

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

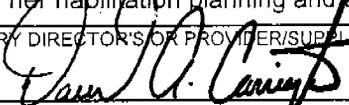
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Printed: 08/08/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G188</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/27/2007</b>
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NAME OF PROVIDER OR SUPPLIER <b>INNOVATIVE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3259 'O' ST. SE WASHINGTON, DC 20020</b>
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W 000	INITIAL COMMENTS  A recertification survey was conducted from July 24, 2007 through July 27, 2007. The survey was initiated using the full survey process. A random sample of three clients was selected from a residential population of six females with mental retardation and other disabilities. A focused review was conducted of two additional clients, in the areas of Active Treatment and Health Care Services. The survey findings were based on observations in the group home and two day programs and interviews with residential and day program staff and clients, including nursing and administrative staff. In addition, the survey included a review of administrative records, including incident reports and the clients' habilitation and medical records.	W 000		
W 113	483.410(c)(3) CLIENT RECORDS  The facility must develop and implement policies and procedures governing the release of any client information, including consents necessary from the client, or 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 failed to implement its policies and procedures on obtaining written consents for the release of confidential client information, for one of the three clients in the sample. (Client #3)  The finding includes:  During the Entrance Conference on July 24, 2007, at approximately 12:50 PM, the Qualified Mental Retardation Professional (QMRP) indicated that Client #3's mother was involved in her habilitation planning and attended "almost	W 113		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE:  TITLE: Executive Director (X6) DATE: 8/17/07

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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**W 113** Continued From page 1  
every" meeting. On July 25, 2007, beginning at 4:35 PM, interview with Client #3 confirmed that she was in agreement with the mother making important decisions on her behalf. On July 26, 2007, at 5:34 PM, review of the client's Individual Support Plan (ISP), dated June 13, 2007, confirmed the mother's involvement and her role in making important decisions for her.

On July 27, 2007, at 11:15 AM, a release of information authorization form was observed in Client #3's records. It had been signed on July 12, 2006. The form had not been fully completed and did not identify what information was to be released, to whom the information would be given and failed to indicate an ending date. Review of the facility's policies revealed that the governing body had established a procedure by which each authorization form must specify the information to be released, to whom the information will be given and indicate that the release of information is invalid beyond 365 days from the time issued. This was not reflected in the form signed by Client #3 and her mother on July 12, 2006.

During follow-up interviews with the Program Manager and QMRP on July 27, 2007, they acknowledged that the form was not in compliance with the facility's policies and procedures.

**W 113**

W113  
ILS will ensure that all release of information form is used appropriately and ILS policies and procedure are been followed with their use. Other individual's books will be review to ensure appropriate use of release of information.

8/6/07

**W 148** 483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS &  
  
The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.

**W 148**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G188</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/27/2007</b>
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W 148	Continued From page 2 This Standard is not met as evidenced by: Based on interview and record verification, the facility failed to notify parents or guardians of significant incidents, for two of the six clients residing in the facility. (Clients #3 and #5)  The findings include:  On July 24, 2007, beginning at 3:30 PM, review of the facility's incident reports and investigations failed to show documented evidence that the facility notified family members immediately of the following significant incidents:  a. On January 23, 2007, Client #5 alleged that a staff person hit her with a stick.  b. On March 23, 2007, Client #5 eloped from the facility.  c. On June 18, 2007, Client #3 was agitated and was taken to the hospital.  d. On June 12, 2007, Client #3 alleged that a staff person hit her in the face.  On July 26, 2007, at 5:30 PM, interview with the QMRP indicated that when a serious incident had occurred, family notification would be reflected on the incident report. The aforementioned incident reports were re-examined with the QMRP, at which time he acknowledged that the incidents had not been reported to the clients' family members.	W 148	<u>W148 (a,b,c,d)</u> The agency's incident management policy and procedure was reviewed and in-service training was done on Incident reporting procedure and documentation of notification. The agency is presently ensuring that all incidents are reported to the IMU and DOH and family Member within 24hours and all investigations are reported within five working days. Monthly QA oversight will be implemented to ensure Compliance with procedure. See attached-in-service sign in sheet	8/4/07
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS  The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported	W 153		

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W 153	<p>Continued From page 3</p> <p>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: Based on review of the facility's incident reports and client records, the facility failed to consistently report allegations of mistreatment, neglect or abuse as well as injuries of unknown origin, to the state agency, for three of the clients that reside in the facility. (Clients #3, #4 and #5)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. On January 23, 2007, Client #5 alleged that a staff person had hit her with a stick.</li> <li>2. Review of Client #4's nursing notes and medical record revealed she had been hospitalized from March 6, 2007 to March 14, 2007 for low blood sugar and low sodium levels. There was evidence that the facility reported her transfer to the ER for further evaluation. There was no evidence, however, that her hospital admission was reported.</li> <li>3. On July 27, 2007, at 8:53 AM, review of Client #3's nursing notes revealed an entry dated May 3, 2007 indicating injury to the client's finger on the evening before. The nurse indicated that the client complained of pain and of "squeezing her little finger on the left hand while on the van." No further information about the source of the injury was indicated by the nurse. The client's finger had "red around the nail, a blood clot had formed under the nail and there was a small amount of swelling around the nail." A warm compress was applied and the client was treated with Cipro antibiotic. There was no corresponding incident</li> </ol>	W 153	<p><u>W153</u> Cross-reference W148</p>	

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W 153	Continued From page 4 report to explain the injury. On July 27, 2007, at 9:16 AM, the QMRP said that he recalled the client having shown him her finger; however, he could not recall what she told him about how the injury had occurred.	W 153		
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 provide evidence that the source of all injuries of unknown origin were consistently investigated within five working days, for one of the six clients residing in the facility. (Client #3)</p> <p>The finding includes:</p> <p>On July 27, 2007, at 8:53 AM, review of Client #3's nursing notes revealed an entry dated May 3, 2007 indicating injury to the client's finger on the evening before. The nurse indicated that the client complained of pain and of "squeezing her little finger on the left hand while on the van." No further information about the source of the injury was indicated by the nurse. The client's finger had "red around the nail, a blood clot had formed under the nail and there was a small amount of swelling around the nail." A warm compress was applied and the client was treated with Cipro antibiotic. There was no corresponding incident report to explain the injury. Review of the client's behavioral data revealed no indication of self injury, and self-injury was not a targeted behavior. On July 27, 2007, at 9:16 AM, the QMRP said that he recalled the client having shown him her finger; however, he could not recall what she told</p>	W 154	<p><u>W154</u></p> <p>The agency's incident management policy and procedure was reviewed and in-service was done. The agency is presently ensuring that all incident report are done for all physical injury and reported to IMU, DOH and family member. The facility Program Manager will provide oversight and monitoring of QA/IM system to ensure all incidents are investigated. See attached - in-service sheet</p>	8/4/07

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W 154	Continued From page 5 him about how the injury had occurred.	W 154		
W 156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS</p> <p>The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>This Standard is not met as evidenced by: Based on interview and record review, the facility failed to ensure that investigations were reported to the administrator and State officials within five working days of the incident, for one of the six clients residing in the facility. (Client #5)</p> <p>The finding includes:</p> <p>On July 24, 2007, at 3:30 PM, review of the facility's incident reports and investigations revealed that on January 23, 2007, Client #5 alleged that a staff person had hit her with a stick. Further record review revealed that the incident was investigated and reported to the administrator. There was no evidence, however, that the results of the investigation were reported to governmental officials in accordance with state law, within five working days.</p>	W 156	<p><u>W156</u> Cross-reference W148 (a, b, c&amp;d)</p>	
W 159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>This Standard is not met as evidenced by: Based on interview and record review, the Qualified Mental Retardation Professional</p>	W 159		

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W 159	<p>Continued From page 6</p> <p>(QMRP) failed to ensure the coordination of services, for two of the six clients residing in the facility. (Clients #2 and #4)</p> <p>The findings include:</p> <p>1. The QMRP failed to ensure the facility provided substitution for menu items to accommodate Client #4's dietary needs.</p> <p>During the breakfast observation on July 24, 2007 at 6:50 AM, Client #4 was observed making her own breakfast-two Eggo waffles, with diet Pepsi. Interview with the staff revealed the client #4 prefers to make her own meals and does not always adhere to the designed menu to meet her 1800 calorie ADA diet. Interview with Client #4 on 7/26/07 at approximately 1:10 PM revealed that she is knowledgeable about what her dietary needs are, but wants to stay "small." Therefore at times will not eat enough to maintain her sugar levels. She indicated that she is currently working on goals to assist her with independent living (apartment) to purchase her own foods and to make her own meals.</p> <p>On July 26, 2007, at approximately 3:30 PM, client #4's ISP record was reviewed. A Nutritional Care Plan ( not dated or signed) had been developed by the nutritionist instructing the staff to document meals on Client #4's daily food intake log. If she refused to eat what was on the menu, staff should offer her alternative choices of ADA appropriate meals. If the client continued to refuse, staff should document her refusal in her ABC data sheet. Staff should then offer her food at a later time. Staff should also notify the nurse at Client #4's finger stick/insulin administration. Nursing will follow the hypoglycemic protocol, if indicated, at the next finger stick/insulin</p>	W 159	<p><u>W159</u></p> <p>The facility has provided training to staff on client #4 meal protocol. QMRP and facility manager will continue to ensure that staffs are implementing the Nutritional care plan as outlined. The nutritionist met with client #4 to discuss her diet order and the reason why she should adhere to her diet. See attached- sign in sheet</p>	8/6/07

