

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

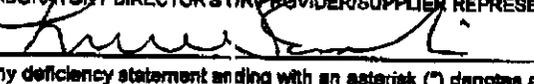
PRINTED: 01/31/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G230	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/08/2012
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NAME OF PROVIDER OR SUPPLIER DC HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 25 MADISON STREET NE WASHINGTON, DC 20011
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W 000	INITIAL COMMENTS A recertification survey was conducted from January 5, 2012 through January 6, 2012. A sample of three clients was selected from a population of six men with varying degrees of intellectual disabilities. This survey was initiated utilizing the fundamental process. The findings of the survey were based on observations in the home and at two day programs, interview with one client's guardian, interviews with staff at the home and at the two day programs, as well as a review of client and administrative records, including incident reports.	W 000		
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that outside services meet the needs of each client, for one of the three clients in the sample. (Client #2) The finding includes: On January 5, 2011, at 11:41 a.m., Client #2 was observed identifying coins. At 11:48 p.m., Client #2 walked to the bookshelf and retrieved a book. At 12:01 p.m., Client #2 walked into the cafeteria with the day program staff. One minute later, the client began to eat a turkey sandwich without washing or sanitizing his hands first. Interview with the day program individual program plan coordinator, at approximately 12:45 p.m.,	W 120	<p>Received 2/10/12</p> <p>Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002</p> <p>Q.I.D.P contacted the case manager of client # 2's Day Program who stated that per the protocol, every individual must wash or sanitize hands 5 minutes before and after meals. The universal precautions policy includes washing after using the rest room. This was shared with the Day Program case manager via phone on 01/09/12. Q.I.D.P met with Day Program on 02/07/12 and discussed the finding and ongoing implementation of protocol. Q.I.D.P will complete random monthly visits to Day Program to ensure completion and continued implementation. (See Attachment #1)</p>	01/09/12 02/07/12

LABORATORY DIRECTOR'S (OR PROVIDER/SUPPLIER REPRESENTATIVE'S) SIGNATURE 	TITLE Program manager	(X6) DATE 2/10/12
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 120	Continued From page 1 revealed that Client #2's activity schedule includes washing his hands five minutes before lunch.	W 120		
W 124	<p>There was no evidence that proper infection control procedures were implemented at the day program.</p> <p>483.420(a)(2) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the rights of each client and their legal guardian to be informed of the client's medical condition, attendant risks of treatment, and the right to refuse treatment, for one of the three clients in the sample. [Client #3]</p> <p>The finding includes:</p> <p>[Cross-ref to W322] Client #3 was edentulous and his diet orders included pureed foods and the use of Thick-It for liquids. On January 6, 2012, beginning at 10:00 a.m., review of the client's medical records revealed he had been uncooperative during a Modified Barium Study (MBS) on September 21, 2011. The facility's consulting speech/language pathologist (SLP) had recommended the MBS back on November</p>	W 124	<p>In-Service training was completed by Program Manager with Q.I.D.P on 02/01/12 on the importance and requirement of notifying guardians of recommendations status changes, etc and documenting ongoing communication in QIDP progress notes. Program Manager will monitor Q.I.D.P monthly for 3 months to ensure ongoing compliance.</p> <p>(See Attachment #2)</p>	02-01-12

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W 124	<p>Continued From page 2</p> <p>8, 2009 "to determine his risk of aspiration" after she determined the client showed "moderate dysphagia."</p> <p>On January 6, 2012, beginning at 10:26 a.m., interview with the facility's qualified intellectual disabilities professional (QIDP) and the Program Manager (PM), coupled with review of Client #3's records, revealed the client's guardian was informed in September 2011 that the MBS procedure had not been completed due to the client's refusal to cooperate. The QIDP and PM then indicated that Client #3's primary care physician (PCP) had decided against pursuing another MBS partly because the potential risks outweighed the potential benefits. In addition, the hospital's radiologist reportedly advised against using pre-sedation and the hospital SLP said she did not think another MBS was possible (due to the client's behavior).</p> <p>Further interview revealed that the QIDP was responsible for communicating with clients' guardians. When asked about the decision not to attempt another MBS, the QIDP stated that he had not spoken with Client #3's guardian since he first informed her that the September 21, 2011 procedure had been unsuccessful. He and the PM further acknowledged that, to date, the facility had not informed the guardian of the PCP's and other medical professionals' opinions and/or recommendations regarding pursuing another MBS in the future.</p> <p>On January 6, 2012, at 4:00 p.m., Client #3's guardian returned a telephone message left earlier that day. She confirmed that, to date, the facility had not informed her of the PCP's and</p>	W 124		
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W 124	Continued From page 3 other medical professionals' opinions and/or recommendations regarding pursuing another MBS in the future.	W 124		
W 125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to allow and encourage clients and their legal guardians to exercise their rights regarding individual finances, for six of the six residents in the facility. (Clients #1, #2, #3, #4, #5 and #6)</p> <p>The findings include:</p> <p>Review of Client # 1's financial records on January 6, 2011, beginning at 12:49 p.m., revealed several withdrawals were noted to come from his personal account. Review of the facility's corresponding financial tracking record that documented a breakdown of how the client's funds were spent revealed that a portion of a cable bill was paid by the client between the months of February 2011 through December 2011. Closer review of Client #1's financial record revealed the following information regarding how cable bills had been paid by the six clients living in the facility:</p>	W 125	<p>Cable was cancelled on 01/12/12. Credit for converter boxes and late fees \$113.15 to be refunded from comcast and deposited equally to individual's accounts. New digital TV was purchased by DHCH for the living room on 01/10/12. Q.I.D.P and IDT's are determining cable and TV needs on an individual basis with guardian notification and involvement in determining expenses and details. Program Manager will monitor to ensure compliance.</p> <p>(See Attachment #3a, #3b)</p>	1/10/12

