

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

RECEIVED
4/6/07

PRINTED: 03/28/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G169	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/09/2007
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NAME OF PROVIDER OR SUPPLIER METRO HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 8020 EASTERN AVENUE, NW WASHINGTON, DC 20012
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W 000	INITIAL COMMENTS This recertification survey was conducted March 7, 2007 through March 9, 2007. The survey was initiated utilizing the fundamental survey process. A random sampling of three clients from the residential population of two males and four females were initially selected for this survey. The findings of the survey were based on observations at the group home and three day programs, interviews with the clients and staff and record review including the review of unusual incident reports.	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations, interviews and the review of records, the facility's Governing Body failed to provide general operating direction over the facility. The findings include: 1. The Governing Body failed to the ensure the guidelines identified in the agreement regarding Client #2's day program attendance hours were effectively implemented. On March 8, 2007, the surveyor visited Client #2's day program. Interview with the day program case manager revealed the client generally does well with her program objectives in the morning. However, she usually refuses to participate in them during the afternoon because she is preoccupied with wanting to go home. Further	W 104	W104 - 1 A communication system between the facility and the day program has been instituted. The client will be picked up from the day program daily before 1.30 pm. See attached - in-service sheet	4/8/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Swamy, Sharan Kishan, MA, VPO* TITLE: *VPO* (X6) DATE: *4/7/07*

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

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W 104	<p>Continued From page 1</p> <p>interview with the case manager revealed the client refuses all outside recreational activities because she is afraid that the van may arrive to take her home before she returns to the day program. An outside recreational activity was in process on the day of the day program visit. Interview with the case manager revealed the Client #2 refused to go.</p> <p>Interview with day program staff indicated when the client is not picked up by 1:30 PM, she exhibits maladaptive behaviors which include pacing, yelling and screaming. Further interview with the day program case manager and the review of the client's behavior support plan dated December 5, 2006 revealed it included a proactive strategy to prevent agitation and depressive symptoms from occurring by reminding her that her van is not due until 1:30 PM. Interview with the case manager and the review of the behavior support plan (BSP) indicated an agreement was made between the group home and the day program that the client be picked up at 1:30 PM daily to prevent maladaptive behavior. The review of attendance logs for 2007 revealed the provider had arrived after 2:00 PM fourteen times and after 3:00 PM on three occasions. There was no evidence an effective system had been implemented to ensure that Client #2 was picked up from her day program by the agreed time. [See also W249, 4]</p> <p>2. The governing body failed to implement timely and effective administrative procedures to ensure Client #2's lack of Supplementary Security Income (SSI) benefits was evaluated.</p> <p>Interview with the current Qualified Mental Retardation Professional (QMRP) on March 9,</p>	W 104	<p>W104 - 2</p> <p>The DDS Case Manager has followed up with the SSI administration and the required paperwork was inadvertently mailed to the wrong address. This has been corrected by the DDS Case Manager and the client should be getting their SSI benefits as soon as possible.</p> <p>The Agency has adopted an Internal Audit System which will review monthly Medicaid and SSI benefits. See attached - note</p>	4/8/07
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W 104	<p>Continued From page 2</p> <p>2007 at 5:15 PM revealed she was informed by the previous QMRP that Client #2 received SSI in the past. Further interview with the QMRP indicated she was recently informed by the agency's accounting department that Client #2's SSI benefits had been stopped for an unspecified reason. The review of the client's bank statements revealed no SSI deposits were made for her during 2006. There was no evidence however that timely interventions were implemented by the governing body on behalf of the client to resume her SSI benefits.</p> <p>3. The facility failed to ensure the back yard was maintained in a condition safe for the Clients' use.</p> <p>a. Observation of the back yard on March 9, 2007 revealed a retaining wall approximately four feet tall which was located at the left of the paved driveway. Further observation revealed the grassy area of the yard was elevated approximately three feet above the driveway and on the left side of the retaining wall. The portion of the retaining wall (at the edge of the grass-covered area) which served as a barrier between the yard and the driveway was approximately 8 inches above ground. Further inspection of the grass covered area revealed sharp metal protruding above ground which appeared to be cut of pipe. Two of the three poles supporting the fence at the other side of the grass-covered area of the yard, lacked protective caps at the top, exposing the metal edges. There was no evidence the facility had maintained the back yard in a safe condition to facilitate the use of the space by the residents.</p> <p>b. Observation of the grassy areas on the left and right of the paved area in the back yard revealed</p>	W 104	<p>W104 - 3 The backyard protruding pipes and poles were fixed and the backyard was deemed safe for the clients. A monthly QA system has been instituted to ensure client safety is maintained at all times. See attached - QA System</p>	4/9/07
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W 104	Continued From page 3 it was several inches lower than the paved area. Observation of the clients revealed that one was blind and two were at risk for falls. Interview with staff and the record verification revealed that two residents had fall prevention protocols. There was no evidence the facility had maintained the back yard in a safe condition so the the space was available for the residents use.	W 104			
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 interviews and record review, the facility failed to ensure the right to have an identified surrogate decision-maker for habilitation and treatment needs for individuals who lacked the capacity to make informed decisions for one of three clients in the sample. (Client #2). The findings include: 1. Observation of Client #2 on March 7, 2007 at revealed she was tall and slim. interview with staff at the day program and the group home indicated that although the client has a good appetite, she had lost some weight. a. According to Client #2's Annual Nutritional Assessment dated October 15, 2006, the client had lost twenty-two (22) pounds during the previous twelve months. The assessment	W 125	W125 - 1 The Facility has submitted Guardianship paperwork to the DDS Case Manager and the medical and psychological affidavit has been submitted to obtain a legal guardian. The 3 rd Breast biopsy has been scheduled and the parent has agreed to sign the consent form. The Agency has instituted that medical and psychological affidavits be submitted to the Case Managers along with the guardianship paperwork. See attached - psychotropic med.consent, copy of affidavit	4/9/07	

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W 125	<p>Continued From page 4</p> <p>revealed the client's height was 5 feet, 7 inches and that she had desirable body weight range of 121 to 159 pounds. Further review of the assessment indicated the client lost eight pounds prior to the removal of a breast cyst and lost an additional ten pounds after the surgery. The nutritionist noted that the client continued to have a good appetite, that the origin of the weight loss was unclear and that the client was evaluated by the primary care physician and also the gastroenterologist.</p> <p>b) Record review revealed Client #2 has a diagnosis of fibrocystic breast. On November 7, 2006, Client #2 went for a second six month follow-up after the excision of a 2 cm left breast mass which was performed on January 6, 2006. Further record review revealed the results of an incisional breast biopsy (of right breast) dated November 16, 2006 which was faxed on December 18, 2006.</p> <p>A consultation report dated January 8, 2007 revealed the gynecologist palpated a large right breast mass. The gynecologist noted that he was aware of the breast biopsy performed in November 2006. He however recommended the client follow-up with a breast surgeon for a possible repeat biopsy, if not already addressed. Frequent breast exams by a breast surgeon were recommended. A physician's order dated January 15, 2007 for a breast sonogram was observed in the client's record.</p> <p>The sonogram of the breast mass was performed on February 7, 2007. A review of a consultation report dated February 24, 2007 revealed a follow-up appointment on February 24, 2007. Excision of the mass was recommended and the</p>	W 125		
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W 125

Continued From page 5
office indicated an appointment would be made and and the group home would be notified. A guardianship assessment was conducted by the Qualified Mental Retardation Professional (QMRP) on February 27, 2007. The review of the assessment concluded that the client cannot make choices in regard to medical treatment and cannot understand the consequence of not accepting medical treatment.

W 125

c. Interview with the RN on March 9, 2007 at 4:47 PM revealed the surgery to remove the cyst was not be performed because the consent for the medical procedure was not signed by the client's family member. The interview revealed the procedure was explained to the client's relative who is not a guardian, however expresses interest in the client's affairs. The nurse indicated that prior to the scheduled surgery, efforts were made to get the consent signed by the family member. The family member agreed to meet the client at the hospital on the day of the surgery to sign the consent. According to the RN, the family member was telephoned again after he failed to arrive at the hospital on the day of the surgery. Further interview with the nurse revealed the family member indicated that he needed about three weeks to think about the surgery before making a decision.

