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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/31/2007
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NAME OF PROVIDER OR SUPPLIER MTS	STREET ADDRESS, CITY, STATE, ZIP CODE 6023 CLAY STREET, NE WASHINGTON, DC 20019
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{W 000}	<p>INITIAL COMMENTS</p> <p>This recertification survey was conducted December 19-22, 2006. This survey was initiated utilizing a fundamental survey process. However as a result of observations and interviews, it was decided to extend the survey process in the areas of Client Protections, Active Treatment and Client behavior and facility practices. A full survey was conducted based on the identification of concerns related to the facility's capacity to furnish adequate services. The facility was deficit in the Conditions of Participation in Governing Body, Client Protections, Active Treatment and Facility Staffing. Four females with varying degrees of disabilities reside in this facility. The survey sample was derived from a random sampling of two of the four clients. Although no other clients were added to the sample, this report may refer to other clients within the setting while observing the clients in the sample.</p> <p>The survey findings were based on observations in the group home and at two day programs. In addition, the findings were based on interviews with residential, nursing, administrative and day program staff. Review of records, including investigations of unusual incidents was also conducted.</p> <p>***** *****</p> <p>This re-survey visit was conducted January 30-31, 2007. This survey was initiated utilizing a fundamental survey process. The facility was deficit in the Conditions of Participation in Governing Body, Client Protections, Active Treatment and Facility Staffing. Four females with varying degrees of disabilities reside in this</p>	{W 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Asst. Director of Residential Services 3/1/07	(X6) DATE
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 30 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 000}	Continued From page 1 facility. The survey sample was derived from a random sampling of two of the four clients. Although no other clients were added to the sample, this report may refer to other clients within the setting while observing the clients in the sample. The survey findings are based on observations in the group home. In addition, the findings are based on interviews with residential, nursing and administrative staff. Review of records, including investigations of unusual incidents was also conducted.	{W 000}		
{W 100}	<p>440.150(c) ICF SERVICES OTHER THAN IN INSTITUTIONS</p> <p>"Intermediate care facility services" may include services in an institution for the mentally retarded (hereafter referred to as intermediate care facilities for persons with mental retardation) or persons with related conditions if:</p> <p>(1) The primary purpose of the institution is to provide health or rehabilitative services for mentally retarded individuals or persons with related conditions,</p> <p>(2) The institution meets the standards in Subpart E of Part 442 of this Chapter; and</p> <p>(3) The mentally retarded recipient for whom payment is requested is receiving active treatment as specified in §483.440.</p> <p>This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure needed Active Treatment services, as evidenced below:</p> <p>The findings include:</p>	{W 100}		

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{W 100}	Continued From page 3 The findings include: 1. Cross Refer to W229. The facility failed to ensure that objectives of the individual program plan were stated separately, in terms of a single behavioral outcome. 2. Cross Refer to W214. The facility failed to ensure that clients were provided needed assessments to determine their developmental abilities or to ensure that the assessments were comprehensive. 3. Cross Refer to W249. The facility failed to ensure that clients were provided continuous learning opportunities and/or that recommendations made by interdisciplinary team members were reviewed and implemented, as appropriate. 4. Cross Refer to W242. The facility failed to ensure that two out of two clients in the sample received training in grooming, to the extent of their capability. The results of these findings identified that the facility failed to meet the Condition of Participation for Active Treatment.	{W 100}	W100 See responses for W229, W214, W249 and W242. Active Treatment as a Condition of Participation will be brought fully into compliance via the action steps outlined in the tag numbers cited here...2-28-07.		
{W 102}	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.	{W 102}			

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{W 102}	Continued From page 4 This CONDITION is not met as evidenced by: The facility's governing body failed to maintain general operating direction over the facility. [Refer to W104 and W111] The systemic effect of these practices results in the failure of the governing body to adequately manage and govern the facility and to ensure its compliance with the Conditions of Client Protections [Refer to W122]; Facility Staffing [Refer to W158]; Active Treatment [Refer to W195]; Client Behavior and Facility Practices [Refer to W266] and Health Care Services [Refer to W318].	{W 102}	W102 See responses for W104, W122, W158 and W195.		
{W 104}	----- ***** The facility's governing body failed to maintain general operating direction over the facility. [Refer to W104] The systemic effect of these practices results in the failure of the governing body to adequately manage and govern the facility and to ensure its compliance with the Conditions of Client Protections [Refer to W122]; Facility Staffing [Refer to W158] and Active Treatment [Refer to W 195]	{W 104}			
{W 104}	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, interviews with staff, and	{W 104}			

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{W 104}	<p>Continued From page 5</p> <p>the review of records, the facility's governing body failed to consistently provide operational direction over the facility.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Cross Refer to W124 and W125. The governing body failed to establish an effective system to ensure that clients' legal guardians were fully informed of the clients' medical condition, developmental and behavioral status, attendant risks of treatment, the right to refuse treatment, and due process rights. 2. Cross Refer to W149. The governing body failed to ensure that nursing staff implemented their policy on storing medications for Clients #1 and #2. 3. Cross Refer to W247, W130, and W136. The governing body failed to ensure that Clients #1 and #2 were provided opportunities for choice and to exercise control over themselves and their environment 4. Cross Refer to W249. The governing body failed to ensure that Clients #1 and #2's Behavioral Support Plans (BSP's) were implemented according to their Individual Support Plans (ISP's). 5. Cross Refer to W263 and W264. The governing body failed to ensure that the facility implemented the governing policies for written consent and failed to ensure that the Human Rights Committee (HRC) evaluated and ensured that the policies established for Clients #1 and #2's protection were adhered to. 	{W 104}			

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{W 104}	<p>Continued From page 6</p> <p>6. Cross Refer to W331. The governing body failed to ensure that nursing services monitored Client #2's weight loss.</p> <p>7. Cross Refer to W338. The governing body failed to ensure that nursing staff secured timely medical follow-up for Clients #1 and #2.</p> <p>8. Cross Refer to W140. The governing body failed to establish policies and procedures to ensure a complete accounting of Clients #1 and #2's funds that were entrusted to the facility.</p> <p>9. Cross Refer to W159. The governing body failed to ensure that the Qualified Mental Retardation Professional (QMRP) coordinated services to meet the clients' needs.</p> <p>10. Cross Refer to W120 and W193. The governing body failed to implement a system to ensure that all nursing consultants were trained on the clients' BSF's.</p> <p>11. The governing body failed to implement a system to ensure that all internal staff memorandums were not posted in client areas, as evidenced by:</p> <p>Observation on December 19, 2006, revealed a memorandum dated December 16, 2006, posted on the upstairs wall leading to Client #1 and Client #2's bedrooms from one of the members of upper management. Further review of the memorandum revealed that there had been many recent reports from within the facility to external agencies regarding concerns of what was going on in the home and that staff were to report these concerns internally first so that the facility would have a chance to address their concerns.</p>	{W 104}			