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W 125	<p>Continued From page 4</p> <p>February 4, 2011- Cable bill \$203.82. The bill was equally divided; each of the clients paid \$33.97 from their personal account.</p> <p>March 11, 2011- Cable bill \$40.04. Clients #1, #2, #4, and #5 each paid \$6.67, while Clients #3 and #6 paid \$6.68.</p> <p>April 7, 2011- Cable bill \$50.56. Clients #1, #3, #4 and #5 each paid \$8.43, while Clients #2 and #6 paid \$8.42.</p> <p>June 23, 2011- Cable bill \$50.00. Clients #2, #4, #5, and #6 paid \$8.30, while Clients #1 and #3 paid \$8.40.</p> <p>July 29, 2011- Cable bill \$50.51. Clients #3, #5 and #6 paid \$12.63, while Client #1 paid \$12.62.</p> <p>August 11, 2011- Cable bill \$90.00. The bill was equally divided by six (each paid \$15.00).</p> <p>September 22, 2011- Cable bill \$50.00. Clients #1, #2, #4 and #5 paid \$8.33, while Clients #3 and #6 paid \$8.34.</p> <p>October 1, 2011- Cable bill \$60.00. The bill was equally divided by six (each paid \$10.00).</p> <p>November 16, 2011- Cable bill \$60.00. The bill was equally divided by six (each paid \$10.00) from their personal account.</p> <p>December 13, 2011- Cable bill \$87.77. Client #5 paid \$14.82 and the remaining five clients paid \$14.63.</p> <p>1. Interview with the qualified intellectual disabilities professional (QIDP) on January 6, 2012, beginning at 1:10 p.m., and review of an actual cable bill dated October 1, 2011, revealed the facility's cable account was in Client #5's name. When further queried, the QIDP revealed that Client #5 had a legal guardian and the guardian was unaware that the account was in his name. Review of Client #5's psychological assessment dated January 3, 2011, at 3:40 p.m.,</p>	W 125		
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W 125	<p>Continued From page 5</p> <p>revealed the client "...does not display the capacity to make decisions on his own behalf regarding ...financial matters."</p> <p>2. The October 1, 2011 bill reflected a \$5.95 late fee and a \$3.95 reactivation fee had been assessed to the account. The QIDP and the program manager both stated that the facility managed the six clients' funds, and the QIDP handled bill-paying responsibilities. Review of Client #1's records indicated that the six clients (none of whom were deemed to have the capacity to make financial decisions) had paid for the penalty fees.</p> <p>3. During the survey, the cable bill dated October 1, 2011 was the only billing statement made available for review. However, on January 12, 2011 (post-survey), the facility submitted to the State agency, via email, three additional cable bills (March 1, 2011, December 1, 2011 and January 1, 2012). Review of the three cable bills revealed that each month, the account had incurred a \$5.95 late fee. As with the October 1, 2011 billing, Client #1's records showed that the six clients routinely paid for these penalties, even though the facility managed the account.</p> <p>4. Client #1's records reflected that on July 29, 2011, he and Clients #3, #5 and #6 paid the bill. Clients #1 and #4 did not contribute.</p> <p>5. On January 6, 2012, further review of the October 1, 2011 cable bill, at approximately 1:10 p.m., revealed that the clients were charged for 7 digital converter boxes, at a cost of \$2.95 each. Post-survey review of another bill (dated March 1, 2011) revealed that the clients had been charged</p>	W 125		
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W 125 Continued From page 6

the same fee that month for 7 digital converter boxes. However, during an environmental inspection of the facility on January 6, 2012, none of the clients' individual televisions had digital converter boxes attached. The sole television with a converter box was situated in the facility's living room.

It should be noted that during the January 6, 2012 environmental inspection, at 1:56 p.m., it was observed that Clients #1 and #2 did not have televisions in their bedrooms. Client #4's television was broken. Clients #3, #5 and #6 all had televisions; however, none of them worked. When turned on, the televisions showed a screen message indicating that a digital converter was needed to receive a signal. When the QIDP was asked about the aforementioned finding, he acknowledged that the televisions required digital converters to operate. He further indicated that the clients did not have the converter boxes because they were very expensive.

[Note: The survey team was unable to determine whether digital converter fees (and/or penalty charges) had been charged the other eight months in 2011 because the applicable cable bills were not available for review.]

At the time of the survey, the facility failed to provide evidence that Client #5's guardian was aware that the cable bill/account was in his name. Additionally, the facility failed to ensure each client and/or their legal guardians were fully aware of how their personal finances were being remitted for payment of the cable bill, including digital converter box charges, late fees and reactivation fees.

W 125

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W 154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENT'S</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to thoroughly investigate an allegation, for one of the three clients in the sample. (Client #2)</p> <p>The finding includes:</p> <p>On January 6, 2012, at 10:14 a.m., review of a day program progress note, dated November 15, 2011, revealed that the qualified intellectual disabilities professional (QIDP) went to the day program to meet with the day program's incident manager to discuss an incident that was alleged to have occurred on October 20, 2011.</p> <p>The QIDP was interviewed for clarification, on January 3, 2012, beginning at 1:40 p.m. He stated that he inadvertently learned of the alleged incident (inappropriate touching) from another source in November 2011, after the fact. The QIDP said he received a copy of the day program incident report during his visit on November 15, 2011. At 1:41 p.m., review of the actual incident report revealed that on October 20, 2011, another individual at the day program alleged that Client #2 "touched me" while pointing to his genital area. Client #2 reportedly denied the accusation when asked about it by day program case manager and social worker.</p> <p>On January 6, 2012, at 2:03 p.m., continued interview with the QIDP revealed that upon</p>	W 154	<p>i. Q.I.D.P received in-service on 02-06-12 from Incident Management Coordinator to ensure that all incidents are to be investigated thoroughly and brought to conclusion. IMC to monitor during monthly/quarterly tracking.</p> <p>ii (See Attachment #4)</p> <p>A case conference was held on 02-08-12 attended by Day Program Staff, Q.I.D.P and Service Coordinator. The incident was an isolated event that did not require intervention. Ongoing supports will be provided to monitor for any further incidents.</p> <p>(See Attachment #5)</p>	02-06-12	2-8-12

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W 154	Continued From page 8 learning of the allegation, he went to the day program on November 15, 2011 to discuss the incident with the day program incident management coordinator (IMC). The IMC, however was not on duty. The QIDP acknowledged that since November 15, 2011, no meeting had been held and no further actions had been taken. Record review on January 6, 2012, at 2:18 p.m., confirmed that the allegation of Client #2's inappropriate touching of another individual at his day program had not been thoroughly investigated by the facility.	W 154		
W 192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that all staff were effectively trained (i.e. demonstrated the skills and competencies needed) on diet textures, for one of the three clients in the sample. (Client #3) The finding includes: On January 5, 2012, at 7:41 a.m., Client #3 was observed carrying his plate from the breakfast table towards the kitchen. There was uneaten, ground meat on the plate. When asked if his foods were always prepared to a ground texture, the house manager replied "his foods are pureed." A moment later, the qualified Intellectual	W 192	The Q.I.D.P and the Program Manager in-serviced staff on 02-09-12 by emphasizing the importance of implementing all recommendations made for all clients. Client # 3's eating protocol and diet texture was reviewed. Q.I.D.P and House Manager will monitor on a daily basis that Client #3 receives his food in pureed form, and that staff implement at all times. (See Attachment #6)	02-09-12

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W 192	Continued From page 9 disabling professional (QIDP) looked at the meat left on the plate, stated that it was of a "ground" texture and continued, saying "it is supposed to be pureed... should be more liquid." The QIDP retrieved the menu and stated that the meat served that morning was turkey. The direct support staff who prepared breakfast (Staff #2) confirmed this. On January 5, 2012, at approximately 4:15 p.m., review of Client #3's speech-language records revealed an Eating Protocol, dated February 9, 2011, that prescribed a pureed food texture. On January 5, 2012, at 9:24 a.m., review of the client's physician's order sheets for January 2012 also confirmed a diet order for pureed foods, as the client was edentulous. On January 6, 2012, at approximately 12:00 p.m., review of the staff in-service training records revealed that all staff had received training for Client #3's Eating Protocol and Diet Textures on October 15, 2011. Observations on January 5, 2012, however, indicated that the training had not been effective.	W 192			
W 193	483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on observations, staff interview and record verification, the facility's staff failed to demonstrate the skills and techniques necessary to implement each client's behavior support plan (BSP), for one of the three clients in the sample.	W 193			

