

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

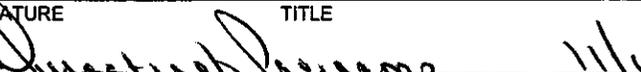
PRINTED: 10/23/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G027	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/16/2009
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NAME OF PROVIDER OR SUPPLIER MY OWN PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 3215 20TH STREET, NE WASHINGTON, DC 20018
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W 000	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted from September 15, 2009 through September 16, 2009. The fundamental survey process was utilized. A random sampling of two clients was selected from a residential population of four females with mental retardation and other disabilities.</p> <p>The survey findings were based on observations in the group home and at two day programs, interviews and a review of records, including unusual incident reports.</p>	W 000	<p><i>Received 11/9/09</i></p> <p>GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002</p>	
W 104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>This STANDARD is not met as evidenced by: Based on observations, interviews, and record reviews, the facility's governing body failed to provide general operating directions over the facility as evidenced by deficiencies cited throughout this report and the following:</p> <p>The facility's governing body failed to ensure that the van used to transport the clients residing in the facility was adapted to suit the needs of two of the four clients residing in the facility. (Clients #2 and #3).</p> <p>On September 15, 2009 at 8:32 a.m. Client #3 was observed walking with an awkward gait toward the van parked in the driveway. A wheelchair lift was observed to be attached to the right rear passenger door of the van. The van was also equipped with a running board which</p>	W 104	<p>W104 See response on page 2 of 22.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE 	(X6) DATE <i>11/6/09</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104 Continued From page 1
was approximately 12 inches above the ground. At 8:40 a.m., Clients #4, then #1 and #3 all boarded the van through the front passenger door. While under staff supervision, the clients held onto the front passenger seat to pull themselves up into the van as they stepped onto the running board. Clients #4 and #1 then walked through a narrow space between the passenger and driver's seats, stepping over a small metal structure behind the space, as they went to the rear of the van. The narrow space and metal structure created a potential trip hazard for the clients. Client #3 remained in the front passenger seat after she entered the van.

W 104

W104
Agency has assessed the current vehicle in use for Client #2 and #3 as well as the other Client's residing at this home and determined that a smaller vehicle with a portable ramp would better suit their needs.

11.9.09

New vehicle will be purchased by 12.15.09 in the interim a portable ramp will be ordered by 11.9.09 for use with the current vehicle and stand by assistance will be provided to all individuals when entering and exiting the vehicle.

12.15.09

QMRP/Residence Manager will monitor the individual's ability to enter and exit the vehicle and follow up as appropriate based on assessment of their needs.

Staff will be trained by QMRP/Residence Manager on observing, recognizing and communicating concerns to the QMRP/Residence Manager with regard to the individual's abilities exiting and boarding the vehicle

11.30.09
Ongoing

W 137 483.420(a)(12) PROTECTION OF CLIENTS RIGHTS

W 137

The facility must ensure the rights of all clients.

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W 137	<p>Continued From page 2</p> <p>Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the right of each client to use appropriate personal possessions and clothing for two of the four clients residing in the facility (Clients #1 and #3).</p> <p>The finding includes:</p> <ol style="list-style-type: none"> 1. The facility failed to ensure each of Clients #3's pants were of the appropriate length. <p>On September 15, 2009 at 8:22 a.m., Client #3 was observed limping as she walked about in the group home. One leg appeared to be shorter than the other, as she stepped on the hems of her gray stretch pants, which were too long. The client commented "Look" several times to the staff. Direct Care Staff #2 attempted to pull the client's pants up higher by the waistband, however the legs of the pants continued to be too long. Direct Care Staff #3, then escorted the client to her bedroom. At 8:27 a.m. the client returned to the living room wearing a pair of slacks which were of the appropriate length. Later that evening (5:22 p.m.), the client was observed again wearing the same gray pants she wore earlier in the morning.</p> <p>Interview with Direct Care Staff #3 on the same day indicated Client #3 liked the gray pants, however, acknowledged that they were too long for her. There was no evidence the facility had ensured Client #3's right to have slacks that were of the appropriate length.</p>	W 137	<p>W 137 See response on page 4 of 22.</p>	

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W 137	Continued From page 3 2. On the morning of September 15, 2009 at 8:18 a.m., the clients were observed in the living room watching cable television as they waited to leave for their day programs. At 8:25 a.m., Client #1 commented, "My TV is broke." Later during the day on September 15, and again on September 16, 2009 upon returning to the group home, the client continued to state, "My TV is broke." On September 16, 2009 at approximately 4:30 p.m., the client's bedroom was observed to be equipped with a flat screen TV. The cable wires did not appear to be connected and there was no picture on the screen. Interview with direct support staff on September 16, 2009 at approximately 10:45 a.m., revealed the client's TV was new, however had not been operable for several months, "Since the boxes changed over." Interview with the residential director (RD) and the Qualified Mental Retardation Professional (QMRP) indicated that the family had purchased Client #1's flat screen TV, further indicating a TV converter had been purchased for the client in June 2009. However, the client's family had not provided the remote control with which to operate the new TV. Interview with staff on September 16, 2009 at 11:28 a.m. revealed the group home was wired for cable and that the cable was operable in the living room. The review of the financial records on September 16, 2009 at 11:50 a.m. revealed the cable bill was shared by the four clients living at the group home. Further record review revealed a bank report with a withdrawal slip dated June 12, 2009 for \$45.00 to pay for a TV converter. At the time of the survey, however, there was no evidence the	W 137	W137 1. All of client #3's pants will be tailored to an appropriate length to avoid potential safety hazard for client #3. QMRP/Residence Mgr or designee will make sure that the individuals try on their clothing before purchase to ensure proper fit. In the event that it is clothing that the individual desires and can be tailored to fit, the clothing will be tailored to fit prior to wear. 2. A universal remote was purchased to operate the television and the converter box was hooked up to the television, however there was still no picture. Therefore, cable Client #1's bedroom. QMRP/Residence Manager will monitor the personal possessions of each individual and follow up in a timely manner on any noted needs that may be delaying its usage or availability for usage.	11.3.09 Ongoing

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W 137	Continued From page 4 facility had implemented effective measures to ensure that Client #1 was able to operate her new TV in her bedroom, when desired.	W 137		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination, monitoring, and implementation of a client's habilitation and planning for two of four clients in the sample. [Clients #1 and #2] The findings include: 1. The facility's QMRP failed to ensure staff received adequate and effective training. [See W189] 2. The facility's QMRP failed to ensure the implementation of programmatic objectives. [See W249] 3. The facility's QMRP failed to ensure all clients received training on and ensured the use of their adaptive equipment. [See W436]	W 159	<p>W159</p> <ol style="list-style-type: none"> 1. Reference response to W189. 2. Reference response to W249. 3. Reference response to W436. 	11.30.09 Ongoing
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.	W 189		

