

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

PRINTED: 07/30/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G175	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/17/2008
NAME OF PROVIDER OR SUPPLIER WHOLISTIC 09			STREET ADDRESS, CITY, STATE, ZIP CODE 7533 12TH STREET, NW WASHINGTON, DC 20012	
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W 000	INITIAL COMMENTS A recertification survey was conducted from July 15, 2008 through July 17, 2008 using the fundamental survey process. However, due to deficient practices in the Conditions of Active Treatment, Health Care Services, and Client Protection, the survey process was extended to examine these conditions on July 17, 2008. A random sample of three clients was selected from a residential population of six females with mental retardation and other disabilities. The findings of the survey were based on observations at the home and one day program, interviews with clients and staff, and the review of records, including incident reports. The survey findings determined that the facility failed to be in compliance with the Conditions of Participation in Active Treatment, Health Care Services, and Client Protection.	W 000		
W 100	440.150(c) ICF SERVICES OTHER THAN IN INSTITUTIONS "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: (1) The primary purpose of the institution is to provide health or rehabilitative services for mentally retarded individuals or persons with related conditions; (2) The institution meets the standards in Subpart E of Part 442 of this Chapter; and (3) The mentally retarded recipient for whom payment is requested is receiving active treatment as specified in §483.440.	W 100		

Received on 8/21/08
GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION
825 NORTH CAPITOL ST., N.E., 2ND FLOOR
WASHINGTON, D.C. 20002

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Mattie Thomas* TITLE *Vice President* (X6) DATE *8/21/08*

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

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W 100	Continued From page 1 This STANDARD is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to meet the Condition of Participation in Active Treatment for one of the three clients in the sample. (Client #1) The finding includes: The facility failed to ensure that Client #1 was in need of continuous active treatment. [W197 and W249]	W 100	See W 197 and W 249	
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 and record review, the facility's governing body provided general operating direction over the facility except for the following: The findings include: 1. The Governing Body failed to ensure aggressive, continuous active treatment. [See W249] 2. The Governing Body failed to ensure that Client #1, who had expressed a desire to live in a least restrictive environment and is capable of caring for their own basic needs, had a developed transition plan. [See W197] 3. The governing body failed to provide other	W 104	See W 249 See W 197	

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W 104	Continued From page 2	W 104		
W 114	general oversight, as evidenced by the deficiencies outlined in this report. 483.410(c)(4) CLIENT RECORDS Any individual who makes an entry in a client's record must make it legibly, date it, and sign it. This STANDARD is not met as evidenced by: Based on record review, the facility failed to ensure that all persons making entries into the clients' records signed the entry, for one of the three clients in the sample. (Client #2) The finding includes: Review of Client #2's Psychiatric assessment (dated June 11, 2008), revealed that it was not signed by the person who completed it.	W 114		
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, interviews with the client and staff, and record review, the facility failed to ensure that outside contracted services met the needs of one of the three client included in the sample. (Client #2) The findings include: a. Client #2 was observed having lunch at her day program on July 15, 2008 at 12:40 PM. The staff encouraged the client to feed herself as much as possible. The client ate her lunch with assistance	W 120	The Psychiatric Assessment dated June 11 th , 2008 has been signed by the person who completed it. See Attached.	8/17/08

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W 120	Continued From page 3 from her one to one staff. The lunch was served on a paper plate. b. Client #2 was observed eating her snack and dinner at the group home on July 15, 2008 at 4:56 PM and 6:28 PM respectively. During the snack, Client #2 ate a cut up banana off of a plate, with some spillage. During dinner she ate her meal off of a plate with a plate guard requiring no assistance. c. Interview with the Qualified Mental Retardation Professional (QMRP) on July 17, 2008 and verified by the client's Individual Support Plan (ISP), revealed that the client was to use a plate guard at the day program. At the time of the survey the facility failed to ensure the day program utilized the recommended adaptive (eating) equipment.	W 120	An adaptive equipment checklist has been instituted to ensure receipt, use and maintenance of the plate guard. See Attached. House Manager shall ensure monthly visit of Day Program and monthly implementation of checklist form.	8/17/08
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: The 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 [See W124]; failed to ensure the right of clients to live in a less restrictive home setting [See W125]; failed to ensure clients rights' to be safe and free from injury [See W125]; failed to implement and/or establish policies to ensure incident management and to prevent neglect [See W149]; the facility failed to ensure that all unusual incidents	W 122	See W 124 See W 125 See W 149	

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W 122	Continued From page 4 including injuries of unknown origin were reported immediately to the administrator and other officials according to District law [See W153] and failed to provide evidence that all incidents involving injuries of unknown origin and possible neglect had been thoroughly investigated in accordance with the agencies policies and procedures [See W154]. The effects of these systemic practices results in the failure of the facility to protect its clients from harm and to ensure their general safety and well being.	W 122	see W153 see W154	
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 review, 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 three of the three clients included in the sample. (Clients #1, #2 and #3) The findings include: 1. During the medication pass on July 15, 2008 at 7:08 PM, Client #1 was administered Remeron	W 124		

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W 124	<p>Continued From page 5</p> <p>15 mg, Zyprexa 5 mg, Nafadone 100 mg and Depakote 1000 mg.</p> <p>Interview with the facility's Qualified Mental Retardation Professional (QMRP) during the entrance conference on July 15, 2008 at 8:25 AM, revealed that the client was prescribed medications for maladaptive behaviors. Review of the client's current physicians orders on July 16, 2008 at approximately 1:53 PM revealed that the psychotropic medications was incorporated in a Behavior Support Plan (BSP) dated June 30, 2007, to address behaviors associated with verbal aggression, self injurious behaviors, crying, false allegations, property abuse, PICA and making excessive demands on staff.</p> <p>The QMRP indicated that Client #1 had a legal guardian, however the QMRP could not find a signed consent form for the use of the psychotropic medication and the implementation of the Behavior support plan.</p> <p>Review of Client #1's Psychological Assessment dated September 15, 2007 on July 16, 2008 at 3:00 PM revealed that the client did not evidence the capacity to make independent decisions on her behalf regarding her habilitation planning, treatment placement, financial, and medical matters.</p> <p>There was no documented evidence that the facility Informed Client #1 or a legally-authorized representative, as appropriate, of the health benefits and risks of treatment associated with the use of his psychotropic medications and corresponding BSP.</p> <p>2. During the medication pass on July 15, 2008</p>	W 124	<p>Each client's psychotropic medication regime and BSP have been approved by their guardian or Notorized surrogate decision maker. Moving forward all consent forms shall be addressed and signed in the ISP meetings. See attached. In addition, DDS has authorized providers to utilize the substitute/surrogate decision making form as long as it is notorized by a family member in lieu of guardianship.</p> <p>8/11/08</p>

