	& MEDICAID SERVICES	. (.		RINTED: 06/29/2 FORM APPRON MB NO. 0938-0:
F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION (X3	DATE SURVEY COMPLETED
	09G125	B. WING		06/21/2007
VIDER OR SUPPLIER		10	04 URELL PLACE, NE	
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLET
NITIAL COMMENT	'S	W 000		<u>_</u>
Indamental survey f three clients was opulation of five m hental retardation a ndings of the surve bservations, intervi nd administrative r incident reports. 83.410(a)(1) GOVI he governing body	process. A random sampling selected from a residential ales with various degrees of and other disabilities. The ey were based on iews, and the review of client ecords, including unusual ERNING BODY	W 104		
ased on observation observation as a construction of the governing of the	on, interviews and record ig body failed to provide			
nplement it's door	chimes protocol to ensure the		The door chimes will be repaired to wor intended.	kas 8/10/
HRC) minutes on J une 22, 2006 the H ensor alarms being f the facility. Furth evealed the chimes henever someone	une 20, 2007 revealed that on IRC reviewed the practice of g installed on each exit doors er review of the minutes were installed to alert staff came into or left the facility			
		9 1 1 1		
	SUMMARY STAT (EACH DEFICIENCY REGULATORY OR LS ITTIAL COMMENT recertification sum 2, 2007 through Ju indamental survey three clients was opulation of five mi- ental retardation a notings of the survey observations, intervind administrative r cident reports 33.410(a)(1) GOVI the governing body udget, and operation ased on observation with the governing body udget, and operation ased on observation with governing body udget, and operation the governing body udget, and operation ased on observation with the governing body the governing body udget, and operation the governing body udget, and operation the governing body the governing bo	VIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) IITIAL COMMENTS recertification survey was conducted from June 9, 2007 through June 21, 2007 utilizing the indamental survey process. A random sampling i three clients was selected from a residential opulation of five males with various degrees of iental retardation and other disabilities. The ndings of the survey were based on bervations, interviews, and the review of client nd administrative records, including unusual cident reports. 33.410(a)(1) GOVERNING BODY the governing body must exercise general policy, udget, and operating direction over the facility. The governing body failed to provide berating direction over the facility as evidenced elow. The governing body failed to effectively uplement it's door chimes protocol to ensure the restem was maintained in good repair. the review of the Human Rights Committee IRC) minutes on June 20, 2007 revealed that on une 22, 2006 the HRC reviewed the practice of ensor alarms being installed on each exit doors the facility. Further review of the minutes vealed the chimes were installed to alert staff henever someone came into or left the facility beservation of the front door on June 20, 2007 revealed the censor was no longer on the door. RECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGN	UDER OR SUPPLIER STR t ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID NITIAL COMMENTS W 000 recertification survey was conducted from June 0, 2007 through June 21, 2007 utilizing the indamental survey process. A random sampling three clients was selected from a residential opulation of five males with various degrees of ental retardation and other disabilities. The ndings of the survey were based on servations, interviews, and the review of client administrative records, including unusual cident reports. W 104 Me governing body must exercise general policy, udget, and operating direction over the facility. W 104 ne governing body failed to provide berating direction over the facility as evidenced by: ased on observation, interviews and record wiew, the governing body failed to provide berating direction over the facility as evidenced elow. W The governing body failed to effectively uplement it's door chimes protocol to ensure the rstem was maintained in good repair. No Nue 22, 2006 the HRC reviewed the practice of ensor alarms being installed on each exit doors the facility. Further review of the minutes vealed the chimes were installed to alert staff henever someone came into or left the facility rol to ensure the safety of all residents beservation of the front door on June 20, 2007 vealed the censor was no longer on the door. RECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	UNDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1004 URELL PLACE, NE SUMMARY STATEMENT OF DEFICIENCIES (EACH DERICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREVENT REGULATORY OR LSC IDENTIFYING INFORMATION) D PREVENT ID PREVENT ITTLAL COMMENTS W 000 ITTLAL COMMENTS W 000 ITTLAL COMMENTS W 000 recertification survey was conducted from June 0, 2007 through June 21, 2007 utilizing the indamental survey process. A random sampling three clients was selected from a residential pulation of five males with various degrees of ental retardation and other disabilities. The didings of the survey were based on oservations, interviews, and the review of client d administrative records, including unusual client reports. W 104 33.410(a)(1) GOVERNING BODY W 104 ne governing body failed to effectively uplement it's door chimes protocol to ensure the restem was maintained in good repair. The door chimes will be repaired to wor inteaded. The governing body failed on each exit doors the facility. Further review of the minutes wealed the chimes were installed to all statiff henever someone came into or left the facility d to ensure the safety of all residents beervation of the front door on June 20, 2007 vealed the censor was no longer on the door. THE

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.

301-441-1329

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PRINTED:	06/29/2007
FORM A	APPROVED
OMB NO.	0938-0391

