

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

PRINTED: 10/31/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2008
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NAME OF PROVIDER OR SUPPLIER IDI	STREET ADDRESS, CITY, STATE, ZIP CODE 4864 ASTOR PLACE, SE WASHINGTON, DC 20019
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W 000	INITIAL COMMENTS A recertification survey was conducted from October 14, 2008 through October 16, 2008. The survey was initiated using the fundamental survey process. A random sample of four clients was selected from a population of eight females with various degrees of disabilities. The findings of this survey were based on observations at the group home, one day program, interviews with the group home and day program staff, and review of clinical and administrative records to include the facility's unusual incident reports.	W 000	Received 12/1/08 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
W 114	483.410(c)(4) CLIENT RECORDS Any individual who makes an entry in a client's record must make it legibly, date it, and sign it. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all persons making entries into the clients' records signed the entry, for one of the four clients in the sample. (Client #1) The finding includes: Review Client #1's Individual Support Plan (ISP) on October 16, 2008 at 3:55 PM revealed a Psychology assessment dated September 29, 2007 and an Occupational Therapy assessment dated July 1, 2007. It was noted that these assessments were not signed by the person(s) that completed them. This observation was brought to the attention of the Qualified Mental Retardation Professional on October 16, 2008 at 2:15 PM; who acknowledged the lack of signatures.	W 114	W114 This Standard will be met as evidenced by: QMRP will review all assessments prior to filing. QMRP will ensure that all assessments are dated and signed prior to filing. QMRP will consult with the identified consultant as needed to secure all necessary information (signature/date).	10/30/08 08/01/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Maria Howard</i>	TITLE <i>MS</i>	DATE <i>11/20</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>The facility must assure that outside services meet the needs of each client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure outside services met each client's needs, for one of four clients in the sample (Client #2)</p> <p>The finding includes:</p> <p>On October 14, 2008 at approximately 1:44 PM, a direct care staff was observed engaging Client #2 with a device that indicated the days of the week when buttons were pushed. Review of Client #2's Individual Program Plan (IPP) on October 15, 2008 at 2:30 PM, revealed a program that reflected given physical assistance, Client #2 will activate a cause and effect item or object for 7 to 10 trials per session as measured by active treatment documentation. Review of the program documentation failed to evidence that the staff was documenting the program.</p> <p>Interview with the QMRP on October 15, 2008 at 2:30 PM revealed that she was not aware that the staff was not documenting on the program. Further review of the IPP quarterly reviews failed to evidence that the Speech Therapist (ST) had been monitoring the clients progress in the program as required in the contractual agreement with the provider. It should be noted that review of the contract between the ST and the provider revealed that the ST was responsible for monitoring the programs quarterly.</p>	W 120	<p>W120</p> <p>This Standard will be met as evidenced by:</p> <p>The QMRP will coordinate additional staff training to address client #2's program objective. (11.24.08)</p> <p>QMRP will ensure that the conducts quarterly monitoring as recommended. QMRP will update records when changes are recommended in the monitoring and oversight of the specified program. QMRP will also follow-up with the consultant in a timely manner to prevent lapses in the monitoring schedule.</p> <p>QMRP/Home Manager will review documentation at least one time weekly. QMRP will address concerns accordingly to ensure active monitoring of programs.</p>	11.24.08 original
W 124	<p>483.420(a)(2) PROTECTION OF CLIENTS</p>	W 124		

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W 124	<p>Continued From page 2 RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the rights of each client and/or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment, for one of the four clients (Client#3) included in the sample.</p> <p>The finding includes:</p> <p>The facility failed to ensure Client #3 received the recommended EEG laboratory study.</p> <p>On October 14, 2008 at 8:00 AM, Client #3 was administered Valproic Acid 10 ml. Interview with the Licensed Practical Nurse (LPN) after the medication pass indicated that the client received the aforementioned medication for her diagnosis of seizure disorder. During the entrance conference with the House Manager and the Licensed Practical Nurse (LPN) on October 14, 2008 at 9:45 AM with the House Manager and day time LPN revealed that Client #3 had a seizure on May 13, 2008 (last seizure recorded was in 1999). Review of the client's medical record on October 14, 2008 revealed a neurology consult dated May 15, 2008. The neurologist</p>	W 124	<p>W124</p> <p>This Standard will be met as evidenced by:</p> <p>The EEG for client #3 has been scheduled.</p> <p>The QMRP will obtain consent for the scheduled appointment. Nurses follow protocol. RN will conduct file reviews and continue to emphasize adherence to protocols and procedures, continued failure to adhere to the procedures will result in disciplinary action. RN/Nurse assigned to the home will track medical appointments via the Medical Activity form which requires that you document the last appointment and recommended follow-up dates. Nurses are required to reference the document on an ongoing basis.</p> <p>The EEG consult will be filed and recommendations followed as outlined.</p>	11-6-08 mgpina

