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

PRINTED: 07/01/2008
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		06/19/2008

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

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W 000	INITIAL COMMENTS A recertification survey was conducted from June 18, 2008, through June 19, 2008, using the fundamental survey process. A random sample of two clients was selected from a residential population of three females 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 records, including unusual incident reports.	W 000		
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure each client's exercised their rights, for three of the three clients residing in the facility. (Clients #1, #2, and #3) The findings include: Observations on June 18, 2008, revealed there was no toilet paper, paper towels, or soap in the facility's first floor bathroom. Interview with the facility's house manager on June 18, 2008, at approximately 10:00 AM revealed the aforementioned toiletries were not in the bathroom due to Client's #2's misuse of them. According to the house manager, Client #2 was known to use an overabundance of the items.	W 125		

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ADMINISTRATION
2008 JUL 10 A 11: 28

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Dr. Rodwell Bradley | Administrator | 7/9/08

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 125	Continued From page 1 Additionally, the client was known to take the same toilet tissue that she wiped herself with and wipe her face, arms and hands. Continued observations throughout the survey revealed the toiletries were kept in a cabinet adjacent to the bathroom. On June 18, 2008 at 3:44 PM, the house manager instructed the direct care staff to remove the toiletries from the bathroom before Client #2 arrived home "because she will stuff the toilet." At 3:51 PM, Client #2 arrived home from the day program. At 3:53 PM, she was observed to use the bathroom independently. The house manager indicated that Client #2 received toilet paper and paper towels after she was finished using the toilet. Observations revealed the toiletries were also given to Clients #1 and #3 when they finished using the toilet. Interview was conducted with the house manager to ascertain if this practice had not been recommended by Client #2's Interdisplinary Team. According to the manager " it was just something that we do, because if we leave it there it will be gone." It should be noted that throughout the survey, the house manger was observed to retrieve the necessary items from the cabinet each time the clients had to use the bathroom. At 4:39 PM, Client #2 was observed to use the bathroom. When the client finished using the bathroom she went to the facility's kitchen and was observed to pull several sheets of paper towels from the roll. Continued observation revealed the client used the towels to wipe her hands, her arms, and her face before placing the towels in the trash can. Client #2 was observated at 5:08 PM to snatch	W 125	**W 125** **From this day (07/10/08) forward, toiletries will remain in all bathrooms. Two program goals geared towards helping Client #2 in learning the appropriate use of toilet tissue and paper towels/napkins have been developed. Please find herewith skill acquisitions and data sheets.** **Staff will be trained on how to assist Client #2 in understanding the use of toilet tissue and paper towels/napkins while in the bathroom.** **07/10/08**	

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W 125	Continued From page 2 several paper towels from the counter top in the facility's kitchen. She hurriedly wiped her mouth and placed the towels in the trash can. Review of Client #2's habilitation record on June 19, 2008, at approximately 6:00 PM revealed a Behavior Support Plan (BSP) dated November 14, 2007. The BSP revealed a section entitled "Behaviors of Concern and Functional Analysis." One of the behavioral concerns was the "inappropriate use of toilet paper/tissues/napkins." The plan indicated that the client had to be watched while she was in the bathroom, because in addition to using the items inappropriately, she uses them in an unhygienic manner. The plan further indicated that the client had been known to use the toilet paper to "wipe different parts of her body (moving from one part of the body to another, in a sequence that was unhygienic) and dropping wads into the toilet. Blockages have resulted in the toilet due to this excessive use." Client #2's BSP verified the interview held with the house manager that the IDT did not recommend the toiletries to be removed from the facility's bathroom. At the time of the survey, the facility failed to ensure that the rights of each client was exercised.	W 125		
W 137	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by:	W 137		

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W 137	Continued From page 3 Based on observation and interview, the facility failed to ensure the right of each client to retain the use of appropriately fitting bras, for one of the two clients (Client #2) included in the sample. The finding includes: On June 18, 2008, at 4:17 PM Client #2 was observed to be obese. Continued observation revealed that the client had very large breast and wore a loose fitting bra providing no brest support. Due to the fit of the client's bra her breast was observed to rest on her abdomen. Interview with the house manager on the aforementioned date revealed that she had just purchased six new bras for Client #2. However, at the time of the survey, the facility failed to ensure Client #2 wore appropriate fitting undergarments.	W 137	**W 137** **Six new well fitted bras have been purchased for Client #2. Please find receipt herewith. The House Manager (HM) will on a weekly basis do quality and quantity check of Client #2's bras. New bras will be purchased as needed.** **07/08/08**	
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 each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP), for three of the four clients (Clients #1, and #2) that resided in the facility. The findings include: 1. The QMRP failed to ensure that each	W 159		

