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

PRINTED: 08/09/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G071	A. BUILDING B. WING	07/23/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEHAVIOR RESEARCH ASSOCIATES	1034 BURNS ST., SE WASHINGTON, DC 20019

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W 000	INITIAL COMMENTS A recertification survey was conducted from 7/20/2010 through 7/23/2010. The survey was initiated using the fundamental survey process. A sample of three clients was selected from a resident population of six men with various degrees of intellectual and/or developmental disabilities. The findings of the survey were based on observations, interviews with staff in the home and at three day programs, as well as a review of client and administrative records, including incident reports.	W 000	Received 8/21/10 DOH HRLA - ICFD	
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure that the day treatment program provided appropriate active treatment (i.e. language development training) based on assessed needs, for one of three clients in the sample. (Client #3) The finding includes: The survey was initiated on 7/20/2010, beginning at 6:48 a.m. Observations in the home that morning suggested that Client #3 was blind. This was confirmed at approximately 9:15 a.m., through interview with the qualified mental retardation professional (QMRP). She said the client was legally blind but had some, limited vision.	W 120	W120 The QMRP will meet the day program to revise the speech and language program for client #3 (terminate the program to identify items by color and add a more functional program). In the future the QMRP will ensure for all individuals are provided with an annual assessment or as indicated in the recommendation on the current assessment report. The QMRP will ensure all individuals programs are modified every six months or when the individual has successfully completed the goals and objectives identified in the individual support plan. The QMRP will make sure all individuals' goals are measurable. The meeting will occur by 8-30-10. The QMRP will review monthly progress reports from the day program to monitor the objectives implemented and will review the status of such programs during her monthly visits. In the future all monthly reports from the day program will be requested by the QMRP in order to review and monitor active treatment by 8-30-10	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Anne Gordon
TITLE: President
(X6) DATE: 8/18/10

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

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W 120	Continued From page 1 Client #3 was observed at his day program on 7/21/2010. At 1:43 p.m., a day program direct support staff person placed a small, red wooden object in his hand and said "Red, look at me <client's name>, red. Can you put your fingers up to your chin?" She took his hand in hers and she provided hand over hand guidance for him to make the gesture for "red" in American Sign Language. The client, however, did not respond to her prompts. She repeated the same requests and prompts at least eight times for the word "red" then made similar attempts to teach him the gestures for "blue" and "orange;" however, the client did not respond accordingly. The staff continued prompting him to make signs/gestures until she stopped at 1:55 p.m. The staff indicated that Client #3 had limited vision. The client extended his hand for a hand shake after this surveyor extended his hand. On 7/21/2010, beginning at 2:17 p.m., interview with the day program speech therapist revealed that she had assessed Client #3 several years earlier. She further indicated that she had not worked directly with the client for two years; however, she believed that he functioned at the 9-12 month level and teaching him to sign colors would not be appropriate. The client's day program coordinator also questioned whether teaching him signs was appropriate. Upon return to the home on 7/21/2010, at 3:34 p.m., review of Client #3's records revealed a Speech/Language Assessment dated 8/16/2008. The assessment did not recommend teaching him sign language. Instead, it recommended a training objective as follows: "<Client's name> will make choice selections when provided with two	W 120		

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W 120	Continued From page 2 or more selections. Choices provided can include exercises, leisure activities and/or chores." At approximately 5:22 p.m., interview with the QMRP revealed that the client used to receive sign language training in the home; however, she had discontinued that program in 7/2009 after he failed to make progress. A direct support staff person who was present at the time, confirmed what the QMRP had just stated. On 7/22/2010, at 4:50 p.m., review of Client #3's day program plan, dated 9/1/2009, revealed that the plan included a training objective for him to learn the signs for four colors. It did not include the choice-making program that was being implemented in the home. At approximately 5:15 p.m., the QMRP stated that she had not observed the sign language program being implemented at the day program and was unfamiliar with it. She again stated that Client #3 had not shown progress from past efforts to teach him sign language.	W 120		
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that clients' involved family members and/or legal guardians were notified of significant incidents, for two of the six clients residing in the facility. (Clients #3 and #5)	W 148	W148 The responsibility to insure that family and legal guardians are notified of incidents will be given to the QMRP exclusively and will be monitored by the incident management coordinator on an incident-by-incident basis...8-20-10 Follow up will be reviewed in weekly management meetings to routinely audit follow up...8-20-10	

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W 148	Continued From page 3 The finding includes: On 7/20/2010 beginning at 9:45 a.m., review of incident reports revealed that on 1/28/2010, the facility received an allegation of neglect from an anonymous caller. According to the anonymous complainant, the driver and driver's aide who were transporting Clients #3 and #5 allegedly were under the influence of illegal drugs. Review of the corresponding internal investigative report, dated 1/31/2010, revealed that the allegation had been "substantiated" after the two employees' urine tested positive for marijuana. Further review of the incident report and investigation failed to show evidence that families and/or legal guardians were notified of the allegation of neglect or the findings of the internal investigation. On 7/23/2010, beginning at 10:10 a.m., concurrent interviews with both the qualified mental retardation professional (QMRP) and the incident management coordinator (IMC) in the facility confirmed that the driver and the aide had both tested positive for marijuana. Both employees' employment was terminated due to the findings. Further interview revealed that either the QMRP or the IMC were responsible for notifying family members and guardians. They both acknowledged, however, that Client #3's guardian and Client #5's uncle were not notified of the allegation of neglect or the findings of the internal investigation.	W 148		
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.	W 159		

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W 159	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's qualified mental retardation professional (QMRP) failed to coordinate and monitor active treatment programs, for three of the three sampled clients. [Clients #1, #2 and #3] The findings include: 1. Cross-refer to W189. The QMRP failed to ensure all staff was effectively trained to assist Clients #1 and #3 with transfers and ambulation. 2. Cross-refer to W194. The QMRP failed to ensure all staff was effectively trained to implement Client #3's meal-time protocol and Client #2's behavior support plan. 3. Cross-refer to W216. The QMRP failed to ensure that clients' self-medication skills were assessed to determine potential training needs. 4. Cross-refer to W220. The QMRP failed to ensure that Client #3 received an updated speech assessment to determine his speech and communication needs. 5. Cross-refer to W252. The QMRP failed to ensure that staff documented Client #2's rumination behavior in accordance with his behavior support plan. 6. Cross-refer to W255. The QMRP failed to revise Client #3's communication/choice-making objective after he successfully achieved the prescribed performance criteria.	W 159	W159 The issues identified under W159 have been addressed as evidenced by the responses for W189, W194, W216, W220, W252, W255, W356, W436 and W474.	