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W 124	Continued From page 3 recommended an EEG laboratory study. Further review of the client's medical record revealed that an EEG was attempted on May 18, 2008 however was unsuccessful due to the client's excessive movement. At that time it was further recommended that an EEG be done under sedation. According to the nurse's quarterly reviews dated 7/08 and 9/08 it was noted that follow up was needed on the EEG laboratory study with sedation. Interview with the Qualified Mental Retardation Professional (QMRP) on October 15, 2008 at approximately 11:00 AM revealed that Client #3 had a very involved/active father who was willing to sign medical consents. At the time of the survey, there was no evidence that the facility had discussed the need for the EEG with client and/or legally sanctioned representative. Additionally, there was no evidence that the facility had obtained the consent to ensure Client #3 received the recommended EEG.	W 124			
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the rights of each client to use and be informed of the use of their money, for	W 125	W125 This Standard will be met as evidenced by: The QMRP will provide additional training for the Home Manager toward encouraging individuals to exercise their rights. QMRP/Home Manager will give each person an opportunity to make choices by first reviewing and discussing their individual financial matters prior to making decisions on their behalf. The legal guardian and/or advocate will also be consulted to assist the individuals toward making informed decisions related to their financial affairs.	10-16-08 orgony	

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W 125	Continued From page 4 one of the four clients in the sample. (Client #5) The finding includes: On October 16, 2008 at 10:45 AM, Client #2's financial record was reviewed. A note was found dated May 28, 2008, that revealed Client #2 owed Client #5 \$88.75. Interview with the House Manager (HM) revealed that she requested \$200.00 for both clients. When the HM turned in the receipts to the accounting office, she was informed by the office staff that \$300.00 had been withdrawn from Client #2's account and \$100.00 had been withdrawn from Client #5's account. Further interview with the HM revealed that Client #5's money was scheduled to be deposited into her account. According to a bank statement dated June 30, 2008, \$88.75 was deposited into Client #5's account on June 17, 2008. Interview during the entrance conference on October 14, 2008 at 9:15 AM revealed that Client #5 had a court appointed legal decision maker. Additionally, review of Client #5's Psychological Assessment on October 16, 2008 revealed the client could not make informed decisions regarding financial matters. At the time of the survey, the facility failed to provide evidence that Client #5 and/or her guardian had been informed of the aforementioned financial matter.	W 125			
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:	W 130	W130 This Standard will be met as evidenced by: QMRP will conduct additional staff training on privacy for all individuals. QMRP/Home Manager and Nurse will monitor staff activities to further ensure that their privacy is adhered to at all times. All concerns will be addressed when situations arise.	11/24/08 original	

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W 130	Continued From page 5 Based on observation and interview, the facility failed to ensure privacy was provided during care of personal needs for three of eight clients residing in the facility. (Clients #2, #4 and #8) The findings include: 1. On October 14, 2008 at 8:26 AM, staff was observed changing Client #8's blouse with the bedroom door wide opened, exposing the client's bare upper body. After the staff noticed the surveyor's presence, she did not attempt to provide privacy for the client. 2. On October 15, 2008 at 3:52 PM, Client #2 was observed in her bedroom in bed. She was positioned on her right side. Her pants were partially lowered and her adult protective undergarment (APU) was exposed. The direct care staff were observed moving about in the facility while the client was in her bed. 3. On October 16, 2008 at 8:51 AM Client #4 was observed in her bedroom. The bedroom door was wide open and the staff was seen from the hallway changing the client's soiled APU. The client's buttocks was exposed and the direct care staff failed to ensure the client's privacy. These observations were brought to the attention of the Qualified Mental Retardation Professional (QMRP) on October 16, 2008 at approximately 2:30 PM. The QMRP indicated that she had recently provided training on privacy however, acknowledged that more training was needed.	W 130			
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	W 140			

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W 140	Continued From page 6 clients' personal funds entrusted to the facility on behalf of clients. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure a system had been implemented to maintain a complete accounting of clients personal funds for one of the four clients in the sample. (Client #1) The finding includes: A review of Client #1's financial record was conducted on October 16, 2008 at 10:45 AM. The bank statements were reviewed from September 2007 through September 2008. The record revealed a withdrawal of \$1,200.00 from the client's account on September 22, 2008. Review of the receipts for the aforementioned withdrawal totaled \$1,032.33. Interview with the House Manager (HM) indicated that she had not spent the entire amount because the surveyors were in the facility during the last several days. A request was made by the surveyor for the HM to provide evidence of the available cash (\$167.67), but, at the time of the completion of the survey, the HM failed to provide requested evidence. The facility failed to ensure a complete accounting of Client #1's personal funds.	W 140	W140 This Standard will be met as evidenced by: The Home Manager will receive disciplinary action for failing to maintain a complete accounting of client's personal funds and to ensure that all requested items were purchased in a timely manner. Upon receipt of the funds the Home Manager or designated person is expected to complete expenditures within (7) seven days and forward all remaining funds and/or receipts to the accounting department. The QMRP will provide direction and feedback as needed for the Home Manager toward maintaining compliance with this standard. QMRP will also check financial records at least quarterly to further ensure that all financial records are reconciled.	10/24/08 ongoing	
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS. The facility must have evidence that all alleged violations are thoroughly investigated.	W 154			