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W 189	<p>Continued From page 5</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that each employee had been provided with adequate training that enabled the employee to perform his or her duties effectively, efficiently and competently to ensure the health and safety of its residents for seven of eight staff in the facility. (LPN #1, Staff #1, #2, #3, #4, #5, #6, and #7)</p> <p>The findings include:</p> <ol style="list-style-type: none"> Interview with the facility's Qualified Mental Retardation Professional, Residential Coordinator, the Program Director and record review on September 16, 2009 at approximately 6:40 p.m. revealed Client #2's Individual Service Plan (ISP) dated October 15, 2008 recommended several areas where staff needed training to ensure her health and safety. The training recommended in the ISP was as follows: <ul style="list-style-type: none"> a. Seizure Management b. Signs and Symptoms c. Assistive Devices or equipment d. Dental care and hygiene e. Behavior management plan <p>Further record review on September 16, 2009 at 7:00 p.m. revealed the facility failed to ensure staff received all the recommended training to maintain Client #2's health and well-being as presented below:</p> <ol style="list-style-type: none"> Of the seven staff records reviewed, only six staff received training on seizure management. None of the seven staff currently employed 	W 189	<p>W189 a-b. Review of records revealed that all staff training were not filed and available for review at the time of survey. The Individual specific training for Staff #1-7 has been placed on file in their personnel records.</p> <p>All staff will receive individual specific training via QMRP and Delegating RN during their Day # Orientation with refresher training on an annual basis and/or as changes occur with the individual's support needs. The QMRP will review each employees' record to ensure that the Day # 3 Orientation document is on file.</p> <p>On an ongoing basis, the Administrative Office will effectively manage, obtain and file all employee training records. On site training will be conducted to enable staff to effectively perform their duties.</p> <p>QMRP, Residence Manager and Delegating RN will utilize monthly staff meetings to conduct individualized employee in-service trainings. The QMRP/Residence manager will coordinate discipline specific training from the applicable consultant.</p> <p>2. The facility nurse will conduct training on infection control to LPN' s by 11.15.09 In addition, facility nurse will observe LPN medication pass every quarter and retrain as deemed necessary.</p>	<p>11/9/09 Ongoing</p> <p>11.30.09</p> <p>11/15/09 Ongoing</p> <p>11.15.09 Ongoing</p>

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W 189	Continued From page 6 received training on " signs and symptoms" , "assistive devices or equipment", "elevated blood pressure and cholesterol levels" and "behavior management plan." 2. (Cross Refer to W455) The facility failed to provide effective, efficient, and competent training for the prevention and control of infection and communicable diseases for one of one staff in the facility. (LPN #1)	W 189		
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, staff interview and record review, the facility failed to ensure the prompt implementation of the individual program plan for one of two sampled clients. (Client #2) The finding includes: Observation on September 15, 2009 at approximately 5:22 p.m., Client #2 was taken for an afternoon walk. Client #2 was also observed to walk with an unsteady gait during the day on September 16, 2009. Staff interview and record review on September 16, 2009 at approximately 4:30 p.m. revealed Client #2's Physical Therapy assessment dated August 4, 2008 recommended	W 249	W 249 See response on page 8 of 22.	

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W 249	<p>Continued From page 7</p> <p>the following programmatic interventions:</p> <p>1. "Navigating the residential stairs with close supervision several times a day would assist in improving [Client #2's] activity level and providing a weight bearing, functional exercise."</p> <p>"GOAL: Maintain independent ambulation and mobility on level surfaces and stairs."</p> <p>2. "Recommendation: Supervise [Client #2's] daily range of motion (ROM) exercise for cervical range of motion (see attached)."</p> <p>"GOAL: Increase active range of motion for left cervical rotation and lateral flexion by 5 degrees."</p> <p>Further record review at approximately 4:35 p.m. revealed there was no data recorded to validate that either of these programs were being implemented at the time of survey. Interview with the Residential Director (RD) and the Program Director (PD) on September 16, 2009 at approximately 5:40 p.m. revealed there was no documented evidence the ROM program was ever implemented. According to the RD, there was not supposed to be any recorded data on the implementation of the ROM program. Furthermore, the RD indicated the Physical Therapist was to re-assess Client #2 at the next Individual Service Plan (ISP) meeting to see how well she has progressed.</p> <p>Note: There was also no evidence that the "attached " program(s) were ever reviewed and/or implemented. The facility's management staff was not able to present the survey team with a copy of the document(s) that were supposed to be "attached" to the PT's recommendation.</p>	W 249	<p>W249 1 & 2 The attachment to Client #2 PT assessment was obtained on 9/18/09.</p> <p>Delegating RN in conjunction with QMRP will meet with the Physical Therapist consultant to review and clarify the PT recommendations. All applicable supporting documentation will be obtained and implemented. Delegating RN and QMRP will coordinate training to be completed with all staff on each recommended goal and objective. QMRP/Residence Manager will monitor the implementation and documentation of the PT goals and objectives. Delegating RN and QMRP will follow through with PT consultant to ensure that Client #2's progress monitored in accordance with recommendations.</p> <p>On an ongoing basis, Delegating RN and QMRP will review all assessments thoroughly upon receipt and provide the necessary follow through to ensure timely implementation of all goals and objectives. The recommended supports necessary for the individual's progress including consultant's monitoring will be coordinated. QMRP will oversee daily documentation, revisions and modifications to recommendations, goals and objectives, document of such efforts will be maintained in the individual's record.</p>	<p>9/18/09</p> <p>11.15.09 Ongoing</p>

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W 249	Continued From page 8	W 249		
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> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that each client's Individual Program Plan (IPP) objectives are documented consistently and accurately for one of four clients included in the facility. (Client #3)</p> <p>The finding includes:</p> <p>During the medication pass observation on September 15, 2009 at approximately 7:35 a.m., Client #3 was observed to punch out the medications on the correct date from the medication card and take the medications with three (3) verbal prompts and physical assistance.</p> <p>Review of Client #3's Individual Program Plan (IPP) dated September 2009 on September 15, 2009 at approximately 8:45 a.m., revealed a goal to improve self medication skills. Further review revealed the following objectives "go to bathroom to wash hands, go into kitchen get cup with water and applesauce if necessary, bring cup of water and applesauce to nursing station, sit in nursing chair, take medication with applesauce if necessary, drink water and walk and take items</p>	W 252	<p>W252</p> <p>Facility Delegating RN and QMRP will train LPN's and TMEs on proper implementation of medication goals by 11.15.09. Delegating RN will review medication goal sheet weekly for accuracy and consistent documentation, routinely reassess the individuals self medication skills and in conjunction with QMRP, monitor implementation during medication administration to ensure accurate implementation and revise/modify based on assessment of needs. Retraining will be provided as deemed necessary based on monitoring and observation.</p> <p>The Director of Health Services will randomly review, observe implementation of the self medication program and documentation for quality assurance.</p> <p>All staff including the medication nurses and LPN's will be reminded of the agencies philosophy of "do with not for" to enable self sufficiency and full participation</p>	11/15/09-Ongoing

