

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

PRINTED: 08/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G188	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/28/2008
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NAME OF PROVIDER OR SUPPLIER INNOVATIVE	STREET ADDRESS, CITY, STATE, ZIP CODE 3259 'O' ST, SE WASHINGTON, DC 20020
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W 000	INITIAL COMMENTS A recertification survey was conducted from July 23, 2008, through July 28, 2008. The survey was initiated using the full survey process. A random sample of three clients was selected from a residential population of five women with mental retardation and other disabilities. The findings of the survey were based on observations, interviews at the facility and at one day program, and a review of records, including unusual incident reports.	W 000	<p style="text-align: center;"><i>Received 9/2/08</i></p> <p style="text-align: center;">GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002</p>	
W 130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure each client's right to privacy, for one of the three clients (Client #1 3) included in the sample. The findings include: Observation on July 25, 2008, at 5:26 PM revealed Client #1 arrived home from her day program. The client's blouse appeared to be constructed of thin material and her bra could be seen through her blouse. The bra gapped and puckered at its center (cup area) and appeared to be too large for her. At 5:35 PM, the surveyor informed the House Manager (HM) of the observation. Interview with the HM confirmed that the bra Client #1 was wearing belonged to her (the client).	W 130		<p>W130 ILS will provide extensive training for management as well as Direct Care staff in the area of clients rights and privacy. ILS will further perform quarterly clothing monitoring to ensure individual clothing is adequate and appropriate.</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Program Manager (X6) DATE 9/2/08
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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 requisite to continued program participation.

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W 137	Continued From page 2 surveyor's observation, and was observed to instruct the staff to assist the client with changing her blouse before leaving the premises. At the time of the survey, the facility failed to ensure Client #3 was supplied with and wore appropriate sized clothing.	W 137	SEE W130	9/2/08
W 140	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. This STANDARD is not met as evidenced by: Based on interview and the record review, the facility failed to provide evidence that assured a system had been established that maintained a complete accounting of each clients' personal funds, for two of the three clients (Clients #1 and #2) included in the sample. The findings include: 1. Interview with the Qualified Mental Retardation Professional (QMRP) and review of the facility's financial records on July 28, 2008, at approximately 6:04 PM revealed that the facility assisted Client #2 with maintaining her finances. Continued interview and record review revealed that the client received Supplemental Security Income (SSI) in the amount of \$70.00 monthly. Further review of the client's record revealed a total of \$1640.00 was withdrawn from the client's account between July 17, 2007, and June 20,	W 140	W140 ILS will provide training for all staff providing and or engaging in the use of clients funds. ILS will develop a new Policy and Procedure on the process of withdrawing and use of client funds as well as the maintaining of receipts.	9/2/08

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W 140	Continued From page 3 2008. At the time of the survey, the facility failed to provide evidence that justified the withdrawals/expenditures from Client #2's personal account. 2. Interview with the Program Director and review of the facility's financial records revealed that the facility assisted Client #1 with maintaining her finances. Continued interview and record review revealed that the client received SSI in the amount of \$100.00 monthly. Further review of the client's record revealed a total of \$1314.13 was withdrawn from the client's account between August 23, 2007, and June 20, 2008. At the time of the survey, the facility failed to provide evidence that justified the withdrawals/expenditures from Client #1's personal account.	W 140		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to implement policies that ensured the client's health and safety, for one of the three clients (Client #3) included in the sample. The finding includes: The facility failed to implement their Incident Management Policy as evidenced below: On July 25, 2008, at 2:35 PM Client #3's mother was interviewed and indicated that she had a concern about an incident involving her daughter.	W 149	W149 ILS will provide training to Staff on incident reporting and documentation. Further investigation was not able to reveal that client #3 mother brought this information to the attention of management staff. Also interview with nursing did not indicate that any bruise was observe on client #3. ILS will continue to ensure that incidents are documented and reported in a timely manner.	9/2/08