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W 154	Continued From page 7 This STANDARD is not met as evidenced by: Based on observation, staff interview, and record verification, the Based on interview and record review, the facility failed to provide evidence that all incidents involving injuries of unknown origin had been thoroughly investigated in accordance with the agencies policies and procedures. The findings include: Interview with the facility's Qualified Mental Retardation Professional (QMRP) and review of the facility's incident reports on October 14, 2008 beginning at 9:00 AM revealed the following injuries of unknown origin: a. On June 3, 2008, staff discovered an abrasion on Client #4's pubic area. Continued review of the facility's incidents failed to provide evidence that the incident had been investigated. b. On November 20, 2007, staff discovered two scratches on Client #1's left upper arm. There was no indication that the origin of the scratches was known. Additionally, there was no evidence the incident had been investigated.	W 154	W140, continued... All receipts have been submitted to the accounting department and a total of .82 cents was returned to client #1's account. W154 This Standard will be met as evidenced by: a. QMRP will ensure that incidents of an unknown origin are investigated in a timely manner and filed for review. b. QMRP will be scheduled to attend training seminar at DDS on Incident Reporting and Investigations. QMRP completed investigations.	
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that each client's active treatment program was monitored by the Qualified Mental Retardation Professional	W 159		10/24/08 ongoing

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W 159	<p>Continued From page 8 (QMRP) for three of the four clients included in the sample. (Clients #1, #2, and #4)</p> <p>The findings include:</p> <p>1. The facility's QMRP failed to monitor Client #2's speech program as evidenced below.</p> <p>On October 14, 2008 at approximately 1:44 PM, a direct care staff was observed engaging Client #2 with a device that indicated the days of the week, when buttons were pushed. Review of Client #2's Individual Program Plan (IPP) revealed a program that reflected, given physical assistance, Client #2 will activate a cause and effect item or object for 7 to 10 trials per session as measured by active treatment documentation. Review of the program documentation record failed to provide evidence that the staff were documenting the program. Interview with the QMRP on October 15, 2008 at 2:30 PM revealed that she was not aware that the staff was not documenting on the program. Review of the QMRP monthly program further verified that the aforementioned program was not being monitored.</p> <p>2. The facility's QMRP failed to ensure that the Individual Program Plan (IPP) included objectives to meet the client's needs as recommended from the comprehensive functional assessments. [See W227]</p> <p>3. The facility's QMRP failed to ensure that each written training program designed to implement the objectives in the individual program plan (IPP) specified the type of data necessary to assess progress toward the desired objective. [See W237]</p>	W 159	<p>W159 This Standard will be met as evidenced by:</p> <p>QMRP/Home Manager will review all program documentation at least one time weekly.</p> <p>QMRP will receive training on active treatment programs, program monitoring, documentation and follow-up. QMRP will provide staff training on implementation and documentation of active treatment programs.</p> <p>QMRP and Home Manager will provide continuous oversight and monitoring to further ensure that staff are able to demonstrate the skills and competency required to maintain compliance with this standard.</p>	11-21-08 ongoing	

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W 159	Continued From page 9 4. The facility's QMRP failed to provide continuous active treatment. [See W249]	W 159	W159, Continued...		
W 194	5. The facility's QMRP failed to ensure documentation of program data in measurable terms. [See W252] 483.430(e)(4) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible. This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to ensure staff demonstrated competency in implementing clients feeding protocol for two of the eight clients residing in the facility. (Clients #3 and #4) The findings include: The medication nurse failed to use adaptive feeding equipment during medication administration. a. During medication administration observation on October 14, 2008 at 9:00 AM, the Licensed Practical Nurse (LPN) was observed administering Client #3 her medications using a regular cup. The liquid was observed to spill from the client's mouth. During lunch and dinner observation on October 14, 2008 at 12:12 PM and 6:05 PM, respectively, staff were observed assisting Client #3 with drinking using a spout cup. Interview with the direct care staff on October 15, 2008 at approximately 10:00 AM indicated that the client required a spout cup	W 184	2. Reference response to W227 3. Reference response to W237. 4. Reference response to W249. 5. Reference response to W252.		

