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DEPARTMENT OF HEALTH
HEALTH REGULATION
ADMINISTRATION

2007 NOV -2 P 3:47

November 2, 2007

Dear Ms. Van Buren,

Please find enclosed the allegation of compliance to the deficiencies cited during a follow up survey at 1613 Taylor Street, NW, on October 11, 2007. The alleged date of compliance is November 15, 2007. Please feel free to contact me on my cell at 301-204-2914, if you have any questions or concerns.

Respectfully,

Dana S. McKenzie, QMRP
Careco, Inc.

PRINTED: 10/23/2007
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
	09G167	A. BUILDING B. WING	R 10/11/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 10	1613 TAYLOR STREET, NW WASHINGTON, DC 20011

(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 follow up survey was conducted from 10/9/07 through 10/11/07 to determine the facility's compliance with previous condition level deficiencies cited on 8/31/07. A random sample of three clients was selected from a client population of four females and two males clients with varying degrees of disabilities. The findings of this survey were based on observations at the group home and two day programs, interviews with one family member, the day program and group home staff, and record review of unusual incident reports and investigations. The survey findings determined that the facility was in compliance with the Condition of Participation in Client Protection and Active Treatment.	{W 000}		
{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 record review, the facility's governing body provided to provide general operating directions except for the deficienct practices detailed below. The findings include: The Governing Body failed to establish and/or implement policies that ensured the health and safety of its clients. [See W149]	{W 104}		
W 130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS	W 130		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dana S. McK	QMRP	11/2/07

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 130	Continued From page 1 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, the facility failed to ensure that the clients' rights for privacy during the medication administration were protected for five of six clients residing in the facility. (Client #1, #2, #3, #5, and #6) The findings include: The facility failed to ensure that Clients received privacy during the evening medication administration as evidenced below: During the evening medication administration observation on 10/9/07 beginning at 8:15 PM, the Licensed Practical Nurse (LPN) was observed to administer medications to Clients #1, #2, #3, #5, and #6 in a designated area (between the dining room and living). This area was opened to the clients and staffs who were sitting in the dining and living rooms; therefore, the clients receiving medications could be observed by others.	W 130	W130 A decorative screen will be purchased to use as a means of providing privacy during medication administration. Whenever possible, other clients will be encouraged to participate in other activities to increase privacy for the person receiving medication. 11/15/07	
{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 establish and/or implement policies that ensured the client's health and safety for one of	{W 149}		

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{W 149}	Continued From page 2 the three clients residing in the facility. (Client #2) The finding includes: The facility failed to ensure its "Medication Administration Protocol" was implemented to address medication errors as evidenced below: Review of the unusual incident reports conducted on 10/11/07 at 2:12 AM revealed an incident dated 9/1/07. According to the incident, the evening medication nurse did not arrive to the facility to administer 8:00 PM medications to Client #2. Further review revealed that the Direct Care Support (DCS) on duty called Designated Nurse (DN) on duty to report the medication error, but received no response back. The DCS then called the Acting Residential Director (RD) who in return called the covering nurse. The RD called back to the facility to inform the DCS on duty that the covering nurse would be sending someone over to administer the medications to Client #2. The scheduled medication nurse arrived at the facility at approximately 11:45 PM and administered medications to Client #2. Review of the corresponding investigation report confirmed the information presented on the incident report. Interview with the QMRP on 10/10/07 at approximately 3:00 PM revealed that the DCS did not follow the established protocol. According to the facility policy . . . " If staff has not received a call from the DN within the 15 minutes, which would then be 30 minutes past the medication time, staff calls the Program Services Coordinator. " Further review of the protocol revealed that "when the Medication Nurse (MN) is going to arrive more than 15 minutes past the medication time, he/she calls the home by that	{W 149}	W149 The DCS and medication nurse will be retrained on the Medication Administration Protocol. This and all incidents are reviewed by the Incident Review Committee to recognize trends and make recommendations to alleviate future occurrences. 11/07/07	

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{W 149}	Continued From page 3 time to notify staff of his/her expected arrival time." The medication nurse also did not follow establish protocols.	{W 149}		
{W 189}	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each employee was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently. The finding includes: Review of unusual incident reports on 10/9/07 at 2:12 PM, revealed an incident dated 9/1/07 that documented a medication error for Client #2. Further review of the incident report and review of the corresponding investigation revealed that the Direct Care Staff (DCS) failed to implement the facility's policy and procedures for "Medication Administration (Medication Administration Protocol)" when the medication nurse failed to show up between the hours of 8 PM to 10 PM to administer Client #2's medications. Interview with the Qualified Mental Retardation Professional (QMRP) and review of the staff training attendance record revealed that staff have been retrained on the Medication Administration Pass Protocol on 9/22/07 after the incident had occurred. Further review of the attendance sheet revealed no evidence that the DCS involved in the incident dated 9/1/07 had received the training on	{W 189}	W189 The DCS involved will receive additional training on the Medication Administration Protocol with appropriate documentation kept on file for review. 11/5/07	

