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	09G163	A. BUILDING _____ B. WING _____	04/30/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D C HEALTH CARE	248 WALNUT STREET, NW WASHINGTON, DC 20011

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W 000	INITIAL COMMENTS A recertification survey was conducted from April 28, 2009, through April 30, 2009. The survey was initiated using the fundamental survey process. A random sample of three clients was selected from a client population of six males with various disabilities. The findings of the survey were based on observations at the group home and three day programs, interviews with management and staff, and the review of administrative records, including the facility's incident management system.	W 000		
W 111	483.410(c)(1) CLIENT RECORDS The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that client records reflected current and accurate information for one of the three clients in the sample. (Clients #1) The finding includes: The facility failed to have documented evidence that a informed consent was obtained for the use of sedation for Client #1's medical procedure. On 4/30/09 at approximately 11:30 PM, interview with the Qualified Mental Retardation Professional (QMRP) and the review of a consultation form dated 4/7/09 located in the nursing section revealed the following:	W 111		

Received 6/12/09
GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION
825 NORTH CAPITOL ST., N.E., 2ND FLOOR
WASHINGTON, D.C. 20002

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mamta Tiwari	Deputy Director / D.C. H.C	6/5/09

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 111	Continued From page 1 1. Sedation administered by anesthesiologist/CRNA 2. Deep sedation required because predicted difficult procedure 3. Supplemental O2 given Monitoring: Oximetry, NIB and Cardiac. Screening for colon cancer PT with MR. The consent was obtained through the guardian prior to patient presenting to the endoscopy suite. Further interview with the QMRP revealed that the guardian provided informed consent for this procedure and the document was provided to the hospital at that time. The medical record failed to evidence a copy of the consent was available for this exploratory procedure in Client #1's medical records. 2. The facility failed to have a consent form for the use of sedation on file for Client #1's dental procedure. [See W124, (2)]	W 111	The signed consent for the colonoscopy was obtained from the legal guardian and was given to the doctor for the colonoscopy procedure at Georgetown University Hospital. But a copy of the signed consent was not filed in the individual's # 1's medical record. The Program Manager trained the QMRP regarding this matter. From now on the QMRP will make sure that a copy of all signed consents are maintained in the medical records. Also Program Manager will do recommended spot check of books periodically. See Attachment # 1	05/19/09
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS 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. This STANDARD is not met as evidenced by: Based on observation, interview and record	W 124		

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W 124	Continued From page 2 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 three clients included in the sample. (Client #1) The finding includes: 1. The facility failed to ensure Client #1 and his representative were informed of the risks and benefits of his behavior management treatment plan as evidenced below: On 4/28/09 at 5:10 PM, Client #1 was observed during the morning medication pass. The Licensed Practical Nurse (LPN) administered the client Carbamazepine 400 mg and Seroquel 100mg as a part of his medication regimen. Interview with the LPN revealed that Client #1 was prescribed these aforementioned medications to address his behaviors. The LPN further indicated that the medications were ordered by the physician in conjunction with the Behavior Support Plan (BSP) to manage the client's maladaptive behaviors (i.e. elopement, food stealing, ruminations, spitting and eye flipping). The verification of the physician's orders dated 4/1/09 and the BSP dated 8/10/09 supported the interview. Interview with the Qualified Mental Retardation Professional (QMRP) on 4/29/09 at approximately 2:00 PM, revealed that written inform consent for the use of the psychotropic medications, treatment and the BSP had been obtained from the client's guardian for these matters. The	W 124		

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W 124	Continued From page 3	W 124		

QMRP further stated that the client's guardian functions in a limited capacity to oversee Client #1's health care concerns. According to the QMRP the guardian was appointed on 6/3/08 by the court.

Record review on the 4/29/09 at approximately 2:15 PM, failed to evidence that informed consent was obtained. Further record review revealed the last consent was obtained on 11/13/07. Review of the psychotropic medication reviews and the Human Rights Committee Minutes at 1:00 PM for an 8 month period indicated that medication changes had been recommended and implemented. It should be noted that the review of the medical record on the same day reflected documentation that the guardian was actively participating in the client care as evident by the consent given for the use of sedation for an ENT consultation completed on 2/2/09.

It should be further noted that the review of the psychological assessment on the same date at approximately 2:33 PM, revealed that "Client #1 was unable to make decisions concerning his welfare. He requires others to make decisions..." for his treatment and medical matters.

2. The facility failed to evidence that a consent was given for the use of sedation for Client #1 prior to a dental consultation.

On 4/29/09 at approximately 3:00 PM, interview with the QMRP and the review of Client #1's medical records revealed a note in the dental section dated 11/13/08. Further review of the dental note revealed the following occurred:

"Client #1 was sedated for the appointment.