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W 194	<p>Continued From page 10 during feeding to reduce spillage. Review of the Client #3's feeding protocol dated July 21, 2008 verified the staff's interview by revealing the client should be fed with an adaptive spout cup to reduce spillage.</p> <p>b. On October 14, 2008 at 7:25 AM, staff was observed feeding Client #4 breakfast. The staff used adaptive feeding equipment including a spout cup, a divided plate and a plastic coated spoon. During medication administration observation on October 14, 2008 at 8:40 AM, the LPN was observed administering Client #4 her medications and provided the client with a regular cup to use for her beverage. The client was observed to spill the beverage from her mouth.</p> <p>Interview with the direct care staff on October 14, 2008 at approximately 10:00 AM revealed the client required a spout cup when drinking. Review of the Client #3's feeding protocol dated July 21, 2008 verified the client's use of a spout cup. The protocol further indicated that the spout cup would reduce spillage. At the time of the survey however, the facility's nurse failed to provide Client #3 with the recommended adaptive equipment during medication administration.</p>	W 194	<p>W194</p> <p>This Standard will be met as evidenced by:</p> <p>The RN will follow-up with the medication nurse to emphasize the importance of adherence to the use of individuals adaptive equipment needs.</p> <p>The QMRP, Home Manager, and RN will monitor on an ongoing basis to further ensure that the medication nurses adhere to adaptive equipment requirements.</p>	11/24/08
W 227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that the</p>	W 227		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/16/2008
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NAME OF PROVIDER OR SUPPLIER IDI	STREET ADDRESS, CITY, STATE, ZIP CODE 4864 ASTOR PLACE, SE WASHINGTON, DC 20019
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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W 227	<p>Continued From page 11</p> <p>Individual Program Plan (IPP) included objectives to meet the client's needs as recommended from the comprehensive functional assessments for one of the four clients in the sample. (Client #4)</p> <p>The finding includes:</p> <p>The facility failed to develop program objectives as identified in the Comprehensive Functional Assessment (CFA) for Client #4.</p> <p>Observations on October 14, 2008 from 7:00 AM through 7:00 PM, revealed Client #4 in a wheelchair with tight extremities. On October 14, 2008 at 4:00 PM, staff was observed assisting Client #4 with range of motion exercises to her shoulder.</p> <p>Review of the Occupational Therapy assessment on October 16, 2008 dated March 30, 2008 revealed program recommendations for the client to receive range of motion exercises to her elbows, wrists, and fingers. Review of the IPP on October 16, 2008 dated September 19, 2008 revealed no evidence of training programs to address the aforementioned recommendations.</p>	W 227	<p>W227</p> <p>This Standard will be met as evidenced by:</p> <p>QMRP will ensure that all recommendations are reviewed and discussed thoroughly prior to implementation. QMRP will coordinate staff training prior to implementation of all program objectives.</p> <p>QMRP will incorporate all program plans into the IPP.</p> <p>QMRP will provide documentation on file in such cases whereby specific recommendations were not accepted by the team.</p>	10/17/08 org/hng
W 237	<p>483.440(c)(5)(iv) INDIVIDUAL PROGRAM PLAN</p> <p>Each written training program designed to implement the objectives in the Individual program plan must specify the type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that each written training program designed to implement</p>	W 237		

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W 237	<p>Continued From page 12</p> <p>the objectives in the individual program plan (IPP) specified the type of data necessary to assess progress toward the desired objective for one of four clients included in the sample. (Client #4)</p> <p>The findings include:</p> <p>1. Observations on October 14, 2008 from 7:00 AM through 7:00 PM, revealed Client #4 in a wheelchair with tight extremities. At 4:00 PM, staff was observed performing range of motion exercises to Client #4's shoulder. Review of the IPP dated September 19, 2008 on October 16, 2008 revealed a program objective which stated, "[the client] will tolerate passive range of motion to bilateral upper extremities, for 15 repetitions at the shoulder on 80% of the trials recorded."</p> <p>According to the data sheets, staff documented the level of assistance needed to perform the exercises. The data sheet did not reflect the number of repetitions completed. It could not be determined how these goals were being measured for progress. Interview with the Qualified Mental Retardation Professional (QMRP) on October 16, 2008 acknowledged that the current data collection system did not provide accurate measurement on the client's progress.</p> <p>2. On October 14, 2008 from 1:50 PM until 2:00 PM, Client #4 was observed participating in art painting with staff assistance. Interview with the direct care staff indicated that the client likes "vivid colors". Review of the client's IPP dated September 19, 2008 on October 16, 2008 revealed a program objective which stated, "three times per week, [the client] will participate in an arts/crafts activity for five minutes with hand over hand assistance for six consecutive months by</p>	W 237	<p>W237</p> <p>This Standard will be met as evidenced by:</p> <p>QMRP will be provided additional training in this area.</p> <p>QMRP will monitor documentation weekly and analyze monthly.</p> <p>QMRP will document in the monthly progress notes relevant information to include but not limited to actions taken to resolve data collection issues and concerns.</p> <p>QMRP will review all program data sheets, add further information to support accurate measurement of the persons progress. QMRP will review future data sheets prior to implementation in order to prevent inaccuracies in data collection system.</p>	11-3-08 ongary
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NAME OF PROVIDER OR SUPPLIER IDI			STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20018		
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W 237	Continued From page 13 March 2009."	W 237			
W 249	<p>Review of the data sheet on October 16, 2008 at 10:00 AM revealed that the client performed the steps with hand over hand assistance. According to the data sheets, staff documented the level of assistance needed to perform the exercises. The data sheet did not reflect the number of minutes the client participated in the activity. It could not be determined how these goals were being measured for progress. Interview with the QMRP on October 16, 2008 acknowledged that the current data collection system did not provide accurate measurement on the client's progress.</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to provide continuous active treatment for two of the four clients included in the sample. (Clients #1 and #4)</p> <p>The findings include:</p> <p>1. The facility failed to implement Client #1's Physical Therapy (PT) objective as evidenced by the following:</p>	W 249	<p>W249</p> <p>This Standard will be met as evidenced by:</p> <p>Wrists weights were present in the home at the time of the survey. Staff located the items afterwards.</p> <p>Program supplies will be maintained in a designated area and staff provided training to ensure that all program supplies are accessible and used in accordance to the program instructions.</p> <p>QMRP will conduct staff training as needed to ensure that all programs are implemented with the frequency and number outlined.</p>	10/18/08 ongon	

