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

PRINTED: 06/25/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G152		06/18/2009

NAME OF PROVIDER OR SUPPLIER: COMP CARE I I

STREET ADDRESS, CITY, STATE, ZIP CODE: 1000 NEWTON STREET NE, WASHINGTON, DC 20019

(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
W 000	INITIAL COMMENTS A recertification survey was conducted from June 17, 2009, through June 18, 2009, using the fundamental survey process. A random sample of two clients was selected from a residential population of three women with mental retardation and other disabilities. The survey findings were based on observations in the group home and at two day programs, interviews, and a review of clinical and administrative records, including unusual incident reports.	W 000	Reviewed 4/1/09 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
W 112	483.410(c)(2) CLIENT RECORDS The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to keep confidential information contained in each client's record, for three of the three clients residing in the facility. (Clients #1, #2 and #3) The finding includes: On June 17, 2009, at 3:00 p.m., a chart was observed posted openly on the refrigerator door in the kitchen. Review of the chart revealed that it included each client's full name and a listing of her prescribed diet. For example, Client #1 was prescribed an 1800 calorie, low fat, low cholesterol diet. The other two clients also had specially prescribed diets. This practice failed to ensure the confidentiality of the clients' personal information. On June 19, 2009, at 3:25 p.m., the House	W 112	**W 112** **All postings related to clients' personal information have been taken off the refrigerator door. Staff will be trained on issues of confidentiality, dignity and respect.**	07/15/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Delma Martin | TITLE: Adm. Asst. | (X6) DATE: 7/7/09

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

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W 112	Continued From page 1 Manager acknowledged that the chart posted in the kitchen contained confidential information re: prescribed diets.	W 112		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all injuries of unknown origin were reported immediately to the administrator and other officials according to District of Columbia Regulations (22 DCMR, Chapter 35, Section 3519.10) for one of the three clients residing in the facility. (Client #1) The finding includes: During the entrance conference on June 17, 2009, at approximately 2:45 p.m., the house manager indicated that there was one incident where Client #1 was taken to the emergency room due to limping at the day program. Review of the unusual incident report (UIR) record book on the same day, at approximately 3:30 p.m., failed to show evidence that a corresponding UIR had been generated. On June 18, 2009, however, at approximately 8:55 a.m., review of the client's medical record revealed that an incident report had been prepared on April 24, 2009. The UIR reflected that the client was taken to the emergency room (ER) after she returned	W 153	**W 153** **Staff will be trained on incident management policies and procedures. All incident reports shall be faxed to the administrative office for review prior to faxing to the state agencies to ensure that all concerned parties are informed, and evidence demonstrated on the incident reports.**	07/15/09

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W 153	Continued From page 2 home that afternoon. She was released that same day with a diagnosis of contusion to the left knee. Interview with the nurse at the day program on June 18, 2009, at approximately 11:10 a.m., revealed that on April 24, 2009, Client #1 had been observed limping. Staff told the nurse that the client had not fallen there at the day program. When the nurse telephoned the group home, reportedly she was told that the client had not fallen in the home either. When interviewed on June 18, 2009, at approximately 1:00 p.m., the Qualified Mental Retardation Professional stated that he had informed the administrator after the client came home from the ER with the diagnosis of "contusion," which signified that there had been an injury. Review of the UIR, however, failed to show evidence that the administrator and state agency had been notified immediately of the injury.	W 153		
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, interview and record review, the facility failed to ensure that each client's dietary texture needs and active treatment programs were coordinated and monitored by the Qualified Mental Retardation Professional (QMRP), for one of the two clients in the sample. (Client #2)	W 159		

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W 159	Continued From page 3 The findings include: 1. Cross-refer to W474. The QMRP failed to seek clarification from the medical team regarding Client #2's prescribed dietary texture. On June 18, 2009, staff were observed giving Client #2 foods that were cut into bite-sized pieces at her breakfast and at lunch. At 1:39 p.m., review of her June 2009 POs (and POs as far back as September 2008) revealed diet orders as follows: "Finely chopped meat and food." The order was consistent with recommendations made by the nutritionist in her April 2008 and April 2009 Annual Assessments. The order was not, however, consistent with recommendations made by the Client #2's speech/language pathologist following an August 26, 2008 barium swallow study. The speech/language pathologist had updated the client's Mealtime Guidelines in October 2008, to reflect: "Food Texture: Mechanical soft low chew chopped diet texture consistency. Foods are cut into small pieces about size of a pea or cheerio)." At approximately 2:25 p.m., the Qualified Mental Retardation Professional (QMRP) stated that Client #2's foods should be "finely chopped... like ground beef hamburger... not bite size." Both the QMRP and the House Manager stated that chopped was smaller than bite-size, and finely chopped was even smaller ("like ground beef, hamburger"). Prior to June 18, 2009, however, the QMRP had not identified the discrepancy between the primary care physician's dietary orders and the texture recommended by the speech/language pathologist.	W 159	**W 159.1** **The speech and language pathologist has been notified of the discrepancy in the diet texture and will make the necessary correction.** **The Qualified Mental Retardation Professional (QMRP) will on a monthly basis review and compare all assessments to ensure consistency in recommendations.**	07/15/09