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W 252	Continued From page 9 to kitchen ". Further review revealed Client #3's level of participation was to be documented on the data collection sheet as follows: (I) Independently; (V.P.) Verbal Prompts; (P.P.) Physical Prompts and (R) Refused. Review of the September, 2009, data on September 15, 2009 at approximately 9:00 a.m., revealed the nursing staff did not document Client #3's level of participation on September 8-9 and September 13, 2009 and August 1, 7-9, 13, 15 and 31, 2009. In an interview with the Registered Nurse (RN), on September 15, 2009, at approximately 9:15 a.m., the RN acknowledged the nursing staff did not document Client #3's level of participation on the aforementioned dates. There was no evidence the data had been collected in accordance with the IPP for Client #3, which was necessary for a functional assessment of the client's progress.	W 252	W 252 Response on page 9 of 22.		
W 371	483.460(k)(4) DRUG ADMINISTRATION The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observations, interviews and the review of records, the facility failed to implement an effective system to ensure that each client participated in a self-medication training program, for two of the four clients in the facility. (Client #3	W 371	W371 Reference response to W252	11.15.09 Ongoing	

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W 371	<p>Continued From page 10 and Client #4)</p> <p>The findings include:</p> <p>1. Observation of the medication administration on September 15, 2009 at 7:35 a.m. revealed the Licensed Practical Nurse #1(LPN #1) went into the kitchen and then poured water into a cup on the dining room table and placed the cup of water and into Client #3's hand. Further observation revealed LPN #1 provided Client #3 with one (1) physical prompt to punch Calcium w/Vit D 600mg/400, Levothyroxine Sodium 125 mg and Taztia XT 180mg tablets from the bubble pack. Interview with LPN #1 on September 15, 2009 at approximately 8:05 a.m., revealed Client #3 had fully participated in her self-medication program.</p> <p>Review of Client #3's Individual Program Plan (IPP) dated September 2009 on September 15, 2009 at approximately 9:05 a.m., revealed a goal to improve self medication skills. Further review indicated Client #3's self- medication program was as follows:</p> <p>a. Go to bathroom and wash hands; b. Go into kitchen get cup with water and applesauce if necessary; c. Bring cup of water and applesauce to nursing station; d. Sit in nursing chair; e. Punch pills (nurse will provide assistance as needed); f. Take medication with applesauce if necessary; g. Drink water and h. Walk and take items to the kitchen.</p> <p>There was no evidence that the client was given the opportunity to fully participate in the self-</p>	W 371	<p>W371 See response on page 10 of 22.</p>	
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W 371	Continued From page 11 medication program. 2. Observation of the medication administration on September 15, 2009 at 7:40 a.m. revealed LPN #1 went into the kitchen and then poured water into a cup on the dining room table and placed the cup of water in Client #4's hand. Further observation revealed LPN #1 provided Client #4 with one (1) physical prompt to punch Calcium w/Vit D 600mg/400, Therapeutic Vitamins w/minerals and Tyzeka F/C 600mg tablets from the bubble pack. Interview with LPN #1 on September 15, 2009 at approximately 8:07a.m., revealed Client #4 had fully participated in her self-medication program. Review of Client #4's IPP dated September 2009 on September 15, 2009 at approximately 9:05 a.m., revealed a goal to improve self medication skills. Further review indicated Client #4's self- medication program was as follows: a. Go to bathroom and wash hands; b. Go into kitchen and get cup of water; c. Take medication basket out; d. Sit in nursing chair; e. Punch pills (nurse will provide assistance as needed); f. Take medication; g. Drink water and h. Walk and take cup to kitchen. There was no evidence that the client was given the opportunity to fully participate in the self-medication program.	W 371	W371 See response on page 10 of 22.	
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses,	W 436		

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W 436	<p>Continued From page 12</p> <p>hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the effective management of client's adaptive equipment for three of the four clients residing in the facility. [Clients #1, #2, and #4]</p> <p>The finding includes:</p> <p>I. The facility failed to ensure that Clients #1, #2, and #4 were taught to make informed choices concerning the wearing of dentures recommended.</p> <p>A. Client #2 was observed on September 16, 2009 at approximately 12:05 p.m. eating her lunch. She was served a hamburger, a small order of fries and a cup of coffee. Interview with the facility's Program Director (PD) on September 16, 2009 at approximately 1:15 p.m. revealed Client #2 was not wearing her dentures during her lunch. During the interview with the PD, the Qualified Mental Retardation Professional (QMRP) indicated Client #2 doesn't normally wear her dentures and that they are kept in her room.</p> <p>Record review on the same day at approximately 3:10 p.m. revealed Client #2's Dental assessment dated October 16, 2008 detailed, "no new diagnosis ... please place Fixodent in both dentures daily for fit and comfort. Please brush dentures."</p>	W 436	<p>W436</p> <p>1 a-c. The Delegeting RN, QMRP and Residence Manager will provide appropriate oversight to make sure that the dentures for Client#1 and #2 are taken with them to all dental consults with written direction included on the consult indicating any concerns that have arisen regarding the individual's ability to tolerate wearing of the dentures as well as any observed concerns with proper fit and function.</p> <p>Recommendations from the dental consult will be reviewed and implemented per Specialists orders and/or a second opinion will be obtained if necessary.</p> <p>QMRP in conjunction with RN and consultation with the Dental provider will develop a toleration/desensitization goal with gradual increase of "wear time" for individuals who are reluctant to wear dentures to improve their ability to tolerate usage. Delegating RN/QMRP and Residence Manager will provide training to staff on the implementation and documentation of the objective and revise, modify as necessary based on the individual progress/support needs.</p>	11.15.09 Ongoing

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W 436	<p>Continued From page 13</p> <p>Further interview with the QMRP on September 16, 2009 at 3:21 p.m. revealed Client #2 was prescribed by her dentist to wear dentures, but she does not like to wear them.</p> <p>A second review of the records revealed Client #2's Individualized Support Plan (ISP) dated October 15, 2008 detailed, " Overall, I am edentulous. I received impressions for full upper and lower dentures on 8/26/2008. I received a full set of dentures on 10/16/2008. With orders to place Fixodent in both dentures daily to promote adequate fit and comfort as well as to brush dentures after each meal. I am able to perform all oral care steps with minimal prompts."</p> <p>There was no evidence presented or on file at the time of survey, to substantiate that efforts were made to ensure Client #2 wore her dentures. There was also no evidence that the Dentist was made aware Client #2 was refusing to wear her dentures or that the fit and comfort of the dentures was ever assessed.</p> <p>B. On September 15, 2009 at 7:58 a.m., Client #1 was observed to have missing teeth as she sat at the dining table eating breakfast. Later during the survey while the client was away from the facility on September 16, 2009 at 2:27 p.m., her dentures were observed stored in a solution in a container on top of her chest of drawers.</p> <p>On September 15, 2009 at 8:01 a.m., Client #1 nodded and answered "Yes", when she was asked if she had dentures. Interview with direct care staff on the same day at 8:07 a.m., revealed that client had recently received dentures, however did not like to wear them, and confirmed that the client was not wearing them. Staff</p>	W 436	<p>W436 See response on page 13 of 22.</p>		