1. Individual # 1 and his legal guardian have been informed of the risks and the benefits of his Behavior Support Plan

QMRP received In-Service training on 5/19/09 from Program Manager for the use of psychotropic medication implementation of the BSP and policies regarding consent issues. QMRP will make sure to obtain consent prior to the administration of psychotropic medication or any change of psychotropic medication and BSP's. Consent for BSP's and psychotropic medication will be reviewed quarterly by HRC. QMRP will ensure yearly review and signature by individual # 1 and his legal guardian. The program manager will be monitoring this on routine basis. 05/19/09

See Attachment # 2 A& B

2. The signed consent for the dental appointments of the individual # 1 was obtained from the legal guardian at the time of the procedure but it was not filed in the medical records, Rather it was left in the PMD's office by mistake. The QMRP has been trained by the Program Manager regarding this matter; The QMRP will make sure that all pertinent information regarding individuals is maintained in the medical records. 05/19/09

See Attachment #3

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W 124	Continued From page 4 Although the client was sedated for this appointment, he was very aggressive and uncooperative. We could not do the scaling. Patient needs to be referred to Howard University to sedate him completely to have his dental procedure." Further interview with the QMRP and subsequent record review did not evidence consent was given prior to the dental consultation and/or no signed consent form was available in Client #1's medical records. 3. The facility failed to ensure that a copy of the Client #1's consent for the use of sedation was maintained in his medical records. [See W111]	W 124	3. Please See the answer to W-111	5-19-09
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 observation, staff interview and record review, the facility failed to ensure the rights and dignity for one of the three client in the sample. (Client #2) The findings include: 1. The facility failed to ensure that Client #2 was provided a private room in a facility which met his needs in accordance with a legal settlement agreement. [See W159]	W 125	Please see answer W 159	5/7/09

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W 125	Continued From page 5	W 125	Please See Answer W436 - C	5/18/09

2. The facility failed to ensure that Client #2 was provided with adaptive supports timely in accordance with his needs. [See W436]

W 159 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL — W 159

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 observations, interviews with the Qualified Mental Retardation Professional (QMRP) and record review, the QMRP failed to ensure integration, coordination and monitoring of client's active treatment regimen for three of the three client in the sample.

The findings include:

1. The QMRP failed to ensure Client #2 transitioned to a new group home that met his needs in accordance with a legal agreement.

On 4/28/09 at approximately 11:06 AM, interview with the QMRP and review of the Human Rights Committee minutes dated 11/20/08 evidence the following

"The Client has a court order to move to Eastern Avenue so that he may have a private room."

Further interview with the QMRP revealed that the statement was true and the court has ordered the client to move to the new facility. However, the QMRP further mentioned that at the time the move was scheduled to occur in January 2009,

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W 159	Continued From page 6 the move was cancelled by Department of Disability Services (DDS) case manager assigned to the client at that time. Reportedly, the QMRP mentioned to the surveyor that the client's personal clothing remains packed awaiting his move. The QMRP further commented that the vacant slot the client was to fill at the Eastern Avenue facility was no longer available. The QMRP was not able to provide any documented information as to how and why the Eastern Avenue group home was selected for the "court ordered" move. On the same day at approximately 3:24 PM, interview with the agency CEO, revealed that the move was not court order, however was a part of a personal settlement agreement in response to a legal matter. The CEO further commented that two items on the settlement agreement that would directly affect the client were as follows: a. The client was to go on a vacation. b. The client was to move to a facility in which he would be provided a private room. According to the CEO, it could not be determine as to why the Eastern Avenue facility was chosen. The CEO further commented that Eastern Avenue group home may not be appropriate for Client #2 Record review on the same day at 3:00 PM failed to evidence a court order and/or a personal settlement agreement for Client #2 to be moved to a new group home. Additionally, there was no evidence of any transition meeting minutes facilitated by the QMRP and DDS case manager. It should be further noted that there was no documented evidence that a dinner, overnight or	W 159	W159 (a) Locations are being explored for Individual # 2's Personal vacation. Final arrangements will be made after Individual #2's annual vacation in July2009. W 159 (16) In order to enhance the quality of life of Client#2 (and also as a part of legal settlement) DCHC offered to provide Client#2 with his own bedroom. This continues to be DCHC's intention. But DCHC wants to make sure that Client#2 moves to the place that best fits his personal needs. DCHC is in the process of developing a new facility which will provide Client#2 with his own bedroom in a barrier free access friendly home. DCHC hopes that the facility will be operational by December 2009. Please see the minutes of the transition meeting held on 1/12/09 and 5/7/09 Attachment # 4 A – 4 E	5/7/09

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W 159	Continued From page 7 weekend visits occurred prior to the client being considered for the Eastern Avenue facility. At the time of the survey, there was no documented evidence that the transition for Client #2 was in process of being implemented and the facility which was selected was the best fit and met his needs. 2. The QMRP failed to ensure that clients receive interventions as specified in their Individual Program Plans. [See W249] 3. The facility's QMRP failed to ensure that the staff were trained effectively to complete their duties. [See W189] 4. The facility's QMRP failed to ensure that client's receive interventions as specified in their Individual Program Plans. [See W249] 5. The facility's QMRP failed to ensure the implementation of an effective system of documenting a client's progress on his program objectives. [See W252] 6. The facility's QMRP failed to ensure to revise clients' objectives. [See W255] 7. The facility's QMRP failed to ensure that the a adaptive support were provided timely. [See W436]	W 159	Please See Answer W249, W 252, W255 and W436	4/28/09 5/28/09, 6/1/09
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.	W 189		