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W 159	<p>Continued From page 7 administration.</p> <p>On October 27, 2006, the nutritionist developed a Meal Protocol that clearly outlined what to do if she refused to eat at meals. 1) Offer her alternatives that coincide with her diabetic diet. Please make sure that a protein is substituted with another protein, a starch for starch, fruit for a fruit, vegetable for vegetable. Protein sizes to be consistent with menu plan. If continues to refuse, try to encourage Client #4 to eat and inform her of the importance of consuming her meals benefits and disadvantages. Notify the nurse and recommend blood sugar to be taken.</p> <p>On 7/25/07 at 12:45 PM, according to the menu, Client #4 was to have the following: Ham/cheese sandwich (2 oz. of ham, 1 slice of cheese), wheat bread-2 slices, potato salad-1/2 cup, banana-1/2, 1% milk/skim milk-8 oz and for a afternoon snack-vanilla wafers-4 each and apple juice-4 oz.</p> <p>Interview with Client #4 on 7/25/07, at 3:45 PM, revealed that she had selected and consumed Oodles of Noodles and a diet soda. There was no evidence that the QMRP ensured that staff were implementing the Nutritional Care Plan as outlined, to encourage Client #4 with selecting an alternative ADA appropriate meal or snack item.</p> <p>2. Review of Client #4's Individual Program Plan record on July 26, 2007 at approximately 3:45 PM, evidenced a Nutritional Care Plan (not dated or signed) that had been developed by the nutritionist instructing the staff to document meals on Client #4's daily food intake log. The care plan outlined to staff, that "If she refused to eat what was on the menu, staff should offer her alternative choices of ADA appropriate meals. If &lt;client&gt; continues to refuse, staff should</p>	W 159		
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W 159	Continued From page 8 document her refusal in her ABC data sheet. Staff should offer her food at a later time. Staff should also notify the nurse at Client #4's finger stick/insulin administration. Nursing will follow the hypoglycemic protocol if indicated at the next finger stick/insulin administration."  Review of Client #4's daily food intake for the period of July 1- 26, 2007 reflected staff inconsistencies in documentation, three different forms were utilized and there was no evidence that staff notified nursing staff about finger sticks. Out of a total of 26 days, and an opportunity of 78 meals and 52 snacks, staff documented a total of 22 meals consumed, and a total of 4 snacks. There was no evidence that the QMRP was ensuring that staff were documenting her daily intake as outlined. The QMRP had not sought clarification from the nutritionist as to which intake form was to be utilized. In addition, there was no evidence that Client #4's meal refusals had been tracked and communicated to medical, as outlined by the the nutritionist.  3. Cross-refer to W255. The QMRP failed to revise Client #2's programs after she met the established performance criteria in two of her programs.	W 159	<u>W159 #2</u> the facility has provided training to staff to ensure accurate documentation of food intake. QMRP and facility manager will provide oversight to ensure accuracy of documentation.  <u>W159 #3</u> Cross Reference W255	8/28/07
W 160	483.430(a)(1) QUALIFIED MENTAL RETARDATION PROFESSIONAL  The qualified mental retardation professional has at least one year of experience working directly with persons with mental retardation or other developmental disabilities.  This Standard is not met as evidenced by: Based on staff interview, the facility failed to	W 160		

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W 160	<p>Continued From page 9 provide evidence that the "Qualified Mental Retardation Professional" (QMRP) possessed the credentials as specified by the federal regulations.</p> <p>The finding includes:</p> <p>According to interview with the individual identified as the facility's QMRP, he had been employed for "about 3 months." Beginning on July 24, 2007, several requests were made to obtain the QMRP's personnel records to review the credentials. His records, however, were not made available for review before the survey ended late in the day on July 27, 2007.</p>	W 160	<p><u>W160</u> Current QMRP posses two degree in environmental planning. QMRP has over six years of experience working with individuals who has mental retardation and three years as a facilities coordinator (House Manager) experience. The facility will ensure that its records for each employee are available for review upon request. ILS provides training and oversight to employee to ensure all staff hired is qualified for duties.</p>	8/28/07
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> <p>This Standard is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to ensure the comprehensive functional assessment identified each clients specific developmental and behavioral needs, for one of the six clients residing in the facility. (Client #5)</p> <p>The finding includes:</p> <p>On July 24, 2007, at 8:59 AM, the medication nurse scheduled for daily morning administrations prepared Client #5's medications in the nursing station in the basement. As he walked upstairs to find the client, he stated that she would likely reject the red (multi-vitamin) pill. Reportedly, this was a routine practice... she often objected to the red multi-vitamin, for reasons not known. At 9:02</p>	W 214	<p>The facility will ensure that its records for each employee are available for review upon request. The facility provides training and oversight to employee to ensure all staff hired is qualified for duties.</p>	

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W 214	<p>Continued From page 10</p> <p>AM, the nurse handed Client #5 her medications. She immediately refused to take them because there was "that red pill in there." The nurse pleaded with her for three or four times. Client #5 manually removed the red pill from the cup. She told the nurse "you said you were going to change it." The nurse said the primary care physician (PCP) had to write a new order. When she asked what "what color is it going to be" the nurse replied "brown." The client refused the water the nurse had brought to her bedroom. She went to the kitchen, accepted a glass of orange juice poured by staff and took the other medications.</p> <p>Review of Client #5's Medication Administration records (MARs) for the months March 2007 - July 2007 revealed documentation that verified the nurse's statement earlier, that the client often rejected the red multi-vitamin pill. For example, her July 2007 MAR documented that she refused to take the red multi-vitamin pill on July 3, 6, 7, 15, 16, 17, 19, 20, 21, 22 and 23, 2007.</p> <p>On July 26, 2007, at 2:32 PM, review of Client #5's psychological evaluation, dated July 6, 2007, revealed that the psychologist had assessed her medication refusals in general. This and other psychology documents, however, failed to show evidence that the psychologist had been made aware that the client was refusing the red multi-vitamin pill (only). Later that afternoon, interview with the Qualified Mental Retardation Professional (QMRP) and the nurse coordinator revealed that neither was aware that Client #5 had an aversion to the red multi-vitamin pill.</p> <p>On July 27, 2007, beginning at 1:06 PM, the primary care physician was interviewed by telephone. He stated that while he knew that Client #5 sometimes rejected her medications, he</p>	W 214	<p><u>W214</u> Client #5 red multivitamin pill has been changed to vitaplex. Client #5 Primary Physician gave the order on 8/7/07. Client #5 started taking the vitaplex on 8/9/07 and has not refuse this medication since the aforementioned date. See attached - P.O.</p>

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W 214	Continued From page 11 was previously unaware that she often refused the red multi-vitamin pill (only).  Interviews and review of Client #5's record failed to show evidence that the client's aversion to the red multi-vitamin pill (in particular) had been assessed and/or otherwise addressed by the medical team.	W 214		
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN  The individual program plan must include opportunities for client choice and self-management.  This Standard is not met as evidenced by: Based on observation, interview and record review, the facility did not promote choice and self-management in dining skills and food selection, for two of the six clients residing in the facility. (Clients #1 and #4).  The findings include:  1. During observation of breakfast on July 24, 2007, at 6:50 AM, Client #1 was served cereal which was portioned by the staff. Staff then gave her two packages of dietetic sugar substitute (Sweet and Low). When asked if there was any regular sugar in the facility, and if Client #1 was on a restrictive diet, the staff indicated that Client #1 was on a regular diet, with no restrictions. Sugar was not kept in the house. On July 26, 2007, at 1:10 PM, review of Client #1's diet orders confirmed that she was on a regular diet. There were no restrictions or contraindications for condiments listed in the record for Client #1.  2. During breakfast on July 24, 2007, at 6:50 AM, and again at dinner observation that evening, at	W 247	<u>W247-1</u> The facility manager purchased regular sugar on 7/28/07. QMRP and facility manager will continue to ensure that different condiments are available at all time.	