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W 436	<p>Continued From page 14</p> <p>indicated that the client was not currently receiving training to encourage her to wear her dentures.</p> <p>Record review on September 16, 2009 at 4:25 p.m. revealed Client #1 had a dental consultations dated October 22, 2008, during which the dentist wrote, "Today: Delivered upper denture and partial lower denture." Follow-up visits were conducted with the dentist on April 2, 2009 and again on September 16, 2009, however failed to evidence that the dentist was informed that the client did not wear the dentures regularly. Additionally, there was no evidence a system had been implemented to increase the client's tolerance and wearing of her new dentures.</p> <p>C. On September 15, 2009 at 8:35 a.m., no teeth were visible as Client #4 opened her mouth widely when she smiled. The client was also observed not wearing her dentures when she returned home from her day program in the afternoon. On September 16, 2009 at 2:29 p.m., the client's teeth were observed soaking in a solution in a container placed on her chest of drawers.</p> <p>Interview with staff on September 15, 2009 at 4:38 p.m. revealed Client #4 had dentures, but did not like to wear them. Although, staff indicated that attempts had been made to encourage the client to wear her dentures, there was no evidence, however to confirm that the client had participated in this training.</p> <p>II. . The facility failed to ensure that Client #1's wrist weights were maintained in good repair as identified below:</p>	W 436	<p>W436 See response on page 13 of 22.</p>	

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W 436

Continued From page 15

On September 15, 2009 at 7:45 a.m., Client #1 was observed wearing padded circular arm weights bilaterally as she ate her breakfast. The arm weights were observed to rest loosely slightly below the client ' s elbows. During dinner observations that same day, at 6:10 PM, Client #1 was again wearing the arm weights in the same manner. During both meals, the client was observed to eat with a utensil that had a slightly built up handle. The client's hands were observed to tremble as she ate her meals.

Interview with staff during both breakfast and dinner on September 15, 2009 indicated the Client #1 ate with a weighted handle utensil. Staff stated that the client was to be provided a choice to wear the wrist weights or use her weighted handle eating utensil during meals to minimize shaking of her hands while eating. Further interview with staff, and later the QMRP revealed the purpose of the wrist weights and weighted utensil during meals was to minimize the trembling of her hands which was associated with her medical diagnosis. Interview with the Program Coordinator on September 16, 2009 at 4:45 p.m., however, revealed the weights were designed to fit the at the client's wrist, and had possibly become larger over time.

On September 16, 2009 at 3:08 p.m., Client #1's Occupational Therapy (OT) assessment dated July 17, 2009 was reviewed. The OT noted that the client had tremors of both hands when hands were at rest. The tremors were reported to be more pronounced in the right hand than in the left. The OT recommended that the client have the option to use weights (as tolerated) to assist with minimizing the effects of the tremors during performance of intentional skills. Further review of

W 436

2..Replacement wrist weights were ordered for Client #1 on 11/4/09. In the interim Client#1 is utilizing the weighted utensils to assist with the decrease of the effects of tremors during mealtime. QMRP and Residence Manager will training Client #1 and staff on choosing between using the weighted utensils or wrist weights. A supporting data collection form for staff to document Client #1's choice will be implemented and maintained on file in Client#1's record.

On an ongoing basis, QMRP will review all assessments thoroughly upon receipt, follow through on the implementation of recommendations including but not limited to, developing the supports necessary for the individual's overall progress.

11.4.09
Ongoing

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W 436	Continued From page 16 the OT recommendations revealed,"(1) Choice of weighted utensils, (2) Choice of weights." At the time of the survey, there was no evidence the client wrist weights had been maintained in good repair. In addition, there was no evidence that the client had been taught to make a choice of weighted utensils or use of weights at mealtimes.	W 436		
W 441	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on staff interview and record review, the Group Home for the Mentally Retarded Person (GHMRP) failed to ensure fire drills encompassed the use of all egress points and varied across each quarter as required by this section to ensure the health and safety of all its residents. (Clients #1, #2, #3, and #4) The finding includes: Observation on September 16, 2009 at 10:12 a.m. revealed there was an additional point of egress from the facility through the utility room adjacent to the kitchen. This point of egress was not listed on the evacuation plan for the facility and according to staff was not being used during fire drills. A large "EXIT" sign was posted above this door. There was a clear pathway through this doorway and out to the front yard. There were only three egress points listed on the evacuation plan (front door, rear exit from the office, and a rear exit from Client #3 and #4's bedroom).	W 441	W441 The point of egress from the facility through the utility room adjacent to the kitchen has never been identified (per fire inspectors) as a point of egress from the facility for use during fire evacuation. As per consultation with and recommendation from the fire inspectors, the utility room will not be included as a point of egress on the evacuation plan. The large exit sign has been removed from above the door.	11/4/09 Ongoing

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W 441	Continued From page 17 Interview with the Qualified Mental Retardation Professional (QMRP) on September 16, 2009 at 2:35 p.m. confirmed the facility does not utilize this egress during fire drills. In addition, the QMRP was not sure if the door could be opened. Upon further inspection, the QMRP later confirmed (same day at 2:50pm) that the door leading out from the utility room was operable and was a viable point of egress.	W 441		
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide an active program for the prevention, control of infection and communicable diseases, for three of four clients in the facility. (Client #1, Client #2 and Client #3) The findings include: 1. During medication administration observation on September 15, 2009, at approximately 7:08 a.m., LPN #1 was observed to wash her hands with soap and water in the kitchen sink prior to administrating medications. However LPN #1 then unlocked the medication lock, touched the medication cabinet door, touched the Medication Administration Records (MAR's) and then touched the rim of the medication cup as she provided Client #2 with physical assistance in pushing medications from the bubble pack. In an interview with LPN #1 on September 15, 2009, at approximately 7:45 a.m., it was	W 455	W455 Response on page 19 of 22.	

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W 455	<p>Continued From page 18</p> <p>acknowledged after washing her hands with soap and water she unlocked the medication lock, touched the medication cabinet door, touched the MAR's and then touched the rim of the medication cup as she provided Client #2 with physical assistance in pushing medications from the bubble pack.</p> <p>There is no evidence that the facility's nursing staff provided an active program for the prevention and control of infection.</p> <p>2. During medication administration observation on September 15, 2009, at approximately 7:25 a.m., LPN #1 was observed to wash her hands with soap and water in the kitchen sink prior to administrating medications. However LPN#1 touched the medication cabinet door touched the MAR's and then used her bare hands to break Client #1's Calcium w/Vit D 600 mg/400 tablet into two pieces.</p> <p>In an interview with LPN #1 on September 15, 2009, at approximately 7:46 a.m., it was acknowledged after washing her hands with soap and water in the kitchen sink she touched the medication cabinet door, touched the MAR's and then used her bare hands to break Client #1's Calcium w/Vit D 600 mg/400 tablet into two pieces.</p> <p>There is no evidence that the facility's nursing staff provided an active program for the prevention and control of infection.</p> <p>3. During medication administration observation on September 15, 2009, at approximately 7:35 a.m., LPN #1 was observed to use hand sanitizer to cleanse her hands prior to administrating</p>	W 455	<p>W455</p> <p>The facility nurse will conduct training on infection control to LPN' s by 11.15.09 In addition, facility nurse will observe LPN medication pass every quarter and PRN and retrain as deemed necessary.</p>	11.15.09 Ongoing