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{W 104}	<p>Continued From page 7</p> <p>12. The governing body failed to ensure the maintenance of the facility's environment, as evidenced by:</p> <ul style="list-style-type: none"> a. Jagged edges protruding from the front yard fence. b. Peeling sliding from fiber board on front panel of house. c. Scatter rug on porch outside of front door presented a potential hazard for falls. d. Damaged metal shed in back yard. e. Broken dishwasher in kitchen. f. Sagging stairs leading to the second floor. g. Running toilet in second floor bathroom. h. Unused, broken and unlocked refrigerator in the basement. i. Carpet worn and torn on stairs leading to the second floor. j. Window air conditioner sitting on broken frame in Client #2's bedroom. k. Curtains covering closet dragging on the floor in Client #2's bedroom l. Window air conditioner leaking residue in Client #1's bedroom. m. Curtains covering closet dragging on the floor in Client #1's bedroom 	{W 104}		
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{W 104}	Continued From page 8 n. Mirror loosely-mounted above dresser in Client #2's bedroom. o. Loose wooden side rails on both sides of the stairs leading to the second floor. p. Wooden splinters protruding from Client #1's head board. q. Wooden splinters protruding from Client #4's head board. r. Carpet sagging in Client #1's bedroom. s. Loose toilet paper holder in second floor bathroom. t. Broken blinds in second floor bathroom. u. Loose metal rings around bathtub grab bars. v. Rust on fire escape platform and stairs. ----- ----- Based on observation, interviews with staff, and the review of records, the facility's governing body failed to consistently provide operational direction over the facility. The findings include: 1. Cross Refer to W124 and W125. The governing body failed to establish an effective system to ensure that clients' legal guardians	{W 104}			

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{W 104}	Continued From page 9 were fully informed of the clients' medical condition, developmental and behavioral status, attendant risks of treatment, the right to refuse treatment, and due process rights. 2. Cross Refer W136. The governing body failed to ensure that Clients #3 and #4 were given the opportunity to participate in community outings. 3. Cross Refer to W159. The governing body failed to ensure that the Qualified Mental Retardation Professional (QMRP) coordinated services to meet the clients' needs. 4. The governing body failed to ensure the maintenance of the facility's environment, as evidenced by: a. Sagging stairs leading to the second floor. b. Carpet worn and torn on stairs leading to the second floor. c. Window air conditioner sitting on broken frame in Client #2's bedroom. d. Window air conditioner leaking residue in Client #1's bedroom. e. Carpet sagging in Client #1's bedroom. f. Rust on fire escape platform and stairs.	{W 104}	W104 See responses for W136 and W159. The six remaining environmental concerns (a through f) are in the process of being corrected and will be addressed by...2-27-07.		
{W 122}	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.	{W 122}			

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{W 122}	Continued From page 10 This CONDITION is not met as evidenced by: Based on interview and record review, the facility failed to ensure that systems had been developed and implemented to: ensure the rights of all clients to manage their financial affairs to the extent of their abilities [Refer to W126]; protect client privacy [Refer to W 130]; provide clients with opportunities to participate in social, religious, and community group activities [Refer to W136]; establish and maintain a system that assures a full and complete accounting of funds entrusted to the facility [Refer to W140]; establish and implement policies that ensure each client's health and safety [Refer to W149]; ensure that individual programs that incorporate restrictive techniques were reviewed and approved the Human Rights Committee (HRC) [Refer to W262]; ensure that restrictive programs were used only with written consents [Refer to W263]; and ensure that the HRC reviewed and monitored programs and services, to protect the client' rights [Refer to W 264]. The effects of these systemic practices resulted in the failure of the facility to protect its clients from potential harm and to ensure their general safety and well being. Based on interview and record review, the facility failed to ensure that systems had been developed and implemented to ensure the rights of all clients to manage their financial affairs to the extent of their abilities [Refer to W126] and provide clients	{W 122}			

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{W 122}	Continued From page 11 with opportunities to participate in social, religious, community group activities [Refer to W 136] and implement its established policies to ensure clients health and safety [Refer to W149]. The effects of these systemic practices resulted in the failure of the facility to protect its clients from potential harm and to ensure their general safety and well being.	{W 122}	W122 See responses for W126, W136 and W149.		
{W 124}	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the facility failed to ensure the right of each client or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment for two of two clients in the sample. (Clients #1 and #2) The findings include: 1. Observation of the evening medication administration on December 19, 2006 at approximately 5:30PM, revealed Client #1 received Risperdal 1 mg every evening. Interview with the nursing staff and review of the client's physicians orders dated December, 2006 revealed the Risperdal was incorporated in a	{W 124}			

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{W 124}	Continued From page 12 Behavior Support Plan (BSP) dated February 1, 2006, to address behaviors such as persistent hand flapping with loud vocalizations. Interview with the Qualified Mental Retardation Professional (QMRP) on December 20, 2006 revealed that Client #1 had a legal guardian. The review of Client #1's BSP dated February 1, 2006, indicated that she was not able to make independent decisions regarding residential or day placement, treatment plans or financial matters and can not give informed consents. Review of court documents dated February 1, 2001 revealed that Client#1 had a court-appointed guardian. Interview with Client #1's guardian on December 28, 2006 revealed that she had not been informed of the clients' psycotropic medications. There was no evidence that Client#1's guardian was informed of attendant risks of the medication treatment, and the right to refuse the medication treatment. 2. Observation of the evening medication administration on December 19, 2006 at approximately 6:30 PM revealed Client #2 received Risperdal 3 mg twice a day, Clomipramine HCl 125 mg twice a day, and Tegretol 200 mg twice a day. Interview with the staff and review of the client's physicians orders dated December, 2006 revealed that the aforementioned psychotropic medications were used in conjunction with a BSP to address targeted behaviors that included stereotyped/ hyperactivity, running away and pica. Interview with the QMRP on December 20, 2006, revealed that the client did not have the ability to make informed decisions regarding her treatment needs and did not have a legal guardian. The review of Client 2's BSP, dated April 1, 2006, indicated that she was not able to make independent decisions	{W 124}			

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(W 124)	<p>Continued From page 13 regarding residential or day placement, treatment plans or financial matters and could not give informed consent. There was no evidence that the facility informed Client #2 or a legally-authorized representative, as appropriate, of the health benefits and risks of treatment associated with the use of her psychotropic medications and corresponding BSP. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity.</p> <p>***** *****</p> <p>Based on observation, interview and record verification, the facility failed to ensure the right of each client or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment for two of two clients in the sample. (Clients #3 and #4)</p> <p>The findings include:</p> <p>1. Interview with the nursing staff and review of Client#3's physicians orders dated December, 2006 revealed that the client is prescribed Risperdal 4 mg twice a day, Lithium 450mg twice a day and Anafasnil 75mg every evening and it is incorporated in a Behavior Support Plan (BSP) dated December 1, 2006, to address her targeted behaviors. Interview with the Qualified Mental Retardation Professional (QMRP) on January 30, 2007 revealed that Client #3 does not have a legal guardian. The review of Client #3's psychological assessment dated December 1, 2006, indicated that she was not able to make</p>	(W 124)		
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{W 124}	Continued From page 14 independent decisions regarding residential or day placement, treatment plans or financial matters and can not give informed consents. There was no evidence that the client was informed of attendant risks of the medication treatment, and the right to refuse the medication treatment. 2. Interview with the nursing staff and review of Client#4's physicians orders dated December, 2006 revealed that the client is prescribed Revia 25 mg twice a day, Haldol 10 mg in the morning, Haldol 15 mg in the evening and Buspar 10mg twice a day and it is incorporated in a BSP dated December 3, 2006, to address her targeted behaviors. Interview with the Qualified Mental Retardation Professional (QMRP) on January 30, 2007 revealed that Client #4 does not have a legal guardian. The review of Client #4's psychological assessment dated December 3, 2006, indicated that she was not able to make independent decisions regarding residential or day placement, treatment plans or financial matters and can not give informed consents. There was no evidence that client was informed of attendant risks of the medication treatment, and the right to refuse the medication treatment.	{W 124}	W124 Nursing and the QMRP will insure that client #3 and #4 are made aware of the risks and benefits of their psychotropic drug regimens and will insure that the decision making support needed is provided during the process. The QMRP will insure that these discussions are properly documented and in the client record...2-28-07.		
{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:	{W 125}			