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

IDENTIFICATION NUMBER: 09G125 CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	REET ADDRESS, CITY, STATE, ZIP CODE 004 URELL PLACE, NE	COMPLETED
TATEMENT OF DEFICIENCIES		004 URELL PLACE, NE	06/21/2007
TATEMENT OF DEFICIENCIES	1 V	004 URELL PLACE, NE	
CY MUST BE PRECEDED BY FULL	ID	VASHINGTON, DC 20017	
	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	LD BE COMPLETION
he manager (HM) on June 21, at no staff had reported that the ne detached from the door. noted that inspection the or on June 21, 2007 revealed ctivated intermittently when the ing body failed to ensure timely measures to assist Client 2 in ay placement concerns and to ity Based Transitional aximize his personal growth. DTECTION OF CLIENTS ensure the rights of all clients. lity must inform each client, t is a minor), or legal guardian, ical condition, developmental atus, attendant risks of	W 104 W 124	The Governing Body will continue to w closely with DDS to ensure timely refer acceptance into appropriate authorized j The QMRP will ensure that written expl risks and benefits of proposed treatments provided to the clients and their decision and that clients and their decision maker have the opportunity to ask questions and further clarification as needed. The infor consent for treatment letters will be signa client or his decision maker and kept wit clients' records.	anation of s are makers, s also d receive med ed by the
tion, interview and record failed to ensure the rights of their legal guardian to be t's rights to refuse behavioral o of three clients (Clients #1 in the sample. de: the evening medication		Clients who are able to understand the ris benefits of their treatments and give cons themselves will continue to do so, with si from family members or other authorized representatives. The QMRP will ensure t Human Rights Committee has evidence of informed consent for use of Behavior Sup Plans.	sent for upport 1 hat the of written
nan root nfina oo gindud ay niyob k fi	A LSC IDENTIFYING INFORMATION) page 1 me manager (HM) on June 21, at no staff had reported that the me detached from the door. noted that inspection the for on June 21, 2007 revealed activated intermittently when the detached from the door. noted that inspection the for on June 21, 2007 revealed activated intermittently when the detached from the door. and body failed to ensure timely f measures to assist Client 2 in the day placement concerns and to nity Based Transitional haximize his personal growth. COTECTION OF CLIENTS ensure the rights of all clients. Illy must inform each client, at is a minor), or legal guardian, dical condition, developmental tatus, attendant risks of the right to refuse treatment. is not met as evidenced by: ation, interview and record of ailed to ensure the rights of r their legal guardian to be ht's rights to refuse behavioral to of three clients (Clients #1 in the sample. atde: f the evening medication June 19, 2007 beginning at	R LSC IDENTIFYING INFORMATION) TAG page 1 W 104 me manager (HM) on June 21, at no staff had reported that the me detached from the door. W 104 noted that inspection the or on June 21, 2007 revealed activated intermittently when the l. W 104 ning body failed to ensure timely f measures to assist Client 2 in day placement concerns and to nity Based Transitional maximize his personal growth. W 124 COTECTION OF CLIENTS W 124 ensure the rights of all clients. Illty must inform each client, nt is a minor), or legal guardian, dical condition, developmental tatus, attendant risks of the right to refuse treatment. W 124 is not met as evidenced by: ation, interview and record v failed to ensure the rights of r their legal guardian to be nt's rights to refuse behavioral vo of three clients (Clients #1 in the sample. M ide: If the evening medication June 19, 2007 beginning at M	LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPRIDEFICIENCY) page 1 W 104 me manager (HM) on June 21, at no staff had reported that the me detached from the door. W 104 noted that inspection the or on June 21, 2007 revealed ctivated intermittently when the . The Governing Body will continue to w closely with DDS to ensure timely refeasores to assist Client 2 in tay placement concerns and to nity Based Transitional waximize his personal growth. COTECTION OF CLIENTS W 124 The QMRP will ensure that written explinits and benefits of proposed treatment provided to the clients and their decision maker have the opportunity to ask questions and further clarification as needed. The infor consent for treatment letters will be significat condition, developmental tatus, attendant risks of the right to refuse behavioral to failed to ensure the rights of their legal guardian to be nt's rights to refuse behavioral to of three clients (Clients #1 in the sample. Clients who are able to understand the rights of their legal guardian to be nt's rights to refuse behavioral to of three clients (Clients #1 in the sample. ide: ft he evening medication

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

TATEMEN	KS FOR MEDICAR	E & MEDICAID SERVICES			FOR OMB M	M APPRO <u>2. 0938</u> -0
ND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		(X3) DATE	
		09G125	B, WING			
AME OF PROVIDER OR SUPPLIER				06/	21/2007	
CARECO	D 04		10	ET ADDRESS, CITY, STATE, ZIP CC 04 URELL PLACE, NE ASHINGTON, DC 20017	DE	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF COF		
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLE DATE
W 124	Continued From pa		W 124		<u> </u>	
	4:37 PM revealed	Client #1 received Depakote				
	1000 mg (for explo	sive behavior). Haloperidol 5	1			1
1	mg (for aggression	i) and Xanax XR 2 mg (for 1)				
	nurse revealed the). Interview with the medication the aforementioned				1
l	medications were	prescribed for behaviors.				
		Disseribled for Denaviors.				1
	Interview with the h	ouse manager on June 19,	ſ			j
	2007 at 8:37 AM re	vealed Client #1 received 1.1				
ļ	statting supports 24	4 hours a day Subsequent				1
	interview with the G	ualified Mental Retardation	1			
	Professional (QMR	P) on June 19, 2007 at 12:50				
	Pivi revealed Client	#2 had a Behavior Support				
	addression elonem	ressed verbal and physical nent, property destruction, and				
	noncompliance. Co	ontinued interview with the				
	QMRP revealed that	at Client #1 did not have a	į.			ĺ
	guardian or the cap	acity to give informed consent				
	for the use of his m	edications, habilitation	I			1
	services, treatments	s and financial matters. This				
	was verified through	review of Client #1's				
Í.	on lung 20 2007	ation dated January 30, 2007	1			
	on June 20, 2007.	vever reveal the client was				
1 1	able to provide limit	ed input in these matters,				
	which should be cor	isidered when appropriate	i			
	during decision-mak	king.				
	At the time of the su	rvey, the facility failed to				
l F	provide evidence that	at Client #1's had a legally				
aut	authorized represen	tative to whom his				
L r	otential side effecte	cluding the benefits and sassociated with the	!			
	nedications and the	associated with the right to refuse treatment,				
ļŀ	ad been explained.	ingin to refuse reatment,				
2	. Observation of the	e evening medication				
a	dministration on Ju	në 19, 2007 beginning at				
4	:43 PM revealed Cl	ient #2 received Depakote				
1		• •				

PRINTED: 06/29/2007

FORM APPROVED

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

CENTER	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES				<u> אראר אס.</u>	<u>0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		,	(X3) DATE SURVEY COMPLETED	
		09G125	B. Wi	NG _		06/21	/2007
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
CARECO	04				004 URELL PLACE, NE /ASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 124	of the MAR reveale medication was pro- behaviors along wi- management interv- Interview with the C review of the client that the client did m not informed of his behavioral manage dated June 28, 200 relative, requested client's guardian. At the time of the s provide evidence t authorized represe treatment needs, in potential side effec medications, and t had been explaine 483.420(d)(1) STA CLIENTS The facility must d policies and proce mistreatment, neg This STANDARD Based on staff inte facility failed to im management polic safety of each clie The finding include	with the nurse and the review ad that the aforementioned escribed for maladaptive th restrictive behavior ventions. DMRP on June 19, 2007 and 's habilitation records revealed oot have a guardian and was of the risks and benefits of his ement treatments. A letter, D6 addressed to the client's the individual to become the survey, the facility failed to hat Client #1's had a legally entative to whom his necluding the benefits and cts associated with the he right to refuse treatment, d. [See W263] UFF TREATMENT OF evelop and implement written dures that prohibit lect or abuse of the client. is not met as evidenced by: arview and record review, the plement established incident by to ensure the health and nt that resides in the facility.		124		The ent QMRPs ain led d will	8/10/07
FORM CMS-2	i 567(02-99) Previous Verslor	· · · · · · · · · · · · · · · · · · ·	<u> </u>	Fa	acility ID: 09G125 If contin	uation shee	tPage 4 of 19