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W 124	<p>Continued From page 6</p> <p>at 7:51 PM, Client #2 was administered Risperdal 3 mg, Trazodone HCL 100 mg, Valproic Acid 750 mg. Interview with the facility's Qualified Mental Retardation Professional (QMRP) during the entrance conference on July 15, 2008 at 8:25 AM, revealed that the client was prescribed medications for maladaptive behaviors. Review of the client's current physicians orders on July 16, 2008 at approximately 1:53 PM revealed that the psychotropic medications was incorporated in a Behavior Support Plan (BSP) dated June 30, 2007, to address behaviors associated with aggression, self injurious behaviors, screaming/crying, attempting to leave, property destruction and non-compliance.</p> <p>The QMRP indicated that Client #2 had a legal guardian, however the QMRP could not find a signed consent form for the use of the psychotropic medication and the implementation of the Behavior support plan.</p> <p>Review of Client #2's Psychological Assessment dated August 2007 on July 16, 2008 8:57 AM, revealed that the client did not evidence the capacity to make independent decisions on her behalf regarding her habilitation planning, treatment placement, financial, and medical matters.</p> <p>There was no documented 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 his psychotropic medications and corresponding BSP</p> <p>3. During the entrance conference on July 15, 2008 at 8:25 AM, the Qualified Mental</p>	W 124		

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W 124	<p>Continued From page 7</p> <p>Retardation Professional (QMRP) indicated that Client #3 received psychotropic medications for her maladaptive behavior. Observations during the medication administration at 7:30 PM revealed that Client #3 received Seroquel 300 mg. Interview with the medication nurse revealed that the client received this medication for her maladaptive behaviors. During the record verification process on July 16, 2008, it was confirmed by the client's current physician orders, that the client received the aforementioned medications in the evening as well as Abillify 15 mg in the morning. Further interview with the LPN revealed that the medications were incorporated into the client's Behavior Support Plan (BSP) dated August 1, 2007 to address targeted behaviors that included Inappropriately touching others, screaming/yelling, self-injurious behaviors (finger biting and head hitting), and property destruction.</p> <p>Interview with the QMRP during the entrance conference on July 15, 2008 at 8:25 AM revealed that Client #3's parents were very involved in his life but is not the client's legal guardians. Review of the client's, psychological assessment on July 13, 2007 revealed that the client does not have the ability to make decisions on his behalf regarding habilitation planning, residential placement, finances, treatment and medical matters. There was no documented evidence that the facility obtained consent from Client #3's parents of the health benefits and risks of treatment associated with the use of his 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>	W 124		

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W 124	Continued From page 8 4. Review of Client #3's current physician orders on July 15, 2008 revealed that the client received the following medications without the consent of the : On August 8, 2007, client received Concerta 18 mg for ADHD; On October 10, 2007, the client received Concerta 54 mg for ADHD; On July 16, 2008, the client received Ability for maladaptive behaviors; and Interview with the QMRP on July 16, 2008 at approximately 11:00 AM revealed that Client #3 did not have a legal guardian. Further interview with the QMRP revealed that Client #2's parents were involved and signed consents for her restrictive measures, however, she was not the legal guardian. The review of Client #3's Psychological Assessment dated July 13, 2007 indicated that the client is not able to make independent decisions covering her residential or placement, treatment plan or financial affairs. There was no documented evidence that the facility informed Client #3 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.	W 124			
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients.	W 125			

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W 125	<p>Continued From page 9</p> <p>Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the right of clients to live in a less restrictive home setting, for one of three clients included in the sample (Client #1) and facility failed to ensure clients rights' to be safe and free from injury for two of the three clients included in the sample (Client #1 and #3).</p> <p>The findings include:</p> <p>1. The facility failed to provide Client #1's right to a live in a less restrictive environment</p> <p>a. On July 16, 2008 at 11:08 AM, Client #1 was observed at her day program. Upon greeting the client, she immediately informed the surveyor that she had a desire to move to her own apartment. She stated that no one had to take care of her. She said she cleaned herself and puts on her own clothing. She did not like people telling her what to do.</p> <p>b. At 4:40 PM, Client #1 was observed setting the table for the evening snack and dinner with no instruction from staff. After she completed her dinner she removed her dishes from the table, and took them to the kitchen. At 5:21 PM the staff instructed client #1 to go to her room to select clothing for the next day. The client did so without assistance.</p>	W 125	<p>Provider has instituted a transition plan for Client #1. A case conference has been held and we are awaiting eligibility approval from DDS. Please find attached supporting documents. In the future, all setting analysis will occur in the ISP meeting and be implemented accordingly.</p>	8/17/08

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W 125	<p>Continued From page 10</p> <p>c. The staff at the day program and the group home indicated that the client had been requesting to move from her present location. Interview with the Qualified Mental Retardation Professional (QMRP) and the Registered Nurse (RN) on July 15, 2008 revealed that the Department of Disability Services (DDS) had in placed a list of seventy (70) people that was to be out-placed from Intermediate Care Facilities to waiver facilities. They indicated that they partitioned that Client #1 be placed on the list, however since client #1 was not a part of the Evans decree, she was not considered at that time. The QMRP and RN also indicated that the request had been made to the clients case manager, however the client is presently on a third case manager and they were unsure of where they were in the process of securing waiver services for Client #1.</p> <p>d. Review of client #1's Annual Social Work assessment dated September 23, 2007, revealed a recommendation that the team should explore the possibility of transitioning the client to a lesser restrictive setting such as the Medicaid Waiver program.</p> <p>Review of the clients Occupational Therapy and Physical therapy assessments reflected that the client was independent in her activities of daily living.</p> <p>e. The QMRP, RN and day program staff were asked if the team had met to discuss the clients request to move. They all acknowledged that they were aware of the clients request and abilities. They also indicated that meetings had been held to discuss a move for the client, however they were unable to produce</p>	W 125		