W 149

2. The facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity for the use of Client #2 psychotropic medication and behavior support plan.[See W263]

483.420(d)(1) STAFF TREATMENT OF CLIENTS

The facility must develop and implement written

W 149

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W 149	<p>Continued From page 6</p> <p>policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to establish and/or implement policies that ensure the health and safety of eight of the six clients (Clients #1, #2, #3, #4, #5, and #6) residing in the facility.</p> <p>The findings include:</p> <p>1. The facility failed to implement its policy for reporting of unusual incidents of client injury to outside agencies.</p> <p>The review of an unusual incident on March 7, 2007 at 10:35 AM revealed Client #3 sustained an laceration to her face when she fell on March 24, 2006. According to the incident report, the client hit her face on the floor during the fall. The review of the internal investigative report dated April 13, 2006, revealed residential staff reported that at approximately 3:45 PM, the client [Client #3] fell as she ascended the steps to enter her residence. According to the investigative report, the client was trying to hit a housemate in retaliation and tripped on the steps. Further review of the investigative report revealed during the fall, Client #3 struck the right side of her face on the steps. The client's injuries were cleaned, and the nurse was notified. After her physical assessment, the LPN notified the primary care physician (PCP). The review of the nursing progress note dated [redacted] revealed the client was treated at the emergency room and required three sutures to close the wound. According to the investigative report dated April 13, 2006, the</p>	W 149	<p>W149 - 1 & 2</p> <p>The Agency's Incident Management Policy and Procedure was revised on 10/10/06. The Agency is presently ensuring that all incidents are reported to the IMC and DOH within 24hrs and all investigations are completed within 5 working days. Moreover all incidents are reviewed weekly at the incident review meetings</p> <p>See attached - Incident P&P in-service sheet</p>	4/2/07	

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W 149	<p>Continued From page 7</p> <p>Department of Health (DOH) was not notified of the clients injury until April 5, 2006.</p> <p>According to the agency's policy and procedure on Incident Management, DOH should be notified immediately of physical injuries that result in a medical emergency. There was no evidence the facility implemented the aforementioned policy by notifying DOH of the client's injury within 24 hours.</p> <p>2. The facility failed to implement it policy for reporting of unusual incidents to it's incident management coordinator.</p> <p>The review of the agency's policy and procedure on incident management on March 8, 2007 revealed if a reportable incident occurs, the incident report should be faxed to the incident management coordinator prior to the end of the shift and not exceed 24 hours from the time of the occurrence. All serious reportable incidents shall be reported immediately. The review of investigative report dated April 13, 2006 regarding Client #3's fall and subsequent injury on March 24, 2006 revealed the incident management coordinator was not notified of the incident until April 3, 2006. There was no evidence the facility followed its established policy and procedure for reporting unusual incidents to the incident management coordinator.</p> <p>[Note: Further review of the investigative report revealed the incident was reported to the agency Administrator and Program Director on March 27, 2006, to Answers Please on March 31, 2006 and to MRDDA on April 6, 2006.]</p> <p>3. The facility failed to ensure its policy of</p>	W 149		
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W 149	Continued From page 8 maintaining a safe environment for the use of each client. a. Observation of the back yard on March 9, 2007 revealed a retaining wall approximately four feet tall which was located at the left of the paved driveway. Further observation revealed the grassy area of the yard was elevated approximately three feet above the driveway and on the leftside of the retaining wall. The portion of the retaining wall (at the edge of the grass-covered area) which served as a barrier between the yard and the driveway was approximately 8 inches above ground. Further inspection of the grass covered area revealed sharp metal protruding above ground which appeared to be cut of pipe. Two of the three poles supporting the fence at the other side of the grass-covered area of the yard, lacked protective caps at the top, exposing the metal edges. There was no evidence the facility had maintained the back yard in a safe condition to facilitate the use of the space by the residents. b. Observation of the grassy areas on the left and right of the paved area in the back yard revealed it was several inches lower than the paved area. Observation of the clients revealed that one was blind and two were at risk for falls. Interview with staff and the record verification revealed that two residents had fall prevention protocols. There was no evidence the facility had maintained the back yard in a safe condition so the the space was available for the residents use.	W 149	W149-3 Refer to 104-3a & b		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as	W 153			

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W 153	<p>Continued From page 9</p> <p>injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure all allegations of mistreatment, abuse, and injuries of unknown origin were immediately reported to the administrator and government officials in accordance with State law.</p> <p>The finding includes:</p> <p>The facility failed to ensure unusual incidents Client #4's injury to her left eye of unknown origin within 24 hours to the Department of Health (DOH).</p> <p>The review of unusual incidents on March 7, 2007 revealed on June 28, 2007, Client #4's day program discovered her to have a bruised eye.</p> <p>The review of an incident report dated June 28, 2006 which was completed by the day program nurse revealed the following information:</p> <p>"[Ms Client #4] was brought inside the nurses office at approximately 10:30 AM and lead counselor Ms... showed the nurse that the observed swelling of client's eye, below the right eye and also a black bruise observed below the right eye. Called and spoke with house manager at group home and he stated that it was not observed. Client arrived at Day program with above site swollen and black bruise." Further review of the incident report revealed it was identified as a serious reportable incident by the</p>	W 153	<p>W153 Refer to W149</p>	
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W 153	Continued From page 10 day treatment program. A nursing progress note documented on June 28, 2007 at 4:50 PM revealed that Client #4 returned home from her day program with a note reporting an unusual swelling of the right eye. Interview with day program staff and the casemanager at the day program, as well as the investigative report on March 8, 2007 revealed the origin of the client's injury was unknown. The review of the unusual incident report revealed that the Department of Health was not notified of the client's injury until June 30, 2006. There was no evidence the client's injury was reported to DOH within 24 hours as required by regulation.	W 153		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure Client #4's injury of unknown origin was thoroughly investigated. The findings include: The facility's unusual incident reports were reviewed on March 7, 2007. This review revealed an unusual incident report written by the day program nurse on June 28, 2006 which stated that 10:30 AM, Client #4 was observed to have swelling below the right eye and also a black bruise below the right eye.	W 154	W154 Refer to W149	

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W 154	<p>Continued From page 11</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) indicated an investigation was completed by the group home and also at the day program to determine the origin of the client's injury. The review of a statement written by the group home manager indicated the client was signed in at the day program at 9:55 AM. At 11:15 AM, the home manager was notified of the injury to the client's eye. The statement further noted that he did not noticed anything wrong with the client's eye. Additionally, the statement indicated no bruise was observed at the bottom of the client's right eye at the time the morning staff left the client at her day program.</p> <p>An addendum to the June 28, 2006 incident report which was dated June 30, 2006 was written by the QMRP. The review of the addendum indicated at the time the client was left at the day program at 9:55 AM, no injury to her client's face was observed. The addendum further documented the call was received from the day program nurse at 11:15 AM regarding Client #4's injury to her eye who stated the investigative report would follow.</p> <p>Further record review revealed a case conference held on July 19, 2006 at Client #4's day program to discuss the incident. The minutes of the meeting indicated that the QMRP interviewed residential staff that worked the night before the day the injury was discovered at the day program. During the case conference it was discuss that Client #4 has Self Injurious Behaviors. According to the the QMRP, staff reported that the residential staff did not notice any SIB that night. The statement from the residential manager indicated there was no swelling, redness or bruise</p>	W 154			

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W 154	<p>Continued From page 12 on the client eye when she was dropped off at her day program.</p> <p>Onsite interview was conducted with the day program staff and case manager on March 8, 2007. Interviews and the review of the investigative report dated July 17, 2007 revealed it concluded that due to the extent of the discoloration on the client's eye, the injury could not have occurred at the day program on June 28, 2006. managerThe review of the Day Program's investigative report on March 8, 2007 revealed the swelling and bruise of the client's right eye were discovered by the lead counselor at 10:30 AM, 35 minutes after she was accepted into the day program.</p> <p>Although the QMRP concluded that the client's injury occurred at the day program program, there was no evidence that the group home conducted a thorough investigation.</p> <p>a) There was no evidence that the group home investigator interviewed day program staff working directly with the client. or received their written statements.</p> <p>b. There was no evidence that the group home investigator interviewed all residential staff working directly with the client or received their written statements.</p> <p>c) There was no evidence their was a review of behavior data or/and consult with the client's psychologist to rule out SIB as the cause of the injury.</p>	W 154		
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W 154	Continued From page 13	W 154		
W 156	<p>There was however, no documented evidence ABC data was reviewed to rule out possible SIB. Additionally, no statements were available from staff working directly with the client client on June 27, 2006 or June 28, 2006. There was no evidence a thorough investigation of the origin of Client #4's injury to her right eye was conducted by the group home.</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS</p> <p>The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the results of the investigation of Client #4's injury of unknown origin was reported to the administrator within five working days of the incident.</p> <p>The findings include:</p> <p>1. The review of an unusual incident report dated June 28, 2006 on March 7, 2007 revealed that Client #4 was observed at her day program to have swelling below the right eye and also a black bruise below the right eye. Interview with the QMRP on March 9, 2007 indicated that, the group home concluded that the client's injury occurred at the day program. Further interview with the QMRP and record review revealed preliminary findings regarding the client's injury were stated in a written statement from the home manager and addendum written by the QMRP which were</p>	W 156	<p>W156 Refer W154, W149</p>	

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W 156	<p>Continued From page 14 dated June 30, 2006.</p> <p>Interview with the day program case manager on March 8, 2007 and the review of the day program's investigative report dated July 17, 2007 revealed it concluded the client's injury did not occur at the day program. The QMRP indicated a case conference was convened at the client's day program on July 19, 2006 to discuss the incident. Further, interview with the QMRP and the record review on March 9, 2007, however failed to provide evidence the group home conducted its own comprehensive investigation of the client's injury or provide results to the administrator or designee within five working days of the incident as required by law. [See also W154]</p> <p>2. The facility failed to ensure that the investigation of Client #3's injury were reported to the administrator within five working days.</p> <p>The review of unusual incidents on March 7, 2007 revealed on March 24, 2006, Client #3 sustained a laceration to the right side of her face during a fall which required sutures at the emergency room. Interview with the Qualified Mental Retardation Professional revealed the agency has an incident manager who investigates unusual incidents. The review of the investigative report revealed the client's injury was reported to the administrator on March 27, 2007. Further record review revealed the incident was not received by the incident manager until April 3, 2007 and that the investigation was not completed until April 13, 2006. There was no evidence the investigation of the client's injury was reported to the agency's designated representative within five days.</p> <p>[Note: Further review of the investigative report</p>	W 156			

