

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
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NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4314 8TH STREET NW WASHINGTON, DC 20011
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W 000	<p>INITIAL COMMENTS</p> <p>On November 2, 2009, the State Agency (SA) received written notification by the facility's Incident Management Coordinator (IMC) of an allegation of client-to-client abuse (sexual advances). An on-site investigation was initiated on November 6, 2009. The findings of the investigation were based on interviews with the qualified mental retardation professional (QMRP), facility's direct and management staff, review of the clients' habilitation, medical, and administrative records, and the review of the facility's incident management system.</p> <p>The investigation revealed that in addition to making inappropriate sexual advances towards her peer, the client in question repeatedly left the facility without proper staff escort for safety. It was determined that the facility failed to adequately protect her safety during the period July 30, 2009 - September 30, 2009.</p> <p>Findings of the investigation led to the annual recertification survey which began on November 16, 2009. The client who had been touched inappropriately by a peer was included in the recertification sample. Two other clients were selected at random. The investigative findings concerning the fourth client were included in this report, as a focused review of her behavior support needs and staff supervision/safety needs.</p> <p>The November 6, 2009 investigation findings led to the determination that the facility was not in compliance with the Condition of Participation in Client Protections.</p>	W 000	<p><i>Received 12/23/09</i></p> <p>GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, O.C. 20002</p>	
W 102	<p>483.410 GOVERNING BODY AND MANAGEMENT</p>	W 102		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Caroline C. Reese</i>	TITLE <i>Program Director</i>	(X6) DATE <i>12/23/09</i>
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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 required to continued program participation.

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W 102	Continued From page 1 The facility must ensure that specific governing body and management requirements are met.	W 102			
W 104	This CONDITION is not met as evidenced by: The governing body failed to maintain general operating direction over the facility to prevent neglect and abuse. [See W104] The results of these systemic practices revealed that the facility's Governing Body failed to adequately govern the facility in a manner that would ensure client protection. [See W122] 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, interview and record review, the governing body failed to have a policy and/or an effective system to ensure that all clients in the facility were protected from neglect and abuse, for four of the six clients residing in the facility. (Clients #1, #2, #3 and #4) The findings include: 1. Cross-refer to W149. A review the facility's records to include administrative and clinical records, and interviews with the qualified mental retardation professional (QMRP) on November 6, 2009 starting at 9:45 a.m., failed to show evidence that the facility governing body had an effective system to ensure that Client #4 was	W 104			

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W 104	Continued From page 2 protected from neglect and potential harm. 2. Cross-refer to W149.2. Review of the facility's records, including administrative and clinical records, and interviews with the QMRP on November 8, 2009, failed to show evidence that the facility had established a policy and an effective system to ensure that Client #3 was protected from sexual abuse. Since that time, however, the facility instructed staff on the overnight shift to position one staff near the bedrooms upstairs to monitor clients' nighttime activities. 3. Cross-refer to W112. The governing body failed to ensure that the facility's management ensured the confidentiality of private and personal information contained in each client's record. 4. Cross-refer to W192. The governing body failed to ensure that all staff were trained and competent to provide assistance in accordance with the health care needs (i.e. denture care and diabetic/prescribed diets), of two of the three clients in the sample. (Clients #1 and #2) 5. Cross-refer to W262 and W263. The governing body failed to ensure that restrictive measures had been approved by the Human Rights Committee (HRC), for two of the three clients in the sample. (Clients #2 and #3) 6. Cross-refer to W381. The governing body failed to ensure that all drugs were stored under proper condition of security, for the one client residing in the facility whose medications (insulin) required refrigeration. (Client #2) 7. Cross-refer to W393. The governing body	W 104	1. Cross reference W149.1 2. Cross reference W149.2 3. Cross reference W112 4. Cross reference W192.1 5. Cross reference W262 and W263	12/24/09 12/24/09 12/24/09 2/1/10 12/18/09	

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W 104	Continued From page 3 failed to ensure that the facility had a certificate of waiver as required by part 493 of the Clinical Laboratory Improvement Act (CLIA) to perform laboratory services, such as glucose monitoring for Client #2. This was previously cited in the Federal Deficiency Report dated September 14, 2009.	W 104			
W 112	483.410(c)(2) CLIENT RECORDS The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to keep confidential information contained in each client's record, for five of the six clients residing in the facility. (Clients #1, #2, #3, #4 and #6) The findings include: 1. On November 16, 2009 at 4:15 p.m., a chart was observed posted openly on the refrigerator door in the kitchen. Review of the chart revealed that it included each client's full name and listed her prescribed diet. For example, Client #1 was prescribed a 1500 calorie, low fat, low cholesterol, chopped texture diet. The full names and specially prescribed diets for Clients #2, #3, #4 and #6 were also listed. Next to the chart was a memo that announced that three clients (full names identified) were to receive Egg Beaters as an egg substitute due to their "low cholesterol diet." 2. Also posted openly on the refrigerator door was a memo titled "Very Important Notice." It	W 112	All confidential information concerning the Client's diet was immediately removed. In the future, all Client's personal information will remain confidential. Staff will receive additional training on the prescribed diets of all Clients. Staff will receive additional training in HIPAA and Confidentiality.	12/24/09	

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W 112	<p>Continued From page 4</p> <p>discussed the staff assignments needed to protect Client #3 from Client #4's "Inappropriate sexual contact." Both clients' full names were cited in the text.</p> <p>This practice failed to ensure the confidentiality of the clients' personal information.</p> <p>The postings were brought to the attention of the house manager and qualified mental retardation professional on November 17, 2009 at 10:25 a.m. They immediately removed the memo about inappropriate sexual contact. The house manager stated "that shouldn't be up there." After further discussion about protecting confidentiality, they removed the clients' dietary information from the refrigerator door.</p>	W 112	<p>2. The posted memo was immediately removed. The QMRP will ensure the Client's personal information remains confidential.</p>	12/18/09
W 122	<p>483.420 CLIENT PROTECTIONS</p> <p>The facility must ensure that specific client protections requirements are met.</p> <p>This CONDITION is not met as evidenced by: Based staff interviews and record reviews, facility failed to establish a system that would ensure clients and legal guardians were informed of the risks and benefits of restrictive programs and supports [See W124]; the facility failed to ensure client privacy in her bedroom while she was asleep [See W129]; the facility failed to ensure clients had the right to access their personal clothing[W137]; the facility failed to establish and implement its incident management policies that ensured each client's health and safety [See W149]; the facility failed to ensure that all incidents of neglect and injuries of unknown origin were reported [See W153]; and the facility failed</p>	W 122	<p>Cross reference W124, W129, W137, W149, W153</p>	12/24/09

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W 122	Continued From page 5 to thoroughly investigate all incidents of neglect [W154].	W 122		
W 124	<p>483.420(a)(2) PROTECTION OF CLIENTS RIGHTS</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, facility failed to establish a system that would ensure clients and legal guardians were informed of the risks and benefits of restrictive programs and supports, for two of the three clients in the sample. (Clients #2 and #3)</p> <p>The findings include:</p> <p>1. The facility failed to provide evidence that informed consent was obtained from Client #3 and/or court appointed legal guardian for sedation given during medical appointments as evidenced below:</p> <p>Review of Client #3's medical records on November 16, 2009, at approximately 2:00 p.m., revealed an order for Ativan 2 mg one hour prior to an ENT appointment dated July 10, 2009.</p>	W 124	<p>1. In the future, prior to a medical appointment the facility will obtain informed consent from the court appointed legal guardian. All potential risks involved in using the medication will also be explained at that time.</p>	12/18/09

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W 124	<p>Continued From page 6</p> <p>During the entrance conference on November 16, 2009 beginning at 9:45 a.m., the qualified mental retardation professional (QMRP) and Residential Manager (RM) indicated that the client had a court appointed legal guardian to assist Client #3 in making health care decisions.</p> <p>Review of Client #3's Psychological Assessment dated August 4, 2009, on November 17, 2009 at 9:46 a.m., revealed that the client was not competent to make decisions regarding his health, safety, financial or residential placement. Further review of Client #3's record failed to provide evidence that written informed consent had been obtained for the use of the sedative medication.</p> <p>At the time of the survey, the facility failed to provide evidence that the potential risks involved in using this medication, or his right to refuse treatment had been explained to the client and/or family member representative.</p> <p>2. The facility failed to ensure that informed consent was obtained from Client #3 and/or her court appointed legal guardian prior to the administration of her psychotropic medications.</p> <p>a. Medication administration observation on November 16, 2009, at 6:00 p.m., revealed that Client #3 received Risperdal 3 mg and Topamax 50 mg. Interview with the licensed practical nurse (LPN) after the medication administration indicated that the client received the aforementioned medication for her maladaptive behaviors.</p> <p>During the entrance conference on November 16,</p>	W 124	<p>2. The facility will obtain an informed consent from the court appointed legal guardian prior to the administration of her psychotropic medications. All potential risks involved in using the medication will also be explained.</p>	12/18/09
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W 124	<p>Continued From page 7</p> <p>2009, beginning at 9:45 a.m., an interview conducted with the QMRP and HM revealed the Client #3 did not have the capacity to give informed consent for the use of medications and habilitation services. Further interview revealed the client had a court appointed legal guardian to assist her in decision making.</p> <p>Review of Client #3's record on November 17, 2009, at 9:46 a.m., revealed a psychological assessment dated August 4, 2009 that verified the QMRP and HM's statement. According to the assessment, Client #3 "is not able to make independent decisions concerning her residential or day placements. She lacked the cognitive skills necessary to understand the implications of such decisions and therefore cannot give her informed consent. She lacks the judgment and insight required to make decisions independently."</p> <p>Review of the Client #3's medical record and additional interview with the QMRP on November 17, 2009, at 9:45 a.m., failed to provide evidence that the client treatment needs, including the benefits and potential side effects associated with her medications, and the right to refuse treatment, had been explained to her and/or her court appointed legal guardian.</p> <p>3. Similarly, there was no evidence that the facility informed Client #2 and her court appointed guardian of the potential risks and benefits associated with new psychotropic medications (or significant increases in dosage) and obtained written consent prior to administering the medications, as follows:</p> <p>Observation of the evening medication pass on</p>	W 124	<p>3. In the future, the facility will obtain an informed consent from the court appointed legal guardian prior to administration of her psychotropic medications. All potential risks involved in using the medication will be explained.</p>	12/18/09
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W 124	<p>Continued From page 8</p> <p>November 16, 2009 revealed that Client #2 received Depakote 1000 mg, Thorazine 400 mg, Trazodone 100 mg and Abilify 30 mg. During the entrance conference, the QMRP and HM had indicated that Client #2 did not have the capacity to give informed consent for the use of medications and habilitation services. The client had a court appointed guardian to assist her in making healthcare decisions. The client's medical records were reviewed on November 18, 2009 beginning at 11:38 a.m.</p> <p>Her physician's orders (POs) indicated that Trazodone 50 mg was first ordered on August 3, 2009, with the first dose documented on her Medication Administration Record (MAR) as administered the next evening (August 4, 2009). The Trazodone was then doubled to 100 mg daily, effective October 16, 2009.</p> <p>Client #2's POs and MARs also reflected an increase in her Depakote from 1000 mg daily to 1500 daily, effective October 17, 2009; and, an increase in Thorazine from 400 mg daily to 500 mg daily, effective October 17, 2009.</p> <p>On November 18, 2009 at 2:53 p.m., the most recent consent form in Client #2's medical record had been signed by her medical guardian on May 29, 2009. This was the date her interdisciplinary team met to review and update her annual plan. The consent was for Abilify 30 mg, Thorazine 400 mg daily (100 mg in the a.m. and 300 mg in the p.m.) and Depakote 1000 mg daily. There was no documented evidence that the facility had approached the medical guardian to discuss the proposed (and now implemented) use of Trazodone and increases in Thorazine and Depakote. A telephone call was placed to the client's court-appointed guardian on November 18, 2009 at 2:09 p.m. She did not, however</p>	W 124		
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W 124	Continued From page 9 return the message before the survey ended the following day at 2:52 p.m.	W 124		
W 129	<p>It should be noted that on November 17, 2009 beginning at 2:28 p.m., review of the facility's Human Rights Committee minutes revealed that on September 5, 2008, the committee approved a recommended decrease in Client #2's daily Thorazine after the client complained of drowsiness/sedation.</p> <p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must provide each client with the opportunity for personal privacy.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure client privacy while sleeping in her bedroom, for one of the six clients residing in the facility. (Client #3)</p> <p>The finding includes:</p> <p>On November 2, 2009, the State Agency (SA) received a written notification by the facility's Incident Management Coordinator (IMC) of an allegation of sexual advance made by another client. According to the incident report received, Client #4 was observed by one of the overnight staff (Staff #1) standing over the bed of Client #3. The report indicated that Client #3 was in her bed with the bed covers pulled down to her ankles. Client #4 was observed sticking her fingers between Client #3's legs, attempting to stick her fingers into her vagina. The report</p>	W 129		

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W 129	Continued From page 10 further describes that staff used maximum verbal prompting to redirect Client #4 back into her bedroom. Approximately five minutes later, Staff #1 observed Client #4 back in Client #3's bedroom attempting to stick her fingers between her legs, again. Reportedly, staff #1 used maximum verbal prompting for the second time to redirect Client #4 back into her bedroom. On November 6, 2009 at approximately 10:15 p.m. interview with the qualified mental retardation professional (QMRP) and the review of the incident management log revealed that Client #4 was involved with a another sexual advance incident on August 18, 2009. Further review of the log revealed that Clients #3 and #4 previously shared a bedroom. According to the incident report, Client #3 was yelling out in their bedroom during the second shift. The staff went into the bedroom to check on the clients and discovered Client #4 in the bed with Client #3 with her finger inserted in her rectum. Reportedly, staff intervened and instructed Client #4 to return to her bed. Because of this incident, Client #3 was moved into another bedroom for her protection. The facility's intervention however was not effective to protect Client #3 from further infringement on rights to privacy. On September 11, 2009, Client #4 had a sexuality assessment conducted by an outside consultant (2 months ago). According to the QMRP and the house manager, the consultant had not forwarded the findings of the assessment, and therefore, a behavior support plan (BSP) addressing the client's inappropriate sexual advances had not completed.	W 129	1. The QMRP will obtain the findings of the sexuality assessment, and consult with the psychologist about addressing Client #4's inappropriate sexual advances in her Behavior Support Plan. However Client #4 will receive 24 hour one/ one staffing until she is discharged from the facility.	12/24/09	
W 137	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS	W 137			

