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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	(X3) DATE SURVEY COMPLETED
	09G139	A. BUILDING _____ B. WING _____	09/05/2008

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CMS	5610 FIRST STREET NW WASHINGTON, DC 20011

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W 000	INITIAL COMMENTS This recertification survey was conducted from September 3, 2008 through September 4, 2008. The survey was initiated using the fundamental survey process. Four male clients with varying degrees of disabilities reside in this facility. Two of the four clients were randomly selected for the sample. The findings of the survey were based on observations at the group home and two day programs, interviews with management and direct care staff in the residence and the review of the administrative records including the facility's incident management system.	W 000	Received 10/10/08 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
W 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 observation, interviews, and the review of records, the facility's governing body failed to provide general operating directions over the facility as evidenced by the following: The findings include: The governing body failed to ensure that contracted nurses were licensed to practice nursing and that licenses were available for review as required by the Health Occupation Revision Act (HORA) Title 3 Chapter 12 Section 3-1205.13 ("Each licensee shall display the license conspicuously in any and all places of business or employment of the licensee.").	W 104	The facility will obtain an updated contractual agreement and current licensures from Nursing Agency that provide services for Client #1.	10/24/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Constance A. Reese | TITLE: Program Director | (X6) DATE: 10-9-08

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 Interview with the Qualified Mental Retardation Professional (QMRP) and the Registered Nurse on September 5, 2008 indicated that the group home contracts with a nurses agency to provide 24 hour nursing services to Client #1. The surveyor requested to review the contractual agreement and licenses for the seven nurses contracted. The documents were not made available at the conclusion of the survey.	W 104		
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 of each client, parent, or legally authorized party of the client's medical conditions, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment for one of the two clients in the sample. (Client #2) The finding includes: The facility failed to ensure Clients #2 and his representative were informed of the risks and benefits of his behavior management plans as evidenced below: On 9/4/08 at 8:05 AM Client #2 was observations during the morning medication pass. The	W 124	Written informed consent was retrieved from the sister of Client #2. In the future, the QMRP will ensure that all guardians are aware of the risks and benefits of Behavior Management Plans and psychotropic medications.	9/26/08

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W 124	Continued From page 2 Trained Medication Employee (TME) administered the client Chlorpromazine 400 mg. After the medication pass, at approximately 9:00 AM, The TME and the Qualified Mental Retardation Professional (QMRP) were interviewed to ascertain the reason for Chlorpromazine. They both indicated that the medication was ordered by the physician in conjunction with the Behavior Management Plan (BMP) to manage the client's to manage the client's maladaptive behaviors. The verification of the order and BMP supported the interviews. The QMRP was asked about written inform consent for the use of the medication, she indicated that written consent had not been obtained. The QMRP further stated that the client's sister was involved in the client care and was the designated person to give consent for treatment. It should be noted that the review of the psychological update dated 6/27/08 revealed that Client #1 was not capable to give informed consent and/or make independent decisions on treatment and medical matters.	W 124		
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 staff interview and record review, the facility failed to ensure that all injuries of unknown	W 153	In the future, the QMRP and Residential Manager will make sure that all incidents of unusual origin or abuse are reported within 24 hours of the incident to the appropriate government agencies for all individuals in the group home facility.	10/6/08

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W 153	Continued From page 3 origin and serious unusual incidents were reported immediately to the governmental agencies as required by DC regulation (22 DCMR Chapter 35 Section 3519.10) The findings include: The review of the facility's unusual incident reports and interview with the Qualified Mental Retardation Professional (QMRP) on September 4, 2008 at 9:45 AM, revealed the facility failed to report timely the following injury of unknown origin: Review of an unusual incident report, dated May 22, 2008, reported that Client #4 was observed limping and his left leg was swollen. Client #4 was taken to the emergency room for evaluation and treatment.	W 153		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure all unusual incidences of injuries of unknown origin were thoroughly investigated. The finding includes: Interview with the QMRP and the review of the facility's Unusual Incident Reports log book on September 4, 2008 at approximately 9:56 AM revealed the following injury of unknown origin which had not been investigated:	W 154	An investigation was completed for the incident that occured on May 22, 2008 with Client #4. In the future, the QMRP will ensure that all incidents are investigated in a timely manner for all individuals.	10/6/08