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W 156	Continued From page 15 revealed the incident was reported to the agency Administrator and Program Director on March 27, 2006, to Answers Please on March 31, 2006 and to MRDDA on April 6, 2006.]	W 156		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observations, interviews, and record review, the Qualified Mental Retardation Professional (QMRP) failed to ensure that clients active treatment programs and needs had been integrated, coordinated and monitored.. The findings include: 1. The facility failed to ensure the individual program plan (IPP) objective to address drooling was stated in terms of a single behavioral outcome. Interview with the QMRP and the record verification on March 9, 2007 at 4:45 PM revealed Client #3 has a behavioral objective which states, "Given verbal prompts, Ms [Client #3] will be encouraged not to keep napkins in her mouth to prevent drooling and use napkins to wipe her mouth when drooling is noted on 80% of the recorded trials for 12 months." There was no evidence the objective was stated as a single outcome. [See W229] 2. The QMRP failed to coordinate Client #1 and #6 weight loss with the nutritionist for follow-up.	W 159	W159 – 1 Client's IPP was amended to address the drooling behavior and the outcome was changed to include a single outcome. See attached – revised IPP	4/9/07

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W 159	<p>Continued From page 16</p> <p>a) Interview with the QMRP on March 8, 2007 revealed that the first quarter and third quarter written reviews are sent to the QMRP and she compiles the these quarterly reports . The review of QMRP monthly progress notes for the months of November and December 2006 revealed no documented weight in the nutritional status section for Client #1. Nursing documentation reflected a weight of 156 pounds in October 2006 and 149 pounds in February and March 2007. There was no evidence this information had been communicated to the nutritionist for assessment.</p> <p>b) On March 7, 2007 at 7:45 AM, Client #6 was observed markedly overweight for her short stature. Interview with the client on March 8, 2007 indicated that she understands that she is on a special diet to help her lose weight. The client also indicated that she has a job at her day program which includes working in the cafeteria. Record review revealed the Client is prescribed a 1500 calorie, NAS (no added salt) Diet. Interview with the LPN on March 8, 2007 indicated the client is provided with her prescribed diet at the group home, but may be consuming excessive calories away from home.</p> <p>Record review revealed the last quarterly assessment was conducted on October 27, 2007. The nutritional assessment documented a desirable body weight of 111 to 148 pounds. The assessment indicated that monthly weights would be monitored and that staff should reweigh the client if she gained 5 pounds in one month. Record review revealed the client had gained 5 pound from January to March 2007 (1/07-262 pounds; 2/07 265 pounds; 3/07- 267 pounds.</p>	W 159	<p>W159 – 2</p> <p>The Nutritionist reviews the client's weights quarterly and a weight fluctuation of 5lb increase is reported to the MD and the nutritionist promptly.</p> <p>The QMRP and the Nurse will visit the day program monthly to review the program and health needs See attached - in-service sheet – for monthly weights and nursing physicals</p>	4/2/07
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W 159	Continued From page 17 There was no evidence the Client #6's nutritional status was monitored at least quarterly and in accordance with her assessed need. 3. The QMRP failed to coordinate the nutritionist's recommendation that Client #3 be evaluated by the Occupational Therapist for spillage of food. Observation on March 7, 2007 at 3:40 PM revealed and on March 8, 2007 at 3:59 PM revealed Client #3 feeding herself a snacks of pureed food from a bowl. Food was observed to fall from the edges of the spoon as the client brought it up to her mouth. The review of Client #3's Nutritional Assessment dated December 18, 2006 revealed a recommendation that the client be evaluated by the Occupational Therapist for spillage of food (possibly for a plate elevator). Interview with the QMRP on March 9, 2007 revealed the evaluation had not been conducted. [See W212]	W 159	W159 - 3 Client was reassessed by the OT and she has recommended a 'raised tray' to assist the client and avoid spillage. W159 - 4 Staff was trained in Fire Drills and Evacuation plans. The Agency has a Fire Evacuation and Drill Policy in place and this will be monitored monthly by the QMRP as part of the Agency wide QA process. See attached - staff in service sheet and QA forms	4/9/07 4/9/07
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. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively,	W 189		

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W 189	<p>Continued From page 18 efficiently, and competently.</p> <p>The findings include:</p> <p>1. The facility failed to ensure the time of day was documented for each fire drill conducted.</p> <p>The review of fire drill records for the last twelve months on March 9, 2007 4:45 PM revealed that the of day the drills were conducted on April 28, 2006, May 10, 2006, November 25, December 14, 2006, January 24, 2007 and February 7, 2007. There was no evidence staff was effectively trained to document the time of day each fire drill was conducted. [See W159,4]</p> <p>2. The facility failed to ensure staff was effectively trained on dental hygiene.</p> <p>On March 9, 2007 at between 12:35 PM and 12:50 PM, the of the toothbrushes heads of Clients #1, #4 and #5 were observed to be worn. Interview with the QMRP indicated that replacement toothbrush heads were available. There was no evidence staff was effectively trained to monitor the condition of the toothbrushes and report when when they were in need of replacement to promote good dental hygiene for the clients.</p> <p>3. The facility failed to ensure effective training on dignity and sensitivity for Client #1 and #3.</p> <p>a. At 4:02 PM on March 8, 2007, Client #3 was observed drinking a pink beverage from a spout cup. The client was observed holding her head back and pouring the supplement into her mouth, allowing some of it to run down her chin and onto her sweater. Staff told her to wipe her mouth.</p>	W 189	<p>W189 Refer to W159 - 4</p> <p>W189 - 2 The Agency has implemented a monthly QA System for Infection Control and the Hygiene Kits will be checked monthly. Presently all the toothbrushes were replaced and staff were in serviced on tooth brushing and Infection Control. See attached - in service sheet for infection control and QA System</p>	4/9/07

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W 189	<p>Continued From page 19</p> <p>The client had finished the supplement. Staff again verbally prompted her to wipe her mouth again at 4:06 PM and the client left the table. At 6:39 PM, the client was observed to still be wearing the soiled sweater. While observing the client's sweater, the client was also noted to have several long strands of hair were observed on her chin.</p> <p>b. At 6:42 PM on March 8, 2007, Client #3 was observed with a large circular wet ring on the front of his shirt which extended down to his chest. Interview with the Qualified Mental Retardation Professional during the entrance conference on March 7, 2007 at 8:40 AM revealed the client has a behavior support plan which addresses "shirt chewing". The client shirt was observed to be substantially dry when he arrived home from the day program on March 8, 2007. Throughout the evening he was observed being monitored by direct care staff. There was no evidence staff was effectively trained to minimize the client's shirt chewing behavior.</p> <p>4. The facility failed to ensure that staff was effectively trained on the implementation of Client #3 handwashing program.</p> <p>Interview with the home manager on staff on March 9, 2007 indicated that Client #4 had a handwashing program to improve her personal hygiene. According to the Individual Program Plan (IPP) objective, the client will "With independence, wash hands on 80% of trials recorded per month." Record revealed no data was collected on this objective for March 2007.</p> <p>Observation of the first floor bathroom in the facility at various times during the survey revealed</p>	W 189	<p>W189 – 3a & b Staff was in serviced on Dignity and Respect and client Sensitivity. The Agency will ensure that staff will interact and treat all clients with respect and dignity at all times. Staff was in serviced on client's BSP – for shirt chewing The Facility will ensure that all staff are knowledgeable and utilize the BSP appropriately See attached – in service sheet on BSP, Respect and Dignity Training</p> <p>W189 – 4 All staff was trained in Hand washing and Infection Control Policy and Procedures. Agency has implemented a monthly QA review of all IPPs and ISPs along with Infection Control QA to ensure accurate implementation and documentation is done by all staff.</p>	<p>4/9/07</p> <p>4/9/07</p>	

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W 189	Continued From page 20 one of more of the aforementioned hygiene items were missing from the bathroom as indicated below: (a) March 7, 2007 at 3:55 PM - No soap in bathroom (b) March 8, 2007 at 2:47 PM - No soap; (c) March 9, 2007 at 8:35 AM - No soap or paper towel. According to the agency's policy on Infection Control Environmental Suveillance Audits, hand washing materials shall be available which include pump style hand soap and paper towels. There was no evidence staff were trained to effectively implement this policy and the client's IPP.	W 189		
W 212	483.440(c)(3)(i) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the presenting problems and disabilities and where possible, their causes. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the comprehensive functional assessment of Client #3's self feeding skills. The findings include: The facility failed to ensure a comprehensive assessment of Client #3 self feeding skills detailed below: a. At 3:59 PM, on March 8, 2007 Client #3 was observed feeding herself applesauce and intermittently drooling applesauce into her bowl as	W 212	W212 The OT will review the client's needs for adaptive eating utensils to lessen or prevent spillage and the hyperextension of the neck. See attached – in service sheet and OT assessment	4/9/07