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W 247	<p>Continued From page 12</p> <p>5:05 PM, all six clients were provided with spoons (only); no forks or knives were made available. The evening meal included BBQ chicken. The clients were observed having difficulty removing the meat from the bones with their spoons. Client #4 requested a fork, but was never given one. She eventually put down her spoon and used her fingers to finish eating her chicken. Interview with the facility staff during the dinner observation revealed that two clients (#1 and #5) could potentially use forks and knives as weapons. At 5:05 PM, when another staff was asked why the clients used spoons to eat, that staff person could not specify a reason.</p> <p>On July 25, 2007, at approximately 3:00 PM, a review of all of the residents habilitation plans did not reflect restrictions on use of forks or knives for Clients #1 or #4. In addition, none of the clients and/or these clients were incapable of using or learning to use utensils other than spoons. Interview with the Administrator after the dinner meal indicated that the facility had a full set of utensils downstairs and would be available for client use henceforth. The clients had them available for use during the remainder of the survey.</p> <p>3. On July 25, 2007, at 3:45 PM, interview with Client #4 revealed that she is a brittle diabetic. She stated that she was aware of the importance of adhering to her diet and to maintain her blood sugar levels. She further stated, however, that she wanted to stay "small" and this led her sometimes to select the wrong foods and not consume enough calories. While she participated in the weekly grocery shopping, she said she wished to establish her own individualized menu. Her menu would reflect her food preferences, rather than using the group home menus. There</p>	W 247	<p><u>W247-2</u> Fork and spoons were made available to individuals on 7/26/07. QMRP and facility manager will continue to ensure that all utensils are available to individuals at all time.</p> <p><u>W247-3</u> The nutritionist, nurse, Case manager and advocate met with client #4 on 8/7/07 to establish client #4 individualized menu as she wished and client #4 was uncooperative. However, the IDT team will develop a menu to present to client #4 for review and approval before implementation. See attached-sign sheet.</p>	8/7/07

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W 247 Continued From page 13  
was no evidence, however, that the nutritionist had met with Client #4 to begin development of an individualized menu and/or outline a list of foods that would constitute appropriate substitutions to address her preferences.

W 247

ILS will provide client #4 with opportunities to participate in meal and menu selection by providing her with opportunities to participate in the purchasing of food and development of menu. Nutritionist will meet with client to develop her individual menu. ILS will further ensure that all consumer participate in the selection of desired food.

8/28/07

W 255 483.440(f)(1)(i) PROGRAM MONITORING & CHANGE  
  
The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan.

W 255

This Standard is not met as evidenced by:  
Based on observations, staff interviews and record review, the Qualified Mental Retardation Professional (QMRP) failed to revise the Individual Program Plan (IPP) once the client successfully completed an objective identified in the IPP, for one of the three clients in the sample. (Client #2)

The findings include:

On the evening of July 24, 2007, the Qualified Mental Retardation Professional (QMRP) stated that the Program Manager was expecting to attend Client #2's interdisciplinary team (IDT) 6-month review meeting in his place on the following day. The meeting was being held at another facility and the QMRP wanted to remain onsite to facilitate this survey.

On July 26, 2007, at 11:41 AM, review of Client #2's QMRP monthly summaries revealed that for two programs (washing her hair with verbal prompts 50% of the time; and participating in an

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W 255	<p>Continued From page 14</p> <p>exercise program three times a week with no more than 2 verbal prompts), the client had achieved or surpassed the specified performance criteria for the past three months (April, May and June 2007). Review of the data collection sheets for those two programs, both with start dates of January 2007, revealed that staff had documented the client's performance at verbal prompts or independent for the past 3 months, effectively meeting or surpassing the criteria as outlined in the programs.</p> <p>At 12:22 PM, the Program Manager and the QMRP confirmed that the IDT met on the previous day. The team reportedly had reviewed her programs and services from the past 6 months and decided that none of her programs would be revised.</p> <p>Beginning at 12:42 PM, the QMRP, Program Manager and surveyors jointly reviewed the client's programs and corresponding data collection sheets from the past 6 months. Not long into the discussion, the QMRP stated that programs were not worded as he would like. Client #2's current programs had been inherited from the previous QMRP. He had started employment in the facility approximately 3 months before the survey. Further discussion revealed that the QMRP had revised programs for some clients prior to recent Individual Support Plans (ISPs). He had not done so, however, for Client #2's 6-month review.</p> <p>The QMRP and the Program Manager subsequently acknowledged that Client #2's programs should be revised and that the facility failed to use the latest IDT meeting to establish new programs, or revise current programs, in accordance with the client's assessed needs.</p>	W 255	<p><u>W255</u></p> <p>A review of formal program goals and objective was completed on 8/6/07. Client #2 programs were revised and developed to include single outcome objective for skill development. QMRP to provide training and oversight to staff to ensure full implementation and adequate documentation of each program.</p> <p><u>W255</u></p> <p>ILS will further ensure the review of all programs for all individuals in the facility and modify up date as indicated. ILS will review indicate modifications and updates.</p>	<p>8/28/07</p> <p>9/15/07</p>

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W 255	Continued From page 15 The QMRP said he wanted to revise the performance criteria. In addition, the QMRP further indicated that he wanted to revise the client's data collection sheets in order to ensure that the information being documented by staff was relevant to her goals and objectives and reflected the length of time she was able to perform the stated objective.	W 255		
W 264	483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE  The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.  This Standard is not met as evidenced by: Based on observation, interview and record review, the facility's specially-constituted committee (Human Rights Committee, HRC) did not review and approve ongoing facility practices of using a door chime to monitor client movements and/or restricting client access to forks and knives, affecting all six of the six clients residing in the facility.  The findings include:  1. Upon entering the facility on July 24, 2007, at 6:25 AM, surveyors noted a multiple chime noise that sounded like a doorbell. At 7:10 AM, Client # 4 exited out the front door to smoke a cigarette and the multiple chime noise was noted again. At 7:35 AM, the alarm went off again. Direct support	W 264	<u>W264 -1</u> Ongoing facility practices of using a door chime to monitor client movement will be presented to Human Right Committee for review and approval.	8/28/07

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W 264	<p>Continued From page 16</p> <p>staff indicated that it was the basement door. Throughout the survey, the doorbell chime sounded each time an exterior door was opened on both floors to the house, with the exception of the back door from the kitchen. When interviewed on July 25, 2007 at 7:35 AM, direct support staff stated that the door chime was for the safety, security and monitoring of the clients and the facility as a whole. They further indicated that the chimes were not for a specific individual's behaviors. The staff said that some of the ladies might elope from the facility, and the door chime gave the staff notification that someone was entering or leaving the facility.</p> <p>On July 26, 2007, at 3:30 PM, review of the Human Rights Committee meetings minutes for each client revealed no evidence that the committee had reviewed and approved the practice of using of door chimes to monitor clients' movements.</p> <p>2. Cross-refer to W247.2. Observations during the breakfast and dinner meals on July 24, 2007 revealed that staff routinely did not make forks and knives available for use by the clients. Interviews with some facility staff indicated that two clients (#1 and #5) might potentially use forks or knives as weapons.</p> <p>On July 26, 2007, at 3:30 PM, review of the Human Rights Committee meetings minutes for each client revealed no evidence of review and approval of the facility practice of restricting client access to forks and knives. Note: On the second day of the survey, the governing body took corrective action and provided all new eating utensils to the clients, to include forks, knives and spoons.</p>	W 264	<p><u>W264-2</u>            QMRP and Facility Manager will continue to ensure that all eating utensils to include forks, knives and spoon are available at all time.</p>	
W 322	483.460(a)(3) PHYSICIAN SERVICES	W 322		