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W 154	Continued From page 4 On May 22, 2008 Client #4 was observed limping and his left leg was swollen. Client #4 was taken to the emergency room for evaluation and treatment of the injury. The origin of this injury was not investigated.	W 154		
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 observations, interviews with the Qualified Mental Retardation Professional (QMRP) and record review, the QMRP failed to ensure integration, coordination and monitoring of client's active treatment regimen. The findings include: 1. The QMRP failed to ensure that failed to ensure that clients receive interventions as specified in their Individual Program Plans. [See W249] 2. On September 4, 2008 at approximately 8:05 AM, Client #2 was observed during the medication administration. The TME was administer Client #2's Chlorpromazine 400 mg medication. Interview with the QMRP on September 5, 2008 at approximately 10:45 AM, revealed that Client #2 was prescribed this medication to address his maladaptive behaviors of self-injurious behaviors and aggression. Further interview revealed that the client had a Behavior Support Plan (BSP) that	W 159	The QMRP has informed the behavior specialist that the medications need to be updated in the BSP for Client #2 and the behavior specialist will provide an updated BSP for the QMRP. In the future, the QMRP will make sure to have all documentation updated when there is a psychotropic medication change for all individuals.	10/8/08

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W 159	Continued From page 5 was being implemented as well. Review of the BSP dated September 27, 2007 indicated that the client was prescribed Carbamazepine and Chlorpromazine to manage maladaptive behaviors. Review of the physician orders dated 8/31/08, however indicated that Client #2 was only prescribed Chlorpromazine. Review of the available psychiatric assessment date 10/06 indicated that both the Carbamazepine and the Chlorpromazine medications were prescribed for the treatment of his maladaptive behaviors. The QMRP failed to ensure that the client's BSP reflected the correct and current information.	W 159		
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 observation, staff interview and record review, the facility failed to ensure that each employee had been provided with adequate training that enables the employee to perform his or her duties effectively, efficiently and competently. The findings include: The facility failed to ensure that direct care staff effective implemented each clients interventions as specified in their Individual Program Plans. [See W249]	W 189	The QMRP will provide training for the staff on the implementation of IPP goals. In the future, the QMRP will make sure that all staff are properly trained.	10/23/08
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION	W 249		

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W 249	Continued From page 6 As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review the facility failed to ensure that clients receive interventions as specified in their Individual Program Plans for three of four client residing in the facility (Clients #1, #2, and #3). The findings include: 1. The facility's Trained Medication Employees (TME) failed to ensure a sanitary environment during the medication pass and as prescribed in Client #3's Behavior Support Plan (BSP). During medication administration on September 4, 2008 at approximately 8:35 AM Client #4 was observed to stick his index finger in his nostril and then stick his finger in his mouth repeatedly. The TME responded by saying "No", and then proceed to give the client his medication. The TME was not observed to encourage the client to wash his hands. Interview with the QMRP revealed that the client had a behavior of sticking his fingers in his nose and mouth. This behavior was addressed in his Client's BSP and the BSP required that the client	W 249	The TME will receive training on infection control and the BSPs of all individuals by the RN and Behavior Specialist respectively	10/23/08