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W 212	<p>Continued From page 21 she sat across the table from Clients #2 and #4.</p> <p>At 4:02 PM, Client #3 was observed drinking a pink beverage from a spout cup. Interview with staff indicated the drink was Ensure Plus (a nutritional supplement). The client was observed holding her head back and pouring the supplement into her mouth, allowing some of it to run down her chin and onto her sweater as she continued to drink the supplement. Staff told her to wipe her mouth. At 4:06 PM, the client had finished the supplement. Staff again verbally prompted her to wipe her mouth.</p> <p>According to the Occupational Therapy (OT) assessment dated December 12, 2006, the client is able to feed her self, has partial lip closure and is seen drooling, but is able to wipe her mouth when given cues. There was no evidence the behavior of hyperextending her neck and pouring the drink into her mouth had been assessed.</p> <p>b. Observation of Client #3 on March 7, 2007 at 3:40 PM revealed her independently eating a snack from a bowl. Direct care staff identified the snack as cookies pureed in milk. The food was observed to fall from the edges of the spoon as the client brought it up to here mouth.</p> <p>The review of Client #3's Nutritional Assessment dated December 18, 2006 and the Mealtime Protocol also dated December 18, 2006 revealed the client is prescribed Ensure Plus 8 oz BID and double portions (pureed diet) to compensate for the food losses by spillage when eating. The nutritionist further noted that spillage from the spoon occurs as the client transports food from the plate to her mouth and also from the client's mouth while eating. According to the nutritionist,</p>	W 212		
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W 212	Continued From page 22 the client also tends to lean her head closer to the plate as though to minimize the food spillage from the spoon, however due to gravity and poor oral motor skills, more spillage occurs. The nutritionist recommended that input be obtained from the OT regarding interventions to help minimize food spillage from the spoon during meals and to consider perhaps a plate elevator. At the time of the Annual Nutritional Assessment, Client #3's weighed 86 pounds, which was 93.4% of her desirable body weight (DBW) of 92 to 124 pounds. Interview with the QMRP on March 9, 2007 at 4:47 PM and the review of the clients record revealed no evidence the recommendation OT evaluation of the food spillage had occurred. [Note: Occupational Therapy Assessment for Client #3 dated December 12, 2007 "Eating Skills" revealed name of another client and incorrect texture of diet.	W 212		
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the comprehensive functional assessment identified each behavioral need of one of three clients in the sample. (Client #2) The findings include: On March 7, 2007 at 8:19 AM, Client #2 was observed wearing her coat and hat on and telling staff and clients, "It is time to go to school!" The	W 214	W214 Psychologist has amended the BSP to include the behaviors exhibited at the day program. In the future the QMRP will ensure that all behaviors impacting the client will be intimated to the psychologist to ensure a comprehensive assessment is completed. See attached – amended psychological assessment	4/9/07

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W 214	<p>Continued From page 23</p> <p>van left the facility at 8:40 AM to carry the six clients to their five different day programs.</p> <p>Interview the home manager on March 7, 2007 at 12:50 PM PM revealed he needed to pickup Client #2 from her day program by 1:30 PM because she will be upset if he is late. The review of the client's comprehensive functional assessment dated November 30, 2006 revealed the client has a support plan to address her maladaptive behaviors at the group home. The review of the current Behavior Support Plan (BSP) (dated October 16, 2006), used at the residential facility, indicated target behaviors of physical aggression, depressed moods, and diminished interests.</p> <p>Interview with the case manager at the day program on March 8, 2008 at 11:50 AM revealed the client had a day program BSP, dated December 2006. This plan was to encourage the client to maintain her composure at all times. Further interview with the case manager and the client classroom instructor revealed that the client becomes agitated if not picked up to go home by 1:30 PM. Further, the client exhibits maladaptive behaviors of screaming/crying, pacing back and forth, and keeps asking about her van. The day program staff further indicated this behavior usually begins after the client eats her lunch; and therefore she does not participate in her scheduled active treatment programs. According to the Annual Psychological Assessment dated October 14, 2006 and the Psychiatric Assessment dated February 9, 2006, the client was not competent to make independent or informed decisions concerning her treatment plan.</p>	W 214		
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W 214	<p>Continued From page 24</p> <p>The review of the behavior support plan developed by the psychologist for the group home failed to provide evidence that the residential psychologist was aware of the extent of the behaviors exhibited by the client at the day program. For example, the residential psychological assessment failed to mention the following behaviors frequently exhibited by the client at her day program:</p> <ul style="list-style-type: none"> a. Wanting to leave day program early daily b. Screaming, crying, pacing back and forth and continuously asking for her van after lunch. c. Failure to participate in any recreational outings held away from the day program. <p>Interview with the Qualified Mental Retardation Professional and the record review on March 9, 2007 revealed no evidence that the impact of these behaviors on the client's active treatment at the day program had been effectively addressed by the Interdisciplinary Team.</p>	W 214		
W 229	<p>483.440(c)(4)(i) INDIVIDUAL PROGRAM PLAN</p> <p>The objectives of the individual program plan must be stated separately, in terms of a single behavioral outcome.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the individual program plan (IPP) objective to address drooling was stated in terms of a single behavioral outcome.</p> <p>The finding includes:</p> <p>On March 7, 2007 at 8:00 AM, Client #3 was</p>	W 229	<p>W229 Refer to W159 – 1</p>	

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W 229	Continued From page 25 observed holding a folded paper towel between her teeth. Several minutes later, she was observed with the paper towel in her mouth, clenched between her upper and lower teeth. At 8:08 AM the client was observed still holding the folded tissue between her teeth. Interview with staff indicated the client has a training program to wipe her mouth to prevent drooling.	W 229		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION 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 observation, interview and record verification, the facility failed to ensure that as soon as the interdisciplinary team formulated the individual program plan, each client received continuous active treatment including sufficient and needed interventions to support achievement of objectives for three of the six clients residing in the facility. (Clients #1 and #3)	W 249		

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W 249	<p>Continued From page 26</p> <p>The findings include:</p> <p>1. The facility failed to continuously implement interventions to prevent Client #1's shirt chewing behavior.</p> <p>On March 7, 2007 at 8:13 AM, a direct care staff was observed putting on Client #1's coat. Another direct care staff observed wet spots on the front of the client's shirt and asked the previous staff to change the client's shirt before leaving for the day program. The staff commented that the client chews on his shirt and causes it to get wet.</p> <p>Interview with the Qualified Mental Retardation Professional during the entrance conference on March 7, 2007 at 8:40 AM revealed the client had a behavior support plan (BSP) which addressed "shirt chewing". Interview with the home manager on May 9, 2007 at 11:54 AM also validated the client had a BSP which included interventions to address shirt chewing. Further interview with the home manager indicated staff is to sit by him to monitor his behavior and keep him busy because he is able to chew a hole in his shirt.</p> <p>At 4:05 PM on March 8, 2007, the front of Client #1's shirt was observed to be dry as he entered the living room with a direct care staff. Between that time and dinner, which was served at 6:00 PM, the client remained with the staff who sat beside him and talked to him, attempted to engage him and implemented his evening programs. During this time, the client was observed to intermittently stand, turn around, and attempt to chew his shirt. At 6:39 PM the client was observed with a large wet circular ring</p>	W 249	<p>W249 - 1 QMRP and staff will ensure that client's BSP is followed to reduce his maladaptive behaviors. Attached - in service.</p>	4/9/07	

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W 249	<p>Continued From page 27</p> <p>extending down the front (to chest level) of the velour shirt he was wearing.</p> <p>Record review revealed the client has a BSP which includes interventions to reduce self-stimulation (leg curling, shirt sucking and twirling). There was no evidence the client received continuous active treatment to minimize the client's shirt chewing behavior.</p> <p>2.The facility failed to ensure Client #3's personal hygiene objective which addresses drooling was implemented as written.</p> <p>On March 7, 2007 at 8:00 AM, Client #3 was observed holding a folded paper towel between her teeth. Several minutes later, she was observed with the paper towel in her mouth, clenched between her upper and lower teeth. At 8:08 AM the client was observed still holding the folded tissue between her teeth. Interview with staff indicated the client being trained to wipe her mouth to prevent drooling. Staff was not observed to intervene at that time. While eating her afternoon snack on March 8, 2007 after returning from her day program, direct care staff was observed to verbally prompt Client #3 several times to wipe her mouth.</p> <p>Record verification on March 9, 2007 at 4:45 PM revealed Client #3 has a behavioral objective which states, "Given verbal prompts, Ms [Client #3] will be encouraged not to keep napkins in her mouth to prevent drooling and use napkins to wipe her mouth when drooling is noted on 80% of the recorded trials for 12 months."</p> <p>There was no evidence the IPP objective to address the client's drooling was implemented as</p>	W 249	<p>W249 - 2 An amended IPP to address the drooling has been implemented Attached - in service on the new IPP</p>	4/9/07
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W 249	<p>Continued From page 28 written.</p> <p>3. The facility failed to ensure continuous active treatment for Client #3 in her training objective to encourage independence in handwashing.</p> <p>Interview with the home manager on staff on March 9, 2007 indicated that Client #4 had a handwashing program to improve her personal hygiene. Review of the Individual Program Plan (IPP) revealed an objective, the client will "With independence, wash hands on 80% of trials recorded per month." Record revealed no data was available for objective for March 2007.</p> <p>Observation of the first floor bathroom in the facility at various times during the survey revealed one of more of the aforementioned hygiene items were missing from the bathroom as indicated below:</p> <p>(a) March 7, 2007 at 3:55 PM - No soap in bathroom (b) March 8, 2007 at 2:47 PM - No soap; (c) March 9, 2007 at 8:35 AM - No soap or paper towel.</p> <p>There was no evidence the handwashing supplies were available at all times to support the client growth toward independence in this objective. [See also W189,5]</p>	W 249	<p>W249 - 3 Staff has been in serviced on accurate documentation and Infection Control and the House Manager has a weekly chore checklist to ensure that Hygiene supplies are made available to the clients and staff. Attached - in service sheet</p>	4/9/07
W 252	<p>483.440(e)(1) PROGRAM DOCUMENTATION</p> <p>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p>	W 252		