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W 149	<p>Continued From page 4</p> <p>According to Client #3's mother, the client spent the weekend with her approximately two weeks ago. During the home visit, the client's mother said she observed her daughter with a bruise on her arm. The mother indicated that she contacted management to inquire about the injury. The client's mother said that she was told that her daughter and her housemates went to the store. Client #3's housemates purchased candy bars, but, Client #3 was not given the same opportunity. Client #3 became angry and was aggressive and attempted to hit the staff. At which time, Client #3 was observed to fall and hit her arm. The client's mother also revealed that when she spoke to management, she was ensured that the incident report would be reviewed. However, during the review of the incident reports on July 24, 2008, there was no documented evidence that an incident report had been completed to reflect the aforementioned event.</p> <p>Review of the facility's "Incident Management Policy" on July 24, 2008, revealed "any incident, which has harmed or may potentially harm an individuals' health, safety or well being will immediately be identified, reported, reviewed, investigated, and corrected following regulatory guidelines." Additionally, the policy revealed that all incidents would be reported/documented on an incident report form. At the time of the survey, the facility failed to implement the its "Incident Management Policy" as written.</p>	W 149	
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>	W 159	

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W 159	<p>Continued From page 5</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP).</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The QMRP failed to ensure the recommendations made by Client #2 's nutritionist were addressed. <p>Interview with the Qualified Mental Retardation Professional (QMRP) on July 23, 2008, at 6:05 PM revealed that Client #2 had diabetes and received dialysis three times per week. Interview was conducted with staff on July 25, 2008, at 9:51 AM to ascertain if Client #2 was prescribed a special diet. According to the staff member, Client #2 was prescribed a renal diet with fluid restrictions. When queried as to the specific amount of fluid Client #2 was supposed to consume daily, the staff member indicated that the client was to be provided with 4 to 6 ounces (1/2 cup to 3/4 cup) of fluid with each meal.</p> <p>Review of Client #2' s most current nutritional assessment dated May 10, 2008, on July 28, 2008, revealed that the client's estimated nutritional needs included 2250 cc of fluid daily. Additionally, the nutritionist documented that the client' s doctor had not noted any fluid restriction at the time of the assessment. The nutritionist further indicated that the client' s menu had been adjusted to include 8 ounces of fluid for breakfast, 4 ounces of fluid at lunch, 4 ounces of fluid at snack and 8 ounces of fluid at dinner.</p>	W 159		9/2/08
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W 159	<p>Continued From page 6</p> <p>Medications were to be administered with 30 cc' s of fluid. Review of the client ' s menu, specifically for July 28, 2008, revealed that the client ' s breakfast included 14 ounces of fluid for breakfast (6 ounce discrepancy), 8 ounces for lunch (4 ounce discrepancy), 4 ounces for snack, and 8 ounces at dinner.</p> <p>Review of Client #2's fluid intake sheets on July 28, 2008, revealed that staff documented the client's fluid intake in cup denominations (i.e. 1 cup, ¾ cup, ½ cup and ¼ cup). Continued review of the fluid intake sheet for June 2008 and July 2008 revealed the client received inconsistent amounts of fluids daily. For example:</p> <p>June 9 and 10, 2008 - Client #2 received 24 ounces of fluid at breakfast, 8 ounces at lunch.</p> <p>July 10, 2008 and July 16, 2008 - Client #2 received 16 ounces at breakfast, 8 ounces at lunch, and 12 ounces at dinner.</p> <p>July 17, 18, and 19, 2008 - Client #2 received 16 ounces at breakfast, no fluid at lunch (the form documented dialysis), and 8 ounces at dinner on the 17th and 18th (12 ounces on the 19th).</p> <p>It should be noted that the forms were not designed for fluids during snack and medication times to be documented. It should be further noted that interview with the nurse on July 28, 2008, revealed staff were trained on the client ' s fluid intake in accordance with the nutritionist ' s recommendations.</p> <p>Review of Client #2' s July 2008 Physician ' s Orders (POS) on July 24, 2008, at 12:00 PM,</p>	W 159	<p><u>W159</u></p> <p>ILS will developed a new fluid restriction sheet as well as have the nutritionist provide further training on client #2 special diet.</p>	9/2/08
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W 159	<p>Continued From page 7</p> <p>revealed the client was prescribed a low cholesterol, low fat, low salt, 1800 calorie American Diabetes Association (ADA) Renal Diet. The order failed to identify information regarding the client 's required fluid intake. Continued review of the client 's May 2008 nutritional assessment revealed a recommendation for the client to receive a renal, no concentrated sweets, no added salt, limited vitamin K diet. At the time of the survey, the QMRP failed to present evidence that Client #2's nutritional needs, including fluid requirements, had been thoroughly addressed making certain that all required parties had been informed of recommendations and provided clear consistent instructions about her needs.</p> <p>2. The QMRP failed to make certain that staff were adequately trained and provided each client with modified and specially-prescribed diets. (See W460)</p> <p>3. The QMRP failed to ensure each client received continuous active treatment services. (See W249)</p>	W 159	<p>ILS will continue to have nursing and nutritionist provide training on diet issues and concerns.</p> <p>ILS will ensure that QMRP, HM and staff are retrain in specially prescribed diet.</p>	<p>9/2/08</p> <p>9/2/08</p>
W 189	<p>483.430(e)(1) STAFF TRAINING PROGRAM</p> <p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each employee was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and</p>	W 189		