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{W 125}	<p>Continued From page 15</p> <p>Based on interviews and record review, the facility failed to ensure that individuals who lacked the capacity to make informed decisions had received assistance with identifying a surrogate decision-maker for habilitation and treatment needs, for one of the two client's in the sample (Client #1) and failed to encourage clients to exercise their right to self management, for four of the four clients residing in the facility. (Clients # 1, #2, #3 and #4)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Cross Refer to W124. On December 21, 2006, a review of Client #2's records was conducted. Client #2 was receiving psychotropic medications and had a Behavior Support Plan (BSP) for the management of stereotyped behaviors. Interviews and record review, however, failed to show evidence that the attendant benefits and risks associated with using the treatments or their right to refuse had been explained to Client #2. Further interview with the the Qualified Mental Retardation Professional (QMRP) revealed that Client #2 did not have a legal guardian or a surrogate decision maker to assist her in decision making. Further record review failed to show documented evidence that the facility attempted to secure an appropriate surrogate decision-maker or guardian, to ensure that Client #2's rights were protected. 2. The facility failed to allow and encourage clients the right to express self-management regarding a lock and alarm system on the door in an unoccupied second floor bedroom. <p>On December 21, 2006, a lock was observed on the door of a bedroom on the second floor.</p>	{W 125}			

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{W 125}	<p>Continued From page 16</p> <p>When the House Manager opened the door an alarm sounded. The House Manager explained that the alarm was used to alert staff and clients in the event of a fire. Further interview revealed that the lock and alarm system had not been approved by the Human Rights Committee (HRC) and that the clients had not been trained on how to unlock the lock on the door. Review of the HRC minutes revealed no evidence that the committee reviewed or made suggestions on the use of the door lock and alarm system.</p> <p>3. Cross Refer to W130. The facility failed to ensure Clients #1 and #4's privacy during activities of daily living and personal needs.</p> <p>4. Cross Refer to W126. The facility failed to ensure the right of Client #1 to manage her financial affairs and teach her to do so, to the extent of her capabilities.</p> <p>5. Cross Refer to W267. The facility failed to implement written policies and procedures to ensure that staff displayed appropriate professional behavior, to protect clients' rights.</p> <p>***** *****</p> <p>Based on interviews and record review, the facility failed to ensure that individuals who lacked the capacity to make informed decisions had received assistance with identifying a surrogate decision-maker for habilitation and treatment needs, for two of the two client's in the sample (Clients #3 and #4) and failed to encourage clients to exercise their right to self management, for two of the four clients residing in the facility. (Clients #</p>	{W 125}		
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{W 125}	Continued From page 17 3 and #4) The findings include: 1. Cross Refer to W124. On January 30, 2007 , a review of Client #3's records was conducted. Client #3 was receiving psychotropic medications and had a Behavior Support Plan (BSP) for the management of stereotyped behaviors. Interviews and record review, however, failed to show evidence that the attendant benefits and risks associated with using the treatments or their right to refuse had been explained to Client #3. Further interview with the the Qualified Mental Retardation Professional (QMRP) revealed that Client #3 did not have a legal guardian or a surrogate decision maker to assist her in decision making. Further record review failed to show documented evidence that the facility attempted to secure an appropriate surrogate decision-maker or guardian, to ensure that Client #3's rights were protected. 2. Cross Refer to W124. On January 30, 2007 , a review of Client #4's records was conducted. Client #4 was receiving psychotropic medications and had a Behavior Support Plan (BSP) for the management of stereotyped behaviors. Interviews and record review, however, failed to show evidence that the attendant benefits and risks associated with using the treatments or their right to refuse had been explained to Client #4. Further interview with the the Qualified Mental Retardation Professional (QMRP) revealed that Client #4 did not have a legal guardian or a surrogate decision maker to assist her in decision making. Further record review failed to show documented evidence that the facility attempted to secure an appropriate surrogate decision-	{W 125}		

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{W 125}	Continued From page 18 maker or guardian, to ensure that Client #4's rights were protected. 3. The facility failed to allow and encourage clients the right to express self-management regarding a lock and alarm system on the door in an unoccupied second floor bedroom. On January 31, 2007, a lock was observed on the door of a bedroom on the second floor. Interview revealed that the lock and alarm system had not been approved by the Human Rights Committee (HRC). Review of the HRC minutes revealed no evidence that the committee reviewed or made suggestions on the use of the door lock and alarm system.	{W 125}	W125 The QMRP will continue her efforts to secure guardians for clients #3 and #4 and will use DDS and Quality Trust support in the process. The QMRP will document the status of follow up monthly in the QMRP notes...2-27-07. The HRC will review the lock and door alarm situation with the Human Rights Committee in its next meeting and the feedback from the committee will be documented in the meeting minutes.. 2-27-07. In addition, the fire safety consultant will retrain both staff and the clients on the use of the second level exit...2-27-07. Clients #3 and #4 will be given money management objectives that reflect their existing skill levels and potential for growth...2-20-07.	
{W 126}	483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the clients' right to be taught to manage their financial affairs to the extent of their capabilities for two of two clients in the sample. (Clients #1 and #2) The findings include:	{W 126}		

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{W 126}	<p>Continued From page 19</p> <p>1. Interview with staff indicated that Client #1 knew what she likes. The review of Client #1's Individual Financial Plan (IFP) included in her Individual Support Plan dated February 10, 2006 indicated that she would be given opportunities to make choices regarding her funds. It was further noted that she had an informal goal to make purchases from the store at least twice a month. Interview with staff revealed that Client #1 was taken to the store; however, all purchases were selected and paid for by the staff. Record review failed to reveal evidence that Client #1's functional level in money management had been fully assessed to determine her capability to manage her financial affairs.</p> <p>2. Interview with the Qualified Mental Retardation Professional (QMRP) on December 21, 2006 revealed that Client #2 had not received a comprehensive money management assessment that outlined her current skills and specific needs in this area. Review of Client #2's record on December 21, 2006 confirmed the QMRP's statement. There was no evidence that the Client #2 was taught to manage her finances to the extent of her capability.</p> <p>***** *****</p> <p>Based on observation, interview and record review, the facility failed to ensure the clients' right to be taught to manage their financial affairs to the extent of their capabilities for two of two clients in the sample (Clients #3 and #4)</p> <p>The findings include:</p> <p>During the follow up survey conducted on January 31, 2007, there was no documented evidence</p>	{W 126}		