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W 455	Continued From page 19 medications. However LPN #1 touched the desk in the office, touched the Medication MAR's and then touched the rim of the medication cup as she provided Client #3 with physical assistance in pushing medications from the bubble pack. In an interview with LPN #1 on September 15, 2009, at approximately 7:47 a.m., it was acknowledged after cleaning her hands with hand sanitizer she touched the desk in the office, touched the MAR's and then touched the rim of the medication cup as she provided Client #3 with physical assistance in pushing medications from the bubble pack. There is no evidence that the facility's nursing staff provided an active program for the prevention and control of infection.	W 455	W455 Response on page 19 of 22.		
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 food was served at a texture in accordance with the developmental needs of three of the four clients residing in the facility. (Clients #2, #3, and #4) The finding includes: The facility failed to ensure that Clients #3 and #4 were offered food in a form consistent with their needs. 1. (Cross refer to W436.C) On September 15, 2009 at 6:17 p.m., Client #4 was observed	W 474	W474 See response on page 21 of 22.		

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W 474	<p>Continued From page 20</p> <p>attempting to bite a piece of baked cheese with her gums, however after several tries, was unable to bite it. The client then left the cheese on the plate. The client also did not eat her toasted garlic bread.</p> <p>Interview with the staff on the same day at 6:25 p.m. revealed the client may not have been able to bite the cheese because it was "kind of tough". The staff who had prepared the meal revealed beef lasagna had been substituted for vegetable lasagna on the menu.</p> <p>Record review on September 16, 2009 at 9:40 a.m. revealed the client was prescribed a 1500 calorie, low fat/low cholesterol, NAS, Soft Diet. There was no evidence the facility ensure the client's food was offered to her in a form consistent with needs.</p> <p>2. (Cross refer to W436.A). On September 15, 2009 at 6:28 p.m., Client #2 did not appear to have teeth as she seemed to be mashing her chopped eggs and sausage with her gums as she ate her breakfast. During dinner that evening, at 6:13 p.m., the client left approximately 50% of her chopped tossed vegetable salad and about 75% of her toasted garlic bread on her plate.</p> <p>Interview with staff on the same day at 6:30 p.m., revealed that the client was edentulous and was not wearing dentures during the meal.</p> <p>There was no evidence the facility ensure the client's food was offered to her in a form consistent with needs.</p> <p>3. On September 15, 2009 at 8:07 a.m. Client #3 did not appear to have teeth as she seemed to be</p>	W 474	<p>W474</p> <p>1-3 QMRP/Delegating RN will schedule a Nutritionist and/or Speech Pathologist re-inservice for staff on preparing food in ensuring that the food is prepared and offered consistent with Clients #2, #3 and #4's needs.</p> <p>QMRP/Residence Manager will monitor mealtimes at least once weekly to observe implementation of nutritional training objective and provide additional hands training to staff training as necessary to ensure that individuals supported have food offered during the meal that is appropriate to their need.</p> <p>Follow up action as appropriate will ensue for those staff who demonstrate the inability to prepare/serve food consistent with the individuals mealtime needs following the retraining.</p>	11.20.09 Ongoing

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W 474	<p>Continued From page 21</p> <p>mashing her chopped eggs and sausage with her gums as she ate her breakfast.</p> <p>Interview with the staff at 8:50 a.m. revealed the client was edentulous and did not wear dentures. There was no evidence the facility ensure the client's food was offered to her in a form consistent with needs.</p>	W 474		

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R 000	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted from September 15, 2009 through September 16, 2009. The fundamental survey process was utilized. A random sampling of two clients was selected from a residential population of four females with mental retardation and other disabilities.</p> <p>The survey findings were based on observations in the group home and at two day programs, interviews and a review of records, including unusual incident reports.</p>	R 000		
R 125	<p>4701.5 BACKGROUND CHECK REQUIREMENT</p> <p>The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Mentally Retarded Person's (GHMRP) failed to ensure criminal background checks disclosed the criminal history of each prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker had worked or resided within the seven (7) years prior to the check.</p> <p>The finding includes:</p> <p>On September 15, 2009 at 7:40 a.m., a direct care staff (S2) was observed monitoring</p>	R 125	<p>R125 See response on page 2 of 2.</p>	

Health Regulation Administration LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE 	(X6) DATE 11/16/09
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R 125	<p>Continued From page 1</p> <p>Residents #1 and #3 as they ate their breakfast at the dining table.</p> <p>Interview with S2 on September 15, 2009 at 7:45 a.m. revealed she was employed by a contract agency, however, was referred to provide services as a direct support staff regularly at the group home. Interview with the Qualified Mental Retardation Professional (QMRP) indicated that the group home's administration had a contract with the outside agency to provide staff to the group home when needed.</p> <p>Review of the GHMRP's administrative records on September 16, 2009 at 10:50 a.m. confirmed the contract. At 2:50 p.m., the program director presented a Maryland criminal background check for S2. There was no evidence, however, that a criminal background check had been conducted for the District of Columbia to disclose a seven year history in that jurisdiction for S2.</p>	R 125	<p>R125</p> <p>Follow up with the contract agency assisting this provider with temporary staffing to ensure appropriate staffing ratios, revealed that the staff#2 had not worked in the District of Columbia prior to his being hired to work for his agency. The background check that was presented for Maryland referenced the place of work within the past 7 years prior to working with the contract agency.</p> <p>Provider agency will continue to obtain a 7 year history in all jurisdiction worked or lived upon employment prior to hiring new staff or deploying contract staff to any of the provider's homes.</p>	9.17.09 ongoing

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I 000	INITIAL COMMENTS A re-licensure survey was conducted from 9/15/09 to 9/16/09. A random sampling of two residents was selected from a population of four individuals with varying degrees of disabilities. The findings of this survey were based on observations at the group home and two day program, interview with direct care staff and management, and a review of the habilitation and administrative records including the unusual incident reports.	I 000		
I 045	3502.4(a) MEAL SERVICE / DINING AREAS At least three (3) meals per day that are nutritious and suited to the special needs of each shall be served, at reasonable times ensuring that the following occurs: (a) There are not more than fourteen (14) hours between a substantial evening meal and breakfast of the following day, except on weekends and holidays; and This Statute is not met as evidenced by: Based on observation, interview, and record review, the Group Home for Mentally Retarded Person's (GHMRP) failed to ensure food was served at a texture in accordance with the developmental needs of three of the four residents residing in the facility. (Residents #2, #3, and #4) The finding includes: The facility failed to ensure that Residents #3 and #4 were offered food in a form consistent with	I 045	I045 See response on page 2 of 15.	