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W 322	<p>Continued From page 17</p> <p>The facility must provide or obtain preventive and general medical care.</p> <p>This Standard is not met as evidenced by:        Based on observation, interview and record review, the facility failed to provide general and preventive care, for one of the six clients residing in the facility. (Client #4)</p> <p>The findings include:</p> <p>Review of Client #4's medical records revealed that her Risk Management Care Plan Summary (RMCPs), dated September 1, 2006, failed to address the following potential health risks that were identified through assessment, as follows:</p> <p>a. Fluid restriction to address Hypotremia. Client #4 was restricted to 180 cc for Breakfast; 180 cc for lunch, 180 cc for dinner and 180 cc for medication pass x 3 (60 CC X3) totaling 720 cc's per day. Review of Client #4's program record evidenced a form on which staff were to document fluid intake. Review of the documentation failed to accurately reflect the amount she had consumed. In addition, inconsistencies were noted with documentation. For example, during the month of July 2007, the only three days that staff documented her fluid intake were on 7/24, 7/25, and 7/26, which coincided with the survey and the fluid intake was written using cup measurements (not cc's).</p> <p>b. Risk for fractures of the hip and spine. According to the record, Client #4 received a bone density assessment on October 31, 2006 and determined to be at high risk of fractures.</p>	W 322	<p><u>W322-a</u>        Medical staff will provide training to staff concerning hypotremia care and documentation. Staff will ensure documentation is appropriate. QMRP and nurse will review and ensure staff documentation is correctly completed at least once a week.</p>	8/28/07
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W 322	<p>Continued From page 18</p> <p>Review of the consult form clearly outlined that she had osteopenia of the lumbar spine and hip, with increased risk of fractures in both locations.</p> <p>c. On 12/21/06, Client #4 was assessed by the psychiatrist, that determined an Axis 1: Dementia - NOS and Eating Disorder. Neither had been added to her current diagnoses. There was no evidence that the facility instituted proactive strategies to address the diagnoses.</p> <p>d. Client #4's RMCPS also failed to incorporate the nutritionist's recommendations as outlined in the Nutritional Care Plan and the October 26, 2006 Meal Protocol (meal refusals).</p>	W 322	<p><u>W322 - (b,c&amp;d)</u></p> <p>The QMRP will ensure that all needs and assessed needs are reviewed by the medical staff and incorporated into the individuals care plan (including ISP and BSP). The QMRP will further ensure staff training on new care issues as they arise.</p>	8/28/07
W 368	<p><b>483.460(k)(1) DRUG ADMINISTRATION</b></p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>This Standard is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that all medications were administered in accordance with the physician's orders, for three of the six clients receiving medications. (Clients #1, #2 and #4)</p> <p>The findings include:</p> <p>1. During the July 24, 2007 morning medication pass, Client #1 was observed receiving Lithium Carbonate 450 mg, Abilify 15 mg and Ranitidine hydrochloride (Zantac) 150 mg, along with other medications at 8:37 AM. Subsequent review of the client's POs and MARs revealed that those three medications were scheduled for a 7:00 AM administration. [Note: Her other morning</p>	W 368	<p><u>W368-1</u></p> <p>ILS will ensure that nurses are providing medications as ordered. Training to LPN will be provide.</p>	8/28/07

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W 368	<p>Continued From page 19</p> <p>medications were scheduled for 8:00 AM.]</p> <p>2. Cross-refer to W369.1. The facility had not established a system to provide the supervision necessary to ensure that Client #4 self-administered her 6:00 AM dose of Synthroid in accordance with physician's orders.</p> <p>3. Cross-refer to W369.2. The facility failed to establish an effective system to ensure that Client #2 received Reglan and Sodium Bicarbonate at recommended times, in relation to her meals at home and at day program.</p> <p>4. Cross-refer to W369.4 - W369.6. Prior to the survey, the facility failed to identify structural deficiencies regarding the morning nurse's scheduled arrival time and medication timing errors.</p>	W 368	<p><u>W368-2</u> LPN will develop a formal protocol to ensure staff monitoring of clients self administrator medication.</p> <p><u>W368-3</u> QMRP and LPN will provide training to day program nursing staff and oversight by monitoring the program at least monthly to ensure medications are given as ordered.</p>	8/28/07  8/28/07
W 369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>This Standard is not met as evidenced by: Based on observation, interview and record review, the facility failed to establish a system to ensure that all medications, including those that were self-administered, were administered without error, for three of the six clients observed receiving medications. (Clients #1, #2 and #4)</p> <p>The findings include:</p> <p>1. The facility failed to establish an effective system to ensure that Client #4 took her Synthroid at the prescribed hour, as follows:</p>	W 369	<p><u>W368-4</u> The program manager will ensure that ILS provides monitoring oversight of medication pass procedure for each individual by providing random monitoring of medication pass on a quarterly basis and or as needed. ILS will ensure the PCP is made aware of concerns related to the medication pass including time missed meds and all issues related to individuals needs. ILS will ensure the full implementation of orders written by PCP.</p>	8/28/07

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W 369	<p>Continued From page 20</p> <p>On July 24, 2007, at 6:48 AM, Client #4 was observed taking a pill independently while standing in the dining room. She swallowed it with Diet Pepsi and went into the kitchen to prepare waffles. At 6:54 AM, the client began eating her breakfast.</p> <p>At 7:16 AM, the client was asked about the pill she had taken. She could not recall the name of the medication or why she was taking it. She said it had to be taken before her meal and was not for treating her diabetes or hypertension. She retrieved a green plastic pill case with one pill in each of the daily compartments through the remainder of the week. The client said the nurse filled the pill case every weekend and she took them every morning independently. "6:00 AM" was written on the pill case in black magic marker.</p> <p>At approximately 7:30 AM, the Qualified Mental Retardation Professional (QMRP) was asked about Client #4's pill. He indicated that he wanted the nurse coordinator to respond to questions about the pill. At approximately 7:36 AM the nurse coordinator said Client #4's pill was Synthroid, which must be taken before meals, to treat hypothyroidism.</p> <p>At 9:37 AM, review of Client #4's July 2007 physician's orders (POs) indicated the Synthroid should be administered at 8:00 AM. Instructions typed on the Synthroid blister pack included "take at least 1/2 hour before breakfast." She was observed eating breakfast that morning, within less than 10 minutes of having taken the Synthroid.</p> <p>2. The facility failed to establish an effective system to ensure that Client #2 received</p>	W 369	<p><u>W369-1</u> Cross-reference W368</p> <hr/> <p>ILS has developed and will implement a formal self medication program that will allow for increased independence in administration of synthoid medication while being monitored by staff.</p> <hr/> <p>ILS will implement protocols that will be posted to ensure that direct care staffs are aware of and comply with recommended medication and meal schedule.</p>	<p>8/28/07</p> <hr/> <p>9/7/07</p>

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W 369	<p>Continued From page 20</p> <p>On July 24, 2007, at 6:48 AM, Client #4 was observed taking a pill independently while standing in the dining room. She swallowed it with Diet Pepsi and went into the kitchen to prepare waffles. At 6:54 AM, the client began eating her breakfast.</p> <p>At 7:16 AM, the client was asked about the pill she had taken. She could not recall the name of the medication or why she was taking it. She said it had to be taken before her meal and was not for treating her diabetes or hypertension. She retrieved a green plastic pill case with one pill in each of the daily compartments through the remainder of the week. The client said the nurse filled the pill case every weekend and she took them every morning independently. "6:00 AM" was written on the pill case in black magic marker.</p> <p>At approximately 7:30 AM, the Qualified Mental Retardation Professional (QMRP) was asked about Client #4's pill. He indicated that he wanted the nurse coordinator to respond to questions about the pill. At approximately 7:36 AM, the nurse coordinator said Client #4's pill was Synthroid, which must be taken before meals, to treat hypothyroidism.</p> <p>At 9:37 AM, review of Client #4's July 2007 physician's orders (POs) indicated the Synthroid should be administered at 8:00 AM. Instructions typed on the Synthroid blister pack included "take at least 1/2 hour before breakfast." She was observed eating breakfast that morning, within less than 10 minutes of having taken the Synthroid.</p> <p>2. The facility failed to establish an effective system to ensure that Client #2 received</p>	W 369	<p><u>W369-1</u> Cross-reference W368</p> <hr/> <p>ILS has developed and will implement a formal self medication program that will allow for increased independence in administration of synthoid medication while being monitored by staff.</p> <hr/> <p>ILS will implement protocols that will be posted to ensure that direct care staffs are aware of and comply with recommended medication and meal schedule.</p>	<p>8/28/07</p> <hr/> <p>9/7/07</p>

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W 369	<p>Continued From page 21</p> <p>medications at recommended times in relation to her meals at home and at day program, as follows:</p> <p>a. During the July 24, 2007 morning medication pass, at 8:15 AM, Client #2 was observed punching her medications out of the blister packs in the presence of the nurse. Metoclopramide (Reglan) 5 mg and Sodium Bicarbonate 650 mg were among the medications she received. During the verification process, at approximately 9:50 AM, review of Client #2's July 2007 POs revealed that the Metoclopramide (Reglan) was to be administered before she ate breakfast and the Sodium Bicarbonate was to be taken along with her meal. She had been observed starting breakfast at approximately 7:05 AM (a little over an hour before the med pass began) therefore, there were timing errors for both medications.</p> <p>b. On July 25, 2007, Client #2's day program nurse and Supervisory IPP Coordinator were interviewed on site. At approximately 10:44 AM, the nurse looked at the client's medical chart and stated that she received Neurontin and Sodium Bicarbonate at approximately 12:00 noon daily. Client #2 reportedly was "very cooperative" with taking her medications. At approximately 10:54 AM, interview with the staff person overseeing the cafeteria revealed that Client #2 and her peers routinely ate lunch at 12:00 noon.</p> <p>On July 26, 2007, at 8:02 AM, Client #2's July 2007 POS were reviewed again. The POs did not indicate she was prescribed Neurontin, therefore it was unclear why the day program nurse had mispoken. At 8:29 AM, the QMRP was asked about monitoring of day programs. He went to retrieve a notebook. At 8:40 AM, the client's MAR showed Metoclopramide (Reglan) 5 mg "4 times</p>	W 369	<p><u>W369-2</u> Cross-reference W368 #4</p> <hr/> <p><u>W369-a</u> Cross-reference W368 #3</p> <hr/> <p><u>W369-b</u> Cross-reference W368 #3</p> <hr/> <p>ILS will meet with the day program to ensure current POS and to address any treatment and or medication issues.</p>	8/28/07