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W 189	Continued From page 8	W 189		

This STANDARD is not met as evidenced by:
Based on observation, staff interview and record review, the facility failed to ensure that each employee had been provided with adequate training that enables the employee to perform his or her duties effectively, efficiently and competently for three of the three client in the sample. (Client #1, #2 and #3)

The findings include:

1. The facility failed to ensure that direct care staff effectively implemented each client's program interventions as specified in their Individual Program Plans. [See W249]

1. Please See Answer to W249. 5/28/09

2. The facility failed to ensure that direct care staff documented program data according to the IPP objectives. [See W252]

2. Please See Answer to W252. 5/28/09

W 249 483.440(d)(1) PROGRAM IMPLEMENTATION

W 249

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.

This STANDARD is not met as evidenced by:
Based on staff interview and record review the facility failed to ensure that clients receive interventions as specified in their Individual Program Plans for two of the three client's in the

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W 249	Continued From page 9 sample (Clients #2 and #3) The findings include: 1. The facility failed to ensure that Client #2 was provided continuos active treatment in accordance with his individual support plan as evidenced below: On 4/30/09 at approximately 9:40 AM, interview with the QMRP and the review of Client #2's Individual Program Plan (IPP) revealed several objectives. Further review of the IPP and the corresponding data sheets reflected the following: a. Client #2 will improve his Home Management skills - "[The client] will safely exit the facility during a fire drill." The frequency in which this objective was to be implemented was twice monthly. Further review of the program data sheet revealed that this program had not been implemented for the month of April 2009. b. Client #2 will improve his Cognitive skills - [The client] will be allowed to make a simple purchase under a $1.00 twice a month with 100 % independence." Further review of the IPP and the corresponding data sheet revealed that this program had not implemented for the month of April 2009. 2. The facility failed to ensure that Client #3 was provided continuos active treatment in accordance with his individual support plan as evidenced below: On 4/30/09 at approximately 9:40 AM, interview with the QMRP and the review of Client #3's Individua Program Plan (IPP) revealed several	W 249	1. 9 2 b In service training was completed on 05/28/09 by the QMRP and the House manager to ensure that Individual #2 and all other residing individuals receive intervention as specified in the Individual Program Plan. Also an IPP warning ticket form was established (please see attached form) to be issued to staff IPP documentation is not done. House manager will check IPP books every day to make sure documentation is done properly. QMRP will also check IPP books on a weekly basis or earlier as needed. See Attachment # 5 a, b	5/28/09

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W 249	Continued From page 10 objectives. Further review of the IPP and the corresponding data sheets reflected the following: a. Client #3 will improve his Home Management skills - "[The client] will safely exit the facility during a fire drill." The frequency in which this objective was to be implemented was twice monthly Further review of the IPP and the corresponding program data sheet revealed that this program had not been implemented for the month of February and March 2009. b. Client #3 will improve his Socialization skills - "[The client] will make a telephone call to his family member on Sunday at 2:00 PM with 25 % reminder and with staff supervision." The frequency in which this objective was to be implemented was four times a month. Further review of the IPP and the corresponding program data sheet revealed that this program had only been implemented once on 3/39/09 for the month of March.	W 249	2. a & b In service training was completed on 05/28/09 by the QMRP and the House manager to ensure that Individual #3 and all other residing individuals receive intervention as specified in the Individual Program Plan. Also an IPP warning ticket form was established (please see attached form) to be issued to staff IPP documentation is not done. House manager will check IPP books every day to make sure documentation is done properly. QMRP will also check IPP books on a weekly basis or earlier as needed. See Attachment # 5 a, b	5/28/09
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure the implementation of an effective system of documenting a client's progress on his program objectives for two of the three client's in the sample. (Clients #1)	W 252		

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W 252	Continued From page 11 The findings include: 1. The facility failed to ensure that direct care staff documented on Client #2's toothbrushing objective in accordance with the plan. On April 30, 2009, at approximately 2:00 PM, interview with the QMRP and review of Client #2's Individual Program Plan (IPP) revealed a program objective to improve his toothbrushing skills. The objective stated "[The client] will participate in a toothbrushing program with independence twice daily." Review of the program data failed to evidence that data had been documented for the months of March in the AM on the 6, 7, 13 and 14. According to the QMRP, this objective should be implemented daily and the data collection was to be recorded in the morning and in the evening as well. At the time of the survey, there was no documented evidence that this objective was being implemented and data documented consistently. 2. The facility failed to ensure that direct care staff documented Client #1's maladaptive behavior of food stealing in accordance with his BSP. On April 28, 2009 at approximately 5:20 PM, Client #1 was observed to pace back and forth from the living room into the kitchen. At approximately 5:24 PM, Client' #1 was observed to take a small bag of cookies from the kitchen counter near the stove. He then was observed to darted quickly into the dining room. The staff in the dining room saw him with the package of cookies and immediately attempted to encourage	W 252	In service training was completed on 05/28/09 by the QMRP and the House manager to ensure that Individual #2 and all other residing individuals receive intervention as specified in the Individual Program Plan. Also an IPP warning ticket form was established (please see attached form) to be issued to staff IPP documentation is not done. House manager will check IPP books every day to make sure documentation is done properly. QMRP will also check IPP books on a weekly basis or earlier as needed. See Attachment # 5 a, b On 5-27-09 the Psychologist conducted an In-Service training for the Direct Care Staff. The Psychologist reviewed behavior management, responsibilities, documentation, and behavior data collection procedure. The implementation and documentation will be monitored on a daily basis by the QMRP and the House Manager and on quarterly basis by the Psychologist See attachment # 6a-6	5-28-09 5/27/09