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W 249	<p>Continued From page 14</p> <p>During the evening observation on October 14, 2008 at 6:38 PM, Client #1 propelled her wheelchair around the facility independently with staff encouragement. Review of the client's Individual Program Plan (IPP) on the same day, revealed an objective that required her to propel her wheelchair with two pound wrist weights for four trips around the interior of the house. The objective further indicated that the client participate with the program two times daily with 100% accuracy for six months. It was noted that the client did not have the wrist weights. The Qualified Mental Retardation Professional (QMRP) was interviewed regarding the weights used to implement the program. The QMRP acknowledged that the staff had not put the wrist weights on the client as required in the IPP.</p> <p>2. The facility failed to implement Client #1's Activity of Daily Living (ADL) goal as evidenced below:</p> <p>On October 14, 2008, during the dinner observations at 6:20 PM, Client #1 fed herself independently. After completing the meal, she removed herself from the table and the staff removed the place mats and wiped the table. Review of the client's IPP on October 15, 2008 revealed an objective that required the client to wipe her place at the table with 75% accuracy for six consecutive months given verbal assistance. At the time of the survey, the facility failed to provide evidence that the client participated in the aforementioned program.</p> <p>3. The facility failed to ensure that Client #4 participated in active treatment programs in accordance with her IPP.</p>	W 249	<p>2. Reference response to W249.1</p> <p>3. Reference response to W249.1</p>	11.24.08 original

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W 249	Continued From page 15 Observations after the dinner on October 14, 2008, revealed staff wiping the dining room table. Review of the Client #4's IPP dated September 19, 2008 on October 16, 2008 revealed a program objective which required the client to wipe the table after dinner. There was no evidence that Client #4 was given the opportunity to participate in the aforementioned program.	W 249			
W 252	483.440(a)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure documentation of program data in measurable terms for one of the two clients included in the sample. (Client #2) The finding includes: On October 14, 2008 at approximately 1:44 PM, a direct care staff was observed engaging Client #2 with a device that indicated the days of the week when buttons were pushed. Review of Client #2's Individual Program Plan (IPP) revealed a program that reflected given physical assistance. Client #2 will activate a cause and effect item or object for 7 to 10 trials per session as measured by active treatment documentation. Review of the program documentation failed to provide evidence that the staff was documenting the program. Interview with the Qualified Mental Retardation Professional (QMRP) on October 15, 2008 at 2:30 PM revealed that she was not aware that the	W 252	W252 This Standard will be met as evidenced by; QMRP/Home Manager will receive additional training related to documentation and implementation of program data. QMRP/Home Manager will monitor program implementation weekly and conduct additional staff training as needed.	11-26-08 ongoing	

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W 252 W 325	Continued From page 16 staff was not documenting on the program. 482.460(a)(3)(iii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician. This STANDARD is not met as evidenced by: Based on observations, staff interview and record verification, the facility failed to ensure recommended laboratory studies were obtained timely, for one of the four clients in the sample. (Client #3). The finding includes: The facility failed to ensure Client #3 received the recommended EEG laboratory study timely. On October 14, 2008 at 9:00 AM, Client #3 was administered Valproic Acid 10 ml. Interview with the Licensed Practical Nurse (LPN) after the medication pass indicated that the client received the aforementioned medication for her diagnosis of seizure disorder. During the entrance conference with the House Manager and the Licensed Practical Nurse (LPN) on October 14, 2008 at 9:45 AM with the House Manager and day time LPN revealed that Client #3 had a seizure on May 13, 2008 (last seizure recorded was in 1999). Review of the client's medical record on October 14, 2008 revealed a neurology consult dated May 15, 2008. The neurologist recommended an EEG laboratory study. Further review of the client's medical record revealed that an EEG was attempted on May 18, 2008 however	W 252 W 325	W325 This Standard will be met as evidenced by: The recommended EEG has been scheduled for client #3. QMRP will review and obtain consent for medical treatments prior to the scheduled appointment. QMRP will discuss the risks and benefits of treatment with the legal guardian/advocate.	11-3-08 jmg/ony