PRINTED: 06/29/2007
FORM APPROVED
OMB NO 0938-0391

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

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	3 FUR MEDICANE	A MEDICAID SERVICES					. 0550-0551
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	ILDING	LE CONSTRUCTION	(X3) DATE S COMPL	
		09G125	B, WI	NĢ		06/2	21/2007
NAME OF F	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZI	P CODE	
CARECO	04				04 URELL PLACE, NE ASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION}	ID PREF TAC	TX	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
W 149	implemented. Interview with the fi Coordinator (IMC) revealed that emer treated as serious i interview with the fi reportable incidents Department of Hea The review of unus and June 20, 2007 emergency room v been reported to D agency's protocol fi detailed below: a. March 6, 2007 - minutes seizure at and the client was evaluation. There v notified of the incid b. July 25, 2007 - V #2 to get off the va the resident went ti door hard, causing resident stated he at the group home with blunt edged a was telephoned.	acility's Incident Management on June 20, 2007 at 4:50 PM gency room visits should be reportable incidents. Further WC revealed that all serious is should be reported to the lith (DOH) within 24 hours. Sual incidents on June 19, 2007 revealed that several isits/ hospitalizations had not OH in accordance with the or incident management as - Client # 2 had a two to three 7:15 AM. 911 was telephoned transported to the ER for was no evidence DOH was lent. When staff required the Client n at 4:15 PM after he refused, o his room and slammed the the knob to break. The would rather be dead than live . He proceeded to pick himself rts and craft-type scissors. 911 The police arrived and the client P. There was no evidence		149	DEFICIEN	ςγ)	
	became verbally a violently pushing h	7- At 6:00 AM Client #1 busive and assaulted a staff by im. 911 was telephoned and It was determined the client					
FORM CMS-	2567(02-99) Previous Version	s Obsolete Event ID: Z0WI	11	Fac	cility ID: 09G125	If continuation she	eet Page 5 of 1

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PRINTED:	06/29/2007
FORM A	PPROVED
OMB NO. 0	938-0391

06/21/2007

(X3) DATE SURVEY COMPLETED

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Jul	11 07	10:02p	Home	Office			301-441-1329
			AND HUMAN				
STATEMEN	f of deficie of correct	NCIES	(X1) PROVIDER/S			MULTIPL JILDING	E CONSTRUCTION
			0	9G125	B. W	ING	
NAME OF P	ROVIDER OF	RSUPPLIER				100	ET ADDRESS, CITY, STATE, ZIP CODE 14 URELL PLACE, NE ASHINGTON, DC 20017
(X4) ID PREFIX TAG	(EACH	I DEFICIENCY	TEMENT OF DEFIN MUST BE PRECE SC IDENTIFYING II	DED BY FULL	ID PRE TA	FIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)
W 149	was at ris was trans where he back to th There was this incide January 2 d. June 3 Client #3 redirecte concrete evaluation notified of f. The rev October taken to blood pre	sported fro was treat he group h as no evide ent or the 29, 2007. 0, 2006 - I kicked an d by his 1: wall. Clien n. There w of the incide view of an 7, 2007 rev the ER due assure. He	was transporte m CPEP to a l ed. Resident v ome on Janua ence DOH was resident's hos During a fire dr other resident. 1 staff, he hit h ht was taken to vas no evidence ent. unusual incide vealed that Clice to profuse sw was evaluate	was discharged ry 24, 2007. a not notified of pitalization until rill at 6::33 AM, While being his hand on the pothe ER for he DOH was not ent dated	t	149	

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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 149	Continued From page 5	W 149		
	was at risk and he was transported to CPEP. He was transported from CPEP to a local hospital where he was treated. Resident was discharged back to the group home on January 24, 2007. There was no evidence DOH was not notified of this incident or the resident's hospitalization until January 29, 2007.			
	d. June 30, 2006 - During a fire drill at 6::33 AM, Client #3 kicked another resident. While being redirected by his 1:1 staff, he hit his hand on the concrete wall. Client was taken to the ER for evaluation. There was no evidence DOH was not notified of the incident.			
	f. The review of an unusual incident dated October 7, 2007 revealed that Client #1 was taken to the ER due to profuse sweating and low blood pressure. He was evaluated and admitted to the hospital. There was no evidence that DOH was notified until October 20, 2007.			
	g. The review of an unusual incident dated April 21, 2007 revealed at 6:25 PM Client #4 walked away from the facility when he was left outside unsupervised by staff. The police were notified after staff was unable to locate him. The client returned to the facility at 8:45 PM. The incident was not reported to DOH until April 23, 2007.			
	h. The review of an unusual incident report dated April 12, 2007 revealed that the day program reported that Client #4 was injured by a piece of light wood that fell on the back of his neck. Client was assessed immediately by the day program nurse who indicated that he was alert, oriented and could move. He was taken to the ER for evaluation after returning to the group home. The ER assessment revealed the client had a scalp			
FORM CMS-24	h. The review of an unusual incident report dated April 12, 2007 revealed that the day program reported that Client #4 was injured by a piece of light wood that fell on the back of his neck. Client was assessed immediately by the day program nurse who indicated that he was alert, oriented and could move. He was taken to the ER for evaluation after returning to the group home. The	1 Fac	sility ID: 09G125 If continuation sho	et Pa

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		AND HUMAN SERVICES				FORMA	06/29/2007 APPROVED 0938-0391	
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		09G125	B, WI	NG		06/21	/2007	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>	<u> </u>		EET ADDRESS, CITY, STATE, ZIP CODE	00/21		
CARECO	0 04				004 URELL PLACE, NE /ASHINGTON, DC 20017			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE	
W 149	Continued From pa	ige 6	W	149				
		as no evidence the incident DH until April 17, 2007.						
W 159	2007, serious repo wherein emergenc and when the Metr (MPD) was involve aforementioned po Management Coor serious reportable to the DOH. There had been impleme 483.430(a) QUALI RETARDATION PI Each client's active	FIED MENTAL	w	159				
		tardation professional.					·	
	Based on observat review the facility f client's active treat coordinated, integr	is not met as evidenced by: ion, interview and record ailed to ensure that each ment program was ated and monitored by the etardation Professional						
	The findings includ	e: ed to ensure Client #2 received			1. The Nutritionist will provide training to client and staff on implementing his thera		8/10/07	
	-	as prescribed. [See W460]			diet.	pourro	· · ·	
	survey leaving on f and staff, including	bserved on each day of the he van with his housemates his 1:1 staff. Interview with the client worked as a voluteer food pantry.			2. The QMRP will review all programs or a monthly basis to determine whether proj are effectively meeting clients' needs.	n at least grams	8/10/07	
ORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID:Z0WI11		Fa	cility ID: 09G125 If continu	lation sheet	Page 7 of 1	

Jul	11 07 10:05p	Home Office			301-441-1329		p.1
		AND HUMAN SERVICES				FORM): 06/29/2007 1 APPROVED 0. 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE S COMPL	SURVEY
		09G125	B. WI	NG _		06/2	21/2007
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE. ZIP CODI		
CARECO	04				004 URELL PLACE, NE VASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 159	Continued From pa	ge 7	w	159			
	Professional (QMR that Client #2 was of program due to age non-compliance. F QMRP indicated th sixteen hours (8:00 QMRP indicated th schedules which was between the hours he did not go to the interview with the C compliance, the clie activities of his cho as in the areas of c According to the ac "With independenc steps of doing a ch- trials recorded per months". The clien objective was sche QMRP. Training put that if needed, the c with cleaning suppl The task analysis for stated that the clier a. Choose the chorn b. Participate in the c. Complete the ac d. Put away items to Interview with the h 1:1 staff indicated t some chores with se	chore tivity					
FORM CMS-28	567(02-99) Previous Versions	Obsolete Event ID: Z0W11	1	Fa	cility ID: 09G125 If c	ontinuation she	et Page 8 of 19