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W 159	Continued From page 5 7. Cross-refer to W356. The QMRP failed to ensure the effective maintenance of Client #3's oral health. 8. Cross-refer to W436. The QMRP failed to ensure clients received their prescribed adaptive equipment during meals. 9. Cross-refer to W474. The QMRP failed to ensure clients received their meals in the form and texture prescribed to meet their needs.	W 159		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure staff was effectively trained to ensure clients received the proper assistance during transfers and ambulation, for two of three sampled clients. [Clients #1 and #3] The findings include: 1. On 7/20/2010, at 7:17 a.m., a direct support staff person (S15) came to the living room sofa where Client #3 was seated. He stood directly in front of the client, stretched out both of his arms and asked him to take his hands. The client took hold of S15's hands as instructed, and S15 pulled the client towards him. With S15 pulling, the client stood up. They walked to the dining room table, with S15 walking backwards (ahead of the client, leading) while the client held his hands.	W 189	W189 1. PT will re-train all staff members on the ambulation assistance protocol for client #3. The training will occur by...9-7-10. The QMRP will train staff by...8-17-10. 2. BRA will insure that all staff who missed the previous training by PT attends the next training and that all staff that were trained in the previous session receive refresher training...9-7-10	

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W 189	Continued From page 6 Moments later, they left the dining room and walked up the stairs into the hallway leading to the clients' bedrooms. They walked together in the same manner observed moments earlier, hand in hand, with S15 in front (walking backwards), and Client #3 following him (walking forwards). Later that morning (7/20/2010), at 10:38 a.m., another staff person (S31) approached Client #3 as he sat on the sofa. She stood directly in front of the client, stretched out both of her arms and instructed him to stand up. The client took hold of S31's hands and she pulled. He stood up. Together, they went upstairs for the client to use the restroom. This staff (S31) walked to the client's left side, rather than walking backwards in front of him, as S15 was observed doing earlier. 2. Client #1 was observed at his day program on 7/21/2010. At 11:21 a.m., the client and his 1:1 staff person (S19) were seated next to one another on a leather sofa. They remained seated for approximately 14 minutes. At 11:35 a.m., the 1:1 staff stood up, moved directly in front of the client, stretched out both of his arms and instructed him to take his hands. Client #1 took hold of S19's hands. With considerable effort, S19 pulled the client towards him and the client stood up. Together, they walked slowly to the nurse's office. On 7/21/2010, at 4:30 p.m., review of Client #1's physical therapy (PT) evaluation, dated 10/28/2009, revealed the following: "...requires moderate to maximum assistance of one person to stand from a low surface. He loses his balance backwards initially... He continues to lose his balance backward when trying to stand from a	W 189		

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W 189	Continued From page 7 low surface." The PT's recommendations included "Do not allow <client's name> to sit on the couch." At 4:32 p.m., interview with the qualified mental retardation professional (QMRP) and the facilities coordinator (FC) revealed that they were previously unaware that Client #3 sat on a sofa at day program. They confirmed that the client was prone to lose his balance while standing. However, they both described how Client #1 might fall forwards (not backwards) and because he lacked the reflex to protect his face when falling, he was at risk of injury. That was the primary reason for assigning 1:1 staff support, 24 hours/7 days a week. Further interview revealed that the physical therapist had conducted a staff in-service training on 7/8/2010. On 7/21/2010, at 4:49 p.m., review of the 7/8/2010 training materials revealed no evidence that staff should assist Clients #1 and #3 to stand up from a sitting position by standing in front of them and pulling on their arms. In addition, review of the 7/8/2010 signature sheets revealed that S19 and S31 had not attended the PT training. Further review of the 7/8/2010 signature sheets revealed that 4 of the 9 staff who were designated to provide 1:1 support for Client #1 had not attended the in-service training. At approximately 5:20 p.m., the QMRP, FC and staff S29 were asked whether staff should stand in front of the client, hold the client's hands and pull him up from a seated position; in unison, they all replied "no." There was no evidence that all staff working with Clients #1 and #3 had received the training necessary to provide them with effective, competent physical assistance.	W 189		
W 194	483.430(e)(4) STAFF TRAINING PROGRAM	W 194		

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W 194	Continued From page 8 Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure all staff were competent in implementing clients' mealtime feeding protocols and behavior support plans, for two of the three sampled clients. [Clients #2 and #3] The findings include: 1. Observation on 7/22/2010, at 1:52 p.m. revealed Client #3 was observed eating a meal of French fries and chicken nuggets from a local fast food restaurant for lunch. The meal appeared consistent with being served a medium order of French fries and six (6) chicken nuggets. Client #3 was also served a small cup of diet cranberry juice and water as part of his lunch. The attending staff was interviewed at the time of the observation and confirmed the contents of the meal and that the meal was from a local fast food restaurant. Record review on 7/23/2010, at 10:47 a.m., revealed Client #3's 7/2010 Physician's Order Sheet prescribed a "1500 calorie - chopped; low cholesterol - low sodium - high fiber - low fat diet." The order had been in effect since 5/2/2008. Interview with the facility's nursing staff and qualified mental retardation professional (QMRP) on 7/23/21010, at approximately 1:45 p.m.	W 194	W194 1. The QMRP will re-train staff on the diet regimen of client #3 by...8-19-10. Nutrition services will follow up with more formal training by...9-7-10. The QMRP (weekly at minimum each shift) and shift leaders will monitor compliance on an ongoing and daily (shift leaders) basis...8-20-10 2. See responses for W249 and W252	

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W 194	Continued From page 9 confirmed Client #3 should not have been served a meal of chicken nuggets and French fries for lunch based on his dietary restrictions. The QMRP indicated she would ensure staff was retrained on Client #3's dietary regimen. The facility failed to ensure the accurate and consistent implementation of Client #3's prescribed diet as written. 2. Cross-refer to W249 and W252. Facility staff failed to demonstrate competence in implementing Client #2's behavior support plan.	W 194		
W 216	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include physical development and health. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that each client was assessed for skills associated with administering their own medical treatment, to include current skills and potential self-medication training needs, for one of the three clients in the sample. (Client #1) The finding includes: On 7/20/2010, at approximately 2:45 p.m., the facility's Registered Nurse (RN) was asked whether the clients had programs designed to develop or strengthen their self-medication skills. The RN replied "yes, the medication nurses do those." The evening medication pass was observed on 7/20/2010, beginning at approximately 5:45 p.m.	W 216	W216 Each individual supported will be reassessed for self-medication skills using a standard tool. Subsequently, the QMRP and RN will collaborate in developing self-medication programs for each person that reflects their existing skill levels and potential for growth. Assessments completed by...8-20-10 New Programs developed by...8-30-10 Staff (LPNs and DSPs) trained by and programs implemented by...9-15-10	

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W 216	Continued From page 10 The licensed practical nurse (LPN) poured and/or prepared the medications for all six clients while in the nurse's office, located on the lower level of the facility. None of the six clients participated in preparing the medications. At 6:16 p.m., the LPN carried the tray of poured medications upstairs to the kitchen, where she proceeded to administer medications to five of the six clients. At 6:24 p.m., the LPN spoon-fed Client #1's medications mixed with apple sauce. For each of the six clients, either a direct support staff person or the LPN herself obtained water for the medication pass. The LPN performed all aspects of the medication pass, except when she asked Client #6 to discard his empty cup. The medication pass was verified the next day (7/21/2010), beginning at 9:02 a.m. None of the six clients' medical records, including the medication administration records (MARs), reflected any programs designed to teach them self-medication skills. On 7/21/2010, at 12:30 p.m., Client #1 was observed feeding himself independently with a spoon while at his day program. The client, however, had not been asked by the LPN to spoon his own apple sauce-medication mixture during the observed medication pass. On 7/23/2010, review of Client #1's Annual Nursing Assessment dated 11/1/2009, and other medical and habilitation records failed to show evidence that his self-medication skills had been assessed within the last eight years.	W 216		
W 220	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include speech and language development.	W 220		