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{W 126}	Continued From page 20 that Client #3 and #4 were able to exercise their rights to be taught to manage their financial affairs to the extent of their capabilities. According to staff interview, client #4 knows nothing about money and will not focus. It was indicated that a vending machine had not been used. (Refer to W214).	{W 126}	W126 Clients #3 and #4 will be given money management objectives that reflect their existing skill levels and potential for growth...2-20-07.	
{W 136}	483.420(a)(11) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to provide varied community opportunities for two of two clients in the sample. (Clients #1 and #2) The findings includes: Interview with the staff revealed that the four clients residing in the facility routinely participated in community outings and activities together. Further interview revealed that out of fourteen activities planned for November and December 2006, the clients only were able to go on two outings because of problems with the van and/or not having van drivers. Review of the activity schedules from November 2006 to December 2006 revealed that Clients #1 and #2 visited Dunkin Donuts on December 6, 2006 and a recreation center on November 25, 2006. Previously, they went on a seven-day vacation to Virginia Beach from September 10-17, 2006.	{W 136}		

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{W 136}	Continued From page 21 There was no documented evidence that the clients had frequent opportunities to engage in community activities based on their individual preferences. Note: During the follow up survey conducted on January 31, 2007, the community outing document for clients #3 and #4 revealed that weekly community activities had been planned for the month of January. There was no documentation to reflect that the planned outings had been attended by either client.	{W 136}	W136 The QMRP will review the outcomes for monthly outings attended on a client-specific basis in the monthly notes for each client...2-27-07.		
{W 149}	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to develop and implement its established policies to ensure the health and safety for two of two clients in the sample (Clients #1 and #2). The findings include: 1. Cross Refer to W268. The facility failed to implement their policy on Staff Treatment of Clients 2. Cross Refer to W120. The facility failed to develop a policy on training medication consultants to prevent mistreatment of clients.	{W 149}			

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{W 149}	Continued From page 22 3. Cross Refer to W381. The facility failed to implement their policy on Medication Storage. 4. The facility failed to implement their policy on Medication Administration as evidenced by: Observation of the morning medication pass revealed that all of the clients were in the kitchen together and received their medication. In an interview with the Medication Consultant she stated " They flock to me. They migrate. This is how we do it every day". 5. Cross Refer to W126. The facility failed to implement their policy on Client Financial Affaires. 6. Cross Refer to W331. The facility failed to implement their policy on Changes in Clients Condition. ***** **** Based on staff interview and record review, the facility failed to develop and implement its established policies to ensure the health and safety for two of two clients in the sample (Clients #3 and #4). The finding includes: Cross Refer to W126. The facility failed to implement their policy on Client Financial Affaires.	{W 149}	W149 The client financial records are full and complete...2-8-07. The client's will be trained to management their own financial affairs to the extent possible given their existing skill levels and potential for growth and given the appropriate amount of staff support. Each will be given a money management objective reflecting all of the above...2-20-07.		
{W 158}	483.430 FACILITY STAFFING The facility must ensure that specific facility staffing requirements are met.	{W 158}			

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{W 158}	Continued From page 23 This CONDITION is not met as evidenced by: Based on staff interviews and record reviewed the facility's Qualified Mental Retardation Professional (QMRP) failed to effectively coordinate services to meet the needs for its Clients; [Refer to W159]; failed to provide sufficiently trained staff to ensure direct care services were adequately provided; [Refer to W 193, and W194]; failed to ensure that seven out of eleven professionals were licensed and/or certified in accordance with the District of Columbia Laws. [Refer to W170]; and to effectively train staff to implement emergency measures. [Refer to W192] The effects of these systemic practices results in the failure of the facility to ensure the availability of adequately trained staff, ensure its clients' health, safety, and well being. ***** Based on staff interviews and record reviewed the facility's Qualified Mental Retardation Professional (QMRP) failed to effectively coordinate services to meet the needs for its Clients; [Refer to W159]. The effects of these systemic practices results in the failure of the facility to ensure the availability of adequately trained staff, ensure its clients' health, safety, and well being.	{W 158}	W158 See responses for W159 and the tags associated with W159 (W249, W229, W436 and W214.	
{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}	<p>Continued From page 24</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed that each client's active treatment program was coordinated, integrated and monitored by the Qualified Mental Retardation Professional (QMRP).</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Cross Refer to W249. The QMRP failed to ensure clients received consistent opportunities to develop and learn new skills based on comprehensive assessments. 2. Cross Refer to W257. The QMRP failed to ensure that individual program plans were revised in accordance to their demonstrated abilities. 3. Cross Refer to W120. The QMRP failed to coordinate with the day program the training objectives developed by the Interdisciplinary Team (IDT) 4. Cross Refer to W194. The QMRP failed to ensure IPPs were implemented as recommended by the IDT. 5. Cross Refer to W252. The QMRP failed to ensure staff documented correctly on the Antecedent Behavior Consequences (ABC) chart as recommended by the Psychologist. 6. Cross refer to W193.1 The QMRP failed to ensure staff implemented Client #1's Behavioral Support Plan (BSP). 7. Cross refer to W193.2. The QMRP failed to 	{W 159}			

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(W 159)	Continued From page 25 ensure, that staff implemented Client #2's BSP. 8. Cross refer to W455. The QMRP failed to ensure that each employee had initial and continuing training in infectious control. 9. Cross refer to W436. The QMRP failed to ensure that each employee had initial and continuing training in the use of adaptive equipment. 10. Cross refer to W120.3 The QMRP failed to coordinate with nursing staff to ensure that nursing services were provided in accordance with the needs Client #1. 11. Cross refer to W440. The QMRP failed to ensure that each employee had initial and continuing training in conducting fire drills quarterly on each shift. 12. Cross refer to W441. The QMRP failed to ensure that each employee had initial and continuing training in conducting fire drills under varied conditions. 13. Cross Refer to W340. The QMRP failed to ensure that each employee had initial and continuing training in Client#1 's mealtime protocol. 14. Cross Refer to W217. The QMRP failed to coordinate with the Speech/Language Pathologist to assess Client #2 for eating/swallowing deficits. 15. Cross Refer to W338. The QMRP failed to monitor staff to ensure Client #2 received supplemental feedings three times a day as recommended by the Nutritionist as evidenced by	(W 159)			

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{W 159}	Continued From page 26 Observation on December 19, 2006, revealed that Client #2 was not offered supplemental feedings before, during or after mealtime. Interview with the QMRP revealed that the client receives all supplemental feedings at the facility. Review of a nutritional consult dated August, 2006, revealed a recommendation that the client receive supplemental feedings three times a day. ***** Based on observation, interview and record review the facility failed that each client's active treatment program was coordinated, integrated and monitored by the Qualified Mental Retardation Professional (QMRP). The findings include: 1. Cross Refer to W249. The QMRP failed to ensure clients received consistent opportunities to develop and learn new skills based on comprehensive assessments. 2. Cross refer to W229. The QMRP failed to ensure that objectives of the individual program plan were stated separately, in terms of a single behavioral outcome. 3. Cross refer to W436. The QMRP failed to ensure that each employee had initial and continuing training in the use of adaptive equipment. 4. Cross Refer to W214. The QMRP failed to coordinate with the social work assessment to	{W 159}		

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{W 159} Continued From page 27
identify the Client #3's level of strengths and needs.