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W 137	<p>Continued From page 11</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure clients had the right to access their personal clothing, for one of the three clients in the sample. (Client #2)</p> <p>The finding includes:</p> <p>An environmental inspection was conducted on November 19, 2009 beginning at 11:10 a.m. During the inspection there were no clothes observed in Client #2's bedroom closet. Interview with the house manager (HM), during the inspection, indicated that the client's clothes were stored in the basement and the client was given an outfit each evening to wear the following day. The HM further indicated that the client "will throw her clothes in the trash can."</p>	W 137	<p>The QMRP will have a case conference with the IDT team to discuss Client #2's behavior of discarding shoes and clothing items. The QMRP will request this behavior to be addressed in her Behavior Support Plan. Until then, the facility requested support from the Human Rights to limit Client #2's access to her shoes. The Human Rights Committee met on Dec. 7th and the team approved Client #2 limited access to her shoes and clothes.</p>	12/24/09
W 149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that staff consistently implemented policies developed to protect client safety, for two of the six clients residing in the facility. (Clients #3 and #4)</p>	W 149		

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W 149	<p>Continued From page 12</p> <p>The findings include:</p> <p>1. On November 6, 2009 beginning at 9:45 a.m., review of the facility's records, including administrative, incident and clinical records, coupled with an interview with the qualified mental retardation professional (QMRP) revealed that Client #4 had a history of leaving the facility without staff escort. For example, there were seven (7) documented incidents of her leaving the facility between July 14, 2009-September 30, 2009. Several incidents indicated that staff did not know her whereabouts and, with the assistance of the Metropolitan Police Department (MPD), she was located elsewhere in the community and brought home. The client's records indicated that her cognitive skills were assessed in the moderate range of mental retardation, her adaptive skills were in the severe range and she required 24-hour supervision.</p> <p>Beginning at approximately 11:00 a.m., additional interview with the QMRP followed by a review of the supports and intervention strategies being implemented failed to show evidence that the facility provided effective staff supervision to ensure Client #4's safety, as follows:</p> <p>On July 14, 2009 at 8:30 p.m., Client #4 left the facility without staff escort. Staff followed her, however, and brought her back into the facility. Her behavior escalated shortly thereafter and the police were contacted.</p> <p>On July 29, 2009 at 4:35 p.m., Client #4 ran out of the facility and into the street.</p> <p>On September 22, 2009 at approximately 7:15</p>	W 149	<p>1. Client #4 will be moved to a new residential placement. Until she moved, one to one staff support will be in place during waking hours to ensure her safety.</p>	12/24/09
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W 149	<p>Continued From page 13</p> <p>p.m., Client #4 left the group home without staff and could not be located. The police were contacted. The client was located at a local restaurant and was escorted back to the facility at approximately 7:38 p.m.</p> <p>On September 24, 2009 at 5:45 p.m., Client #4 attempted to leave the group home without staff escort. Staff intervened before she actually left. However, according to the incident report, the client succeeded at leaving the facility alone 15 minutes later. The police were again contacted after staff could not locate her. At approximately 6:35 p.m., the police located the client and escorted her back to the facility.</p> <p>On September 30, 2009, Client #4 left the group home without staff escort on three separate occasions (2:05 p.m., 3:15 p.m., and 3:45 p.m.).</p> <p>According to the QMRP of November 19, 2009, Client #4 received one to one staff support from 8:00 a.m. - 4:00 p.m., for assistance while at the day program. In addition, according to the Plan of Correction received by the State Agency on October 8, 2009, the psychologist was to provide staff training regarding Client #4's behavior support plan (BSP) by October 23, 2009. On November 18, 2009, review of the facility's in-service training records revealed that training by the psychologist had been documented on August 28, 2009. The training, however, was ineffective in that staff failed to supervise Client #4 at all times on the dates identified on the incident reports.</p> <p>It should be noted that the facility's program director indicated in a letter to the Department of Disability Services on July 30, 2009, that the</p>	W 149			

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W 149	<p>Continued From page 14</p> <p>client's safety was at risk due to her attempts to leave the home without staff supervision. The program director requested that the client be discharged from the home and that funding be established to provide one to one staffing in the interim. The funding, however, had not been approved, to date.</p> <p>2. Review of the facility's records, including administrative and clinical records, and interviews with the QMRP on November 6, 2009, failed to show evidence that the facility had established a policy and an effective system to ensure that Client #3 was protected from sexual abuse, as evidenced by the following:</p> <p>According to an incident report, Client #4 was observed by a direct care staff standing over Client #3's bed on November 2, 2009 at approximately 12:03 a.m. Staff had documented that they found Client #3 lying on her stomach with the bed blankets pulled down to her ankles. Staff reported that Client #4 had her hand between Client #3's legs, attempting to insert her fingers into her vagina. The report further described that staff used maximum verbal prompting to redirect Client #4 back to her own bedroom. Approximately five minutes later, however, the staff observed Client #4 back in Client #3's bedroom, attempting to stick her fingers between her legs again. Staff #1 verbally redirected Client #4 back into her bedroom.</p> <p>On November 6, 2009 at approximately 10:15 a.m., interview with the QMRP and review of the incident management log revealed that Client #4 had made previous sexual advances towards Client #3. According to an August 18, 2009 incident report, Client #3 was heard yelling in her</p>	W 149	<p>2. Client #3's one to one protocol was updated and signed by all staff who work with Client #3. Staff will receive additional training on Client #3's one to one protocol. The facility has instructed an overnight staff to position themselves in the hallway to monitor Client's night time activities and ensure the safety of all individuals in the facility.</p>	12/24/09	

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W 149	<p>Continued From page 15</p> <p>bedroom. Staff went into the bedroom to check on her and discovered Client #4 lying next to Client #3 in Client #3's bed, with a finger inserted in Client #3's rectum. Reportedly, staff intervened and instructed Client #4 to return to her bed. Following this incident, Client #3 had been moved into another bedroom for her protection. This action, however, had not been sufficient to prevent Client #4 from touching Client #3's private areas, as documented on the November 2, 2009 incident report.</p> <p>On September 11, 2009, Client #4 had a sexuality assessment conducted by an outside consultant. According to the QMRP and the house manager, the consultant had not forwarded the findings of the assessment; and therefore, a behavior support plan addressing the client's inappropriate sexual advances had not been completed.</p> <p>Interview with the House Manager and QMRP on November 17, 2009 at 10:25 a.m. and review of an administrative memo posted on the refrigerator door revealed that the facility instructed staff on the overnight shift to position one staff near the bedrooms upstairs to monitor clients' nighttime activities.</p>	W 149			
W 153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS</p> <p>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.</p> <p>This STANDARD is not met as evidenced by:</p>	W 153			

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W 153	<p>Continued From page 16</p> <p>Based on interview and record review, the facility failed to ensure that injuries of unknown origin and incidents of neglect were consistently reported to the administrator and to other officials in accordance with District law (22 DCMR, Chapter 35, Section 3519.10), for three of the six clients residing in the facility. (Clients #3, #4 and #6)</p> <p>The findings include:</p> <p>1. On November 18, 2009 at approximately 10:30 a.m., review of a nursing note dated November 1, 2009 revealed that Client #3's upper left eyelid was moderately swollen. Interview with the registered nurse (RN) on November 18, 2009 at approximately 10:45 a.m. indicated that she instructed staff to apply cool/warm compresses on the eyelid. She also notified her supervisor. Further interview revealed that she did not know what happened to the client's eyelid. There was no evidence the facility reported the injury of unknown origin immediately to the administrator and to the Department of Health.</p> <p>2. On November 16, 2009 at approximately 4:00 p.m., Client #6 informed a direct care staff that she had been hit on her buttock by a "boy" at her day program. The client then stated that it "hurts." At 6:10 p.m., the client told a licensed practical nurse (LPN) that her right buttock hurt. The LPN attempted to assess the area, however, the client refused. A moment later, the house manager/trained medication employee (HM/TME) assessed the client's buttock and stated that no bruising or visible injury was noted. The LPN then administered Tylenol for pain. On November 18, 2009, follow-up interview with the HM/TME revealed that the injury of unknown origin had not</p>	W 153	<p>1. In the future, all incidents of unknown origin will be reported to the Department of Health within 24 hours or the next business day.</p> <p>2. In the future, all incidents of unknown origin will be reported to the Department of Health within 24 hours or the next business day. QMRP and Residential Manager will review incidents to ensure completion.</p>	12/18/09	12/18/09

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W 153	<p>Continued From page 17 been reported to the administrator as required.</p> <p>3. Cross-refer to W149.1. According to incident reports, and confirmed through interviews with the QMRP, Client #4 ran out of the facility and into the street on July 29, 2009. On September 22, 2009, Client #4 left the group home without staff escort at approximately 7:15 p.m. and could not be located. Law enforcement (Metropolitan Police Department - MPD) was contacted. The client was located at a local restaurant and was escorted back to the facility at approximately 7:38 p.m. Then on September 24, 2009, Client #4 attempted to leave the group home without staff escort at 5:45 p.m. Staff intervened; however, the client succeeded at leaving the facility without staff 15 minutes later. Law enforcement (MPD) was again contacted and they escorted her back to the facility at approximately 6:35 p.m. Six days later, on September 30, 2009, Client #4 left the group home without staff escort on three separate occasions (2:05 p.m., 3:15 p.m., and 3:45 p.m.). The SA only received notifications of the incidents that occurred on July 29, 2009 and September 30, 2009.</p> <p>There was no evidence that the SA was notified of the incidents on September 22 and 24, 2009.</p>	W 153	<p>3. In the future, all incidents will be reported to the Department of Health within 24 hours or the next business day. Fax confirmation sheets to DOH will be attached to the investigation report.</p>	12/18/09
W 154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to thoroughly investigate all incidents, for two of the six clients residing in the facility. (Clients #3 and #4)</p>	W 154		

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W 154	<p>Continued From page 18</p> <p>The finding includes:</p> <p>Review of the facility's unusual incident reports (UIR) and investigative reports on November 16, 2009, beginning at 10:00 a.m., revealed a UIR dated November 2, 2009 at 12:03 a.m., involving Clients #3 and #4. The UIR indicated that a direct care staff person passed by Client #3's bedroom and observed Client #4 sticking her finger between Client #3's legs, attempting to stick her finger into Client #3's vagina. The direct care staff used maximum verbal prompting to redirect Client #4. Approximately five minutes later, staff observed Client #4 back in Client #3's bedroom, making another attempt to stick her finger between Client #4's leg and into her vagina.</p> <p>On November 16, 2009 beginning at 3:11 p.m., interview with the qualified mental retardation (QMRP) and house manager (HM) revealed that the HM conducted the investigation into the November 2, 2009 incident. The HM indicated that she had interviewed staff who were on duty at the time of the incident. Her report, however, did not reflect any staff interviews, therefore, this could not be verified. The HM acknowledged that the report did not document staff interviews. She also confirmed that she had not interviewed Client #4 (who was verbal).</p>	W 154	<p>In the future, the QMRP/ House Manager will complete a thorough internal investigation within five days of the incident.</p>	12/18/09
W 192	<p>483.430(e)(2) STAFF TRAINING PROGRAM</p> <p>For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record</p>	W 192		

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W 192	<p>Continuad From page 19</p> <p>review, the facility failed to ensure that all staff were trained and competent to provide assistance in accordance with the health care needs, for two of the three clients in the sample. (Clients #1 and #2)</p> <p>The findings include:</p> <p>1. Cross-refer to W436. On November 16, 2009, staff at Client #1's day program indicated that they had not received training regarding the client's denture care needs. They had observed the client removing her dentures prior to eating and/or drinking and re-inserting them afterwards without applying denture adhesive. They further indicated that they had never seen the client bring adhesive with her to the day program. This was confirmed through interview with the House Manager later that day in the home.</p> <p>2. Cross-refer to W460. Interviews with direct support staff, including those staff who purchased groceries for all clients in the facility, revealed that they had not received training on Client #2's diabetic diet, and the other clients' specialized diets. Five of the six clients were prescribed specialized diets. Review of staff in-service training records on November 18, 2009 beginning at 1:00 p.m. revealed to documented evidence that staff had received nutrition training. Observations and interviews throughout the survey revealed that Client #2 did not receive necessary dietary supports and services to address her diabetic needs.</p>	W 192	<p>1. The QMRP will consult with the day program concerning Client #1's dental care needs when Client #1 receives her new dentures.</p> <p>2. Cross reference W460.5</p>	1/24/10 12/18/09
W 214	<p>483.440(c)(3)(III) INDIVIDUAL PROGRAM PLAN</p> <p>The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs.</p>	W 214		