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W 369	<p>Continued From page 22</p> <p>daily before meals," including at noon. The MARs did not, however, indicate how much earlier she should receive the Reglan, before the meal. The POs confirmed that she also received Sodium Bicarbonate at noon. At 8:56 AM, the QMRP returned to the room, said he had discussed the client's medications with the day program nurse during a recent visit; however, he could not find his note providing the date of the visit. The QMRP acknowledged that it appeared the two medications (Reglan and Sodium Bicarbonate) should not be administered at the same time.</p> <p>3. The facility failed to establish an effective system to ensure that Client #1 received medications at recommended times, as follows:</p> <p>During the July 24, 2007 morning medication pass, Client #1 was observed receiving Lithium Carbonate 450 mg, Abilify 15 mg and Ranitidine hydrochloride (Zantac) 150 mg, along with other medications at 8:37 AM. Review of the client's POs and MARs revealed that those three medications were scheduled for a 7:00 AM administration. Her other medications, however, were scheduled for 8:00 AM. Interview with the nurse coordinator revealed that she was previously unaware of a timing error.</p> <p>4. The arrival time of the routine morning medication nurse did not facilitate observing clients and/or administering clients' medications before or during breakfast, as follows:</p> <p>On July 24, 2007, at 6:46 AM, a direct support staff person said that on most mornings, the medication nurse usually arrived at 8:00 AM. On this day, however, a nurse who identified herself as the nurse coordinator arrived in the facility at</p>	W 369	<p>ILS will ensure that clear parameter for eating meals are defined by PCP for client #2 and any consumer when indicated.</p> <p><u>W369-3</u> Cross-reference W368</p> <p>ILS will modify current MARs to reflect appropriate medication administration.</p> <p><u>W369-4</u> Cross - reference W368</p>	8/28/07
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W 369	<p>Continued From page 23</p> <p>approximately 7:25 AM. She indicated that another nurse routinely passed morning meds. She further indicated that three clients had medical appointments that day so she came early to facilitate the morning medication pass. At approximately 8:57 AM, the scheduled medication nurse arrived at the facility and completed the final two clients' administrations. On July 25, 2007, at approximately 1:40 PM, review of the staff activities log corroborated what the direct support staff had said the previous day; the morning medication nurse's arrivals to the facility were documented at 8:26 AM, 8:30 AM and 8:32 AM on July 11, 12 and 13, 2007, respectively. On the same mornings, staff had documented the clients ate breakfast before the nurse arrived.</p> <p>5. The consulting Registered Nurse (RN) was interviewed by telephone on July 25, 2007, beginning at 5:33 PM. The RN said she did not monitor medications because she did not administer medications.</p> <p>6. There was no evidence that the primary care physician (PCP) had been made aware of medication timing errors for Clients #1, #2 and #4, as follows:</p> <p>a. Review of MARs for Clients #1, #2 and #4 revealed no documentation indicating timing errors with respect to meals, and there were no nursing notes indicating notification of the PCP of such timing errors. The survey, however, revealed ongoing timing errors, as detailed in the preceding paragraphs.</p> <p>b. On July 27, 2007, the primary care physician was interviewed over the telephone, beginning at 1:06 PM. He stated that he was previously</p>	W 369	<p>ILS will ensure that clear parameter for eating meals are defined by PCP for client #2 and any consumer when indicated.</p> <p><u>W369-5</u> Cross - reference W368 #4</p> <p><u>W369-6</u> Cross-reference 368#4</p>	9/7/07

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W 369	Continued From page 24 unaware that Client #4 took her Synthroid independently, before a nurse arrived in the facility. He said the Synthroid should be taken "a minimum of 1 hour or 2" before eating. He also indicated that he was previously unaware that Client #2 was receiving the Reglan and Sodium Bicarbonate after breakfast.	W 369	<u>W369-b</u> Cross-reference 368 #4	
W 381	483.460(l)(1) DRUG STORAGE AND RECORDKEEPING  The facility must store drugs under proper conditions of security.  This Standard is not met as evidenced by: Based on observation and staff interview, the facility failed to store drugs under proper conditions of security.  The findings include:  During the medication administration on July 24, 2007 at 8:11 AM, the medication nurse was observed to leave the medication cabinet unlocked when she left the nurse's area and went to supervise and assist Client #2 with her self-medication training program in an adjoining room. The same process was repeated at 8:25 AM, 8:36 AM and at 8:47 AM when the nurse left the closet door unlocked while assisting Clients #4, #1 and #6, respectively, with their medications in an adjoining room.	W 381		8/28/07
W 385	483.460(l)(3) DRUG STORAGE AND RECORDKEEPING  The facility must maintain records of the receipt and disposition of all controlled drugs.  This Standard is not met as evidenced by:	W 385	<u>W381</u> QMRP will provide training to nurses to ensure medication cabinet is secure at all times when not in use.	



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W 385	<p>Continued From page 26</p> <p>On July 24, 2007, at 4:52 PM, the nurse coordinator acknowledged that the May, June and July 2007 MARs did not reflect administration of an Ativan injection. Her April 2007 MARs, however, documented 2 separate occasions when the psychiatrist authorized the emergency use of injections of Ativan with Haldol. At 4:56 PM, the nurse coordinator re-examined the labels on the 2 orange plastic medication containers in the refrigerator. She discovered that the label indicated only 2 doses of Ativan were filled on May 11, 2007. She did not know why an empty bottle had been placed in the container, after it was delivered in May.</p> <p>It should be noted that on July 25, 2007, at 4:00 PM, review of Client #5's monthly Psychotropic Medication Review (PMR) summaries from September 2006 through June 20, 2007 revealed no evidence that the PMR team (psychologist, pharmacist, LPN nurse coordinator and psychiatrist) had discussed the administration/ injection of liquid Ativan with Haldol. Client #5's MARs had documented 2 such injections in January 2007 and another 2 injections in April 2007.</p> <p>3. During the medication pass observation on July 24, 2007, at 8:39 AM, the nurse coordinator dropped a Lorazepam/ Ativan 1 mg tablet onto the floor while preparing Client #1's medications. She placed the wasted tablet in a separate cup and put the cup on a shelf in the nurse/ medication closet. She continued with the medication pass until the regularly-scheduled morning nurse arrived in the facility, at approximately 8:55 AM. At approximately 8:58 AM, the second nurse assumed responsibility for the med pass and at 9:15 AM, he indicated that</p>	W 385	<p>ILS will investigate questionnaire response by LPN and provide random monitoring of medication passes and documentation as well as ensure that nurse are trained on disposal of medication.</p>	9/7/07

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W 385	<p>Continued From page 27 he had finished.</p> <p>Five minutes later, at 9:20 AM, the nurse called this surveyor to the bathroom to witness him flushing the red multi-vitamin pill that Client #5 had refused to take earlier. As he flushed it, this surveyor walked to the nurse/ medication closet in the adjoining room. The cup that had held the wasted Ativan 1 mg tablet was empty. The nurse came to the closet and was asked if there was another pill that needed to be discarded. He replied "no." This surveyor then said I would ask the nurse coordinator about the pill that she had dropped on the floor; perhaps she had already disposed of it. Within one or two seconds, the nurse reached into the closet and this surveyor heard the plop of a pill into a cup. Observation revealed that the Ativan tablet was again in the cup on the closet shelf. When asked, the nurse said he had been holding the tablet in his hand. When asked for further clarification, the nurse said there was "no reason" that he had not flushed it along with the red multi-vitamin a few minutes earlier.</p> <p>At 11:13 AM later that morning, the nurse coordinator acknowledged having shown the other nurse the cup holding the wasted Ativan and had asked him to discard the tablet. Upon review of this surveyor's observation and interview notes, the nurse coordinator said she would relay the information to the consulting Registered Nurse (RN). When asked about the facility's policies, the nurse coordinator said ILS policy was to have two nurses witness the disposal, which was why she had not discarded it immediately, she was waiting for the second nurse to arrive. She acknowledged not having accompanied the nurse to witness the disposal.</p>	W 385	<p>ILS will further monitor use of psychotropic medications via random monitors as well as review of medication log sheet.</p> <p>The facility program manager and RN will ensure that all medications pass nurses are aware of the policy concerning destruction of medication, by providing on going training and monthly meetings with LPN Coordinator to ensure compliance.</p>	<p>9/7/07</p> <p>8/28/07</p>