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				APPROVED _0938-0391
STATEMEN	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G125	B. WING		06/2	1/2007
NAME OF P	ROVIDER OR SUPPLIER		STI	REET ADDRESS, CITY, STATE, ZIP CODE		
CARECO	0 04			1004 URELL PLACE, NE WASHINGTON, DC 20017		
(X4) ID PRÉFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 159	instructions.	ige 8 ence the QMRP had monitor	W 159			
W 189	the program to determeeting the client r 3. The QMRP failed IPP were considered demonstrated a lact the established crit 483.430(e)(1) STA The facility must pr initial and continuin employee to perfo efficiently, and corr This STANDARD Based on observat review, the facility to employee with initial	ermine if the program was needs. d to ensure that revisions in the ed when Client #2 sk of achievement in attaining erion level. [See W257] FF TRAINING PROGRAM rovide each employee with ng training that enables the rm his or her duties effectively,	3. See #2 above. The QMRP programming appropriately ba findings in the monthly review W 189		ed upon the)	
	duties, effectively, Client #2. The findings includ 1. The facility faile on therapeutic diet Observation of the revealed that vege the main entree. C wanted a substitute He was provided w substitute. The rev	efficiently, and competently for e: d to ensure effective training s and menu substitutions. dinner meal on June 19, 2007 table lasagna was served as lient #2 expressed that he e for the vegetable lasagna. <i>i</i> th a turkey bacon as a view of the physician's orders lient was prescribed a Low Fat,		1. The Nutritionist will retrain all staff of therapeutic diets. The QMRP and Facili will ensure that clients are able to partic food selections within their diet orders, substitutions are readily available. The will ensure that there is a current list for client on food preferences and dislikes.	ty Director ipate in and that QMRP	8/10/07

301-441-1329 p.2

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Jui i		Home Office		301-441-1329		p.3
		AND HUMAN SERVICES			FORM	: 06/29/2007 APPROVED . 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	URVEY
		09G125	B. WING		06/2	1/2007
NAME OF F	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		112001
CARECO	04			1004 URELL PLACE, NE WASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(XS) COMPLETION DATE
W 189	Continued From pa	ge 9	W 18	9	<u> </u>	
W 257	assessment dated "Provide appropriat [Client #2] does not review of training re revealed staff recei and the clients' diet again on May 2, 20 however that this tr the client received a and food in accorda Fat, Low Cholester 2. The facility failed to assist/supervise in accordance with Low Salt Diet. [See 483.440(f)(1)(iii) PF CHANGE The individual prog least by the qualifie professional and re but not limited to sit failing to progress t after reasonable eff This STANDARD i Based on record re (IDT) failed to ensu individual program when Client #2 den	d to ensure staff were trained Client #2 in packing his lunch his Low Fat, Low Cholesterol, W460] ROGRAM MONITORING & ram plan must be reviewed at d mental retardation vised as necessary, including, tuations in which the client is oward identified objectives forts have been made. s not met as evidenced by: view, the interdisciplinary team re that revisions in the plan (IPP) were considered honstrated a lack of hining the established criterion	W 25	 2. The Facility Director will ensure that oversee and assist the clients to pack lur appropriately and in accordance with the diets. 7 See responses to W159 1 and #2. The D Disability Services and the Quality Assustaff will review the QMRP's program n plans every 90 days to ensure that prograppropriately revised in accordance with clients' progress or lack thereof. 	irector of rance otes and unming is	8)10/07 8/10/07

FORM CMS-2567(02-99) Previous Versions Obsolete

Fadlity ID: 09G125

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PRINTED:	06/29/2007
FORM	APPROVED
OMB NO	0938-0391

DEPARTMENT	OF HEALTH AND	HUMAN :	SERVICES
CENTERS FOR	MEDICARE & MI	EDICAID S	SERVICES

CENTER	<u>KS FOR MEDICARE</u>	& MEDICAID SERVICES					0900-0091	
STATEMENT	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		09G125	B, WI	B. WING		06/21/2007		
NAME OF P	ROVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE 004 URELL PLACE, NE NASHINGTON, DC 20017			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	ו <u>.</u> או:	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
W 257	On the mornings o 2007, Client #2 wa box and leaving the Interview with the O revealed that Cliend day program due to non-compliance. If QMRP indicated th hours a day. The O has an activity sch for him to follow be and 4:00 PM when program. Record review rev 30, 2006 for 9:00 A the two objectives a. According to C Plan dated Octobe improve his intervi scheduled reflected implemented at 1: plan objective stat [Client #2] will ans 100% of trials reco consecutive mont were included in th a. Tell me a little a b. Why do you wa c. What kind of jo d. What are some Record review rev initiated in July 20 this objective at th	f June 19, 2007 and June 20, s observed carrying a lunch e group home with staff. QMRP on June 19, 2007 t #2 was discharged from his o aggressive behavior and Further interview with the ne client has a 1:1 staff for 16 QMRP confirmed that the client edules which was developed etween the hours of 9:00 AM in he does not go to the day ealed a schedule dated June AM to 4:00 PM which included below: lient #2's Individual Support er 25, 2006, the has a goal to iew skills. Review of the ed that this objective should be 00 PM. The individual program ded "With verbal prompt, Mr. wer interview questions on orded per month for 3 hs". The following questions he task analysis: about yourself? Int to work? b are you looking for?		257				

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Facility ID: 09G125

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

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PRINTED: 06/29/2007 FORM APPROVED

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING		(X3) DATE SURVEY COMPLETED		
		09G125	B. WING		0.04	04/0007
	PROVIDER OR SUPPLIER		10	EET ADDRESS, CITY, STATE, ZIP (104 URELL PLACE, NE ASHINGTON, DC 20017		21/2007
(X4) ID PREFIX TAG	EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETION DATE
W 257	Continued From p	age 11		·····		
	verbal prompts lev January 2007 thro evidence this obje #2 failed to show p b. According to th	e activity schedule, at 9:00 AM				, ,
W 263	steps of doing a cf trials recorded per months". The cliet objective was sche QMRP. Interview program data indic progressed beyond objective. There w was revised when progress. [See W1	ce [Client #2] will complete the nore of his choice for 100% of month for three consecutive ht's performance in the eduled to be monitored by the with staff and the review cated the client had not d the verbal prompt in this as no evidence this objective Client #2 failed to show [59] ROGRAM MONITORING &	W 263	· · · · · · · · · · · · · · · · · · ·		
	are conducted only	ould insure that these programs with the written informed nt, parents (if the client is a urdian.		See response to W124.		8/10/07
	Based on observatives review, the facility's (HRC) failed to ensighed had been obtained legal guardian for t	is not met as evidenced by: tion, interview and record s Human Rights Committee sure written informed consent from the client and/or their he use of behavior support e three clients (Clients #1 and sample.				
	The finding include	es:				
	1. Observation of	the evening medication				
ORM CMS-25	67(02-99) Previous Version	s Obsolete Event ID: Z0WI11	Facil	ity ID: 09G125	f continuation sheet	 Page 12 of 1