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W 214	<p>Continued From page 20</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure each client had a comprehensive assessment that depicted her behavior management needs, for two of the six clients residing in the facility. (Clients #2 and #4)</p> <p>The findings include:</p> <p>1. The facility failed to assess Client #2's money-begging behavior, as follows:</p> <p>On November 16, 2009, Client #2 returned home from her day program at 3:27 p.m. Upon entering the facility, she immediately approached this surveyor in the living room and requested \$3. Although she was directed to go locate staff, she remained standing in place. A moment later, Client #5 walked near Client #2. Client #2 asked her for money. Client #5 agreed to give her \$1, reached into her purse and gave her a \$1 bill.</p> <p>Similarly, on November 17, 2009, Client #2 returned home from her day program at 3:10 p.m. Within a minute or two, she approached another visitor and asked him for money. At 3:18 p.m., interview with a direct support staff person revealed that Client #2 asked strangers for money "all of the time ... anyone she sees out in stores ... community ...even if she already has money..." The staff person responded "yes" when asked if it was one of the client's targeted maladaptive behaviors. When asked what the psychologist recommended, the staff person stated she did not know because she did not "go to those appointments." On November 18, 2009 at 11:20 a.m., the house manager stated that Client #2</p>	W 214	<p>The QMRP will consult with the psychologist about addressing money begging behaviors in her BSP. In the future, behavior management needs will be reviewed by the psychologist and QMRP quarterly.</p>	1/18/10
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W 214	<p>Continued From page 21</p> <p>frequently asked people to give her money. She too indicated that it was a targeted behavior.</p> <p>However, on November 19, 2009 beginning at approximately 9:50 a.m., review of Client #2's behavior support plan (BSP) dated April 16, 2009 revealed that it did not address begging for money, and her Annual Psychological Evaluation dated May 22, 2009 showed no evidence that the behavior had been assessed.</p> <p>2. There was no evidence that Client #2's behavior of exposing herself to men had been assessed by the psychologist, as follows:</p> <p>On November 16, 2009, Client #2 returned home from her day program at 3:27 p.m. and immediately approached this surveyor in the living room. After seeking money from a few people, she turned to this surveyor and pulled her loose-fitting blouse down so that both breasts were fully exposed. The action appeared to be deliberate.</p> <p>When interviewed on November 18, 2009 beginning at 11:20 a.m., the house manager stated that Client #2 was not known to expose her breasts to men. A few minutes further into the interview, however, the house manager revealed that the client previously had exposed herself to the (male) evening medication nurse. This reportedly had occurred several times. The client had even started taking her showers at a time that coincided with the nurse's arrival to the facility for evening medication pass. According to the house manager, staff were now telling Client #2 that she should shower at other times of the day. The house manager acknowledged that staff were mostly female and there were not many</p>	W 214	<p>2. The QMRP will consult with the psychologist concerning Client #2's behavior of exposing herself to men. At that time, interventions will be determined.</p>	1/18/10

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W 214	<p>Continued From page 22</p> <p>occasions when men were in the facility. Further interview and review of her Annual Psychological Evaluation dated May 22, 2009 revealed no evidence that this behavior had been brought to the attention of the psychologist and/or interdisciplinary team to determine what, if any, interventions might be warranted.</p> <p>3. Cross-refer to W104. On November 6, 2009 at approximately 11:30 a.m., a review of Behavior Support Plan (BSP) dated May 27, 2009, revealed that one of Client #4's target behaviors was "Inappropriate touching (non-sexual touching of others)." Further review of the BSP failed to reveal that sexual advances on her peers had been reported as a target behavior. According to the staff, this sexual behavior was a new behavior which allegedly had been reported to the psychologist. Further review of the habilitation records, however, did not evidence that any documentation or any baseline data had been completed to determine the frequency of this new behavior.</p> <p>Note: The qualified mental retardation professional (QMRP) and the house manager indicated that Client #4 had received a sexuality assessment on September 11, 2009 (nearly 2 months ago). Further interview, however, revealed that the assessment report had not yet been forwarded to the psychologist and QMRP in order to establish appropriate intervention strategies.</p>	W 214	3. Cross reference W129	12/24/09
W 242	<p>483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training,</p>	W 242		

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W 242	<p>Continued From page 23</p> <p>personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure each client's individual program plan (IPP) included training in activities of dental hygiene and personal grooming/ hair care, for one of the three clients in the sample. (Client #3)</p> <p>The findings include:</p> <p>1. On November 16, 2009, at 8:00 a.m., Client #3 was observed with brown stains on her teeth. Interview with the registered nurse (RN) on November 16, 2009 at approximately 1:00 p.m. revealed that it was difficult to schedule a dental appointment for Client #3.</p> <p>Review of Client #3's medical record on November 16, 2009 at 3:10 p.m. revealed dental consultations dated September 20, 2008 and February 26, 2009. The dentist diagnosed the client with gingivitis, plaque on teeth and poor oral hygiene. The dentist recommended that the client "brush her teeth, twice a day and recall every two months for professional cleaning."</p> <p>Continued review of the client's records revealed a staff evaluation form for quarterly review dated May 7, 2009. Despite the dentist's findings of gingivitis, plaque on teeth and poor oral hygiene, the staff evaluation indicated that the client required minimal assistance in tooth brushing.</p>	W 242	<p>1. The QMRP will add a toothbrushing goal to Client #3's IPP to address poor oral hygiene.</p>	1/8/10

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W 242	<p>Continued From page 24</p> <p>Further review of the client's IPP dated August 7, 2009 revealed no evidence of a training program to address the client's poor oral hygiene.</p> <p>2. On November 16, 2009 at 7:30 a.m. Client #3 was observed screaming and pointing to a file cabinet in the dining room. The direct care staff asked the client "What do you need?" She continued to scream while pointing at the file cabinet. Seconds later, the client retrieved a comb and brush from the file cabinet. The direct care staff was then observed combing the client's hair.</p> <p>Review of Client #3's records on November 18, 2009 at approximately 2:00 p.m. revealed a staff evaluation form for quarterly review dated May 7, 2009. The evaluation indicated that the client required maximal assistance for hair care. Further review of the client's IPP dated August 7, 2009 revealed no evidence of a training program to address the client's assessed need with grooming/hair care.</p>	W 242	<p>2. Due to increased maladaptive behaviors requiring a one to one staff, the QMRP will consider adding on additional home goals to address grooming and hair care needs at the next quarterly review.</p>	1/24/10
W 249	<p>463.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, facility staff failed to consistently</p>	W 249		

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W 249	<p>Continued From page 25</p> <p>implement client behavior support plans at the needed frequency, for two of the three clients included in the sample. (Clients #2 and #3)</p> <p>The findings include:</p> <p>1. Client #2 was observed in her home on November 16, 2009 between 3:27 p.m. - 6:25 p.m. During the first part of the observation period, facility staff failed to implement proactive/preventive as well as intervention strategies as outlined in the client's behavior support plan (BSP), as follows:</p> <p>At 3:27 p.m., Client #2 entered the home with staff and peers. She immediately approached this surveyor in the living room and requested \$3. Although she was directed to seek staff, she remained standing in place. A moment later, Client #5 walked up to her location. Client #2 asked her for money. Client #5 agreed to give her \$1, reached into her purse and gave her a \$1 bill. There were no direct support staff nearby observing these interactions. Staff did not engage Client #2 during the first 15-minute period.</p> <p>At 3:42 p.m., Client #2 asked staff for a peanut butter and jelly sandwich. Staff first suggested a cheese sandwich as an alternative but then gave her a banana. At 3:55 p.m., she was offered a glass of water, which she drank while standing behind Client #3's chair. A brief, physical altercation between Client #3 and Client #2 transpired (after Client #3 hit #2). For the 10 minutes that followed, Client #2 stood at one corner of the dining room table, muttering in a low voice and staff did not interact with her.</p>	W 249	<p>1. The staff will receive adequate training by the psychologist on consistently implementing Client #2's behavior support plan.</p> <p>2. The staff will receive adequate training by the psychologist on implementing intervention strategies of Client #3's behavior support plan.</p>	1/15/10	1/15/10

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W 249	<p>Continued From page 26</p> <p>At approximately 4:06 p.m., staff tried to engage Client #2 in a puzzle or other activity; however, did not respond. The staff then asked "What do you like" to which she replied "nothing." For the next 28 minutes, Client #2 sat at the dining room table watching pears and staff, not engaged in any meaningful activity, and muttering incessantly in a low voice. At 4:36 p.m., she stuck her finger in her nose briefly but there was no staff intervention. At 4:41 p.m., Client #2 told a peer sitting near her to let go of her \$1 bill; the peer complied and staff said nothing. By then, staff had not engaged Client #2 for over a half-hour. At 4:43 p.m., Client #2 suddenly pounded her fist on the dining room table, loudly, which startled Clients #1, #3 and others at the table. Staff told Client #2 to "stop" but then said nothing more. The client remained seated at the table for another 40 minutes, until 5:26 p.m., muttering in a low voice and not engaged in a meaningful activity. The medication nurse arrived at approximately 5:26 p.m. and Client #2 followed him upstairs.</p> <p>On November 17, 2009 at 3:18 p.m., interview with a direct support staff person revealed that Client #2 asked strangers for money "all of the time ... anyone she sees out in stores ... community ...even if she already has money..."</p> <p>On November 18, 2009 at 11:20 a.m., the house manager stated that staff were instructed to "keep within earshot but not hover" over her. They should monitor her, keep her engaged to the extent that she allows and intervene when necessary to address behaviors. She further indicated that Client #2 frequently asked people to give her money.</p> <p>On November 19, 2009 beginning at</p>	W 249		

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W 249	<p>Continued From page 27</p> <p>approximately 9:50 a.m., review of Client #2's BSP dated April 16, 2009 revealed the following: "Prevention ... is the most important factor ... observe closely for signs of deteriorating behaviors and act promptly ... If staff notice <client's name> starting to get upset they should intervene before she has a full fledged episode. Early signs include pacing ... mumbling ... Staff should take control the moment they see <client's name> starting to lose control. There is no reason to wait for a full-blown problem behavior ... As <client's name> calms down, she should be told exactly what to do next. When she starts the requested behavior, staff should reward her" for following their request. "Intervention ... Tell her to STOP!... when <client's name> starts to do something inappropriate ... tell her specifically something to do." Observations on November 16, 2009, however, revealed that:</p> <p>a. Staff did not stay within earshot during the first 15 minutes after Client #2 and her peers returned from day program. Interviews indicated that staff were unaware that the client had asked this surveyor and Client #5 for money.</p> <p>b. Staff made only two attempts to engage Client #2 in a meaningful activity during the two-hour observation period (3:27 p.m. - 5:26 p.m.), even though she was observed pacing and mumbling throughout much of that time.</p> <p>c. When Client #2 pounded her fist on the table that afternoon, staff told her to "stop!" They did not, however, tell her specifically something to do, as indicated in her BSP.</p> <p>2. On November 18, 2009 at 3:45 p.m., Client #3 was observed having a snack. After the client</p>	W 249			

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W 249	<p>Continued From page 28</p> <p>completed her snack, she was observed hitting Client #2, three times. Staff immediately asked Client #3 to "STOP." The client started screaming and staff replied "just stand there and continue screaming." A moment later, the client walked into the kitchen, placed a cup in the trash can, then moved to the sink and started screaming and banging her spoon on the sink. Staff ignored the second outburst at the sink.</p> <p>interview with the direct care staff at 3:58 p.m. revealed that Client #3 had a behavior support plan (BSP) to address her behaviors of screaming and physical aggression. Subsequent review of Client #3's BSP dated August 4, 2009 confirmed the targeted behaviors of "screaming and physical aggression." Intervention strategies to address the screaming behavior were as follows:</p> <ul style="list-style-type: none"> - the client should be under the supervision of a dedicated 1:1 staff member at all times; - the client should be encouraged to engage in activities that calm her (i.e., taking a walk, listening to preferred music looking at magazines, etc.); and, - if behavior continues, staff should escort the client to an unoccupied area to calm her down. When <the client> has remained calm for at least five minutes, staff should give verbal praise paired with tactile praise for calming down. <p>Intervention strategies to address physical aggression were as follows:</p> <ul style="list-style-type: none"> - staff should calmly and firmly direct the client to "STOP <client>", the client should be given 	W 249		
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W 249	Continued From page 29 prompts at least two times with no more than a five second interval; - staff should also attempt to create a SAFE AREA; and - During the safe area, staff should try to determine the source of the client's anger and assist her in calming down by talking. After calming down, the client should be returned to her activities. There was no evidence that the staff implemented the intervention strategies as written. 3. During evening observations on November 16, 2009, from 4:10 p.m. until 4:57 p.m., Client #3 and her 1:1 support staff were participating in table top activities, with no peer interaction. Interview with direct care staff on November 17, 2009 at approximately 5:00 p.m., indicated that the client "only" likes to participate with her one to one support staff. Review of the client's Individual Program Plan (IPP) dated August 4, 2009 on November 18, 2009 at approximately 10:00 a.m., revealed an objective which stated, "[the client] will participate in structured activities for 15 minutes at home and will interact with at least one of peers without being disruptive, for one out of four trials, twice a week. There was no evidence that the 1:1 support staff encouraged or implemented peer interaction for Client #3.	W 249	3. The staff will receive adequate training on implementing and documenting active treatment goals.	1/15/10	
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.	W 252			