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W 385	Continued From page 28 Subsequent interviews on July 25, 2007 with the Executive Director (on site, at 5:02 PM) and the consulting RN (by telephone, at 5:33 PM) revealed that the facility's policies did not require a second nurse to witness the disposal. They both did, however, state that the nurse who drops a pill is responsible for ensuring that it is disposed of properly. This was verified through review of the facility's policies and procedures shortly thereafter.	W 385		
W 386	483.460(l)(4) DRUG STORAGE AND RECORDKEEPING  The facility must, on a sample basis, periodically reconcile the receipt and disposition of all controlled drugs in schedules II through IV (drugs subject to the Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. 801 et seq., as implemented by 21 CFR Part 308).  This Standard is not met as evidenced by: Based on observation, interview and record review, the facility failed to document the reconciliation of the receipt and disposition of controlled drugs, for four of the four clients in the facility receiving Schedule IV medications (Ativan and Klonopin). (Clients #1, #3, #4 and #5)  The findings include:  1. On July 24, 2007 at approximately 8:35 AM, a 1 mg tablet of Lorazepam (Ativan) fell to the floor while the nurse prepared Client #1's medications. The nurse placed the tablet in a separate cup, set it aside in the medication closet, and punched another tablet from the blister pack. The med pass ended at 9:15 AM. The tablet was flushed at approximately 9:23. Review of Client #1's	W 386	W386-1 Cross-reference 385 #1	

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W 386	<p>Continued From page 29</p> <p>Medication Administration Record (MAR) revealed disposition of controlled substances sheets that were completed through December 2006. There were no disposition sheets observed in the record for more recent months.</p> <p>2. When surveyors examined the MARs on July 25, 2007, there were no reconciliation records observed in the MAR, for Client #1 or any of her peers who also received controlled substances. [Note: Clients #3 and #4 received Ativan and Client #5 received Klonopin as well as Ativan/Haldol injections.] When asked, neither the Qualified Mental Retardation Professional (QMRP) nor the Nurse Coordinator could account for the missing disposition sheets. At approximately 1:30 PM, review of the facility's Policies and Procedures Manual failed to show evidence of a policy on the reconciliation of controlled substances. At 1:39 PM, the Qualified Mental Retardation Professional (QMRP) was asked to determine whether the facility had such a policy.</p> <p>The consulting Registered Nurse (RN) was interviewed by telephone later that day (July 25, 2007), beginning at 5:33 PM. The RN said she did not monitor medications, including controlled medications, because she did not administer medications. She further stated that she did not know what, if any, forms the facility used for tracking and reconciling controlled substances.</p> <p>Additional interviews and record verification that evening failed to show evidence that the facility periodically reconciled the receipt and disposition of all controlled substances. No additional information was presented before the survey ended the evening of July 27, 2007.</p>	W 386	<p><u>W386-2</u> Cross -reference 385 #1</p>	
W 390	483.460(m)(2)(i) DRUG LABELING	W 390		

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W 390	<p>Continued From page 30</p> <p>The facility must remove from use outdated drugs.</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to remove from use, out dated medication.</p> <p>The finding include:</p> <p>On July 24, 2007, at 3:01 PM, inspection of the refrigerator in the locked nurse/ medication closet revealed a vial of liquid Lorazepam (Ativan) containing a 1 mg dose. The label indicated that the medication was for a client who had been discharged from the facility (discharge date not provided by nursing staff upon request). The label also stated "discard after July 12, 2007."</p>	W 390	<p><u>W390</u></p> <p>Through regular monitoring quarterly or as needed, the nurses will ensure that the refrigerator and all medications items are appropriate for individuals living in the home. The agency will implement its policy for medication disposal.</p>	8/28/07
W 426	<p>483.470(d)(3) CLIENT BATHROOMS</p> <p>The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.</p> <p>This Standard is not met as evidenced by: Based on observations, the facility failed to maintain water temperatures not to exceed 110 degrees Fahrenheit.</p> <p>The findings include:</p> <p>On July 24, 2007 at 6:25 PM, the hot water temperature felt hot to the touch. Readings from the surveyor's thermometer were 120 degrees Fahrenheit in the bathroom sink and shower in which all six clients bathe (on the main floor).</p>	W 426		

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

Printed: 08/08/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G188</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/27/2007</b>
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NAME OF PROVIDER OR SUPPLIER <b>INNOVATIVE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3259 'O' ST. SE WASHINGTON, DC 20020</b>
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W 426	<p>Continued From page 31</p> <p>The Qualified Mental Retardation Professional ( QMRP) was unable to obtain a reading using the facility's thermometer, as it was not calibrated correctly.</p> <p>On July 25, 2007, the QMRP informed the surveyors that corrective action had been taken and a new water thermometer had been purchased. The QMRP further stated that the water temperature had been adjusted by maintenance to not exceed the 110 degrees Fahrenheit. On July 25, 2007, at 1:21 PM, the facility's hot water registered at 92 degrees Fahrenheit in the main bathroom. On July 27, 2007 at 1:10 PM, the facility's hot water was rechecked for verification. The water temperature was at 100 degrees Fahrenheit in the main bathroom.</p>	W 426	<p><u>W426</u></p> <p>QMRP and facility manager will continue to ensure that the water thermometer is in working condition and water temperature remains within the required limit. QMRP and facility manager will continue to ensure that water temperature is taking and documented on a daily basis.</p>	8/28/07
W 436	<p>483.470(g)(2) SPACE AND EQUIPMENT</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 provide and maintain in good repair adaptive equipment for one of the three clients in the sample. (Client #1)</p> <p>The findings include:</p> <p>1. Interview with the facility staff on July 24, 2007 at 8:00 AM, revealed that Client #1 had recently lost her dentures. The QMRP noted that the</p>	W 436		

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W 436	<p>Continued From page 32</p> <p>client had lost them while on a recent home visit. (7/18/07). Record review on July 25, 2007 of the ISP record, verified that she received her new dentures on June 19, 2007. Also documented was a May 19, 2007 training session from the dentist on denture care and the use of adhesive in the lower partial denture; this was one month before she received the dentures. According to her July 11, 2007 ISP, it was noted that she often refused to wear them. Review of Client #1's training records failed to show evidence that the facility provided formal, ongoing training to ensure that Client #1 understood completely how to manage and take care of her dentures. In addition, there was no evidence in the record as to how the facility managed her refusals to wear the dentures.</p> <p>2. On July 25, 2007, at 1:10 PM, review of Client #1's July 11, 2007 Individual Support Plan (ISP) revealed that the client was prescribed glasses for reading. Client #1 was not observed wearing reading glasses throughout the survey, from July 24 - 27, 2007. Further review of the ISP and staff interview revealed that the client did not wish to wear her glasses. Review of her records, however, failed to show evidence that the facility had provided training and encouragement on wearing her glasses. In addition, there was no documentation in her record that her refusals to use glasses for reading had been addressed by the interdisciplinary team.</p>	W 436	<p><u>W436</u></p> <p>1. The QMRP and nurse will ensure client #1 receives a follow up from the dentist including training. Formal program data collection will be implemented to address refusal to wear dentures.</p> <p><u>W436</u></p> <p>2. The QMRP and nurse will ensure all clients' needs are addressed. QMRP will locate prescription and find out if it is current and if glasses can be replaced. QMRP will ensure client is addressed if needed for new prescription. QMRP will ensure staff and client training to refusal.</p>	8/28/07  8/28/07
W 440	<p>483.470(i)(1) EVACUATION DRILLS</p> <p>The facility must hold evacuation drills at least quarterly for each shift of personnel.</p> <p>This Standard is not met as evidenced by:          On July 25, 2007, at 9:10 AM, interview with the</p>	W 440		

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W 440	<p>Continued From page 33</p> <p>Qualified Mental Retardation Professional (QMRP) and review of the weekly staffing schedule indicated that there were three designated shifts (8:00 AM - 4:00 PM; 4:00 PM -12:00 AM and 12:00 AM - 8:00 AM). Review of the facility's documentation for the period June 23, 2007 - July 24, 2007 revealed no evidence that the facility conducted simulated fire drills at least four times (4) a year for each shift, as follows:</p> <p>a. There was a 7 1/2 month gap (from October 24, 2006 until June 7, 2007) between drills held during the morning shift.</p> <p>b. The last fire drill documented on the evening shift was conducted March 20, 2007.</p> <p>c. The last fire drill documented on the overnight shift was conducted January 16, 2007.</p> <p>The above findings were referred to the Office of the Fire Marshal.</p>	W 440	<p><u>W440</u></p> <p>Staff training on fire drills and evacuation plan was done on 8/11/07. Documentation of drills will be maintained in the home. The agency has a fire evacuation and drill policy in place and this will be monitored monthly by the QMRP as part of QA process. See- attached - in-service sheet</p>	