Jul 11 07	10:08p	Home Office			301-441-13	129	p.1
		AND HUMAN SERVICES				FC	TED: 06/29/2007 DRM APPROVED NO: 0938-0391
STATEMENT OF DEFIC AND PLAN OF CORRE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ILDING		(X3) DA	TE SURVEY MPLETED
		09G125	B, WI	NG			06/21/2007
NAME OF PROVIDER	OR SUPPLIER			1004 UREL	RESS, CITY, STATE, ZIP LL PLACE, NE GTON, DC 20017		
	CH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF C ACH CORRECTIVE ACTI DSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
4:37 Pl 1000 m mg (for explosi reveale were pl Intervie Profess reveale (BSP) f aggres noncon Mental 19, 200 receive Continu Client # not hav the use treatme the Hun reveale by the I the faci had ob of Clien W124)	stration on J M revealed C aggression ve behavior) ed that the af- rescribed to w with the C sional (QMR ed the client I that address sion, eloper npliance. In Retardation 7 at 12:50 F d 1:1 staffing red interview f1 did not have the capaci- e of his medi- ents and fina man Rights C d the restric HRC. At the lity failed to tained written at #1's behav	ye 12 une 19, 2007 beginning at Client #1 received Depakote sive behavior), Haloperidol 5 and Xanax XR 2 mg (for . Interview with the nurse orementioned medications address behaviors. ualified Mental Retardation P) and the record review nas a behavior support plan ed verbal and physical pent, property destruction, and terview with the Qualified Professional (QMRP) on June M revealed Client #3 also g supports 24 hours a day. With the QMRP revealed that ve a legal guardian and did ty to give informed consent for cations, habilitation services, ncial matters. The review of Committee (HRC) minutes tive measures were approved time of the survey, however, provide evidence that its HRC n informed consent for the use rior support plan. (See also		263			

2. Observ administration on June 19, 2007 beginning at 4:43 PM revealed Client #2 received Depakote 500 mg (for behavior). Interview with the nurse revealed that the aforementioned medications were prescribed to address maladaptive behaviors.

Interview with the QMRP and the record review

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Z0Wi11

Facility ID: 09G125

If continuation sheet Page 13 of 19

DEPARTMENT OF HEALTH AND HUMAN SERVICES

301-441-1329

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILD		(X3) DATE S COMPLE	URVEY
		09G125	B. WING	;	- 06/2	1/2007
	ROVIDER OR SUPPLIER	• • • • • • • • • • • • • • • • • • •	S	STREET ADDRESS, CITY, STATE, ZIP 1004 URELL PLACE, NE WASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE	(X5) COMPLETION DATE
	(BSP) that elopeme aggression, making noncompliance, sui peers. Interview w Retardation Profess 2007 at 12:50 PM r received 1:1 staffin Continued interview Client #2 did not ha not have the capac the use of his medi- treatments and fina the Human Rights (revealed the restric by the HRC. At the the facility failed to had obtained writter of Client #2's behave 483.460(j)(1) DRUC A pharmacist with it team must review the at least quarterly. This STANDARD is Based on interview to ensure that quart were conducted tim the sample. (Clients The findings include Interview with the p June 20, 2007 reve the clients' prescrib review of the Drug medical records of	has a behavior support plan ent physical and verbal g excessive demands of staff, cidal threats, and teasing ith the Qualified Mental sional (QMRP) on June 19, evealed Client #2 also g supports 16 hours a day. / with the QMRP revealed that we a legal guardian and did ity to give informed consent for cations, habilitation services, ncial matters. The review of Committee (HRC) minutes tive measures were approved time of the survey, however, provide evidence that its HRC n informed consent for the use rior support plan. S REGIMEN REVIEW hput from the interdisciplinary he drug regimen of each client s not met as evidenced by: and record, the facility failed terly reviews of drug regimens hely for three of three clients in s #1, #2, and #3) e: rimary LPN for the facility on aled the pharmacist reviews ed medications quarterly. The Regimen Review forms in the Clients #1, #2, and #3	W 26	The Director of Disability Serv that the Pharmacist's contract s requirement for quarterly review prescribed medications. The Q will ensure that these reviews o with the contract and the facility Director of Disability Services a Assurance staff will review qua compliance.	pecifies the ws of the clients' MRP and the DON ccur in accordance y policy, and the and the Quality rterly to ensure	8/10/07
	667(02-99) Previous Versions			Facility ID: 09G125	If continuation sheet	Page 14 of 19

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PRINTED: 06/29/2007
FORM APPROVED
OMP NO 0020 0204