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W 189	Continued From page 8 competently. The finding includes: Review of the facility's in-service training records on July 23, 2008 revealed an in-service entitled "Incident Protocol" on February 11, 2008, however, at the time of the survey the facility failed to ensure their employees were effectively trained. [See W149]	W 189	<u>189</u> ILS will ensure adequate training is provided for all staff to effectively perform all duties by ensuring that staff have monthly training by QMRP and HM. ILS will also ensure minimum of quarterly training from professional consultant staff.	9/2/08
W 192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure employees received adequate training on each client dietary requirements, for one of the three client's (Client #2) included in the sample. The finding includes:	W 192	SEE W189	9/2/08
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management.	W 247	ILS will develop infection control training program which will include hand washing and other infection control issue to ensure compliance. This training will be done quarterly.	

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W 247

Continued From page 9

This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement a system that provided an opportunity for clients' choice and self management. for three of the three clients (Clients #1, #2, and #3) in the sample.

The finding includes:

Observation on July 24, 2008, at 3:55 PM revealed Clients #1, #2, and #3 arrived home from their day treatment programs . At 4:07 PM, the direct care staff provided the clients with a snack that consisted of a granola bar and apple juice. There was no evidence that the staff offered the clients a choice of snack.

W 247

W247
ILS will provide training for staff on clients rights which include providing them with choices while continuing to ensure compliance with appropriate diets.

9/2/08

W 262

483.440(f)(3)(i) PROGRAM MONITORING & CHANGE

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.

This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that Client #1 and #3's psychotropic medication had been reviewed and approved by their Human Rights Committee (HRC).

The findings include:

1. Observation of the evening medication administration on July 23, 2008, beginning at

W 262

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W 262	Continued From page 11 (HRC) meeting minutes on July 28, 2008, at 4:37 PM revealed the last HRC meeting was held on October 12, 2007. At the time of the survey, the facility failed to provide evidence that Client #3's medications were presented for review/approval by the facility's HRC.	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 observation, interview and record review, the facility's Human Rights Committee (HRC) failed to ensure written informed consent had been obtained from the client and/or their legal guardian for the use of behavior support plans, for one of the four clients (Client #1) included in the sample. The finding includes: Observation of the evening medication administration on July 23, 2008, beginning at approximately 7:47 PM revealed Client #1 received medications including Lorazepam 1 mg, Lithium 300 mg, Seroquel 400 mg, Abilify 15 mg, and Depakote 500 mg. Interview with the medication nurse during the medication administration revealed the aforementioned medications were used to address the client's behaviors and were included as part of the client's behavior support plan. There was no evidence that written informed consents were obtained to use the above behavior medications as part of a	W 263	<u>W263</u> Inform consent on client #1 psychotropic medication is on file. ILS will ensure that written inform consent are obtained from the client and or their legal guardian for the use of psychotropic medication. Nurse and QMRP will be train on ensuring that informed consent are obtained.	9/2/08

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W 263 W 368	<p>Continued From page 12 behavior management program.</p> <p>483.460(k)(1) DRUG ADMINISTRATION</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 interview and record review, the facility failed to ensure that medications were administered in compliance with the physician's orders, for one of three clients (Client #1) included in the sample.</p> <p>The finding includes:</p> <p>Review of Client #1's medical record on July 24, 2008, beginning at 3:56 PM revealed a written Physician's Order (POS) dated September 20, 2007 at 10:00 AM. According to the written POS, the physician gave the following telephone order:</p> <ol style="list-style-type: none"> 1. D/C Abilify, Seroquel and Depakote 2. Seroquel XR 400 MG 1 TAB AM, 2 TABS HS (at bedtime) 3. Depakote 500 mg qd (once a day) 4. Lamital 25 mg qd (once a day) <p>Continued review of the written POS revealed another telephone order written dated September 20, 2007, at 12:15 PM that recommended "All Above Orders To Put On Hold Until Re-evaluation Assessment Received from (the psychiatrist)."</p> <p>Interview with the facility's nursing coordinator on July 24, 2008, revealed that the aforementioned medications were not held and that Client #1 continued the drug regimen. Review of Client</p>	W 263 W 368	<p>9/2/08</p> <p><u>W368</u></p> <p>In the near future, ILS will ensure that client #1 drugs were administered in accordance with her physician order. ILS has put a system in place whereby RN will review physicians orders on a monthly basis to ensure that all clients medications were administered as ordered.</p>