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W 249	Continued From page 7 be encouraged to wash his hands at each occurence. According to the nurse the TME had been trained on proper infection control practices earlier this year. There was no evidence that the medication nurse implemented the clients BSP. 2. The facility failed to ensure that direct care staff implement Client #2's program for table setting. Observation on September 4, 2008 at approximately 4:55 PM the direct care staff started setting the table for dinner while Client #2 was seated at the dining room table. Interview with the QMRP revealed that Client #2 had a table setting objective. Further interview revealed that the direct care staff appeared to be rushing through dinner and did not allow the client time to set the table. Review of Client #2's Individual Program Plan (IPP) revealed that he had a program objective to "set the table for dinner". The frequency of this objective was described as Monday through Friday for data documentation. Reportedly, staff are to allow for other appropriate opportunities. 3. On September 4, 2008 at approximately 8:04 AM, the TME administered Client #2's medication. The TME passed the client his cup of medication and the client threw his cup in the trash can in the kitchen. During the evening medication pass on the same day at approximately 5:05 PM, the nurse was observed providing hand over hand assistance to	W 249	Cross reference W189 Cross reference W189	10/23/08 10/23/08

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W 249	Continued From page 8 Client #2 while he punched out medications from his bubble packs. Once completed, the medication nurse provided the cup of pills to the client and the client consumed the pills and then threw the cup in the trash can independently. A review of the medical records on the same day approximately 4:00 PM revealed that the client had a self-medication program which was being implemented and the task included the following: 1. Approach the nurse with verbal prompts 2. Get a glass of water 3. Take his medication 4. Swallow medicine 5. Discard cup in the trash The TME failed to follow/implement all of the steps of the program as designed.	W 249		
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 observation, staff interview and record review, the facility failed to ensure that each client's behavior intervention program, including the use of behavior modification drugs, was conducted only with the written informed consent of a legal guardian, for one of the two clients in the sample. (Client #2) The finding includes:	W 263	Cross reference W124	9/26/08

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W 263	Continued From page 9 [Cross Refer to W124] Observations of the morning medication administration on 9/4/08 at 8:05 AM revealed that Client #2 was administered Chlorpromazine 400 mg to control maladaptive behaviors. Review of the records and interviews with the QMRP failed to provide evidence that written inform consent was received for the use of Chlorpromazine, a psychotropic medication.	W 263		
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 staff interview and record review, the facility failed to ensure nursing services were provided in accordance with each clients needs. The findings include: 1. The facility failed to ensure that Client #1's walking protocol was being implemented as written. On September 4, 2008 at approximately 12:24 PM Client #1 was observed at his day program in the sensory room. He was observed walking to the day room without assistance. A staff person identifed as his one to one nurse was observed walking a few steps behind him. Although he was wearing a gait belt, the nurse did not use the belt. Later on that evening at approximately 6:24 PM, Client #1 stood up independently and walked across the living room. Although the nurse observed client #1 walking, she/he failed to provide any assistance. Interview with the QMRP on September 5, 2008	W 331	The one-to-one nurses for Client #1 will receive fall prevention and walking protocol training.	10/24/08

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W 331	Continued From page 10 at 2:00 PM, revealed that Client #1 was required to have one on one nursing supports to assist the with medical concerns, to include assistance with ambulation. Review of the Physical Therapist assessment dated 8/12/08 revealed a walking and falling protocol which required contact guard assistance at the gait belt when ambulating. 2. The nursing staff failed to ensure the facility failed to ensure that medications were administered in accordance with physician's orders. [See W368] 3. The nursing staff failed to ensure the facility failed to ensure that medication nurse administered prescribed medication with out error. [See W369]	W 331	Cross reference W368 Cross reference W369	10/24/08 10/24/08
W 365	483.460(j)(4) DRUG REGIMEN REVIEW An individual medication administration record must be maintained for each client. This STANDARD is not met as evidenced by: Based on observation, interview and record reviews, the facility failed to establish and maintain a systems that ensures that an individuals medication records were maintained for two of the four client's residing in the facility. (Client #1, #3 and #4) The findings include: The facility failed to ensure an effective system for documenting Client medication administration as evidence by the following: 1. Observation of the medication pass on September 4, 2008 at approximately 8:05 AM,	W 365		