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W 252	<p>Continued From page 30</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that data was collected in the form and required frequency, for one of the three clients in the sample. (Client #3)</p> <p>The findings include:</p> <p>1. On November 16, 2009 at 3:45 p.m., Client #3 was observed having a snack. After the client completed her snack, Client #3 was observed hitting Client #2, three times. Staff asked Client #3 to "STOP", the client screamed and staff replied, "just stand there and continue screaming. The client was observed walking into the kitchen and placing a cup into the trash can. The client then moved to the sink and started screaming, and banging her spoon on the sink. Interview with the direct care staff, at 3:58 p.m., indicated that Client #3 has a behavior support plan (BSP) to address her behaviors of screaming and physical aggression.</p> <p>Record verification of Client #3's BSP dated August 4, 2009, on November 17, 2009, at approximately 12:30 p.m., revealed the plan that identified maladaptive behavior of screaming and physical aggression. According to the data collection instructions, staff were to record behaviors on the Antecedent Behavior Consequence (ABC) chart. Further review of the data chart on November 17, 2009 at approximately 12:45 p.m. revealed that Client #3 had no behaviors documented of physical aggression on November 16, 2009. There was no evidence that data had been collected in</p>	W 252	<p>1. The staff will receive adequate training on documenting maladaptive behaviors.</p>	1/15/10
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W 252	<p>Continued From page 31 accordance with the client's BSP.</p> <p>2. On November 16, 2009 at 5:50 p.m., Client #3 was observed going for a walk in the community. Interview with the house manager on November 16, 2009 at 7:10 p.m., confirmed that the client went on a community walk.</p> <p>Review of the Client #3's Individual Program Plan (IPP) dated August 7, 2009 on November 17, 2009, at 9:50 a.m., revealed an objective which stated, "[the client] will lose ten pounds this year." Further interview and record verification indicated the client will participate in an exercise program five times a week. The activities can consist of walking, dancing, or riding stationary bike, etc. Review of the data sheet on November 18, 2009, at 10:00 a.m., revealed that the client rode a bike for five minutes and refused participation. However, staff did not document that the client participated in a community walk for at least 45 minutes. Interview with the house manager at 11:00 a.m. confirmed that direct care staff did not document although the program was implemented</p> <p>There was no evidence that data had been collected in accordance with Client #3's IPP, which was necessary for a functional assessment of the client's progress.</p>	W 252	<p>Cross reference W249.3</p>	1/15/10
W 262	<p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE</p> <p>The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.</p>	W 262		

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W 262	<p>Continued From page 32</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the facility failed to ensure that restrictive measures had been approved by the Human Rights Committee (HRC), for two of three clients in the sample. (Clients #2 and #3)</p> <p>The findings include:</p> <p>1. Minutes taken at meetings of the facility's Human Rights Committee for the period September 8, 2008 - November 2009 were reviewed on November 17, 2009 beginning at 2:28 p.m. Review of Client #3's medical chart on November 17, 2009 beginning at 9:45 a.m., revealed an order for Ativan 2 mg one hour prior to an ENT appointment dated July 10, 2009.</p> <p>Interview and further record review on November 18, 2009 at approximately 3:00 p.m. revealed that Client #3 had received the sedation to address her non-compliance prior to an ENT medical appointment. There was no evidence, however, that the facility's HRC reviewed and/or approved this use of sedation for Client #3.</p> <p>2. The facility failed to ensure that clients' Behavior Support Plans (BSPs) were reviewed and approved by the HRC, as follows:</p> <p>On November 18, 2009 at 9:45 a.m., during the Entrance conference, the qualified mental retardation professional (QMRP) and house manager (HM) indicated that Clients #2 and #3 had BSPs and received psychotropic medications.</p> <p>a. This was verified later that day (November 16,</p>	W 262	<p>1. The Human Rights Committee will review and/ or approve the use of sedation prior to the medical appointment.</p> <p>2. The Human Rights Committee will review and/ or approve Behavior Support Plans including medications. Human Rights minutes will be placed in the book following the monthly meeting.</p>	12/18/09	12/18/09

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W 262	Continued From page 33 2009) at 6:00 p.m., when Client #3 was observed being administered Risperdal and Topamax. Interview with the licensed practical nurse (LPN) after the medication administration indicated that the client received the aforementioned medications for her maladaptive behaviors. However, review of the HRC minutes on November 18, 2009 at 11:33 a.m. revealed no evidence that the HRC had reviewed or approved Client #3's BSP, including the medications. b. Similarly, Client #2 received Depakote, Trazodone, Abilify and Thorazine during the evening medication pass. On November 19, 2009 at approximately 9:55 a.m., review of her BSP dated April 16, 2009 revealed that in addition to the psychotropic medications, her plan also incorporated the use of "touch control" and "manual restraint" if the client's behaviors were to escalate. Review of the HRC minutes had revealed no evidence, however, that the committee had reviewed and approved her BSP. Interview with the QMRP and HM on November 18, 2009 at approximately 10:20 a.m., indicated HRC meetings had been held monthly.	W 262			
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on interview and record review, the facility's specially-constituted committee failed to ensure that restrictive programs were used only	W 263			

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W 263	Continued From page 34 after written consents had been obtained, for two of the three clients in the sample. (Clients #2 and #3) The findings include: Minutes taken at meetings of the facility's Human Rights Committee for the period September 8, 2008 - November 2009 were reviewed on November 17, 2009 beginning at 2:28 p.m. Client #2's medical chart, including written consents, were reviewed on November 18, 2009 beginning at 11:38 a.m. Client #3's medical chart was reviewed on November 17, 2009 beginning at 9:45 a.m. 1. Cross-refer to W124.1. The facility failed to obtain consents prior to the use of sedation for Client #3's medical appointments and/or to notify her court appointed legal guardian of the risk and benefits of treatments. 2. Cross-refer to W124.2. The facility failed to ensure that informed consent was obtained prior to the administration of Client #3's psychotropic medications. 3. Cross-refer to W124.3. The facility failed to ensure that informed consent was obtained from Client #2's court appointed guardian prior to administering new psychotropic medications (Trazodone) or implementing significant increases in the daily dosage of Depakote and Thorazine.	W 263	1. Cross reference W124.1 2. Cross reference W124.2 3. Cross reference W124.3	12/18/09 12/18/09 12/18/09
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care.	W 322		

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W 322	<p>Continued From page 35</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure timely review and intervention by the medical team, for one of the two clients residing in the facility using CPAP machines to address sleep apnea and for one client involved in client to client abuse. (Client #2 and #3)</p> <p>The findings include:</p> <p>On November 18, 2009 at approximately 11:50 a.m., review of Client #2's physician's orders (POs) revealed a hand written order for "CPAP" on her August 2009 POs. Beginning April 2009, the diagnosis "Obstructive Sleep Apnea" was added to her POs. Her POs also indicated that she had been receiving Melatonin 3 mg every evening since May 15, 2008. Trazodone 50 mg was added to her evening medication regimen on August 4, 2009. The Trazodone was increased to 100 mg daily, effective October 16, 2009. Although the POs did not indicate why the Trazodone was prescribed, interview with the qualified mental retardation professional (QMRP) and house manager (HM) at approximately 3:30 p.m. revealed that its sedative effect was used to promote sleep.</p> <p>1. At approximately 3:35 p.m., review of her Health Management Care Plan (HMCP) dated May 29, 2009 revealed that direct support staff were to "encourage use of CPAP machine during hours of sleep." The client was to "gradually tolerate use of CPAP machine." The QMRP and HM explained that the client had been refusing to wear the CPAP mask and a behavior support plan (BSP) had been developed by a</p>	W 322		
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W 322	<p>Continued From page 36</p> <p>psychologist. Further review of the HMCP revealed that the RN and primary care physician (PCP) were to monitor the progress. There was no documented evidence, however, that nurses and/or the PCP had monitored the use of the CPAP and made appropriate recommendations.</p> <p>On November 19, 2009 at approximately 11:07 a.m., interview with the RN revealed that she had not observed staff implementing Client #2's BSP for gradually tolerating use of the CPAP mask. She explained that she worked during daytime hours only. She indicated that she had not received training on how to use the CPAP machine. She further stated that to date, she had not discussed the issue of the client rejecting the CPAP machine with the facility's Director of Nursing or the primary care physician (PCP).</p> <p>2. On November 19, 2009 beginning at approximately 9:50 a.m., Client's #2's BSP dated April 14, 2009 was reviewed. It addressed the client's refusals to wear the CPAP mask. At approximately 10:30 a.m., review of Client #2's behavior data sheets revealed marginal cooperation with the program in May and June 2009. Refusals to use the CPAP mask were documented beginning July 2, 2009, with continued refusals documented almost every night in August, September and October 2009. There was no behavior data sheet for the 4:00 p.m. - 12 midnight shift for November 2009. At 10:43 a.m., the HM examined the book and stated "No, I don't see it." She located a data sheet for the 12 midnight - 8:00 a.m. shift. She acknowledged, however, that staff had recorded data only on one of the first 19 days that month (November 1, 2009).</p>	W 322	<p>1. In the future, the physician and nurses notes will include the use of CPAP.</p> <p>The primary RN will receive training on CPAP.</p> <p>2. The staff will receive adequate training by the psychologist on documenting behavior data.</p>	<p>1/1/10</p> <p>1/8/10</p> <p>1/15/10</p>
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W 322	<p>Continued From page 37</p> <p>3. On November 19, 2009 at approximately 11:12 a.m., interview with the QMRP revealed that she had not observed the use of Client #2's CPAP machine since she was assigned to "fill-in" for the QMRP (who was away on leave at the time of the survey). She thought the permanent QMRP and/or psychologist would document their reviews in the client's record. Subsequent review, however, of QMRP monthly and quarterly summaries revealed no evidence that the QMRP had brought the issue of the client rejecting the CPAP machine to the attention of the facility's Director of Nursing or the primary care physician (PCP).</p> <p>4. Even though Client #2's record reflected that she had been refusing to cooperate with the use of the CPAP machine since early July 2009 (almost 5 months before the survey), review of the client's record revealed no evidence that the psychologist had monitored the client's CPAP-related BSP since its initiation in May 2009. On November 19, 2009 at 11:20 a.m., the QMRP and the RN acknowledged that there was no evidence that the psychologist had been monitoring the program and/or made recommendations if deemed necessary and appropriate.</p> <p>5. Client #2's medical record did not show evidence that the PCP had monitored the use of the CPAP machine since her annual medical evaluation on May 15, 2009. There was no evidence that the medical team sought information regarding alternative methods of treatment, to ensure timely response to her ongoing sleep apnea.</p> <p>It should be noted that in August 2009, the facility</p>	W 322	<p>3. The QMRP will ensure pertinent information is communicated to the primary care physician and Director of Nursing. Documentation will be reflected in the QMRP monthly notes and/ or quarterly review.</p> <p>4. A case conference will be held with the IDT including the psychologist to discuss recommendations and/ or interventions necessary as a result of Client #2 refusing to wear her CPAP machine.</p> <p>5. In the future, the PCP will review and monitor the use of Client #2's CPAP machine on a quarterly basis. Evidence of the review will be reflected in the PCP's quarterly notes.</p>	<p>12/18/09</p> <p>1/8/10</p> <p>1/1/10</p>
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W 371	<p>483.460(k)(4) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to implement an effective system to ensure each client participated in a self-medication program, for one the three clients in the sample. (Client#3)</p> <p>The finding includes:</p> <p>During the medication administration on November 16, 2009 at 6:00 p.m., the licensed practical nurse (LPN) was observed asking Client #3 to punch her medications from the bubble pack. The client refused and the LPN was observed preparing the client's medication and pouring a cup of water. Interview with the LPN during the medication administration indicated that Client #3 did not have a program goal/objective to participate in the self administration process.</p> <p>Review of Client #3's record on November 17, 2009 at approximately 10:00 a.m. revealed no evidence of a self-medication assessment. At 10:30 a.m., further review of Client #3's IPP dated August 7, 2009 revealed no program goal or objective for the client to receive training in self-medication skills.</p>	W 371	<p>Self medication administration assessment will be completed and reviewed annually by the RN. If the Client is a candidate for self medication, a program will be developed and implemented.</p>	1/10/10
W 381	<p>483.460(l)(1) DRUG STORAGE AND RECORDKEEPING</p>	W 381		

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W 381	<p>Continued From page 40</p> <p>The facility must store drugs under proper conditions of security.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to store drugs under proper condition of security, for one of the three clients in the sample. (Client #2)</p> <p>The finding includes:</p> <p>On November 16, 2009 at 2:50 p.m. a plastic bag of medication vials (five) was observed in the facility's refrigerator. The bag of medications contained two full vials of Lantus insulin and three full vials of Novolog 100 units/ml. At 2:58 p.m., the house manager (HM) was informed that the bag of medication was stored in the refrigerator unsecured. The HM acknowledged the unsecured vials of medication.</p> <p>At 5:27 p.m., the licensed practical nurse (LPN) arrived in the facility and shortly thereafter, opened the refrigerator and retrieved the plastic bag of insulin. When interviewed, the LPN acknowledged that all medications should be locked. After the LPN completed the medication administration at 6:20 p.m., he was observed to replace the medication bag back into the refrigerator, unsecured.</p> <p>On November 17, 2009 at 8:45 a.m., the bag of medication was stored in the butter compartment section of the refrigerator, still not secured. On November 18, 2009 at approximately 9:05 a.m., the RN was observed removing the bag of insulins from the refrigerator, placing the bag into</p>	W 381			

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W 381	Continued From page 41 a black lockbox and returning the box with medications to the refrigerator.	W 381	The facility obtained a lock box for Insulin.	11/21/09
W 393	<p>483.460(n)(1) LABORATORY SERVICES</p> <p>If a facility chooses to provide laboratory services, the laboratory must meet the requirements specified in part 493 of this chapter.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure it met the requirements for performing glucose monitoring testing, for one of three clients in the sample. (Client #2)</p> <p>The finding includes:</p> <p>On November 16, 2009 at 5:32 p.m., the evening medication nurse was observed performing a fingerstick glucose test on Client #2 using a glucometer. Interview with the nurse revealed that Client #2 had a diagnosis of Type II diabetes and was prescribed Lantus Insulin and Novolog (on a sliding scale) to treat her health condition.</p> <p>Interview the next day (November 17, 2009) with the RN, qualified mental retardation professional and house manager, followed by the review of records beginning at approximately 11:00 a.m. revealed that the provider did not have a certificate of waiver as required by part 493 of the Clinical Laboratory Improvement Act (CLIA) to perform laboratory services, such as glucose monitoring within the facility.</p>	W 393	<p>Application for CLIA certification will be submitted.</p>	1/1/10
W 436	483.470(g)(2) SPACE AND EQUIPMENT	W 436		