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W 193	Continued From page 10 (Client #3) The findings include: 1. [Cross-refer to W249.2] On January 5, 2012, facility staff failed to implement intervention strategies that were outlined in Client #3's behavior support plan (BSP), at 7:25 a.m. and at 5:33 p.m. 2. [Cross-refer to W252] On January 6, 2012, beginning at 8:32 a.m., review of Client #3's behavior data sheets revealed that facility staff failed to document observed incidents of self-hitting on the day before (at 7:25 a.m. and 5:33 p.m.). Staff also failed to document when the client left the table during his dinner on January 5, 2012 (at 6:15 p.m.), in accordance with his BSP. On January 8, 2012, at 7:46 a.m., review of the staff in-service training records revealed that all staff had received training for Client #3's BSP on October 15, 2011. Observations on January 5, 2012, however, indicated that the training had not been effective.	W 193	1. Staff received in-service training on 02-09-12 from Q.I.D.P and Program Manager on 02/09/12 on the implementation and documenting of the BSP. Detailed training and discussion included the importance of implementing the BSP as written at all times when a behavior is exhibited by Client #3. Staff should document as required and implement the BSP. Q.I.D.P will monitor the BSP implementation and documentation weekly to ensure that BSP and data is being implemented and documented consistently. Program Manager to monitor monthly.	02-09-12	
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation and interview, facility staff failed to ensure client choice during snack, for six of the six clients residing at the facility. (Clients #1, #2, #3, #4, #5, and #6)	W 247	(See Attachment #7)		

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W 247 Continued From page 11

The finding includes:

On January 5, 2012, at 5:03 p.m., observations during snack revealed a direct support staff verbally assisting Client #2 to pour water for himself and Client #1, #3, #4, #5, and #6. At no time during snack, did the staff offer different beverages to drink.

Interview with the qualified intellectual disabilities professional (QIDP) on January 6, 2012 at approximately 4:30 p.m., revealed that the clients should have been offered a choice for beverage.

At the time of the survey, the facility's staff failed to consistently allow clients to exercise their independence and allow options of choice.

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 review, the facility failed to ensure continuous active treatment, for one of the three clients in the sample. (Client #3)

The findings include:

W 247

Program Manager in-serviced staff on ensuring that Clients have the opportunity to make choices throughout the day. Discussed verbal and non-verbal communication and use of gestures. Snack and activities were focused on for training. Q.I.D.P, Program Manager will monitor on daily basis/weekly basis. (See Attachment #8)

02-09-12

W 249

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W 249	<p>Continued From page 12</p> <p>1. Facility staff failed to implement Client #3's "Communication" program when presented the opportunity, as evidenced by the following:</p> <p>On January 5, 2012, at 4:51 p.m., Client #3 entered the facility and went to his bedroom. He left his bedroom at 5:00 p.m., walked to the living room and then went into the kitchen, where he stood and watched a direct support staff interacting with Client #4. At the same time, Client #2 was observed pouring water into six beverage glasses at the dining room table. At 5:04 p.m., Client #3 left the kitchen, sat at the dining room table and began eating a snack (pudding).</p> <p>Client #3 was observed seated on the living room sofa from 5:40 p.m. until 6:11 p.m. His dinner plate and beverage glass (water) were observed on the table at 6:10 p.m. At 6:11 p.m., he and his peers came to the dining room for dinner.</p> <p>On January 6, 2012, at 10:00 a.m., review of a summary report for the period Sept./Oct./Nov. 2011 (dated December 9, 2011), written by the qualified intellectual disabilities professional (QIDP), revealed Client #3 had the following formal "Communication" training program: "<client's name> will touch Go Talk button to access the speech a need or desire (sic) with 50% independence by the end of the..." year. The program instructed staff to show him the buttons on the Go Talk device, place his hands on it, and ask him "which one do you need or want." After the client pushed a button, staff should repeat to enforce his message then respond to his request."</p>	W 249	<p>1. An in-service training was held on 02-07-12 to discuss the communication needs of Client#3 and use of the "Go Talk Device " Staff to implement the program daily as stated during natural event timing. QIDP, House Manager and Program Manager to monitor daily and monthly for ongoing implementation (See Attachment #9:)</p>	02-07-12
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W 249	<p>Continued From page 13</p> <p>On January 6, 2012, at 12:13 p.m., the house manager (HM) demonstrated how to use the Go Talk device (located in the kitchen/ dining room area). The device had two buttons: one with a picture of a toilet and another with a picture of a beverage glass. She stated that staff using hand-over-hand assistance, were to push the button with the picture of a glass, when the client wants something to drink. Staff would then say "drink" and assist him with getting a drink. Further interview with the HM revealed that a direct support staff person told her Client #3 had refused to participate with her on the previous day. Staff, however, had not been observed interacting with Client #3 at or near the Go Talk device during the afternoon/ evening observations.</p> <p>Staff was not observed implementing Client #3's "Communication" program when presented with the opportunity, at 5:04 p.m. and 6:11 p.m. on January 5, 2012.</p> <p>2. Facility staff failed to implement behavior intervention methods prescribed in Client #3's behavior support plan (BSP), as evidenced by the following:</p> <p>a. On January 5, 2011, at 7:25 a.m., Staff #1 assisted Client #3 into the nurse area to receive medications. Immediately upon sitting in a chair, the client hit himself on the head, using moderate force with his right hand. The client repeated the gesture every 5 - 10 seconds, for almost two minutes. He also hit his right thigh with his fist a few times. Each time he hit his head, a dull 'clunk' sound was audible to this surveyor,</p>	W 249	<p>2. In-service training conducted on 02-09-12 to review Client#3's BSP. Staff must ensure to redirect the client whenever head/chin hitting is observed and to follow the strategies spelled out in the BSP. The Q.I.D.P will continually monitor for targeted events, implementation and documentation daily. (See Attachment #7)</p>	02-09-12
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W 249	<p>Continued From page 14</p> <p>standing approximately two feet away. Neither the medication nurse nor Staff #1 intervened during the two minutes of self-hitting.</p> <p>b. On January 5, 2011, at 5:33 p.m., Staff #2 assisted Client #3 into the nurse area to receive medications. Immediately upon sitting in a chair, the client hit himself three times on the chin, lightly. Staff #2, who was standing nearby and witnessed his chin-hitting behavior, did not respond.</p> <p>On January 5, 2012, beginning at 1:52 p.m., review of Client #3's BSP, dated November 14, 2011, revealed the following: "<client's name> frequently hits his head and chin... the self-hitting is light and does not appear to hurt..." At 2:11 p.m., continued review of the BSP revealed the following intervention strategy: "Whenever <client's name> hits his head say 'No <client's name>, do not hit your head (or chin).' If he continues to hit his head or chin lightly ignore him. Do not talk about his behavior. If he hits his head or chin with force, say '<client's name>, do not hit your head (or chin).' Guide <client's name> hands to his lap where they should remain for two minutes."</p> <p>Staff did not respond to Client #3's head/ chin hitting behavior in the manner prescribed in his BSP, when the behavior was observed on January 5, 2012, at 7:25 a.m. and 5:33 p.m.</p> <p>3. Facility staff failed to implement Client #3's "Eating Protocol" when presented the opportunity, as evidenced by the following:</p> <p>On January 5, 2012, beginning at 6:11 p.m.,</p>	W 249	<p>3. In-service training was conducted 02-09-12 to re-emphasize and review the importance of following the clients eating protocol during all meals /snacks. The protocol</p>	02-09-12	