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W 159	Continued From page 4 2. Cross-refer to W249.2. The QMRP failed to ensure that staff encouraged Client #2 to alternate between food bites and beverage sips during meals, in accordance with her Mealtime Guidelines (MG, dated October, 2008) and Health Management Care Plan (HMCP, dated March 28, 2009). 3. Cross-refer to W340. The QMRP failed to ensure that the facility's nursing staff implemented Client #2's self-medication training program during every medication pass, to include mornings. 4. Cross-refer to W249.4. The QMRP failed to ensure that staff implemented Client #2's community inclusion goals to dress appropriately for church and to attend church on Sundays.	W 159	**W 159.2** **The speech and language pathologist will in-service staff on clients' mealtime guidelines.** **Once weekly, the QMRP and the HM will monitor staff during meal service to ensure adherence with the mealtime guidelines.** **W 159.3** **Cross reference W340** **W 159.4** **Cross reference W249.4**	07/15/09
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 observations, staff interviews and record review, the facility failed to implement a system that provided an opportunity for clients' choices and self management, for three of the three clients residing in the facility. (Clients #1, #2, and #3) The findings include: 1. On June 17, 2009, at approximately 3:05 p.m., Clients #1, #2 and #3 were observed having snacks. Staff presented Clients #1 and #2 with an individual serving of fat-free chocolate	W 247		

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W 247	Continued From page 5 pudding. Staff gave Client #3 4 vanilla wafers and apple juice. At no time during this observation were the clients encouraged to identify their preferences or to communicate their choices. Staff had presented only one food item to each client. 2. On June 18, 2009, at 7:26 a.m., Client #3 was observed clearing her place setting from the dining room table, after finishing her breakfast. She had not, however, eaten any of the grapefruit segments that staff had given to her that morning. A direct support staff person was asked in the kitchen about Client #3's decision to discard the grapefruit. The staff replied "she don't eat this." A moment later, the same staff was asked for clarification and she repeated that the client did not like grapefruit. Staff, however, were not observed to offer the client a fruit substitute. Later that day, at 3:24 p.m., the house manager stated that staff were expected to offer clients an appropriate substitute if/when it was known (or discovered) that the client did not like a particular food item.	W 247	**W 247.1** **The nutritionist will on a quarterly basis in-service staff on providing choices during meals. The QMRP and HM will on a monthly basis conduct random monitoring of staff on issues of choice, diet type and texture.** **W 247.2** **The nutritionist will on a quarterly basis in-service staff on food substitutes. Food substitutes shall be documented monthly and reviewed by the nutritionist quarterly. The QMRP and HM will on a monthly basis conduct random monitoring of staff on the provision and tracking of food substitutes.**	07/15/09
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 interviews and record	W 249		07/15/09

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W 249	Continued From page 6 review, facility staff failed to ensure implementation of clients' training programs and mealtime protocol, for one of the two clients in the sample. (Client #2) The findings include: 1. Facility staff failed to allow or encourage Client #2 to eat foods and beverages independently, in accordance with her Mealtime Guidelines (MG, dated October, 2008) and Individual Support Plan (ISP, dated April 6, 2009), as follows: a. On June 17, 2009, at 3:08 p.m., Client #2 was observed in the facility's living room being spoon fed pudding by the house manager. b. On June 18, 2009, Client #2 was observed at breakfast, beginning at 7:16 a.m. The client held her teaspoon in her left hand and began eating raisin bran cereal. A direct support staff person sitting next to her took hold of her hand and tried directing her movements. The client, however, resisted and kept moving her hand away from the staff. After this continued for approximately two minutes, another staff person assisting at breakfast informed the staff that Client #2 preferred to feed herself. At 7:26 a.m., the client was observed feeding herself independently. The staff then provided her with minimal physical support and verbal direction through the remainder of her meal. c. Later on June 18, 2009, at 11:56 a.m., Client #2 was observed in the facility eating pudding. A staff person seated next to her was observed spoon feeding her pudding. This was followed by lunch a short time later (between 12:11 p.m. - 12:24 p.m.). Instead of allowing the client to eat	W 249	**W 249.1(a, b, c)** **The speech and language pathologist will in-service staff on the implementation of the mealtime guidelines for client #2. The in-service will put emphasis on the need for staff to refrain from spoon feeding any of the clients.** **The House Manager (HM) will on a weekly basis monitor staff during meals to ensure compliance.**	07/15/09

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W 249	Continued From page 7 her peanut butter and jelly sandwich independently, the same staff person stuck a fork into pieces of the sandwich, which had been cut bite-size, and fed the client. On June 18, 2009, at 1:33 p.m., review of the client's Mealtime Guidelines (MG) revealed that she was able to eat "independently after set-up with close staff supervision." The client's ISP also stated that she was assessed as being capable of eating independently with staff supervision and minimal assistance. 2. Facility staff failed to encourage Client #2 to alternate between food bites and beverage sips, in accordance with her Mealtime Guidelines (MG, dated October, 2008), and Health Management Care Plan (HMCP, dated March 28, 2009) as follows: During the June 18, 2009 breakfast, Client #2 was observed eating her foods independently and/or with verbal guidance from staff. At 7:32 a.m., staff placed the client's bowl and plate to the side after she finished her cereal, toast with jelly and grapefruit. Staff then moved three beverage glasses closer to her and instructed her to drink. She drank orange juice, then water and finished the meal by drinking Ensure nutritional supplement. On June 18, 2009, at 1:33 p.m., review of the client's MG revealed that staff should "encourage single sips of beverage throughout the meal and after meal is finished." The client's HMCP also said to "alternate food and liquid during meals." Staff, however, had not encouraged her to alternate between food and beverages throughout her breakfast.	W 249	**W 249.2** **Cross reference W249.1 (a, b, c)**	