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{W 189}	Continued From page 4 the Medication Administration Pass Protocol. [See W149]	{W 189}		
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that clients (#3 and #6) were provided the opportunities for making choices as part of their self-management. The findings include: 1. Evening observations was conducted from 3:10 PM to 8:02 PM on 10/9/07. At 6:00 PM, Client #3 was observed sitting on the sofa in the living room area while one staff wiped off the dining table and another staff swept the living room floor. Review of Client #3's Individual Program Plan (IPP) on 10/11/07 at approximately 11:19 AM revealed an objective that states "Given verbal prompts, the client will complete household chores on 80% of trials per month". (i.e. cleaning table after meal, take dishes to sink, sweep of the steps, etc.). Further review of Client #3's records revealed Social Work Assessment dated 8/7/07 revealed a recommendation to "possibly do a chore of wiping the table after meals with assistance. There was no evidence that the Client #3 was afforded opportunities for choice, self-management, or to participate in his IPP regimen to the extent of his capabilities. 2. Evening observations was conducted from 3:10 PM to 8:02 PM on 10/9/07. At 6:00 PM,	W 247	W247 1. Client #3 has a new objective in place to complete a chore of his choice. This allows him the opportunity to make choices and participate in the management and upkeep of his own home. 2. Client #2 will be afforded the opportunity to participate in home management tasks as tolerated. A chore schedule will be developed and rotated so that all have an opportunity to participate in preferred activities. 11/14/07	

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W 247	Continued From page 5 Client #6 was observed to be sitting in her personal chair watching television in the living room area while one staff wiped off the dining table and another staff swept the living room floor. At approximately 5:06 PM, interview with Client #6 stated that she loves cleaning off the tables. Interview with the Qualified Mental Retardation Professional (QMRP) on 10/10/07 at approximately 2:00 PM revealed that Client #6 used to clean of the table all the time. The QMRP further revealed that due to Client #6's mobility and gait concerns, she does not clean the table off as much as she use to. At the time of the survey, Client #6 was not given the opportunity to wipe of the table after dinner with the opportunity was presented.	W 247		
{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 observations interview, and record review, the facility failed to ensure that data was collected in the form and required frequency for one of three clients included in the sample. (Client #3) The findings include: The facility failed to ensure that data had been collected in accordance with the IPP for Client #3, which was necessary for a functional assessment of the client's progress as evidenced below:	{W 252}		

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NAME OF PROVIDER OR SUPPLIER: CARECO 10

STREET ADDRESS, CITY, STATE, ZIP CODE: 1613 TAYLOR STREET, NW, WASHINGTON, DC 20011

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{W 252}	Continued From page 6 Evening observations conducted on 10/9/07 at beginning at 3:10 PM to 8:02 PM revealed Client #3's communication device sitting on top of the shelf. At no time did staff encourage or offer Client #3 the opportunity to use the communication device. Review of the client's Individual Program Plan (IPP) revealed a program objective which read "Given verbal prompts, the client will answer a yes/no question using his communication device 50% of the trials for one month". Review of the data collection revealed that the communication device (Mini-Merc) should be implemented seven (7) days a week. Further review of the data collection sheets revealed staff documented the objective one time (10/7/07) as of 10/11/07. Interview with the Qualified Mental Retardation Professional (QMRP) on 10/11/07 at approximately 10:15 AM acknowledged the lack of documentation for the month of October 2007. The QMRP indicated the staff was recently hired.	{W 252}	W252 All staff have been re-trained on the importance of program implementation and documentation. All newly hired staff will participate in a New Employee Orientation, which occurs in the home, to ensure understanding of the Program Plans and required documentation. 11/01/07	
{W 331}	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review, the facility failed to provide nursing services in accordance with the needs of one of six clients residing in the facility. (Client #2) The finding includes: The facility's nursing services failed to ensure that Client #2 received her medications in accordance to the medication administration schedule. [See W149]	{W 331}	W331 The medication nurse will receive additional training in administering medication according to the Agency's policies. Further, the RN Supervisor will participate in monthly incident review meetings to identify trends and take appropriate action to prevent recurrences.	

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{I 000}	INITIAL COMMENTS A follow up licesure survey was conducted from 10/9/07 through 10/11/07 to determine the facility's compliance with previous condition level deficiencies cited on 8/31/07. A random sample of three residents was selected from a client population of four females and two males residents with varying degrees of disabilities. The findings of this survey were based on observations at the group home and two day programs, interviews with one family member, the day program and group home staff, and record review of unusual incident reports and investigations.	{I 000}		
{I 203}	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on record review, the GHMRP failed to provide evidence that the supervisor discussed the contents of job descriptions with each employee at the beginning of their employment and annually thereafter. The findings include: Review of the personnel records was completed on 10/11/07 at 11:12 AM. Seven of the eleven staff identified on the current staffing schedule did not have current annual signed job descriptions. [S5,S6,S7,S8,S9,S10, and S11]	{I 203}	I 203 All job descriptions have been reviewed and signed. They will be reviewed and signed annually, in conjunction with the performance evaluation. 11/05/07	

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: GHMRP — (X9) DATE: 11/2/07

CARECO

Careco, Inc. ◊ Careco Mental Health Services, Inc. ◊ Careco Home Health Services, Inc.
8115 Fenton St.
Silver Spring, MD 20910
(301) 565-9400 Fax (301) 565-4541

FACSIMILE TRANSMITTAL SHEET

To: DOH

From: Dana Mckenzie

Fax No: 442-9430

Date: 11/2/07

Total No. of Pages Including Cover: 10

RE: Allegation of compliance

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