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W 252	Continued From page 12 him to hand over the cookies. Client #1 was observed to begin to get agitated and instead of the staff creating a struggle in this situation, they backed off from their attempts. The staff were unsuccessful in their efforts to get the cookies from Client #1. Interview with the staff on the same day at approximately 5:59 PM revealed that Client #1 had a behavior of stealing food and had a BSP which address the behavior. Review of the BSP on 4/29/09 at 1:30 PM, revealed proactive strategies were to be implemented as follows: a. Monitor [the client's] whereabouts at all times to prevent food stealing. b. Do not leave food out on the counter following meals. c. Document all incidents in the behavior management section of the IPP book. The direct care staff failed to continuously monitor Client #1 s movements. Additionally, staff after the client s had their afternoon snack, failed to put away the remaining package of cookies left on the kitchen counter. Review of the data collection section of the BSP for food stealing evidence that the staff also failed to documented Client #1's episode of food stealing in the program book.	W 252	On 5-27-09 the Psychologist conducted an In-Service training for the Direct Care Staff. The Psychologist reviewed behavior management, responsibilities, documentation, and behavior data collection procedure. The implementation and documentation will be monitored on a daily basis by the QMRP and the House Manager and on quarterly basis by the Psychologist See attachment # 6/A-M	5/27/09
	3. The facility direct care staff failed to implement Client #2 IPP program objectives as written. [See W249]	3.	Please See Answer to W249 - 1	5/28/09
	4. The facility direct care staff failed to implement	4.	Please See Answer to W249. - 2	5/28/09

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	09G163	A. BUILDING _____ B. WING _____	04/30/2009

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W 252	Continued From page 13 Client #3 IPP program objectives as written. [See W249]	W 252		
W 255	483.440(f)(1)(i) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: On April 30, 2009 at approximately 10:55 AM interview with the QMRP and review of Client #3's individual program plan revealed a speech language program. Further review of the communication program revealed an objective to " [The client] will be able to locate month and mark date/day on the calendar." Further interview with the QMRP revealed that the client was able to complete the task independently and had done so over the past 6 month. The QMRP presented the calendars as evidence that Client #3 had the ability to independently participate in this program. According to the QMRP, she contacted the therapist with her concerns in the beginning of the 2009. Reportedly, the therapist she mentioned was no longer providing communication related services to the agency. However, the QMRP stated that the supervising Speech Pathologist had not followed up to ensure that the communication objective was revised and the amended objective was implemented. Review of the corresponding data sheet for the communication objective indicated that the client was unable to complete the task independently as	W 255		

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W 255	Continued From page 14 reported. According to the QMRP the staff assigned to Client #3 was transferred to this facility several months ago. The QMRP noted on several occasions that the staff in question was not correctly recording the data for the communication program. The QMRP ensured the surveyor that the staff was in need of training on accurate documentation for this communication program for Client #3. Review of the Speech noted on the same day at 11:30 AM, revealed that the last speech consult entry was dated January 9, 2009. At the time of the survey, there was no evidence that the Speech Pathologist had assessed the communication objective and revised the program objective as recommended by the facility's QMRP.	W 255	The Speech Language Program objective for individual # 3 was to locate the month and mark the day/date on the calendar. Since individual # 3 was following the objective for 2 years consecutively and was able to perform with verbal reminder. Therefore at the IPP review meeting it was discussed and the team agreed upon making changes for this objective. Since the Speech Therapist resigned the objective was not implemented. The current Speech Therapist prepared the new objective as of 05/20/09 . The staff was trained on05/20/09 to implement and document the objectives. The House Manager and QMRP will monitor the books on a daily basis. The Program Manager will oversee as needed. The program will be monitored by the Speech Therapist on a quarterly basis. Please See Attachment # 7A-7G-	6-1-09
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that each client's behavior intervention program, including the use of behavior modification drugs, was conducted only with the written informed consent of a legal guardian, for one of the three clients in the sample. (Client #1) The finding includes: [Cross Refer to W124] Observations of the	W 263		