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W 249	Continued From page 8	W 249		
	3. Cross-refer to W340. The facility failed to ensure that Client #2's self-medication objective was implemented at each medication pass.		**W 249.3** **Cross reference W340**	
	4. Facility staff failed to implement Client #2's community inclusion goal to attend church on Sundays, as follows: On June 18, 2009, at 3:09 p.m., review of Client #2's Individual Program Plan (dated April 6, 2009) revealed the following community inclusion goal (Goal #2): "I will go to church on Sundays" with direct care staff. She had a related goal: "I will dress appropriately for church." Neither goal, however, had been implemented since her team included it in her updated annual plan in April 2009. At approximately 3:12 p.m., interview with the house manager revealed that the client only went to church "once in a while" due to behavioral concerns. She confirmed that Client #2 had not been to church recently. The Qualified Mental Retardation Professional (QMRP) was present at the time. He concurred with the house manager, saying that Client #2's behaviors in church were disruptive at times. He further stated that the same goal was included in the other clients' programs as well. He then acknowledged that staff should have recorded data regarding attempts to implement the goal. Staff, however, had not documented in her records attempts to take Client #2 to church. It should be noted that the client's IPP stated that the goal should be monitored monthly by the house manager, QMRP and DDS service coordinator.		**W 249.4** **Staff will be in-serviced on implementation and documentation of Individual Program Plan (IPP) goals.** **The QMRP and HM will on a monthly basis review implementation and documentation of program goals to ensure that staff are accurately documenting outcomes.**	07/15/09
W 331	483.460(c) NURSING SERVICES	W 331		

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W 331	Continued From page 9 The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's nurses failed to clarify physician's orders, for two of the two clients in the sample. (Clients #1 and #2) The findings include: 1. On June 17, 2009, at approximately 3:05 p.m., Client #1 returned from day program. She was noted to be of very large stature and her breathing was audible and labored. During the medication administration on June 18, 2009, at approximately 6:55 a.m., the client received Hydrochlorothiazide (a medication prescribed for hypertension). Review of the client's medical record on the same day, at approximately 8:55 a.m., revealed that on April 20, 2009 the client was evaluated by the primary care physician for an elevated blood pressure. The consultation report reflected a recommendation that appeared to read "Sodium (Na+) restriction." Interview with the facility's nurse on the same day, at approximately 3:30 p.m., revealed that he was not sure what the notation meant. Further review of the client's diet order failed to evidence the reduction in her sodium intake. At the time of the survey, the facility's nurse failed to follow-up on entries in the medical record that were unclear. 2. Cross-refer to W159.1. The facility's nurse failed to seek clarification from the medical team (i.e. the primary care physician, RN,	W 331	**W 331, 1 & 2** **The facility's nurse has clarified with the primary care physician (pcp) the meaning of the notation Na+. According to the pcp, "Na is the chemical symbol for sodium and the + is the ionic charge." In essence, client #1 should be on sodium restricted diet.** **The facility's Licensed Practical Nurse(LPN) will o a quarterly basis meet with the pcp to review clients' records.**	07/15/09

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W 331	Continued From page 10 speech/language pathologist and nutritionist) regarding Client #2's prescribed dietary texture.	W 331		
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. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's nursing staff failed to ensure that one of the two clients in the sample received training in self-medication, as recommended by the interdisciplinary team. (Client #2) The finding includes: On June 17, 2009, the facility's LPN was asked about self-medication training programs. At approximately 2:45 p.m., he thought Client #1 was the only individual (of three) with a formal program. He did state, however that he was not sure about the other two. The morning medication pass was observed the next day (June 18, 2009), beginning at 6:53 a.m.. After the nurse punched Depakote, Gabapentin and Lorazepam into a plastic medication cup, she held the cup to Client #2's mouth and tipped it, so that the medications went into the client's open mouth. She then handed her a cup of orange juice, instructing her to "drink your juice." Later that day, beginning at 12:53 p.m., review of the monthly summary reports prepared by the	W 340	**W 340** **The LPNs will be trained on the implementation of self-meds programs.** **The QMRP will on a quarterly basis monitor the morning LPN on the implementation of self-meds programs.** **Direct Support Staff and the morning LPN will be in-serviced on accurate collection of data. The QMRP and HM will on a monthly basis review data collection sheets to ensure accurate documentation of program goals.**	07/15/09