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W 436	<p>Continued From page 42</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to teach clients to use and make informed choices about the use of dentures, for the one (of three) sampled clients who had been prescribed dentures. (Client #1)</p> <p>The findings include:</p> <p>During the November 16, 2009 Entrance Conference, at approximately 9:45 a.m., the house manager (HM) and qualified mental retardation professional (QMRP) stated that Client #1 had prescribed dentures. The client, however, reportedly left her dentures in a restaurant while on vacation the first week of October 2009. During a visit to Client #1's day program, at 11:56 a.m., their program manager confirmed that the client used dentures. She thought, however, that the dentures had not fit properly, saying "I'm not sure if they're too big or too small." She explained that while Client #1 wore them upon arrival in the morning, she would remove them to drink water or eat. She further stated that the client would put her dentures back into her mouth without applying denture adhesive. She never saw the client bring adhesive with her to day program and did not know whether she had received training on correctly inserting the</p>	W 436	<ol style="list-style-type: none"> 1. A case conference was held on November 20, 2009, regarding Client #1's use of dentures. Client #1 will have her dentures replaced. The psychologist will develop a plan that would assist Client #1 with keeping up with her dentures. 2. The primary care nurse will consult with the dentist on how often Client #1 should apply Polygrip. 3. Cross reference W192 	<p>2/1/10</p> <p>1/15/10</p> <p>2/1/10</p>
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W 436	<p>Continued From page 43 dentures.</p> <p>At 5:10 p.m. later that day, Client #1 asked this surveyor if he would attend her meeting Friday. The HM, who was present at the time, explained that there was a case conference scheduled to discuss her dentures. It was not clear whether she would receive new dentures. At 5:12 p.m., the client told the HM that she wanted her dentures replaced. Further interview with the HM revealed that she was unsure whether the client's denture-maintenance skills had been assessed. Since she became HM in June 2009, she had only seen staff applying the adhesive (Polygrip). She too had seen the client remove her dentures at meals. She did not know whether there was any adhesive left on the dentures when the client put them back in afterwards. She thought perhaps the client licked the adhesive off the dentures. She also confirmed that the client did not take Polygrip with her to day program.</p> <p>Client #1's interdisciplinary team had met on September 21, 2009 for her annual Individual Support Plan (ISP) meeting. On November 17, 2009 at 10:33 a.m., review of the ISP revealed that she had seen her dentist a year earlier, on November 26, 2008 and there was "no issue - continue to use Polygrip." For personal hygiene, the ISP indicated that staff were responsible for providing "reminders for thorough dental care." Further review of her records, however, failed to show evidence that her denture-maintenance skills had been fully assessed. Her plan did not reflect any past or current denture-related goals or objectives.</p> <p>On November 17, 2009 at 4:16 p.m., review of Client #1's dental records revealed that she had</p>	W 436	<p>4. Client #1 and staff will receive adequate training on dental care needs including how to apply Polygrip before meals.</p>	1/15/10

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W 436	<p>Continued From page 44</p> <p>been to the dentist on October 22, 2008 for an "annual" evaluation. The dentist wrote the following: "Pt should wear adhesive (Polygrip) to secure dentures. This will assist her eating with the dentures. Apply 30 minutes before meals. Remove dentures and clean at night." Client #1 returned to the dentist approximately 1 month later. On November 26, 2008, the dentist wrote "Pt should put Polygrip to lower denture before meals to eat comfortably and to secure the dentures. No other problems were found."</p> <p>The Registered Nurse, QMRP and HM were interviewed a few minutes later. The RN, who had worked in the facility since May 2009, stated that she had not assessed Client #1's denture-care skills nor had she observed the client apply adhesive or install the dentures into her mouth. The HM shared with the others what she had stated the previous evening: that she had seen staff apply the adhesive but not the client, and that she suspected that the client might lick the Polygrip off her gums and/or dentures. The HM thought the facility had been cited previously and had subsequently developed a denture-related training program. She and the QMRP agreed to seek relevant progress notes, assessments, training data or any other documentation. No additional information was presented before the survey ended two days later.</p> <p>In summary, there was no evidence that the facility assessed Client #1's denture-care skills and developed appropriate training. In addition, there was no evidence that the facility's QMRP monitored and coordinated her denture needs with the day program to ensure that she received necessary and appropriate support and/or</p>	W 436		
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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
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W 436	Continued From page 45 training.	W 436		
W 455	<p>483.470(l)(1) INFECTION CONTROL</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement infectious control procedures to prevent communicable infectious diseases, for six of the six clients residing in the facility. (Clients #2, #3, #4, and #6)</p> <p>The findings include:</p> <p>On November 18, 2009, at 7:40 a.m., direct care staff was observed combing and brushing Client #4's hair. At 7:42 p.m., direct care staff was observed coming and brushing Client #2, #3 and #6's hair. All the while, the direct care staff used the same comb and brush on all four of the clients. Interview with the Qualified Mental Retardation Professional (QMRP) and House manager on November 16, 2009, at approximately 10:30 a.m., indicated that the clients have individual combs and brushes. During the environmental inspection on November 19, 2009, at 11:10 a.m., a comb and brushes was observed in each clients bedrooms.</p>	W 455	<p>All individuals will receive their own comb and brush. Staff will receive adequate training on implementing infectious control procedures to prevent communicable infectious diseases.</p>	12/24/09
W 460	<p>483.480(a)(1) FOOD AND NUTRITION SERVICES</p> <p>Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p>	W 460		

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

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FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
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NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4314 9TH STREET NW WASHINGTON, DC 20011
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W 460	<p>Continued From page 46</p> <p>This STANDARD is not met as evidenced by: Based on observation and record review, the facility failed to ensure that clients received foods that were consistent with their prescribed diabetic diet, for the one client with diabetes out of a total resident population of six. (Client #2)</p> <p>The findings include:</p> <p>On November 16, 2009 at approximately 5:48 p.m., Client #2 sat down at the dining room table. The client, who had insulin-dependent diabetes, had just come downstairs from having her blood sugar checked and receiving insulin. A direct support staff person brought family-style serving plates of foods to the table, including broiled fish, green beans and pasta noodles.</p> <p>1. After assisting Client #2 with the fish and green beans, the staff person handed her a 1/2-cup measuring cup and walked back to the kitchen. Using the measuring cup, the client (now seated alone) placed four 1/2-cup servings of pasta noodles onto her plate. At 5:53 p.m., the staff person returned to the table and saw the pile of noodles on the plate. The staff told the client "you're not supposed to have so much" and began removing noodles from the plate. The client immediately protested and the staff person stopped the process after removing approximately 1/2 cup of noodles. Approximately 1 1/2 cup of noodles remained on the plate, which was 3 times the quantity (1/2 cup) prescribed on the menu. She ate everything on her plate within the next seven minutes.</p> <p>2. At the same dinner, staff brought Client #2 a bottle of regular ketchup from the refrigerator. The client squeezed a generous portion of</p>	W 460	<ol style="list-style-type: none"> 1. Cross reference W460.5 2. Cross reference W460.5 3. Cross reference W460.5 	<p>12/18/09</p> <p>12/18/09</p> <p>12/18/09</p>

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

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W 460	<p>Continued From page 47</p> <p>ketchup onto her fish. Subsequent review of the label on the ketchup bottle revealed that it was sweetened with 4 grams sugar per Tablespoon, and provided 15 calories per Tablespoon.</p> <p>3. The next day, November 17, 2009, Client #2 returned from day program with her peers at 3:10 p.m. Within a few minutes, she asked staff for a peanut butter and jelly sandwich. At 3:28 p.m., Client #2 made her own peanut butter and jelly sandwich, using approximately 3 Tablespoons of Concord Grape Jam. Subsequent review of the label revealed that the jam was made with regular sugar, and provided 50 calories per Tablespoon.</p> <p>4. On November 18, 2009, review of Client #2's physician's orders revealed the diet order: 1800 calorie ADA, low fat, low cholesterol, low sodium diet. As such, staff were to discourage concentrated sweets, use artificial sweeteners and sugar-free, unsweetened food items. Earlier that day, beginning at approximately 10:25 a.m., interview with two direct support staff (one of whom did the grocery shopping for the house), revealed that they sought food items that were low fat, but not sugar-free or reduced sugar. When asked about diabetes, the staff affirmed that they were both aware that Client #2 had diabetes. However, as the interview progressed, they kept returning to the issue of "low fat." When asked if they purchase reduced sugar foods such as condiments and jams, they replied "no," adding that they did not see such items offered in the grocery store where they did the shopping. At 10:40 a.m., one of the two staff said she thought it would be difficult to offer meals that were suited to the specialized needs of 5 or 6 different prescribed diets.</p>	W 460	4. Cross reference W460.5	12/18/09
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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W 460	<p>Continued From page 48</p> <p>5. Further interview with the two staff on the morning of November 18, 2009 revealed that neither staff had received dietary training from the facility's nutrition consultant. At 1:00 p.m., review of staff in-service training records confirmed that there had been no documented nutrition training, to include speciality diets such as diabetic diets, menu planning, food substitutions and portion control.</p> <p>6. On November 19, 2009, observation of the facility's refrigerator confirmed what staff had stated on the day before, that they did not purchase foods indicated for a diabetic diet. They had just shopped for groceries on the previous day; however, there were no sugar-free or reduced sugar condiments, jams or other food items observed in the refrigerator.</p> <p>It should be noted that Client #2 received finger sticks twice daily, to monitor her blood sugar. According to her orders, she received a Lantus insulin injection every morning, regardless of the blood sugar reading. In addition to the Lantus, she was to receive an injection of Novolog insulin if her blood sugar levels warranted it in the morning or evening. If her blood sugar reading was below 150, she would not need a Novolog injection. If it were above 150, then she received an injection of Novolog on a "sliding scale;" the amount administered was dependent on the actual blood sugar reading. On November 18, 2009 at approximately 11:55 a.m., review of the client's Medication Administration Records for September, October and November 2009 revealed frequent Novolog injections were documented.</p> <p>There was no evidence that the facility provided</p>	W 460	<p>5. The staff will receive adequate training by the nutritionist on diabetic diets, menu planning, food substitutions and portion control. Staff will continue to receive follow-up dietary training on a quarterly basis. Sugar-free items will be purchased for Client #2.</p> <p>6. Cross reference W460.5</p>	<p>12/18/09</p> <p>12/18/09</p>

**DEPARTMENT OF HEALTH AND HUMAN SERVICES
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W 460	Continued From page 49 dietary supports and services to adequately address Client #2's diabetic needs, and minimize the frequency of administering multiple injections of Insulin.	W 460		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
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1 000	<p>INITIAL COMMENTS</p> <p>On November 2, 2009, the State Agency (SA) received written notification by the facility's Incident Management Coordinator (IMC) of an allegation of resident-to-resident abuse (sexual advances). An on-site investigation was initiated on November 6, 2009. The findings of the investigation were based on interviews with the qualified mental retardation professional (QMRP), facility's direct and management staff, review of the resident's habilitation, medical, and administrative records, and the review of the facility's incident management system.</p> <p>The investigation revealed that in addition to making inappropriate sexual advances towards her peer, the resident in question repeatedly left the facility without proper staff escort for safety. It was determined that the facility failed to adequately protect her safety during the period July 30, 2009 - September 30, 2009.</p> <p>Findings of the investigation led to the annual licensure survey which began on November 16, 2009. The resident who had been touched inappropriately by a peer was included in the recertification sample. Two other residents were selected at random. The investigative findings concerning the fourth resident were included in this report, as a focused review of her behavior support needs and staff supervision/safety needs.</p>	1 000	Cross reference W129	12/24/09
1 090	<p>3504.1 HOUSEKEEPING</p> <p>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.</p>	1 090		

Health Regulation Administration

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

DATE FORM

6899

7ZC111

TITLE

(X6) DATE

Program Director 12/23/09

If continuation sheet 1 of 37

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
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1206	Continued From page 3 This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that each employee, prior to employment and annually thereafter, provided evidence of a physician's certification that documented a health inventory had been performed and that the employee's health status would allow him or her to perform the required duties, for five of the eleven staff, two of the six nurses, and one of the ten consultants. The finding includes: Interview with the qualified mental retardation professional (QMRP) and review of the personnel records on November 16, 2009, beginning at 12:06 p.m., revealed the GHMRP failed to provide evidence that current health certificates were on file for five of the eleven staff (Staff #1, #2, #3, #5 and #7); two of the six nurses (Nurses #1 and #2) and one of the ten consultants (Consultant #1).	1206	Management Staff will coordinate health certification for all Direct Care Aids annually. Evidence of renewed physical certification will be in all employees personnel file one month prior to the expiration of the current certificate on file. Evidence of physician's certifications for staff (#1, #2, #3, #5, and #7) two nurses (#1 and #2) and one consultant will be placed in their personnel by Jan 15, 2010.	1/15/10 1/15/10
1227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans; This Statute is not met as evidenced by: Based on interview and record review, the Group	1227		

Health Regulation Administration

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1227	Continued From page 4 Home for Mentally Retarded Persons (GHMRP) failed to have on file for review current training in CPR and first aid, for two of the eleven staff. The finding includes: Review of the personnel and training records on November 16, 2009, beginning at 12:06 p.m., revealed the GHMRP failed to provide documentation of staff training in cardiopulmonary resuscitation (CPR), for two of the eleven staff (Staff #4 and #6) and first aid training, for two of the eleven staff (Staff #4 and #8).	1227	The Management Staff will coordinate CPR and First Aid trainings for staff #4, #6, and #8. In the future, evidence of renewed CPR and First Aid certificates will be placed in all employees personnel file one month prior to the expiration of the current certificate on file.	1/15/10
1229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that all staff were trained and competent to provide assistance in accordance with the residents nutritional needs, for one of the three residents in the sample. (Resident #2) The finding includes: On November 16, 2009 at approximately 5:46 p.m., Resident #2 sat down at the dining room table. The resident, who had insulin-dependent diabetes, had just come downstairs from having her blood sugar checked and receiving insulin. A	1229		