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W 252	<p>Continued From page 29</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure Client #4's s progress in her Individual Program Plan (IPP) objectives to improve her personal hygiene was documented in measurable terms for two clients residing in the facility (Clients #3 and #4).</p> <p>The finding includes:</p> <ol style="list-style-type: none"> 1. Interview with the home manager on staff on March 9, 2007 indicated that Client #3 had a handwashing program to improve her personal hygiene. Interview with the home manager on March 9, 2007 at 11:50 AM indicated the client requires staff assistance to successfully perform the task. According to the IPP objective, the client will "With independence, wash hands on 80% of trials recorded per month." Record revealed no data was collected on this objective for March 2007. There was no documented evidence of performance in the objective. 2. At 3:59 PM on March 8, 2007, Client #4 was observed hitting Client #2 three times and growling while eating a snack. Client #2 did not respond. Client #6 commented that Client #4 had been hitting people on the van on the way home. At 4:03 Client #4 was observed to hit Client #2 again. Interview with staff indicated that Client #4 has as behavior plan which addresses hitting (aggression) and that behaviors are documented in her program book. <p>According to the revalidated BSP dated February 7, 2007, the client had an objective "To reduce physical aggression self injurious behaviors to zero over the next twelve months. Physical</p>	W 252	<p>W252 Staff has been in serviced on Infection Control and documentation practices. In the future the QMRP and House Manager will ensure that daily monitoring of the IPPs data collection is accurate and completed. Attached in service sheet</p>	4/9/07	

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W 252	Continued From page 30 aggression was defined in the BSP as head butting, hitting others, pulling other's nose and scratching others.	W 252		
W 263	Although aggressive behavior was observed by staff during the survey, the review of the data collection sheet for March 2007 reflected no data related to physical aggression. There was no evidence Client #4's physical aggression was documented in measurable terms. 483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's specially-constituted committee (Human Rights Committee, HRC) failed to ensure that restrictive programs were used only with written consents, for one three clients in the sample. (Client #2) The finding includes: On March 8, 2007 at Client #2 was observed to be administer Zyprexa 15 mg by mouth. Interview with the Qualified Mental Retardation Professional (QMRP) revealed the Client #2 was prescribed a behavior support plan (BSP) that included Zyprexa to manage the client's agitation. Further interview revealed the client had family involvement in her affairs, but did not have an advocate or guardian to give consent for the use of restrictive measures.	W 263	W263 See attached Medication consent form and Human Rights Approval and family consent	4/9/07

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W 263	Continued From page 31	W 263			
W 322	<p>Although the Human Rights Committee (HRC) approved the implementation of the BSP, there was no evidence written consent was obtained from a legally-sanctioned guardian and/or a surrogate health care decision-maker to implement these restrictive programs/strategies.</p> <p>483.460(a)(3) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain preventive and general medical care.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and the record review, the facility failed to implement preventive measure to ensure client's health two of the five clients living in the facility (Client #1 and #6).</p> <p>The findings include:</p> <p>1. The On March 8, 2007 at 3:51 PM during snack time, Client #1 was observed being supervised by direct care staff who assisted him in eating whole oatmeal cookies and fresh apple wedges. The size of the apple pieces offered appeared to be approximately 1/2 of the wedge. The client was observed to move the apple pieces around the front of his mouth and to eventually chew and swallow them.</p> <p>At 3:59 PM Client #1 was observed biting from the oatmeal cookie. The client finished eating the cookie at 4:01 PM. Interview with staff indicated the client is on a regular, chopped diet. The review of the client's current physician's revealed he is prescribed a Regular, High Fiber Diet (finely chopped). The revised Mealtime Protocol dated</p>	W 322	<p>W322 Staff was in serviced on the mealtime protocol for this client to ensure that the correct texture of food is administered. The Agency has implemented a monthly QMRP and Nursing visit to the day program to ensure client's program and health needs are met. Attached – in service sheet</p>	4/9/07	

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W 322	<p>Continued From page 32</p> <p>February 2, 2007 indicated the client's diet should be chopped with a knife and fork to a size where 3 to 4 pieces will fit on a teaspoon because he does minimal chewing. There was no evidence the texture of the the client was modified as prescribed to ensure the client did not experience chewing difficulty and was not at risk for choking.</p> <p>2. On March 7, 2007 at 7:45 AM, Client #6 was observed markedly overweight for her short stature. Interview with the client on March 8, 2007 indicated that she understands that she is on a special diet to help her lose weight. The client also indicated that she has a job at her day program which includes working in the cafeteria. Record review revealed the Client is prescribed a 1500 calorie, NAS (no added salt) Diet.</p> <p>Interview with the LPN on March 8, 2007 indicated the client was provided with her prescribed diet at the group home, but may have consumed excessive calories away from home.</p> <p>Record review revealed the last quarterly assessment was conducted on October 27, 2006. The nutritional assessment documented a desirable body weight of 111 to 148 pounds. The assessment indicated that monthly weights would be monitored and that staff should reweigh the client if she gained 5 pounds in one month. Record review revealed the client had gained 5 pound from January to March 2007 (1/07-262 pounds; 2/07 265 pounds; 3/07- 267 pounds. There was no evidence the Client #6's nutritional status was monitored at least quarterly and in accordance with her assessed need.</p>	W 322		
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT	W 356		

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W 356	Continued From page 33 The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on interview and record review, the facility must ensure comprehensive dental treatment services that included restoration of teeth for one of six clients in the survey. (Client #6). The finding include: Observation of Client #6 on March 7, 2007 at 7:55 AM revealed she had no front teeth. Interview with the client and staff on March 7, 2007 at 3:50 PM indicated the client had dentures however she did not wear them all of the time. Further interview with the client indicated that she went to the dentist recently. Record review on March 9, 2007 indicated the client had a dental consultation on December 11, 2006. During this visit the dentist documented that the filling in tooth #31 was broken and that she had an accumulation of calculus on her teeth. The consultation report reflected that treatment services would be provided once the authorization was received from Medicaid. Further record review revealed that the scaling was performed on March 5, 2007. Interview with the nurse and the record review indicated that a treatment plan for repair of the broken filling in tooth #31 had not been identified by the dentist. There was no evidence the client received treatment services to repair her broken tooth.	W 356	W356 Client's dental appointment has been scheduled for 5/7/07 at 11.30 am to fix the broken tooth. In the future the DON will complete Quarterly chart QA to ensure all recommendations are completed.	4/9/07	
W 390	483.460(m)(2)(i) DRUG LABELING	W 390			

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W 390	Continued From page 34 The facility must remove from use outdated drugs. This STANDARD is not met as evidenced by: Based on observation, the facility failed to remove from use, an out dated topical treatment for one of six clients residing in the facility. (Client #1) The finding includes: Observation of the personal kit of Resident #5 on March 9, 2007 at 12:35 PM revealed it contained a partially used tube Bactroban Ointment prescribed on September 8, 2005. The expiration date printed at the bottom of the tube was December 2006. Interview with the the nurse indicated the resident was prescribed to use the medication when needed, however should have been discarded once it reached the expiration date. There was no evidence each medication was promptly destroyed once it reached its expiration date.	W 390	W390 The Nursing staff will ensure that all expired medications are discarded as per the Medication administration Policy and Procedure. All nurses were in serviced	4/9/07
W 460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observation interview and the record review, the facility filed to ensure that Client #6 received monitoring of the effectiveness of her therapeutic diet The finding includes:	W 460		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/28/2007
FORM APPROVED
OMB NO. 0938-0391

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W 460	Continued From page 35 On March 7, 2007 at 7:45 AM, Client #6 was observed looking out of the window and stated "It's snowing. Further observation of the client revealed that she was markedly overweight for her short stature. Interview with the client on March 8, 2007 indicated that she understands that she is on a special diet to help her lose weight. The client also indicated that she has a job at her day program which includes working in the cafeteria. Record review revealed the Client is prescribed a 1500 calorie, NAS (no added salt) Diet. Interview with the LPN on March 8, 2007 indicated the client is provided with her prescribed diet at the group home, but may be consuming excessive calories away from home. Record review revealed the last quarterly assessment was conducted on October 27, 2007. The nutritional assessment documented a desirable body weight of 111 to 148 pounds. The assessment indicated that monthly weights would be monitored and that staff should reweigh the client if she gained 5 pounds in one month. Record review revealed the client had gained 5 pound from January to March 2007 (1/07-262 pounds; 2/07 265 pounds; 3/07- 267 pounds. There was no evidence the Client #6's nutritional status was monitored at least quarterly and in accordance with her assessed need.	W 460	W460 Refer to 159 - 2	
W 474	483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that Client #1's	W 474		