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W 340	Continued From page 11 Qualified Mental Retardation Professional (QMRP) revealed that Client #2 had a formal self-medication training objective. According to her program, the nurse was to punch the medications, place the medication cup on a counter top (or table) and then instruct the client to take her medications. The data collection sheets listed three tasks, as follows: (1) accept medications from the nurse; (2) put medications in her mouth; and, (3) swallow her medication. The QMRP monthlies indicated that the program had been run, even though it had not been observed being implemented that morning. At 2:05 p.m., the QMRP was asked about Client #2's self-medication program. He stated that the program was a carry-over from the previous year (ISP was updated April 6, 2009) and a former registered nurse had trained their medication nurses sometime in the past. He then presented data collection sheets from May and June 2009 on which the client's performance had been documented. He further indicated that while it was evening staff who were documenting the client's performance during the evening medication pass, he expected the morning nurse to implement the program as well. There was no evidence, however, that the program had been implemented consistently, to include mornings. It should be noted that Client #2's data sheets showed that throughout the month of May, and much of June 2009, staff had placed an "H" in the row for the task "swallow her medication." The key indicated that an H represented hand-over-hand assistance. When asked about the H's, the QMRP acknowledged that staff had probably documented their impression of the client's overall performance. He further indicated	W 340		

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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
W 340	Continued From page 12 that he did not believe that staff had actually provided hand-over-hand assistance with her swallowing.	W 340		
W 391	483.460(m)(2)(ii) DRUG LABELING The facility must remove from use drug containers with worn, illegible, or missing labels. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure topical medications were labeled, for one of the two clients in the sample. (Client #2) The finding includes: On June 18, 2009, at approximately 2:20 p.m., the house manager was asked about the location of topical medications. She opened a locked cabinet in the dining room and pointed to the topical medications for all three clients. There were two tubes of Ammonium Lactate 2% cream in a container that was marked for Client #2's use. Both tubes were without labels. The house manager, who was present at the time, acknowledged the lack of labels. She did not offer any reason why the labels were missing.	W 391	**W 391** **Once quarterly, the LPN and HM will collectively inspect all medicines in the medication cabinet to ensure compliance with state regulation regarding storage and drug labeling.**	07/15/09
W 448	483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with evacuation drills, including accidents. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to implement a system to identify problems encountered with evacuation drills, for all three clients that reside in the facility. (Clients #1 - #3)	W 448		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G152		06/18/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMP CARE I I	1000 NEWTON STREET NE WASHINGTON, DC 20019

(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
W 448	Continued From page 13 The findings include: Review of the fire drill documents on June 17, 2009, at approximately 2:57 p.m., revealed the following concerns regarding the facility's system for evaluating the effectiveness of its fire drills: 1. Method of fire drill: The only method of fire drills was the use of the pull station. Review of the Fire/Evacuation Report (FER) revealed that the smoke detector had not been used to conduct the fire drills. When asked, the house manager indicated that the smoke detector should be used for some of the drills. 2. Method of egress: The only method of egress used in conducting the drills was out the front door. There were, however, other doors to the facility, including an exit on the second floor, an exit in the kitchen (out the back) as well as an exit from the basement. The FER's failed to evidence that the staff was utilizing all methods of egress from the facility during drills. The house manager acknowledged that staff had only used one of the four doors during drills held over the past year. 3. System checklist: The only check that was documented on the FER's was the Alarm panel. There was no evidence that the strobe, bells, and magnetic doors had been checked during the drills. 4. Staffing during the drills: Interview with the house manager on June 17, 2009, at approximately 3:00 p.m., revealed that the staffing pattern for the facility was two staff for the three clients on every shift. On two occasions, however, there was only one staff on duty during	W 448	**W 448. 1 &2** **1. Staff will be trained on how to conduct fire drills using the smoke detector.** **2. Staff will be trained on utilizing all exits in the facility during fire drills.** **The HM will, on a quarterly basis work with staff in conducting fire drills to ensure compliance with 1 & 2.**	07/15/09 07/15/09

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	09G152		06/18/2009

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W 448	Continued From page 14 the drills. The house manager acknowledged the lack of the required staff during those drills. [Note: The drill reports did not indicate any concerns or problems during those two drills.] 5. Review of the drills: The drill report form had a line on which whoever reviewed the results of the drill were expected to mark with their signature and date. Of the 43 drill reports reviewed, there were no signatures on 20 of them for verification that they had been reviewed. Interview with the house manager revealed that she was responsible for reviewing the drills. The house manager did not offer any additional information.	W 448	**W 448. 3 & 4** **3. The HM will on a monthly basis review the system checklist to ensure that staff are accurately utilizing and documenting the use of strobe, bells, and magnetic doors during drills.** **4. From now henceforth, the QMRP and HM shall ensure that fire drills are conducted only when the facility is fully staffed. It should be noted that in an instance a client is on leave of absence with his family, the ratio of staff to client shall be 1 to 2. In such circumstance, staff shall be advised not to conduct fire drills.**	07/15/09 07/15/09
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 provide foods in a form consistent with the client's assessed needs, for two of the two clients in the sample. (Clients #1 and #2) The findings include: 1. Facility staff failed to ensure that Client #2's foods were "finely chopped," in accordance with her physician's orders (POs), as follows: On June 18, 2009, Client #2 was given a 1/2 of a jelly-on-toast sandwich at breakfast. Staff had cut the sandwich into bite-sized pieces. Staff also gave her some grapefruit that had been cut into bite-sized pieces. Later that day, staff gave her a peanut butter and jelly sandwich. The sandwich	W 474	**W 448.5** **The QMRP will on a monthly basis conduct audits pertaining to the House Manager's verification of the fire drill forms.**	07/15/09