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I 229	<p>Continued From page 5</p> <p>direct support staff person brought family-style serving plates of foods to the table, including broiled fish, green beans and pasta noodles.</p> <p>1. After assisting Resident #2 with the fish and green beans, the staff person handed her a 1/2-cup measuring cup and walked back to the kitchen. Using the measuring cup, the resident (now seated alone) placed four 1/2-cup servings of pasta noodles onto her plate. At 5:53 p.m., the staff person returned to the table and saw the pile of noodles on the plate. The staff told the resident "you're not supposed to have so much" and began removing noodles from the plate. The resident immediately protested and the staff person stopped the process after removing approximately 1/2 cup of noodles. Approximately 1 1/2 cup of noodles remained on the plate, which was 3 times the quantity (1/2 cup) prescribed on the menu. She ate everything on her plate within the next seven minutes.</p> <p>2. At the same dinner, staff brought Resident #2 a bottle of regular ketchup from the refrigerator. The client squeezed a generous portion of ketchup onto her fish. Subsequent review of the label on the ketchup bottle revealed that it was sweetened with 4 grams sugar per Tablespoon, and provided 15 calories per Tablespoon.</p> <p>3. The next day, November 17, 2009, Resident #2 returned from day program with her peers at 3:10 p.m. Within a few minutes, she asked staff for a peanut butter and jelly sandwich. At 3:28 p.m., Resident #2 made her own peanut butter and jelly sandwich, using approximately 3 Tablespoons of Concord Grape Jam. Subsequent review of the label revealed that the jam was made with regular sugar, and provided 50 calories per Tablespoon.</p>	I 229	<p>1. Cross reference W460.5</p> <p>2. Cross reference W460.5</p> <p>3. Cross reference W460.5</p>	<p>12/18/09</p> <p>12/18/09</p> <p>12/18/09</p>

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I 229	<p>Continued From page 6</p> <p>4. On November 18, 2009, review of Resident #2's physician's orders revealed the diet order: 1800 calorie ADA, low fat, low cholesterol, low sodium diet. As such, staff were to discourage concentrated sweets, use artificial sweeteners and sugar-free, unsweetened food items. Earlier that day, beginning at approximately 10:25 a.m., interview with two direct support staff (one of whom did the grocery shopping for the house), revealed that they sought food items that were low fat, but not sugar-free or reduced sugar. When asked about diabetes, the staff affirmed that they were both aware that Resident #2 had diabetes. However, as the interview progressed, they kept returning to the issue of "low fat." When asked if they purchase reduced sugar foods such as condiments and jams, they replied "no," adding that they did not see such items offered in the grocery store where they did the shopping. At 10:40 a.m., one of the two staff said she thought it would be difficult to offer meals that were suited to the specialized needs of 5 or 6 different prescribed diets.</p> <p>5. Further interview with the two staff on the morning of November 18, 2009 revealed that neither staff had received dietary training from the facility's nutrition consultant. At 1:00 p.m., review of staff in-service training records confirmed that there had been no documented nutrition training, to include speciality diets such as diabetic diets, menu planning, food substitutions and portion control.</p> <p>6. On November 19, 2009, observation of the facility's refrigerator confirmed what staff had stated on the day before, that they did not purchase foods indicated for a diabetic diet. They had just shopped for groceries on the</p>	I 229	<p>4. Cross reference W460.5</p> <p>5. Cross reference W460.5</p> <p>6. Cross reference W460.5</p>	<p>12/18/09</p> <p>12/18/09</p> <p>12/18/09</p>

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I 229	Continued From page 7 previous day; however, there were no sugar-free or reduced sugar condiments, jams or other food items observed in the refrigerator. It should be noted that Resident #2 received finger sticks twice dally, to monitor her blood sugar. According to her orders, she received a Lantuss insulin injection every morning, regardless of the blood sugar reading. In addition to the Lantuss, she was to receive an injection of Novolog insulin if her blood sugar levels warranted it in the morning or evening. If her blood sugar reading was below 150, she would not need a Novolog injection. If it were above 150, then she received an injection of Novolog on a "sliding scale;" the amount administered was dependent on the actual blood sugar reading. On November 18, 2009 at approximately 11:55 a.m., review of the client's Medication Administration Records for September, October and November 2009 revealed frequent Novolog injections were documented. There was no evidence that the facility provided dietary supports and services to adequately address Resident #2's diabetic needs, and minimize the frequency of administering multiple injections of insulin.	I 229		
I 232	3510.5(l) 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 observation, interview and record review, the facility failed to teach clients to use	I 232		

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I 232	Continued From page 8 and make informed choices about the use of dentures, for the one (of three) sampled residents who had been prescribed dentures. (Resident #1) The findings include: During the November 16, 2009 Entrance Conference, at approximately 9:45 a.m., the house manager (HM) and qualified mental retardation professional (QMRP) stated that Resident #1 had prescribed dentures. The resident, however, reportedly left her dentures in a restaurant while on vacation the first week of October 2009. During a visit to Resident #1's day program, at 11:56 a.m., their program manager confirmed that the resident used dentures. She thought, however, that the dentures had not fit properly, saying "I'm not sure if they're too big or too small." She explained that while Resident #1 wore them upon arrival in the morning, she would remove them to drink water or eat. She further stated that the resident would put her dentures back into her mouth without applying denture adhesive. She never saw the client bring adhesive with her to day program and did not know whether she had received training on correctly inserting the dentures. At 5:10 p.m. later that day, Resident #1 asked this surveyor if he would attend her meeting Friday. The HM, who was present at the time, explained that there was a case conference scheduled to discuss her dentures. It was not clear whether she would receive new dentures. At 5:12 p.m., the client told the HM that she wanted her dentures replaced. Further interview with the HM revealed that she was unsure whether the resident's denture-maintenance skills had been assessed. Since she became HM in	I 232	Cross reference W436	1/15/10

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I 232	<p>Continued From page 9</p> <p>June 2009, she had only seen staff applying the adhesive (Polygrip). She too had seen the resident remove her dentures at meals. She did not know whether there was any adhesive left on the dentures when the resident put them back in afterwards. She thought perhaps the resident licked the adhesive off the dentures. She also confirmed that the client did not take Polygrip with her to day program.</p> <p>Resident #1's interdisciplinary team had met on September 21, 2009 for her annual Individual Support Plan (ISP) meeting. On November 17, 2009 at 10:33 a.m., review of the ISP revealed that she had seen her dentist a year earlier, on November 26, 2008 and there was "no issue - continue to use Polygrip." For personal hygiene, the ISP indicated that staff were responsible for providing "reminders for thorough dental care." Further review of her records, however, failed to show evidence that her denture-maintenance skills had been fully assessed. Her plan did not reflect any past or current denture-related goals or objectives.</p> <p>On November 17, 2009 at 4:16 p.m., review of Resident #1's dental records revealed that she had been to the dentist on October 22, 2008 for an "annual" evaluation. The dentist wrote the following: "Pt should wear adhesive (Polygrip) to secure dentures. This will assist her eating with the dentures. Apply 30 minutes before meals. Remove dentures and clean at night." Resident #1 returned to the dentist approximately 1 month later. On November 26, 2008, the dentist wrote "Pt should put Polygrip to lower denture before meals to eat comfortably and to secure the dentures. No other problems were found."</p> <p>The Registered Nurse, QMRP and HM were</p>	(232		

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I 232	<p>Continued From page 10</p> <p>Interviewed a few minutes later. The RN, who had worked in the facility since May 2009, stated that she had not assessed Resident #1's denture-care skills nor had she observed the client apply adhesive or install the dentures into her mouth. The HM shared with the others what she had stated the previous evening: that she had seen staff apply the adhesive but not the client, and that she suspected that the client might lick the Polygrip off her gums and/or dentures. The HM thought the facility had been cited previously and had subsequently developed a denture-related training program. She and the QMRP agreed to seek relevant progress notes, assessments, training data or any other documentation. No additional information was presented before the survey ended two days later.</p> <p>In summary, there was no evidence that the facility assessed Resident #1's denture-care skills and developed appropriate training. In addition, there was no evidence that the facility's QMRP monitored and coordinated her denture needs with the day program to ensure that she received necessary and appropriate support and/or training.</p>	I 232		
I 379	<p>3519.10 EMERGENCIES</p> <p>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 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.</p>	I 379		

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1379	<p>Continued From page 11</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that injuries of unknown origin and incidents of neglect were consistently reported to the Department of Health, Health Regulation and Licensing Administration, in accordance with District law (22 DCMR, Chapter 35, Section 3519.10), for three of the six residents residing in the facility. (Residents #3, #4 and #6)</p> <p>The findings include:</p> <p>1. On November 16, 2009 at approximately 4:00 p.m., Resident #6 informed a direct care staff that she had been hit on her buttock by a "boy" at her day program. The client then stated that it "hurts." At 6:10 p.m., the client told a licensed practical nurse (LPN) that her right buttock hurt. The LPN attempted to assess the area, however, the resident refused. A moment later, the house manager/trained medication employee (HM/TME) assessed the resident's buttock and stated that no bruising or visible injury was noted. The LPN then administered Tylenol for pain. On November 18, 2009, follow-up interview with the HM/TME revealed that the injury of unknown origin had not been reported to the administrator as required.</p> <p>2. Cross-refer to W149.1a-d. According to incident reports, and confirmed through interviews with the QMRP, Resident #4 ran out of the facility and into the street on July 29, 2009. On September 22, 2009, Resident #4 left the group home without staff escort at approximately 7:15 p.m. and could not be located. Law</p>	1379	<p>1. Cross reference W153.2</p> <p>2. Cross reference W153.3</p>	<p>12/18/09</p> <p>12/18/09</p>

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1379	<p>Continued From page 12</p> <p>enforcement (Metropolitan Police Department - MPD) was contacted. The resident was located at a local restaurent and was escorted back to the facillity at approximately 7:38 p.m. Then on September 24, 2009, Resident #4 attempted to leave the group home without staff escort at 5:45 p.m. Staff intervened; however, the client succeeded at leaving the facillity without staff 15 minutes later. Law enforcement (MPD) was again contacted and they escorted her back to the facillity at approximately 6:35 p.m. Six days later, on September 30, 2009, Resident #4 left the group home without staff escort on three separate occasions (2:05 p.m., 3:15 p.m., and 3:45 p.m.). The SA only received notifications of the incidents that occurred on July 29, 2009 and September 30, 2009.</p> <p>There was no evidence that the SA was notified of the incidents on September 22 and 24, 2009.</p>	1379		
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1401	<p>3520.3 PROFESSION SERVICES: GENERAL PROVISIONS</p> <p>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.</p> <p>This Statute Is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure each resident had a comprehensive assessment that depicted her behavior management needs, for two of the six residents of the facility. (Residents #2 and #4)</p> <p>The findings include:</p>	1401		
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I 401	<p>Continued From page 13</p> <p>1. The facility failed to assess Resident #2's money-begging behavior, as follows:</p> <p>On November 16, 2009, Resident #2 returned home from her day program at 3:27 p.m. Upon entering the facility, she immediately approached this surveyor in the living room and requested \$3. Although she was directed to go locate staff, she remained standing in place. A moment later, Resident #5 walked near Resident #2. Resident #2 asked her for money. Resident #5 agreed to give her \$1, reached into her purse and gave her a \$1 bill.</p> <p>Similarly, on November 17, 2009, Resident #2 returned home from her day program at 3:10 p.m. Within a minute or two, she approached another visitor and asked him for money. At 3:18 p.m., interview with a direct support staff person revealed that Resident #2 asked strangers for money "all of the time ... anyone she sees out in stores ... community ... even if she already has money..." The staff person responded "yes" when asked if it was one of the resident's targeted maledaptive behaviors. When asked what the psychologist recommended, the staff person stated she did not know because she did not "go to those appointments." On November 18, 2009 at 11:20 a.m., the house manager stated that Resident #2 frequently asked people to give her money. She too indicated that it was a targeted behavior.</p> <p>However, on November 19, 2009 beginning at approximately 9:50 a.m., review of Resident #2's behavior support plan (BSP) dated April 16, 2009 revealed that it did not address begging for money, and her Annual Psychological Evaluation dated May 22, 2009 showed no evidence that the</p>	I 401	1. Cross reference W214	1/8/10

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1401 Continued From page 15

approximately 11:30 a.m., a review of Behavior Support Plan (BSP) dated May 27, 2009, revealed that one of Resident #4's target behaviors was "Inappropriate touching (non-sexual touching of others)." Further review of the BSP failed to reveal that sexual advances on her peers had been reported as a target behavior. According to the staff, this sexual behavior was a new behavior which allegedly had been reported to the psychologist. Further review of the habilitation records, however, did not evidence that any documentation or any baseline data had been completed to determine the frequency of this new behavior.

Note: The qualified mental retardation professional (QMRP) and the house manager indicated that Resident #4 had received a sexuality assessment on September 11, 2009 (nearly 2 months ago). Further interview, however, revealed that the assessment report had not yet been forwarded to the psychologist and QMRP in order to establish appropriate intervention strategies.

1401

1422 3521.3 HABILITATION AND TRAINING

Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan.