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W 125	<p>Continued From page 11</p> <p>documentation supporting their claims. At the time of the survey there was no evidence of a transition plan for this client.</p> <p>It should be noted that interview with the facility's QMRP during the entrance conference on July 15, 2008 at 8:25 AM, revealed that Client #1 had a legal guardian, however it could not be determined if the guardian had been made aware of the clients desires and employed to assist the client in obtaining alternate placement.</p> <p>2. The facility failed to provide Client #1's with prompts medical follow-up as recommended.</p> <p>a. Observation of Client #1 revealed that her bottom jaw seemed to jut forward when she spoke. Review of her medical record on July 16, 2008 at approximately 9:43 AM revealed that while she was having a behavioral episode, on December 20, 2007, Client #1 fell down the stairs at her home. Staff observed that her face was swollen and was instructed to transport the client to the emergency room. The client was assessed to have a contusion to her head, back and left hand. The emergency room physician recommended that the client be followed-up by her primary care physician within five (5) days.</p> <p>On the next day, December 21, 2007, Client #1 complained of an excessive headache and chest pain, which was not relieved by pain medication. She was again transported to the emergency room. She was assessed and diagnosed with a contusion to face and bilateral TMJ (temporomandibular joint) dislocation. The emergency room's physician recommended that the client be evaluated by an oral surgeon.</p>	W 125	<p>The facility QMRP has discussed the transition plan with guardian and documented discussions in the Client #1's monthly note.</p>	7/24/08
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W 125	Continued From page 13 snack, the client received a banana. The client requested another banana but staff did not respond to her request. At 4:57 PM, the client took another banana from Client #4's plate. At 6:20 PM during dinner observations, Client #3 was observed to receive a single portion of the meal. The meal consisted of baked potatoes, broccoli with cheese, soup (beef/vegetable), diet soda, water and Ensure Plus. The client consumed three fourths portion of her meal. The direct care staff removed the plate and silverware from the table and put the items in the kitchen sink. The client drank the remaining soup from the bowl and requested from staff more food on three occasions (chicken, baked potatoes and broccoli). At no time during the meal did the client receive additional portions. [See W194]	W 125	Staff have been trained on the Diet orders of Client #3 and the the importance of offering additional portions. Staff shall also provide additional portions if requested.	8/17/08
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 interview and record review, the facility failed to implement established procedures of reporting all of significant health changes to the State Agency, and to investigate incidents to rule out neglected and/or mistreatment. The findings include: Review of the incident reports on July 15, 2008 beginning at 9:00 AM, the facility failed to ensure that all emergency room visits were reported to the Department of Health as required by the facility's incident management policy as	W 149	Investigations had been completed at the time of the surveys. Staff have been trained on the Incident Management Protocol and Internal Investigations, as well as the location of the investigation book.	8/17/08

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W 125	<p>Continued From page 12</p> <p>Review of the medical record revealed that the client was evaluated by her PCP on January 28, 2008, (39 days after the emergency room visit). Although there was evidence that the client was seen by the primary care physician, there was no notation in the records that the Primary Care Physician (PCP) addressed the TMJ or the recommendation for an assessment by an oral surgeon.</p> <p>It should be noted that the record made reference to a fracture TMJ as well as a dislocated TMJ. The records were not clear if the two references were describing the same injury.</p> <p>b. As a result of client #2 complaint of chest pains, on December 21, 2007 the client was seen at the emergency room. She received a CT scan which revealed an mediastinal mass. Although there was evidence that the client was seen by her primary care physician 38 days later on January 28, 2008. There was no notation in the medical records that PCP had acknowledged the CT scan finding of a mass.</p> <p>Interview with the Registered Nurse on July 16, 2008, revealed that the PCP usually does not write much on the consultation sheets and there was no information reflect the physician's notes concerning the emergency room diagnoses. Also there was no evidence that the discovery of the mediastinal mass was acknowledged by the PCP.</p> <p>3. The facility failed to ensure Client #3's right to have a second serving of food during meals as evidence by the following.</p> <p>On July 15, 2008 at 8:00 AM, Client #3 was observed small in stature. At 4:45 PM, during</p>	W 125	<p>The two references are describing the same injury. In the future the RN's quarterly review shall include a review of ER recommendations and whether or not timely follow-up occurred. Also, the PCP has been notified about the concerns the need to be more qualitative and descriptive on his documentation.</p>	8/17/08

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W 149	Continued From page 14 evidenced below: 1. While in a behavior, on December 20, 2007, Client #1 fell down the stairs at her home. Staff observed that her face was swollen and was instructed to take her to the emergency room. Her discharge diagnosis was contusion to head, back and left hand. It was recommended that she follow-up with her primary care physician in five days. On the next day, (December 21, 2007), Client #1 complained of an excessive headache and chest pain, which was not relieved by pain medication. She was transported to the emergency room. Her discharge diagnosis was contusion to face and bilateral TMJ (temporomandibular joint) dislocation. The emergency room physician recommended that the client be evaluated by an oral surgeon. 2. On December 6, 2007 Clients #1, #3, #4, and # 5, was on the facility van which was involved in a motor vehicle accident. The clients were transported to the emergency room for evaluation.			W 149	Please find Investigations attached.		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD Is not met as evidenced by: Based on interview and record review, the facility			W 153			

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W 153	<p>Continued From page 15</p> <p>failed to ensure that all unusual incidents including injuries of unknown origin were reported immediately to the administrator and other officials according to district law (22 DCMR, Chapter 35, Section 3519.10) two of the three clients in the sample. (Clients #1 and #3)</p> <p>The findings include:</p> <p>Review of the Clients #1 and #3's medical record on July 15, 2008, revealed the following injuries of unknown origin were not reported.</p> <p>1. Observation of Client #1 revealed that her bottom jaw seemed to jut forward when she spoke. Review of her medical record on July 16, 2008 at approximately 9:43 AM revealed that while she was having a behavioral episode, on December 20, 2007, Client #1 fell down the stairs at her home. Staff observed that her face was swollen and was instructed to transport the client to the emergency room. The client was assessed to have a contusion to her head, back and left hand. The emergency room physician recommended that the client be followed-up by her primary care physician within five (5) days.</p> <p>On the next day, December 21, 2007, Client #1 complained of an excessive headache and chest pain, which was not relieved by pain medication. She was again transported to the emergency room. She was assessed and diagnosed with a contusion to face and bilateral TMJ (temporomandibular joint) dislocation. The emergency room's physician recommended that the client be evaluated by an oral surgeon.</p> <p>It should be noted that the record made reference to a fracture TMJ as well as a dislocated TMJ.</p>	W 153	<p>All of the aforementioned incidents were reported to the Facility Administration in accordance with the regulations. In addition, ODS via the MCLIS electronic reporting system were notified of the incidents. In the future a phone call will be made to HCA by the IMUW coordinator when an incident or incident of unknown origin occurs.</p>	8/17/08

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W 153	Continued From page 16 The records were not clear if the two references were describing the same injury. Review of the behavioral data collection revealed two episodes of crying in the month of December 2007. There was no evidence that the client exhibited a behavior that may have resulted in a fall. There was also no evidence that this incident had been reported. 2. On May 24, 2008, Client #1 fell and was transported to the emergency room and diagnosed with a head injury and lip laceration. There was no evidence that this incident had been reported. 3. On July 16, 2008 at approximately 11:00 AM revealed a nursing note in Client #3's medical record. The nursing note dated November 8, 2007 revealed the direct care staff had awoken the client and observed a lot of blood around the client nose. A "small" bruise was also noticed on her nose. There was no evidence that this incident had been reported.	W 153	Often times we fax reports and they are received. The DOH reporting system is antiquated. Please develop an electronic mechanism to determine receipt of incidents.	received On-going	
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record verification, the facility failed to provide evidence that all incidents involving injuries of unknown origin and possible neglect had been thoroughly investigated in accordance with the agencies policies and procedures.	W.154	Please find attached investigations. DOS has also conducted their own investigations.	8/17/08	