5. There was no evidence that the facility and the day program for Client # 4 had integrated programs to allow the client to perform goals/ objectives at every given opportunity.

6. According to Client #4's program documentation, the client had refused to participate in her three programs from 85% to 100 % of the time during the month of January 2007. There was no evidence that the QMRP had evaluated the cause of the decrease in the client's performance. During the previous month, the data reflects that the client did consistently participate.

{W 195} 483.440 ACTIVE TREATMENT SERVICES

The facility must ensure that specific active treatment services requirements are met.

This CONDITION is not met as evidenced by: Based on observation, staff interviews, and record review, the facility failed to develop active treatment programs to meet each client's needs [Reference W196]; failed to ensure that clients were provided assessments to determine their needs [Reference W212, W214 and W217]; failed to ensure that the individual program plan (IPP) objectives were developed to address needs that were identified by the interdisciplinary team (IDT) [W227]; failed to ensure that clients were encouraged to make choices and self determination [Reference W247]; failed to incorporate training programs in the group home for personal skills training [Reference W242];

{W 159} W159
The QMRP supported by the interdisciplinary team is taking the action steps necessary to correct all issues cited in the associated tags (W249, W229, W436 and W214).

5. The QMRP will continue follow up with the day program of client #4 to insure that the day activity schedule reflects plans to consistently implement the IPP objectives agreed upon as well as provide other meaningful tasks and experiences...2-20-07.
The QMRP will visit the program monthly at minimum to insure continuous compliance....2-27-07.

6. The QMRP notes reflect her analysis of the recent refusals to perform objectives (client #4) and how she will address the issue as supported by the team...2-20-07.

{W 195}

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{W 195}	<p>Continued From page 28</p> <p>failed to ensure each client's Individual Program Plan (IPP) is implemented on a timely and consistent basis [Reference W249]; the facility failed to ensure that each client's Individual Program Plan (IPP) objectives are documented consistently and accurately [Reference W252]; failed to revise programs in accordance with clients' demonstrated performance [Reference W 257] and failed to ensure that the specially constituted committee reviewed and approved restrictive programs [Reference W263].</p> <p>The effects of these systemic practices results in the failure of the facility to provide mandated active treatment to its clients.</p> <p>*****</p> <p>Based on observation, staff interviews, and record review, the facility failed to develop active treatment programs to meet each client's needs [Reference W229] failed to ensure that clients were provided assessments to determine their needs [Reference W214]; failed to incorporate training programs in the group home for personal skills training [Reference W242] and failed to ensure each client's Individual Program Plan (IPP) is implemented on a timely and consistent basis [Reference W249]. The effects of these systemic practices results in the failure of the facility to provide mandated active treatment to its clients.</p>	{W 195}	<p>W195</p> <p>See responses for W229, W214, W242 and W249.</p>	
{W 214}	<p>483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN</p> <p>The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs.</p>	{W 214}		

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{W 214}	<p>Continued From page 29</p> <p>This STANDARD is not met as evidenced by: Based on review of clients' individual support plan (ISP) records, the facility failed to ensure that comprehensive functional financial assessments were conducted for to of three clients in the sample.</p> <p>The findings include:</p> <p>Cross Refer to W126. The facility failed to ensure that Clients #1 and #2 had financial assessments conducted to ascertain their skill levels in managing finances.</p> <p>Note:</p> <p>1. Client #3's social work assessment failed to identify the client's level of strengths and needs. The assessment further failed to identify how recommended objectives would be achieved. The assessment read "seems to get along adequately with her housemates. She gets stubborn, verbalizes inappropriate words and disrobes in inappropriate places." It could not be determined how these behaviors impacted on the client's overall social skill development. The recommendations from this assessment included: "continue to provide recreational activities in the home and to continue to be provided choices of community outings. There was no objective determined from these recommendations and neither were there measures provided to identify how these recommendation could be carried out. (Refer to W136)</p> <p>2. The facility failed to ensure that Clients #3 and #4 had financial assessments conducted to</p>	{W 214}			

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{W 214}	<p>Continued From page 30</p> <p>ascertain their skill levels in managing finances.</p> <p>3. According to client #4's social work assessment dated January 10, 2007, the client "needs encouragement to interact with others as she would rather be by herself; she enjoys staff attention, she likes to hug as well". The recommendations included "provide social opportunities whenever possible in the home with her peers and staff, provide outside activities".</p> <p>The psychological assessment dated December 1, 2006 indicated relative strength includes her "play behaviors are good, socialization increased, showing social behaviors.</p> <p>It was unclear as to the specific and accurate social strength and needs of client #4 as a result of the conflicting statements made by the professionals.</p> <p>483.440(c)(4)(i) INDIVIDUAL PROGRAM PLAN</p> <p>The objectives of the individual program plan must be stated separately, in terms of a single behavioral outcome.</p> <p>This STANDARD is not met as evidenced by: Based on record review, the Qualified Mental Retardation Professional (QMRP) failed to ensure that objectives of the individual program plan were stated separately, in terms of a single behavioral outcome.</p> <p>The finding includes:</p> <p>1. Client #4's individual program plan included an objective which read "use swab/toothbrush with</p>	{W 214}	<p>W214</p> <p>Client #3's social skills will be reassessed to more clearly identify areas of strength and weakness. A revised social skills objective will be developed based on the findings that will reflect an area of weakness where growth potential exists...2-20-07.</p> <p>2. Clients #3 and #4 will be reassessed in terms of their financial skills by...2-20-07.</p> <p>3. Client #4 enjoys staff attention and interacts readily with staff but needs to be encouraged to do likewise with peers. However, she is improving in this regard. There remain frequent occasions when she wishes to be alone as opposed to interacting with peers. The two disciplines do not state this as clearly but this is essentially what they are saying.</p> <p>A social skills checklist will be completed for client #4 making it more clear what her strengths and weaknesses are in this area. Her measurable objective will reflect an attempt to strengthen her in an area of true weakness where there is the potential to improve...2-27-07.</p>	
W 229		W 229		

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W 229	Continued From page 31 verbal prompting 80% of the trials." It could not be determined that this objective stated single behavioral objectives to ensure a single behavioral outcome. 2. Client #4 had an objective "express herself at the appropriate time with minimal physical assistance down to verbal prompts on 4/5 trials". It could not be determined that this objective was measurable to identify a single level of achievement.	W 229	W229 Assisted by the team, the QMRP will develop a toileting program for client #3 and #4 aimed at reducing toileting accidents and improving their level of independence.....2-27-07.		
{W 242}	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review the facility failed to ensure that two out of two clients in the sample received training in grooming, to the extent of their capability. (Clients #1 and #2) The findings include: 1. Observations of Client #1 on December 19-21, 2006 revealed that when her hands needed washing, staff would wash the client's hands. Interview with staff on December 19, 2006, revealed that Client #1 was unable to bath herself even with assistant because she is non-verbal	{W 242}			