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

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 09G125 B. WING 06/21/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 06/21/2007 CARECO 04 SUMMARY STATEMENT OF DEPICIENCIES IDD PROVIDER'S PLAN OF CORRECTION 06/21/2007 (X4) ID SUMMARY STATEMENT OF DEPICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD BE (X5) TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DEFICIENCY) W 362 Continued From page 14 W 362 W 362 W 362 W 362 Continued From page 14 W 362 W 362 W 362 W 361 be kept in the resident's drug regimen review shall be kept in the resident's drug regimens were reviewed at least quarterly. W 362 W 362			& MEDICAID SERVICES				<u>OMB NO</u>	. 0938-0391
06/21/2007 NAME OF PROVIDER OR SUPPLIER CARECO 04 STREET ADDRESS, CITY, STATE, ZIP CODE 1004 URELL PLACE, NE WASHINGTON, DC 20017 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTIVE ACTION SHOLLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE W 362 Continued From page 14 revealed the the pharmacist conducted reviews of the clients' medication regimens on July 7, 2006 and again on October 10, 2006. The review of the agency's Medication Policy revealed a record of each resident's drug regimen review shall be kept in the resident's drug regimens were reviewed at least quarterly. W 362			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE S COMPLI	URVEY ETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CARECO 04 1004 URELL PLACE, NE WASHINGTON, DC 20017 WASHINGTON, DC 20017 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEPICIENCIES (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) COMPLETION DATE W 362 Continued From page 14 revealed the the pharmacist conducted reviews of the clients' medication regimens on July 7, 2006 and again on October 10, 2006. The review of the agency's Medication Policy revealed a record of each resident's drug regimen review shall be kept in the resident's medical chart. There was no evidence the clients' drug regimens were reviewed at least quarterly. W 362			09G125	B. WI	IG_	<u>_</u>	06/2	4/2007
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) completion DATE W 362 Continued From page 14 revealed the the pharmacist conducted reviews of the clients' medication regimens on July 7, 2006 and again on October 10, 2006. The review of the agency's Medication Policy revealed a record of each resident's drug regimen review shall be kept in the resident's medical chart. There was no evidence the clients' drug regimens were reviewed at least quarterly. W 362			<u>.</u>		1	004 URELL PLACE, NE	06/2	1/2007
revealed the the pharmacist conducted reviews of the clients' medication regimens on July 7, 2006 and again on October 10, 2006. The review of the agency's Medication Policy revealed a record of each resident's drug regimen review shall be kept in the resident's medical chart. There was no evidence the clients' drug regimens were reviewed at least quarterly.	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	(X5) COMPLETION DATE
W 369 483.460(k)(2) DRUG ADMINISTRATION W 369 The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. The DON will retrain the Primary LPN and the medication administration is accurately documented. The OMRP will coordinate training for the DON, LPN and Medication nurses on client Behavior Support Plans. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each medication surses on client Behavior Support Plans. g/pc/p7 The findings include: Based on observation, interview and record review, the facility failed to ensure that each drug was administered as ordered. The finding include: Based on observation, interview and record review, the facility failed to ensure that each drug was administered as ordered. The finding include: Medication administration observations were conducted on June 19, 2007 beginning at 4:37 PM. Client #2 was observed to participate in a self medication program. The client was offered the opportunity to self administer his eye drops. He was observed and put one drop of the medication rontainer confirmed that this medication container confirmed that this medication container confirmed that this medication container confirmed that this medication trans to be bow point of the medication torder was offered the opportunity to both eyes for	W 362	revealed the the pr of the clients' medic 2006 and again on of the agency's Med record of each resid shall be kept in the There was no evide were reviewed at le 483.460(k)(2) DRUG The system for drug that all drugs, include self-administered, a This STANDARD is Based on observation review, the facility far medications were are one of three clients The findings includes Based on observation review, the facility far was administered as The finding includes Medication administ conducted on June PM. Client #2 was of self medication prog the opportunity to se He was observed ar medication into his of the medication conta medication was Cos	harmacist conducted reviews bation regimens on July 7, October 10, 2006. The review dication Policy revealed a dent's drug regimen review resident's medical chart. Ince the clients' drug regimens ast quarterly. G ADMINISTRATION g administration must assure ling those that are re administered without error. Is not met as evidenced by: on, interview and record ailed to ensure that each dministered as prescribed for in the sample. (Client #2). e: on, interview and record ailed to ensure that each drug s ordered. ration observations were 19, 2007 beginning at 4:37 observed to participate in a irram. The client was offered alf administer his eye drops. ad put one drop of the own left eye. Observation of ainer confirmed that this forf. Instructions on the label		:	The DON will retrain the Primary LPN medication nurses to ensure that medica administration is accurately documente QMRP will coordinate training for the l and Medication nurses on client Behavi	ation d. The DON, LPN	8/10/07

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 09G125

If continuation sheet Page 15 of 19

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IATEMEN					<u>3 NO. 0938-0</u> 3
ND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION (X3) D	ATE SURVEY
			A, BUILDI		OMPLETED
		09G125	B. WING		0010410000
IAME OF I	PROVIDER OR SUPPLIER		st	REET ADDRESS, CITY, STATE, ZIP CODE	06/21/2007
CARECO	0 04			1004 URELL PLACE, NE	
<u> </u>	<u> </u>			WASHINGTON, DC 20017	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETI DATE
W 369	Continued From pa	ge 15	W 369		· · · · · · · · · · · · · · · · · · ·
	glaucoma".	- İ			
	that the client instille both eyes. Interview licensed practical nu- self medication the r client did not place to Further interview with client was sometime his eye drops. Both primary LPN acknow behavior support pla non-compliance for no evidence howeve documented the adr the client's right eye. 483.470(i)(1) EVACU The facility must hole varied conditions. This STANDARD is Based on interview a drill records, the facil emergency evacuation of the day and night. The finding includes: Interview with the ho 2007 revealed fire ex- monthly on each shift	taking medication. There was er that the nurse accurately ministration of the Cosoft to UATION DRILLS d evacuation drills under not met as evidenced by: and record review of the fire lity failed to conduct on drills during different times me manager on June 20, vacuation drills are held its. The review of fire drill 2007 at for the period June	W 441	The QMRP and Facility Manager will ensure the tire drills are held between the hours of 7:30 p.r. and 5:30 a.m. at least once each quarter. The Director of Disability Services and the Quality Assurance staff will monitor quarterly to ensure compliance.	n.

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

		a MEDICAID SERVICES				<u>). 09</u> 38-039
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII	ULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G125	B. WIN	G	06/	21/2007
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
CARECO	04			1004 URELL PLACE, NE WASHINGTON, DC 20017		
(X4) ID		TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		(MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETION
W 441	Continued From pa	ge 16	W 4	41		
W 460	PM and 5:30 AM du with the QMRP faile drill records were a question.	d between the hours of 7:30 uring this period. Interview ed to reveal that additional fire vailable for the hours in D AND NUTRITION	W 4	60		
;	Each client must re well-balanced diet in specially-prescribed	ncluding modified and		See responses to W159 a	nd W189.	s/10/07
		s not met as evidenced by: ensure t hat Client #2 inced diet.				
	The findings include	5:				
	facility to escort clie programs. The stat volunteers at a food packaging and distr departing from the f with a large lunch b client what he had f	AM a staff arrived at the nts to their respective day ff indicated Client #2 I pantry, where he assists in ibuting free food. upon facility the client was observed ox. The surveyor asked the or lunch. The client opened ow the surveyor several small				
		sage and potted meat, a can				:
	of potted meat and crackers, a box of o The client was also	nt was observed to have cans vienna sausages, packages of orange juice in his lunch box. observed to have serveral rkey bacon in his lunch box.				
		ome manager revealed that f how many cans of meat the				
RM CMS-25	67(02-99) Previous Versions	Obsolete Event ID; Z0WI11	!	Facility ID: 09G125	If continuation sheel	Page 17 of 1

