

RE 02/01

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

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 08/31/2007
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NAME OF PROVIDER OR SUPPLIER IDI	STREET ADDRESS, CITY, STATE, ZIP CODE 4854 ASTOR PLACE, SE WASHINGTON, DC 20019
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W 000	INITIAL COMMENTS A recertification survey was conducted from August 29, 2007 through August 31, 2007. The survey was initiated using the fundamental survey process. A random sample of four clients 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, one day program, interviews at both the group home and day program, review of clinical and administrative records to include the facility's unusual incident reports.	W 000		
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observations, staff interview, and record review, the facility failed to effectively monitor each client's day program to assure that the needs were met for one of four clients in the sample. (Client #3) The finding includes: Review of the Client #3's medical record on August 29, 2007 at approximately 11:00 AM revealed an emergency room report dated April 18, 2007. The ER report indicated a diagnosis of ingestion of a styrofoam cup. Interview with the Qualified Mental Retardation Professional on August 30, 2007 at approximately 11:00 AM revealed that the day program staff was feeding the client using a styrofoam cup.	W 120	W120 This Standard will be met as evidenced by: QMRP will follow-up with day program staff, provide additional trainings as needed on mealtime protocol and use of adaptive feeding equipment.	9-13-07 ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Nancy Branch	TITLE Director Residential Services	(X6) DATE 10/1/07
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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	Continued From page 1	W 120	W120, continued...	
W 130	Review of Client #3's feeding protocol dated October 20, 2006 revealed that the client should be fed with an adaptive cup (spout cup). Further interview with the QMRP indicated that the proper adaptive equipment was available at the day program. However the day program staff failed to use the proper equipment as ordered. 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, the facility failed to implement an effective system to protect the clients' right for privacy during morning medication administrations for three of the four clients residing in the facility. (Clients #1, #2, #6 and #7) The finding includes: The morning medication administration observations on August 29, 2007 beginning at 7:20 AM. The Licensed Practical Nurse (LPN) was observed administering medications to Clients #1, #2, #6 and #7 at the dining room table. The nurse interrupted the clients breakfast to administer their medications. At the time, direct care staff were assisting clients with eating their breakfast.	W 130	QMRP will conduct follow-up visits at the day program site, address concerns, and issues as they arise.	
W 137	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients,	W 137	W130 This Standard will be met as evidenced by: • RN will address CPN who failed to implement privacy standards. • LPN's will receive additional training on adherence to privacy during medication passes. • RN will conduct random medication pass monitoring to further ensure compliance with this standard.	9-20-07 ongoing

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W 137	<p>Continued From page 2</p> <p>Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure each clients clothing and personal belongings were maintained for eight of eight clients (Clients: #1, #2, #3, #4, # 5, #6, #7 and #8) residing in the facility.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. During the environmental inspection conducted on August 31, 2007, the surveyor observed that all of the clients undergarments (T-shirts, and brassieres) were worn and tattered. The white clothing was dingy. 2. During the environmental inspection conducted on August 31, 2007, the surveyor observed that none of the clients had underpants in their dresser drawers. Interview with the House Manager (HM) on the same day revealed that all of the clients wore adult protective undergarments and did not have a need for underwear. Further interview revealed that none of the clients had been asked if they wanted to wear underwear or not. 3. During the environmental inspection in Client #1's bedroom conducted on August 31, 2007, a painting was observed on her dresser. The painting was separated from the frame and was not mounted but leaning against the wall. The HM acknowledged that the painting needed to be repaired and mounted on the wall for Client #1's enjoyment. 	W 137	<p>W137</p> <p>This Standard will be met as evidenced by:</p> <ol style="list-style-type: none"> (1) Home Managers will replace all undergarments. (2) QMEP/Coordinator will discuss with each person if they want to wear underwear. <p>Coordinator will ensure that undergarments are purchased and stored in their drawers.</p>	9.5.07 ongoing
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W 148	<p>483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS &</p> <p>The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to document prompt notification of parents or guardians of significant incidents or change in client's condition, for one of the four clients in the sample. (Client #3)</p> <p>The finding includes:</p> <p>On August 29, 2007 at 7:50 PM, during the entrance conference via telephone, the Qualified Mental Retardation Professional (QMRP) indicated the Client #3 had family involvement. Review of the client's medical record on August 29, 2007 at approximately 11:00 AM revealed an emergency room report dated April 18, 2007. The ER report indicated a diagnosis of ingestion of a styrofoam cup. Review of the incident revealed that the family members were not notified of this incident. The QMRP further indicated that notification of guardians/family members should be document on incident reports.</p>	W 148	<p>W137 continued...</p> <p>(3) Home manager will repair and/or replace picture frame.</p> <p>Home Manager will conduct routine environmental audits, document findings and address items requiring repairs. Documentation will be filed for review.</p> <p>W148</p> <p>This Standard will be met as evidenced by: QMRP will ensure that family members are notified in accordance to the incident policy.</p>	9.5.07 ongoing
W 153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS</p> <p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other</p>	W 153		9.7.07 ongoing