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W 474	Continued From page 15 was cut bite-size (approximately 1-inch square pieces). [Note: The client did not show any signs of difficulty while eating here meals.] At 1:39 p.m., review of her June 2009 POs (and POs as far back as September 2008) revealed diet orders as follows: "Finely chopped meat and food." The order was consistent with a dietary chart that was posted in the kitchen. It was also consistent with recommendations made by the nutritionist in her April 2008 and April 2009 Annual Assessments. [Note: Client #2's Mealtime Guidelines dated October 2008 showed "Food Texture: Mechanical soft low chew chopped diet texture consistency. Foods are cut into small [pieces about size of a pea or cheerio)."] At approximately 2:25 p.m., the Qualified Mental Retardation Professional (QMRP) stated that Client #2's foods should be "finely chopped... like ground beef hamburger... not bite size." Similarly, at 3:06 p.m., the house manager stated the "chopped" meant food pieces were approximately the size of peas; whereas "finely chopped" was more like ground beef. She further stated that "chopped" did not mean cut bite-size. 2. On June 18, 2009, Client #1 was given a jelly-on-toast sandwich at breakfast. Staff had not cut the sandwich into pieces. Staff also gave her a hard boiled egg. The egg had been cut in half. At 11:07 a.m., review of her diet orders revealed that she was to receive a "1500 calorie low cholesterol chopped foods" diet. Staff did not, however, ensure that Client #1 received a chopped texture breakfast earlier that day.	W 474	**W 474** **The nutritionist will on a quarterly basis in-service staff on issues of diet type and texture.** **The QMRP and HM will on a monthly basis conduct random monitoring of staff on issues of diet type and texture.**	07/15/09

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	HFD03-0128		06/18/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMP CARE I I	1000 NEWTON STREET NE WASHINGTON, DC 20019

(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) COMPLETE DATE
I 000	INITIAL COMMENTS A licensure survey was conducted from June 17, 2009, through June 18, 2009. A random sample of two residents was selected from a residential population of three women with mental retardation and other disabilities. The survey findings were based on observations in the group home and at two day programs, interviews, and a review of clinical and administrative records, including unusual incident reports.	I 000		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to maintain the interior and exterior of the GHMRP in a safe, clean, orderly, and attractive manner, for three of the three residents of the facility. (Residents #1 - #3) The findings include: During the inspection of the interior and exterior of the GHMRP on June 18, 2009, the following was observed: Interior: 1. A portion (approximately 10 inches long) of caulking was missing at the base of the bathtub located in the bathroom on the second floor. The missing caulking was where the tub met the floor, immediately behind the bathroom door.	I 090	**I 090. 1** **The caulking has been replaced.** **The facility's maintenance team will on a quarterly basis conduct a tour of the facility to ensure that all maintenance issues are fully addressed.**	07/15/09

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Johnna Harkins

TITLE: Adm. Asst.

(X6) DATE: 7/7/09

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0128	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/18/2009
NAME OF PROVIDER OR SUPPLIER COMP CARE I I	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 NEWTON STREET NE WASHINGTON, DC 20019		

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I 090	Continued From page 1 Exterior: 2. The vent from the dryer leading to the exterior of the house contained an abundant accumulation of lint. The house manager was present during the inspection and acknowledged the above-mentioned observations.	I 090	**I 090. 2** **The House Manager (HM) will twice weekly conduct random inspection of the vent to ensure that staff are cleaning the vent after use.** **Staff will be constantly reminded by the HM to ensure that the vent is cleaned after each use of the dryer. A notice will be posted on the dryer to remind staff.**	
I 136	3505.6 FIRE SAFETY Each GHMRP shall maintain records of each simulated fire drill. This Statute is not met as evidenced by: Based on record review and interview, the facility failed to implement a system to identify problems encountered with evacuation drills, for all three residents that reside in the facility. (Residents #1 - #3) The findings include: Review of the fire drill documents on June 17, 2009, at approximately 2:57 p.m., revealed the following concerns regarding the facility's system for evaluating the effectiveness of its fire drills: 1. Method of fire drill: The only method of fire drills was the use of the pull station. Review of the Fire/Evacuation Report (FER) revealed that the smoke detector had not been used to conduct the fire drills. When asked, the house manager indicated that the smoke detector should be used for some of the drills.	I 136		07/15/09

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I 136	Continued From page 2	I 136		
	2. Method of egress: The only method of egress used in conducting the drills was out the front door. There were, however, other doors to the facility, including an exit on the second floor, an exit in the kitchen (out the back) as well as an exit from the basement. The FER's failed to evidence that the staff was utilizing all methods of egress from the facility during drills. The house manager acknowledged that staff had only used one of the four doors during drills held over the past year.		**I 136.1& 2** **Cross reference W 448.1&2**	
	3. System checklist: The only check that was documented on the FER's was the Alarm panel. There was no evidence that the strobe, bells, and magnetic doors had been checked during the drills.			
	4. Staffing during the drills: Interview with the house manager on June 17, 2009, at approximately 3:00 p.m., revealed that the staffing pattern for the facility was two staff for the three residents on every shift. On two occasions, however, there was only one staff on duty during the drills. The house manager acknowledged the lack of the required staff during those drills. [Note: The drill reports did not indicate any concerns or problems during those two drills.]		**I 136. 3& 4** **Cross reference W 448.3&4**	
	5. Review of the drills: The drill report form had a line on which whoever reviewed the results of the drill were expected to mark with their signature and date. Of the 43 drill reports reviewed, there were no signatures on 20 of them for verification that they had been reviewed. Interview with the house manager revealed that she was responsible for reviewing the drills. The house manager did not offer any additional information.		**I 136. 5** **Cross reference W 448.5**	