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W 365	Continued From page 11 Client #4 was administered Puralube Ophtha eye solution, one drop in both eyes. Later review of the Medication Administration Record (MAR) failed to evidence that the Trained Medication Employee initial in the MAR after administering the eye medication in accordance with the agency's policy. 2. Review of the June 2008 MAR's on September 5, 2008 at approximately 12:30 PM, revealed Client #1 Metoclopramide HCL 5 mg/5 ml 10 ml dosage was not initialed in the MAR on 6/9/08, 6/16/08 and 6/30/08 after administration. 3. Review of the April 2008 MAR's on September 5, 2008 at approximately 12:30 PM, revealed Client #1 ISO Source 1.5 cal/ML give 125 ML/hr indicated that the 7:00 AM tube feeding had not been initialed for 4/7/08 and 4/22/08 after administration. 4. Review of the March 2008 MAR's on September 5, 2008 at approximately 12:30 PM, revealed Client #1 Metoclopramide HCL 5 mg/5 ml solution 10:00 PM dosage had not been initial for 3/10/08 after administration. 5. Review of the February 2008 MAR's on September 5, 2008 at approximately 12:30 PM, revealed Client #1 order to hold tube feedings 30 minutes after administering the client anti-convulsant medication 12:30 PM dosage on 2/12/08 and 11:30 PM dosage on 2/27/08, 2/28/08 and 2/29/08.	W 365	The nursing staff and the Trained Medication Employees will receive additional training on documentation. In the future, the primary nurse will monitor the MAR on a weekly basis.	10/24/08
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.	W 368		

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W 368	Continued From page 12 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that medications were administered in accordance with physician's orders for four of the four clients receiving medications. [Clients #2 and #4] The findings include: 1. The facility nursing personnel failed to ensure that Client #2's medication was available at the time of his medication administration. Observation of the medication pass on September 4, 2008 at approximately 8:05 AM, revealed that the TME did not have Client #6's prescribed dosage of Lactulose 30 mg to administer. Interview with the nurse revealed that the TME was to have called at least three days prior to the medication running out. Further interview with the nurse revealed that once she was notified the pharmacy was contacted to reorder the medication and it is delivered the following day. According to the facility's Registered Nurse (RN) the agency's nursing policy required the nurse's to monitor all medications weekly and to reorder prior to completion of the medication. There was no evidence that the nurse were monitoring the client's medication in accordance with the agency's policy. 2. Observation of the medication pass on September 4, 2008, revealed that Client #4	W 368	The nursing staff and the Trained Medication Employees will receive additional training in reordering medications. In the future, the primary nurse will monitor the medication box for availability of all meds.	10/24/08

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W 368	Continued From page 13 receive Fluoxetine 60 mg for his maladaptive behaviors. The bubbles packs revealed the medication dosage for the morning of September 1st and 2nd remained in the bubble packaging. Interview with the nurse revealed that the medication should have been administered as prescribed by the physician for both these dates. Review of the MAR and the nurses notes fail to provided any information as to why Client #4's was not administered his psychotropic medication as ordered by the physician.	W 368		
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that medication nurse administered prescribed medication with out error, for two of the four client's residing in the facility. (Client #3 and #4) The findings include: 1. On September 4, 2008 at approximately 8:05 AM, Client #3 was observed during the medication administration. The TME was observed to administer Client #3's medications to include Keppra 500 mg and Chlorpromazine 400 mg. According to the TME, Client #3 was also to receive Lactulose 15ml/ 30 ml, but this medication was not available to administer. Interview with the RN later the same day at approximately 11:30 AM, revealed that the TME	W 369	Cross reference W368	10/24/08

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W 369	Continued From page 14 were to have informed the nursing staff when the medication was low. Once notified, the nurse would contact the pharmacy in order to reorder the client's medication. The nurse further indicated that this process is a part of the agency's policy. Review of the Medication Administration Records (MAR) for the and Client #2's September 2008 physician's order confirmed that Client #2 was to have received Lactulose during the medication pass for constipation.	W 369		
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to hold evacuation drills quarterly on all shifts. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the staffing pattern on September 5, 2008 at approximately 12:15 PM revealed the following shifts: Weekdays and Weekends 1st Shift 8 AM to 3:30 PM 2nd Shift 3 PM to 11:30 PM 3rd Shift 11 PM to 8:30 AM Further interview with the QMRP revealed that the staff was required to conduct a drill once per month on each shift. Review of the fire drill log	W 440	In the future, the QMRP and Residential Manager will monitor the fire drill log book quarterly to ensure ~~that~~ fire drills are done every 3 months on every shift.	10/6/08