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W 154	<p>Continued From page 17</p> <p>The findings include:</p> <p>Review of the Clients #1 and #3's medical record on July 15, 2008, revealed the following injuries of unknown origin that were not investigated.</p> <p>1. Observation of Client #1 revealed that her bottom jaw seemed to jut forward when she spoke. Review of her medical record on July 16, 2008 at approximately 9:43 AM revealed that while she was having a behavioral episode, on December 20, 2007, Client #1 fell down the stairs at her home. Staff observed that her face was swollen and was instructed to transport the client to the emergency room. The client was assessed to have a contusion to her head, back and left hand. The emergency room physician recommended that the client be followed-up by her primary care physician within five (5) days.</p> <p>On the next day, December 21, 2007, Client #1 complained of an excessive headache and chest pain, which was not relieved by pain medication. She was again transported to the emergency room. She was assessed and diagnosed with a contusion to face and bilateral TMJ (temporomandibular joint) dislocation. The emergency room's physician recommended that the client be evaluated by an oral surgeon.</p> <p>It should be noted that the record made reference to a fracture TMJ as well as a dislocated TMJ. The records were not clear if the two references were describing the same injury.</p> <p>Review of the behavioral data collection revealed two episodes of crying in the month of December 2007. There was no evidence that the client exhibited a behavior that may have resulted in a</p>	W 154			

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W 154	Continued From page 18 fall. There was also no evidence that the this incident had been investigated to rule out abuse or neglect. 2. On May 24, 2008, Client #1 fell and was transported to the emergency room and diagnosed with a head injury and lip laceration. There was no evidence that the this incident had been investigated to rule out abuse or neglect. 3. On July 16, 2008 at approximately 11:00 AM revealed a nursing note in Client #3's medical record. The nursing note dated November 8, 2007 revealed the direct care staff had awoken the client and observed a lot of blood around the client nose. A "small" bruise was also noticed on her nose. There was no evidence that the aforementioned incidents were investigated to determine their origin and or cause.	W 154			
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to ensure the programmatic oversight and coordination of services to ensure the health and safety of the individuals residing in the facility. The findings include:	W 159			

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W 159	Continued From page 19 1. The QMRP failed to ensure that outside contracted services met the needs of Client #2 in the sample. [See W120] 2. The QMRP failed to ensure that Clients received continuous active treatment to support achievement of individual program plan (IPP) objectives identified by the interdisciplinary team. [See W249] 3. The QMRP failed to ensure that each client's behavior intervention technique, including the use of behavior modification drugs was conducted with the written informed consent of the client, parents (if the client is a minor) or legal guardian. [See W263] 4. The QMRP 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. [See W124]	W 159	See w120 See w249 See w263 See w124	
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 observations, staff interviews and record reviews, the facility failed to ensure that each employee had been provided with adequate training that enables the employee to perform his or her duties effectively, efficiently and competently. The findings include:	W 189		

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W 189	Continued From page 20 1. The facility's TME failed to implement Client #1's self-medication programs as written in her individual program plan. [See W249.1] 2. The facility failed to ensure that staff utilized Client #2's plate guard during meals. [See W436.1]	W 189	See W 249.1 see W 436.1	
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, client and staff interviews and record review, failed to ensure that clients who had expressed a desire for a least restrictive environment and is capable of caring for their own basic needs have a developed transition plan for an alternate living environment [See W197]; and the facility failed to ensure aggressive, continuous active treatment [W249]; and the facility failed to ensure that program data had been collected in accordance with the Individual Program Plan.	W 195	See W 197 see W 249	
W 197	483.440(a)(2) ACTIVE TREATMENT Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.	W 197		

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W 197	Continued From page 21 This STANDARD is not met as evidenced by: Based on observation, clients and staff interview, and record verification, the facility failed to ensure that clients, who had expressed a desire to live in a least restrictive environment and is capable of caring for their own basic needs, had a developed transition plan for one of the three clients in the sample. (Client #1) The finding includes: The facility failed to provide evidence of Client #1's need for intermediate care supports and services as detailed below: a. On July 15, 2008 at 11:08 AM, Client #1 was observed at her day program. Upon greeting the client, she immediately informed the surveyor that she had a desire to move to her own apartment. She stated that no one had to take care of her. She said she cleaned herself and puts on her own clothing. She did not like people telling her what to do. b. At 4:40 PM, Client #1 was observed setting the table for the evening snack and dinner with no instruction from staff. After she completed her dinner she removed her dishes from the table, and took them to the kitchen. At 5:21 PM, the staff instructed the client to go to her room to select clothing for the next day. The client did so without assistance. c. The staff at the day program and the group home indicated that the client had been requesting to move from her present location. Interview with the Qualified Mental Retardation	W 197	A transition plan has been developed and is being implemented. see Attached.	7/24/08

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W 197	Continued From page 22 Professional (QMRP) and the Registered Nurse (RN) on July 15, 2008 revealed that the Department of Disability Services (DDS) had placed a list of seventy (70) people that were to be out-placed from Intermediate Care Facilities to Waiver facilities. They indicated that they partitioned that Client #1 be placed on the list, however since the client was not a part of the Evans Decree, she was not considered at that time. The QMRP and RN also indicated that the request had been made to the clients DDC Case Manager, however the client was presently on a third Case Manager and they were unsure of where they were in the process of securing waiver services for Client #1. d. Review of Client #1's annual Social Work assessment dated September 23, 2007, revealed a recommendation that the team should explore the possibility of transitioning the client to a lesser restrictive setting such as the Medicaid Waiver program. Review of the Client #1's current Occupational Therapy and Physical Therapy assessments reflected that the client was independent in her activities of daily living. e. The QMRP, RN and day program staff were asked if the team had met to discuss the clients request to move. They all acknowledged that they were aware of the clients request and abilities. They also indicated that meetings had been held to discuss a move for the client, however they were unable to produce documentation supporting their claims. At the time of the survey there was no evidence of a transition plan for this client.	W 197			
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION	W 249			

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W 249	Continued From page 23 As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that clients received continuous active treatment to support achievement of individual program plan (IPP) objectives identified by the interdisciplinary team for two of three clients in the sample. (Clients #1 and #3) The findings include: 1. The facility failed to ensure Client #1's self-medication program was implemented as evidenced below: On July 15, 2007, at 7:08 PM Client #1 was observed receiving her medication. The Trained Medication Employee (TME) punched the medication into a cup and handed the cup to the client. The client independently took the medication and drank the water that was offered. Client #1 took the medication cup and the water cup and placed them in the trash can that was located in the kitchen. Review of the Medication Administration Record (MARs) on July 16, 2008 at approximately 9:42	W 249	This regulation is not congruent with finding 3. It clearly states that continuous active treatment consists of 1) needed interventions & 2) services in <u>sufficient</u> number and frequency to achieve the objectives identified in the IPP. Client #1's program is being implemented in morning. All indications are that she is progressing towards independence [According to data]. Thus, the service must be sufficient in meeting the objective. Staff will conduct program informal however think this citation has been interpreted incorrectly.	8/17/08