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W 159	Continued From page 4 employee was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently. [See W189] 2. The QMRP failed to ensure staff were effectively trained to implement Client #2's Behavior Support Plan. [See W193] 3. The QMRP failed to ensure a comprehensive functional assessment of behavioral needs was conducted for Client #1. [See W214] 4. The QMRP failed to ensure that clients' individual program plans (IPP) included training in personal skills. [See W242]	W 159	**W 159, 1** **W 189 was not specified in the deficiency report.** **W 159, 2** **Please see W 193** **W 159, 3** **Please see W 214** **W 159, 4** **Please see W 242**	
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, interview and the review of the record, the facility failed to ensure staff were able to demonstrate the skills and techniques necessary to administer interventions to manage each client's behaviors, for one of the two clients (Client #2) included in the sample. The finding includes: The facility failed to provide evidence that staff was effectively trained on Client #2's Behavior Support Plan (BSP) including the use of interventions to manage the client's inappropriate	W 193		

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W 193	Continued From page 5 behavior. 1. Observations on June 18, 2008, revealed that there was no toilet paper, paper towels, or soap in the facility's first floor bathroom. Interview with the facility's house manager on June 18, 2008, at approximately 10:00 AM revealed that it was their practice to ensure the aforementioned toiletries were not in the bathroom due to Client's #2 misuse of them. According to the house manager, Client #2 is known to use an overabundance of the items. Additionally, she will also take the same toilet tissue that she wiped herself with and wipe her face, arms and hands. Continued observations throughout the survey revealed the toiletries were kept in a cabinet adjacent to the bathroom. On June 18, 2008, at 3:44 PM the house manager instructed the direct care staff to remove the toiletries from the bathroom before Client #2 arrived home, "because she will stuff the toilet." At 3:51 PM, Client #2 arrived home from the day program. She was observed at 3:53 PM using the bathroom independently. According to the house manager "they have to give Client #2 toilet paper and paper towels when she had finished using the bathroom." The house manger was observed to retrieve the necessary toiletries from the cabinet each time the client had to use the bathroom. At 4:39 PM, Client #2 was observed to use the bathroom and she was observed to get paper towels from the roll in the facility's kitchen. She pulled several sheets of towels, wiped her hands, her arms, and her face before placing the towels in the trash can. At 5:08 PM, Client #2 was observed to snatch several paper towels from the counter top	W 193	**W 193, 1** **Staff have been re-trained on implementing Client #2's Behavior Support Plan (BSP). Please find evidence herewith. The House Manager and/or QMRP will, on a weekly basis review the BSP with staff to ensure compliance.** **07/07/08**	

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W 193	Continued From page 6 in the facility's kitchen. She hurriedly wiped her mouth and placed the towels in the trash can. Review of Client #2's habilitation record on June 19, 2008 at approximately 6:00 PM revealed a Behavior Support Plan (BSP) dated November 14, 2007. The BSP revealed a section entitled "Behaviors of Concern and Functional Analysis." One of the behavioral concerns was the "inappropriate use of toilet paper/tissues/napkins." The plan outlined strategies to address the behaviors. Although the staff had been trained to implement the BSP, at the time of the survey they failed to demonstrate the techniques required to manage the behavior. 2. Observations on June 18, 2008, at 5:07 PM revealed Client #2 spitting on the floor as she entered the living room. At 5:37 PM, the client was observed taking a sip of her ice tea and then spit in her cup. At 5:46 PM, Client #2 had finished her dinner, she got up from the dining room table and was observed spitting in the floor. It should be noted that the facility's staff also observed the aforementioned behavior, but did not intervene. Review of Client #2's BSP revealed the plan outlined strategies to address the aforementioned behavior. Although the staff had been trained to implement the BSP, at the time of the survey they failed to demonstrate the techniques required to manage the behavior.	W 193	**W 193, 2** **Cross reference W 193, 1** **07/07/08**	
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs.	W 214		

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W 214	Continued From page 7 This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a comprehensive functional assessment of developmental needs was conducted for one of two clients (Client#1) included in the sample. The finding includes: Observation of the administration of medication was conducted on June 18, 2008, beginning at 6:39 PM. At 6:44 PM, Client #1 was observed with the assistance of the medication nurse, participating in the following activities related to the administration of her medication: The facility's medication nurse was observed to punch Client #1's medication from her bubble pack in a medication cup. The medication nurse was observed to give the cup of medication to the client. The client was observed to take the pill and place in her mouth independently. She was also observed to pick up a cup of water (already poured) and drank it independently. Interview with the nurse was conducted to ascertain if Client #1 had a self-medication assessment. The facility's Licensed Practical Nurse (LPN) proceeded to look for a self-medication assessment in Client #1's medical record and verified that the client had not been assessed. At the time of the survey, the facility failed to ensure Client #1 was assessed for self-medication administration.	W 214	**W 214** **Self-medication assessment has been done for Client #1. Please find herewith. Self-medication program is currently being implemented** **07/01/08**	
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan,	W 249		