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W 153	<p>Continued From page 4 officials in accordance with State law through established procedures.</p> <p>This STANDARD is not met as evidenced by: Based on interview, review of unusual incidents, and review of medical records, the facility failed to ensure that all unusual incidents including injuries of unknown origin were reported immediately to the administrator and other officials according to district law (22 DCMR, Chapter 35, Section 3519.10) for one of the four clients included in the sample. (Client #3)</p> <p>The finding includes:</p> <p>Review of the Client #3's medical record on August 29, 2007 at approximately 11:00 AM revealed an emergency room report dated April 18, 2007. The ER report indicated a diagnosis of ingestion of a styrofoam cup. There was no evidence that this incident has been reported to other officials (Department of Health) as required 483.420(d)(4) STAFF TREATMENT OF CLIENTS</p>	W 153	<p>W153, Continued...</p> <p>This Standard will be met as evidenced by:</p> <ul style="list-style-type: none"> Day Program staff reportedly made all notifications. QMEP will confer with day program whenever incidents occur to ensure completion of notifications. QMEP will maintain documentation/verification to support notification to administrator and other officials. 	9.14.07 ongoing
W 156	<p>The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that investigations were reported to the administrator and State officials within five working days of the incident, for two of the four clients in the sample. (Clients #1 and #3)</p>	W 156	<p>W156</p> <p>This Standard will be met as evidenced by:</p>	

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W 156	<p>Continued From page 5 The findings include:</p> <p>1. The facility's unusual incident reports were reviewed on August 29, 2007. An incident dated March 2, 2007 indicated that staff observed a bruise on the left leg of Client #1. The client was taken to the emergency room. No further information was documented on the incident report. Interview with the nurse and the Qualified Mental Retardation Professional (QMRP) on the same day revealed that the client was admitted to the hospital with a diagnosis of fractured leg and urinary tract infection (UTI). The QMRP stated that the incident was investigated and revealed that during a medical appointment on March 1, 2007, Client #1 fell from her wheelchair and sustained a fracture. The three staff involved in the incident was terminated.</p> <p>Further interviews with the QMRP failed to provide evidence that the state agency was notified of the results of the investigation as required by Federal Regulations.</p> <p>2. Review of the Client #3's medical record on August 29, 2007 at approximately 11:00 AM revealed an emergency room report dated April 18, 2007. The ER report indicated a diagnosis of ingestion of a styrofoam cup. Interview with the Qualified Mental Retardation Professional on August 30, 2007 at approximately 11:00 AM revealed that an investigation had been completed. However the results of the investigation was not forwarded to other officials in accordance with State law within five working days of the incident.</p>	W 156	<p>W156 Continued...</p> <p>① OMRP will file verification of notifications with the incident report and investigation summary to provide evidence that the state agency was notified and results of the investigation were sent in accordance to the required regulations and policies.</p> <p>② Reference response to W156 #①.</p>	<p>9.4.07 ongoing</p> <p>9.4.07 ongoing</p>
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL	W 159		

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W 159	<p>Continued From page 6</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by. Based on observation, interview and record review the facility failed to ensure that each client's active treatment program was coordinated, integrated and monitored by the Qualified Mental Retardation Professional (QMRP).</p> <p>The findings include:</p> <ol style="list-style-type: none"> The facility's QMRP failed to ensure that clients' individual program plans (IPP) included training in personal skills in both formal and informal setting. [See W242] The facility's QMRP failed to ensure that clients were provided the opportunities for continuous active treatment in accordance with their individual program plans. [See W249] The facility's QMRP failed to review and revise the Individual Program Plan (IPP) once the client has successfully completed an objective identified in the IPP. [See W255] The facility's QMRP failed to revise objectives identified in the IPPs that had not been achieved. [See W257] The facility's QMRP failed to ensure that a Comprehensive Functional Assessment (CFA)/Individual Support Plan (ISP) had been implemented timely. [See W259] 	W 159	<p>W159</p> <p>This standard will be met as evidenced by:</p> <ol style="list-style-type: none"> Reference response to W242 and W249. Reference response to W255. Reference response to W257 Reference response to W259. 	
W 242	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN	W 242		9/10/07 ongoing 9/10/07 ongoing