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W 249	Continued From page 15 Client #3 was observed eating dinner. He independently ate approximately six or seven spoonfuls of pureed roast beef sandwich. He then took two spoonfuls of pureed peaches. He returned to the main course, eating several more spoonfuls before he stood up at 6:15 p.m. and left the dining table. Client #3 subsequently ignored several attempts to coax him back to the table. At 6:23 p.m., a direct support staff covered the dinner plate, stating that it would be offered to Client #3 later. On January 5, 2012, at approximately 4:15 p.m., review of Client #3's speech-language records revealed an Eating Protocol, dated February 9, 2011, that included the following: "Staff should provide verbal prompts to alternate liquids/solids." Staff was not observed providing verbal prompts for him to alternate between liquids and pureed foods when presented the opportunity at dinner on January 5, 2012.	W 249	must be followed and implemented. The Q.I.D.P and/or House Manager will observe and monitor at least one meal daily for 3 months to ensure ongoing implementation of eating protocol. (See Attachment #6)	1/6/12 and 2/9/12	
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observation, interview and record review, facility staff failed to document behavior data in accordance with the behavior support plan (BSP), for one of the three clients in the sample. (Client #3) The findings include:	W 252			

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W 252	<p>Continued From page 18</p> <p>1. [Cross-refer to W249.2] On January 5, 2011, at 7:25 a.m., Client #3 hit himself on the head, using moderate force with his right hand, repeatedly for almost two minutes. The morning medication nurse and Staff #1 were with him at the time. Later that day, at 5:33 p.m., the client hit himself three times on the chin, lightly, while the evening nurse prepared his medications and Staff #2 looked on.</p> <p>On January 5, 2012, beginning at 1:52 p.m., review of Client #3's BSP, dated November 14, 2011, revealed that hitting himself on the head or chin is one of his targeted maladaptive behaviors. On January 6, 2012, beginning at 8:32 a.m., review of the client's behavior data sheets, revealed that neither Staff #1 nor Staff #2 had documented the incidents of self-hitting observed on January 5, 2012.</p> <p>When interviewed on January 6, 2012, at 7:35 a.m., Staff #1 indicated that he had received training on Client #3's BSP. When asked about his target behaviors, Staff #1 said he "hits his chest." When asked if he sometimes hit other body parts, the staff replied "no, just the chest." When asked if Client #3 had hit himself on the day before, Staff #1 replied "no, yesterday was a good day." Further interview revealed that each episode should be documented on a behavior data sheet.</p> <p>2. On January 5, 2012, beginning at 6:11 p.m., Client #3 was observed eating dinner. At 6:15 p.m., he stood up and left the dining table. Much of his meal remained uneaten on the plate. He ignored several attempts by staff to coax him</p>	W 252	<p>1. Staff received in-service training on</p> <p>2. 02/07/12 from Q.I.D.P and Program Manager on implementing and documenting BSP. Detailed training and discussion was made. Staff were reminded on the importance of implementing the BSP strategies as written and that when a behavior is exhibited by Client #3. Staff should document as required. Q.I.D.P will monitor the BSP implementation and documentation weekly to ensure that BSP and data is being implemented and documented consistently. (See Attachment #7)</p>	02-07-12

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W 252	Continued From page 17 back to the table during the eight minutes that followed. At 6:23 p.m., a direct support staff covered the dinner plate, stating that his meal would be offered to him again later. On January 5, 2012, beginning at 1:52 p.m., review of Client #3's BSP, dated November 14, 2011, revealed that "Leaving the Table During Mealtime" was a targeted maladaptive behavior. Staff were instructed to document each episode of the behavior on the designated behavior data sheet. On January 6, 2012, at approximately 8:45 a.m., review of the client's behavior data sheets, revealed that the incident of his leaving the dinner table on the previous evening had not been documented in accordance with the BSP. It should be noted that review of Client #3's behavior data sheets for the period December 1, 2011 through January 5, 2012 revealed the only information that was documented had been recorded by staff assigned to work on the evening shift.	W 252			
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that restrictive measures had been reviewed and/or approved by the Human Rights Committee (HRC), for one of the three	W 262			

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W 262	Continued From page 18 clients in the sample. (Client #3) The finding includes: On January 5, 2012, at 10:15 a.m., review of Client #1's incident report dated June 2, 2011, revealed Client #3 was taken to the emergency room one hour after being sedated for a Dexa-Scan appointment. Review of Client #3's medical administration record on January 6, 2012, at approximately 9:00 a.m., confirmed that the client received a Lytic cocktail on June 2, 2011, at 10:00 a.m. The cocktail consisted of Demero 50 mg, Thorazine 25 mg and Phenergan 20 mg. Interview with the qualified intellectual disabilities professional (QIDP) on January 6, 2012, at 12:00 p.m., indicated that the HRC discussed the client's sedation during their August 2011 meeting. However, there was no evidence that the HRC approved Client #3's sedation prior to the June 2, 2011 administration of the lytic cocktail. The facility failed to evidence that the HRC approved Client #3's sedation prior to his Dexa Scan appointment.	W 262	In-service training was completed by the Program Manager on 02-08-12. Q.I.D.P. must ensure that all consent for sedation and approval from H.R.C be noted in the HRC minutes. If date falls between HRC meeting dates, the "Consent for pre-sedation" form must be completed and filed. Program Manager will monitor monthly. (See Att #10a and Att #10b)	
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W 340	483.460(c)(5)(i) NURSING SERVICES Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods.	W 340		
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W 340	<p>Continued From page 19</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility's nursing staff failed to show evidence that medication nurses had been trained on procedures for administering crushed medications, to ensure clients' health and safety, for three of the six clients residing in the facility. (Clients #1, #3 and #6)</p> <p>The finding includes:</p> <p>On January 5, 2012, at 7:15 a.m., the medication nurse informed this surveyor that she would crush Client #1's medications, as she was reaching for a ceramic mortar and pestle. A white powdery substance was observed on the inside of the mortar and pestle. The nurse placed a 25 mg tablet of Hydroxyzine HCL into the mortar and pestle, followed by a Calcium with Vitamin D supplement tablet and a Multi-Vitamin supplement tablet. After crushing these together, she stirred the powdered mixture into three small plastic medication cups and administered Client #1's medications.</p> <p>At 7:20 a.m., the nurse began preparing Client #6's medications. She placed an OsCal tablet (500mg Calcium with 600mg Vitamin D) into the mortar and pestle without first wiping it clean. She then added a 200 mg tablet of Carbamazepine, crushed the two tablets and stirred the crushed medications into apple sauce in two small plastic medication cups. At 7:23 a.m., Client #6 took his medications and then left the room.</p> <p>At 7:26 a.m., the nurse began preparing Client #3's medications. She placed a 1/2 tablet of</p>	W 340	<p>An In-service was conducted by D.O.N nurses on 01/09/12 to ensure that the procedure for administering crushed medication is followed. Nursing standards renewed to utilize the metal pill-crushing device with paper souffle cups or if pestle is used, it must be wiped thoroughly before crushing the next set of pills. Review of dispensing and administering meds discussed. The RN will conduct supervision during med administration monthly to ensure that all procedures are properly followed. (See Attachment #11)</p>	01-09-12
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W 340	<p>Continued From page 20</p> <p>Metoclopramide HCL (25 mg) into the mortar and pestle without first wiping it clean. She then added Calcium with Vitamin D supplement tablet and a Multi-Vitamin with Iron supplement tablet and crushed the three tablets. The nurse was then observed to stir the crushed medications into apple sauce in three small plastic medication cups. A moment later, she retrieved Phenobarbital from a locked box, crushed a 60 mg tablet and stirred it into apple sauce in another medication cup. She administered his medications in apple sauce at 7:31 a.m.</p> <p>The Nursing Director (ND) was interviewed by telephone on January 6, 2012, beginning at 10:05 a.m. When informed that the medication nurse had not wiped the mortar and pestle before each use, the ND expressed surprise that the nurse had not utilized a metal pill-crushing device, with paper scuffle cups, to ensure there was no medication residue remaining after each use. At 11:11 a.m., the facility's program manager stated that the ND typically would observe the medication nurses during administration passes.</p> <p>There was no evidence that the medication nurses had received training appropriate to meet the safety and hygiene needs of clients who were administered crushed medications.</p>	W 340			
W 369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>This STANDARD is not met as evidenced by: Based on observation and record review, the</p>	W 369			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G230	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/06/2012
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NAME OF PROVIDER OR SUPPLIER DC HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 25 MADISON STREET NE WASHINGTON, DC 20011
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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W 369 Continued From page 21
facility failed to ensure that all drugs were administered without error, for one of the six clients residing in the facility. (Client #5)