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W 474	Continued From page 36 diet was provided in the prescribed texture. The findings include: On March 8, 2007 at 3:51 PM during snack time, Client #1 was observed being supervised by direct care staff who assisted him in eating whole oatmeal cookies and fresh apple wedges. The size of the apple appeared to be approximately 1/2 of the wedge. The client was observed to move the apple pieces around the front of his mouth and to eventually chew , then swallow them. At 3:59 PM Client #1 was observed biting from the oatmeal cookie. The client finished eating the cookie at 4:01 PM. Interview with staff indicated the client is on a regular, chopped diet. The review of the client's current physician's revealed he is prescribed a Regular, High Fiber Diet (finely chopped). The revised Mealtime Protocol dated February 2, 2007 revealed the client's diet should be chopped with a knife and fork to a size where 3 to 4 pieces will fit on a teaspoon because he does minimal chewing. There was no evidence the texture of the the client was modified as prescribed to ensure the client did not experience chewing difficulty.	W 474	W474 Refer to W322		

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I 000	INITIAL COMMENTS This licensure survey was conducted from March 7, 2007 through March 9, 2007. The survey was initiated utilizing the fundamental survey process. A random sampling of residents from the residential population of two males and four females were initially selected for this survey. The findings of the survey were based on observations at the group home and three day programs, interviews with the clients and staff and record review including the review of unusual incident reports.	I 000		
I 042	3502.2(b) MEAL SERVICE / DINING AREAS Modified diets shall be as follows: (b) Planned, prepared, and served by individuals who have received instruction from a dietitian; and... This Statute is not met as evidenced by: The finding includes: On March 8, 2007 at 3:51 PM during snack time, resident #1 was observed being supervised by direct care staff who assisted him in eating whole oatmeal cookies and fresh apple wedges. The size of the apple appeared to be approximately 1/2 of the wedge. The resident was observed to move the apple pieces around the front of his mouth and to eventually chew, then swallow them. At 3:59 PM resident #1 was observed biting from the oatmeal cookie. The resident finished eating the cookie at 4:01 PM. Interview with staff indicated the resident is on a regular, chopped diet. The review of the resident's current physician's revealed he is prescribed a Regular, High Fiber Diet (finely chopped). The revised Mealtime Protocol dated February 2,	I 042	I042 Refer to W322	

Health Regulation Administration

Swain J. Sloan, BA, MA

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

TITLE

VTO

(X6) DATE

4/7/07

STATE FORM

6899

DU2X11

If continuation sheet 1 of 23

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I 042	Continued From page 1 2007 revealed the resident's diet should be chopped with a knife and fork to a size where 3 to 4 pieces will fit on a teaspoon because he does minimal chewing. There was no evidence the texture of the the resident was modified as prescribed to ensure the resident did not experience chewing difficultyBased on observation, interview and record review, the facility failed to ensure that resident #1's diet was provided in the prescribed texture:	I 042		
I 043	3502.2(c) MEAL SERVICE / DINING AREAS Modified diets shall be as follows: (c) Reviewed at least quarterly by a dietitian. This Statute is not met as evidenced by: The facility filed to ensure that Resident #6's therapeutic diet was reviewed at least quarterly by a dietitian. The finding includes: On March 7, 2007 at 7:45 AM, Client #6 was observed looking out of the window and stated "It's snowing. Further observation of the client revealed that she was markedly overweight for her short statue. Interview with the client on March 8, 2007 indicated that she understands that she is on a special diet to help her lose weight. The client also indicated that she has a job at her day program which includes working in the cafeteria. Record review revealed the Client is prescribed a 1500 calorie, NAS (no added salt) Diet. Interview with the LPN on March 8, 2007 indicated the client is provided with her prescribed diet at the group home, but may be	I 043	I043 Refer to W159 - 2	

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I 043	Continued From page 2 consuming excessive calories away from home. Record review revealed the last quarterly assessment was conducted on October 27, 2007. The nutritional assessment documented a desirable body weight of 111 to 148 pounds. The assessment indicated that monthly weights would be monitored and that staff should reweigh the client if she gained 5 pounds in one month. Record review revealed the client had gained 5 pound from January to March 2007 (1/07-262 pounds; 2/07 265 pounds; 3/07- 267 pounds. There was no evidence the Client #6's nutritional status was monitored at least quarterly and in accordance with her assessed need.	I 043		
I 052	3502.10 MEAL SERVICE / DINING AREAS Each GHMRP shall equip dining areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each resident. This Statute is not met as evidenced by: The finding includes: On March 9, 2007 two of the chairs for the dining table were observed to be in the basement due to needed repairs.	I 052	I052 The dining room chairs have been fixed	4/9/07
I 062	3502.20 MEAL SERVICE / DINING AREAS Dishes and eating utensils shall be cleaned after each meal and stored to maintain their sanitary condition. This Statute is not met as evidenced by:	I 062		

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I 062	<p>Continued From page 3</p> <p>The finding includes:</p> <p>The facility failed to ensure that dishes and food service equipment was stored to maintain sanitary conditions when not in use.</p> <p>1. On March 7, 2007 at 11: 30 AM cups were observed on the counter beside the dishrack with the rims turned in an upright position. The cups were observed in the same location at 2:21 PM. There was no evidence the facility ensured that dishes and equipment were stored to maintained their sanitary condition.</p> <p>2. On March 7, 2007 at 2:21 PM, a roach was observed crawling on the inside of the blender which was placed in the dishrack upside down. Staff was immediately informed, removed the roach from the edge of the dishrack and killed the roach.</p> <p>3. Observation of the cabinet underneath the sink in the first floor bathroom at approximately 12:30 PM on March 9, 2007, revealed several dead roaches on the bottom. Interview with the QMRP and the Home Manager revealed the exterminator treated the facility for pests in February 2007 and that exterminations were conducted quarterly and as needed. On March 12 2007 an invoice dated February 20, 2007 which reflected the facility was inspected and treated for for roaches and rodents. An extermination contract dated March 12, 2007 was provided on March 13, 2007. There was no evidence that the February 20, 2007 extermination was effective to kill all roaches.</p>	I 062	<p>I062</p> <p>Staff has been in serviced on Infection Control. The QMRP and House Manager will ensure that an effective extermination is completed quarterly.</p> <p>A monthly QA System has been implemented to avoid such reoccurrences.</p> <p>Attached – in service sheet</p>	4/9/07
I 082	<p>3503.10 BEDROOMS AND BATHROOMS</p> <p>Each bathroom that is used by residents shall be</p>	I 082		

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I 082	Continued From page 4 equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting. This Statute is not met as evidenced by: The findings include: Observation on March 9, 2007 of the two bathrooms located on the first floor of the facility which were used by the residents revealed there were no cup dispensers. Observation of the bathroom located off the hallway on the first floor at various times during the survey revealed one of more of the following items were missing from the bathroom as indicated below: (a) March 7, 2007 at 3:55 PM - No soap in bathroom (b) March 8, 2007 at 2:47 PM - No soap; (c) March 9, 2007 at 8:35 AM - No soap or paper towel. There was no evidence each bathroom was equipped as required by the regulation. [According to the agency's policy on Infection Control Environmental Suveillance Audits, hand washing materials shall be available which include pump style hand soap and paper towels.]	I 082	I082 Refer to W249		
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.	I 090			

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I 090	<p>Continued From page 5</p> <p>This Statute is not met as evidenced by: The findings include:</p> <p>A. Exterior</p> <p>1. The facility failed to ensure the back yard was maintained in a condition safe for the Clients' use.</p> <p>a. Observation of the back yard on March 9, 2007 revealed a retaining wall approximately four feet tall to the left of the paved driveway. Further observation revealed the grassy area of the yard was elevated approximately three feet above and to the left of the driveway. The portion of the retaining wall (approximately 8 inches above ground) beside grass-covered area which served as a barrier between the yard and the driveway was observed to be minimal. Further inspection of the area covered with grass revealed sharp metal protruding above ground which appeared to be cut of pipe. Two of three the poles supporting the fence at the other side of the grass-covered area of the yard, lacked protective caps at the top, exposing the metal edges. metal. There was no evidence the facility had maintained the back yard in a safe condition to allow use of the the the space by the residents.</p> <p>b. Observation of the grassy areas on the left and right of the paved area in the back yard revealed they were several inches lower than the paved area. Observation of the clients revealed that one was blind and two were at risk for falls. Interview with staff and the record verification revealed that two residents had fall prevention protocols. There was no evidence the facility had maintained the back yard in a safe condition so the the space was available for the residents use.</p>	I 090	<p>I090 1 a & b Refer to W104 -3</p>	
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I 090	Continued From page 6 2. The front walkway had an area of previously repaired pavement which was broken in several places. 3. Self closure device on the front entrance storm door was observed to be not operable. The basement storm door was observed to stay in an open position and to lack a self closure device. 4. Scaling paint was observed on the exterior window sill. Scaling paint was also observed on the area directly underneath the edge of the roof at the front of the facility. caling paint was also observed on the porch of the back porch. B. Interior of the facility 1. The closet doors of the closet located in the first floor hallway were not secured at the bottom. This caused to doors to move inward and outward when pressure was applied. 2. The doors of the closet in the bedroom of Residents #3 and #4 were observed to not be secured in the tract at the top, which caused them to drag against the floor. 3. The water control device was loose in the shower of the master bedroom. 4. Two knobs were observed missing from drawers of Resident #2's chest used to store her clothing. 5. The door knob on the basement door exit door located on the side of the facility as not secured in place.	I 090	I090 -2 -The front walk way has been fixed - 3 - self closure device on storm door has been fixed - 4- The window sills and porches have been scrapped and painted B. -1- The closet door has been fixed -2- Bedroom closet door has been fixed -3- Water faucet has been fixed in the master bedroom -4 -Drawer knobs have been replaced -5 -Basement door knob has been secured -6- Both headboards have been repaired -7- The recliner will be replaced	