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W 242	<p>Continued From page 7</p> <p>The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that clients' individual program plans (IPP) included training in personal skills in both formal and informal settings for one of the four clients in the sample. (Client #4)</p> <p>The finding includes:</p> <p>Interview with the Qualified Mental Retardation Professional on August 30, 2007 at approximately 11:00 AM revealed that the Client #4 had an Individual Support Plan (ISP) meeting on August 15, 2007. During the ISP meeting, the Interdisciplinary Team (IDT) recommended and approved that the client receive training to improve her personal hygiene skills. Review of the IPP revealed no evidence that the QMRP developed or implement a toothbrushing program.</p>	W 242	<p>W242</p> <p>This Standard will be met as evidenced by:</p> <ul style="list-style-type: none"> QMRP will implement training objective to improve her personal hygiene skills in accordance with the ISP recommendations. QMRP will monitor status on a monthly basis. Following ISP meeting QMRP will review and double check recommendations to further ensure that training objectives are outlined on the IPP and implemented in accordance with the recommendations. 	9/10/07 ongoing
W 249	<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</p>	W 249		

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W 249	<p>Continued From page 8</p> <p>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 staff interviews and record review, the facility failed to ensure that clients were provided the opportunities for continuous active treatment in accordance with their individual program plans (IPPs) for two of four clients included in the sample. (Clients #1 and #4)</p> <p>The findings include:</p> <p>1. Client #1 was observed during the breakfast and lunch observations on August 29, 30, and 31, 2007. She ate her meals independently and upon completion, the staff took her plate and placemats to the kitchen. Review of Client #1's Individual Program Plan (IPP) objectives on August 30, 2007 revealed a program objective that indicated the following: "given verbal assistance, (Client #1) will wipe her place at the table with 75% accuracy for six consecutive months." The client was not observed to wiping her place at the table and the staff were not observed to encourage the client to do so.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on August 30, 2007 at 11:00 AM, revealed that the client's programs had been put on hold because the client was placed on bedrest to promote the healing of a sacral decubitus ulcer. Further interview revealed that the client was receiving her meals in bed. The QMRP also stated that Client #1 had been taken</p>	W 249	<p>W249</p> <p>This Standard will be met as evidenced by:</p> <p>(1) Program objective to wipe her place at the table had been implemented as outlined.</p> <p>QMRP will continue to monitor Client #1's progress and provide training as needed.</p> <p>(2) QMRP will ensure that program objective for client #1 is implemented as outlined thru observation, monitoring documentation and additional staff training as needed.</p>	<p>9/10/07 ongoing</p> <p>9/11/07 ongoing</p>

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W 249	<p>Continued From page 9 off bedrest on August 20, 2007 and that her programs should have been implemented.</p> <p>2. The facility failed to ensure that Client #4 participated in active treatment programs in accordance with her IPP.</p> <p>During observations from August 29, 31, 2007, staff was observed feeding and wiping Client #4's mouth during meals. Review of his IPP dated August 16, 2006 revealed a program objective which stated, "given hand over hand assistance, [the client] will wipe her mouth using a paper napkin with 75% accuracy for ..."</p> <p>There was no evidence that Client #1 received continuous active treatment in accordance with her IPP.</p>	W 249		
W 255	<p>483.440(f)(1)(i) PROGRAM MONITORING & CHANGE</p> <p>The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan.</p> <p>This STANDARD is not met as evidenced by: Based on observations, staff interviews and record review, the Qualified Mental Retardation Professional (QMRP) failed to review and revise the Individual Program Plan (IPP) once the client had successfully completed an objective identified in the IPP for one of the four clients in the sample. (Client #3)</p> <p>The finding includes:</p>	W 255	<p>W255</p> <p><i>This standard will be met as evidenced by:</i></p>	

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W 255	<p>Continued From page 10</p> <p>The facility's QMRP failed to revise Client #3's program objectives.</p> <p>On August 29, 2007 at 6:15 PM, Client #3 was observed washing her hands with staff providing hand over hand assistance. Interview with the direct care staff indicated that the client required assistance to perform all of her activities of daily living skills.</p> <p>On August 30, 2007 at approximately 11:00 AM, in reviewing client's IPP dated October 25, 2006, the client had a program objective which stated, "given hand over hand assistance, [the client] will wash her hands with a disposable cloth before PM meals on 80% of the trials recorded per month for six consecutive months ...". Record verification of the data sheets on August 30, 2007 indicated that the client achieved the established criteria since June 2006.</p>	W 255	<p>W 255, Continued...</p> <p>QMRP will monitor and track client #3's progress on a monthly basis.</p> <p>QMRP will update/revise and/or modify objectives as needed.</p> <p>QMRP will document status in monthly/quarterly progress notes.</p>	9/10/07 ongoing
W 257	<p>483.440(f)(1)(ii) PROGRAM MONITORING & CHANGE</p> <p>The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made.</p> <p>This STANDARD is not met as evidenced by: Based on record review, the Qualified Mental Retardation Professional (QMRP) failed to revise objectives identified in the individual program plans (IPPs) that had not been achieved for two of four clients in the sample. (Clients #2 and #3)</p>	W 257	<p>W 257</p> <p>This Standard will be met as evidenced by.</p>	