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STATEMEN	T OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUL1		OMB NO (X3) DATE S	APPROV 0.0938-03
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII		COMPLE	
09G125 NAME OF PROVIDER OR SUPPLIER		09G125	09G125 B. WING			
				REET ADDRESS. CITY, STATE, ZIP CODE 1004 URELL PLACE, NE WASHINGTON, DC 20017		
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DRE	(X5) COMPLET DATE
	client had in his lung QMRP indicated that was carrying cannel Interview with staff (2007 as well as the the client was presed Cholesterol, Low Sa client's annual nutrit September 12, 2006 provided needed su participate in meal p activities. There was assisted with lunch packed foods that m requirements of his prescribed menu. 483.480(a)(6) FOOD SERVICES Unless otherwise sp diet must be prepare the latest edition of t allowances of the Fo National Research O Sciences, adjusted f activity. This STANDARD is Based on observatio review, the facility fai was prepared in accu- edition of the recomm for three of three clie #1, #2 and #3) The findings include:	ch box. Interview with the at she was not aware the client d meats for his lunch. Dreparing dinner on June 19, physician's orders revealed with Diet. According to the cional assessment dated b, the client should be pports that allow him to preparation and other is no evidence the client was preparation to ensure he net the nutritional prescribed diet and reflect the D AND NUTRITION ecified by medical needs, the ed at least in accordance with the recommended dietary bod and Nutrition Board of the Council, National Academy of or age, sex, disability and not met as evidenced by: n, interview and record lied to ensure that each diet ordance with the latest mended dietary allowances onts in the sample. (Clients	W 460	· · · · · · · · · · · · · · · · · · ·	nus in	8/10/0

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

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TATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	000		<u>OMB NO</u>	<u>). 0938-0</u>	
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	ULTIPLE CONSTRUCTION	(X3) DATE COMP	SURVEY	
	09G125		B. WING		-		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZII 1004 URELL PLACE, NE	06/ P CODE	21/2007	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		WASHINGTON, DC 20017			
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFU TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	NON SHOULD BE	(X5) COMPLET DATE	
W 466	Continued From pa	ge 18		ee		<u> </u>	
	#2 and #3 were obs Clients were served of meat in gravy, wild dark green vegetab spinach; biscuits; fm Record review revea prescibed roast turk spinach (1/2 cup), fr roll (1), margarine b beverage. The revia revealed 2 ounce of cup fruit cocktail, 1 t sugar free beverage Inquiry of the staff co being served at the served in accordance to the menu for June Menu, Week 2, We only vegetable scheo There was no evider planned in accordance	served during dinner. The d the following: circular pieces hich was identified as turkey; ele, which was identified as uit cocktail; and sodas. aled a regular diet menu that key breast (3 - 4 ounces), ruit cocktail (1/2 cup), dinner everage (8 ounce), and a ew of the 1200 calorie menu turkey, 1/2 cup spinach, 12 teaspoon margarine and e should be served. oncerning any additional food meal indicated the meal was the with the menu. According e 20, 2007 (Spring/Summer dnesday) spinach was the duled to be served all day. nce that menu had been ce with U.S. Department of furtition Information Services clusion of three to five es in the diet daily.	W 4				
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Health Regulation Administration

÷ · · · · · · · · · · · · · · · · · · ·	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI 09G125		A. BUILDIN		
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, 1	STATE, ZIP CODE	
CARECO	04			LL PLACE, TON, DC 2		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
1 000	INITIAL COMMEN	TS		1 000		
	2007 through June sampling of three residential populat degrees of mental disabilities. The fit based on observat	was conducted from 21, 2007. A randor residents was selecte ion of five males with retardation and other ndings of the survey v tions, interviews, and and administrative re reports.	n ed from a various r were the			
1 090	3504.1 HOUSEKE	EPING		1 090		1
	maintained in a sa and sanitary mann	xterior of each GHMR ife, clean, orderly, attr ier and be free of dirt, rubbish, and obje	ractive,			
	Based on observa	t met as evidenced by tion and interview, the the interior and exterio air.	e GHMRP			
	The findings includ	de:				
		walk through of the fa e 21, 2007 beginning				
	1. The front porch light was observed to be not operable. Interview with the home manager indicated the reason the light was not working had not been identified.				1. The front porch light will be diagnosed and repaired as needed to make it operable.	\$/10/07
_	clogged with dirt. to not fit securely position when tour	basement exit was r The drain cover was over the drain and to ched.	observed		2. The drain will be cleaned and the cover secured	8/10/0
lealth Regu	lation Administration	Himpson		_		(X6) DATE
ABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESE	NTATIVE'S SIG		Director of Disability Services	1/11/07

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Health Regulation Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B, WING _ 06/21/2007 09G125 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1004 URELL PLACE. NE CARECO 04 WASHINGTON, DC 20017 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 1090 1 090 Continued From page 1 3. The old paint will be scraped and the window 3. Heavily scaling paint was observed above the 8/10/07 will be freshly painted. right window and on the window sill at the rear of house. 4. The walkway at the rear of the facility had an 4. The broken pavement will be repaired. area of broken pavement, which prevented the section from being properly aligned. This created a potential trip hazard. 8/10/07 5. The bottom of the bath cabinet located above 5. The bath cabinet/cabinet door will be replaced. the sink in the first floor bathroom was rusted. 6. There was no source of ventilation in the first 6. The ceiling fan in the first floor bathroom will 8/10/07 floor bathroom. Additionally, the ceiling fan in the be repaired. first floor bathroom was not operable. ~/10/07 7. The strike plate on the rear exit door was not 7. The strike plate on the rear exit door will be repaired/realigned. properly aligned. This prevented locking of the door. \$ 10/07 8. The broken chair will be replaced/repaired. 8. The back of the sitting chair was broken in the right front bedroom. 8/10/07 9. The springs were palpable in the mattress on 9. The mattress will be replaced. Resident #1's bed. 8/10/07 10. The door of the closet in the bathroom 10. The door will be shaved/replaced/rehung as located on the second floor would not close needed. completely. 8/10/0 11. The board placed underneath the air 11. The board will be replaced. conditioner in the window in the right front bedroom had a gagged left edge. 8/10/0 12. The carpet will be cleaned, or if too damaged. 12. Heavily soiled carpet was observed on the will be replaced. floor in Resident #1's bedroom. 1206 1 206 3509.6 PERSONNEL POLICIES Health Regulation Administration If continuation sheet, 2 of 8 6899 Z0WI11 STATE FORM

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED			
					06/2	1/2007	
NAME OF PROVIDER OR SUPPLIER STREET ADD							
CARECO	04			ELL PLACE, STON, DC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
1 206	Continued From pa	uge 2		1 206	· · · · · · · · · · · · · · · · · · ·		
	annually thereafter, certification that a t performed and that	ior to employment an shall provide a phys nealth inventory has b the employee ' s hea her to perform the re	ician ' s been alth status		The Pharmacist will submit a c certificate as required by policy contract.		8/10/0
	Based on interview GHMRP failed to en prior to employment provided evidence that documented a performed and that	met as evidenced by and record review, the nsure that each emplet and annually thereat of a physician's certif health inventory had the employee's health her to perform the re	ne oyee, Ifter, ication been th status				
	The finding include	s:					
	Professional and th on June 21, 2007 a GHMRP failed to pr	Qualified Mental Retain e review of the person t 4:30 PM revealed the rovide evidence of a consultant pharm	nnel files 1e current				
379	3519.10 EMERGE	NCIES		379			
	each GHMRP shall Health, Health Faci unusual incident or interferes with a res arrangement, well t places the resident	porting requirement i notify the Departmen lities Division of any o event which substan sident ' s health, welfa being or in any other at risk. Such notification one immediately and en polification within	nt of other tially are, living way tion shall		The QMRP will ensure that inc to DOH per Careco policy and regulations. The Director of Di and Incident Management Coor the QMRPs and Facility Direct retrain facility staff. The Incide Coordinator will continue to ho Incident Review Committee Me address any policy or other disc incident reporting	District isability Services rdinator will retrain ors, who will then ent Management ld scheduled setings and will	8/10/07