This Statute is not met as evidenced by: Based on observation, interview and record review, facility staff failed to consistently implement residents behavior support plans at the needed frequency, for two of the three residents in the sample. (Residents #2 and #3)

The findings include:

1422

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I 422	Continued From page 16 1. Resident#2 was observed in her home on November 16, 2009 between 3:27 p.m. - 6:25 p.m. During the first part of the observation period, facility staff failed to implement proactive/preventive as well as intervention strategies as outlined in the resident's behavior support plan (BSP), as follows: At 3:27 p.m., Resident #2 entered the home with staff and peers. She immediately approached this surveyor in the living room and requested \$3. Although she was directed to seek staff, she remained standing in place. A moment later, Resident #5 walked up to her location. Resident #2 asked her for money. Resident #5 agreed to give her \$1, reached into her purse and gave her a \$1 bill. There were no direct support staff nearby observing these interactions. Staff did not engage Resident #2 during the first 15-minute period. At 3:42 p.m., Resident #2 asked staff for a peanut butter and jelly sandwich. Staff first suggested a cheese sandwich as an alternative but then gave her a banana. At 3:55 p.m., she was offered a glass of water, which she drank while standing behind Resident #3's chair. A brief, physical altercation between Resident #3 and Resident #2 transpired (after Resident #3 hit #2). For the 10 minutes that followed, Resident #2 stood at one corner of the dining room table, muttering in a low voice and staff did not interact with her. At approximately 4:06 p.m., staff tried to engage Resident #2 in a puzzle or other activity; however, did not respond. The staff then asked "What do you like" to which she replied "nothing." For the next 28 minutes, Resident #2 sat at the dining room table watching peers and staff, not engaged	I 422	1. Cross reference W249.1	1/15/10

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I 422	<p>Continued From page 17</p> <p>In any meaningful activity, and muttering incessantly in a low voice. At 4:38 p.m., she stuck her finger in her nose briefly but there was no staff intervention. At 4:41 p.m., Resident #2 told a peer sitting near her to let go of her \$1 bill; the peer complied and staff said nothing. By then, staff had not engaged Resident #2 for over a half-hour. At 4:43 p.m., Resident #2 suddenly pounded her fist on the dining room table, loudly, which startled Residents #1, #3 and others at the table. Staff told Resident #2 to "stop" but then said nothing more. The client remained seated at the table for another 40 minutes, until 5:26 p.m., muttering in a low voice and not engaged in a meaningful activity. The medication nurse arrived at approximately 5:26 p.m. and Resident #2 followed him upstairs.</p> <p>On November 17, 2009 at 3:18 p.m., interview with a direct support staff person revealed that Resident #2 asked strangers for money "all of the time ... anyone she sees out in stores ... community ...even if she already has money..."</p> <p>On November 18, 2009 at 11:20 a.m., the house manager stated that staff were instructed to "keep within earshot but not hover" over her. They should monitor her, keep her engaged to the extent that she allows and intervene when necessary to address behaviors. She further indicated that Resident #2 frequently asked people to give her money.</p> <p>On November 19, 2009 beginning at approximately 9:50 a.m., review of Resident #2's BSP dated April 16, 2009 revealed the following: "Prevention ... is the most important factor ... observe closely for signs of deteriorating behaviors and act promptly ... If staff notice <resident's name> starting to get upset they should intervene before she has a full fledged</p>	I 422		

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1422	<p>Continued From page 18</p> <p>episode. Early signs include pacing ... mumbling ... Staff should take control the moment they see <client's name> starting to lose control. There is no reason to wait for a full-blown problem behavior ... As <resident's name> calms down, she should be told exactly what to do next. When she starts the requested behavior, staff should reward her" for following their request. "Intervention ... Tell her to STOP!... when <resident's name> starts to do something inappropriate ... tell her specifically something to do." Observations on November 16, 2009, however, revealed that:</p> <p>a. Staff did not stay within earshot during the first 15 minutes after Resident #2 and her peers returned from day program. Interviews indicated that staff were unaware that the client had asked this surveyor and Resident #5 for money.</p> <p>b. Staff made only two attempts to engage Resident #2 in a meaningful activity during the two-hour observation period (3:27 p.m. - 5:26 p.m.), even though she was observed pacing and mumbling throughout much of that time.</p> <p>c. When Resident #2 pounded her fist on the table that afternoon, staff told her to "stop!" They did not, however, tell her specifically something to do, as indicated in her BSP.</p> <p>2. On November 16, 2009 at 3:45 p.m., Resident #3 was observed having a snack. After the client completed her snack, she was observed hitting Resident #2, three times. Staff immediately asked Resident #3 to "STOP." The client started screaming and staff replied "just stand there and continue screaming." A moment later, the client walked into the kitchen, placed a cup in the trash can, then moved to the sink and started</p>	1422	2. Cross reference W249.2	1/15/10

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1422	Continued From page 19 screaming and banging her spoon on the sink. Staff ignored the second outburst at the sink. Interview with the direct care staff at 3:58 p.m. revealed that Resident #3 had a behavior support plan (BSP) to address her behaviors of screaming and physical aggression. Subsequent review of Resident #3's BSP dated August 4, 2009 confirmed the targeted behaviors of "screaming and physical aggression." Intervention strategies to address the screaming behavior were as follows: - the resident should be under the supervision of a dedicated 1:1 staff member at all times; - the resident should be encouraged to engage in activities that calm her (i.e., taking a walk, listening to preferred music looking at magazines, etc.); and, - If behavior continues, staff should escort the resident to an unoccupied area to calm her down. When <the resident >has remained calm for at least five minutes, staff should give verbal praise pared with tactile praise for calming down. Intervention strategies to address physical aggression were as follows: - staff should calmly and firmly direct the client to "STOP <resident>", the client should be given prompts at least two times with no more than a five second interval; - staff should also attempt to create a SAFE AREA; and - During the safe area, staff should try to determine the source of the resident's anger and	1422		

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I 422	Continued From page 20 assist her in calming down by talking. After calming down, the resident should be returned to her activities. There was no evidence that the staff implemented the intervention strategies as written. 3. During evening observations on November 16, 2009, from 4:10 p.m. until 4:57 p.m., Resident #3 and her 1:1 support staff were participating in table top activities, with no peer interaction. Interview with direct care staff on November 17, 2009 at approximately 5:00 p.m., indicated that the client "only" likes to participate with her one to one support staff. Review of the resident's Individual Program Plan (IPP) dated August 4, 2009 on November 18, 2009 at approximately 10:00 a.m., revealed an objective which stated, "[the resident] will participate in structured activities for 15 minutes at home and will interact with at least one of peers without being disruptive, for one out of four trials, twice a week. There was no evidence that the 1:1 support staff encouraged or implemented peer interaction for Resident #3.	I 422	3. Cross reference W249.3	1/15/10
I 436	3521.7(f) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (f) Health care (including skills related to nutrition, use and self-administration of medication, first aid, care and use of prosthetic and orthotic devices, preventive health care, and safety); This Statute is not met as evidenced by: Based on observations, interviews and the review	I 436		

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I 436	Continued From page 21 of records, the facility failed to implement an effective system to ensure that each resident participated in a self-medication training program, for one of the three residents in the sample. (Resident #3) The finding includes: During the medication administration on November 16, 2009 at 6:00 p.m., the licensed practical nurse (LPN) was observed asking Resident #3 to punch her medications from the bubble pack. The client refused and the LPN was observed preparing the client's medication and pouring a cup of water. Interview with the LPN during the medication administration indicated that Resident #3 did not have a program goal/objective to participate in the self administration process. Review of Resident #3's record on November 17, 2009 at approximately 10:00 a.m. revealed no evidence of a self-medication assessment. At 10:30 a.m., further review of Resident #3's IPP dated August 7, 2009 revealed no program goal or objective for the resident to receive training in self-medication skills.	I 436	Cross reference W371	1/10/10
I 480	3522.7 MEDICATIONS Medication, requiring refrigeration shall be maintained either in a separate and secure medication refrigerator or, if in a refrigerator with foods, shall be in a secure and closed compartment or container so as to prevent cross contamination. This Statute is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to store medications,	I 480		

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1 480	Continued From page 22 requiring refrigeration under proper condition of security, for one of the three residents in the sample. (Resident #2) The finding includes: On November 16, 2009 at 2:50 p.m. a plastic bag of medication vials (five) was observed in the facility's refrigerator. The bag of medications contained two full vials of Lantuss insulin and three full vials of Novolog 100 units/ml. At 2:58 p.m., the house manager (HM) was informed that the bag of medication was stored in the refrigerator unsecured. The HM acknowledged the unsecured vials of medication. At 5:27 p.m., the licensed practical nurse (LPN) arrived in the facility and shortly thereafter, opened the refrigerator and retrieved the plastic bag of insulin. When interviewed, the LPN acknowledged that all medications should be locked. After the LPN completed the medication administration at 6:20 p.m., he was observed to replace the medication bag back into the refrigerator, unsecured. On November 17, 2009 at 8:45 a.m., the bag of medication was stored in the butter compartment section of the refrigerator, still not secured. On November 18, 2009 at approximately 9:05 a.m., the RN was observed removing the bag of insulins from the refrigerator, placing the bag into a black lock box and returning the box with medications to the refrigerator.	1 480	Cross reference W381	11/21/09
1 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this	1 500		

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1500	<p>Continued From page 23</p> <p>chapter, and other applicable District and federal laws.</p> <p>This Statute is not met as evidenced by: Based on observations, interviews and record review, the GHMRP failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and other District and federal laws that govern the care and rights of persons with mental retardation, for five of the six residents of the facility. (Residents #1, #2, #3, #4 and #6)</p> <p>The findings include:</p> <p>1. The facility failed to protect residents' rights by not informing the residents' medical guardians of changes in their condition and the use of psychotropic medications for sedation and behavior management [Title 7, Chapter 13, § 7-1305.05(h), formerly § 6-1965(h)], as follows:</p> <p>Based on observation, staff interview, and record review, facility failed to establish a system that would ensure residents and legal guardians were informed of the risks and benefits of restrictive programs and supports, for two of the three residents in the sample. (Residents #2 and #3)</p> <p>The findings include:</p> <p>a. The facility failed to provide evidence that informed consent was obtained from Resident #3 and/or court appointed legal guardian for sedation given during medical appointments as evidenced below:</p> <p>Review of Resident #3's medical records on</p>	1500	1 a. Cross reference W124.1	12/18/09

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1500	<p>Continued From page 24</p> <p>November 16, 2009, at approximately 2:00 p.m., revealed an order for Ativan 2 mg one hour prior to an ENT appointment dated July 10, 2009.</p> <p>During the entrance conference on November 16, 2009 beginning at 9:45 a.m., the qualified mental retardation professional (QMRP) and Residential Manager (RM) indicated that the resident had a court appointed legal guardian to assist Resident #3 in making health care decisions.</p> <p>Review of Resident #3's Psychological Assessment dated August 4, 2009, on November 17, 2009 at 9:46 a.m., revealed that the resident was not competent to make decisions regarding his health, safety, financial or residential placement. Further review of Resident #3's record failed to provide evidence that written informed consent had been obtained for the use of the sedative medication.</p> <p>At the time of the survey, the facility failed to provide evidence that the potential risks involved in using this medication, or his right to refuse treatment had been explained to the resident and/or family member representative.</p> <p>b. The facility failed to ensure that informed consent was obtained from Resident #3 and/or her court appointed legal guardian prior to the administration of her psychotropic medications.</p> <p>Medication administration observation on November 16, 2009, at 6:00 p.m., revealed that Resident #3 received Risperdal 3 mg and Topamax 50 mg. Interview with the licensed practical nurse (LPN) after the medication administration indicated that the resident received the aforementioned medication for her maladaptive behaviors.</p>	1500	b. Cross reference W124.2	12/18/09

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I 500	Continued From page 25 During the entrance conference on November 16, 2009, beginning at 9:45 a.m., an interview conducted with the QMRP and HM revealed the Resident #3 did not have the capacity to give informed consent for the use of medications and habilitation services. Further interview revealed the resident had a court appointed legal guardian to assist her in decision making. Review of Resident #3's record on November 17, 2009, at 9:46 a.m., revealed a psychological assessment dated August 4, 2009 that verified the QMRP and HM's statement. According to the assessment, Resident #3 "is not able to make independent decisions concerning her residential or day placements. She lacked the cognitive skills necessary to understand the implications of such decisions and therefore cannot give her informed consent. She lacks the judgment and insight required to make decisions independently." Review of the Resident #3's medical record and additional interview with the QMRP on November 17, 2009, at 9:45 a.m., failed to provide evidence that the resident treatment needs, including the benefits and potential side effects associated with her medications, and the right to refuse treatment, had been explained to her and/or her court appointed legal guardian. c. Similarly, there was no evidence that the facility informed Resident #2 and her court appointed guardian of the potential risks and benefits associated with new psychotropic medications (or significant increases in dosage) and obtained written consent prior to administering the medications, as follows:	I 500	1 c. Cross reference W124.3	12/18/09

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I 500	<p>Continued From page 26</p> <p>Observation of the evening medication pass on November 16, 2009 revealed that Resident #2 received Depakote 1000 mg, Thorazine 400 mg, Trazodone 100 mg and Abilify 30 mg. During the entrance conference, the QMRP and HM had indicated that Resident #2 did not have the capacity to give informed consent for the use of medications and habilitation services. The resident had a court appointed guardian to assist her in making healthcare decisions. The resident's medical records were reviewed on November 18, 2009 beginning at 11:38 a.m.</p> <p>Her physician's orders (POs) indicated that Trazodone 50 mg was first ordered on August 3, 2009, with the first dose documented on her Medication Administration Record (MAR) as administered the next evening (August 4, 2009). The Trazodone was then doubled to 100 mg daily, effective October 16, 2009.</p> <p>Resident #2's POs and MARs also reflected an increase in her Depakote from 1000 mg daily to 1500 mg daily, effective October 17, 2009; and,</p> <p>an increase in Thorazine from 400 mg daily to 500 mg daily, effective October 17, 2009.</p> <p>On November 18, 2009 at 2:53 p.m., the most recent consent form in Resident #2's medical record had been signed by her medical guardian on May 29, 2009. This was the date her interdisciplinary team met to review and update her annual plan. The consent was for Abilify 30 mg, Thorazine 400 mg daily (100 mg in the a.m. and 300 mg in the p.m.) and Depakote 1000 mg daily. There was no documented evidence that the facility had approached the medical guardian to discuss the proposed (and now implemented) use of Trazodone and increases in Thorazine and</p>	I 500		

