 5 1. Interview with the Residential Director on June 13, 2007 at approximately 9:15AM revealed that she did not know if the QMRP informed Resident # 2 of her medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. Further interview revealed that the client does not have a legally authorized guardian or decision maker. Review of Resident #2's Psychological Assessment dated April 21, 2007 on June 13, 2007 at approximately 9:20AM indicated that she does not evidence the capacity to make independent decisions on her behalf regarding her habilitation planning, placement, treatment, financial and medical matters and can not give informed consent. Review of the medical and habilitation records on June 13, 2007 at approximately 9:30AM revealed no documented evidence the QMRP informed the client of her medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. 2. Interview with the Residential Director on June 13, 2007 at approximately 10:20AM revealed that she did not know if the QMRP informed Resident # 3 of her medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. Further interview revealed that the client does not have a legally authorized guardian or decision maker. Review of the medical and habilitation records on June 13, 2007 at approximately 10:30AM revealed no documented evidence the QMRP informed the client of her medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.	{I 500}		

CARECO INC.
HEALTH CARE PROVIDERS
8115 FENTON ST., SUITE 203 SILVER SPRING, MD 20910
(301) 565-9400 FAX (301) 565-4541

To: Patricia Van Buren
DOH / HRA

FR: Careco, Inc

Re: Plan of Correction for 1701 24th Street, NE
(Careco II)

Please see attached POC. If you have questions or concerns, pls contact Marsha Thompson at 202-812-2078

Thank you

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0002	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/27/2007
NAME OF PROVIDER OR SUPPLIER N C C	STREET ADDRESS, CITY, STATE, ZIP CODE 6609 9TH ST, 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
I 000	INITIAL COMMENTS A licensure survey was conducted on March 27, 2007. Three males with varying degrees of disabilities reside in the facility. Two of the four residents were randomly selected for the sample. The findings of the survey were based on observations at the group home, interviews with staff, and the review of records including incident reports.	I 000		
I 061	3502.19 MEAL SERVICE / DINING AREAS Each GHMRP shall have effective procedures for cleaning all equipment and work areas used in the preparation and serving of foods. This Statute is not met as evidenced by: Based on observation, and staff interview, the facility failed to ensure procedures were provided for cleaning the GHMRP's kitchen stove hood. The finding includes: Observation of the GHMRP's kitchen stove on March 27, 2007 revealed a large amout of grease encrusted under its hood. At the time of the survey, there was no documented evidence of procedures to clean any equipment used in the preparation and serving of foods.	I 061	NCC has develop a housekeeping check list that will be used daily for the cleaning of the varies areas in the house Staff will be trained in this area. Attachment 1	5/15/07
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.	I 090		

Health Regulation Administration

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

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