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I 000	INITIAL COMMENTS	I 000		
	<p>The licensure survey was conducted from July 24, 2007 through July 27, 2007. A random sample of three residents was selected from a residential population of six females with mental retardation and other disabilities. The survey findings are based on observations in the Group Home for Persons with Mental Retardation (GHMRP), two day programs and interviews with residential and day program staff and residents, including nursing and administrative staff. In addition, the survey included a review of administrative records, including incident reports and the residents' habilitation and medical records.</p>			
I 043	<p>3502.2(c) MEAL SERVICE / DINING AREAS</p> <p>Modified diets shall be as follows:</p> <p>(c) Reviewed at least quarterly by a dietitian.</p> <p>This Statute is not met as evidenced by: Based on record review, the GHMRP failed to ensure that the modified diet of one resident had been reviewed at least quarterly by the consulting dietitian. (Resident #4)</p> <p>The finding includes:</p> <p>Review of Resident #4's records failed to show evidence that the Nutritionist had reviewed her diet and meal plan on a quarterly basis.</p> <p>Resident #4's Individual Program Plan record included a Nutritional Care Plan (not dated or signed) that had been developed by the nutritionist instructing the staff to document meals on Resident #4's daily food intake log.</p>	I 043		

Health Regulation Administration LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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1052	<p>Continued From Page 2</p> <p>resident use during meals.</p> <p>The findings include:</p> <p>On July 24, 2007, during the breakfast and dinner observations, at 6:50 and 5:05 PM respectively, all residents were provided with spoons to eat with. There were no forks or knives presented to the residents and inspection of the kitchen revealed there were none available. Residents were not encouraged to utilize other utensils as appropriate. Review of all the residents habilitation records did not reflect that the residents were incapable of using or learning to use utensils other than spoons.</p> <p>Interview with the facility staff during dinner indicated that Residents #1 and # 5 could potentially use forks and knives as weapons therefore they were not made available.</p> <p>Also see Federal Deficiency Report - Citation W264</p>	1052	<p><b>1052</b> See Federal Deficiency Report citation W264</p>	
1056	<p>3502.14 MEAL SERVICE / DINING AREAS</p> <p>Each GHMRP shall train staff in the storage, preparation and serving of food, the cleaning and care of equipment, and food preparation in order to maintain sanitary conditions at all times.</p> <p>This Statute is not met as evidenced by: Based on observation, interview, and record review, the GHMRP failed to ensure staff were trained in the storage, preparation and serving of food, the cleaning and care of equipment, and food preparation in order to maintain sanitary conditions at all times.</p>	1056	<p><b>1056</b> QMRP will ensure that at least one staff person is trained on safe food handling guidelines on each shift.</p> <p>ILS has scheduled training for food handling on 9/1/07 and 9/2/07 for staff that are not certified. Until such time the QMRP as well as house manager and other. ILS staff will assist in ensuring that there trained staff on every shift.</p>	8/28/07

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I 056	Continued From Page 3  The finding includes:  Review of personnel records on July 26, 2007 revealed the GHMRP failed to provide evidence that a certified food handler was on duty during meal preparation for all shifts.	I 056		
I 090	<b>3504.1 HOUSEKEEPING</b>  The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.  This Statute is not met as evidenced by: Based on observations, interviews and review of records, the facility's governing body provided general operating direction over the facility, except in the following areas:  The findings include:  Observation of the environment on July 27, 2007, beginning at 1:10 PM, revealed the following concerns.  a. Overhead stove light was burned out.  b. Kitchen cabinet knob was missing.  c. Paint on the kitchen cabinet by the stove was chipped and peeling.  d. Emergency light above Resident #1's door was broken. One side of the light fixture was hanging down.  e. Cross-refer to Federal Deficiency Report -	I 090	<b>1090</b> Through weekly monitoring of the home the QMRP and Facility Manager will ensure that the home is well Maintained. -Stove light replaced -Kitchen cabinet knob replaced -Peeling and chipped paint repaired Emergency light was replaced.	8/15/07

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I 090	Continued From Page 4  Citation W426. On July 24, 2007 at 6:25 PM, the hot water temperature felt hot to the touch. Readings from the surveyor's thermometer were 120 degrees Fahrenheit in the bathroom sink and shower in which all six clients bathe (on the main floor). The Qualified Mental Retardation Professional ( QMRP) was unable to obtain a reading using the facility's thermometer, as it was not calibrated correctly. This deficient practice was corrected within less than 24 hours.	I 090	<u>1090 - e</u> Cross- reference W426	
I 135	3505.5 FIRE SAFETY  Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift.  This Statute is not met as evidenced by: On July 25, 2007, at 9:10 AM, interview with the Qualified Mental Retardation Professional (QMRP) and review of the weekly staffing schedule indicated that there were three designated shifts (8:00 AM - 4:00 PM; 4:00 PM -12:00 AM and 12:00 AM - 8:00 AM). Review of the facility's documentation for the period June 23, 2007 - July 24, 2007 revealed no evidence that the facility conducted simulated fire drills at least four times (4) a year for each shift, as follows:  a. There was a 7 1/2 month gap (from October 24, 2006 until June 7, 2007) between drills held during the morning shift.  b. The last fire drill documented on the evening shift was conducted March 20, 2007.  c. The last fire drill documented on the overnight shift was conducted January 16, 2007.	I 135	<u>1135</u> Cross Reference W440	

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I 135	Continued From Page 5  The above findings were referred to the Office of the Fire Marshal.	I 135		
I 200	<p>3509.1(a) PERSONNEL POLICIES</p> <p>3509.1 personnel policies, which meet the following requirements, shall be developed according to the GHMRP 's particular needs and distributed to each employee:</p> <p>(a) The Residence Director shall be at least twenty-one (21) years of age, have a high school diploma or the equivalent, at least two (2) years of experience in human services including one (1) year of working with mentally retarded individuals and demonstrate supervisory capability; and...</p> <p>This Statute is not met as evidenced by: Based on staff interview, the facility failed to provide evidence that the "Qualified Mental Retardation Professional" (QMRP) possessed the credentials as specified by federal regulations.</p> <p>The finding includes:</p> <p>According to interview with the individual identified as the QMRP for the facility, he had been employed for "about 3 months." Beginning on July 24, 2007, several requests were made to obtain the QMRP's/Residential Director personnel record to review the credentials; however, the requested records were not provided before the survey ended late on July 27, 2007.</p>	I 200	<p><b>1200</b> Cross Reference W160</p>	

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I 206	Continued From Page 6	I 206		
I 206	<p><b>3509.6 PERSONNEL POLICIES</b></p> <p>Each employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been performed and that the employee's health status would allow him or her to perform the required duties.</p> <p>This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current health certificates for all employees annually.</p> <p>The findings include:</p> <p>On July 26, 2007, review of personnel records failed to show evidence of current health certifications for the following:</p> <ul style="list-style-type: none"> <li>- One direct care staff (S2)</li> <li>- Primary care physician (C1)</li> <li>- Psychologist (C2)</li> <li>- Nutrition (C3)</li> <li>- Pharmacy (C4)</li> <li>- Behavior Specialist (C5)</li> <li>- Speech Therapist (C6)</li> <li>- Recreation Therapist (C7)</li> </ul> <p>This is a repeat deficiency. See State licensure survey report dated September 25, 2006.</p>	I 206	<p><b>1206</b></p> <p>The facility will ensure that health certificate for current employee's are in place and available for review upon request.</p>	8/28/07
I 300	<p><b>3515.1 CONFIDENTIALITY OF RECORDS</b></p> <p>Each GHMRP shall have written policies governing access to, duplication, of, and release of information from each resident's record</p>	I 300		