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W 220	Continued From page 11 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to reassess speech and language needs, to determine if a client might benefit from new training objectives for one of the three clients in the sample. (Client #3) The finding includes: Cross-refer to W120. Observations in the home on 7/20/2010 followed by interview with the qualified mental retardation professional (QMRP) revealed that Client #3 was legally blind but had some, limited vision. The client was observed at his day program the next day (7/21/2010). Beginning at 1:43 p.m., a day program direct support staff person was observed trying to teach him how to sign the words "red," "blue" and "orange." The client, however, did not respond to her prompts. Upon return to the home on 7/21/2010, at 3:34 p.m., review of Client #3's records revealed a Speech/Language Assessment dated 8/16/2008. The assessment did not recommend teaching him sign language. Instead, it recommended a training objective as follows: "<Client's name> will make choice selections when provided with two or more selections. Choices provided can include exercises, leisure activities and/or chores." At approximately 4:20 p.m., the QMRP stated that she witnessed the speech therapist perform a partial swallow safety assessment in the home on 7/11/2010. According to the QMRP, the assessment did not include language skills. Further interview with the QMRP, at 5:22 p.m., revealed that the client used to receive sign	W 220	W22D The speech pathologist has been notified and has begun working on a new speech and language assessment for client #3. In the future the QMRP will ensure that annual assessments are completed as indicated in the recommendations of the current assessment and all recommended goals and objectives are measurable. It will be completed by...8-30-10. If a new speech and language program is recommended, staff will be trained on its mandates. The QMRP will ensure in the future that annual assessment are received as outlined with measurable objectives and it will be implemented by...9-15-10 All findings will be shared with the day program to insure service coordination. In the future the QMRP will monitor day program on an at least monthly basis. This will occur by...9-15-10 The QMRP will track and monitor the implementation of all recommendations accepted and will review progress in her monthly notes. In the future all active treatment in the home and the day program will be reviewed and monitored by the QMRP and day program reports will be reviewed and requested on a monthly basis...9-1-10	

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	09G071	A. BUILDING _____ B. WING _____	07/23/2010

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W 220	Continued From page 12 language training in the home; however, she had discontinued that program in July 2009 after he failed to make progress. A direct support staff person who was present at the time, confirmed what the QMRP had just stated. The QMRP also acknowledged that Client #3's speech and communication skills had not been assessed in two years. It should be noted that Client #3's Speech/Language Assessment dated 8/16/2008, had recommended "annual evaluation of communication skills."	W 220		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, interview and record review, facility staff failed to consistently implement client behavior support plans, for one of the three clients in the sample. (Client #2) The finding includes: On 7/20/2010, Client #2 was observed having breakfast at 7:02 a.m. Afterwards, he sat on the living room sofa. He was not engaged in a meaningful activity while seated on the sofa. At approximately 7:05 a.m., the client started making	W 249	W249 While staff acknowledge that client #2 exhibited the rumination behavior on the day indicated by the surveyor, staff also are steadfast that the behavior had not been exhibited for an extended period of time before the survey date. Psychology services have begun a new baseline data sheet to re-examine the frequency and intensity of the rumination behavior. Staff was trained on collecting the baseline data on...8-11-10. In the future the QMRP will ensure that there are baseline data sheets for all the individuals in the home and the information reported to the Psychologist. The Psychologist will provide training on a quarterly basis for staff so that new staff in the home is also properly trained by the Psychologist. Staff was also reinforced to engage client #2 as per his protocol strategies in the am after the breakfast meal and to otherwise follow the preventative strategies outlined...8-13-10 In the future the QMRP will ensure that all individuals BSP are properly followed with routine training and mealtime observations as needed. The QMRP will also ensure that routine monitoring follow up during weekly active treatment observations is completed in a timely manner...8-13-10.	

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W 249	Continued From page 13 a guttural sound in his throat. He stopped briefly but then resumed making the grunt/snorting sounds at 7:11 a.m. His legs were crossed, his head faced downward, his mouth was moving, and he had his right hand up to his mouth. A direct support staff person was seated next to Client #2 at the time. The client made more of those sounds while moving his mouth at 7:14 a.m. Later that day, at 1:10 p.m., a day program staff person indicated that in the past, Client #2 had a behavior support plan (BSP) that was discontinued on 2/27/2009. The BSP had addressed "rumination." The day program staff stated that the behavior had improved since the client's diet was changed to a liquid diet and he was not observing the behavior. The qualified mental retardation professional (QMRP) and facilities coordinator (FC) were interviewed later that afternoon (7/20/2010) in the home. At approximately 2:30 p.m., they confirmed that Client #2's ruminating behavior had improved since the change in diet. The QMRP referred to it as "an old behavior...<he> has not done it" in a while. The FC affirmed this but then added "they <staff> still should document it." When provided a verbal description of the morning observations, they confirmed that this was consistent with Client #2's "rumination" behavior. On 7/23/2010, at approximately 10:55 a.m., review of Client #2's behavior support plan (BSP) dated 2/1/2010, revealed "rumination" was one of five challenging maladaptive behaviors currently being addressed. The BSP outlined pro-active strategies for staff to implement, including the following: "After <client's name> washes up after breakfast, he should be engaged in an activity	W 249		

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W 249	Continued From page 14 until it is time to leave for the day program. Examples of activities may include assisting in a household chore, manipulating an object or various other multi-sensory activities." Staff were not observed implementing Client #2's BSP on the morning of 7/20/2010.	W 249		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure consistent documentation of progress on the Individual Program Plan (IPP) objectives, for one of the three clients in the sample. (Client #2) The findings include: 1. Cross-refer to W249. Observation on 7/20/2010, between 7:04 - 7:14 a.m., revealed Client #2 ruminating while seated on the living room sofa. A direct support staff person was seated next to him and failed to intervene. Client #2's behavior support plan (BSP) dated 2/1/2010, was reviewed on 7/23/2010, beginning at 10:55 a.m. "Rumination" was one of five challenging maladaptive behaviors identified in the BSP. According to the BSP, staff should document each episode of a targeted behavior that was observed. Review of the client's behavior data on 7/23/2010, at 11:15 a.m. revealed that staff had not documented the	W 252	W252 The QMRP will ensure that all support staff are re-trained by the behavioral specialist as well as on-going training provided by the QMRP on all individuals behavior implementation. The QMRP will ensure that the day program staff are documenting each time client #2 displays the behavior of rumination as well as informing the home of the displayed behavior on the monthly report that is sent to the home. The QMRP will ensure that the behavior support plan addresses the target behavior for rumination. In the future baseline behavior data sheets will be placed in all the individuals' program books so support staff is able to document old behaviors and any new behaviors. The QMRP will also ensure that support staff is trained on behavioral documentation and the ABC data sheet. Implementation is an on-going process with training on the behavioral support plans for all individuals at least quarterly...08-30-10	