The finding includes:

The morning medication administration was observed on January 5, 2012, between 6:49 a.m. - 7:40 a.m. At approximately 9:40 a.m., while verifying the administered medications, it was revealed that Client #5 was prescribed "Refresh P.M. 42.5-57.3% ointment. Apply to the left eye twice daily for lubrication." The eye ointment was not administered on the morning of January 5, 2012. Concurrent review of Client #5's January 2012 medication administration record (MAR) revealed the nurse had initialed the MAR, indicating the medication was given.

Note: This surveyor returned to the facility at 7:19 a.m. on January 6, 2012, to interview the medication nurse. The nurse, however, had already administered the clients' medications and left the facility.

W 369

In-service training by DON was conducted with nurses on 01/09/12 to ensure that all medications/drugs/treatments are administered as ordered at all times. RN will monitor medication administration at least 1x per month.
(Attachment #11)

1-9-12

W 426 483.470(d)(3) CLIENT BATHROOMS

The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.

This STANDARD is not met as evidenced by:
Based on observation and interview, the facility failed to ensure that the temperature of the water did not exceed 110 degrees Fahrenheit, for six of six clients residing in the facility. (Clients #1, #2,

W 426

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

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W 426	<p>Continued From page 22 #3, #4, #5 and #6)</p> <p>The finding includes:</p> <p>On January 6, 2012, at 1:19 p.m., this surveyor noted that the hot water temperature felt very warm to touch at the hand sinks in the two bathrooms located off the hallway, in the bedroom area. Upon immediately checking the temperatures of the hot water in the aforementioned bathrooms, they measured 124 degrees Fahrenheit and 125 degrees Fahrenheit. The administrative office was immediately notified of the hot water temperature.</p> <p>Interview with staff on January 6, 2011, at 1:23 p.m., revealed that the hot water temperatures should not exceed 110 degrees Fahrenheit. Staff further indicated that the hot water temperatures had not been observed to exceed 110 degrees Fahrenheit. On January 6, 2012, at approximately 1:35 p.m., the maintenance supervisor, who was present during the observation, stated that he would adjust the water temperature to ensure that it did not exceed 110 degrees.</p> <p>On January 6, 2012, at 2:47 p.m. and again at 4:45 p.m., the temperatures were observed to measure 120 and 122 degrees Fahrenheit at the aforementioned bathroom hand sinks. The facility was then requested to develop a plan to ensure the individuals' safety when washing their hands at the hand sinks. At 5:30 p.m., however, the water temperatures still measured 120 degrees Fahrenheit. At 6:23 p.m., the facility's program manager submitted a written plan, via email, which identified measures to ensure the</p>	W 426	<p>All staff received in-service training by Program Manager to ensure that the water temperature does not exceed 110 at all times in all locations. Reviewed procedure to notify upon any elevated temperature findings. A corrective action plan was immediately put into place. The plumber corrected the problem on 01-06-12. The water temperatures were brought to normal. D.O.H. inspector who visited the facility on 01-09-12 tested water temp and did not exceed 110 degrees. Testing of water temperatures are being completed at all locations of running water and documented on every shift. Q.I.D.P and House Manager to monitor daily to ensure the temperature does not exceed 110 degrees. Program Manager to monitor monthly. (Attachments #12a, #12b, #12c)</p>	1-6-12	

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W 426	Continued From page 23 Individuals' safety during hand washing while using the bathroom sinks. The plan also revealed that a plumber was scheduled to be onsite during the evening of January 6, 2012 to address the problem with the water temperatures. At the time of the survey, however, there was no evidence that the facility had ensured that the temperature of the water did not exceed 110 degrees Fahrenheit at all times.	W 426			
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, staff interview and record review, the facility failed to ensure all clients received their meals in the form and consistency prescribed, for one of the three clients in the sample. (Client #3) The finding includes: On January 5, 2012, at 7:41 a.m., Client #3 was observed carrying his plate from the breakfast table towards the kitchen. There was uneaten, ground meat on the plate. When asked if his foods were always prepared to a ground texture, the house manager replied "his foods are pureed." A moment later, the qualified intellectual disabilities professional (QIDP) looked at the meat left on the plate, stated that it was of a "ground" texture and continued, saying "it is supposed to be pureed... should be more liquid." The QIDP retrieved the menu and stated that the meat served that morning was turkey. The direct support staff who prepared breakfast (Staff #2)	W 474	An In-Service was completed on 02/09/12 by The Q.I.D.P and the Program Manager to review and discuss the importance of implementing all recommendations at all times for all clients. Client # 3's eating protocol and diet texture was reviewed. Q.I.D.P and House Manager will monitor on a daily basis that Client #3 receives his food in pureed form, and that staff implement at all times. Program Manager to monitor monthly. (Attachment #6)	1-6-12 and 2-9-12	

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W 474	<p>Continued From page 24 confirmed this.</p> <p>On January 5, 2012, at approximately 4:15 p.m., review of Client #3's speech-language records revealed an Eating Protocol, dated February 9, 2011, that prescribed a pureed food texture. On January 5, 2012, at 9:24 a.m., review of the client's physician's order sheets for January 2012 also confirmed a diet order for pureed foods, as the client was edentulous.</p> <p>There was no evidence the facility ensured that Client #3 received his food in a pureed texture at all times, as prescribed.</p>	W 474			

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1 000 INITIAL COMMENTS

A licensure survey was conducted from January 5, 2012 through January 6, 2012. A sample of three residents was selected from a population of six men with varying degrees of intellectual disabilities.