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W 249	Continued From page 8 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 each client received continuous active treatment services, including needed interventions, for one of the four clients (Client #2) included in the sample. The finding includes: The facility failed to implement Client #2's Behavior Support Plan (BSP). [See W193]	W 249	W 249 Cross reference W 193. 07/07/08	
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility's nursing services failed to ensure that each client received nursing services in accordance with their needs, for one of the two clients (Client #2) included in the sample. The finding includes: 1. The facility's nursing personnel failed to maintain a Medication Administration Record (MAR) for Client #3. [See W365]	W 331	W 331, 1 Please see W 365 07/07/08	

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W 331	Continued From page 9 2. Observations of the evening administration of medication on June 18, 2008 beginning at 6:39 PM revealed Client #3 received Lorazepam 1mg. On June 19, 2008 at 9:42 AM, the facility's Medication Administration Record (MAR) was reviewed to verify the aforementioned medication. Continued review of the MAR revealed a physician's order for Lorazepam 1mg twice a day. Review of Client #3's bubble pack revealed that there was no medication (Lorazepam) for the dates of June 8th, 16th, 23rd, and 24th, 2008. The bubble pack was delivered empty for those aforementioned dates. Interview with the the facility's LPN on June 19, 2008, at 9:42 AM revealed that he had contacted the pharmacy regarding June 23, 2008 and June 24, 2008. According to the LPN he had no knowledge of June 8, 2008 or June 16, 2008, because he was on vacation during that time, but verified that the medication was not given on those dates. At the time of the survey, the facility's nursing personnel failed to ensure the medication calendar card for Client #3 was complete before accepting it from the pharmacist for administration.	W 331	**W 331, 2** **Medication delivery verification form has been put in place to ensure checks and balances of complete delivery of all medicines. A protocol on how to resolve the problem of incomplete delivery of medications has been put in place.** **07/07/08**	
W 365	483.460(j)(4) DRUG REGIMEN REVIEW An individual medication administration record must be maintained for each client. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to maintain Medication Administration Records (MARs) for one of the two clients included in the sample. (Client #3)	W 365		

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W 365	Continued From page 10 The finding includes: The facility's medication nurse failed to document administration of each client's medication in the MAR as evidenced below: Observations of the evening administration of medication on June 18, 2008, beginning at 6:39 PM revealed Client #3 received Lorazepam 1 mg. On June 19, 2008 at 9:42 AM, the facility's Medication Administration Record (MAR) was reviewed to verify the aforementioned medication. Review of the buble pack revealed that the Lorazepam was missing from the package. Continued review of the MAR revealed that there was no documented evidence that the Lorazepam had been administered on June 1, 2008. At the time of the survey, there was no evidence that the MAR was initialed indicating the administration of the medication or circled to note why the medication had not been administered. An interview with the facility's Licensed Practical Nurse (LPN) was conducted on June 19, 2008, at 10:02 AM to ascertain Client #3's unexplained blank MAR for the evening of June 1, 2008. The LPN proceeded to the facility's medication cabinet to show the surveyor the client's bubble pack. Review of Client #3's bubble pack revealed the evening Lorazepam was punched out for June 1, 2008. Further interview with the LPN verified that the client's other medications were observed to be administered on the same day (June 1, 2008), and offered the explaination that perhaps the medication nurse mistakenly forgot to initial the designated box for the Lorazepam. At the time of the survey, the facility's medication nurse failed to maintain the June 2008, MAR for Client #3.	W 365	**W 365** **Nurses have been trained on appropriate documentation of administered medication, missed medication, and medication error. Emphases of the training were the concepts of medication omission(the date circled and explanation at the back of the MAR) and medication error(circle and initial in the circle with explanation at back of MAR).** **07/07/08**	
W 454	483.470(l)(1) INFECTION CONTROL	W 454		