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I 227	Continued From page 3	I 227		
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 facility failed to ensure that all staff were trained to implement emergency measures (CPR and First Aid), for one of five staff employed in the GHMRP. (Staff #5) The findings include: During the entrance conference on June 17, 2009, at 4:27 p.m., the Qualified Mental Retardation Professional (QMRP) stated that all staff were required to have current Cardiopulmonary Resuscitation (CPR) and First Aid certifications. He agreed to make available the training records for staff working in the facility. Review of said records on June 18, 2009, begining at approximately 11:51 a.m., failed to show evidence that Staff #5 had current certifications in CPR and First Aid. The QMRP was made aware of the above, and acknowledged the lack of current certifications and training.	I 227	**I 227** **The Assistant Administrator shall conduct monthly audits of personnel folders to ensure that all personnel certificates or documents are current.**	07/15/09
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following:	I 229		

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I 229	Continued From page 4 (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, interview and record review, the facility failed to ensure that staff were effectively trained on providing foods in a form consistent with the resident's assessed needs, for two of the two residents in the sample. (Residents #1 and #2) The findings include: 1. Facility staff failed to ensure that Resident #2's foods were "finely chopped," in accordance with her physician's orders (POs), as follows: On June 18, 2009, Resident #2 was given a 1/2 of a jelly-on-toast sandwich at breakfast. Staff had cut the sandwich into bite-sized pieces. Staff also gave her some grapefruit that had been cut into bite-sized pieces. Later that day, staff gave her a peanut butter and jelly sandwich. The sandwich was cut bite-size (approximately 1-inch square pieces). [Note: The resident did not show any signs of difficulty while eating here meals.] At 1:39 p.m., review of her June 2009 POs (and POs as far back as September 2008) revealed diet orders as follows: "Finely chopped meat and food." The order was consistent with a dietary chart that was posted in the kitchen. It was also consistent with recommendations made by the nutritionist in her April 2008 and April 2009 Annual Assessments. [Note: Resident #2's Mealtime Guidelines dated October 2008	I 229	**I 229.1 & 2** **The nutritionist will on a quarterly basis in-service staff on issues of diet type and texture.** **The QMRP and HM will on a monthly basis conduct random monitoring of staff on issues of diet type and texture.**	07/15/09

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I 229	Continued From page 5 showed "Food Texture: Mechanical soft low chew chopped diet texture consistency. Foods are cut into small [pieces about size of a pea or cheerio)."] At approximately 2:25 p.m., the Qualified Mental Retardation Professional (QMRP) stated that Resident #2's foods should be "finely chopped... like ground beef hamburger... not bite size." Similarly, at 3:06 p.m., the house manager stated the "chopped" meant food pieces were approximately the size of peas; whereas "finely chopped" was more like ground beef. She further stated that "chopped" did not mean cut bite-size. 2. On June 18, 2009, Resident #1 was given a jelly-on-toast sandwich at breakfast. Staff had not cut the sandwich into pieces. Staff also gave her a hard boiled egg. The egg had been cut in half. At 11:07 a.m., review of her diet orders revealed that she was to receive a "1500 calorie low cholesterol chopped foods" diet. Staff did not, however, ensure that Resident #1 received a chopped texture breakfast earlier that day. On June 18, 2009, at 1:52 p.m., review of staff in-service training records revealed that the nutritionist had documented training on October 10, 2008. Review of the agenda, however, failed to show evidence that the topic of specialized diet textures was included in the training. No additional staff training documents were presented before the survey ended later that afternoon. 3. Cross-refer to I422.1 and I422.2. Facility staff failed to allow or encourage Resident #2 to eat foods and beverages independently, and failed to encourage Resident #2 to alternate between food bites and beverage sips, in accordance with her	I 229	**I 229.3** **Cross reference W 249 (1a, b, c).**	

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I 229	Continued From page 6 Mealtime Guidelines (MG, dated October, 2008). There was no evidence that staff had been trained effectively on her MG.	I 229		
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that all injuries of unknown origin were reported immediately to the administrator and other officials according to District of Columbia Regulations (22 DCMR, Chapter 35, Section 3519.10) for one of the three residents residing in the facility. (Resident #1) The finding includes: During the entrance conference on June 17, 2009, at approximately 2:45 p.m., the house manager indicated that there was one incident where Resident #1 was taken to the emergency room due to limping at the day program. Review of the unusual incident report (UIR) record book on the same day, at approximately 3:30 p.m., failed to show evidence that a corresponding UIR had been generated. On June 18, 2009, however, at approximately 8:55 a.m., review of	I 379		

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I 379	Continued From page 7 the resident's medical record revealed that an incident report had been prepared on April 24, 2009. The UIR reflected that the resident was taken to the emergency room (ER) after she returned home that afternoon. She was released that same day with a diagnosis of contusion to the left knee. Interview with the nurse at the day program on June 18, 2009, at approximately 11:10 a.m., revealed that on April 24, 2009, Resident #1 had been observed limping. Staff told the nurse that the resident had not fallen there at the day program. When the nurse telephoned the group home, reportedly she was told that the resident had not fallen in the home either. When interviewed on June 18, 2009, at approximately 1:00 p.m., the Qualified Mental Retardation Professional stated that he had informed the administrator after the resident came home from the ER with the diagnosis of "contusion," which signified that there had been an injury. Review of the UIR, however, failed to show evidence that the administrator and state agency had been notified immediately of the injury.	I 379	**I 379** **Cross reference W 153.**	
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, staff interviews and record review, facility staff failed to ensure implementation of residents' training programs and mealtime protocol, for one of the two residents in the sample. (Resident #2)	I 422		