The findings of the survey were based on observations in the home and at two day programs, interview with one resident's guardian, interviews with staff in the home and at the two day programs, as well as a review of resident and administrative records, including incident reports.

It should be noted that on January 5, 2012, at 1:19 p.m., the hot water temperature was measured at 124 and 125 degrees Fahrenheit in two hand sinks. An immediate adjustment was made to the thermostat of one of the facility's two hot water heaters. At 5:30 p.m., however, the water still measured at 120 degrees Fahrenheit. At 6:23 p.m., the facility's program manager submitted a written plan, via email, for ensuring client safety while they awaited the arrival of a plumber later that evening.

A State agency surveyor returned to the facility on January 9, 2012, at 8:15 a.m. The program manager stated that a plumber had come and made further adjustments. Readings taken at the same two locations showed the hot water now measured 110 degrees Fahrenheit.

1 090 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.

Health Regulation & Licensing Administration

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



TITLE
Program Manager (X5) DATE 2/10/12

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1090	Continued From page 1 This Statute is not met as evidenced by: Based on observation and interview, the group home for persons with intellectual disabilities (GHPID) failed to ensure the interior of the facility was maintained in a safe and orderly manner to meet the needs of six of six residents in the GHPID. Residents #1, #2, #3, #4, #5 and #6) The findings include: On January 6, 2012, beginning at 12:45 p.m., the program manager and the maintenance supervisor accompanied this surveyor during observations of the environment. The following concerns were identified: 1. The GHPID failed to ensure that the temperature of the water did not exceed 110 degrees Fahrenheit. On January 6, 2012, at 1:19 p.m., the surveyor noted that the hot water temperature felt very warm to touch at the hand sinks in the two bathrooms located off the hallway in the bedroom area. Upon immediately checking the temperatures of the hot water in the aforementioned bathrooms during this time, they measured 124 degrees Fahrenheit and 125 degrees Fahrenheit. The administrative office was immediately notified of the hot water temperature. Interview with the staff on January 6, 2011, at 1:23 p.m., revealed that the hot water temperatures should not exceed 110 degrees Fahrenheit. Staff further indicated that the hot water temperatures had not been observed to exceed 110 degrees Fahrenheit. On January 6,	1090	All staff received in-service training by Program Manager to ensure that the water temperature does not exceed 110 at all times in all locations. Reviewed procedure to notify upon any elevated temperature findings. A corrective action plan was immediately put into place. The plumber corrected the problem on 01-06-12. The water temperature was brought to normal. D.O.H. inspector who visited the facility on 01-09-12 tested water temp and did not exceed 110 degrees. Testing of water temperatures are being completed at all locations of running water and documented on every shift. Q.I.D.P and House Manager to monitor daily to ensure the temperature does not exceed 110 degrees. Program Manager to monitor monthly. (Attachments #12a, #12b, #12c)	01-06-12

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1090	Continued From page 3 4. Observation of Resident #4's television revealed that it did not come on when connected to the electrical power source. Interview with the staff revealed that the television was broken. 5. Observation of the televisions located in the bedrooms of Resident's #3, #5 and #6 revealed they were not operable. Interview with the qualified intellectual disabilities professional (QIDP) revealed the televisions were not operable because they required cable converter boxes. When turned on, the screen on each television showed a message which stated that a converter box was required to view the television. 6. The lid on the trash can used to store recycleable items had a torn area. The lid was warped causing it to not close securely on the can.	1090	4. The broken TV was removed on 1-6-12. A new digital TV was bought for client #4 on 2-8-12. 5. TV's were removed on 1-6-12. New digital TV was purchased on 2-8-12 for client # 3 (client # 5, #6 N/A) 6. A new Recycle Bin was requested from DC Govt.	01-06-12 and 02-08-12 02-09-12
1229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on observation, staff interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that staff received effective training on residents' behavior support plans and prescribed dietary textures, for one of the three residents in the sample. (Resident #3)	1229		

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I 229	Continued From page 5 confirmed this. On January 5, 2012, at approximately 4:15 p.m., review of Resident #3's speech-language records revealed an Eating Protocol, dated February 9, 2011, that prescribed a pureed food texture. On January 6, 2012, at 9:24 a.m., review of the resident's physician's order sheets for January 2012 also confirmed a diet order for pureed foods, as the resident was edentulous. On January 6, 2012, at approximately 12:00 p.m., review of the staff in-service training records revealed that all staff had received training for Resident #3's Eating Protocol and Diet Textures on October 15, 2011. Observations on January 5, 2012, however, indicated that the training had not been effective.	I 229		
I 405	3520.7 PROFESSIONAL SERVICES: GENERAL PROVISIONS Professional services shall be provided by programs operated by the GHMRP or personnel employed by the GHMRP or by arrangements between the GHMRP and other service providers, including both public and private agencies and individual practitioners. This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure professional services had been provided in accordance with each resident's needs, for one of the three residents included in the sample. (Resident #2) The finding includes:	I 405		

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I 405	Continued From page 6 On January 5, 2011, at 11:41 a.m., Resident #2 was observed identifying coins. At 11:48 p.m., Resident #2 walked to the bookshelf and retrieved a book. At 12:01 p.m., Resident #2 walked into the cafeteria with the day program staff. One minute later, the resident began to eat a turkey sandwich without washing or sanitizing his hands. Interview with the day program individual program plan coordinator, at approximately 12:45 p.m., revealed that Resident #2's activity schedule includes washing his hands five minutes before lunch. There was no evidence that proper infection control procedures were implemented at the day program.	I 405	Q.I.D.P contacted the case manager of client # 2's Day Program who stated that per the protocol, every individual must wash or sanitize hands 5 minutes before and after meals. The universal precautions policy includes washing after using the rest room. This was shared with the Day Program case manager via phone on 01/09/12. Q.I.D.P met with Day Program on 02/07/12 and discussed the finding and ongoing implementation of protocol. Q.I.D.P will complete random monthly visits to Day Program to ensure completion and continued implementation. (See Attachment #1)	01/09/12
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, facility staff failed to implement training programs and behavior support plans in accordance with residents' Individual Support Plans, for one of the three residents in the sample. (Resident #3) The findings include: 1. Facility staff failed to implement Resident #3's "Communication" program when presented the opportunity, as evidenced by the following: On January 5, 2012, at 4:51 p.m., Resident #3 entered the facility and went to his bedroom. He left his bedroom at 5:00 p.m., walked to the living	I 422		