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W 368	Continued From page 13 #1's September 2007 and October 2007 Medication Administration Records (MARs) on July 24, 2008, verified the medications were not held. According to the MARs, Client #1 received Abilify 15 mg, Seroquel 100 mg 1 tab, Depakote 500 mg, and Seroquel 200 mg (2 tabs twice daily) for both of the aforementioned months. At the time of the survey, the facility failed to ensure Client #1's drugs were administered in accordance with her physician's orders.	W 368		
W 393	483.460(n)(1) LABORATORY SERVICES If a facility chooses to provide laboratory services, the laboratory must meet the requirements specified in part 493 of this chapter. 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 the three clients (Client #2) included in the sample. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) on July 23, 2008 at 6:05 PM revealed that Client #2 had diabetes and received dialysis three times per week. Observation of the evening medication administration on July 23, 2008, at 8:25 PM revealed Client #2 had her blood glucose level checked (via fingerstick) prior to the administration of her insulin (Lantus). Review of Client #2's July 2008 Physician's Orders (POS) on July 24, 2008, at 12:00 PM revealed the client had an order to receive	W 393	<u>W393</u> ILS is working in obtaining waiver certification to meet the requirement for providing laboratory services for client #2. In the near future ILS will ensure that waiver certification is obtain for any Individual who receives blood glucose level checked via finger stick.	9/2/08

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

PRINTED: 08/13/2008
FORM APPROVED
OMB NO. 0938-0391

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W 455 Continued From page 15
at the table being served dinner (pot roast, rice, and salad). None of the clients were observed to be asked to or independently washed their hands prior to consuming their dinner.

W 455

Note: Review of the facility's incident report forms and investigations on July 24, 2008 at 3:32 PM revealed Client #2 was hospitalized on April 15, 2008 and March 5, 2008. Continued review of the reports revealed the client was diagnosed with an infectious disease (Methicillin-Resistant Staphylococcus Aureus, MRSA).

W 460 483.480(a)(1) FOOD AND NUTRITION SERVICES

W 460

Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.

This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that each client received modified and specially-prescribed diets, for one of the three clients (Client #2) included in the sample.

The finding includes:

Interview with the Qualified Mental Retardation Professional (QMRP) on July 23, 2008, at 6:05 PM revealed that Client #2 had diabetes and received dialysis three times per week. Interview with staff on July 25, 2008, at 9:51 AM revealed Client #2 was prescribed a renal diet with fluid restrictions. On July 28, 2008, the facility's House Manager (HM) on July 28, 2008 was interviewed to gain further clarity about the client's prescribed diet. The HM provided a copy of the client's

W460
In-service training on client #2 diet will be provided to all staff by the Nutritionist. QMRP and HM will provide ongoing training and monitoring to ensure that all clients receives their diet as ordered.

9/2/08

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 460	<p>Continued From page 16</p> <p>menu for review. According to the HM and review of the menu for July 28, 2008, the client was to receive a turkey sandwich and unsalted pretzels for lunch.</p> <p>Observation of the client's lunch at 1:41 PM revealed Client #2 was served a cold cut sandwich and salted pretzels. According to observation and interview with staff during the lunch, the House Manager (HM) was the person that prepared Client #2's lunch. Review of Client #2's July 2008 Physician's Orders (POS) on July 24, 2008, at 12:00 PM, revealed the client was prescribed a low cholesterol, low fat, low salt, 1800 calorie American Diabetes Association (ADA) Renal Diet. At the time of the survey, the facility failed to ensure Client #2 was provided her lunch in accordance with the documented menu and as ordered.</p>	W 460		9/2/08
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1 000	INITIAL COMMENTS A licensure survey was conducted from July 23, 2008, through July 28, 2008. A random sample of three residents was selected from a residential population of five women with mental retardation and other disabilities. The findings of the survey were based on observations, interviews with staff in the home and at one day program, and a review of records, including unusual incident reports.	1 000		
1 042	3502.2(b) MEAL SERVICE / DINING AREAS Modified diets shall be as follows: (b) Planned, prepared, and served by individuals who have received instruction from a dietitian; and... This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that modified diets were served as prescribed, for one of the two residents (Resident #2) included in the sample. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) on July 23, 2008, at 6:05 PM revealed that Client #2 had diabetes and received dialysis three times per week. Interview with staff on July 25, 2008, at 9:51 AM revealed Client #2 was prescribed a renal diet with fluid restrictions. On July 28, 2008, the facility's House Manager (HM) on July 28, 2008 was interviewed to gain further clarity about the client's prescribed diet. The HM provided a copy of the client's menu for review. According to the HM and	1 042	<u>1042</u> SEE W460	9/2/08