Health Regulation Administration

[Signature]
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature]
TITLE

(X6) DATE
11/4/09

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I 045	<p>Continued From page 1</p> <p>their needs.</p> <p>1. (Cross refer to W436.C) On September 15, 2009 at 6:17 p.m., Resident #4 was observed attempting to bite a piece of baked cheese with her gums, however after several tries, was unable to bite it. The client then left the cheese on the plate. The client also did not eat her toasted garlic bread.</p> <p>Interview with the staff on the same day at 6:25 p.m. revealed the client may not have been able to bite the cheese because it was "kind of tough". The staff who had prepared the meal revealed beef lasagna had been substituted for vegetable lasagna on the menu.</p> <p>Record review on September 16, 2009 at 9:40 a.m. revealed the client was prescribed a 1500 calorie, low fat/low cholesterol, NAS, Soft Diet. There was no evidence the facility ensure the client's food was offered to her in a form consistent with needs.</p> <p>2. (Cross refer to W436.A). On September 15, 2009 at 6:28 p.m., Resident #2 did not appear to have teeth as she seemed to be mashing her chopped eggs and sausage with her gums as she ate her breakfast. During dinner that evening, at 6:13 p.m., the resident left approximately 50% of her chopped tossed vegetable salad and about 75% of her toasted garlic bread on her plate.</p> <p>Interview with staff on the same day at 6:30 p.m., revealed that the resident was edentulous and was not wearing dentures during the meal.</p> <p>There was no evidence the facility ensure the resident's food was offered to her in a form consistent with needs.</p>	I 045	<p>I045</p> <p>1-3 QMRP/Delegating RN will schedule a Nutritionist and/or Speech Pathologist re-inservice for staff on preparing food in ensuring that the food is prepared and offered consistent with Clients #2, #3 and #4's needs.</p> <p>QMRP/Residence Manager will monitor mealtimes at least once weekly to observe implementation of nutritional training objective and provide additional hands training to staff training as necessary to ensure that individuals supported have food offered during the meal that is appropriate to their need.</p> <p>Follow up action as appropriate will ensue for those staff who demonstrate the inability to prepare/serve food consistent with the individuals mealtime needs following the retraining.</p>	11.20.09 Ongoing

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I 045	Continued From page 2 3. On September 15, 2009 at 8:07 a.m. Resident #3 did not appear to have teeth as she seemed to be mashing her chopped eggs and sausage with her gums as she ate her breakfast. Interview with the staff at 8:50 a.m. revealed the client was edentulous and did not wear dentures. There was no evidence the facility ensure the resident's food was offered to her in a form consistent with needs.	I 045		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: The Group Home for Mentally Retarded Person's (GHMRP) failed to ensure the integrity of the physical environment as required by this section and as evidenced below. The findings include: During the environmental inspection on September 16, 2009, at approximately 11:30 a.m., the following deficiencies were identified: 1. Feces found in the toilet in the bathroom in Resident #3 and #4's bedroom. 2. The television in Resident #1's bedroom was inoperable. The unit was able to power on, but was not able to tune into any channels. Staff interviewed on the same day at approximately	I 090	I090 1. Resident #3 and #4's bathroom toilet was cleaned. The restroom was used just prior the individuals leaving for day program and the clean up was inadvertently overlooked. 2. A universal remote was purchased to operate the television and the converter box was hooked up to the television, however there was still no picture. Therefore, cable Client #1's bedroom will be installed. QMRP/Residence Manager will monitor the personal possessions of each individual and follow up in a timely manner on any noted needs that may be delaying its usage or availability for usage.	9.16.09 9.19.09 Ongoing

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I 090	Continued From page 3 2:15 p.m. revealed Resident #1 has been without the use of her TV since March 2009. 3. Several rusted cooking utensils (pots/pans/skillet) found being stored in cabinets in the kitchen. 4. Closet door in Resident #1's bedroom does not slide properly. Hard to slide open and shut. 5. A protruding nail on the front screen door on the main entrance to the facility. 6. A pile up of rubbish (old furniture, old dismembered Christmas tree, and other debris) observed out along the wall of the facility in the back yard.	I 090	3. New pots have been obtained and put into use. The rusted pots have been discarded. 4. The sliding door was repaired on 9.20.09 5. The protruding nail was repaired/hammered in on 9.18.09 6. Bulk trash has removed the old furniture and old Christmas tree pile of debris from the back yard on 9.18.09. The debris was placed there awaiting the arrival of bulk trash pick up during the time of survey. QMRP and Residence Manager will continue to conduct environmental checks weekly, document and follow up in a timely manner and correct findings as necessary.	9.30.09 9.20.09 9.18.09 9.18.09 9.16.09 Ongoing
I 128	3505.4(a)(6) FIRE SAFETY Each GHMRP shall have on the premises the following items: (a) Written policies and procedures that are approved by the Fire Chief, which shall be kept readily accessible to staff and residents and shall include the following: (6) The frequency of fire drills; This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for the Mentally Retarded Person (GHMRP) failed to ensure the creation and proper approval of policies and/or procedures to manage the implementation of fire drills as required by this section to ensure the health and safety of all its residents. (Residents #1, #2, #3, and #4)	I 128	I128 Response on page 5 of 15.	

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I 128	Continued From page 4 The finding includes: Interview with the facility's Qualified Mental Retardation Professional (QMRP) and the Program Director on September 16, 2009 at 2:57 p.m. revealed the "back door" that's documented on the fire drills made available, was actually the door leading from the staff's office out to the back yard. It was not clear why the egress from Resident #3 and #4's bedroom leading to the back yard was not used between the months of April 2009 and August 2009 during fire drills. Further record review by the Program Director revealed there was no evidence in the Policies and Procedures manual that a policy, governing the implementation of fire drills, was ever created or approved by the fire chief. Further interview with the Program Director on the same day at approximately 8:58 p.m. revealed, they did not have a written policy on managing and /or implementing fire drills at this time. (Cross Reference Licensure Citation 3505.5)	I 128	I128 Provider Agency adheres to and provides staff training on the written regulatory requirements of Chapter 35 which includes the frequency of fire drills. The Director of Programs will incorporate those regulations into a manual that is on site and accessible to all staff. The agency will forward the fire safety policies to the fire chief for approval. Cross reference response to I135 with regard to frequency of fire drills.	11.15.09 Ongoing
I 135	3505.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift. This Statute is not met as evidenced by: Based on record review and staff interview, the Group Home for Mentally Retarded Person's (GHMRP) failed to provide evidence of having completed the number of fire drills as required by this section and as evidenced below. The finding includes:	I 135	I135 See response on page 6 of 15.	