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I 422	<p>Continued From page 7</p> <p>room and then went into the kitchen, where he stood and watched a direct support staff interacting with Resident #4. At the same time, Resident #2 was observed pouring water into six beverage glasses at the dining room table. At 5:04 p.m., Resident #3 left the kitchen, sat at the dining room table and began eating a snack (pudding).</p> <p>Resident #3 was observed seated on the living room sofa from 5:40 p.m. until 6:11 p.m. His dinner plate and beverage glass (water) were observed on the table at 6:10 p.m. At 6:11 p.m., he and his peers came to the dining room for dinner.</p> <p>On January 6, 2012, at 10:00 a.m., review of a summary report for the period Sept./Oct./Nov. 2011 (dated December 9, 2011), written by the qualified intellectual disabilities professional (QIDP), revealed Resident #3 had the following formal "Communication" training program: "<resident's name> will touch Go Talk button to access the speech a need or desire (sic) with 50% independence by the end of the..." year. The program instructed staff to show him the buttons on the Go Talk device, place his hands on it, and ask him "which one do you need or want." After the resident pushed a button, staff should "repeat to enforce his message then respond to his request."</p> <p>On January 6, 2012, at 12:13 p.m., the house manager (HM) demonstrated how to use the Go Talk device (located in the kitchen/ dining room area). The device had two buttons: one with a picture of a toilet and another with a picture of a beverage glass. She stated that staff using hand-over-hand assistance, were to push the button with the picture of a glass, when the</p>	I 422	<p>1. An in-service training was held on 02-07-12 to discuss the communication needs of Client#3 of using a "Go Talk Device " Staff to implement the program daily as stated during natural event timing.</p> <p>QIDP, House Manager and Program Manager to monitor daily and monthly for ongoing implementation.</p> <p>(See Attachment #9)</p>	02-07-12

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1422	<p>Continue from page 8</p> <p>resident wants something to drink. Staff would then say "drink" and assist him with getting a drink. Further interview with the HM revealed that a direct support staff person told her Resident #3 had refused to participate with her on the previous day. Staff, however, had not been observed interacting with Resident #3 at or near the Go Talk device during the afternoon/ evening observations.</p> <p>Staff was not observed implementing Resident #3's "Communication" program when presented with the opportunity, at 5:04 p.m. and 6:11 p.m. on January 5, 2012.</p> <p>2. Facility staff failed to implement behavior intervention methods prescribed in Resident #3's behavior support plan (BSP), as evidenced by the following:</p> <p>a. On January 5, 2011, at 7:25 a.m., Staff #1 led Resident #3 into the nurse area to receive medications. Immediately upon sitting in a chair, the resident hit himself on the head, using moderate force with his right hand. The resident repeated the gesture every 5 - 10 seconds, for almost two minutes. He also hit his right thigh with his fist a few times. Each time he hit his head, a dull 'clunk' sound was audible to this surveyor, standing approximately two feet away. Neither the medication nurse nor Staff #1 intervened during the two minutes of self-hitting.</p> <p>b. On January 5, 2011, at 5:33 p.m., Staff #2 led Resident #3 into the nurse area to receive medications. Immediately upon sitting in a chair, the resident hit himself three times on the chin, lightly. Staff #2, who was standing nearby and witnessed his chin-hitting behavior, did not respond.</p>	1422	<p>2. Staff received in-service training on 02-09-12 from Q.I.D.P and Program Manager on 02/09/12 on the implementation and documenting of the BSP. Detailed training and discussion included the importance of implementing the BSP as written at all times when a behavior is exhibited by Client #3. Staff should document as required and implement the BSP. Q.I.D.P will monitor the BSP implementation and documentation weekly to ensure that BSP and data is being implemented and documented consistently. Program Manager to monitor monthly. (See Attachment #7)</p>	02-09-12

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NAME OF PROVIDER OR SUPPLIER DC HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 25 MADISON STREET NE WASHINGTON, DC 20011		
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1422	<p>Continued From page 9</p> <p>On January 5, 2012, beginning at 1:52 p.m., review of Resident #3's BSP, dated November 14, 2011, revealed the following: "<resident's name> frequently hits his head and chin... the self-hitting is light and does not appear to hurt..."</p> <p>At 2:11 p.m., continued review of the BSP revealed the following intervention strategy: "Whenever <resident's name> hits his head say 'No <resident's name>, do not hit your head (or chin).' If he continues to hit his head or chin lightly ignore him. Do not talk about his behavior. If he hits his head or chin with force, say '<resident's name>, do not hit your head (or chin).' Guide <resident's name> hands to his lap where they should remain for two minutes..."</p> <p>Staff did not respond to Resident #3's head/ chin hitting behavior in the manner prescribed in his BSP, when the behavior was observed on January 5, 2012, at 7:25 a.m. and 5:33 p.m.</p> <p>3. Facility staff failed to implement Resident #3's "Eating Protocol" when presented the opportunity, as evidenced by the following:</p> <p>On January 5, 2012, beginning at 6:11 p.m., Resident #3 was observed eating dinner. He independently ate approximately six or seven spoonfuls of pureed roast beef sandwich. He then took two spoonfuls of pureed peaches. He returned to the main course, eating several more spoonfuls before he stood up at 6:15 p.m. and left the dining table. Resident #3 subsequently ignored several attempts to coax him back to the table. At 3:23 p.m., a direct support staff covered the dinner plate, stating that it would be offered to Resident #3 later.</p> <p>On January 5, 2012, at approximately 4:15 p.m.,</p>	1422	<p>3. In-service training was conducted 02-09-12 re-emphasize to the staff the importance of following the clients eating protocol during all meals /snacks. The protocol must be followed and implemented. The Q.I.D.P and/or House Manager will observe monitor at least one meal daily for 3 months to ensure ongoing implementation of eating protocol. (See Attachment #6)</p>	02-09-12

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NAME OF PROVIDER OR SUPPLIER DC HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 25 MADISON STREET NE WASHINGTON, DC 20011		
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I 422	Continued From page 10 review of Resident #3's speech-language records revealed an Eating Protocol, dated February 9, 2011, that included the following: "Staff should provide verbal prompts to alternate liquids/solids." Staff was not observed providing verbal prompts for him to alternate between liquids and pureed foods when presented the opportunity at dinner on January 5, 2012.	I 422			
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observations, interviews and record review, the group home for persons with intellectual disabilities (GHPID) failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and federal regulations 42 CFR 483 Sub-Part 1 (for Intermediate Care Facilities for Persons with Mental Retardation), for six of the six residents of the facility. (Residents #1, #2, #3, #4, #5 and #6) The findings include: 1. [§483.420(a)(2) and 483.460(a)(3)] The GHPID failed to ensure the rights of Resident #3 and his legal guardian to be informed of the resident's medical condition, attendant risks of treatment, and the right to refuse treatment, as follows:	I 500	1. In-Service training was completed by Program Manager with Q.I.D.P on 02/01/12 on the importance and requirement of notifying guardians of recommendations, status changes, etc and documenting ongoing communication in QIDP Progress Notes. Program Manager will monitor Q.I.D.P monthly for 3 months to ensure ongoing compliance. (See Attachment #2)	02-01-12	