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W 252	Continued From page 15 episode of rumination. 2. The 7/23/2010 review of Client #2's behavior data sheets revealed that while there were data collection sheets for the first four targeted maladaptive behaviors (agitation; picking up cigarette butts; seeking food during nighttime hours; and, masturbating in public), there were no similar data collection sheets in his program book for documenting the fifth targeted behavior, rumination. It should be noted that on 7/20/21010, at approximately 2:30 p.m., the qualified mental retardation professional referred to his rumination behavior as "an old behavior...<he> has not done it" in a while.	W 252		
W 255	483.440(f)(1)(i) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's qualified mental retardation professional (QMRP) failed to revise the individual plan after the client successfully completed an objective, for one of the three clients in the sample. (Client #3) The finding includes: Cross-refer to W120 and W220. Observations at	W 255	W255 The communications program for client #3 will be modified subsequent to the speech pathology assessment...8-30-10 At minimum quarterly, the QMRP will review progress on all objectives implemented per the ISP and insure that program implementation strategies are modified based on the individual's progress or the lack thereof. In the future the QMRP will ensure that all assessments are completed by each clinician as specified in the annual assessment recommendation and modification to programs are completed as needed....9-1-10 In the assessment process, the speech pathologist will determine if client #3 would benefit from the use of adaptive equipment to support expressive language and recommend the appropriate device needed. The QMRP will also request that all individuals in the home be assessed for the use of a communication device where needed....09-01-10	

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W 255	Continued From page 16 Client #3's day program revealed that he did not respond to prompts from staff when she attempted to implement a communication (sign language) program. The QMRP stated that the client's failure to learn sign language in the home led her to drop that program a year earlier, in 7/2009. On 7/21/2010, beginning at 3:45 p.m., review of the Client #3's program book revealed that the QMRP had been monitoring the implementation (in the home) of the following program:"<Client's name> will make choice selections when provided with two or more selections. Choices provided can include exercises, leisure activities and/or chores." At 3:50 p.m., review of QMRP Monthly Progress Notes for the period August 2009 - June 2010, revealed that each month, the QMRP wrote "<Client #3's name> has met the criteria for the above objective. <Client's name> will continue current objective as outlined." On 7/22/2010, at approximately 5:30 p.m., the QMRP acknowledged that the program had not been revised since the client met the performance criteria eleven months earlier. It should be noted that the QMRP stated that she witnessed the speech therapist perform a partial swallow safety assessment in the home on 7/11/2010. However, the QMRP indicated that the observed assessment process had not addressed language/communication skills. She further stated that to her knowledge, the client had not been assessed to determine potential benefit from the use of adaptive communication devices.	W 255		
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental	W 356		

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W 356	Continued From page 18 inflammation. Tooth #6 root tip needs extraction." The dentist recommended: "Scaling of remaining teeth indicated." Further record review on 7/23/2010, at 1:10 p.m. revealed Client #3's individual program plan (IPP) dated 8/3/2009, outlined "Objective: 2.B - [Client #3] will brush his teeth with verbal and physical assistance from staff twice daily (morning and evening) 75% of the time for six consecutive months." Despite the evidence of a written plan and the implementation of said plan, Client #3's oral health had declined between his 11/9/2009 and 5/10/2010 appointments. Interview with the facility's nursing staff and qualified mental retardation professional (QMRP) on 7/23/2010, at approximately 2:00 p.m. confirmed, Client #3's oral health had declined between 11/2009 and 5/2010. In addition, the QMRP and the facility's nurse indicated Client #3's oral health needs would be reassessed and adjusted to meet his declined status. The facility failed to ensure that Client #3's oral health did not worsen after his 11/2009 assessment.	W 356		
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that all drugs were administered in compliance with the physician's orders, for two of the six clients	W 368		

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W 356	Continued From page 17 treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to effectively maintain the oral health of one of three sampled clients. [Client #3] The finding includes: Observation during the evening of 7/22/2010, revealed Client #3 was missing some of his front teeth. Record review on 7/23/2010, at 10:55 a.m. revealed the following dental history: 1. Dental assessment dated 7/22/2009, detailed: "Patient presents to this office for routine dental care but refused treatment ... Next appointment: 10/27/2009, at 11:15 a.m." 2. Dental assessment dated 11/9/2009, included the following findings: "Annual oral examination. Plaque and calculus deposits are present on all remaining teeth surfaces. Full mouth scaling is recommended." The consult also indicated: "patient is uncooperative during dental procedures please sedate the patient one hour prior to the next dental appt." 3. Dental assessment on 5/10/2010, revealed the following: "Clinical examination reveals heavy deposits of plaque and calculus present on all remaining teeth surfaces ... Oral hygiene very poor. Periodontal examination reveals presence of sub-g calculus that cause gingival	W 356	W356 There have been problems with denials of dental services for client #3 and others. BRA will seek alternatives to the incumbent dentist and will work with the service coordinator and Georgetown support RN to insure that the needed deep scaling is completed...9-15-10	

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W 368	Continued From page 19 residing in the facility. (Clients #5 and #6) The findings include: The evening medication pass was observed on 7/20/2010, beginning at approximately 5:45 p.m. 1. Cross-refer to W369.1. Client #6 was administered Hydroxyzine HCL (Atarax) 10 mg at approximately 6:26 p.m. However, review of his physician's orders and medication administration record (MAR) on 7/21/2010, at 9:10 a.m., revealed an order: "Hydroxyzine HCL 10 mg take 1 tablet daily at bedtime." Further review of Client #6's 7/2010 MAR revealed that he consistently received the Hydroxyzine HCL with his 6:00 p.m. medications, 3-4 hours prior to bedtime. Subsequent interview with the RN revealed that the medical team had not identified the ongoing timing error prior to the survey. 2. Cross-refer to W369. Client #5's July 2010 POs reflected 30 ml Lactulose to be administered at 6:00 p.m. every evening. During the 7/20/2010 evening medication administration, the medication nurse was observed to prepare 29 - 29 1/2 ml of Lactulose instead. After she poured the stool softener, she placed it on the medication tray and began preparing another medication. After she was informed that the Lactulose was not 30 ml, she examined it, acknowledged that it was low, then added more Lactulose, to the 30 ml mark on the medication cup.	W 368	W368 1. The medication regimen has been changed for client #6 to reflect the time the medication is actually given and the Primary Care Physician has confirmed that the change will not affect the effectiveness of the regimen...8-13-10 2. The RN has provided feedback to the medication administration LPN reinforcing the importance of accurately measuring liquid medication...8-12-10. The RN will periodically observe med passes to insure compliance...8-30-10.	
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.	W 369		

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W 369	Continued From page 20 This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that all drugs were administered without error, for two of the six clients residing in the facility. (Clients #5 and #6) The findings include: 1. The evening medication pass was observed on 7/20/2010, beginning at approximately 5:45 p.m. Client #6 was administered Hydroxyzine HCL (Atarax) 10 mg at approximately 6:26 p.m. On 7/21/2010, at 9:10 a.m., review of Client #6's 7/2010 physician's orders (POs) revealed an order: "Hydroxyzine HCL 10 mg take 1 tablet daily at bedtime." The qualified mental retardation professional (QMRP) was present at that time. She stated that clients typically took their showers between 8:00-8:30 p.m. and went to bed some time between 9:00-10:00 p.m. At 10:08 a.m., review of Client #6's July 2010 medication administration record (MAR) revealed that he consistently received the Hydroxyzine HCL with his 6:00 p.m. medications, three or four hours prior to bedtime. At approximately 10:20 a.m., the RN replied "no" when asked if Client #6's medical team had discussed the difference between how the order was written ("at bedtime") versus the ongoing administration time of 6:00 p.m. She examined the MAR, confirmed the discrepancy and then telephoned the primary care physician (PCP). A few minutes later, she reported that based on her conversation with the PCP, Client #6's order would be changed to reflect an earlier administration time. 2. Client #5's July 2010 POs reflected 30 ml	W 369	W369 1. The medication regimen has been changed for client #6 to reflect the time the medication is actually given and the Primary Care Physician has confirmed that the change will not affect the effectiveness of the regimen...8-13-10 2. The RN has provided feedback to the medication administration LPN reinforcing the importance of accurately measuring liquid medication...8-12-10. The RN will periodically observe med passes to insure compliance...8-30-10.	