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{W 242}	<p>Continued From page 32 and low functioning. There was no evidence that the client received training in grooming, to the extent of their capability.</p> <p>2. Observations of Client #2 on December 19-21, 2006 revealed her seated in a chair in the dining room with her hair in disarray. Further observation revealed that staff groomed the client's hair with a hair brush three times with-in ten minutes. Interview with the staff revealed that the client is unable to groom her own hair although the client can hold a hair brush because she is non-verbal and low functioning. There was no evidence that the client received training in grooming, to the extent of their capability.</p> <p>3. Cross Refer to W130. Clients #1 and #4 were observed using the toilet while the bathroom door was open. Although staff interviews revealed that both clients required reminders to close the door for privacy, neither client had a training program to address this need. It should be noted that staff failed to close the bathroom door while assisting Clients #1 and #4.</p> <p>Note:</p> <p>1. Staff interview conducted on January 31, 2007 revealed that Client #3 wears adult attends. The occupational therapy assessment dated December 5, 2006 indicated that the client acknowledges her need to go to the bathroom by walking towards the bathroom. It was indicated that the client does require staff assistance. There was a charting being maintain to document when the client was soiled at the times that she went to the bathroom; however, there was no program to determine that the client was being taught to enhance her abilities to use the toilet as</p>	{W 242}			

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{W 242}	Continued From page 33 independently as possible.	{W 242}			
{W 249}	<p>2. According to staff interview conducted on January 31, 2007 client #4 pulls her clothing down or just goes to the bathroom to indicate that she needs to use it. The client wears adult attends. It could not be determined that measures to teach Client #4 to increase her self help skills in toileting had been provided.</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observations, interviews, and record verification, the facility failed to demonstrated that two out of two clients in the sample are actively and consistently encouraged to engage in learning opportunities to maintain or enhance their skill levels. (Clients #1 and #2)</p> <p>The findings include:</p> <p>1. During observations conducted on December 19, 2006, from 7:10 - 8:45 AM Clients #1 and #2 were not observed to be engaged in any learning opportunities. During the observations (other than the mealtime) on December 19, 2006, from 4:20 to 7:15 PM, Clients #1 and #2 sat in the dining</p>	{W 249}			

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{W 249}	<p>Continued From page 34</p> <p>room area ignoring the games on the table or walking back and forth thru the living room engaging in targeted behaviors. There were no observed opportunities to engage in their IPP objectives. Interview with staff conducted on December 19, 2006 through out the day revealed that the clients were " non verbal and too low functioning to do much ". The Qualified Mental Retardation Professional (QMRP) was informed and interviewed about the observations. She indicated that the staff had been trained on how to engage the clients in learning opportunities to maintain or enhance their skill levels. There was no evidence that clients are provided and encouraged to participate in learning opportunities to maintain or enhance their skill levels.</p> <p>2. During observations conducted on December 19-21, 2006, Client #1 was not observed using speech, sign language or pictures to communicate with staff or peers. The client did demonstrate the ability to follow instructions from the staff. Interview staff revealed that Client #1 communicates with gestures. Interview with the House Manger on December 22, 2006 revealed that Client #1 has a Picture Communication Exchange System (PECS) to express her wants and needs. Review of Client#1's Individual Program Plan (IPP) dated February, 2006 revealed that the client was to use the PECS to express her wants and needs. There was no evidence that Client #1 was being encouraged to use to maintain her assessed strengths in communication.</p> <p>3. During observations conducted on December 19-21, 2006, Client #2 was not observed using speech or sign language to communicate with</p>	{W 249}			

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{W 249}	<p>Continued From page 35</p> <p>staff or peers in the facility. During observation at the day program on December 19, 2006, Client # 2 the day program staff communicated some words to client #2 and the client responded by signing the words: for good work, thank you, and eat. The client did demonstrate the ability to follow instructions from the group home staff. Interview with staff, revealed that Client #2 can use some sign language. The staff was unable to tell the surveyor specifically which words that the client was able to sign. Further interview revealed that the staff had not been trained in sign language. There was no evidence that Client #2 was being encouraged to use sign language to maintain her assessed strengths in signing in all settings.</p> <p>4. Cross Refer to W193. The facility staff failed to demonstrate competency in implementation of Client #1 and #2's Behavior Support Plan 's (BSP 's).</p> <p>5. During observation on December 19, 2006 Client #1 was observed walking up and down the stairs leading to the second floor, only once with verbal prompts from staff. Interview with staff revealed that the client has an exercise program to walk up and down the stairs daily. Review of the IPP dated February, 2006, revealed that Client #1 has an objective to walk up and down the stairs one trip every hour in the evening. There was no evidence that staff demonstrate competency in the implementation of the client's exercise program.</p> <p>Note</p> <p>1. The facility failed to provide every opportunity for learning new task and maintaining learned</p>	{W 249}		
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{W 249}	<p>Continued From page 36 skills.</p> <p>A. According to staff interviews conducted on January 30, 2007, all clients participate in some activities (i.e. assisting with setting the table and clearing their eating areas). At the time of the survey, no client was provided the opportunity to engage in dinner preparation or clean up. Client #2 was called to the kitchen to help with clean up but was interrupted by having to have her medications. The staff told the client that they did the task for her.</p> <p>B. According to client #3's individual program plan (IPP), the client had a program to shake hands with her peers. When strangers entered the client's facility (surveyors), the client was not expected to greet with a handshake. It could not be determined that client #3 was provided the learning opportunity to further her skills in appropriately greeting others.</p> <p>Note:</p> <p>1. According to the staff on January 30, 2007, client #4 uses a tech-talk to assist with communicating. The staff showed the device. The devices had symbols and voice to state " have a nice day, drink, and eat. When the sign for drink was pressed, it would not speak. The staff indicated that client #4 is to use the device daily. Interview with staff conducted on January 31, 2007 also revealed that client #4 is to use her communications board daily doing activity times. During the follow up survey, the communications device was not provided to the client to enhance her communications while eating or drinking.</p>	{W 249}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 01/31/2007
NAME OF PROVIDER OR SUPPLIER MTS			STREET ADDRESS, CITY, STATE, ZIP CODE 6023 CLAY STREET, NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{W 249}	Continued From page 37 2. There was no evidence that the facility and the day program for client 4# had integrated programs to allow the client to perform goals/objectives at every given opportunity. 3. During observation of clients #3 and #4 conducted on January 30, 2007, the clients were engaged in leisure activities (puzzles, coloring, musical instruments) from 3:45 PM to 5:30 PM. These clients had dinner at approximately 5:30 PM until 6:30 PM. The staff was asked what the clients would be doing after their dinner and brief rest. The staff indicated and started to again gather the same recreational/leisure activities. Staff indicated that the clients would participate in the activities until approximately 8:00 PM when they prepare for bed. Although clients' behavioral objectives were being achieved as they were active and they were provided choices, it could not be determined that the clients were encouraged to participate in alternative learning opportunities.	{W 249}	W249 A. The staff member in question will be retrained to insure that if an interruption occurs during a client chore or during the implementation of a measurable objective, it is appropriate to wait until the client is finished with the issue that caused the interruption as opposed to completing the task without the consumer or for her/him. Staff will be reinforced that such tasks present opportunities for the consumers to enhance their skills...2-27-07. B. Staff will be retrained to insure that they encourage client #4 to shake hands with everyone they greet who enters the home and not just when they are implementing the training objective...2-20-07. The QMRP will follow up to insure that client #4's tech-talk is in good repair and will retrain staff on its use, upkeep and storage...2-20-07. The QMRP will also insure that the daily activity schedule reflects the specific time frames the tech talk is to be used...2-20-07. 2. Addressed. See responses for W159. 3. The QMRP will modify the daily, individual activity schedules to reflect functional daily living activities as well as recreation/leisure activities and train staff to do both in properly integrated fashion as per the revised schedules...2-20-07.		
{W 264}	483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. This STANDARD is not met as evidenced by: Based on review of client's medical records, facility's policies, and Human Rights Committee ({W 264}			