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I 422	Continued From page 8 The findings include: 1. Facility staff failed to allow or encourage Resident #2 to eat foods and beverages independently, in accordance with her Mealtime Guidelines (MG, dated October, 2008) and Individual Support Plan (ISP, dated April 6, 2009), as follows: a. On June 17, 2009, at 3:08 p.m., Resident #2 was observed in the facility's living room being spoon fed pudding by the house manager. b. On June 18, 2009, Resident #2 was observed at breakfast, beginning at 7:16 a.m.. The resident held her teaspoon in her left hand and began eating raisin bran cereal. A direct support staff person sitting next to her took hold of her hand and tried directing her movements. The resident, however, resisted and kept moving her hand away from the staff. After this continued for approximately two minutes, another staff person assisting at breakfast informed the staff that Resident #2 preferred to feed herself. At 7:26 a.m., the resident was observed feeding herself independently. The staff then provided her with minimal physical support and verbal direction through the remainder of her meal. c. Later on June 18, 2009, at 11:56 a.m., Resident #2 was observed in the facility eating pudding. A staff person seated next to her was observed spoon feeding her pudding. This was followed by lunch a short time later (between 12:11 p.m. - 12:24 p.m.). Instead of allowing the resident to eat her peanut butter and jelly sandwich independently, the same staff person stuck a fork into pieces of the sandwich, which had been cut bite-size, and fed the resident.	I 422	**I 422.1a, b, c** **Cross reference W 249.1 (a, b, c)**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0128	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/18/2009
NAME OF PROVIDER OR SUPPLIER COMP CARE I I	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 NEWTON STREET NE WASHINGTON, DC 20019		

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I 422	Continued From page 9 On June 18, 2009, at 1:33 p.m., review of the resident's Mealtime Guidelines (MG) revealed that she was able to eat "independently after set-up with close staff supervision." The resident's ISP also stated that she was assessed as being capable of eating independently with staff supervision and minimal assistance. 2. Facility staff failed to encourage Resident #2 to alternate between food bites and beverage sips, in accordance with her Mealtime Guidelines (MG, dated October, 2008), and Health Management Care Plan (HMCP, dated March 28, 2009) as follows: During the June 18, 2009 breakfast, Resident #2 was observed eating her foods independently and/or with verbal guidance from staff. At 7:32 a.m., staff placed the resident's bowl and plate to the side after she finished her cereal, toast with jelly and grapefruit. Staff then moved three beverage glasses closer to her and instructed her to drink. She drank orange juice, then water and finished the meal by drinking Ensure nutritional supplement. On June 18, 2009, at 1:33 p.m., review of the resident's MG revealed that staff should "encourage single sips of beverage throughout the meal and after meal is finished." The resident's HMCP also said to "alternate food and liquid during meals." Staff, however, had not encouraged her to alternate between food and beverages throughout her breakfast. 3. Cross-refer to W340. The facility failed to ensure that Resident #2 received training in self-medication, as recommended by the interdisciplinary team, es evidenced by the	I 422	**I 422.2** **Cross reference W 249.1 (a, b, c)**	

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I 422	Continued From page 10 following: On June 17, 2009, the facility's LPN was asked about self-medication training programs. At approximately 2:45 p.m., he thought Resident #1 was the only individual (of three) with a formal program. He did state, however that he was not sure about the other two. The morning medication pass was observed the next day (June 18, 2009), beginning at 6:53 a.m.. After the nurse punched Depakote, Gabapentin and Lorazepam into a plastic medication cup, she held the cup to Resident #2's mouth and tipped it, so that the medications went into the resident's open mouth. She then handed her a cup of orange juice, instructing her to "drink your juice." Later that day, beginning at 12:53 p.m., review of the monthly summary reports prepared by the Qualified Mental Retardation Professional (QMRP) revealed that Resident #2 had a formal self-medication training objective. According to her program, the nurse was to punch the medications, place the medication cup on a counter top (or table) and then instruct the resident to take her medications. The data collection sheets listed three tasks, as follows: (1) accept medications from the nurse; (2) put medications in her mouth; and, (3) swallow her medication. The QMRP monthlies indicated that the program had been run, even though it had not been observed being implemented that morning. At 2:05 p.m., the QMRP was asked about Resident #2's self-medication program. He stated that the program was a carry-over from the previous year (ISP was updated April 6, 2009) and a former registered nurse had trained their medication nurses sometime in the past. He then	I 422	**I 422.3** **Cross-refer to W 340.**	