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Health R	egulation Administra	ation		····			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		(X2) MULTI A. BUILDIN B. WING		(X3) DATE S COMPLI	ETED
	<u> </u>	09G125				<u> </u>	1/2007
NAME OF PI	ROVIDER OR SUPPLIER						
CARECO	04			LL PLACE, TON, DC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
I 379		met as evidenced by		379			
	GHMRP failed to ea Health (DOH), Hea notified of unusual interfered with the l	and record review, to nsure the Departmer alth Facilities Division incidents that substa health for four of five #3, and #4) residing	nt of was ntially residents				
	The findings includ	e:					
		IRP's incident report: e 19, 2007 and June ing incidents:					
		d to ensure that the I es the residents' heal					
	three minutes seize telephoned and the	Resident # 2 had a ure at 7:15 AM, 911 e resident was transp on. There was no evi of the incident.	was orted to				
	incident report reve 7:55 PM, Resident from the communit	007 - Review of an ur ealed while on an out #2 was hit by a male ty while fighting with I 00H was notified of th	ing at individual him. There				
	#2 to get off the va he went to his roor causing the knob t he would rather be	When staff required F in at 4:15 PM after he m and slammed the c o break. The resider dead than live at the	e refused, loor hard, nt stated				
Health Regu	lation Administration			6899	Z0WI11	If contin	uation sheet 4 of 8

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Health F	Regulation Administra	ation				FORM	APPROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULT A. BUILDIN B. WING	······································	(X3) DATE S COMPL	
	· · · · · · · · · · · · · · · · · · ·	09G125				06/2	21/2007
NAME OF F	ROVIDER OR SUPPLIER	1			STATE, ZIP CODE		
CARECO	D 04			ELL PLACE, STON, DC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SCIDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
1 379	Continued From pa	ige 4		1379			
	home. He proceed edged arts and crait telephoned. The pro- was taken to CPEP DOH was notified of d. January 19, 2007 became verbally at violently pushing hit the police arrived, was at risk and he was transported fro wher he was treate back to the group h There was no evide	ed to pick himself wi ft-type scissors. 911 plice arrived and the c. There was no evid	was resident ence a staff by ned and e resident PEP. He ospital charged 2007. otified of				
	Resident #3 kicked redirected by his 1: concrete wall. Resi evaluation. There w notified of the incide 2. The facility failed	to ensure that the	hile being d on the e ER for I was not				
	24 hours or the nex a. The review of an October 7, 2006 rev taken to the ER due blood pressure. He to the hospital. The was notified until O	Ith received notificat t work day as detaile unusual incident dat vealed that Resident to profuse sweating was evaluated and ere was no evidence ctober 20, 2006. unusual incident dat	d below: ed #1 was and low admitted that DOH				
	21, 2007 revealed a walked away from t	at 6:25 PM Resident the facility when he w ed by staff. The polic	#4 /as left				

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If continuation sheet 5 of 8

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Health I	Regulation Administr	ation				FORM	
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULT A. BUILDIN		(X3) DATE S COMPLI	
		09G125		B. WING	······································	06/2	1/2007
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		
CAREC	D 04			ELL PLACE, GTON, DC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
I 379	notified after staff w resident returned to incident was not re 2007. c. The review of ar April 12, 2007 reve reported that Resid of light wood that fe resident was asses program nurse who alert, oriented and a to this group home, ER for evaluation. he had a scalp con the incident was re 2007. 3520.3 PROFESSI PROVISIONS Professional servic and evaluation, incl developmental leve services, and servic	vas unable to locate k o the facility at 8:45 P ported to DOH until aled that the day pro- lent #4 was injured by ell on the back of his issed immediately by to o documented that he able to move. After re- tusion. There was no ported to DOH until A ON SERVICES: GEN es shall include both luding identification o els and needs, treatm ces designed to preve	M. The April 23, bort dated gram y a piece neck. The he day was eturning ten to the revealed evidence vpril 17, NERAL diagnosis f ent ent	I 379 I 401	See responses to federal deficiencies V W369.	W159 and	8/10/07
Hogelik Bogu	resident. This Statute is not Based on interview GHMRP failed to en Resident #2. The findings include	her loss of function b met as evidenced by and record review, th nsure professional se e: iency Report - Citatio	r he ervices for				

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IDENTIF		(X1) PROVIDER/SUPPLI IDENTIFICATION NU 09G125	er/clia JMBER;	(X2) MUL A. BUILDI B. WING		(X3) DATE COMPI	
NAME OF I	PROVIDER OR SUPPLIER	000120			STATE, ZIP CODE	06/:	21/2007
CARECO				LL PLACE	. NE		
(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	IN SHOULD BE	(X5) COMPLETE DATE	
1 420	Continued From pa	ge 6		1 420	······································		
l 420	3521.1 HABILITATI	ON AND TRAINING	6	l 420			1
	training to its reside and maintain those	provide habilitation nts to enable them t life skills needed to n the demands of the p achieve their optim and social functionin	o acquire cope eir um levels		See responses to federal deficien W257.	ncies W159 and	\$10/07
	This Statute is not r Based on interview a GHMRP failed to pro- to Resident #2 that y and maintain life ski environment and ac physical, mental and The findings include (See Federal Deficie and W257)	and record review, t ovide habilitation and would enable him to lls needed to cope w hieve an optimum le f social functioning.	he d training acquire vith his vel of				
ĺ	3523.1 RESIDENT'S	S RIGHTS		1 500			
	Each GHMRP reside that the rights of resi protected in accorda chapter, and other a laws.	ence director shall en dents are observed nce with D.C. Law 2	nsure and -137. this		See responses to federal deficit W149, W159 and W263	encies W124,	8/10/0;
	This Statute is not m Based on observatio review, the GHMRP protection of each re	n, interview and reco failed to ensure the	ord				
-	The findings include:			ļ			
	(See Federal Deficie) W149, W159 and W2	ncy Report Citations	- W124,				

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	egulation Administ	tration	<u> </u>	_		FORM	D: 06/29/2 APPROV
STATEMENT AND PLAN C	IT OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER; A. BUILDING 09G125 B. WING		(X3) DATE COMP	(X3) DATE SURVEY COMPLETED			
NAME OF PROVIDER OR SUPPLIER						06/	<u>21/2007</u>
					TATE, ZIP CODE	<u> </u>	
CARECO			WASHING	ELL PLACE, I GTON, DC 20	NE 9017		
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	Eller	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLE DATE
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