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W 369	Continued From page 21 Lactulose to be administered at 6:00 p.m. every evening. During the 7/20/2010 evening medication administration, the medication nurse was observed to prepare 29 - 29 1/2 ml of Lactulose instead. After she poured the stool softener, she placed it on the medication tray and began preparing another medication. After she was informed that the Lactulose was not 30 ml, she examined it, acknowledged that it was low, then added more Lactulose, to the 30 ml mark on the medication cup.	W 369		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure clients received their prescribed adaptive equipment during meals, for one of the three sampled clients. [Client #3] The findings include: 1. Observation on 7/22/2010, at 1:52 p.m. revealed Client #3 was provided an elevated tray, a divided plate and a built-up handled spoon for him to eat his lunch. Record review on 7/23/2010, at 10:33 a.m., however, revealed Client #3's 9/25/2009 annual Nursing assessment outlined "the use of a plate guard, built up handled spoon, sectional plate" as part of his	W 436	W436 1. The new RN made in error in indicating a plate guard for client number three in her nursing assessment. The other equipment indicated is accurate and is being provided. The RN will correct her assessment...8-17-10. The QMRP will review all assessments before they are finalized to audit for such considerations...8-30-10 2. The QMRP re-trained staff on providing the proper eating equipment for meals and snacks...8-8-10	

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W 436	Continued From page 22 adaptive equipment. The facility failed to ensure he was provided his plate guard for lunch. Interview with the facility's nursing staff and qualified mental retardation professional on 7/23/2010, at approximately 7:50 p.m. confirmed Client #3 should have been provided his plate guard during lunch. The QMRP indicated she would ensure staff received additional training on Client #3's adaptive equipment needs. 2. Observation on 7/22/2010, at approximately 4:35 p.m. revealed Client #3 was provided his snack of sliced bananas on a napkin which was placed on the dining room table. He was not provided any eating utensils during snack. Record review on 7/23/2010, at 10:38 a.m., however, revealed Client #3's 6/19/2010 Mealtime Protocol outlined "Sectional divided plate, slightly built-up handled spoon, plate lifter and regular cup" as part of his adaptive equipment. The facility failed to ensure he was provided his divided plate, the slight built-up spoon and his plate lifter during snack. Interview with the facility's nursing staff and qualified mental retardation professional on 7/23/2010, at approximately 7:55 p.m. confirmed Client #3 should have been provided his adaptive equipment during snack. The QMRP indicated she would ensure staff received additional training on Client #3's adaptive equipment needs.	W 436		
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:	W 474		

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	09G071	A. BUILDING _____ B. WING _____	07/23/2010

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W 474	Continued From page 23 Based on observation, staff interview and record review, the facility failed to ensure clients received their meals in the form and texture prescribed to meet their needs, for one of three sampled clients. [Client #3] The finding includes: Observation on 7/22/2010, at 1:52 p.m. revealed Client #3 ate a meal of French fries and chicken nuggets from a local fast food restaurant for lunch. The French fries were served whole and the chicken nuggets were cut into bite sized chunks. The attending staff was interviewed at the time of the observation and confirmed the contents of the meal and that the nuggets were in bite sized pieces. Record review on 7/23/2010, at 10:47 a.m., revealed Client #3's 7/2010 Physician's Order Sheet prescribed a "1500 calorie - chopped; low cholesterol - low sodium - high fiber - low fat diet." The order had been in effect since 5/2/2008. Interview with the facility's nursing staff and qualified mental retardation professional (QMRP) on 7/23/2010, at approximately 1:50 p.m. confirmed, all Client #3's meals should be served chopped as prescribed on his physician's orders. The QMRP indicated she would ensure staff was retrained on Client #3's food texture restrictions. The facility failed to ensure the accurate and consistent implementation of Client #3's prescribed diet as written.	W 474	W474 The QMRP will re-train staff on the diet regimen of client #3 by...8-19-10. Nutrition services will follow up with more formal training by...9-7-10. The QMRP (weekly at minimum each shift) and shift leaders will monitor compliance on an ongoing and daily (shift leaders) basis...8-20-10	

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I 000	INITIAL COMMENTS A licensure survey was conducted from 7/20/2010 through 7/23/2010. A sample of three residents was selected from a population of six men with various degrees of cognitive and intellectual disabilities. The findings of the survey were based on observations, interviews with staff in the home and at three day programs, as well as a review of resident and administrative records, including incident reports.	I 000		
I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group Home for Persons with Mental Retardation (GHMRP)'s qualified mental retardation professional (QMRP) failed to coordinate and monitor habilitation programs, for three of the three sampled residents. [Residents #1, #2 and #3] The findings include: 1. Cross-refer to I229.1. The QMRP failed to ensure all staff was effectively trained to assist Residents #1 and #3 with transfers and ambulation. 2. Cross-refer to I229.2. The QMRP failed to ensure all staff was effectively trained to implement Resident #3's meal-time protocol and Resident #2's behavior support plan.	I 180	3508.1 The issues identified under 3508.1 have been addressed as evidenced by the response for 1229, 1229.2, 1401.1, 1401.2, 1229.3, 1424, W356, W436, and W474.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Linda Graham, Program Director TITLE (X6) DATE 08/18/2010

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I 180	Continued From page 1 3. Cross-refer to I401.1. The QMRP failed to ensure that cleints' self-medication skills were assessed to determine potential training needs. 4. Cross-refer to I401.2. The QMRP failed to ensure that Resident #3 received an updated speech assessment to determine his speech and communication needs. . 5. Cross-refer to I229.3. The QMRP failed to ensure that staff documented Resident #2's rumination behavior in accordance with his behavior support plan. 6. Cross-refer to I424. The QMRP failed to revise Resident #3's communication/choice-making objective after he successfully achieved the prescribed performance criteria. 7. Cross-refer to Federal Deficiency Report - Citation W356. The QMRP failed to ensure the effective maintainance of Resident #3's oral health. 8. Cross-refer to Federal Deficiency Report - Citation W436. The QMRP failed to ensure residents received their prescribed adaptive equipment during meals. 9. Cross-refer to Federal Deficiency Report - Citation W474. The QMRP failed to ensure residents received their meals in the form and texture prescribed to meet their needs.	I 180		
I 192	3508.8(c) ADMINISTRATIVE SUPPORT Each GHMRP licensee shall carry or ensure that the premise carries the following insurance in at least the following amounts:	I 192		