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W 249	<p>Continued From page 24</p> <p>AM, revealed the client had a self medication program that reflected the following steps:</p> <ul style="list-style-type: none"> - Identify medication basket; - Identify PM medications by color; and - Identify PM medications by name. <p>Interview with the Registered Nurse (RN) on July 16, 2008, revealed that the program was usually implemented in the morning. The client was not afforded an opportunity to participate in her self medication program at all opportunities.</p> <p>2. During the evening morning medication administration observation, the TME was observed administering Client #3's evening medication. The TME punched the medications from the bubble pack, crushed the medication in applesauce, poured a cup of water, spoon fed the client's medications and gave the cup of water to the client. The client consumed the water with verbal prompts and put the empty water cup in the kitchen sink. The TME was observed throwing the medication cup in the trash can.</p> <p>Interview with the RN on April 16, 2008 at 2:00 PM indicated that the Client #3 had a self medication program. Further interview with the RN revealed that the program was implemented in the morning. Review of the clients self medication assessment dated January 30, 2008. The assessment indicated that the client is recommended for a training program to participate in administration of medications under licensed personnel.</p> <p>Review of the MARs on July 16, 2008 at approximately 10:0 AM revealed the client had a self medication program with the following</p>	W 249			

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W 249	Continued From page 25 objective which stated, "[the client] will independently perform all tasks during the administration of medications 100% of the recorded trials". The objective reflected the following steps: - get glass/cup of water; - fill cup up with water; - drink water in cup; - put empty medication cup in trash; and - place cup in sink. There was no evidence that the facility's TME allowed Client #3 to participate in self medication as opportunity allowed.	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, staff interview, and record review, the facility failed to ensure that program data had been collected in accordance with the Individual Program Plan (IPP) for one of the three clients in the sample. (Client #1) The finding includes: Review of an incident report dated December 20, 2007 revealed that during a behavior episode, Client #1 fell down stairs and sustained a contusion to her head, back and left hand, and was diagnosed with a bilateral TMJ (temporomandibular joint) dislocation. Interview	W 252	Staff have been re-trained on Client #1's BSP. 8/17/08

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W 252

Continued From page 26
with the staff revealed that she fell because of her noncompliant behavior. Review of the behavioral data collection revealed two episodes of crying in the month of December 2007. There was no documentation in the records that that noncompliance had been observed during the month of December.

W 252

W 261

483.440(f)(3) PROGRAM MONITORING & CHANGE

The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility.

W 261

This STANDARD is not met as evidenced by: Based on review of the Human Rights Committee (HRC) minutes, the facility failed to ensure that persons with no ownership or controlling interest in the facility consistently participated on this committee.

The finding includes:

During the entrance conference on July 15, 2008 at 8:25 AM, the Qualified Mental Retardation Professional (QMRP) indicated that Client #3 received psychotropic medications for her maladaptive behavior. Observations during the medication administration at 7:30 PM revealed that Client #3 received Seroquel 300 mg. Review of the Human Rights Committee (HRC) meeting minutes was conducted on July 15, 2008 at approximately 1:00 PM. According to the HRC

HRC for August and the future will include person with no control or ownership.

8/17/08

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W 261	<p>Continued From page 27</p> <p>minutes dated March 2008 through June 4, 2007, Client #3's Behavior Support Plan (BSP) was updated and approved. Further review of the corresponding signature sheet attached to the minutes evidence a community representative name which had the same hand print of the HRC Chairperson and Clients #1, #2, #3, #4, #5, and #6. It should be noted that there was a signature of the community representative during the months of January and February 2008 HRC minutes. Interview with the QMRP on July 15, 2008 at approximately 2:00 PM confirmed the same hand print of the community representative and the HRC Chairperson. Further interview with the QMRP indicated that the community representative was not present at the HRC meetings. Interview with the Registered Nurse on July 16, 2008 at approximately 2:00 PM conqerued with the QMRP.</p> <p>There was no evidence that the facility's HRC committee included persons with no ownership or controlling interest in the facility was present. Interview with the Qualified Mental Retardation Professional (QMRP) on July 16, 2008 indicated that the facillty had a community representative; however, the community representative could not be account for during the past three months.</p>	W 261		
W 263	<p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE</p> <p>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record</p>	W 263		

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W 263	Continued From page 28 review, the facility failed to ensure that each client's behavior intervention technique, including the use of behavior modification drugs was conducted with the written informed consent of the client, parents (if the client is a minor) or legal guardian for three of the three clients in the sample. (Clients #1, #2 and #3) The finding includes: The facility failed to obtain informed consent prior to the use of restrictive measures as described in Client #1, #2 and #3's Behavior Support Plan. [See W124]	W 263		
W 318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on observation, interviews, and record review, failed to develop a system that ensured its medical staff addressed recommendations made by consultants and ensured all clients received diets in accordance with their orders [Cross Refer to W322]; failed to ensure nursing care services as indicated by change in the clients health care status [Cross Refer to W331]; and failed to ensure comprehensive treatment services for the maintenance of dental health [Cross Refer to W356]. The results of these systemic practices results in the demonstrated failure of the facility to provide health care services.	W 318	Consent has been obtained 8/17/08 for all restrictive measures described in BSP. Moving forward ISP meetings will facilitate the informed consent of the guardians/surrogate decision makers. see W 322 see W 331 see W 356	
W 322	483.460(a)(3) PHYSICIAN SERVICES	W 322		

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W 322	<p>Continued From page 29</p> <p>The facility must provide or obtain preventive and general medical care.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to develop a system that ensured its medical staff addressed recommendations made by consultants for one of three clients in the sample (Client #1) and ensured all clients received diets in accordance with their orders for one of three clients in the sample (Client #3).</p> <p>The findings include:</p> <p>1. Observation of Client #1 revealed that her bottom jaw seemed to jut forward when she spoke. Review of her medical record on July 16, 2008 at approximately 9:43 AM revealed that while she was having a behavioral episode, on December 20, 2007, Client #1 fell down the stairs at her home. Staff observed that her face was swollen and was instructed to transport the client to the emergency room. The client was assessed to have a contusion to her head, back and left hand. The emergency room physician recommended that the client be followed-up by her primary care physician within five (5) days.</p> <p>On the next day, December 21, 2007, Client #1 complained of an excessive headache and chest pain, which was not relieved by pain medication. She was again transported to the emergency room. She was assessed and diagnosed with a contusion to face and bilateral TMJ (temporomandibular joint) dislocation. The emergency room's physician recommended that the client be evaluated by an oral surgeon.</p>	W 322	<p>Provider has met with the PCP and reviewed his obligations under the ICF/MR regulatory system, specifically address ^{the must} recommendations made by consultants. Executive Director shall meet with PCP quarterly and ensure compliance.</p>	8/14/08