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NAME OF PROVIDER OR SUPPLIER IDI	STREET ADDRESS, CITY, STATE, ZIP CODE 4964 ASTOR PLACE, SE WASHINGTON, DC 20019
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W 257	<p>Continued From page 11 The findings include:</p> <p>1. Client #2's program objectives were reviewed on August 30, 2007. Client #2 has a program objectives that indicated the following: [Given model demonstration, [client's name] will discriminate five activities of daily living using picture representations with 80% accuracy per session as measured by Active Treatment (AT) documentation." Review of the AT documentation and the Qualified Mental retardation Professional (QMRP) documentation revealed that the client had consistently not met the criteria for the past three quarters. Interview with the QMRP on August 30, 2007, acknowledged that the client was not meeting the criteria for the objective and that the objective had not been revised.</p> <p>2. The QMRP failed to review Client #3's speech program in which the client failed to make progress toward identified objective after reasonable efforts have been made.</p> <p>Review of Client #3's Individual Program Plan (IPP) dated October 25, 2007, revealed that the client will improve her functional communication skills. Further review revealed that Client #3 had an objective which stated, "given physical assistance, [the client] will perform an action with an object for 6 out of 10 trials per session for three consecutive months as measured by AT documentation". Review of the Speech Pathologist's quarterly reviews from January 27, 2007 through August 15, 2007 revealed that the client required hands on assistance on all the trials, recorded. There is no evidence that the objective had been revised.</p>	W 257	<p>W257, continued...</p> <p>QMRP will monitor client #2, #3 and #4 program objectives on a monthly basis.</p> <p>QMRP will evaluate and analyze documentation and monitor implementation of program objectives and revise as needed, in a timely manner.</p>	9/15/07 ongoing
W 258	483.440(f)(2) PROGRAM MONITORING &	W 259		

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W 259	<p>Continued From page 12 CHANGE</p> <p>At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record reviews, the facility failed to ensure that a Comprehensive Functional Assessment (CFA)/Individual Support Plan (ISP) had been implemented timely for one of the four clients in the sample (Client #4).</p> <p>The finding includes:</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) and review of Client #4's record on August 30, 2007 at 11:00 AM revealed, Client #4's annual Individual Support Plan (ISP) meeting was held on August 15, 2007. Review of the ISP in the record revealed the plan was dated August 15, 2006. Further interview was conducted to ascertain information about the current ISP (dated August 15, 2007). According to the QMRP, the plan had not been updated and new program objectives recommended at the ISP had not been implemented. At the time of the survey, the facility failed to provide evidence that Client #4's ISP had been completed and updated as required.</p>	W 259	<p>W259</p> <p>This Standard will be met as evidenced by:</p> <p>QMRP has completed and updated the ISP for client #4.</p> <p>QMRP will complete ISP documents in a timely manner, and in accordance to the standards set forth.</p>	9/6/07 ongoing
W 436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p>	W 436	<p>W436</p>	