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I 192	Continued From page 2 (c) Professional Liability This Statute is not met as evidenced by: Based on record review and interview, the Group Home for Persons with Mental Retardation (GHMRP) failed to have on file for review, professional liability insurance for two of seventeen consultants. (Speech and Occupational Therapist #3) The finding includes: Review of the personnel records at approximately 9:00 a.m. on 7/23/2010, revealed the GHMRP failed to have evidence of professional liability insurance for the speech and language therapist and the occupational therapist. These deficiencies were acknowledged by the facilities coordinatɒr 7/23/10 at approximately 5:15 p.m.	I 192	3508.8 (c) The QMRP will ensure the Speech and Language Therapist and the Occupational Therapist and all of other clinicians turn in their current Health Certificate, License, and Insurance in a timely manner. The QMRP will ensure all required documents to include health certificates, licenses, and liability insurance is kept up to date by monitoring the records and sending out reminders letters to all clinicians of their up-coming due date.....8-19-10	
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Persons with Mental Retardation	I 206		

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I 206	Continued From page 3 (GHMRP) failed to ensure each staff and consultant had a current health certificate on file for review, for two of thirty-two staff and four of seventeen consultants. The finding includes: On 7/22/2010, beginning at 3:30 p.m., interview with the qualified mental retardation professional (QMRP) and review of the personnel records revealed the GHMRP failed to provide evidence that current health certificates were on file for two of the thirty-two staff (Staff #9 and #12) and four of the seventeen consultants (occupational therapist, podiatrist, one LPN and the speech and language therapist). These deficiencies were acknowledged by the QMRP and the facilities coordinator on the next day (7/23/2010), at approximately 8:45 am. This is a repeat deficiency. --- Previously, the Licensure Deficiency Report, dated 6/19/2009, cited the failure to show evidence of health certificates for four out of sixteen direct support staff and four consultants.	I 206	3509.6 The QMRP will ensure all personnel records to include direct care staff health certificates are kept current and on file at all times. The QMRP will also ensure that all clinicians records to include health certificates, license, and liability insurance is current and on file at all times. In the future the QMRP will ensure all required documents to include health certificates, licenses, and liability insurance is kept up to date by monitoring the records and sending out reminders letters to all staff and clinicians of their up-coming due date....8-19-10	
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;	I 227		

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I 227	Continued From page 4 This Statute is not met as evidenced by: Based on record review, the Group Home for Persons with Mental Retardation (GHMRP) failed to have on file for review, current training in cardiopulmonary resuscitation (CPR), for six of the thirty-two staff (Staff #17, #20, #21, #25, #27 and #29), and current training in first aid, for five of the thirty-two staff (Staff #17, #20, #21, #27 and #29). The finding includes: Review of the personnel and training records on 7/23/2010, beginning at 9:30 a.m., revealed the GHMRP failed to provide documentation of staff training in CPR, for six of the thirty-two staff (Staff #17, #20, #21, #25, #27 and #29) and training in first aid, for five of the thirty-two staff (Staff #17, #20, #21, #27 and #29). This is a repeat deficiency. --- Previously, the Licensure Deficiency Report, dated 6/19/2009, cited the failure to show evidence of CPR and First Aid training for seven out of sixteen direct support staff.	I 227	3510.5 (d) The QMRP will ensure all direct care staff are certified with current CPR and First Aid certifications. The QMRP will ensure the required CPR and First Aid certifications are kept up to date by monitoring the records and scheduling timely trainings....8-19-10	
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies;	I 229		

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I 229	Continued From page 5 This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group Home for Persons with Mental Retardation (GHMRP) failed to ensure staff was effectively trained to ensure residents received the proper assistance during transfers and ambulation, implemented mealtime protocols and implemented behavior support plans, for three of the three sampled residents. [Residents #1, #2 and #3] The findings include: 1. There was no evidence that all staff working with Residents #1 and #3 had received the training necessary to provide them with effective, competent physical assistance, as follows: a. On 7/20/2010, at 7:17 a.m., a direct support staff person (S15) came to the living room sofa where Resident #3 was seated. He stood directly in front of the resident, stretched out both of his arms and asked him to take his hands. The resident took hold of S15's hands as instructed, and S15 pulled the resident towards him. With S15 pulling, the resident stood up. They walked to the dining room table, with S15 walking backwards (ahead of the resident, leading) while the resident held his hands. Moments later, they left the dining room and walked up the stairs into the hallway leading to the residents' bedrooms. They walked together in the same manner observed moments earlier, hand in hand, with S15 in front (walking backwards), and Resident #3 following him (walking forwards). Later that morning (7/20/2010), at 10:38 a.m., another staff person (S31) approached Resident #3 as he sat on the sofa. She stood directly in	I 229	3510.5 (f) a. The QMRP will ensure all direct support staff is properly trained by the Physical Therapist on providing the correct and appropriate level of assistance when clients #1 and #3 are getting up from a seated position as well as when ambulating . In the future the QMRP will ensure all training is provided and implemented by direct care staff according to the clients assessments and specific protocols 8-19-10	

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I 229	Continued From page 6 front of the resident, stretched out both of her arms and instructed him to stand up. The resident took hold of S31's hands and she pulled. He stood up. Together, they went upstairs for the resident to use the restroom. This staff (S31) walked to the resident's left side, rather than walking backwards in front of him, as S15 was observed doing earlier. b. Resident #1 was observed at his day program on 7/21/2010. At 11:21 a.m., the resident and his 1:1 staff person (S19) were seated next to one another on a leather sofa. They remained seated for approximately 14 minutes. At 11:35 a.m., the 1:1 staff stood up, moved directly in front of the resident, stretched out both of his arms and instructed him to take his hands. Resident #1 took hold of S19's hands. With considerable effort, S19 pulled the resident towards him and the resident stood up. Together, they walked slowly to the nurse's office. On 7/21/2010, at 4:30 p.m., review of Resident #1's physical therapy (PT) evaluation, dated 10/28/2009, revealed the following: "...requires moderate to maximum assistance of one person to stand from a low surface. He loses his balance backwards initially... He continues to lose his balance backward when trying to stand from a low surface." The PT's recommendations included "Do not allow <resident's name> to sit on the couch." At 4:32 p.m., interview with the qualified mental retardation professional (QMRP) and the facilities coordinator (FC) revealed that they were previously unaware that Resident #3 sat on a sofa at day program. They confirmed that the resident was prone to lose his balance while standing. However, they both described how Resident #1 might fall forwards (not backwards) and because he lacked the reflex to	I 229	b. The QMRP will ensure that client #1 is provided with the appropriate chair to sit in while at the Day Program and is not sitting on a couch as indicated by the Physical Therapist. The QMRP will also ensure that the Day Program provider is aware of clients #1 appropriate seating arrangements to meet client #1 needs.....8-19-10	