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I 500	<p>Continued From page 27</p> <p>Depakote. A telephone call was placed to the resident's court-appointed guardian on November 18, 2009 at 2:09 p.m. She did not, however return the message before the survey ended the following day at 2:52 p.m.</p> <p>It should be noted that on November 17, 2009 beginning at 2:28 p.m., review of the facility's Human Rights Committee minutes revealed that on September 5, 2008, the committee approved a recommended decrease in Resident #2's daily Thorazine after the resident complained of drowsiness/sedation.</p> <p>2. Based on interview and record review, the facility failed to ensure that staff consistently implemented policies developed to protect resident safety, for two of the six residents residing in the facility. (Residents #3 and #4)</p> <p>The findings include:</p> <p>a. On November 6, 2009 beginning at 9:45 a.m., review of the facility's records, including administrative, incident and clinical records, coupled with an interview with the qualified mental retardation professional (QMRP) revealed that Resident #4 had a history of leaving the facility without staff escort. For example, there were seven (7) documented incidents of her leaving the facility between July 14, 2009-September 30, 2009. Several incidents indicated that staff did not know her whereabouts and, with the assistance of the Metropolitan Police Department (MPD), she was located elsewhere in the community and brought home. The resident's records indicated that her cognitive skills were assessed in the moderate range of mental retardation, her adaptive skills were in the severe range and she required</p>	I 500	2 a. Cross reference W149.1	12/24/09

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I 500	<p>Continued From page 28</p> <p>24-hour supervision.</p> <p>Beginning at approximately 11:00 a.m., additional interview with the QMRP followed by a review of the supports and intervention strategies being implemented failed to show evidence that the facility provided effective staff supervision to ensure Resident #4's safety, as follows:</p> <p>On July 14, 2009 at 8:30 p.m., Resident #4 left the facility without staff escort. Staff followed her, however, and brought her back into the facility. Her behavior escalated shortly thereafter and the police were contacted.</p> <p>On July 29, 2009 at 4:35 p.m., Resident #4 ran out of the facility and into the street.</p> <p>On September 22, 2009 at approximately 7:15 p.m., Resident #4 left the group home without staff and could not be located. The police were contacted. The resident was located at a local restaurant and was escorted back to the facility at approximately 7:38 p.m.</p> <p>On September 24, 2009 at 5:45 p.m., Resident #4 attempted to leave the group home without staff escort. Staff intervened before she actually left. However, according to the incident report, the resident succeeded at leaving the facility alone 15 minutes later. The police were again contacted after staff could not locate her. At approximately 6:35 p.m., the police located the resident and escorted her back to the facility.</p> <p>On September 30, 2009, Resident #4 left the group home without staff escort on three separate occasions (2:05 p.m., 3:15 p.m., and 3:45 p.m.).</p>	I 500		

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1 500	<p>Continued From page 29</p> <p>According to the QMRP of November 19, 2009, Resident #4 received one to one staff support from 8:00 a.m. - 400 p.m., for assistance while at the day program. In addition, according to the Plan of Correction received by the State Agency on October 8, 2009, the psychologist was to provide staff training regarding Resident #4's behavior support plan (BSP) by October 23, 2009. On November 18, 2009, review of the facility's in-service training records revealed that training by the psychologist had been documented on August 28, 2009. The training, however, was ineffective in that staff failed to supervise Resident #4 at all times on the dates identified on the incident reports.</p> <p>It should be noted that the facility's program director indicated in a letter to the Department of Disability Services on July 30, 2009, that the resident's safety was at risk due to her attempts to leave the home without staff supervision. The program director requested that the resident be discharged from the home and that funding be established to provide one to one staffing in the interim. The funding, however, had not been approved, to date.</p> <p>b. Review of the facility's records, including administrative and clinical records, and interviews with the QMRP on November 6, 2009, failed to show evidence that the facility had established a policy and an effective system to ensure that Resident #3 was protected from sexual abuse, as evidenced by the following:</p> <p>According to an incident report, Resident #4 was observed by a direct care staff standing over Resident #3's bed on November 2, 2009 at approximately 12:03 a.m. Staff had documented that they found Resident #3 lying on her stomach</p>	1 500	2 b. Cross reference W149.2	12/24/09

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I 500	<p>Continued From page 30</p> <p>with the bed blankets pulled down to her ankles. Staff reported that Resident #4 had her hand between Resident #3's legs, attempting to insert her fingers into her vagina. The report further described that staff used maximum verbal prompting to redirect Resident #4 back to her own bedroom. Approximately five minutes later, however, the staff observed Resident #4 back in Resident #3's bedroom, attempting to stick her fingers between her legs again. Staff #1 verbally redirected Resident #4 back into her bedroom.</p> <p>On November 6, 2009 at approximately 10:15 a.m., interview with the QMRP and review of the incident management log revealed that Resident #4 had made previous sexual advances towards Resident #3. According to an August 18, 2009 incident report, Resident #3 was heard yelling in her bedroom. Staff went into the bedroom to check on her and discovered Resident #4 lying next to Resident #3 in Resident #3's bed, with a finger inserted in Resident #3's rectum. Reportedly, staff intervened and instructed Resident #4 to return to her bed. Following this incident, Resident #3 had been moved into another bedroom for her protection. This action, however, had not been sufficient to prevent Resident #4 from touching Resident #3's private areas, as documented on the November 2, 2009 incident report.</p> <p>On September 11, 2009, Resident #4 had a sexuality assessment conducted by an outside consultant. According to the QMRP and the house manager, the consultant had not forwarded the findings of the assessment; and therefore, a behavior support plan addressing the resident's inappropriate sexual advances had not been completed.</p>	I 500		

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1500	<p>Continued From page 31</p> <p>Interview with the House Manager and QMRP on November 17, 2009 at 10:25 a.m. and review of an administrative memo posted on the refrigerator door revealed that the facility instructed staff on the overnight shift to position one staff near the bedrooms upstairs to monitor residents' nighttime activities.</p> <p>3. The facility failed to protect residents' rights to receive training on the care and selection of clothing, the care and maintenance of dentures, tooth brushing/oral hygiene and hair care/grooming skills [Title 7, Chapter 13, § 7-1302, formerly § 8-1962], as follows:</p> <p>a. An environmental inspection was conducted on November 19, 2009 beginning at 11:10 a.m. During the inspection there were no clothes observed in Resident #2's bedroom closet. Interview with the house manager (HM), during the inspection, indicated that the resident's clothes were stored in the basement and the resident was given an outfit each evening to wear the following day. The HM further indicated that the resident "will throw her clothes in the trash can."</p> <p>b. Based on observation, interview and record review, the facility failed to teach Resident #1 to care for and use prescribed dentures, as follows:</p> <p>During the November 18, 2009 Entrance Conference, at approximately 9:45 a.m., the house manager (HM) and qualified mental retardation professional (QMRP) stated that Resident #1 had prescribed dentures. The resident, however, reportedly left her dentures in a restaurant while on vacation the first week of October 2009. During a visit to Resident #1's day program, at 11:58 a.m., their program</p>	1500	<p>3 a. Cross reference W137</p> <p>3 b. Cross reference W436.4</p>	<p>12/24/09</p> <p>1/15/10</p>

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1500	<p>Continued From page 32</p> <p>manager confirmed that the resident used dentures. She thought, however, that the dentures had not fit properly, saying "I'm not sure if they're too big or too small." She explained that while Resident #1 wore them upon arrival in the morning, she would remove them to drink water or eat. She further stated that the resident would put her dentures back into her mouth without applying denture adhesive. She never saw the resident bring adhesive with her to day program and did not know whether she had received training on correctly inserting the dentures.</p> <p>At 5:10 p.m. later that day, Resident #1 asked this surveyor if he would attend her meeting Friday. The HM, who was present at the time, explained that there was a case conference scheduled to discuss her dentures. It was not clear whether she would receive new dentures. At 5:12 p.m., the resident told the HM that she wanted her dentures replaced. Further interview with the HM revealed that she was unsure whether the resident's denture-maintenance skills had been assessed. Since she became HM in June 2009, she had only seen staff applying the adhesive (Polygrip). She too had seen the resident remove her dentures at meals. She did not know whether there was any adhesive left on the dentures when the resident put them back in afterwards. She thought perhaps the resident licked the adhesive off the dentures. She also confirmed that the resident did not take Polygrip with her to day program.</p> <p>Resident #1's interdisciplinary team had met on September 21, 2009 for her annual Individual Support Plan (ISP) meeting. On November 17, 2009 at 10:33 a.m., review of the ISP revealed that she had seen her dentist a year earlier, on November 26, 2008 and there was "no issue -</p>	1500		

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1500	<p>Continued From page 33</p> <p>continue to use Polygrip." For personal hygiene, the ISP indicated that staff were responsible for providing "reminders for thorough dental care." Further review of her records, however, failed to show evidence that her denture-maintenance skills had been fully assessed. Her plan did not reflect any past or current denture-related goals or objectives.</p> <p>On November 17, 2009 at 4:16 p.m., review of Resident #1's dental records revealed that she had been to the dentist on October 22, 2008 for an "annual" evaluation. The dentist wrote the following: "Pt should wear adhesive (Polygrip) to secure dentures. This will assist her eating with the dentures. Apply 30 minutes before meals. Remove dentures and clean at night." Resident #1 returned to the dentist approximately 1 month later. On November 26, 2008, the dentist wrote "Pt should put Polygrip to lower denture before meals to eat comfortably and to secure the dentures. No other problems were found."</p> <p>The Registered Nurse, QMRP and HM were interviewed a few minutes later. The RN, who had worked in the facility since May 2009, stated that she had not assessed Resident #1's denture-care skills nor had she observed the resident apply adhesive or install the dentures into her mouth. The HM shared with the others what she had stated the previous evening: that she had seen staff apply the adhesive but not the resident, and that she suspected that the resident might lick the Polygrip off her gums and/or dentures. The HM thought the facility had been cited previously and had subsequently developed a denture-related training program. She and the QMRP agreed to seek relevant progress notes, assessments, training data or any other documentation. No additional information was</p>	1500		

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1500	<p>Continued From page 34</p> <p>presented before the survey ended two days later.</p> <p>In summary, there was no evidence that the facility assessed Resident #1's denture-care skills and developed appropriate training. In addition, there was no evidence that the facility's QMRP monitored and coordinated her denture needs with the day program to ensure that she received necessary and appropriate support and/or training.</p> <p>c. Cross-refer to the Federal Deficiency Report - Citation W242.1. Resident #3 was diagnosed with gingivitis, plaque on the teeth and poor oral hygiene. There was no evidence, however that the GHMRP developed and implemented a training program to address the client's poor oral hygiene.</p> <p>d. Cross-refer to the Federal Deficiency Report - Citation W242.2 Resident #3 received total assistance from staff for combing and brushing her hair. It was a sought-after activity. There was no evidence, however, that the GHMRP developed and implemented a training program to teach her grooming/hair care skills.</p> <p>4. Cross-refer to 1229. The facility failed to protect Resident #2's right to receive nourishment in accordance with her specially prescribed (diabetic) diet [Title 7, Chapter 13, § 7-1305.05(f), formerly § 6-1965(f)].</p> <p>5. The facility failed to protect residents' rights to have personal information maintained in a manner that protects confidentiality [Title 7, Chapter 13, § 7-1305.12, formerly § 6-1972], as follows:</p>	1500	<p>3 c. Cross reference W242.1</p> <p>3 d. Cross reference W242.2</p> <p>4. Cross reference W460.5</p> <p>5a. Cross reference W112.1</p>	<p>1/8/10</p> <p>2/5/10</p> <p>12/18/09</p> <p>12/24/09</p>

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4314 9TH 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
1500	<p>Continued From page 35</p> <p>Based on observation and staff interview, the facility failed to keep confidential information contained in each resident's record, for five of the six residents residing in the facility. (Residents #1, #2, #3, #4 and #6)</p> <p>The findings include:</p> <p>a. On November 16, 2009 at 4:15 p.m., a chart was observed posted openly on the refrigerator door in the kitchen. Review of the chart revealed that it included each resident's full name and listed her prescribed diet. For example, Resident #1 was prescribed a 1500 calorie, low fat, low cholesterol, chopped texture diet. The full names and specially prescribed diets for Residents #2, #3, #4 and #6 were also listed. Next to the chart was a memo that announced that three residents (full names identified) were to receive Egg Beaters as an egg substitute due to their "low cholesterol diet."</p> <p>b. Also posted openly on the refrigerator door was a memo titled "Very Important Notice." It discussed the staff assignments needed to protect Resident #3 from Resident #4's "Inappropriate sexual contact." Both residents' full names were cited in the text. This practice failed to ensure the confidentiality of the residents' personal information.</p> <p>The postings were brought to the attention of the house manager and qualified mental retardation professional on November 17, 2009 at 10:25 a.m. They immediately removed the memo about inappropriate sexual contact. The house manager stated "that shouldn't be up there." After further discussion about protecting confidentiality, they removed the residents' dietary information from the refrigerator door.</p>	1500	5b. Cross reference W112.2	12/18/09

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/19/2009
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