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W 322	<p>Continued From page 30</p> <p>Review of the medical record revealed that the client was evaluated by her PCP on January 28, 2008, (39 days after the emergency room visit). Although there was evidence that the client was seen by the primary care physician, there was no notation in the records that the Primary Care Physician (PCP) addressed the TMJ or the recommendation for an assessment by an oral surgeon.</p> <p>It should be noted that the record made reference to a fracture TMJ as well as a dislocated TMJ. The records were not clear if the two references were describing the same injury.</p> <p>2. As a result of client #2 complaint of chest pains, on December 21, 2007 the client was seen at the emergency room. She received a CT scan which revealed an mediastinal mass. Although there was evidence that the client was seen by her primary care physician 38 days later on January 28, 2008. There was no notation in the medical records that PCP had acknowledged the CT scan finding of a mass.</p> <p>Interview with the Registered Nurse on July 16, 2008, revealed that the PCP usually does not write much on the consultation sheets and there was no information reflect the physician's notes concerning the emergency room diagnoses. Also there was no evidence that the discovery of the mediastinal mass was acknowledged by the PCP.</p> <p>3. On July 15, 2008 at 8:00 AM, Client #3 was observed small in stature. At 4:45 PM, during snack, the client received a banana at snack time. The client requested another banana and staff did not respond. At 4:57 PM, the client took</p>	W 322			

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W 322 Continued From page 31
another banana from Client #4's place setting and ate it. At 6:20 PM during dinner observations, Client #3 was observed to receive a single portion of the meal. The meal consisted of baked potatoes, broccoli with cheese, soup (beef/vegetable), diet soda, water and Ensure Plus. The client consumed three fourths portion of her meal. The direct care staff removed the plate and silverware from the table and put the items in the kitchen sink. The client drank the remaining soup from the bowl and requested from staff more food on three occasions (chicken, baked potato and broccoli). At no time during the meal did the client receive additional portions.

W 322

Staff have been re trained on Client #3's diet order and Ensure is now given 3x a week. See Attached.

8/17/08

Interview with the direct care staff and the RN on July 15, 2008 at approximately 7:00 PM indicated that the client always request additional snacks (i.e., pudding, yogurt). Review of the client's current physician order revealed a diet order of regular diet. According to the Nutritionist assessment dated July 12, 2007, it was recommended that the client receive a regular diet with seconds, and Ensure Plus, three times per day. Review of the MARs and interview with the QMRP on July 16, 2008 at approximately 2:00 PM from January 2007 through July 16, 2008 revealed that the client was only receiving Ensure Plus twice a day. There was no evidence that the facility ensure that the client received the recommended diet.

W 331 483.460(c) NURSING SERVICES

W 331

The facility must provide clients with nursing services in accordance with their needs.

This STANDARD is not met as evidenced by:
Based on observation, client and staff interview,

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W 331	Continued From page 32 the facility failed to ensure nursing care services as indicated by change in the clients health care status for one of the three clients in the sample. (Clients #1)	W 331		
W 356	The finding includes: The facility failed to ensure Client #1 received follow-up services as recommended by emergency room physician. [See W322] 483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental 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 interview and record review, the facility failed to ensure comprehensive treatment services for the maintenance of dental health for two of the three clients in the sample. (Clients #1 and #3) The findings include: 1. Review of Client #3's medical record on July 16, 2008 at appropriately 12:30 PM revealed a dental consultation dated March 27, 2007. The dentist noted that the client had moderate calculus deposits and needed scaling. Interview with the Qualified Mental Retardation Professional (QMRP) on July 17, 2008 at 10:00 AM indicated that the client needs preauthorization prior to returning to the dentist office. Review of the client's nursing note dated	W 356	See W322 Oral Surgical appointment is scheduled for October 3, 2008. Dental consult Scheduled for October 28, 2008	8/17/08 8/17/08

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W 356	Continued From page 33 September 10, 2007 revealed that the nurse called the dental office to schedule an appointment for scaling. The nurse was informed that authorization had not yet been approved. The dental office would submit preauthorization again. At the time of the survey, there was no evidence that the client received dental scaling.	W 356		
W 436	2. [Cross Refer to W322] The facility failed to provide oral surgery assessment for Client #1. 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 furnish the recommended adaptive equipment for two of the three clients in the sample. (Clients #1 and #2) The findings include: 1. Client #2 was observed having lunch at her day program on July 15, 2008 at 12:40 PM. The staff encouraged the client to feed herself as much as possible. The client ate her lunch with assistance from her one to one staff. The lunch was served on a paper plate. Client #2 was observed eating her snack and dinner at the group home on July 15, 2008 at 4:56 PM and 6:28 PM, respectively. During the snack,	W 436	see W322 Adaptive Equipment Checklist has been established and will be monitored monthly by the QMRP AND HOUSE MANAGER. SEE Attached	8/17/08

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W 436	<p>Continued From page 34</p> <p>Client #2 ate a banana off of a plate. During dinner she ate her meal off a plate using a plate guard.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on July 17, 2008 and verified by the client's individual Support Plan, revealed that the client was to use a plate guard during meals. At the time of the survey, the facility failed to ensure the day program utilized the recommended adaptive (eating) equipment.</p> <p>2. Review of Client #1's ophthalmology assessments for 2007 and 2008, revealed that the client lost her glasses. Throughout the survey, the client was not observed with glasses. Interview with the QMRP on July 16, 2008 at 12:20 PM revealed that Client #1 told her that she threw her glasses into the trash. Additionally, the QMRP indicated that the client is supposed to wear the glasses at all times. Review of Client #1 training programs, failed to show evidence that the importance of the care and use glasses had been developed or implemented.</p>	W 436	<p>Glasses program has been approved by ISP team and placed in IPP for implementation.</p>	8/1/08
W 487	<p>483.480(d)(4) DINING AREAS AND SERVICE</p> <p>The facility must assure that each client receives enough food.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that client received second services of food as recommended by the nutritional assessment, for one of the three client in the sample. (Client #3)</p> <p>The finding includes:</p>	W 487		