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I 229	Continued From page 7 protect his face when falling, he was at risk of injury. That was the primary reason for assigning 1:1 staff support, 24 hours/7 days a week. Further interview revealed that the physical therapist had conducted a staff in-service training on 7/8/2010. On 7/21/2010, at 4:49 p.m., review of the 7/8/2010 training materials revealed no evidence that staff should assist Residents #1 and #3 to stand up from a sitting position by standing in front of them and pulling on their arms. In addition, review of the 7/8/2010 signature sheets revealed that S19 and S31 had not attended the PT training. Further review of the 7/8/2010 signature sheets revealed that 4 of the 9 staff who were designated to provide 1:1 support for Resident #1 had not attended the in-service training. At approximately 5:20 p.m., the QMRP, FC and staff S29 were asked whether staff should stand in front of the resident, hold the resident's hands and pull him up from a seated position; in unison, they all replied "no." 2. The facility failed to ensure the accurate and consistent implementation of Resident #3's prescribed diet, as follows: Observation on 7/22/2010, at 1:52 p.m. revealed Resident #3 was observed eating a meal of French fries and chicken nuggets from a local fast food restaurant for lunch. The meal appeared consistent with being served a medium order of French fries and six (6) chicken nuggets. Resident #3 was also served a small cup of diet cranberry juice and water as part of his lunch. The attending staff was interviewed at the time of the observation and confirmed the contents of the meal and that the meal was from McDonald's.	I 229	The QMRP will ensure all Direct Support Staff are properly trained on client #3 current diet and caloric intake of 1500 calories – chopped; low cholesterol, low sodium, high fiber , low fat diet. In the future the QMRP will monitor and provide on-going training on all current diets for all clients in the home.....8-19-10	

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I 229	Continued From page 8 Record review on 7/23/2010, at 10:47 a.m., revealed Resident #3's 7/2010 Physician's Order Sheet prescribed a "1500 calorie - chopped; low cholesterol - low sodium - high fiber - low fat diet." The order had been in effect since 5/2/2008. Interview with the facility's nursing staff and qualified mental retardation professional (QMRP) on 7/23/21010, at approximately 1:45 p.m. confirmed Resident #3 should not have been served a meal of chicken nuggets and French fries for lunch based on his dietary restrictions. The QMRP indicated she would ensure staff was retrained on Resident #3's dietary regimen. 3. Facility staff failed to demonstrate competence in implementing Resident #2's behavior support plan, as follows: a. On 7/20/2010, Resident #2 was observed having breakfast at 7:02 a.m. Afterwards, he sat on the living room sofa. He was not engaged in a meaningful activity while seated on the sofa. At approximately 7:05 a.m., the resident started making a guttural sound in his throat. He stopped briefly but then resumed making the grunt/snorting sounds at 7:11 a.m. His legs were crossed, his head faced downward, his mouth was moving, and he had his right hand up to his mouth. A direct support staff person was seated next to Resident #2 at the time. The resident made more of those sounds while moving his mouth at 7:14 a.m. Later that day, at 1:10 p.m., a day program staff person indicated that in the past, Resident #2 had a behavior support plan (BSP) that was discontinued on 2/27/2009. The BSP had addressed "rumination." The day program staff stated that the behavior had improved since the resident's diet was changed to a liquid diet and he was not observing the	I 229	a. The QMRP will ensure all staff are properly trained by the Behavior Specialist as well as on-going training provided by the QMRP on client #2 current Behavior Support Plan when addressing the behavior of rumination. The QMRP will ensure that the Day Program staff are documenting each time client #2 displays the behavior of ruminating as well as informing the home of the displayed behavior on the monthly report that is sent to the home...8-19-10.	

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I 229	Continued From page 9 behavior. The qualified mental retardation professional (QMRP) and facilities coordinator (FC) were interviewed later that afternoon (7/20/2010) in the home. At approximately 2:30 p.m., they confirmed that Resident #2's ruminating behavior had improved since the change in diet. The QMRP referred to it as "an old behavior...<he> has not done it" in a while. The FC affirmed this but then added "they <staff> still should document it." When provided a verbal description of the morning observations, they confirmed that this was consistent with Resident #2's "rumination" behavior. On 7/23/2010, at approximately 10:55 a.m., review of Resident #2's behavior support plan (BSP) dated 2/1/2010, revealed "rumination" was one of five challenging maladaptive behaviors currently being addressed. The BSP outlined pro-active strategies for staff to implement, including the following: "After <resident's name> washes up after breakfast, he should be engaged in an activity until it is time to leave for the day program. Examples of activities may include assisting in a household chore, manipulating an object or various other multi-sensory activities." Staff were not observed implementing Resident #2's BSP on the morning of 7/20/2010. It should be noted that a staff person whose shift ended at 8:00 a.m. that morning (7/20/2010) wrote the following progress note in Resident #2's record: "...ate 100% of his breakfast and now is relaxing in the day room." b. According to Resident #2's behavior support plan (BSP) dated 2/1/2010, staff should document each episode of a targeted behavior	I 229		

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I 229	Continued From page 10 that was observed. Review of the resident's behavior data on 7/23/2010, at 11:15 a.m. revealed that staff had not documented the episode of rumination.	I 229		
I 372	3519.3 EMERGENCIES Each GHMRP shall post by each telephone emergency numbers, which include at least fire and rescue squads, the local police department, each resident ' s physician, and the agency ' s on-duty administrator. This Statute is not met as evidenced by: Based on observation and interview, the Group Home for Persons with Mental Retardation (GHMRP) failed to post by each telephone, emergency numbers, which include at least fire and rescue squads, the local police department, each resident's physician, and the agency's on-duty administrator. The finding includes: On 7/22/2010, at 3:30 p.m., there was no listing of emergency phone numbers posted in the facility. This deficiency was acknowledged by the qualified mental retardation professional a short time later, at 3:45 p.m.	I 372	3519.3 The QMRP will ensure that the Emergency Contact numbers are posted in the home at all times to include Fire and rescue squad, the local police department the clients Primary Care Physician and on-duty administrator. In the future the QMRP will ensure that all homes have a current posting of all Emergency Contact numbers available to staff....08-19-10	
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident.	I 401		

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BEHAVIOR RESEARCH ASSOCIATES	1034 BURNS ST., SE WASHINGTON, DC 20019

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I 401	Continued From page 11 This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Persons with Mental Retardation (GHMRP) failed to ensure that each resident received professional assessments (specifically, skills associated with administering their own medications, and speech and language needs), for two of the three sampled residents. (Residents #1 and #3) The findings include: 1. On 7/20/2010, at approximately 2:45 p.m., the facility's Registered Nurse (RN) was asked whether the residents had programs designed to develop or strengthen their self-medication skills. The RN replied "yes, the medication nurses do those." The evening medication pass was observed on 7/20/2010, beginning at approximately 5:45 p.m. The licensed practical nurse (LPN) poured and/or prepared the medications for all six residents while in the nurse's office, located on the lower level of the facility. None of the six residents participated in preparing the medications. At 6:16 p.m., the LPN carried the tray of poured medications upstairs to the kitchen, where she proceeded to administer medications to five of the six residents. At 6:24 p.m., the LPN spoon-fed Resident #1's medications mixed with apple sauce. For each of the six residents, either a direct support staff person or the LPN herself obtained water for the medication pass. The LPN performed all aspects of the medication pass, except when she asked Resident #6 to discard his empty cup.	I 401	3520.3 The QMRP and RN will ensure that each client receive professional assessments and individually developed self-medication programs to enhance their skills. In the future the QMRP and RN will ensure all programs are appropriate, individualized to meet each client's needs and each client is given the opportunity to perform the tasks indicated on the self medication program.....8-19-10	