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W 454	Continued From page 11 The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a sanitary environment to avoid sources and transmissions of infection. The finding includes: The entrance interview was conducted with the facility's house manager on June 18, 2008, at 9:30 AM. The house manager revealed that Client #2 had a Behavior Support Plan (BSP) for spitting and that the client was known to use an overabundance of the toilet paper and paper towels. Continued interview with house manager revealed Client #2 will also take the same toilet tissue that she wiped herself with and wipe her face, arms and hands. Observations on June 18, 2008, at 5:07 PM revealed Client #2 spitting on the floor as she entered the living room. At 5:37 PM, the client was observed taking a sip of her ice tea and spit in her cup. At 5:43 PM, Client #2 was observed eating icecream. When she finished her icecream she took her dish to the kitchen and was observed to spit in the cup of unfinished icecream. At 5:46 PM, the client got up from the dining room table and was observed spitting in the floor. It should be noted that the facility's staff also observed the aforementioned behavior, but did not intervene. At the time of the survey, the facility failed to ensure the environment was sanitary to avoid sources and transmissions of infection.	W 454	**W 454** **Staff have been trained on environmental sanitation and infection control. Please find attached, training record.** **07/07/08**	

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

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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		06/19/2008

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

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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 06/19/2008
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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R 000	INITIAL COMMENTS A re-licensure survey was conducted from June 18, 2008, through June 19, 2008. A random sample of two residents was selected from a residential population of three females 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 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 record review, the GHMRP failed to ensure criminal background checks disclosed the criminal history of any prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker had worked or resided within the seven (7) years prior to the check. The finding includes: 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	R 125	**R 125** **Background checks will be conducted in all the states the two employees have resided. In the future, the facility will ensure that global (all states) background checks are conducted for all new staff.** **07/30/08**	

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Dr. [signature] TITLE Administrator (X6) DATE 7/9/08

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R 125	Continued From page 1 worked for two direct care staff.	R 125		

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	HFD03-0128	A. BUILDING B. WING	06/19/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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I 000	INITIAL COMMENTS A re-licensure survey was conducted from June 18, 2008, through June 19, 2008. A random sample of two residents was selected from a residential population of three females 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 records, including unusual incident reports.	I 000		
I 407	3520.9 PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall obtain from each professional service provider a written report at least quarterly for services provided during the preceding quarter. This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Mentally Retarded Persons' (GHMRP) Nutritionist failed to provide evidence of a written quarterly report for each resident. (Resident #1) The finding includes: Observation of Resident #1 on June 18, 2008, at 3:37 PM revealed the client was obese. Interview with the house manager on the aforementioned date revealed the client was prescribed a 1500 calorie, low cholesterol diet. Review of Resident #1's habilitation record on June 19, 2008 revealed a Nutritional Assessment dated April 20, 2007. Further review of the assessment revealed a recommendation to weigh the client monthly and to report any weight increase of 5 lbs above/below to the nurse.	I 407	**I 407** **The nutritionist has updated all quarterlies.** **The Qualified Mental Retardation Professional has developed a form which will be used as an auditing tool to remind consultants to submit needed reports. Please find attached the auditing form.** **07/07/08**	

Health Regulation Administration Dr. Rodwell [signature]

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

TITLE Administrator

(X6) DATE 7/9/08

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I 407	Continued From page 1 Continued review of the record revealed nutritional quarterlies dated January 2008 and April 2008. The aforementioned quarterlies revealed that they were incomplete. At the time of the survey, there was no documented evidence to substantiate that the nutritionist provided written reports at least on a quarterly basis for Resident #1.	I 407		
I 436	3521.7(f) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (f) Health care (including skills related to nutrition, use and self-administration of medication, first aid, care and use of prosthetic and orthotic devices, preventive health care, and safety); This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure the habilitation and training of its residents in the area of self-administration of medication. The finding includes: Observation of the administration of medication was conducted on June 18, 2008, beginning at 6:39 PM. Resident #2 was observed with the assistance of the medication nurse, participating in the following activities related to the administration of her medication: The facility's medication nurse was observed to punch Resident #2's medication from her bubble pack in a medication cup. The medication nurse gave the cup of medication to the client. The client was observed to take the pill out of the cup	I 436		

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I 436	Continued From page 2 and place it in her mouth independently. She was also observed to pick up a cup of water (already poured) and drank it independently. Review of Resident #2's medical record on June 19, 2008 at 6:28 PM revealed that the client had been assessed on November 30, 2007. Continued review of the client's record revealed that Resident #2 "may self-administer medication with the supervision of a licensed, trained or duly authorized person in this facility." At the time of the survey, the facility failed to ensure Client #2 was given the opportunity to participate in a self-medication program.	I 436	**I 436** **Self-medication assessment has been done for Client #1. Please find herewith. Self-medication program is currently being implemented** **07/01/08**	
I 474	3522.5 MEDICATIONS Each GHMRP shall maintain an individual medication administration record for each resident. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure that nursing staff maintained Medication Administration Records (MAR), as follows: The finding includes: The facility's medication nurse failed to document administration of each client's medication in the MAR as evidenced below: Observations of the evening administration of medication on June 18, 2008, beginning at 6:39 PM revealed Client #3 received Lorazepam 1 mg. On June 19, 2008 at 9:42 AM, the facility's Medication Administration Record (MAR) was reviewed to verify the aforementioned medication. Review of the buble pack revealed that the	I 474		