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W 436	<p>Continued From page 13</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to provide buny boots for one of the four clients in the sample. (Client #3)</p> <p>The finding includes:</p> <p>Observations during the survey from August 29-30, 2007 revealed that Client #3 was observed wearing custom molded shoes.</p> <p>On August 29, 2007 at 8:30 AM, Client #3 was observed wearing custom molded shoes. At 5:30 PM, the client was observed wearing socks on her feet. Review of the clients physician orders dated January 30, 2007 revealed an order for one pair of "buny boots" to give the client foot comfort. Additional review of the podiatry consult and a nursing progress note dated January 30, 2007 revealed a prescription for "buny boots".</p> <p>Further observation and interview with the Licensed Practical Nurse (LPN) revealed that the client had a pair of slippers with bunny faces on them. Interview with the Qualified Mental Retardation Professional (QMRP) indicated that the client had recently received the molded shoes, however the QMRP was not aware of the "buny boots".</p>	W 436	<p>W436 continued...</p> <p>This Standard will be met as evidenced by:</p> <p>QMRP will follow-up ^{on} physicians order to wear "buny boots".</p> <p>QMRP will obtain "buny boots/slippers" as recommended.</p> <p>QMRP will provide additional staff training on wearing of "buny boots/slippers."</p>	9/15/07 ongoing
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1000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from August 29, 2007 through August 31, 2007. 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.</p> <p>The findings of this survey were based on observations at the group home, one day program, interviews at both the group home and day program, review of clinical and administrative records to include the facility's unusual incident reports.</p>	1000		
1052	<p>3502.10 MEAL SERVICE / DINING AREAS</p> <p>Each GHMRP shall equip dining areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each resident.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review the GHMRP failed to ensure the availability of recommended adaptive equipment at Resident #3's day program.</p> <p>The finding includes:</p> <p>See Federal Deficiency Report - Citation W120</p>	1052	<p>3502.10 1052</p> <p>This Statute will be met as evidenced by:</p> <p>Reference response to Federal Deficiency Report W120</p>	
1090	<p>3504.1 HOUSEKEEPING</p> <p>The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.</p>	1090	<p>3504.1 1090</p>	

Health Regulation Administration

Nancy Branch

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

TITLE
Director Residential Services

(X6) DATE

10/1/07

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1090	Continued From page 1 This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure the interior of the facility was maintained in a safe, clean, orderly, attractive and sanitary manner. The findings includes: During the environmental inspection conducted on August 31, 2007, the following was observed: 1. The doors to the bedrooms of the residents had unsightly dark marks caused by the residents wheel chairs. 2. In resident #1's bedroom, a painting was observed on her dresser. The painting was separated from the frame and was not mounted but leaning against the wall. The House Manager acknowledged that the painting needed to be repaired and mounted on the wall for Client #1's enjoyment. 3. The kitchen cabinet shelves had crumbs/debris from food and were sticky to touch. 4. The ceilings throughout the house had peeling paint. 5. The oven had baked on food and grease on the inside.	1090	3504.1, continued... This Statute will be met as evidenced by: (1) Door ways have been painted. (2) Home Manager will replace/repair frame. (3) Kitchen has been cleaned. Home Managers check status of home daily, address concerns as they arise. (4) Maintenance request submitted for necessary repairs. Home Manager will continue to report all concerns and maintain documentation to support issues addressed.	9/3/07 ongoing
1108	3504.15 HOUSEKEEPING Each GHMRP shall assure that each resident has at least seven (7) changes of clothing appropriate to his or her daily activities.	1108		

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1108	Continued From page 2 This Statute is not met as evidenced by: Based on observation and interview, the facility failed to provide evidence that each resident was provided with the at least seven changes of appropriate clothing. The findings include: 1. During the environmental inspection conducted on August 31, 2007, it was observed that all of the residents undergarments (T-shirts, and brassieres) were worn and tattered. The white clothing was dingy. 2. During the environmental inspection conducted on August 31, 2007, it was observed that none of the residents had underpants in their dresser drawers. Interview with the house manager on the same day revealed that all of the residents wear adult protective undergarments and did not have a need for underwear. Further interview revealed that none of the residents had been asked if they wanted to wear underwear or not.	1108	3504.1, continued... (5) Oven has been cleaned. Home Manager will continue to complete routine home inspections, address concerns as they arise, and provide additional staff training as needed. 3504.15 Reference response to W137 Federal Deficiency Report.	9-5-07 ongoing
1110	3504.17 HOUSEKEEPING Each GHMRP shall ensure that each resident's clothing is kept in good condition, laundered, and cleared. This Statute is not met as evidenced by: Based on observation, the GHMRP failed to ensure each resident's clothing was maintained in good condition and clean. Residents #1, #2, #3, #4, #5, #6, #7, and #8)	1110	1110 3504.17 This Statute will be met as evidenced by: Reference response to W137 Federal Deficiency Report.	9-5-07 ongoing

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I 110	Continued From page 3 The finding includes: During the environmental inspection conducted on August 31, 2007, it was observed that all of the residents undergarments (T-shirts, and brassieres) were worn and tattered. The white clothing was dingy.	I 110		
I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at their beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current job descriptions for all employees. The finding includes: Thirteen of fourteen direct care staff and Qualified Mental Retardation Professional records failed to show evidence that the staff's job duties were reviewed with them on annual basis. (Staff #1, #2, #3, #4, #5, #6, #7, #9, #10, #11, #12, #13, and #14)	I 203	1203 3509.3 This Statute will be met as evidenced by: GHMRP/Coordinator will ensure that all outstanding job descriptions are reviewed with each employee. Human Resource department will continue to review and discuss job descriptions at the time of hire.	9.7.07 ongoing
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been performed and that the employee's health status would allow him or her to perform the required duties.	I 206	GHMRP/Coordinator will review job descriptions monthly and update as needed to ensure ongoing compliance with this Standard	