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W 440	Continued From page 15 book revealed that the facility failed to hold simulated fire drills at least four times a year for 8:00 AM - 3:30 PM shift, during the periods of April 2008 to September 2008. There was no evidence that fire drills were conducted quarterly on all shifts.	W 440		
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation, the facility failed to implement infectious control procedures to prevent communicable infectious diseases. The finding includes: [Cross Refer to W249]. The facility's Trained Medication Employees(TME) failed to ensure a sanitary environment during the medication pass and as prescribed in Client #3's Behavior Support Plan (BSP).	W 455	Cross reference W249	10/23/08
W 474	483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to serve foods in a form consistent with dietary orders for one of the two clients in the sample. (Clients #2) The finding includes:	W 474	The staff will receive training by the nutritionist on food consistency for all individuals.	10/23/08

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W 474	Continued From page 16 The facility failed to ensure that food was prepared in a form consistent with Client #2's prescribed dietary needs as evidenced below: Observation on September 4, 2008 at approximately 5:15 PM, revealed Client #2 was given a ground diet of salad, meat balls, juice, water, and wheat bread. Client #2 was observed to then pick up his fork and attempt to pierce his food; however, he had difficulty getting his food to stay on the fork. The client continued to eat, however, the remaining ground toss salad in his plate continued to flow off his fork back into his plate. At no time was staff noted to provide him with a regular spoon to assist him in scooping up the salad. Interview with the QMRP, revealed that Client #2 was on a chopped diet. According to the QMRP, the staff may have allowed the new food processor to chop his food to long. Review of the Nutritional Assessment dated 9/7/07 and the September 2008 physician order verified that the client was required to have a chopped diet.	W 474		

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I 000	INITIAL COMMENTS This licensure survey was conducted from September 3, 2008 through September 4, 2008. Four male residents with varying degrees of disabilities reside in this 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 and two day programs, interviews with management and direct care staff in the residence and the review of the administrative records including the facility's incident management system.	I 000	Received 10/10/08 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation, the GHMRP failed to ensure the interior and exterior of the GHMRP was maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. The findings include: Internal 1. The basement exit door was lined with several bricks which is a trip and safety hazard. 2. The basement door did not have any weather strip to keep out unwarranted pest. The area	I 090	1. The bricks were removed from the doorway. 10/7/08 2. A weather strip will be added to the basement door. 10/24/08	

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TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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I 090	Continued From page 1 exposed about a 2 -3 inch opening underneath the door. 3. A blue leather chair in the living room was ripped and torn. 4. A large crack was observed in the plaster above the front door. 5. The arch way shared with the dining room and the living room had plaster on both sides. According to the QMRP the maintenance man was repairing the wall area and was allowing the plaster to dry in order to paint. 6. The support rail at the top of the steps on the level with the bedrooms was loose. External A long black wire was hanging form the right side of the basement exit landing area.	I 090	The leather chair will be repaired. The crack will be repaired. The archway will be completed by maintenance. The support rail will be tightened.	10/24/08 10/24/08 10/24/08 10/24/08
I 095	3504.6 HOUSEKEEPING Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach of each resident. This Statute is not met as evidenced by: Based on observation the GHMRP failed to lock caustic agents being stored. The finding includes: Observations during the environmental walk-through on 9/5/08 approximately 1:40 PM, revealed a variety of caustic agents (bathroom cleaner, toilet cleaner, glass cleaner, etc.) were	I 095	All caustic agents were placed in a locked cabinet in the basement. In the future, the QMRP will ensure that all caustic agents are locked up and out of reach of all individuals by making a daily check of cabinet. Staff will receive additional training.	10/24/08