Health Regulation Administration

TITLE

(X6) DATE

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

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I 042 Continued From page 1
review of the menu for July 28, 2008, the client was to receive a turkey sandwich and unsalted pretzels for lunch.

Observation of the client's lunch at 1:41 PM revealed Client #2 was served a cold cut sandwich and salted pretzels. According to observation and interview with staff during the lunch, the House Manager (HM) was the person that prepared Client #2's lunch. Review of Client #2's July 2008 Physician's Orders (POS) on July 24, 2008, at 12:00 PM, revealed the client was prescribed a low cholesterol, low fat, low salt, 1800 calorie American Diabetes Association (ADA) Renal Diet. At the time of the survey, the facility failed to ensure Client #2 was provided her lunch in accordance with the documented menu and as ordered.

I 042

I 082 3503.10 BEDROOMS AND BATHROOMS

Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting.

This Statute is not met as evidenced by:
Based on observation and interview, the facility failed to ensure all bathrooms were equipped cup dispensers.

The finding includes:

Observation of the GHMRP's environment and interview with the House Manager on July 28, 2008 during the environmental inspection, revealed the hallway bathroom utilized by the residents failed to have a cup dispenser for its disposable cups.

I 082

I082
All bathrooms are now equipped with cup dispensers. QMRP and HM will ensure that all bathroom have adequate cup dispenser for its disposable cups at all time.

9/2/08

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I 161 3507.2 POLICIES AND PROCEDURES

The manual shall be approved by the governing body of the GHMRP and shall be reviewed at least annually.

This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide evidence that the governing body approved and reviewed its policies and procedures annually.

I 161

I161
ILS policy and procedures manual have been reviewed, updated by the governing body and signed. In the near future ILS will ensure that policy and procedure manual is reviewed and updated annually.

9/2/08

The finding includes:

Interview with the Qualified Mental Retardation Professional (QMRP) and review of the policy and procedures manual on July 23, 2008 failed to provide evidence that the manual had been reviewed and approved by the governing body as required since January 31, 2007.

I 189 3508.7 ADMINISTRATIVE SUPPORT

Each GHMRP shall maintain records of residents' funds received and disbursed.

This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to maintain a record of all resident funds received and disbursed, for two of the three residents (Residents #1 and #2) included in the sample.

I 189

The findings include:

1. Interview with the Qualified Mental Retardation Professional (QMRP) and review of the facility's financial records on July 28, 2008, at approximately 6:04 PM revealed that the facility

I189
SEE W140

9/2/08

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I 189	Continued From page 3 assisted Client #2 with maintaining her finances. Continued interview and record review revealed that the client received Supplemental Security Income (SSI) in the amount of \$70.00 monthly. Further review of the client's record revealed a total of \$1640.00 was withdrawn from the client's account between July 17, 2007, and June 20, 2008. At the time of the survey, the facility failed to provide evidence that justified the withdrawals/expenditures from Client #2's personal account. 2. Interview with the Program Director and review of the facility's financial records revealed that the facility assisted Client #1 with maintaining her finances. Continued interview and record review revealed that the client received SSI in the amount of \$100.00 monthly. Further review of the client's record revealed a total of \$1314.13 was withdrawn from the client's account between August 23, 2007, and June 20, 2008. At the time of the survey, the facility failed to provide evidence that justified the withdrawals/ expenditures from Client #1's personal account.	I 189		
I 226	3510.5(c) STAFF TRAINING This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure that staff were effectively trained to ensure infection control procedures were implemented. The finding includes: The facility failed to ensure that handwashing occurred prior to food consumption. a. Observation on July 24, 2008 at 4:05 PM	I 226	1226 SEE W455	9/2/08

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I 226 Continued From page 4

revealed the clients (Client #1, #2, #3, #4, and #5) going to the table after their arrival (3:55 PM) for their snack. Clients #1, #3, #4, and #5 received a snack of a granola bar and juice. Client #1 received a yogurt and juice. None of the clients were observed to be asked to or independently wash their hands prior to consuming their snack.

b. Observation on July 24, 2008 at 5:18 PM revealed the clients (Client #1, #2, #3, #4, and #5) at the table being served dinner (pot roast, rice, and salad). None of the clients were observed to be asked to or independently washed their hands prior to consuming their dinner.