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1206	Continued From page 4 This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that all staff had current health certificates on file. The finding includes: Review of the GHMRP's personnel files on August 31, 2007 revealed three direct care staff (Staff #2, #8 and 13); Speech Pathologist and Podiatrist failed to have evidence of a health inventory certifying their health status and their ability to perform their job duties.	1206	1206 3509.6 This Statute will be met as evidenced by: Personnel files will be updated. Health inventories have been requested. Human Resources and Administrative Assistant will continue to monitor and track compliance and timely submission of health certificates.	9/10/07 ongoing
1226	3510.5(c) STAFF TRAINING This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that current training on cardiopulmonary resuscitation (CPR) was maintained for each employee. The finding includes: Review of the GHMRP's personnel files revealed that two of the fourteen staff files lacked evidence of current CPR certification. (Staff #7 and #12)	1226	1226 3510.5 Staff #7 and #12 have been scheduled to attend the next CPR certification training.	9/19/07 ongoing
1374	3519.5 EMERGENCIES After medical services have been secured, each GHMRP shall promptly notify the resident's guardian, his or her next of kin if the resident has no guardian, or the representative of the sponsoring agency of the resident's status as soon as possible, followed by written notice and documentation no later than forty-eight (48) hours	1374	Home Manager/Training Director will continue to monitor and schedule staff as needed to ensure ongoing compliance w/ this standard.	

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1374	Continued From page 5 after the incident. This Statute is not met as evidenced by: Based on staff interview and record review, the GHMRP failed to provide evidence of the prompt notification of parents or guardians of significant incidents for one of the four residents in the sample. The finding includes: See Federal Deficiency Report - Citation W148	1374	1374 3519.5 This Statute will be met as evidenced by: Reference response to Federal Deficiency Report - Citation W148.	
1379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.51 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. This Statute is not met as evidenced by: Based on interview record review, the GHMRP failed to ensure the Department of Health, was notified of unusual incidents or events that substantially interfered with each resident's health and welfare within twenty-four hours or the next work day. The finding includes: Refer to Federal Deficiency Report W153	1379	1379 3519.10 This Statute will be met as evidenced by: Reference response to Federal Deficiency Report W153.	9/7/07 ongoing

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1407	Continued From page 6	1407		
1407	<p>3520.9 PROFESSION SERVICES: GENERAL PROVISIONS</p> <p>Each GHMRP shall obtain from each professional service provider a written report at least quarterly for services provided during the preceding quarter.</p> <p>This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for Mentally Retarded Persons' (GHMRP) Speech Pathologist failed to provide evidence of a written quarterly report one of the four residents in the sample. (Resident #4)</p> <p>The finding includes:</p> <p>Review of Client #4's clinical record revealed that the client had a speech program program objective which stated, "given model demonstration, [the resident] will TURNION and OFF an item of daily living with 80% accuracy per session as measured by active treatment documentation". However there was no written report at least quarter from the Speech Pathologist.</p>	1407	<p>1407 3520.9</p> <p>This Statute will be met as evidenced by:</p> <p>GHMRP will follow-up with the Speech Pathologist to obtain written quarterly report for resident #4.</p>	9.14.07 ongoing
1420	<p>3521.1 HABILITATION AND TRAINING</p> <p>Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning.</p> <p>This Statute is not met as evidenced by: Based on staff interviews and record review, the facility failed to ensure that residents were</p>	1420	<p>1420 3521</p> <p>This Statute will be met as evidenced by:</p>	9.1.07 ongoing

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1420	Continued From page 7 provided the opportunities for continuous active treatment in accordance with their Individual Program Plans (IPPs) for one of four residents included in the sample. (Resident #1) The finding includes: Resident #1 was observed during the breakfast and lunch observations on August 29, 30, and 31, 2007. She ate her meals independently and upon completion, the staff took her plate and place mats to the kitchen. Review of Resident #1's IPP objectives on August 30, 2007 revealed a program objective that indicated the following: Given verbal assistance, (Resident #1) will wipe her place at the table with 75% accuracy for six consecutive months. The resident was not observed wiping her place at the table nor were staff observed encouraging her to do so. Interview with the Qualified Mental Retardation Professional (QMRP) on August 30, 2007 at 11:00 AM, revealed that the residents programs had been put on hold and the resident was placed on bed rest to promote the healing of a sacral decubitus ulcer and that the resident was receiving her meals in bed. The QMRP also stated that Resident #1 had been taken off bedrest on August 20, 2007 and that her programs should have been implemented.	1420	1420 3521.1, continued... • Program objectives for resident #1 have been implemented in accordance to the IPP. • QMRP will continue to provide opportunities for continuous active treatment in accordance w/their Individual Program Plans.	9.1.07 ongoing
1422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure habilitation, training and	1422	1422 3521.3 This statute will be met as evidenced by:	