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I 135	Continued From page 5 Record review on September 16, 2009 at 10:36 a.m. provided evidence of the following fire drill deficiencies for the period covering 4/2009 to 8/2009: 1. There were no fire drills conducted for the 2:30 p.m. to 11:00 p.m. shift during the months of June 2009 and August 2009. 2. There were no fire drills conducted for the 11:00 p.m. to 9:00 a.m. shift over the weekends between the months of April 2009 and August 2009. 3. The facility failed to utilize all four egress points in conducting their fire drills (front door, back door, office door, and the front door leading from the utility room).	I 135	I135 1 & 2. QMRP/Residence Manager will retrain staff on the importance of conducting fire drills on all shifts and review the fire drills routinely to QA compliance. 3. The point of egress from the facility through the utility room adjacent to the kitchen has never been identified (per fire inspectors) as a point of egress from the facility for use during fire evacuation. As per consultation with and recommendation from the fire inspectors, the utility room will not be included as a point of egress on the evacuation plan. The large exit sign has been removed from above the door.	10.10.09 Ongoing 11.4.09
I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for the Mentally Retarded Person's (GHMRP) failed to ensure all staff received the benefit of having their job descriptions reviewed with them on an annual basis as required by this section for four of twelve staff records reviewed. (QMRP, Staff #6, RN #2, and LPN #1) The finding includes: Interview with the facility's Program Director, Qualified Mental Retardation Professional (QMRP), the Residential Director and record	I 203	I203 The Job Descriptions for QMRP, Staff#6, RN#2 and LPN#1 have been reviewed acknowledged and placed in their personnel files. On an ongoing basis Human Resources Coordinator will audit the personnel records and notify supervisors, staff of expiration dates of applicable required documents prior to expiration. Up to date documents will be maintained in each employee's personnel record.	10.21.09 Ongoing

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I 203	Continued From page 6 review on September 16, 2009 at approximately 8:40 p.m. revealed the QMRP, Staff #6, RN #2, and LPN #1 either did not have a job description on file or did not have a valid/current job description on file.	I 203		
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for the Mentally Retarded Person's (GHMRP) failed to secure copies of a current health certificate to ensure the viability of an employee's health status as required by this section for eight of twenty-two staff records reviewed. (Staff #1, #3, #4, #7, LPN #1, LPN #2, Consultant Psychologist, Physical Therapist) The finding includes: During the entrance conference with the residential director on September 15, 2009 at 10:40 a.m., the facility was requested to provide the current health certificates for all staff and consultants providing services to the clients in the group home. Record review on September 16, 2009 at 10:10 a.m. revealed the health certificate provided for the consultant psychologist and physical therapist	I 206	I206 All staff not in compliance with required health certificates/inventories will be suspended until compliance is met. To monitor compliance on a ongoing basis, Human Resources will develop and implement a training compliance checklist to be utilized by QMRP/Residence Managers and reviewed with staff. All new employees will are required to present a valid health certificate prior to the first day of employment. In conjunction with Health Services and Human Resources a training compliance checklist will be implemented to monitor compliance. All consultants with outstanding health certificates/inventories will not be employed until compliance is made. The QMRP/Residence Manager will review with Human Resources residential staff personnel files quarterly for compliance.	11.15.09 Ongoing

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I 206	Continued From page 7 had expired. Interview with the Qualified Mental Retardation Professional (QMRP) confirmed that current health certificates were not available. Record review on September 16, 2009 at approximately 8:45 p.m. revealed Staff #1, #3, #4, #7, LPN #1, and LPN #2 either did not have a health certificate on file or did not have a valid/current health certificate on file. Interview with the facility's Program Director, Qualified Mental Retardation Professional, and the Residential Director confirmed that current health certificates were not available for Staff #1, #3, #4, #7, LPN #1, and LPN #2.	I 206	I206 Response page 7 of 15.	
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently for three of the four residents in the facility. (Residents #1, #2 and #3) The findings include: 1. Cross refer to federal deficiency report - W104. The Group Home for Mentally Retarded Persons (QMRP) failed to ensure each staff was trained on strategies to minimize the risk of injury to each client when loading the van. 2. Interview with the program director on September 16, 2009 revealed that offsite training was scheduled and held for agency staff. Record	I 222	I222 1. Agency has assessed the current vehicle in use for Client #2 and #3 as well as the other Client's residing at this home and determined that a smaller vehicle with a portable ramp would better suit their needs. New vehicle will be purchased by 12.15.09 in the interim a portable ramp will be purchased for use with the current vehicle and stand by assistance will be provided to all individuals when entering and exiting the vehicle. QMRP/Residence Manager will monitor the individual's ability to enter and exit the vehicle and follow up as appropriate based on assessment of their needs. Staff will be trained by QMRP/Residence Manager on observing, recognizing and communicating concerns to the QMRP/Residence Manager with regard to the individual's abilities exiting and boarding the vehicle	10.20.09 12.15.09 9.19.09 Ongoing 11.9.09 Ongoing

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I 222	Continued From page 8 review 11:05 a.m., however, failed provide evidence that the specific topics covered during these sessions were documented.	I 222	2. Documentation of contract agency staff has been placed on file. QMRP/ Residence Manager will provide site specific training orientation to agency staff prior to deploying them to work with the individuals and maintain documentation of training provided on site at all locations where the agency staff is assigned.	10/3/09 Ongoing
I 226	3510.5(c) STAFF TRAINING Each training program shall include, but not be limited to, the following: (c) Infection control for staff and residents; This Statute is not met as evidenced by: Based on observation and interview, the facility failed to provide an active program for the prevention, control of infection and communicable diseases, for three of four residents in the facility. (Resident #1, Resident #2 and Resident #3) The findings include: 1. During medication administration observation on September 15, 2009, at approximately 7:08 a.m., LPN #1 was observed to wash her hands with soap and water in the kitchen sink prior to administrating medications. However LPN#1 than unlocked the medication lock, touched the medication cabinet door, touched the Medication Administration Records (MAR's) and then touched the rim of the medication cup as she provided Resident #2 with physically assistance in pushing medications from the bubble pack. In an interview with LPN #1 on September 15, 2009, at approximately 7:45 a.m., it was acknowledged after washing her hands with soap and water she unlocked the medication lock, touched the medication cabinet door, touched the MAR's and then touched the rim of the medication cup as she provided Resident #2 with	I 226		

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I 226	<p>Continued From page 9</p> <p>physical assistance in pushing medications from the bubble pack.</p> <p>There is no evidence that the facility's nursing staff provided an active program for the prevention and control of infection.</p> <p>2. During medication administration observation on September 15, 2009, at approximately 7:25 a.m., LPN #1 was observed to wash her hands with soap and water in the kitchen sink prior to administrating medications. However LPN#1 touched the medication cabinet door, touched the MAR's and then used her bare hands to break Resident #1's Calcium w/Vit D 600 mg/400 tablet into two pieces.</p> <p>In an interview with LPN #1 on September 15, 2009, at approximately 7:46 a.m., it was acknowledged after washing her hands with soap and water in the kitchen sink she touched the medication cabinet door, touched the MAR's and then used her bare hands to break Resident #1's Calcium w/Vit D 600 mg/400 tablet into two pieces.</p> <p>There is no evidence that the facility's nursing staff provided an active program for the prevention and control of infection.</p> <p>3. During medication administration observation on September 15, 2009, at approximately 7:35 a.m., LPN #1 was observed to use hand sanitizer to cleanse her hands prior to administrating medications. However LPN#1 touched the desk in the office, touched the Medication MAR's and then touched the rim of the medication cup as she provided Resident #3 with physical assistance in pushing medications from the bubble pack.</p>	I 226	15.	