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W 325	Continued From page 17 was unsuccessful due to the client's excessive movement. At that time it was further recommended that an EEG be done under sedation. According to the nurse's quarterly reviews dated 7/08 and 9/08, it was noted that follow up was needed on the EEG laboratory study with sedation. Interview with the Qualified Mental Retardation Professional (QMRP) on October 15, 2008 at approximately 11:00 AM revealed that Client #3 had a very involved/active father who was willing to sign medical consents. At the time of the survey, there was no evidence Client #3 received the recommended EEG.	W 325			
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, staff interview, the facility failed to ensure nursing care services as indicated by change in the clients health care status. The findings include: 1. The facility's nurse failed to ensure that the client received all prescribed medications without error. [See W389] 2. The facility's nurse failed to store drugs under proper conditions of security during administration. [See W381]	W 331	W356 This Standard will be met as evidenced by: RN will review with all nurses the expectations related to dental appointments. The QMRP/nurse will emphasize to direct care staff to request the dental office to schedule the follow-up appointment at the time of the visit. If this does not occur, the nurse must schedule the appointment to prevent delays in dental treatments. Nurse must also document actions taken toward securing recommended services. RN will continue to conduct file reviews and provide direction and feedback for staff	11-24-08 ongoing	
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT	W 356			

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W 356	<p>Continued From page 18</p> <p>The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure timely comprehensive treatment services for the maintenance of dental health for one of the four clients in the sample. (Client #3)</p> <p>The findings include:</p> <p>Review of Client #3's medical record on October 14, 2008 at 3:30 PM revealed a dental consultation dated January 28, 2008. The dentist noted that the client had moderate calculus deposits and needed scaling. Interview with the Licensed Practical Nurse (LPN) on October 15, 2008 at approximately 11:00 AM revealed that the client needed preauthorization prior to returning to the dentist office for scaling. Further interview indicated that the Residential Services Director sent out a written correspondence dated October 1, 2008 that documented, "effective immediately, clients no longer have to wait for preauthorization for scaling." At the time of the survey, the facility failed to ensure Client #3 received timely dental services (scaling).</p>	W 356	<p>W369</p> <p>This Standard will be met as evidenced by:</p> <p>The RN will review adherence to medication administration and adherence to prescribed physician orders. RN will implement disciplinary action for the nurse who failed to administer medications as ordered. Nurse will be encouraged to review the MAR prior to concluding medication passes to be sure all medications have been given.</p>	
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:</p>	W 369		<p>11.24.08 ONG/ML</p>

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W 369	Continued From page 19 Based on observation, and record review, the facility failed to ensure that the client received all prescribed medications without error for one of the four clients in the sample. (Client #4) The finding includes: Observation of the medication administration on October 14, 2008 at 8:40 AM, revealed Client #4 was administered Oyster Shell Calcium with Vitamin D, Oxcarbazepine, Macrobid, Certagen Vitamin with minerals, Cranberry fruit capsules, and Lactulose. Interview with the Licensed Practical Nurse (LPN) on October 14, 2008 at 9:25 AM revealed that she had completed the medication administration. Review of the medication administration records (MARs) and the physician orders dated September 2008 on October 14, 2008 at approximately 2:00 PM revealed that the client should have additionally received Polyethylene Glycol powder.	W 369			
W 381	483.460(J)(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, staff interview and record verification, the facility failed to store drugs under proper conditions of security during medication administration. The finding includes: During the medication administration on October 14, 2008 beginning at 8:05 AM, the Licensed Practical Nurse (LPN) was observed to leave	W 381	W381 This Standard will be met as evidenced by: Reference response to W369. RN will conduct training to emphasize the importance of proper security of medications during administration. RN will conduct medication administration reviews to further ensure compliance with this standard.	10/24/08 mgm	

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W 381	Continued From page 20 Client #8's medications on the dining room table while administering the client her medication in her bedroom. At 8:40 AM, the LPN was additionally observed to leave Client #4's medication on the dining room table while administering the client her medications in her bedroom. It should be noted that while the aforementioned medications were left on the table unsecured, clients, staff and the surveyor were noted to be in the area.	W 381		
W 455	483.470(I)(X1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to implement infectious control procedures to prevent communicable infectious diseases for one of the eight clients residing in the facility. (Client #7) The finding includes: On October 14, 2008, at approximately 6:20 PM, the staff was observed preparing the clients for dinner. A staff member observed obtaining a bib for Client #7 when the bib was placed on the table, it fell to the floor. The staff member picked it up and placed it around Client #7's neck. The observation was brought to the attention of the Qualified Mental Retardation Professional on October 16, 2008 at approximately 2:45 PM who acknowledged that the staff should have used a clean bib.	W 455	W455 This Standard will be met as evidenced by: QMRP will coordinate infection control training for all staff. QMRP/Home Manager will monitor and supervise staff activities and provide feedback and direction as needed to ensure compliance with this standard.	11/20/08 ongoing