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I 474	Continued From page 3 Lorazepam was missing from the package. Continued review of the MAR revealed that there was no documented evidence that the Lorazepam had been administered on June 1, 2008. At the time of the survey, there was no evidence that the MAR was initialed indicating the administration of the medication or circled to note why the medication had not been administered. An interview with the facility's Licensed Practical Nurse (LPN) was conducted on June 19, 2008, at 10:02 AM to ascertain Client #3's unexplained blank MAR for the evening of June 1, 2008. The LPN proceeded to the facility's medication cabinet to show the surveyor the client's bubble pack. Review of Client #3's bubble pack revealed the evening Lorazepam was punched out for June 1, 2008. Further interview with the LPN verified that the client's other medications were observed to be administered on the same day (June 1, 2008), and offered the explaination that perhaps the medication nurse mistakenly forgot to initial the designated box for the Lorazepam. At the time of the survey, the facility's medication nurse failed to maintain the June 2008, MAR for Client #3.	I 474	**I 474** **Cross reference W 365** **07/0708**	
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 observation, interview and record review, the facility failed to implement practices to allow the client's to exercise their rights, for three	I 500		

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I 500	Continued From page 4 of the three client's (Residents #1, #2, and #3's) rights residing in the facility. The findings include: Observations on June 18, 2008, revealed there was no toilet paper, paper towels, or soap in the facility's first floor bathroom. Interview with the facility's house manager on June 18, 2008, at approximately 10:00 AM revealed the aforementioned toiletries were not in the bathroom due to Client's #2's misuse of them. According to the house manager, Client #2 was known to use an overabundance of the items. Additionally, the client was known to take the same toilet tissue that she wiped herself with and wipe her face, arms and hands. Continued observations throughout the survey revealed the toiletries were kept in a cabinet adjacent to the bathroom. On June 18, 2008 at 3:44 PM, the house manager instructed the direct care staff to remove the toiletries from the bathroom before Client #2 arrived home "because she will stuff the toilet." At 3:51 PM, Client #2 arrived home from the day program. At 3:53 PM, she was observed to use the bathroom independently. The house manager indicated that Client #2 received toilet paper and paper towels after she was finished using the toilet. Observations revealed the toiletries were also given to Clients #1 and #3 when they finished using the toilet. Interview was conducted with the house manager to ascertain if this practice had not been recommended by Client #2's Interdisplinary Team. According to the manager " it was just something that we do, because if we leave it there it will be gone."	I 500		

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I 500	Continued From page 5 It should be noted that throughout the survey, the house manger was observed to retrieve the necessary items from the cabinet each time the clients had to use the bathroom. At 4:39 PM, Client #2 was observed to use the bathroom. When the client finished using the bathroom she went to the facility's kitchen and was observed to pull several sheets of paper towels from the roll. Continued observation revealed the client used the towels to wipe her hands, her arms, and her face before placing the towels in the trash can. Client #2 was observated at 5:08 PM to snatch several paper towels from the counter top in the facility's kitchen. She hurriedly wiped her mouth and placed the towels in the trash can. Review of Client #2's habilitation record on June 19, 2008, at approximately 6:00 PM revealed a Behavior Support Plan (BSP) dated November 14, 2007. The BSP revealed a section entitled "Behaviors of Concern and Functional Analysis." One of the behavioral concerns was the "inappropriate use of toilet paper/tissues/napkins." The plan indicated that the client had to be watched while she was in the bathroom, because in addition to using the items inappropriately, she uses them in an unhygienic manner. The plan further indicated that the client had been known to use the toilet paper to "wipe different parts of her body (moving from one part of the body to another, in a sequence that was unhygienic) and dropping wads into the toilet. Blockages have resulted in the toilet due to this excessive use." Client #2's BSP verified the interview held with the house manager that the IDT did not recommend the toiletries to be removed from the facility's bathroom. At the time of the survey, the facility failed to ensure that the rights of each	I 500		

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I 500	Continued From page 6 client was exercised.	I 500	**I 500** **Cross reference W 125.** **07/10/08**	