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I 500	<p>Continued From page 11</p> <p>[Cross-refer to Federal Deficiency Report - Citation 1N322]</p> <p>Resident #3 was edentulous and his diet orders included pureed foods and the use of Thick-It for liquids. On January 6, 2012, beginning at 10:00 a.m., review of the resident's medical records revealed he had been uncooperative during a Modified Barium Study (MBS) on September 21, 2011. The facility's consulting speech/language pathologist (SLP) had recommended the MBS back on November 8, 2009 "to determine his risk of aspiration" after she determined the resident showed "moderate dysphagia."</p> <p>On January 6, 2012, beginning at 10:26 a.m., interview with the facility's qualified intellectual disabilities professional (QIDP) and the Program Manager (PM), coupled with review of Resident #3's records, revealed the resident's guardian had been informed in September 2011 that the MBS procedure had not been completed due to the resident's refusal to cooperate. The QIDP and PM then indicated that Resident #3's primary care physician (PCP) had decided against pursuing another MBS partly because the potential risks outweighed the potential benefits. In addition, the hospital's radiologist reportedly advised against using pre-sedation and the hospital SLP said she did not think another MBS was possible (due to the resident's behavior).</p> <p>Further interview revealed that the QIDP was responsible for communicating with residents' guardians. When asked about the decision not to attempt another MBS, the QIDP stated that he had not spoken with Resident #3's guardian since he first informed her that the September 21, 2011 procedure had been unsuccessful. He and the PM further acknowledged that, to date, the facility had not informed the guardian of the PCP's and</p>	I 500		

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I 500	<p>Continued From page 12</p> <p>other medical professionals' opinions and/or recommendations regarding pursuing another MBS in the future.</p> <p>On January 6, 2012, at 4:00 p.m., Resident #3's guardian returned a telephone message left earlier that day. She confirmed that, to date, the facility had not informed her of the PCP's and other medical professionals' opinions and/or recommendations regarding pursuing another MBS in the future.</p> <p>2. [§483.420(a)(3)] The GHPID failed to observe and protect the financial rights of the six residents, as follows:</p> <p>Review of Resident # 1's financial records on January 6, 2011, beginning at 12:49 p.m., revealed several withdrawals were noted to come from his personal account. Review of the facility's corresponding financial tracking record that documented a breakdown of how the resident's funds were spent revealed that a portion of a cable bill was paid by the resident between the months of February 2011 through December 2011. Closer review of Resident #1's financial record revealed the following information regarding how cable bills had been paid by the six residents living in the facility:</p> <p>February 4, 2011- Cable bill \$203.82. The bill was equally divided; each of the residents paid \$33.97 from their personal account.</p> <p>March 18, 2011- Cable bill \$40.04. Residents #1, #2, #4, and #5 each paid \$6.67, while Residents #3 and #6 paid \$6.68.</p> <p>April 7, 2011- Cable bill \$50.56. Residents #1, #3, #4 and #5 each paid \$8.43, while Residents #2 and #6 paid \$8.42.</p> <p>June 23, 2011- Cable bill \$50.00. Residents #2,</p>	I 500		

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NAME OF PROVIDER OR SUPPLIER DC HEALTH CARE!		STREET ADDRESS, CITY, STATE, ZIP CODE 25 MADISON STREET NE WASHINGTON, DC 20011		
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I 500	<p>Continued From page 13</p> <p>#4, #5, and #6 paid \$8.30, while Residents #1 and #3 paid \$8.40.</p> <p>July 29, 2011- Cable bill \$50.51. Residents #3, #5 and #6 paid \$12.63, while Resident #1 paid \$12.62.</p> <p>August 11, 2011- Cable bill \$90.00. The bill was equally divided by six (each paid \$15.00).</p> <p>September 22, 2011- Cable bill \$50.00. Residents #1, #2, #4 and #5 paid \$8.33, while Residents #3 and #6 paid \$8.34.</p> <p>October 9, 2011- Cable bill \$60.00. The bill was equally divided by six (each paid \$10.00).</p> <p>November 16, 2011- Cable bill \$60.00. The bill was equally divided by six (each paid \$10.00) from the r personal account.</p> <p>December 13, 2011- Cable bill \$87.77. Resident #5 paid \$14.62 and the remaining five residents paid \$14.63.</p> <p>1. Interview with the qualified intellectual disabilities professional (QIDP) on January 6, 2012, beginning at 1:10 p.m., and review of an actual cable bill dated October 1, 2011, revealed the facility's cable account was in Resident #5's name. When further queried, the QIDP revealed that Resident #5 had a legal guardian and the guardian was unaware that the account was in his name. Review of Resident #5's psychological assessment dated January 3, 2011, at 3:40 p.m., revealed the resident "...does not display the capacity to make decisions on his own behalf regarding ...financial matters."</p> <p>2. The October 1, 2011 bill reflected a \$5.95 late fee and a \$3.95 reactivation fee had been assessed to the account. The QIDP and the program manager both stated that the facility managed the six residents' funds, and the QIDP handled bill-paying responsibilities. Review of Resident #1's records indicated that the six</p>	I 500		

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1500	<p>Continued From page 14</p> <p>residents (none of whom were deemed to have the capacity to make financial decisions) had paid for the penalty fees.</p> <p>3. During the survey, the cable bill dated October 1, 2011 was the only billing statement made available for review. However, on January 12, 2011 (post-survey), the facility submitted to the State agency, via email, three additional cable bills (March 1, 2011, December 1, 2011 and January 1, 2012). Review of the three cable bills revealed that each month, the account had incurred a \$5.95 late fee. As with the October 1, 2011 billing, Resident #1's records showed that the six residents routinely paid for these penalties, even though the facility managed the account.</p> <p>4. Resident #1's records reflected that on July 29, 2011, he and Residents #3, #5 and #6 paid the bill. Residents #1 and #4 did not contribute.</p> <p>5. On January 6, 2012, further review of the October 1, 2011 cable bill, at approximately 1:10 p.m., revealed that the residents were charged for 7 digital converter boxes, at a cost of \$2.95 each. Post-survey review of another bill (dated March 1, 2011) revealed that the residents had been charged the same fee that month for 7 digital converter boxes. However, during an environmental inspection of the facility on January 6, 2012, none of the residents' individual televisions had digital converter boxes attached. The sole television with a converter box was situated in the facility's living room.</p> <p>It should be noted that during the January 6, 2012 environmental inspection, at 1:56 p.m., it was observed that Residents #1 and #2 did not have televisions in their bedrooms. Resident #4's</p>	1500		

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1500	Continued From page 15 television was broken. Residents #3, #5 and #6 all had televisions; however, none of them worked. When turned on, the televisions showed a screen message indicating that a digital converter was needed to receive a signal. When the QIDP was asked about the aforementioned finding, he acknowledged that the televisions required digital converters to operate. He further indicated that the residents did not have the converter boxes because they were very expensive. [Note: The survey team was unable to determine whether digital converter fees (and/or penalty charges) had been charged the other eight months in 2011 because the applicable cable bills were not available for review.] At the time of the survey, the facility failed to provide evidence that Resident #5's guardian was aware that the cable bill/account was in his name. Additionally, the facility failed to ensure each resident and/or their legal guardians were fully aware of how their personal finances were being remitted for payment of the cable bill, including digital converter box charges, late fees and reactivation fees.	1500	In-service training conducted on 01-06-12 with QIDP and staff. Reviewed individual's legal rights with regards to finances. Notification, discussion and agreement must be completed with legal guardian and documented. Program Manager to monitor monthly for ongoing compliance (Please also refer to POC, W125, P.4 of 25) (See Attachment #14)	01-16-12