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W 487	Continued From page 35 On July 15, 2008 at 8:00 AM, Client #3 was observed small in stature. At 4:45 PM, during snack, the client received a banana. The client requested another banana but staff did not respond to her request. At 4:57 PM, the client took another banana from Client #4's plate. At 6:20 PM during dinner observations, Client #3 was observed to receive a single portion of the meal. The meal consisted of baked potatoes, broccoli with cheese, soup (beef/vegetable), diet soda, water and Ensure Plus. The client consumed three fourths portion of her meal. The direct care staff removed the plate and silverware from the table and put the items in the kitchen sink. The client drank the remaining soup from the bowl and requested from staff more food on three occasions (chicken, baked potatoes and broccoli). At no time during the meal did the client receive additional portions. [See Also W322]	W 487	see W 322		

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1 000	<p>INITIAL COMMENTS</p> <p>A re-licensure survey was conducted from July 15, 2008 through July 17, 2008 using the fundamental survey process. However due to deficient practices in the Condition of Participation of Active Treatment, the facility's Qualified Mental Retardation Professional (QMRP) was notified that the survey was extended to examine this condition on July 17, 2008. A random sample of three residents was selected from a residential population of six females with mental retardation and other disabilities.</p> <p>The findings of the survey were based on observations at the home and one day program, interviews with clients and staff, and the review of records, including incident reports.</p>	1 000	<p><i>Received 8/21/08</i></p> <p>GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002</p>	
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1 203	<p>3509.3 PERSONNEL POLICIES</p> <p>Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter.</p> <p>This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current job descriptions for all employees.</p> <p>The findings include:</p> <p>Review of the personnel files conducted on July 15, 2008 at approximately 3:12 PM, revealed the GHMRP failed to provide evidence of current signed job descriptions for ten staff at the time of the survey. (Staff #1, #2, #3, #4, #5, #7, #8, #9, #10 and #13)</p>	1 203	<p><i>Job descriptions have all been signed.</i></p>	<p><i>8/17/08</i></p>
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Health Regulation Administration
Mattie Jones
 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE
Vice President

(X6) DATE
8/20/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/17/2008
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NAME OF PROVIDER OR SUPPLIER WHOLISTIC 09	STREET ADDRESS, CITY, STATE, ZIP CODE 7533 12TH STREET, NW WASHINGTON, DC 20012
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I 206	Continued From page 1	I 206		
I 208	<p>3509.6 PERSONNEL POLICIES</p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on interviews and record review, the facility failed to achieve compliance with State regulations pertaining to health (22 DCMR Chapter 35, Section 3509.6).</p> <p>The finding includes:</p> <p>The State regulatory agency conducted a review of personnel records on July 15, 2008, at which time there was no evidence that two direct care staff (Staff #1, #4, #7, 11 and #13), Primary Care Physician , Physical Therapist, Psychologist, Psychiatrist, Pharmacist and Social Worker had current health certificate.</p>	I 206	<p>Health certificates are current for all employees and consultants.</p>	8/19/08
I 291	<p>3514.2 RESIDENT RECORDS</p> <p>Each record shall be kept current, dated, and signed by each individual who makes an entry.</p> <p>This Statute is not met as evidenced by: Based on record review, the facility failed to ensure that all persons making entries into the resident's records signed the entry, for one of the three residents in the sample. (Resident #2)</p> <p>The finding includes:</p>	I 291		

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I 291	Continued From page 2 Review of Resident #2's Psychiatric assessment (dated June 11, 2008), revealed that it was not signed by the person who completed it.	I 291	Psychiatric assessment for client # 2 has been signed by the staff person who completed it.	8/17/08
I 374	<p>3519.5 EMERGENCIES</p> <p>After medical services have been secured, each GHMRP shall promptly notify the resident's guardian, his or her next of kin if the resident has no guardian, or the representative of the sponsoring agency of the resident's status as soon as possible, followed by written notice and documentation no later than forty-eight (48) hours after the incident.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all unusual incidents including injuries of unknown origin were reported immediately to the administrator and other officials according to district law (22 DCMR, Chapter 36, Section 3519.10) two of the three residents in the sample. (Residents #1 and #3)</p> <p>The findings include:</p> <p>The facility failed to report the following incidents in accordance with district law:</p> <p>1. Observation of Resident #1 revealed that her bottom jaw seemed to jut forward when she spoke. Review of her medical record on July 16, 2008 at approximately 9:43 AM revealed that while she was having a behavioral episode, on December 20, 2007, Resident #1 fell down the stairs at her home. Staff observed that her face was swollen and was instructed to transport the resident to the emergency room. The resident was assessed to have a contusion to her head,</p>	I 374	<p>Staff have been retrained on the Incident Reporting protocol and shall inform the relevant government entity. QMAP will be responsible for ensuring timely reporting.</p>	8/17/08

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I 374	<p>Continued From page 3</p> <p>back and left hand. The emergency room physician recommended that the client be followed-up by her primary care physician within five (5) days.</p> <p>On the next day, December 21, 2007, Resident #1 complained of an excessive headache and chest pain, which was not relieved by pain medication. She was again transported to the emergency room. She was assessed and diagnosed with a contusion to face and bilateral TMJ (temporomandibular joint) dislocation. The emergency room's physician recommended that the resident be evaluated by an oral surgeon.</p> <p>Review of the medical record revealed that the resident was evaluated by her PCP on January 28, 2008, (39 days after the emergency room visit). Although there was evidence that the client was seen by the primary care physician, there was no notation in the records that the Primary Care Physician (PCP) addressed the TMJ or the recommendation for an assessment by an oral surgeon.</p> <p>It should be noted that the record made reference to a fracture TMJ as well as a dislocated TMJ. The records were not clear if the two references were describing the same injury.</p> <p>2. As a result of Resident #2 complaint of chest pains, on December 21, 2007 the client was seen at the emergency room. She received a CT scan which revealed an mediastinal mass. Although there was evidence that the client was seen by her primary care physician 38 days later on January 28, 2008. There was no notation in the medical records that PCP had acknowledged the CT scan finding of a mass.</p>	I 374		

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1374	Continued From page 4 Interview with the Registered Nurse on July 16, 2008, revealed that the PCP usually does not write much on the consultation sheets and there was no information reflect the physician's notes concerning the emergency room diagnoses. Also there was no evidence that the discovery of the mediastinal mass was acknowledged by the PCP. 3. On December 6, 2007 Residents #1, #3, #4, and # 5, was on the facility van which was involved in a motor vehicle accident. The clients were transported to the emergency room for evaluation.	1374		
1379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and record verification, GHMRP staff failed to consistently report significant incidents to the Department of Health within the required time frame for two of the three residents in the sample. (Residents #1 and #3) The findings include: The facility failed to report the following incidents	1379	See answer above	