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	<p>Continued From page 8</p> <p>assistance was provided to residents in accordance with his Individual Habilitation Plan (IHP) for two of the four residents in the sample. (Residents #1 and #4)</p> <p>The finding includes:</p> <p>1. Resident #1 was observed during the breakfast and lunch observations on August 29, 30, and 31, 2007. She ate her meals independently and upon completion, the staff took her plate and placemats to the kitchen. Review of Resident #1's Individual Program Plan (IPP) objectives on August 30, 2007 revealed a program objective that indicated the following: "given verbal assistance, (Resident #1) will wipe her place at the table with 75% accuracy for six consecutive months." The resident was not observed wiping her place at the table nor were staff observed to encourage the client to do so.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on August 30, 2007 at 11:00 AM, revealed that the residents programs had been put on hold and the client was placed on bedrest to promote the healing of a sacral decubitus ulcer and that the resident was receiving her meals in bed. The QMRP also stated that the resident had been taken off bedrest on August 20, 2007 and that her programs should have been implemented.</p> <p>2. The facility failed to ensure that Resident #4 participated in active treatment programs in accordance with his IPP.</p> <p>During observations from August 29, 31, 2007, staff was observed feeding and wiping Resident #4's mouth during meals. Review of his IPP dated August 16, 2006 revealed a program</p>		<p>(1) QMRP will conduct additional staff training. QMRP/Home manager will monitor during mealtimes to further ensure compliance with this standard.</p> <p>(2) QMRP will complete additional staff training on implementation of active treatment programs. QMRP will monitor program implementation and provide direction and feedback as</p>	10/2/07 ongoing

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1422	Continued From page 9 objective which stated, "given hand over hand assistance, [the resident] will wipe her mouth using a paper napkin with 75% accuracy for ..." There was no evidence that Resident #1 received continuous active treatment in accordance with her IPP.	1422	1422, continued... as needed to further ensure compliance with this standard.	
1423	3521.4 HABILITATION AND TRAINING Each GHMRP shall monitor and review each resident's Individual Habilitation Plan on an ongoing basis to ensure participation of the resident and appropriate GHMRP staff in revision of such Plans whenever necessary. The schedule for the reviews shall be documented within each IHP. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure each resident's Individual Habilitation Plan had been monitored to make certain each resident participated and the plans were revised as needed. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of Resident #4's record on August 30, 2007 at 11:00 AM revealed, the resident's annual Individual Support Plan (ISP) meeting was held on August 15, 2007. Review of the ISP in the record revealed the plan was dated August 15, 2006. Further interview was conducted to ascertain information about the current ISP (dated August 15, 2007). According to the QMRP, the plan had not been written and new program objectives recommended at the ISP had not been implemented. At the time of the	1423	1423 3521.4 This Statute will be met as evidenced by: Reference response to Federal Deficiency Report W259.	9.6.07 ongoing

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1423	Continued From page 10 survey, the facility failed to provide evidence that the resident's ISP had been completed and updated as required.	1423		
1424	3521.5(a) HABILITATION AND TRAINING Each GHMRP shall make modifications to the resident's program at least every six (6) months or when the client: (a) Has successfully completed an objective or objectives identified in the Individual Habilitation Plan; This Statute is not met as evidenced by: Based on observation, staff interview and record review, the GHMRP failed to ensure habilitation and training was provided to its residents that would enable them to acquire and maintain life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning. The finding includes: The facility's QMRP failed to revise Resident #3's program objectives. On August 29, 2007 at 6:15 PM, Resident #3 was observed washing her hands with staff providing hand over hand assistance. Interview with the direct care staff indicated that the resident requires assistance to perform all of her activities of daily living skills. Review of the resident's IPP dated October 25, 2006, the resident had a program objective which stated, "given hand over hand assistance, [the resident] will wash her hands with a disposable	1424	1424 3521.5 This Statute will be met as evidenced by: QMRP will review/revise/modify objective as needed. QMRP will monitor resident #3's progress on a monthly basis and address concerns/issues as they arise.	10-2-07 ongoing