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I 095	Continued From page 2 being store in the basement in a large bin unlocked. Additionally, large box of open detergent was observed open on the floor near the washing machine unlocked.	I 095		
I 135	3505.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift. This Statute is not met as evidenced by: Based on interview and record review the GHMRP failed to ensure that each shift conducted a fire drill 4 times a year. The finding includes: See Federal Deficiency Report Citation W440	I 135	Cross reference W440	10/6/08
I 188	3508.6 ADMINISTRATIVE SUPPORT Documentation that services have been provided as required by each resident ' s Individual Habilitation Plan including contracts, vendor agreements, receipts, and paid bills shall be available for review by authorized regulatory personnel. This Statute is not met as evidenced by: Based on interview and record review the GHMRP failed to ensure that contract for outside services were on file for the regulatory agency's review. The findings include: Interview with the QMRP and a review of the	I 188	Cross reference W104	10/24/08

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I 188	Continued From page 3 available outside contracta on September 5, 2008 failed to evidence an contractual agreement with a nursing agency who were suppling the nurse(s) to the group home to work with Resident #1. According to the QMRP, the nurses were used as one to one support to the resident's due to his medical concerns.	I 188		
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 have on file for review current job descriptions for all employees annually. The finding includes: Review of the personnel files conducted on 9/5/08 revealed that GHMRP failed to provide evidence of a current signed job descriptions for the four direct care staff. (Staff #1 - #4)	I 203	All staff were instructed to sign current job descriptions. In the future, the QMRP will make sure that all staff have signed current job descriptions on file.	10/7/08
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by:	I 206	The QMRP will obtain physical health clearences for staff #1-3 and the primary care physician. In the future, the QMRP and Residential Manager will make sure that all staff have current physical examination clearences on file.	10/10/08

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I 206	Continued From page 4 Based on staff interview and record review, the GHMRP failed to ensure its staff received annual health screenings in the form and manner as required by this section. The findings include: Interview and review of the personnel records on September 5, 2008 revealed the GHMRP failed to have evidence of physical examination for three direct care staff [Staff #1, #2 and #3] and the primary care physician.	I 206		
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on observations, interview and record verification, the GHMRP failed to ensure continuous, ongoing in-service training programs were conducted for all personnel. The finding includes: See Federal Deficiency Report Citation W189	I 222	Cross references W189	10/23/08
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;	I 229		

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I 229	Continued From page 5 This Statute is not met as evidenced by: Based on interview and review of training documents, the GHMRP failed to provide evidence to validate staff training as indicated by residents' need. The findings include: Interview with the QMRP and the review of the in service training records on 9/5/08, revealed that the GHMRP failed to provide training on sexuality.	I 229		
I 232	3510.5(i) STAFF TRAINING Each training program shall include, but not be limited to, the following: (i) Training of the residents in the maintenance of oral health and hygiene. This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for Mental Retardation (GHMRP) failed to ensure that staff received training. The finding includes: On 9/5/08 at approximately 2:00 PM, interview with the QMRP and the review of the in-service records failed to provide oral health and hygiene training to the direct care staff.	I 232	All staff will be trained on oral health and hygiene by the RN. In the future, the QMRP will make sure all staff are currently trained on oral health and hygiene.	10/24/08
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially	I 379	Cross reference W153	10/6/08

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I 379	Continued From page 6 interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to report to governmental officials within 24 hours in accordance with this regulatory requirement. The findings include: The review of the facility's unusual incident management system and interview with the Qualified Mental Retardation Professional (QMRP) on September 4, 2008 at 10:30 AM, revealed the facility failed to timely notify the to the governmental agency of the following incident(s): 1. An unusual incident report, dated May 17, 2008, revealed that Resident #1 was observed by his one on one nurse to fall in the tub and received an injury to the back of his head. He was transported the the emergency room for treatment. 2. An unusual incident report, dated February 25, 2008, revealed that Client #1 was observed to vomit repeatedly and was taken to the emergency room for evaluation and treatment. 3. An unusual incident report, dated March 25, 2008, Resident #4 was observed to be lethargic	I 379		