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I 090	Continued From page 7 6. The headboards of the beds of Residents #3 and #5 lacked a screw to secure them tightly in place. 7. The right arm of the recliner in the living room was observed to have a tear which was approximately eight inches in length. 8. Dust, several dead roaches and an unprotected roll of toilet paper were observed in the cabinet underneath the sink in the bathroom located on the first floor. 9. There was no spindle to hold the toilet tissue available in either of the bathrooms. Interview with the staff on March 9, 2007 indicated the toilet paper holders were broken.	I 090	-8- Bathroom under the sink area has been cleaned -9 - Spindle for toilet paper has been replaced	4/9/07
I 092	3504.3 HOUSEKEEPING Each GHMRP shall be free of insects, rodents and vermin. This Statute is not met as evidenced by: The findings include: The facility failed to the facility was maintained free of roaches. 1. Observation of the cabinet underneath the sink in the first floor bathroom at approximately 12:30 PM on March 9, 2007, revealed several dead roaches on the bottom. Interview with the QMRP and the Home Manager revealed the exterminator treated the facility for pests on February 2007 and that exterminations were conducted quarterly and as needed. On March 12, 2007 an invoice dated was provided which reflected that the facility was exterminated on	I 092	I092 Refer to I062	

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I 092	Continued From page 8 February 20, 2007. An extermination contract dated March 12, 2007 was provided on March 13, 2007. There was no evidence the extermination was effective to maintain the facility free of roaches. 2. [See also Citation 0062]	I 092		
I 188	3508.6 ADMINISTRATIVE SUPPORT Documentation that services have been provided as required by each resident ' s Individual Habilitation Plan including contracts, vendor agreements, receipts, and paid bills shall be available for review by authorized regulatory personnel. This Statute is not met as evidenced by: The facility failed to ensure a record was maintained of each podiatry service received for three of three clients in the sample (Clients #1, #2, and #3). The finding includes: Interview with the LPN revealed the podiatrist comes to the facility quarterly to assess and treat the client's feet and nails as needed. Record review revealed podiatry consultations were conducted on January 28, 2006, July 29, 2006, November 25 , 2006. At the time of the record review, there was no evidence that a consultation was conducted between January 28, 2006 and July 29, 2006. Further interview with the LPN indicated the podiatrist also treated the clients in April 2006. Upon contacting the podiatrist, the nurse confirmed the podiatrist was at the facility on April 2006. The April 2006 consultation reports for each of the clients were faxed to the facility on March 8, 2007. There was no evidence	I 188	I188 Podiatry consults are done every 3-5 mths and was received and is attached	4/9/07

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I 224	Continued From page 10 (a) Overview of mental retardation including, but not limited to, definition, causes of mental retardation, associated health implications, and frequently used medications, the history of care of individuals with mental retardation, and daily living skills; This Statute is not met as evidenced by: The finding includes: The facility failed to ensure staff were effectively trained to address the residents identified needs. [See Federal Deficiency Report - 159 and W189]	I 224	I224 Refer to W159 and W189	
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: The findings include: 1. The facility failed to ensure unusual incidents Client #4's injury to her left eye of unknown origin within 24 hours to the Department of Health (DOH). The review of unusual incidents on March 7,	I 379	I379 Refer to W149	

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I 379	<p>Continued From page 11</p> <p>2007 revealed on June 28, 2007, Client #4's day program discovered her to have a bruised eye.</p> <p>The review of an incident report dated June 28, 2006 which was completed by the day program nurse revealed the following information:</p> <p>"[Ms Client #4] was brought inside the nurses office at approximately 10:30 AM and lead counselor Ms... showed the nurse that the observed swelling of client's eye, below the right eye and also a black bruise observed below the right eye. Called and spoke with house manager at group home and he stated that it was not observed. Client arrived at Day program with above site swollen and black bruise." Further review of the incident report revealed it was identified as a serious reportable incident by the day treatment program.</p> <p>A nursing progress note documented on June 28, 2007 at 4:50 PM revealed that Client #4 returned home from her day program with a note reporting an unusual swelling of the right eye. Interview with day program staff and the casemanager at the day program, as well as the investigative report on March 8, 2007 revealed the origin of the client's injury was unknown.</p> <p>The review of the unusual incident report revealed that the Department of Health was not notified of the client's injury until June 30, 2006. There was no evidence the client's injury was reported to DOH within 24 hours as required by law.</p> <p>2. The review of an unusual incidents on March 7, 2007 at 10:35 AM revealed Client #3 sustained an laceration to her face when she fell on March 24, 2006. According to the incident report, the</p>	I 379		
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I 379	<p>Continued From page 12</p> <p>client hit her face on the floor during the fall. The review of the internal investigative report dated April 13, 2006, revealed residential staff reported that at approximately 3:45 PM, the client [Client #3] fell as she ascended the steps to enter her residence. According to the investigative report, the client was trying to hit a housemate in retaliation and tripped on the steps. Furthe review of the investigative report revealed during the fall, Client #3 struck the right side of her face on the steps. The client's injuries were cleaned, and the nurse was notified. After her physical assessment, the LPN notified the primary care physician (PCP). The review of the nursing progress note dated revealed the client was treated at the emergency room and required three sutures to close the wound. According to the investigative report dated April 13, 2006, the Department of Health (DOH) was not notified of the client's injury until April 5, 2006.</p> <p>According to the agency's policy and procedure on Incident Management, DOH should be notified immediately of physical injuries that result in a medical emergency. There was no evidence the facility implemented the aforementioned policy by notifying DOH of the client's injury within 24 hours.</p>	I 379		
I 391	<p>3520.2(a) PROFESSION SERVICES: GENERAL PROVISIONS</p> <p>Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals</p>	I 391		

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I 391	Continued From page 13 trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (a) Medicine; This Statute is not met as evidenced by: The finding includes: Interview and record review on March 8, 2007 at 5:50 PM revealed the facility failed to maintain a copy of the professional license for the primary care physician.	I 391	I 391 The Physician's license is attached In the future the Agency has a QA system to ensure that consultants' files are updated accordingly.	4/9/07
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: The findings include: The facility failed to ensure comprehensive assessments. 1. The facility failed to ensure a comprehensive assessment of resident #3 self feeding skills detailed below: a. At 3:59 PM, on March 8, 2007 resident #3 was observed feeding herself applesauce and intermittently drooling applesauce into her bowl as she sat across the table from residents #2 and #4.	I 401	I401- 1 Refer to W212	

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I 401	<p>Continued From page 14</p> <p>At 4:02 PM, resident #3 was observed drinking a pink beverage from a spout cup. Interview with staff indicated the drink was Ensure Plus (a nutritional supplement). The resident was observed holding her head back and pouring the supplement into her mouth, allowing some of it to run down her chin and onto her sweater as she continued to drink the supplement. Staff told her to wipe her mouth. At 4:06 PM, the resident had finished the supplement. Staff again verbally prompted her to wipe her mouth.</p> <p>According to the Occupational Therapy (OT) assessment dated December 12, 2006, the resident is able to feed her self, has partial lip closure and is seen drooling, but is able to wipe her mouth when given cues. There was no evidence the behavior of hyperextending her neck and pouring the drink into her mouth had been assessed.</p> <p>b. Observation of resident #3 on March 7, 2007 at 3:40 PM revealed her independently eating a snack from a bowl. Direct care staff identified the snack as cookies pureed in milk. The food was observed to fall from the edges of the spoon as the resident brought it up to here mouth.</p> <p>The review of resident #3's Nutritional Assessment dated December 18, 2006 and the Mealtime Protocol also dated December 18, 2006 revealed the resident is prescribed Ensure Plus 8 oz BID and double portions (pureed diet) to compensate for the food losses by spillage when eating. The nutritionist further noted that spillage from the spoon occurs as the resident transports food from the plate to her mouth and also from the resident's mouth while eating. According to the nutritionist, the resident also tends to lean her head closer to the plate as though to minimize</p>	I 401		

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I 401	<p>Continued From page 15</p> <p>the food spillage from the spoon, however due to gravity and poor oral motor skills, more spillage occurs. The nutritionist recommended that input be obtained from the OT regarding interventions to help minimize food spillage from the spoon during meals and to consider perhaps a plate elevator. At the time of the Annual Nutritional Assessment, resident #3's weighed 86 pounds, which was 93.4% of her desirable body weight (DBW) of 92 to 124 pounds. Interview with the QMRP on March 9, 2007 at 4:47 PM and the review of the residents record revealed no evidence the recommendation OT evaluation of the food spillage had occurred.</p> <p>[Note: Occupational Therapy Assessment for resident #3 dated December 12, 2007 "Eating Skills" revealed name of another resident and incorrect texture of diet.</p> <p>2. The facility failed to ensure that resident #2 received a comprehensive assessment for her maladaptive behaviors which interfered with her active treatment at her day program.</p> <p>Interview the home manager on March 7, 2007 at 12:50 PM PM revealed he needed to pickup resident #2 from her day program by 1:30 PM because she will be upset if he is late. The review of the resident's comprehensive functional assessment dated November 30, 2006 revealed the resident has a support plan to address her maladaptive behaviors at the group home. The review of the current Behavior Support Plan (BSP) (dated October 16, 2006), used at the residential facility, indicated target behaviors of physical aggression, depressed moods, and diminished interests.</p> <p>Interview with the case manager at the day</p>	I 401	I401 -2 Refer to W214	