Health Regulation Administration

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1 000	INITIAL COMMENTS A relicensure survey was conducted from October 14, 2008 through October 16, 2008. The survey was initiated using the fundamental survey process. A random sample of four residents were selected from a population of eight females with various degrees of disabilities. The findings of this survey were based on observations at the group home, and one day program, interviews with the group home and day program staff, and review of clinical and administrative records to include the facility's unusual incident reports.	1 000		
1 226	3510.5(c) STAFF TRAINING Each training program shall include, but not be limited to, the following: (c) Infection control for staff and residents; This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure effective training on infection control for staff. The finding includes: On October 14, 2008, at approximately 6:20 PM, the staff was observed preparing the clients for dinner. A staff member observed obtaining a bib for Resident #7 when the bib was placed on the table, it fall to the floor. The staff member picked it up and placed it around Resident #7's neck. The observation was brought to the attention of the Qualified Mental Retardation Professional on October 16, 2008 at approximately 2:45 PM who acknowledged that the staff should have used a	1 226	3510.5c This Statute will be met as evidenced by: Reference response to W455.	11-20-08 ongoing

Health Regulation Administration
Nancy Branch
 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
 STATE FORM

TITLE
 ORS
 (X8) DATE
 11/12/08
 If continuation sheet 1 of 8

Health Regulation Administration

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1226	Continued From page 1 clean bib.	1226		
1291	3514.2 RESIDENT RECORDS Each record shall be kept current, dated, and signed by each individual who makes an entry. This Statute is not met as evidenced by: Based on interview, and record review the GHMRP failed to ensure each clients records were kept current, dated and signed by each individual that made an entry. The finding includes: Review Resident #1's Individual Support Plan (ISP) on October 15, 2008 at 3:56 PM revealed a Psychology assessment dated September 29, 2007 and an Occupational Therapy assessment dated July 1, 2007. It was noted that these assessments were not signed by the person(s) that completed them. This observation was brought to the attention of the Qualified Mental Retardation Professional on October 16, 2008 at 2:15 PM; who acknowledged the lack of signatures.	1291	3514.2 This Statute will be met as evidenced by: Reference response to W114.	10-30-08 onqomw
1407	3520.9 PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall obtain from each professional service provider a written report at least quarterly for services provided during the preceding quarter. This Statute is not met as evidenced by: Based on observation, staff interview, and record review, the GHMRP failed to ensure and obtain	1407	3520.9 This Statute will be met as evidenced by: Reference response to W120.	11-24-08 onqomw

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NAME OF PROVIDER OR SUPPLIER IDI	STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20019
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1407	<p>Continued From page 2</p> <p>that each professional service provider provided a written report at least quarterly for services provided during the proceeding quarter for one of the four residents in the sample. (Residents #2)</p> <p>The finding includes:</p> <p>On October 14, 2008 at approximately 1:44 PM, a direct care staff was engaging Resident #2 with a device that indicated the days of the week when buttons were pushed. Review of Resident #2's Individual Program Plan (IPP) on October 15, 2008 at 2:30 PM, revealed a program that reflected given physical assistance, Resident #2 will activate a cause and effect item or object for 7 to 10 trials per session as measured by active treatment documentation. Review of the program documentation failed to evidence that the staff was documenting the program.</p> <p>Interview with the QMRP on October 15, 2008 at 2:30 PM revealed that she was not aware that the staff was not documenting on the program. Further review of the IPP quarterly reviews failed to evidence that the speech therapist (SP) had been monitoring the residents progress in the program as required in the contractual agreement with the provider. It should be noted that review of the contract between the SP and the provider revealed that the SP was responsible for monitoring the programs quarterly.</p>	1407		
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	<p>3521.3</p> <p>This Statute will be met as evidenced by:</p> <p>Reference response to W227 and W159.</p>	<p>11.24.08 org/pmr</p>

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NAME OF PROVIDER OR SUPPLIER IDI		STREET ADDRESS, CITY, STATE, ZIP CODE 4954 ASTOR PLACE, SE WASHINGTON, DC 20018		
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1422	<p>Continued From page 3</p> <p>GHMRP failed to provide training and assistance to residents in accordance with the their Individual Habilitation Plans for three of the four residents included in the sample. (Resident #1, #2 and #4)</p> <p>The findings include:</p> <p>1. The facility failed to develop program objectives as identified in the Comprehensive Functional Assessment (CFA) for Resident #4.</p> <p>Observations on October 14, 2008 from 7:00 AM through 7:00 PM, revealed Resident #4 in a wheelchair with tight extremities. On October 14, 2008 at 4:00 PM, staff was observed assisting Resident #4 with range of motion exercises to her shoulder.</p> <p>Review of the Occupational Therapy assessment on October 16, 2008 dated March 30, 2008 revealed program recommendations for the Resident to receive range of motion exercises to her elbows, wrists, and fingers. Review of the IPP on October 16, 2008 dated September 19, 2008 revealed no evidence of training programs to address the aforementioned recommendations.</p> <p>2. The facility failed to implement Resident #1's Physical Therapy (PT) objective as evidenced by the following:</p> <p>During the evening observation on October 14, 2008 at 6:38 PM, Resident #1 propelled her wheelchair around the facility independently with</p>	1422		