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I 379	Continued From page 7 and reportedly did not eat lunch or dinner. Resident #4 was taken to the emergency room for evaluation and treatment. Reportedly, the Resident #4 was diagnosed with pneumonia. 4. An unusual incident report, dated May 22, 2008, Resident #4 was observed limping and his left leg was swollen. Resident #4 was taken to the emergency room for evaluation and treatment of the injury of unknown origin to his left leg.	I 379		
I 395	3520.2(e) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (e) Nursing; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure its nurses had current licenses on file. The finding includes: Review of the personnel records on June 11, 2008, revealed that the GHMRP failed to have current license on file for one License Practical Nurse(LPN) and the contract nurses (seven LPN).	I 395	The facility will obtain current licenses for all nursing staff.	10/24/08

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I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on interview and record review the GHMRP failed to provided diagnosis, evaluation, treatment services and necessary follow up service to prevent deterioration or further loss of functioning for each resident in the facility. The finding includes: See Federal Deficiency report Citation W331,	I 401	Cross reference W331	10/24/06
I 473	3522.4 MEDICATIONS The Residence Director shall report any irregularities in the resident ' s drug regimens to the prescribing physician. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that medications were administered in accordance with physician's orders for one of residents who resided in the facility. (Resident #1) The findings include: On September 4 2008 at approximately 8:45 AM review of the Medication Administration Records (MAR's) revealed the following medications were not available for the TME's at the time of	I 473	The TME will receive training by the RN on appropriate protocol for refilling medication for all individuals.	10/24/08

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0044	A. BUILDING _____ B. WING _____	09/05/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CMS	5610 FIRST 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) COMPLETE DATE
I 473	Continued From page 9 administration as follows: The facility nursing personnel failed to ensure that Resident #2 medication was available at the time of his medication administration. Observation of the medication pass on September 4, 2008 at approximately 8:05 AM, revealed that the TME did not have Resident #2's prescribed dosage of Lactulose 30 mg to administer. Interview with the nurse revealed that the TME was to have called at least three days prior to the medication running out. Further interview with the nurse revealed that once she was notified, the pharmacy was contacted to reorder the medication. The medication was to be delivered the following day. According to the facility's Registered Nurse (RN), the agency's nursing policy required the nurse's to monitor all medications weekly and to reorder prior to completion of the medication. There was no evidence that the nurse were monitoring the client's medication in accordance with the agency's policy. It should be noted that the TME documented on the back of the MAR's that the nurse was informed when she arrived that the medication had "run out". The facility nurse failed to have an effective system of monitoring Resident #1's medication to ensure prescribed medications were available and administered as prescribed.	I 473		

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R 000	INITIAL COMMENTS This licensure survey was conducted from September 3, 2008 through September 4, 2008. Four male clients with varying degrees of disabilities reside in this facility. Two of the four clients were randomly selected for the sample. The findings of the survey were based on observations at the group home and two day programs, interviews with management and direct care staff in the residence and the review of the administrative records including the facility's incident management system.	R 000		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on the review of records, the GHMRP failed to ensure criminal background checks disclosed the criminal history of any prospective employee or contract worker for the previous seven (7) years in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. The findings include: Review of the personnel records on 9/5/08 at 1:30 PM revealed that the GHMRP failed to provide evidence that ensured criminal background checks were on file for one direct	R 125	The Director of Human Resources will ensure that criminal background checks are completed per regulations.	10/21/08

Health Regulation Administration

Marsha H. Thompson

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Director of Disability Svcs

(X6) DATE: 9/29/08

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R 125	Continued From page 1 care staff (#1 and the Qualified Mental Retardation Professional.	R 125		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Constance A. Reese TITLE Program Director (X6) DATE 10-9-08

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R 125	Continued From page 1 care staff (#1) and the Qualified Mental Retardation Professional.	R 125		