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I 401	Continued From page 12 The medication pass was verified the next day (7/21/2010), beginning at 9:02 a.m. None of the six residents' medical records, including the medication administration records (MARs), reflected any programs designed to teach them self-medication skills. On 7/21/2010, at 12:30 p.m., Resident #1 was observed feeding himself independently with a spoon while at his day program. The resident, however, had not been asked by the LPN to spoon his own apple sauce-medication mixture during the observed medication pass. On 7/23/2010, review of Resident #1's Annual Nursing Assessment dated 11/1/2009, and other medical and habilitation records failed to show evidence that his self-medication skills had been assessed within the last eight years. 2. Observations in the home on 7/20/2010 followed by interview with the qualified mental retardation professional (QMRP) revealed that Resident #3 was legally blind but had some, limited vision. The resident was observed at his day program the next day (7/21/2010). Beginning at 1:43 p.m., a day program direct support staff person was observed trying to teach him how to sign the words "red," "blue" and "orange." The resident, however, did not respond to her prompts. Upon return to the home on 7/21/2010, at 3:34 p.m., review of Resident #3's records revealed a Speech/Language Assessment dated 8/16/2008. The assessment did not recommend teaching him sign language. Instead, it recommended a training objective as follows: "<Resident's name> will make choice selections when provided with two or more selections. Choices provided can include exercises, leisure activities and/or	I 401	The QMRP and RN will ensure that each self-medication program is reviewed and revised annually or as each skill is accomplished to the client's fullest potential....8-19-10 2. The QMRP will ensure that the goals and objectives are measurable and competent for client #3 at his current Day Program. In the future the QMRP will monitor the current goals, objectives and progress made on a routine basis at the Day Program....8-19-10	

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I 401	Continued From page 13 chores." At approximately 4:20 p.m., the QMRP stated that she witnessed the speech therapist perform a partial swallow safety assessment in the home on 7/11/2010. According to the QMRP, the assessment did not include language skills. Further interview with the QMRP, at 5:22 p.m., revealed that the resident used to receive sign language training in the home; however, she had discontinued that program in July 2009 after he failed to make progress. A direct support staff person who was present at the time, confirmed what the QMRP had just stated. The QMRP also acknowledged that Resident #3's speech and communication skills had not been assessed in two years. It should be noted that Resident #3's Speech/Language Assessment dated 8/16/2008, had recommended "annual evaluation of communication skills."	I 401	The QMRP will ensure client #3 receives a current Speech and Language assessment and is provided a program that will also be implemented in the Day Program. In the future the QMRP will ensure client #3 is provided with an annual assessment or as indicated in the recommendations on the current assessment report....8-19-10	
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, facility staff failed to consistently implement resident behavior support plans, for one of the three residents in the sample. (Resident #2) The finding includes: Cross-refer to I229.3. Staff were not observed implementing Resident #2's behavior support plan (BSP) on the morning of 7/20/2010. Minutes after finishing his breakfast, the resident began	I 422		

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I 422	Continued From page 14 ruminating (a targeted maladaptive behavior) while seated on the living room sofa next to a direct support staff person. The staff did not intervene and failed to document the episode of rumination behavior in the resident's record, as prescribed in the BSP.	I 422	3521.3 The QMRP will ensure that all Direct Support Staff are properly trained by the Behavior Specialist as well as on-going training provided by the QMRP on client #2 current Behavior Support Plan when addressing the behavior of rumination. In the future the QMRP will ensure that the Direct Care Staff are implementing the current Behavior Support Plan as well as documenting each time client #2 displays the behavior of ruminating. This information will be monitored on a routine basis.....8-19-10	
I 424	3521.5(a) HABILITATION AND TRAINING Each GHMRP shall make modifications to the resident ' s program at least every six (6) months or when the client: (a) Has successfully completed an objective or objectives identified in the Individual Habilitation Plan; This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Persons with Mental Retardation (GHMRP)'s qualified mental retardation professional (QMRP) failed to revise the individual plan after the resident successfully completed an objective, for one of the three residents in the sample. (Resident #3) The finding includes: Cross-refer to the Federal Deficiency Report - Citations W120 and W220. Observations at Resident #3's day program revealed that he did not respond to prompts from staff when she attempted to implement a communication (sign language) program. The QMRP stated that the resident's failure to learn sign language in the home led her to drop that program a year earlier, in 7/2009. On 7/21/2010, beginning at 3:45 p.m., review of the Resident #3's program book revealed that the QMRP had been monitoring the implementation (in the home) of the following	I 424	3521.5 (a) The QMRP will ensure all programs are modified every six months or when the clients have successfully completed the goal and objectives identified in the Individual Support Plan. In the future the QMRP will ensure that all programs are measurable and appropriate for client #3 and all other clients....8-19-10	

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I 424	Continued From page 15 program:"<Resident's name> will make choice selections when provided with two or more selections. Choices provided can include exercises, leisure activities and/or chores." At 3:50 p.m., review of QMRP Monthly Progress Notes for the period August 2009 - June 2010, revealed that each month, the QMRP wrote "<Resident #3's name> has met the criteria for the above objective. <Resident's name> will continue current objective as outlined." On 7/22/2010, at approximately 5:30 p.m., the QMRP acknowledged that the program had not been revised since the resident met the performance criteria eleven months earlier. It should be noted that the QMRP stated that she witnessed the speech therapist perform a partial swallow safety assessment in the home on 7/11/2010. However, the QMRP indicated that the observed assessment process had not addressed language/communication skills.	I 424		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observations, interviews and record review, the Group Home for Persons with Mental Retardation (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.	I 500		

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I 500	Continued From page 16 The finding includes: The facility failed to demonstrate protection of residents' rights to have their parent or guardian notified in writing whenever an instance of neglect occurred. [Title 7, Chapter 13, § 7-1305.10(f), formerly § 6-1970(f)] as follows: On 7/20/2010 beginning at 9:45 a.m., review of incident reports revealed that on 1/28/2010, the facility received an allegation of neglect from an anonymous caller. According to the anonymous complainant, the driver and driver's aide who were transporting Clients #3 and #5 allegedly were under the influence of illegal drugs. Review of the corresponding internal investigative report, dated 1/31/2010, revealed that the allegation had been "substantiated" after the two employees' urine tested positive for marijuana. Further review of the incident report and investigation failed to show evidence that families and/or legal guardians were notified of the allegation of neglect or the findings of the internal investigation. On 7/23/2010, beginning at 10:10 a.m., concurrent interviews with both the qualified mental retardation professional (QMRP) and the incident management coordinator (IMC) in the facility confirmed that the driver and the aide had both tested positive for marijuana. Both employees' employment was terminated due to the findings. Further interview revealed that either the QMRP or the IMC were responsible for notifying family members and guardians. They both acknowledged, however, that Client #3's guardian and Client #5's uncle were not notified of the allegation of neglect or the findings of the internal investigation.	I 500	3523.1 The QMRP will ensure the protection of residents rights by informing each clients parents, family or guardians of all incidents to include neglect, abuse and the outcome of the incident each time an incident occurs. In the Future the QMRP will ensure that all parents, family or guardians are informed of all incidents to include but not limited to neglect and abuse....8-19-10	

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I 500	Continued From page 17 This is a repeat deficiency. Previously, the Federal Deficiency Report dated 6/19/2009, included the following: "There was no documented evidence that" Client #1's guardian had been notified of the client's swollen ankle on 2/13/2009, or that Client #2's guardian was notified that the client was taken to a hospital emergency room on 4/8/2009.	I 500		