Note: Review of the facility's incident report forms and investigations on July 24, 2008 at 3:32 PM revealed Client #2 was hospitalized on April 15, 2008 and March 5, 2008. Continued review of the reports revealed the client was diagnosed with an infectious disease (Methicillin-Resistant Staphylococcus Aureus, MRSA).

I 226

I 379 3519.10 EMERGENCIES

In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially 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.

I 379

This Statute is not met as evidenced by:

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1379	<p>Continued From page 5</p> <p>Based on interview and record review, the GHMRP failed to ensure the Department of Health (DOH), Health Facilities Division was immediately notified, followed by written notification within 24 hours, of unusual incidents that substantially interfered with a resident's health, for one of the three residents (Resident #2) included in the sample.</p> <p>The finding includes:</p> <p>Review of the facility's incident reports and interview Qualified Mental Retardation Professional (QMRP) on July 24, 2008, at 3:32 PM, revealed the following incidents were not reported as required:</p> <p>On January 14, 2008, staff reported that Resident #2 was not feeling well and vomited. Emergency medical services were called and the resident was taken to the emergency room and admitted. Continued review of the report revealed the DOH was notified of the incident on January 17, 2008.</p> <p>On April 15, 2008, the nurse reported that Resident #2 had a low grade fever with an elevated blood pressure. The resident was subsequently taken to the emergency room and admitted. Continued review of the report revealed the DOH was notified of the incident on April 17, 2008.</p>	1379	<p><u>1379</u></p> <p>In-service training will be provided to all staff on incident reporting procedure. In the near future ILS will ensure that unusual incidents are reported to DOH in a timely manner.</p>	9/2/08
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1422	<p>3521.3 HABILITATION AND TRAINING</p> <p>Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the</p>	1422		
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I 422 Continued From page 6

GHMRP failed to ensure habilitation, training and assistance was provided to its residents in accordance with their Individual Habilitation Plan(s), for one of the three residents (Resident #1) included in the sample.

The finding includes:

Review of Client #1's habilitation record on July 28, 2008, at 9:04 AM revealed an Individual Support Plan (ISP) dated June 13, 2008.

Interview with the Qualified Mental Retardation Professional (QMRP) on July 28, 2008, at 9:14 AM and continued review of the client's habilitation record revealed the interdisciplinary team recommended the following program objectives:

Given no more than 1 verbal prompt, 3 times per week, [Client #1] will engage in and out of home activities that will include bowling, card playing, attending a recreational center, dancing, and other activities that [Client #1] enjoys 50% of the time.

[Client #1] will use the telephone to call friends and relatives at least 75 % of the time.

Further interview with the QMRP and review of the client's records failed to provide evidence that the aforementioned program objectives had been initiated/implemented at the time of the survey.

I 422

I422
QMRP will provide in-service training on client #1 IPP goals and documentation. QMRP will monitor IPP goals weekly to ensure implementation and documentation of all goals as written.

9/2/08

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R 000 INITIAL COMMENTS

A licensure survey was conducted from July 23, 2008, through July 28, 2008. A random sample of three clients was selected from a residential population of five women with mental retardation and other disabilities. The findings of the survey were based on observations, interviews, and a review of records, including unusual incident reports.

R 000

R 125 4701.5 BACKGROUND CHECK REQUIREMENT

The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check.

R 125

This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure criminal background checks disclosed the criminal history of any prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker had worked or resided within the seven (7) years prior to the check.

The finding includes:

Interview with the Qualified Mental Retardation Professional (QMRP) and review of the GHMRP's personnel records on July 28, 2008, at approximately 5:30PM revealed that the GHMRP failed to provide evidence that criminal background checks were on file and disclosed a seven year history of all the jurisdictions where the employee resided and worked for three staff.

9/2/08

R125
Criminal backgrounds have been obtained for the three staff in question. In the future ILS will ensure that criminal background checks are obtain on all staff prior to hiring.

Health Regulation Administration

TITLE

(X5) DATE

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

STATE FORM

6899

Z5RQ11

If continuation sheet 1 of 2

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