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W 263	Continued From page 15 morning medication administration on 4/28/09 at 5:10 PM, revealed that Client #1 was administered Carbamazepine 400 mg and Seroquel 100 mg to control his maladaptive behaviors. Interviews with the QMRP and review of the records failed to provide evidence that written inform consent was received for the use of the aforementioned psychotropic medication.	W 263	Individual # 1 and his legal guardian have been informed of the risks and the benefits of his Behavior Support Plan (Attachment 2A, 2B)	5/5/09
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, interview and record review, the facility's nurse failed to ensure the coordination of health care services for three of three clients in the sample. (Clients #1, #2 and #3) The findings includes: 1. The nursing staff failed to establish and maintain a system that ensured that an individuals medication records were maintained. [See W365] 2. The nursing staff failed to ensure that medications were administered in compliance with the physician's orders. [See W368] 3. The nursing staff failed to ensure that medications were appropriately stored and secured. [See W381]	W 331	1. Please See Answer to W365. 2. Please See Answer to W368. 3. Please See Answer to W381.	
W 365	483.460(j)(4) DRUG REGIMEN REVIEW An individual medication administration record must be maintained for each client.	W 365		

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W 365	483.460(j)(4) DRUG REGIMEN REVIEW An individual medication administration record must be maintained for each client.	W 365		

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W 365	Continued From page 16 This STANDARD is not met as evidenced by: Based on interview and record reviews, the facility failed to establish and maintain a system that ensured that individual medication records were maintained for one of the three client's in the sample. (Client #3) The finding includes: The facility failed to ensure an effective system for documenting Client medications as evidence by the following: Interview with the QMRP and record review of the staff treatment Medication Administration Records (MAR) on 4/30/09 at approximately 12:30 PM, revealed that staff were responsible to administered Client #3's Mycocide NS antifungal Solution. According to the MAR this topical medication was to be applied to his great toe twice daily. Further review of the MAR failed to evidence a signature signifying administration of the antifungal solution on 4/28/09 in the AM.	W 365	W 365 An In- Service training was conducted on 05/25/09 by the nursing staff .The Direct Care Staff were instructed on how to read the directions for application, check expiration dates, get the refills and also documentation on T.A.R. The Implementation and the documentation will be monitored by the QMRP and the House Manager on a daily basis and L.P.N on a weekly basis. R.N will oversee an monthly basis as needed. Please See Attachment # 8	5/25/09
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that medications were administered in compliance with the physician's orders, for two of the three clients included in the sample. (Client #1, #3)	W 368		

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W 368	Continued From page 17 The findings include: The facility failed to ensure each client's medication regimen was administered according to the physician's orders as evidenced below: 1. Interview with the nurse and the review of the Medication Administration Records (MAR) on 4/30/09 at 1:00 PM, revealed that Client #1's Actonel 35 mg tablet was not administered on Saturday, April 23, 2009. According to the nurse, the medications are received a few weeks prior to the months end. Review of the medication bubble packaging on the same day at 12:40 PM, revealed the last slot was observed to contain the Actonel pill and had not been administered as prescribed. It should be further noted that this weekly dosage of medication was prescribed for Client #1's diagnosis of Osteoporosis. 2. Interview QMRP and record review of the staff treatment MAR on 4/30/09 at approximately 1:00 PM, failed to evidence that staff administered Client #3's Mycocide NS antifungal Solution. The MAR did not have a signature signifying administration for this medication on 4/28/09 in the AM. This topical medication was to be applied to his great toe twice daily.	W 368	1. It should be noted that even though DCHC medication cycle begins from 8th of each month (that means medication arrives from pharmacy 3-4 days prior to start date) these are certain medication don't come routine cycle and requires order placement call prior to last dose. For example all liquid medication, eye and ear drops, nasal sprays, birth control pills, Tums, inhalers, topical patches, suppositories and Actonel etc. For month of April the new card was started on 04/11/09. Each Actonel card has 4 tabs. 1st pill given on – 4/11/09 2nd pill given on – 4/18/09 3rd pill given on – 4/25/09 (which was not signed error on nurses part though training was done on 5/01/09) 4th pill was on – 5/01/09 (still on card) Also it should be noted that 4/23 was a Thursday not Saturday. On weekly round RN will check MAR and medicines to avoid further error.	5/2/09
W 381	483.460( )(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, interview and record review, the facility failed to ensure that medications were appropriately stored and	W 381	2. An in-service training was done on 5/25/09 to instruct staff on how to read the directions for application, check expiration date, get the refills and also documentation on treatment administration record. QMRP and HM will continue to monitor IPP and Treatment book to ensure proper documentation.	5/25/09