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I 379	<p>Continued From page 5</p> <p>in accordance with district law:</p> <p>1. On July 16, 2008 at approximately 11:00 AM revealed a nursing note in Resident #3's medical record. The nursing noted dated November 8, 2007 revealed the direct care staff had awoken the resident and observed a lot of blood around the resident nose. A "small" bruise was also noticed on her nose. The nurse applied first aid and notified the Registered Nurse (RN) the following morning. Interview with the RN revealed that the injury of unknown origin was not documented. Review of the facility's policy revealed that all injuries are to be reported on an incident report and notifications made. There was no evidence that the injury of unknown origin was documented as per the facility's policy or reported as required by local regulations.</p> <p>2. Observation of Resident #1 revealed that her bottom jaw seemed to jut forward when she spoke. Review of her medical record on July 16, 2008 at approximately 9:43 AM revealed that while she was having a behavioral episode, on December 20, 2007, Resident #1 fell down the stairs at her home. Staff observed that her face was swollen and was instructed to transport the resident to the emergency room. The resident was assessed to have a contusion to her head, back and left hand. The emergency room physician recommended that the resident be followed-up by her primary care physician within five (5) days.</p> <p>On the next day, December 21, 2007, Resident #1 complained of an excessive headache and chest pain, which was not relieved by pain medication. She was again transported to the emergency room. She was assessed and diagnosed with a contusion to face and bilateral</p>	I 379		

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1379	<p>Continued From page 6</p> <p>TMJ (temporomandibular joint) dislocation. The emergency room's physician recommended that the resident be evaluated by an oral surgeon.</p> <p>Review of the medical record revealed that the client was evaluated by her PCP on January 28, 2008, (39 days after the emergency room visit). Although there was evidence that the client was seen by the primary care physician, there was no notation in the records that the Primary Care Physician (PCP) addressed the TMJ or the recommendation for an assessment by an oral surgeon.</p> <p>It should be noted that the record made reference to a fracture TMJ as well as a dislocated TMJ. The records were not clear if the two references were describing the same injury. There was no evidence that the incident was reported as required by local regulations.</p> <p>3. As a result of Resident #2 complaint of chest pains, on December 21, 2007 the resident was seen at the emergency room. She received a CT scan which revealed an mediastinal mass. Although there was evidence that the resident was seen by her primary care physician 38 days later on January 28, 2008. There was no notation in the medical records that PCP had acknowledged the CT scan finding of a mass.</p> <p>Interview with the Registered Nurse on July 16, 2008, revealed that the PCP usually does not write much on the consultation sheets and there was no information reflect the physician's notes concerning the emergency room diagnoses. Also there was no evidence that the discovery of the mediastinal mass was acknowledged by the PCP. There was no evidence that the incident was reported as required by local regulations.</p>	1379			

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1379	Continued From page 7 4. On December 6, 2007 Residents #1, #3, #4, and # 5, was on the facility van which was involved in a motor vehicle accident. The residents were transported to the emergency room for evaluation. There was no evidence that the incident was reported as required by local regulations.	1379		
1436	3521.7(f) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (f) Health care (Including skills related to nutrition, use and self-administration of medication, first aid, care and use of prosthetic and orthotic devices, preventive health care, and safety); This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure the habilitation and training to residents in the domain of self medication for two of the three residents in the sample. (Resident #1 and #3) and the use of adaptive equipment (glasses) for one of the three residents in the sample. (Resident #1) The findings include: 1. The GHMRP failed to ensure Resident #1's self-medication program was implemented as evidenced below: On July 15, 2007, at 7:08 PM Resident #1 was observed receiving her medication. The Trained Medication Employee (TME) punched the medication into a cup and handed the cup to the	1436	Medication programs will be implemented informally in the evening and formally in the morning.	8/17/08

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I 436	<p>Continued From page 8</p> <p>resident. The resident independently took the medication and drank the water that was offered. Resident #1 took the medication cup and the water cup and placed them in the trash can that was located in the kitchen.</p> <p>Review of the Medication Administration Record (MARs) on July 16, 2008 at approximately 9:42 AM, revealed the Resident had a self medication program that reflected the following steps:</p> <ul style="list-style-type: none"> - Identify medication basket; - Identify PM medications by color; and - Identify PM medications by name. <p>Interview with the Registered Nurse (RN) on July 16, 2008, revealed that the program is usually implemented in the morning. Resident #1 was not afforded an opportunity to participate in her self medication program at all opportunities.</p> <p>2. During the evening morning medication administration observation, the TME was observed administering Resident #3's evening medication. The TME punched the medications from the bubble pack, crushed the medication in applesauce, poured a cup of water, spoon fed the resident's medications and gave the cup of water to the resident. The resident consumed the water with verbal prompts and put the empty water cup in the kitchen sink. The TME was observed throwing the medication cup in the trash can.</p> <p>Interview with the RN on April 16, 2008 at 2:00 PM indicated that Resident #3 had a self medication program. Further interview with the RN revealed that the program is implemented in the morning. Review of the resident's self medication assessment dated January 30, 2008. The assessment indicated that the resident is</p>	I 436		

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I 436	Continued From page 9 recommended for a training program to participate in administration of medications under licensed personnel. Review of the MARs on July 16, 2008 at approximately 10:0 AM revealed the resident had a self medication program with the following objective which stated, "[the resident] will independently perform all tasks during the administration of medications 100% of the recorded trials". The objective reflected the following steps: - get glass/cup of water; - fill cup up with water; - drink water in cup; - put empty medication cup in trash; and - place cup in sink. There was no evidence that the GHMRP's TME allowed Resident #3 to participate in self medication as opportunity allowed. 3. Review of Resident #1's ophthalmology assessments for 2007 and 2008, revealed that the resident lost her glasses. Throughout the survey, the resident was not observed with glasses. Interview with the QMRP on July 16, 2008 at 12:20 PM revealed that Resident #1 told her that she threw her glasses into the trash. Additionally, the QMRP indicated that the resident is supposed to wear the glasses at all times. Review of the resident training programs, failed to show evidence that the importance of the care and use glasses had been developed or implemented.	I 436		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure	I 500		

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I 500	<p>Continued From page 10</p> <p>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.</p> <p>This Statute is not met as evidenced by: Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with federal laws.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The GHMRP failed to ensure that Resident #1, who had expressed a desire for a least restrictive environment and is capable of caring for their own basic needs, had a developed transition plan. [See Federal Deficiency report W197] 2. The GHMRP failed to ensure the right of each resident or their legal guardian to be informed of the Resident's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment for three of the three residents included in the sample. [See Federal Deficiency report W124] 3. The GHMRP failed to ensure that individuals who lacked the capacity to make informed decisions had received assistance from their surrogate decision-maker for habilitation and treatment needs, for one of three clients included in the sample and facility failed to ensure clients' rights to be safe and free from injury for two of the three clients included in the sample. [See Federal Deficiency report W125] 4. The GHMRP failed to develop a system that ensured its medical staff addressed 	I 500	<p>see w197</p> <p>see w124</p> <p>see w125</p>

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1500	Continued From page 11 recommendations made by consultants and ensured all clients received diets in accordance with their orders. [See Federal Deficiency report W322]	1500	See W322	