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{W 264}	<p>Continued From page 38</p> <p>HRC) minutes, the governing body failed to ensure that the facility implemented the governing policies and that the HRC evaluated and ensured that the policies are adhered to protect the rights of clients.</p> <p>The finding includes:</p> <ol style="list-style-type: none"> 1. Cross Refer to W263. There was no evidence that the HRC had made suggestions about the facility not securing formal consent prior to the implementation of restrictive programs as per the governing body's policies for Client #1. 2. Cross Refer to W263. There was no evidence that the HRC had made suggestions about the facility not securing formal consent prior to the implementation of restrictive programs as per the governing body's policies for Client #2 . 3. Cross Refer to W125 and W140. The HRC failed to ensure policies are adhered to protect the rights of clients and funds. <p>*****</p> <p>Based on review of client's medical records, facility's policies, and Human Rights Committee (HRC) minutes, the governing body failed to ensure that the facility implemented the governing policies and that the HRC evaluated and ensured that the policies are adhered to protect the rights of clients.</p> <p>The finding includes:</p> <p>Cross Refer to W125. The HRC failed to ensure policies are adhered to protect the rights of clients</p>	{W 264}	<p>W264</p> <p>See responses for W125</p>	
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MTS

Multi-Therapeutic Services, Inc.

4201 Connecticut Avenue, NW, Suite #405, Washington, DC 20008

FAX COVER SHEET

FAX NO.: (202) 244-8048

DATE: 3/5/07

TO: Shula Panell

COMPANY/AGENCY: DoH. HRA

FAX NO.: 202-442-9430

NO. OF PAGES TRANSMITTED (INCLUDING COVER SHEET) 51 pages

MESSAGE:

See attached

FROM: John Bee PHONE NO.: (202)244-4500

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(1 000)	<p>INITIAL COMMENTS</p> <p>This recertification survey was conducted December 19-22, 2006. This survey was initiated utilizing a fundamental survey process. However as a result of observations and interviews, it was decided to extend the survey process in the areas of Client Protections, Active Treatment and Client behavior and facility practices. A full survey was conducted based on the identification of concerns related to the facility's capacity to furnish adequate services. The facility was deficit in the Conditions of Participation in Client Protections, Active Treatment, Client behavior and Facility Practices and Health Care Services. Four females with varying degrees of disabilities reside in this facility. The survey sample was derived from a random sampling of two of the four clients. Although no other clients were added to the sample, this report may refer to other clients within the setting while observing the clients in the sample.</p> <p>The survey findings are based on observations in the group home and at two day programs. In addition, the findings are based on interviews with residential, nursing, administrative and day program staff. Review of records, including investigations of unusual incidents was also conducted.</p> <p>***** *****</p> <p>This re-survey visit was conducted January 30-31, 2007. This survey was initiated utilizing a fundamental survey process. The facility was deficit in the Conditions of Participation in Governing Body, Client Protections, Active Treatment and Facility Staffing. Four females with varying degrees of disabilities reside in this facility. The survey sample was derived from a random</p>	(1 000)		

Health Regulation Administration

TITLE

(X6) DATE

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

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{1 000}	Continued From page 1 sampling of two of the four clients. Although no other clients were added to the sample, this report may refer to other clients within the setting while observing the clients in the sample. The survey findings are based on observations in the group home. In addition, the findings are based on interviews with residential, nursing and administrative staff. Review of records, including investigations of unusual incidents was also conducted.	{1 000}		
{1 090}	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on the complainant observation, interviews with staff, and the review of records, the facility's governing body failed to consistently provide operational directions over the facility. The findings include: 1. The governing body failed to ensure the maintenance of the facility 's environment as evidenced by: a. Jagged edges protruding from the front yard fence. b. Peeling sliding from fiber board on front panel of house. c. Scatter rug on porch outside of front door causing a potential hazard for	{1 090}		

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{1090}	Continued From page 2 falls. d. Damaged metal shed in back yard. e. Broken dishwasher in kitchen. f. Sagging stairs leading to the second floor. g. Running toilet in second floor bathroom. h. Unused broker , unlocked refrigerator in the basement. i. Carpet worn and torn on stairs leading to the second floor. j. Window air conditioner sitting on broken frame in Client #2's bedroom. k. Curtains covering closet dragging on the floor in Client #2's bedroom l. Window air conditioner leaking residue in Client #1's bedroom. m. Curtains covering closet dragging on the floor in Client #1's bedroom n. Loose mounted dresser mirror in Client #2's bedroom. o. Loose wooden side rails on both sides of the stairs leading to the second floor. p. Wooden splinters protruding from Client #1's head board. q. Wooden splinters protruding from Client #4's head board.	{1090}		

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(I 090)	Continued From page 3 r. Carpet sagging in Client #1's bedroom. s. Loose toilet paper holder in second floor bathroom. t. Broken blinds in second floor bathroom. u. Loose metal rings around bathtub grab bars. u. Rust on fire escape platform and stairs. ***** 4. The governing body failed to ensure the maintenance of the facility's environment, as evidenced by: a. Sagging stairs leading to the second floor. b. Carpet worn and torn on stairs leading to the second floor. c. Window air conditioner sitting on broken frame in Client #2's bedroom. d. Window air conditioner leaking residue in Client #1's bedroom. e. Carpet sagging in Client #1's bedroom. f. Rust on fire escape platform and stairs.	(I 090)	Chapter 35 3504.1 The remaining environmental concerns (a - f) will be addressed by... 2-27-07.	
(I 449)	3521 7(s) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not	(I 449)		