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W 381	Continued From page 18 secured. The finding includes: Observation on 4/28/09 at approximately 6:05 PM, revealed the medication nurse preparing Client #2's treatment medication. The nurse was then observed to ask staff to assist Client #2 to his bed room in preparation to administer his suppository medication. The nurse left the nursing area and left the medication cabinet unlocked, went into the client's bedroom and left the medication cabinet unsupervised while attending to Client #2's treatment.	W 381	An in service training was done on 05/01/09 with nurse in question about administration of medication. Upon investigation it was determined that Actonel was administered as prescribed and by mistake not signed which was an oversight on part of the nurse. See attachment # 9	5/1/09
W 436	483.470(g)(2) SPACE AND EQUIPMENT 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. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that a adaptive supports were provided timely as recommended for one of the three clients sample. [Client #2] The finding includes: 1. On April 29, 2009 at approximately 2:15 PM, interview with the QMRP and the review of the 11/20/08 Human Rights Minutes, revealed a case conference was held 10/28/08 to address Client #2's difficulty with ambulation and transportation. The minutes described the following	W 436		

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W 436	Continued From page 19 recommendations: a. Purchase a tub transfer bench B. Lift chair - recliner c. Schedule an appointment to the Seating Clinic at National Rehabilitation Hospital (NRH) for a new wheelchair. According to further interview with the QMRP, the Physical Therapist was to determine the type of tub transfer bench and lift chair/recliner to be ordered. Additionally the therapist would need to provide training for the use of the new adaptive equipment once they arrived to the facility. Further review of the record failed to evidence that prior to the survey [six month since the case conference] was any documented evidence that any movement has been initiated to ensure these recommendations were implemented to meet the clients specified mobility and transportation needs. However, the QMRP showed the surveyor the old wheelchair the client was previously using. The old wheelchair had bent wheels, had broken brakes, and was worn and dirty. At the time of the survey, the NRH appointment had not been scheduled to have the client assessed for a new wheelchair either. There was no evidence that these adaptive supports were provided timely. 2. Observation on April 28, 2009 at approximately 4:15 PM reveals that Client #2 was given a nurf football to throw to the staff. Interview with the staff revealed that the client #2	W 436	A A tub transfer bench was obtained and replaced at the time of survey. House manager will check the bench on daily basis to ensure the proper maintenance of the bench. B A recliner was purchased on 04/28/09 and was placed in the facility. House manager will check on Daily basis to ensure the proper maintenance of the chair. An in service training was done by P.T on 04/29/09 Please see attachment # 10.A, 10B C O n 05/18/09 individuals # 3 went to the seating clinic at NRH for measurements for a new wheel chair. The measurements were taken and individuals # 2 is expected to obtain his new wheel chair in a month's time. See Attachment # 11 Once wheel chair is obtained. a training will given by physical therapist for transfer of individual in and out of the wheel chair and the use. The House Manager and QMRP will check wheelchair on daily basis to ensure proper maintenance of the chair.	4/28/09 5/18/09

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W 436	Continued From page 20 had slight contractures in both his hands. Further interview with the staff revealed that Client #1 uses a soft splint at night to assist with controlling further contractures in his left hand. Review of the Physician order dated April 2009, revealed that "soft splint at night on at 9:00 PM and off at 6:00 AM for left hand". These aforementioned orders indicated that staff was to ensure the placement and removal of the splint and document the client's use. Review of the staff's documentation sheet did not reveal a signature signifying implementation on April 27, 28 and 29 in the PM. At the time of the survey, there was no documented evidence that the direct care staff use Client #2's soft splint as prescribed.	W 436	Individual # 1 does not use soft splint but individual # 2 uses soft splint at night to assist with controlling further contractures in his left hand. In service training was completed on 05/28/09 by the QMRP and the House manager to ensure that Individual #2 and all other residing individuals receive intervention as specified in the Individual Program Plan. Also an IPP warning ticket form was established (please see attached form) to be issued to staff IPP documentation is not done. House manager will check IPP books every day to make sure documentation is done properly. QMRP will also check IPP books on a weekly basis or earlier as needed. See Attachment # 5 a, b	5-28-09

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I 000	INITIAL COMMENTS A licensure survey was conducted from April 28, 2009, through April 30, 2009. A random sample of three clients was selected from a client population of six males with various disabilities. The findings of the survey were based on observations at the group home and three day programs, interviews with management and staff, and the review of administrative records, including the facility's incident management system.	I 000		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation, the GHMRP failed to ensure the interior and exterior of the GHMRP was maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. The findings include: Internal The trash can top in the kitchen was soiled.	I 090	The trash can and the top of the trash can was cleaned during the survey itself. Shift supervisor's will be responsible for cleaning the trash can on each after empting the trash House Manager will check trash can on weekly basis to ensure proper cleanliness.	4/30/09
I 095	3504.6 HOUSEKEEPING Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach	I 095		

Mamta Tiwari Deputy Director / D.C.H.C
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE