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I 300	<p>Continued From Page 7</p> <p>consistent with D.C. Law 2-137, D.C. Code § 6-1972 and this chapter.</p> <p>This Statute is not met as evidenced by: During the Entrance Conference on July 24, 2007, at approximately 12:50 PM, the Qualified Mental Retardation Professional (QMRP) indicated that Resident #3's mother was involved in her habilitation planning and attended "almost every" meeting. On July 25, 2007, beginning at 4:35 PM, interview with Resident #3 confirmed that she was in agreement with the mother making important decisions on her behalf. On July 26, 2007, at 5:34 PM, review of the resident's Individual Support Plan (ISP), dated June 13, 2007, confirmed the mother's involvement and her role in making important decisions for her.</p> <p>On July 27, 2007, at 11:15 AM, a release of information authorization form was observed in Resident #3's records. It had been signed on July 12, 2006. The form had not been fully completed and did not identify what information was to be released, to whom the information would be given and failed to indicate an ending date. Review of the GHMRP's policies revealed that the governing body had established a procedure by which each authorization form must specify the information to be released, to whom the information will be given and indicate that the release of information is invalid beyond 365 days from the time issued. This was not reflected in the form signed by Resident #3 and her mother on July 12, 2006.</p> <p>During follow-up interviews with the Program Manager and QMRP on July 27, 2007, they acknowledged that the form was not in compliance with the GHMRP's policies and procedures.</p>	I 300	<p><b><u>1300</u></b> Cross Reference W113</p>	
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I 300	Continued From Page 8	I 300		
I 374	<p><b>3519.5 EMERGENCIES</b></p> <p>After medical services have been secured, each GHMRP shall promptly notify the resident ' s guardian, his or her next of kin if the resident has no guardian, or the representative of the sponsoring agency of the resident ' s status as soon as possible, followed by written notice and documentation no later than forty-eight (48) hours after the incident.</p> <p>This Statute is not met as evidenced by: Based on interview and record verification, the GHMRP failed to notify parents or guardians of significant incidents for two of the six residents residing in the facility. (Residents #3 and #5)</p> <p>The findings include:</p> <p>Review of the GHMRP incident reports and investigations on July 24, 2007, at 3:30 PM, failed to show evidence that the facility notified family members immediately of the following significant incidents:</p> <ol style="list-style-type: none"> <li>1. On January 23, 2007, Resident #5 alleged that a staff person had hit her with a stick.</li> <li>2. On March 23, 2007, Resident #5 eloped from the facility.</li> <li>3. On June 18, 2007, Resident #3 was agitated and was taken to the hospital.</li> <li>4. On June 12, 2007, Resident #3 alleged that a staff person had hit her in the face.</li> </ol> <p>Interview with the QMRP on July 26, 2007, at 5:30 PM, indicated that when an incident occurs,</p>	I 374	<p><b>1374</b> Cross Reference W148</p>	

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I 374	Continued From Page 9  family notifications are to be reflected on the incident report. Subsequent re-examination of the aforementioned incident reports with the QMRP confirmed that the facility had not documented having notified Resident #3's and #5's family members of the incidents.	I 374		
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> <p>This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to consistently report significant incidents to the Department of Health, Health Regulation Administration within twenty-four (24) hours or the next work day.</p> <p>The findings include:</p> <p>On July 24, 2007, beginning at 3:30 PM, review of the GHMRP incident reports and investigations revealed the following significant incidents for which the facility failed to notify the Department of Health:</p> <p>1. On January 23, 2007, Resident #5 alleged that a staff person had hit her with a stick.</p>	I 379		

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I 379	Continued From Page 10  2. On March 6, 2007, Resident #4 was transported to the hospital due to low blood sugars. The actual incident of transporting to the hospital had been reported to the Department of Health, however the change in her health status that required admission for eight days had not, been communicated.  This is a repeat deficiency. See State licensure survey report dated September 25, 2006.	I 379	<b>1379</b> Cross Reference W148	
I 399	3520.2(i) PROFESSION SERVICES: GENERAL PROVISIONS  Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services:  (i) Speech and language therapy; and...  This Statute is not met as evidenced by: Based on record review, the GHMRP failed to provide evidence that the Speech and Language Therapist had a valid license on file.  The finding includes:  Review of personnel records on July 26, 2007 revealed the GHMRP failed to have evidence of a current license on file for the speech consultant.	I 399	<b>1399</b> The facility will ensure that the license for the speech therapist is current and available for review upon request	8/28/07

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I 399	Continued From Page 11	I 399		
I 401	<p><b>3520.3 PROFESSION SERVICES: GENERAL PROVISIONS</b></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: Cross-refer to Federal Deficiency Report - Citation W214</p> <p>On July 24, 2007, the medication nurse scheduled for daily morning administrations stated that Resident #5 routinely rejected a red, multi-vitamin pill, for reasons not known. The resident refused to take her medications that morning because there was "that red pill in there." The nurse pleaded with her for three or four times. Resident #5 manually removed the red pill from the cup. She told the nurse "you said you were going to change it." The nurse said the primary care physician (PCP) had to write a new order. When she asked what "what color is it going to be" the nurse replied "brown."</p> <p>Review of Resident #5's Medication Administration records (MARs) for the months March 2007 - July 2007 confirmed the nurse's statement earlier, that the resident often rejected the red multi-vitamin pill. For example, her July 2007 MAR documented that she refused to take the red multi-vitamin pill on July 3, 6, 7, 15, 16, 17, 19, 20, 21, 22 and 23, 2007.</p> <p>On July 26, 2007, review of Resident #5's records failed to show evidence that the</p>	I 401		

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I 401	<p>Continued From Page 12</p> <p>psychologist had been made aware that the resident was refusing the red multi-vitamin pill (only). Later that afternoon, interview with the Qualified Mental Retardation Professional (QMRP) and the nurse coordinator revealed that neither was aware that she had an aversion to the red multi-vitamin pill.</p> <p>On July 27, 2007, the primary care physician was interviewed by telephone. He stated that while he knew that Resident #5 sometimes rejected her medications, he was previously unaware that she often refused the red multi-vitamin pill (only).</p> <p>Interviews and review of Resident #5's record failed to show evidence that her aversion to the red multi-vitamin pill (in particular) had been assessed and/or otherwise addressed by the medical team.</p>	I 401	<p><b>1401</b> Cross Reference W214</p>	
I 424	<p>3521.5(a) HABILITATION AND TRAINING</p> <p>Each GHMRP shall make modifications to the resident ' s program at least every six (6) months or when the client:</p> <p>(a) Has successfully completed an objective or objectives identified in the Individual Habilitation Plan;</p> <p>This Statute is not met as evidenced by: Cross-refer to Federal Deficiency Report - Citation W255. Resident #2's interdisciplinary team (IDT) held a 6-month review meeting on July 25, 2007. On July 26, 2007, review of the resident's QMRP monthly summaries revealed that for two programs (washing her hair with verbal prompts 50% of the time; and participating in an exercise program three times a week with no more than 2 verbal prompts), the resident had</p>	I 424		

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I 424	<p>Continued From Page 13</p> <p>achieved or surpassed the specified performance criteria for the past three months (April, May and June 2007). Review of the data collection sheets for those two programs, both with start dates of January 2007, revealed that staff had documented the resident's performance at verbal prompts or independent for the past 3 months, effectively meeting or surpassing the criteria as outlined in the programs.</p> <p>On July 26, 2007, interviews with the Program Manager and the QMRP indicated that the team reportedly had reviewed her programs and services from the past 6 months and decided that none of her programs would be revised. Further interviews, however, revealed that the QMRP and the Program Manager thought that Resident #2's programs should be revised and that the facility failed to use the latest IDT meeting to establish new programs, or revise current programs, in accordance with the resident's assessed needs. The QMRP said he wanted to revise the performance criteria. In addition, the QMRP further indicated that he wanted to revise the resident's data collection sheets in order to ensure that the information being documented by staff was relevant to her goals and objectives and reflected the length of time she was able to perform the stated objective.</p>	I 424	<p><u>1424</u> Cross Reference W255</p>	
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I 500	<p>3523.1 RESIDENT'S RIGHTS</p> <p>Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws.</p>	I 500		
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I 500	<p>Continued From Page 14</p> <p>This Statute is not met as evidenced by:</p> <ol style="list-style-type: none"> <li>1. Cross-refer to I300. A release of information authorization form observed in Resident #3's records had not been fully completed and did not identify what information was to be released, to whom the information would be given and failed to indicate an ending date. Review of the GHMRP's policies procedures, however, revealed that these elements were required. During follow-up interviews with the Program Manager and QMRP on July 27, 2007, they acknowledged that the form was not in compliance with the GHMRP's policies and procedures.</li> <li>2. Cross-refer to Federal Deficiency Report - Citation W247.1. Resident #1 was given packages of dietetic sugar substitute (Sweet and Low) during observed meals. Staff interviews and inspection of the kitchen revealed that regular sugar was never made available for her use in the GHMRP because some of her peers had diabetes. Resident #1's diet orders indicated that she was on a regular diet. Further review of the resident's record failed to show justification for restricting her access to regular sugar.</li> <li>3. Cross-refer to Federal Deficiency Report - Citation W247.2. During each observed meal, all six clients were provided with spoons (only). During the dinner meal on July 24, 2007, Resident #4 was observed having difficulty eating chicken on a bone and subsequently requested a fork. Staff did not present a fork and the resident eventually used her fingers to finish eating her chicken. Interviews with facility staff and inspection of the kitchen revealed that forks and knives were not available for resident use. Review of the six residents' habilitation plans failed to show evidence or justification for</li> </ol>	I 500	<p><b><u>1500</u></b></p> <p>1. Cross Reference W113</p>	
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I 500	Continued From Page 15  restricting access to forks or knives. It should be noted that review of the GHMRP's Human Rights Committee minutes and interview with the administrator revealed that they were previously unaware of this staff practice.	I 500		