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1422	<p>Continued From page 4</p> <p>staff encouragement. Review of the client's Individual Program Plan (IPP) on the same day, revealed an objective that required her to propel her wheelchair with two pound wrist weights for four trips around the interior of the house. The objective further indicated that the Resident participate with the program two times daily with 100% accuracy for six months. It was noted that the Resident did not have the wrist weights. The Qualified Mental Retardation Professional (QMRP) was interviewed regarding the weights used to implement the program. The QMRP acknowledged that the staff had not put the wrist weights on the Resident as required in the IPP.</p> <p>3. The facility failed to implement Resident #1's Activity of Daily Living (ADL) goal as evidenced below:</p> <p>On October 14, 2008, during the dinner observations at 6:20 PM, Resident #1 fed herself independently. After completing the meal, she removed herself from the table and the staff removed the place mats and wiped the table. Review of the client's IPP on October 15, 2008 revealed an objective that required the Resident to wipe her place at the table with 75% accuracy for six consecutive months given verbal assistance. At the time of the survey, the facility failed to provide evidence that the Resident participated in the aforementioned program.</p> <p>4. The facility failed to ensure that Resident #4 participated in active treatment programs in accordance with her IPP.</p> <p>Observations after the dinner on October 14, 2008, revealed staff wiping the dining room table. Review of the Resident #4's IPP dated September 19, 2008 on October October 16,</p>	1422		

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1422	Continued From page 5 2008 revealed a program objective which required the Resident to wipe the table after dinner. There was no evidence that Resident #4 was given the opportunity to participate in the aforementioned program.	1422		
1473	3522.4 MEDICATIONS The Residence Director shall report any irregularities in the resident's drug regimens to the prescribing physician. This Statute is not met as evidenced by: Based on observation, and record review, the Residence Director failed to ensure that the residents received all prescribed medications without error for one of the four residents in the sample. (Resident #4) The finding includes: Observation of the medication administration on October 14, 2008 at 8:40 AM, revealed Client #4 was administered Oyster Shell Calcium with Vitamin D, Oxcarbazepine, Macrobid, Certagen Vitamin with minerals, Cranberry fruit capsules, and Lactulose. Interview with the Licensed Practical Nurse (LPN) on October 14, 2008 at 9:25 AM revealed that she had completed the medication administration. Review of the medication administration records (MARs) and the physician orders dated September 2008 on October 14, 2008 at approximately 2:00 PM revealed that the client should have additionally received Polyethylene Glycol powder.	1473	3522.4 This Statute will be met as evidenced by: Reference response to W325 and W369.	11/3/08 0190M4
1500	3623.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure	1500		

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1500	<p>Continued From page 6</p> <p>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> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure each resident's rights were observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and Federal Laws.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. A review of Resident #1's financial record was conducted on October 16, 2008 at 10:45 AM. The bank statements were reviewed from September 2007 through September 2008. The record revealed a withdrawal of \$1,200.00 from the client's account on September 22, 2008. Review of the receipts for the aforementioned withdrawal totaled \$1,032.33. Interview with the House Manager (HM) indicated that she had not spent the entire amount because the surveyors were in the facility during the last several days. A request was made by the surveyor for the HM to provide evidence of the available cash (\$167.67), but, at the time of the completion of the survey, the HM failed to provide requested evidence. The facility failed to ensure a complete accounting of Resident #1's personal funds. 2. On October 16, 2008 at 10:45 AM, Resident #2's financial record was reviewed. A note was found dated May 28, 2008, that revealed Resident #2 owed Resident #5 \$88.75. Interview with the House Manager (HM) revealed that she 	1500		

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1500	Continued From page 7 requested \$200.00 for both clients. When the HM turned in the receipts to the accounting office, she was informed by the office staff that \$300.00 had been withdrawn from Resident #2's account and \$100.00 had been withdrawn from Resident #5's account. Further interview with the HM revealed that Resident #5's money was scheduled to be deposited into her account. According to a bank statement dated June 30, 2008, \$88.75 was deposited into Resident #5's account on June 17, 2008. Interview during the entrance conference on October 14, 2008 at 9:15 AM revealed that Resident #5 had a court appointed legal decision maker. Additionally, review of Resident #5's Psychological Assessment on October 16, 2008 revealed the Resident could not make informed decisions regarding financial matters. At the time of the survey, the facility failed to provide evidence that Resident #5 and/or her guardian had been informed of the aforementioned financial matter.	1500	3523.1 This Statute will be met as evidenced by: Reference response to W140.	10.26.08 mgainy