(X6) DATE 6/5/09

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I 095	Continued From page 1 of each resident. This Statute is not met as evidenced by: Based on observation the GHMRP failed to lock caustic agents being stored. The finding includes: Observations during the environmental walk-through on 4/30/09 approximately 2:40 PM, revealed a variety of caustic agents (bathroom cleaner, toilet cleaner, glass cleaner, etc.) were being store in the basement in a large cabinet unlocked.	I 095	During the Surveyor's visit to the home a new latch and lock were placed on the cabinet to ensure caustic agents are stored properly. House Manager will ensure cabinet remains locked at all times. QMRP and Program Manager will continue to check this-unannounced to make sure above is followed properly.	4/30/09
I 161	3507.2 POLICIES AND PROCEDURES The manual shall be approved by the governing body of the GHMRP and shall be reviewed at least annually. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP's governing body failed to review its policies and procedures annually. The finding includes: Review of the policy and procedures manual on April 30, 2009 failed to provide evidence that the agency's policy manual had not been reviewed and approved annually by the governing body as required. The last noted date for review was in 2006.	I 161	Policy and Procedure manual was reviewed and signed on 5/1/09. D.C.H.C will make sure that manual is reviewed and signed annually. Please See Attachment # 12	
I 222	3510.3 STAFF TRAINING	I 222		

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I 222	Continued From page 2 There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that each employee had been provided with adequate training that enables the employee to perform his or her duties effectively, efficiently and competently for three of the three Resident's in the sample. (Resident #1, #2 and #3) The findings include: 1. The facility failed to ensure that direct care staff effective implemented each client ' s interventions as specified in their Individual Program Plans. [See Federal Deficiency Report Citation W249] 2. The facility failed to ensure that direct care staff documented program data according to the IPP objectives. [See Federal Deficiency Report Citation W252]	I 222	In service training was completed on 05/28/09 by the QMRP and the House manager to ensure that Individual #2 and all other residing individuals receive intervention as specified in the Individual Program Plan. Also an IPP warning ticket form was established (please see attached form) to be issued to staff IPP documentation is not done. House manager will check IPP books every day to make sure documentation is done properly. QMRP will also check IPP books on a weekly basis or earlier as needed. See Attachment # 5 a, b	
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on interview and record review the GHMRP failed to provided diagnosis, evaluation, treatment services and necessary follow up	I 401		

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	HFD03-0188	A. BUILDING _____ B. WING _____	04/30/2009

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I 401	Continued From page 3 service to prevent deterioration or further loss of functioning for each resident in the facility. The finding includes: See Federal Deficiency Report Citation W331	I 401	Please see answer as "Attachment - 13"	5/25/09, 5/2/09, 5/1/09
I 422	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 staff interview and record review the facility failed to ensure that residents receive interventions as specified in their Individual Program Plans for two of the three resident's in the sample. (Resident #2 and #3) The findings include: 1. The facility failed to ensure that Resident #2 was provided continuos active treatment in accordance with his individual support plan as evidenced below: On 4/30/09 at approximately 9:40 AM, interview with the QMRP and the review of Resident #2's Individual Program Plan (IPP) revealed several objectives. Further review of the IPP and the corresponding data sheets reflected the following: a. Resident#2 will improve his Home Management skills - "[The client] will safely exit the facility during a fire drill." The frequency in which this objective was to be implemented was twice monthly. Further review of the program data sheet revealed that this program had not been implemented for the month of April 2009.	I 422	1. a & b In service training was completed on 05/28/09 by the QMRP and the House manager to ensure that Individual #2 and all other residing individuals receive intervention as specified in the Individual Program Plan. Also an IPP warning ticket form was established (please see attached form) to be issued to staff IPP documentation is not done. House manager will check IPP books every day to make sure documentation is done properly. QMRP will also check IPP books on a weekly basis or earlier as needed. See Attachment # 5 a, b	5/28/09

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I 422	Continued From page 4	I 422		

b. Resident #2 will improve his Cognitive skills - [The resident] will be allowed to make a simple purchase under a $1.00 twice a month with 100 % independence." Further review of the IPP and the corresponding data sheet revealed that this program had not implemented for the month of April 2009.

2. The facility failed to ensure that resident #3 was provided continuos active treatment in accordance with his individual support plan as evidenced below:

On 4/30/09 at approximately 9:40 AM, interview with the QMRP and the review of resident #3's Individual Program Plan (IPP) revealed several objectives. Further review of the IPP and the corresponding data sheets reflected the following:

a. Resident #3 will improve his Home Management skills - "[The client] will safely exit the facility during a fire drill." The frequency in which this objective was to be implemented was twice monthly. Further review of the IPP and the corresponding program data sheet revealed that this program had not been implemented for the month of February and March 2009.

b. Resident #3 will improve his Socialization skills - "[The resident] will make a telephone call to his family member on Sunday at 2:00 PM with 25 % reminder and with staff supervision." The frequency in which this objective was to be implemented was four times a month. Further review of the IPP and the corresponding program data sheet revealed that this program had only been implamented once on 3/39/09 for the month of March.

2. 925

In service training was completed on 05/28/09 by the QMRP and the House manager to ensure that Individual #3 and all other residing individuals receive intervention as specified in the Individual Program Plan. Also an IPP warning ticket form was established (please see attached form) to be issued to staff IPP documentation is not done. House manager will check IPP books every day to make sure documentation is done properly. QMRP will also check IPP books on a weekly basis or earlier as needed.