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I 226	Continued From page 10 In an interview with LPN #1 on September 15, 2009, at approximately 7:47 a.m., it was acknowledged after cleaning her hands with hand sanitizer she touched the desk in the office, touched the MAR's and then touched the rim of the medication cup as she provided Resident #3 with physical assistance in pushing medications from the bubble pack. There is no evidence that the facility's nursing staff provided an active program for the prevention and control of infection.	I 226		
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans; This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for the Mentally Retarded Person's (GHMRP) failed to secure copies of a current first aid or CPR certificate from its staff as required by this section for seven of twelve staff records reviewed. (QMRP, RD, Staff #1, #3, LPN #1, LPN #2 and RN #2) The finding includes: During the entrance conference on September 15, 2009 at 10:10 a.m., staff training records were requested to be provided for review by the surveyors.	I 227	I227 Evidence of CPR/First Aid training compliance as applicable for identified staff have been filed in their personnel records. On an ongoing basis Program Development/Human Resources Coordinator will monitor compliance with training requirements and notify supervisors, staff of expiration dates of applicable required documents prior to expiration. Up to date documents will be maintained in each employee's personnel record.	10.21.09 Ongoing

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I 227	Continued From page 11 Interview with the facility's Program Director, Qualified Mental Retardation Professional, the Residential Director and record review on September 16, 2009 at approximately 8:28 p.m. revealed the QMRP, RD, Staff #1, #3, LPN #1, LPN #2 and RN #2 either did not have a CPR or First Aid certificate and/or did not have a valid/current CPR or First Aid certificate on file. Record review on September 16, 2009 at approximately 8:37 p.m. revealed that the evidence of CPR and first aid certification was not available for each of the required employees.	I 227	I227 See response on page 11 of 15.	
I 230	3510.5(g) STAFF TRAINING Each training program shall include, but not be limited to, the following: (g) Habilitation planning and implementation; This Statute is not met as evidenced by: Based on observation, interview, and record review, the GHMRP failed to ensure nursing staff were effectively trained in providing habilitation services for one of four residents in the sample. (Resident #4) The finding includes: During the medication pass observation on September 15, 2009 at approximately 7:35 a.m., Resident #3 was observed to punch out the medications on the correct date from the medication card and take the medications with three (3) verbal prompts and physical assistance. Review of Resident #3's Individual Program Plan (IPP) dated September 2009 on September 15,	I 230	I230 See response on mage 13 of 15.	

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I 230	Continued From page 12 2009 at approximately 8:45 a.m., revealed a goal to improve self medication skills including the following objectives "go to bathroom to wash hands, go into kitchen get cup with water and applesauce if necessary, bring cup of water and applesauce to nursing station, sit in nursing chair, take medication with applesauce if necessary, drink water and walk and take items to kitchen". Further review revealed Resident #3's level of participation was to be documented on the data collection sheet as follows: (I) Independently; (V.P.) Verbal Prompts; (P.P.) Physical Prompts and (R) Refused. Review of the September, 2009, data on September 15, 2009 at approximately 9:00 a.m., revealed the nursing staff did not document Resident #3's level of participation on September 8-9 and September 13, 2009 and August 1, 7-9, 13, 15 and 31, 2009. In an interview with the Registered Nurse (RN), on August 19, 2009, at approximately 9:15 a.m., it was acknowledged the nursing staff did not document Resident #3's level of participation on the aforementioned dates. There was no evidence the data had been collected in accordance with the IPP.	I 230	I230 Facility RN will train LPN's and TMEs on proper implementation of medication goals by 11.15.09. Delegating RN will review medication goal sheet weekly for accuracy and consistent documentation, routinely reassess the individuals self medication skills and in conjunction with QMRP, monitor implementation during medication administration to ensure accurate implementation and revise/modify based on assessment of needs. Retraining will be provided as deemed necessary based on monitoring and observation. The Director of Health Services will randomly review, observe implementation of the self medication program and documentation for quality assurance.	11.15.09 Ongoing
I 436	3521.7(f) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (f) Health care (including skills related to nutrition, use and self-administration of medication, first aid, care and use of prosthetic and orthotic devices, preventive health care, and safety); This Statute is not met as evidenced by:	I 436		

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I 436	<p>Continued From page 13</p> <p>Based on observations, interviews and the review of records, the facility failed to implement an effective system to ensure that each resident participated in a self-medication training program, for two of the four residents in the facility. (Resident #3 and Resident #4)</p> <p>The findings include:</p> <p>1. Observation of the medication administration on September 15, 2008 at 7:35 a.m. revealed the Licensed Practical Nurse #1(LPN #1) went into the kitchen and then poured water into a cup on the dining room table and placed the cup of water and held Resident #3's hand. Further observation revealed LPN #1 provided Resident #3 with one (1) physical prompt to punch Calcium w/Vit D 600mg/400, Levothyroxine Sodium 125 mg and Taztia XT 180mg tablets from the bubble pack. Interview with LPN #1 on September 15, 2009 at approximately 8:05 a.m., revealed Resident #3 had fully participated in her self-medication program. Review of Resident #3's Individual Program Plan (IPP) dated September 2009 on September 15, 2009 at approximately 9:05 a.m., revealed a goal to improve self medication skills. Further review indicated Resident #3's self-medication program was as follows:</p> <p>a. Go to bathroom and wash hands; b. Go into kitchen get cup with water and applesauce if necessary; c. Bring cup of water and applesauce to nursing station; d. Sit in nursing chair; e. Punch pills (nurse will provide assistance as needed); f. Take medication with applesauce if necessary; g. Drink water and h. Walk and take items to the kitchen.</p>	I 436	<p>I436 Reference response to I230.</p>	

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I 436	Continued From page 14 There was no evidence that the resident was given the opportunity to fully participate in the self- medication program. 2. Observation of the medication administration on September 15, 2008 at 7:40 a.m. revealed LPN #1 went into the kitchen and then poured water into a cup on the dining room table and placed the cup of water in Resident #4's hand. Further observation revealed LPN #1 provided Resident #4 with one (1) physical prompt to punch Calcium w/Vit D 600mg/400, Therapeutic Vitamins w/minerals and Tyzeka F/C 600mg tablets from the bubble pack. Interview with LPN #1 on September 15, 2009 at approximately 8:07a.m., revealed Resident #4 had fully participated in her self-medication program. Review of Resident #4's IPP dated September 2009 on September 15, 2009 at approximately 9:05 a.m., revealed a goal to improve self medication skills. Further review indicated Resident #4's self- medication program was as follows: a. Go to bathroom and wash hands; b. Go into kitchen and get cup of water; c. Take medication basket out; d. Sit in nursing chair; e. Punch pills (nurse will provide assistance as needed); f. Take medication; g. Drink water and h. Walk and take cup to kitchen. There was no evidence that the resident was given the opportunity to fully participate in the self- medication program.	I 436		