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1424	Continued From page 11 cloth before PM meals on 80% of the trials recorded per month for six consecutive months ...". Record verification of the data sheets indicated that the resident achieved the established criteria since June 2007.	1424		
1426	3521.5(c) HABILITATION AND TRAINING Each GHMRP shall make modifications to the resident's program at least every six (6) months or when the client: (c) Is failing to progress toward identified objectives after reasonable efforts have been made; This Statute is not met as evidenced by: Based on record review, the Qualified Mental Retardation Professional (QMRP) failed to revise objectives identified in the individual program plans (IPPs) that had not been achieved for one of four residents in the sample (Client #2). The findings include: 1. Resident #2's program objectives were reviewed on August 30, 2007. Client #2 has a program objectives that indicated the following: Given model demonstration, [resident's name] will discriminate 5 activities of daily living using picture representations with 80% accuracy per session as measured by Active Treatment (AT) documentation." Review of the AT documentation and the Qualified Mental Retardation Professional (QMRP) documentation revealed that the client had consistently not met the criteria for the past three quarters. Interview with the QMRP on August 30, 2007, acknowledged that the resident was not meeting the criteria for the objective and that the objective	1426	1426 3521.5 (c) This Statute will be met as evidenced by (b) QMRP will modify change program objective as needed. QMRP will monitor and track progress as well as complete observations of program implementation. QMRP will document in monthly progress note status of program	10-2-07 ongoing

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1426	Continued From page 12 had not been revised. 2. 2. The QMRP failed to review Client #3's speech program in which the resident failed to make progress toward identified objective after reasonable efforts have been made. Review of resident #3's IPP dated October 25, 2007, revealed that the client will improve her functional communication skills. Further review revealed that Resident #3 had an objective which stated, "given physical assistance, [the resident] will perform an action with an object for 6 out of 10 trials per session for three consecutive months as measured by AT documentation". Review of the Speech Pathologist's quarterly reviews from January 27, 2007 through August 15, 2007 revealed that the resident required hands on assistance on all the trials, recorded. There is no evidence that the objective had been revised.	1426	1426 3521.5 (c) Objective.	
1432	3521.7(c) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (c) Personal hygiene (including washing, bathing, shampooing, brushing teeth, and menstrual care); This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure residents were effectively trained in hand washing, and tooth brushing. The finding includes:	1432	1432 3521.7 This Statute will be met as evidenced by:	

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I 432	Continued From page 13 Interview with the Qualified Mental Retardation Professional on August 30, 2007 at approximately 11:00 AM revealed that the Resident #4 had an Individual Support Plan (ISP) meeting on August 15, 2007. During the ISP meeting, the Interdisciplinary Team (IDT) recommended and approved that the resident receive training to improve her personal hygiene skills. Review of the IPP revealed no evidence that the QMRP developed or implemented a toothbrushing program.	I 432	1432, continued... QMRP will ensure that toothbrushing objective has been implemented as outlined in the IPP. QMRP will review IPP at least monthly to ensure that all program objectives have been implemented as outlined.	
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure the protections of each resident rights. The finding includes: See Federal Deficiency Report - Citation W130, W137, W148, W153, W156, W159, W242, W249, W255, W257, W259 and W436.	I 500	1500 3523.1 This Statute will be met as evidenced by: Reference response to Federal Deficiency Report (W130, W137, W148, W153, W156, W159, W242, W249, W255, W257, W259, W436)	10-2-07 ongoing

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R 000	INITIAL COMMENTS A licensure survey was conducted from August 29, 2007 through August 31, 2007. 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, one day program, interviews at both the group home and day program, review of clinical and administrative records to include the facility's 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. This Statute is not met as evidenced by: Based on the review of records, the GHMRP failed to ensure criminal background checks disclosed the criminal history of any prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. The finding includes: Review of the personnel files on August 31, 2007 revealed the GHMRP failed to provide evidence of criminal background checks for two direct care	R 125	R125 This Statute will be met as evidenced by: Human Resource Director will continue to conduct criminal background checks for all prospective employees prior to employment. Human Resource Director will ensure that all documents are filed and available for review.	9/3/07 ongoing

Health Regulation Administration

Nancy Branch

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

TITLE
ORS

(X6) DATE
9/25/07

STATE FORM

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If continuation sheet 1 of 2

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R 125	Continued From page 1 staff (Staff #5 and #6).	R 125	R125 Periodic audits will be conducted to further ensure compliance with this standard. Background checks for staff #5 and #6 have been filed.	