5/28/09

See Attachment # 5 a, b

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I 427	Continued From page 5	I 427		
I 427	3521.5(d) HABILITATION AND TRAINING Each GHMRP shall make modifications to the resident ' s program at least every six (6) months or when the client: (d) Is being considered for training toward a new objective or objectives; or... This Statute is not met as evidenced by: Based on staff interview and record review, the GHMRP's Qualified Mental Retardation Professional (QMRP) failed to revise residents' program objective for one of three residents in the sample. [Resident #3] The finding includes: On April 30, 2009 at approximately 10:55 AM, interview with the QMRP and review of Resident #3 individual program plan revealed a speech language program. Further review of the communication program revealed a objective to " [The resident] will be able to locate month and mark date/day on the calendar." Further interview with the QMRP revealed that the resident is able to complete the task independently and has done so over the past 6 month. The QMRP presented the calendars as evidence that Resident #3 had the ability to independently participated in this program. According to the QMRP, she contacted the therapist with her concerns in the beginning of the 2009. Reportedly, the therapist she mentioned is no longer providing communication related services to the agency. However, the QMRP stated that the supervising Speech Pathologist has not follow up to ensure that the communication objective was revised and the	I 427	The Speech Language Program objective for individual # 3 was to locate the month and mark the day/date on the calendar. Since individual # 3 was following the objective for 2 years consecutively and was able to perform with verbal reminder. Therefore at the IPP review meeting it was discussed and the team agreed upon making changes for this objective. Since the Speech Therapist resigned the objective was not implemented. The current Speech Therapist prepared the new objective as of 05/20/09 . The staff was trained on05/20/09 to implement and document the objectives. The House Manager and QMRP will monitor the books on a daily basis. The Program Manager will oversee as needed. The program will be monitored by the Speech Therapist on a quarterly basis. Please See Attachment # 7/	6-1-09

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I 427	Continued From page 6 amended objective was implemented.	I 427		
I 474	3522.5 MEDICATIONS Each GHMRP shall maintain an individual medication administration record for each resident. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP's nursing staff failed to ensure medication administration records were reviewed and maintained for two of the two residents in the sample. (Resident #1 and #3) The finding includes: I. The facility failed to ensure an effective system for documenting Resident medications as evidence by the following: Interview with the QMRP and record review of the staff treatment Medication Administration Records (MAR) on 4/30/09 at approximately 12:30 PM that staff were responsible to administered Resident #3's Mycocide NS antifungal Solution. According to the MAR this topical medication was to be applied to his great toe twice daily. Further review of the MAR failed to evidence a signature signifying administration of the antifungal solution on 4/28/09 in the AM. II. The facility failed to ensure each residents medication regimen was administered according to the physician's orders as evidenced below: 1. Interview with the nurse and the review of the Medication Administration Records (MAR) on 4/30/09 at 1:00 PM, revealed that Resident #1's Actonel 35 mg tablet was not administered on	I 474	An In- Service training was conducted on 05/25/09 by the nursing staff .The Direct Care Staff were instructed on how to read the directions for application, check expiration dates, get the refills and also documentation on T.A.R. The Implementation and the documentation will be monitored by the QMRP and the House Manager on a daily basis and L.P.N on a weekly basis. R.N will oversee an monthly basis as needed. Please See Attachment # 8	5-25-09

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I 474	Continued From page 7 Saturday, April 23, 2009. According to the nurse the medication are received a few weeks prior to the months end. Review of the medication bubble packaging on the same day at 12:40 PM, revealed the last slot was observed to contain the Actonel pill and had not been administered as prescribed. It should be further noted that this weekly dosage of medication was prescribed for Resident #1's diagnosis of Osteoporosis. 2. Interview QMRP and record review of the staff treatment MAR on 4/30/09 at approximately 1:00 PM failed to evidence that staff administered Resident #3's Mycocide NS antifungal Solution. The MAR did not have a signature signifying administration for this medication on 4/28/09 in the AM. This topical medication was to be applied to his great toe twice daily.	I 474	1. It should be noted that even though D.C.H.C medication cycle begins from 8th of each month (that means medication arrive from pharmacy 3-4 days prior to start date) these are certain medication don't come routine cycle and requires order placement call prior to last dose. For example All liquid medication eye & ears drops, nasal sprays, Birth control pills, Tums, inhalers, Topical patches, suppositories and Actonel etc. For month of April the new card was started on 04/11/09. Each Actonel card has 4 tabs 1st Pill was given on -04/11/09 2nd Pill was given on - 04/18/09 3rd Pill was given on – 04/25/09 (which was not signed error on nurses part though training was done on 05/01/09) 4th Pill was on – 05/01/09 (which was still on card) Also it should be noted that 4/23rd was a Thursday not Saturday. On weekly round R.N will check M.A.R and medicines to avoid future error.	5/2/09
			2. An in-service training was done on 5/25/09 to instruct staff on how to read the directions for application, check expiration date, get the refills and also documentation on treatment administration record. QMRP and HM will continue to monitor IPP and Treatment book to ensure proper documentation.	5/25/09