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{1449}	<p>Continued From page 4</p> <p>be limited to, the following areas:</p> <p>(s) Opportunity for social, recreational and religious activities utilizing community resources.</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to provide varied community oppo rtunities for two of two clients in the sample. (Clients #1 and #2)</p> <p>The finding includes:</p> <p>Interview with the staff revealed that all of the clients in the group home participate in activities together. Further interview revealed that out of fourteen activities planned the clients only were able to go on two outings in November and December because of problems with the van and not having van drivers. Review of the activity schedules from November, 2006 to December 2006 revealed the Client's #1, and #2, visited Dunkin Donuts on December 6, 2006 and the TR center on November 25, and went on a seven-day vacation to Virginia Beach from September 10-17, 2006. There was no documented evidence that the clients had frequent opportunities to engage in community opportunities based on their individual</p> <p>.....</p> <p>.....</p> <p>Note:</p> <p>During the follow up survey conducted on January 31, 2007, the community outing document for Clients #3 and #4 revealed that weekly community activities had been planned for</p>	{1449}		

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{1 449}	Continued From page 5 the month of January. There was no documentation to reflect that the planned outings had been attended by either client.	{1 449}	3521.7 (s) The January QMRP note summaries will address each client's participation in outings and their level of enjoyment...2-27-07.	
{1 500}	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 verification, the facility failed to ensure the right of each client or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment for two of two clients (Clients #1 and #2) in the sample. The findings on include: 1. Cross Refer to W263. Observation of the evening medication administration on December 19, 2006 at approximately 5:30PM, revealed Client #1 received Risperdal 1 mg every evening. Interview with the nursing staff and review of the client's physicians orders dated December, 2006 revealed the Risperdal was incorporated in a Behavior Support Plan (BSP) dated February 1, 2006, to address behaviors such as persistent hand flapping, with loud vocalizations. Interview with the Qualified Mental Retardation Professional (QMRP) on December 20, 2006 revealed that Client #1 had a legal guardian. The review of Client #1's BSP dated February 1, 2006 indicated that she is not able to make	{1 500}		

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{1 500}	Continued From page 6 independent decisions regarding residential or day placement, treatment plans or financial matters and can not give informed consents. Review of court documents dated February 1, 2001 revealed that Client#1 has a legal court appointed guardian. Interview with Client #1's guardian on December 28, 2006 revealed that she was not made informed about the clients' psycotropic medications. There was no evidence that Client#1's guardian was informed of attendant risks of the medication treatment, and the right to refuse the medication treatment. 2. Cross Refer to W263. Observation of the evening medication administration on December 19, 2006 at approximately 6:30 PM, revealed Client #2 received Risperdal 3 mg twice a day, Clomipramine HCL 125 mg twice a day, and Tegretol 200 mg twicw a day. Interview with the staff and review of the client's physicians orders dated December, 2006 revealed the the aforementioned psychotropic medications are used in conjunction with a BSP to address targeted behaviors that included stereotyped/ hyperactivity, running away, and pica. Interview with the QMRP on December 20, 2006, revealed that the client does not have not have the ability to make informed decisions regarding her treatment needs and does not have a legal guardian. The review of Client 2's BSP dated April 1, 2006, indicated that she is not able to make independent decisions regarding residential or day placement, treatment plans or financial matters and can not give informed consents. The facility failed to ensure Client #2 was informed of the health benefits and risks of treatment associated with the use of her psychotropic medications and corresponding BSP. Additionally, the facility failed to provide evidence that substituted consent had been obtained from	{1 500}		

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{1 500}	Continued From page 7 a legally recognized individual or entity. ----- 1. On January 30, 2007 , a review of Client #3's records was conducted. Client #3 was receiving psychotropic medications and had a Behavior Support Plan (BSP) for the management of stereotyped behaviors. Interviews and record review, however, failed to show evidence that the attendant benefits and risks associated with using the treatments or their right to refuse had been explained to Client #3. Further interview with the the Qualified Mental Retardation Professional (QMRP) revealed that Client #3 did not have a legal guardian or a surrogate decision maker to assist her in decision making. Further record review failed to show documented evidence that the facility attempted to secure an appropriate surrogate decision-maker or guardian, to ensure that Client #3's rights were protected. 2. On January 30, 2007 , a review of Client #4's records was conducted. Client #4 was receiving psychotropic medications and had a Behavior Support Plan (BSP) for the management of stereotyped behaviors. Interviews and record review, however, failed to show evidence that the attendant benefits and risks associated with using the treatments or their right to refuse had been explained to Client #4. Further interview with the the Qualified Mental Retardation Professional (QMRP) revealed that Client #4 did not have a legal guardian or a surrogate decision maker to assist her in decision making. Further record review failed to show documented evidence that the facility attempted to secure an appropriate surrogate decision-maker or guardian, to ensure that Client #4's rights were protected.	{1 500}		

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{1 500}	Continued From page 8 The facility failed to allow and encourage clients the right to express self-management regarding a lock and alarm system on the door in an unoccupied second floor bedroom. 3. On January 31, 2007, a lock was observed on the door of a bedroom on the second floor. Interview revealed that the lock and alarm system had not been approved by the Human Rights Committee (HRC). Review of the HRC minutes revealed no evidence that the committee reviewed or made suggestions on the use of the door lock and alarm system. 4. The facility failed to ensure the right of Client # 3 and #4 to manage their financial affairs.	{1 500}	3521.1 The QMRP notes monthly will reflect the status of follow up on obtaining legal guardians for the consumers who need them...2-27-07. The HRC will review the lock and alarm situation as reflected by the meeting minutes.....2-27-07. Client's #3 and #4 will have money management objectives that reflect their existing skill levels and potential for growth by...2-20-07.	

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{W 436}	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that clients owned and/or consistently utilized prescribed adaptive equipment, for two of the four clients in the facility. (Clients #1 and #3)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Observation of the evening meal revealed that Client #1 was served her food (turkey, greens, mashed potatoes and peaches) mixed together in one bowl in a liquefied consistency. It was noted that the client repeatedly moved her fingers around the rim of the bowl to judge where her food was positioned before using her spoon to pick up the food. Review of the Meal Time Protocol dated February 24, 2006, revealed that Client #1 revealed a recommendation that the client use a plate guard. Interview revealed that the client does have a plate guard to use in the facility. There was no evidence that the plate guard was utilized during meal time. 2. Client #3 was observed during the dinner meal on December 19, 2006 to eat with her face close to her plate. Further observation revealed that the Client #3's plate was placed on top of a plastic box that contained art supplies (crayons and 	{W 436}		
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{W 436}	<p>Continued From page 40</p> <p>magic makers) and was draped over with the ends of the bid that the client was wearing. Interview with the staff revealed that the client was to use a plate elevator. Review of the Individual Support Plan (ISP) dated December 5, 2006 revealed a recommendation that a four-inch riser and a Dycem mat be utilized during mealtime. There is no evidence that the appropriate riser and Dycem mat was utilized as recommended by the ISP.</p> <p>Note:</p> <p>According to the staff on January 30, 2007, client #4 uses a tech-talk to assist with communicating. The staff showed the device. The devices had symbols and voice to state "have a nice day, drink, and eat. When the sign for drink was pressed, it would not speak. According to the documentation for January 2007, the machine was noted to be out of batteries on January 12, and 17, 2006.</p>	{W 436}	<p>W436</p> <p>See responses for W249 (client #4 tech talk).</p>		