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I 401	<p>Continued From page 16</p> <p>program on March 8, 2008 at 11:50 AM revealed the resident had a day program BSP, dated December 2006. This plan was to encourage the resident to maintain her composure at all times. Further interview with the case manager and the resident classroom instructor revealed that the resident becomes agitated if not picked up to go home by 1:30 PM. Further, the resident exhibits maladaptive behaviors of screaming/crying, pacing back and forth, and keeps asking about her van. The day program staff further indicated this behavior usually begins after the resident eats her lunch; and therefore she does not participate in her scheduled active treatment programs. According to the Annual Psychological Assessment dated October 14, 2006 and the Psychiatric Assessment dated February 9, 2006, the resident was not competent to make independent or informed decisions concerning her treatment plan.</p> <p>The review of the behavior support plan developed by the psychologist for the group home failed to provide evidence that the residential psychologist was aware of the extent of the behaviors exhibited by the resident at the day program. For example, the residential psychological assessment failed to mention the following behaviors frequently exhibited by the resident at her day program:</p> <p>a. Wanting to leave day program early daily b. Screaming, crying, pacing back and forth and continuously asking for her van after lunch. c. Failure to participate in any recreational outings held away from the day program.</p> <p>Interview with the Qualified Mental Retardation Professional and the record review on March 9, 2007 revealed no evidence that the impact of</p>	I 401		

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I 401	Continued From page 17 these behaviors on the resident's active treatment at the day program had been effectively addressed by the Interdisciplinary Team. 3. The facility must ensure comprehensive dental treatment services that included restoration of teeth for Resident #6. Observation of resident #6 on March 7, 2007 at 7:55 AM revealed she had no front teeth. Interview with the resident and staff on March 7, 2007 at 3:50 PM indicated the resident had dentures however she did not wear them all of the time. Further interview with the resident indicated that she went to the dentist recently. Record review on March 9, 2007 indicated the resident had a dental consultation on December 11, 2006. During this visit the dentist documented that the filling in tooth #31 was broken and that she had an accumulation of calculus on her teeth. The consultation report reflected that treatment services would be provided once the authorization was received from Medicaid. Further record review revealed that the scaling was performed on March 5, 2007. Interview with the nurse and the record review indicated that a treatment plan for repair of the broken filling in tooth #31 had not been identified by the dentist. There was no evidence the resident received treatment services to repair her broken tooth.	I 401	I 401 Refer to W356	
I 420	3521.1 HABILITATION AND TRAINING 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.	I 420		

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I 420	<p>Continued From page 18</p> <p>This Statute is not met as evidenced by: The findings include:</p> <p>1. The facility failed to continuously implement interventions to prevent Client #1's shirt chewing behavior.</p> <p>On March 7, 2007 at 8:13 AM, a direct care staff was observed putting on Client #1's coat. Another direct care staff observed wet spots on the front of the client's shirt and asked the previous staff to change the client's shirt before leaving for the day program. The staff commented that the client chews on his shirt and causes it to get wet.</p> <p>Interview with the Qualified Mental Retardation Professional during the entrance conference on March 7, 2007 at 8:40 AM revealed the client had a behavior support plan (BSP) which addressed "shirt chewing". Interview with the home manager on May 9, 2007 at 11:54 AM also validated the client had a BSP which included interventions to address shirt chewing. Further interview with the home manager indicated staff is to sit by him to monitor his behavior and keep him busy because he is able to chew a hole in his shirt.</p> <p>At 4:05 PM on March 8, 2007, the front of Client #1's shirt was observed to be dry as he entered the living room with a direct care staff. Between that time and dinner, which was served at 6:00 PM, the client remained with the staff who sat beside him and talked to him, attempted to engage him and implemented his evening programs. During this time, the client was observed to intermittently stand, turn around, and attempt to chew his shirt. At 6:39 PM the client</p>	I 420	<p>I420 1-4 1. - All staff was in serviced on client's BSP and IPPs .</p>	4/9/07

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I 420	<p>Continued From page 19</p> <p>was observed with a large wet circular ring extending down the front (to chest level) of the velour shirt he was wearing.</p> <p>Record review revealed the client has a BSP which includes interventions to reduce self-stimulation (leg curling, shirt sucking and twirling). There was no evidence the client received continuous active treatment to minimize the client's shirt chewing behavior.</p> <p>2. The facility failed to ensure Client #3's personal hygiene objective which addresses drooling was implemented as written.</p> <p>On March 7, 2007 at 8:00 AM, Client #3 was observed holding a folded paper towel between her teeth. Several minutes later, she was observed with the paper towel in her mouth, clenched between her upper and lower teeth. At 8:08 AM the client was observed still holding the folded tissue between her teeth. Interview with staff indicated the client being trained to wipe her mouth to prevent drooling. Staff was not observed to intervene at that time. While eating her afternoon snack on March 8, 2007 after returning from her day program, direct care staff was observed to verbally prompt Client #3 several times to wipe her mouth.</p> <p>Record verification on March 9, 2007 at 4:45 PM revealed Client #3 has a behavioral objective which states, "Given verbal prompts, Ms [Client #3] will be encouraged not to keep napkins in her mouth to prevent drooling and use napkins to wipe her mouth when drooling is noted on 80% of the recorded trials for 12 months."</p> <p>There was no evidence the IPP objective to address the client's drooling was implemented as</p>	I 420	<p>2. - The IPP for drooling has been amended and all staff were in serviced on this</p> <p>3. - Refer to W189-5</p> <p>4. - All staff were in serviced on client's BSP and accurate documentation</p> <p>In the future QMRP will ensure that Agency QA System is implemented</p>	

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I 420	<p>Continued From page 20 written.</p> <p>3. The facility failed to ensure continuous active treatment for Client #3 in her training objective to encourage independence in handwashing.</p> <p>Interview with the home manager on staff on March 9, 2007 indicated that Client #4 had a handwashing program to improve her personal hygiene. Review of the Individual Program Plan (IPP) revealed an objective, the client will "With independence, wash hands on 80% of trials recorded per month." Record revealed no data was available for objective for March 2007.</p> <p>Observation of the first floor bathroom in the facility at various times during the survey revealed one of more of the aforementioned hygiene items were missing from the bathroom as indicated below:</p> <p>(a) March 7, 2007 at 3:55 PM - No soap in bathroom (b) March 8, 2007 at 2:47 PM - No soap; (c) March 9, 2007 at 8:35 AM - No soap or paper towel.</p> <p>There was no evidence the handwashing supplies were available at all times to support the client growth toward independence in this objective. [See also W189,5]</p> <p>4. At 3:59 PM on March 8, 2007, Client #4 was observed hitting Client #2 three times and growling while eating a snack. Client #2 did not respond. Client #6 commented that Client #4 had been hitting people on the van on the way home. At 4:03 Client #4 was observed to hit Client #2 again. Interview with staff indicated that Client #4 has as behavior plan which addresses hitting</p>	I 420		

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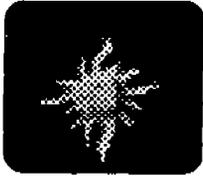
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I 420	Continued From page 21 (aggression) and that behaviors are documented in her program book. According to the revalidated BSP dated February 7, 2007, the client had an objective "To reduce physical aggression self injurious behaviors to zero over the next twelve months. Physical aggression was defined in the BSP as head butting, hitting others, pulling other's nose and scratching others. Although aggressive behavior was observed by staff during the survey, the review of the data collection sheet for March 2007 reflected no data related to physical aggression. There was no evidence Client #4's physical aggression was documented in measurable terms.	I 420		
I 484	3522.11 MEDICATIONS Each GHMRP shall promptly destroy prescribed medication that is discontinued by the physician or has reached the expiration date, or has a worn, illegible, or missing label. This Statute is not met as evidenced by: The finding includes: Observation of the personal kit of Resident #5 on March 9, 2007 at 12:35 PM revealed it contained a partially used tube of Bactroban Ointment which was prescribed on September 8, 2005. The expiration date printed on the bottom of the tube was December 2006. Interview with the the nurse indicated the resident was prescribed to use the medication when needed, however it should have been discared once it reached the expiration date. There was no evidence each medication was promptly destroyed once it reached its expiration date.	I 484	I484 Refer to W390	

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April 6, 2007

Pat VanBuren
Department of Health and Human Services
Intermediate Care Facilities Division
825 North Capitol Street NE 2nd Floor
Washington, DC 20002

Dear Ms. VanBuren,

Attached you will find our plan of corrections for 8020 Eastern Avenue NW Washington, DC (Maxine House). If any other additional information is needed please contact me at the above mentioned number.

Sincerely,

Susan Sloan
Vice President of Operations

cc: Sheila Panell, Supervisor DOH
Stephanie Black, Health Regulatory Administration



METRO HOMES, INC.