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I 422	Continued From page 11 presented data collection sheets from May and June 2009 on which the resident's performance had been documented. He further indicated that while it was evening staff who were documenting the resident's performance during the evening medication pass, he expected the morning nurse to implement the program as well. There was no evidence, however, that the program had been implemented consistently, to include mornings. It should be noted that Resident #2's data sheets showed that throughout the month of May, and much of June 2009, staff had placed an "H" in the row for the task "swallow her medication." The key indicated that an H represented hand-over-hand assistance. When asked about the H's, the QMRP acknowledged that staff had probably documented their impression of the resident's overall performance. He further indicated that he did not believe that staff had actually provided hand-over-hand assistance with her swallowing. 4. Facility staff failed to implement Resident #2's community inclusion goal to attend church on Sundays, as follows: On June 18, 2009, at 3:09 p.m., review of Resident #2's Individual Program Plan (dated April 6, 2009) revealed the following community inclusion goal (Goal #2): "I will go to church on Sundays" with direct care staff. She had a related goal: "I will dress appropriately for church." Neither goal, however, had been implemented since her team included it in her updated annual plan in April 2009. At approximately 3:12 p.m., interview with the house manager revealed that the resident only went to church "once in a while" due to behavioral concerns. She confirmed that Resident #2 had	I 422	**I 422.4** **Cross reference W 249.4**	

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I 422	Continued From page 12 not been to church recently. The Qualified Mental Retardation Professional (QMRP) was present at the time. He concurred with the house manager, saying that Resident #2's behaviors in church were disruptive at times. He further stated that the same goal was included in the other residents' programs as well. He then acknowledged that staff should have recorded data regarding attempts to implement the goal. Staff, however, had not documented in her records attempts to take Resident #2 to church. It should be noted that the resident's IPP stated that the goal should be monitored monthly by the house manager, QMRP and DDS service coordinator.	I 422		
I 484	3522.11 MEDICATIONS Each GHMRP shall promptly destroy prescribed medication that is discontinued by the physician or has reached the expiration date, or has a worn, illegible, or missing label. This Statute is not met as evidenced by: Based on observation and interview, the facility failed to ensure topical medications were labeled, for one of the two residents in the sample. (Resident #2) The finding includes: On June 18, 2009, at approximately 2:20 p.m., the house manager was asked about the location of topical medications. She opened a locked cabinet in the dining room and pointed to the topical medications for all three residents. There were two tubes of Ammonium Lactate 2% cream in a container that was marked for Resident #2's	I 484		

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I 484	Continued From page 13 use. Both tubes were without labels. The house manager, who was present at the time, acknowledged the lack of labels. She did not offer any reason why the labels were missing.	I 484	**I 484** **Cross reference W 391.**	
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 GHMRP 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) that governs the care and rights of persons with mental retardation. The findings include: The facility failed to demonstrate protection of residents' rights to receive training and habilitation to enable residents to acquire and maintain life skills and achieve their optimum functioning, for one of the two residents in the sample. [Title 7, Chapter 13, § 7-1305.01(b), formerly § 6-1961(b)] as follows: Cross-refer to I422. The facility failed to ensure that Resident #2's training programs for self-medication and dressing appropriately for church were implemented. In addition, staff did not adhere to Resident #2's mealtime protocol.	I 500	**I 500** **Cross reference W 422.**	

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R 000	INITIAL COMMENTS A licensure survey was conducted from June 17, 2009 through June 18, 2009. A random sample of two residents was selected from a residential population of three women with mental retardation and other disabilities. The survey findings were based on observations in the group home and at two day programs, interviews, and a review of clinical and administrative records, including unusual incident reports.	R 000		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on interview and review of personnel records, the GHMRP failed to ensure criminal background checks for all jurisdictions in which the employees had worked or resided within the seven (7) years prior to the check, for one of the five direct care staff. (Staff #3) The finding includes: Review of personnel files on June 18, 2009, beginning at approximately 11:51 a.m., revealed that all staff had criminal background checks. Staff #3's record, however, documented that she had been employed in the state of Virginia within the last 7 years. There was no evidence that a criminal background check had been secured for that jurisdiction (Virginia).	R 125		

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R 125	Continued From page 1 Note: On June 22, 2009 (post-survey), the facility submitted via facsimile a background check for Staff #3. The document indicated that the background had been ordered on June 18, 2009, during the survey. On June 23, 2009, at 3:40 PM, telephone interview with the house manager revealed that the staff in question had been employed by the facility for approximately three years. This is a repeat deficiency. ********** Previously, the State licensure deficiency report dated June 19, 2008 included the following: "Interview with the Qualified Mental Retardation Professional (QMRP) and review of the GHMRP's personnel records on June 19, 2008, revealed that the GHMRP failed to provide evidence that criminal background checks were on file and disclosed a seven year history of all the jurisdictions where the employee resided and worked for two direct care staff." And the State licensure deficiency report dated June 19, 2007 included the following: "Review of the review of personnel files on August 3, 2007 at 9:20 AM revealed the GHMRP failed to evidence criminal background checks for the previous seven years in all jurisdiction where two staff had worked or resided. The review of criminal background checks provided for Staff #6 and #8 were noted to not be for the jurisdiction in which they currently reside."	R 125	**R 125** **The facility has put in place a forty-eight hour online criminal background check.** **The Assistant Administrator will retroactively conduct criminal background checks for all jurisdictions in which the employees had worked or resided within the seven (7) years prior to the check.** **From now forward, the Assistant Administrator shall conduct criminal background checks for all jurisdictions in which a prospective employees had worked or resided within the seven (7) years prior to the check.**	07/15/09