

PRINTED: 12/01/2008
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0022	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/13/2008
NAME OF PROVIDER OR SUPPLIER M T S		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 TEWKESBURY PL, NW WASHINGTON, DC 20012		
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1 000	INITIAL COMMENTS A licensure survey was conducted from November 12, 2008, through November 13, 2008. A random sample of three residents was selected from a residential population of six male residents with mental retardation and other disabilities. The survey findings were based on observations in the group home, interviews, and a review of records, including unusual incident reports.	1 000	<p><i>Received 12/15/08</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>	
1 047	3502.5 MEAL SERVICE / DINING AREAS Each GHMRP shall be responsible for ensuring that meals, which are served away from the GHMRP, are suited to the dietary needs of residents as indicated in the Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure that meals served away from the GHMRP suited the resident's dietary needs, for one of three residents (Resident #1) included in the sample. The finding includes: Observation of Resident #1 on November 12, 2008, at 2:25 PM revealed that he was in the facility's kitchen. Continued observation of the resident revealed that he had a Styrofoam container of food in the facility's microwave. Interview with Resident #1 revealed the container was leftovers from his lunch. When asked what he had for lunch, the resident indicated that he had chicken wings and fried rice. Observation of the resident's food verified that he had fried chicken wings and shrimp fried rice. It should be	1 047		

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

TITLE

(X6) DATE

B21411

continuation sheet 1 of 1

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1047	<p>Continued From page 1</p> <p>noted that the staff was in the community with Resident #1 when he purchased his lunch.</p> <p>Interview with the facility's Nurse Coordinator revealed that the staff was aware that Resident #1 should not have any fried foods. Additionally, the nurse indicated that the facility's nutritionist recommended to remove the skin from any chicken before preparing a meal.</p> <p>Review of Resident #1's medical record on November 12, 2008, at 12:45 PM revealed a Physician's order dated September 1, 2008. Review of the POS revealed that the resident was prescribed a "regular low fat, low cholesterol diet." Further review of the resident's medical record revealed that Resident #1 had a Nutritional Assessment dated May 18, 2008. According to the assessment the residents Ideal Body Weight Range (IBWR) was between 135 -167 lbs. Review of the resident's monthly weight chart on November 12, 2008, revealed that Resident #1's weight had fluctuated between 179 and 180 lbs. (13 lbs. overweight).</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP), the Facility's Manager, and review of the training records on November 13, 2008 at 1:15 PM revealed the facility's nutritionist inserviced the direct care staff. Continued review of the inservice training record revealed that the consultant's agenda did include the discussion of Client #1's diet.</p> <p>At the time of the survey, the facility failed to ensure staff were adequately trained to demonstrate competency in the implementation of Client 1's prescribed diet.</p>	1047	<p>3502.5</p> <p>Staff will be retrained on proper implementation of Resident #1's diet. In addition, the QMRP will collaborate with psychology to develop a counseling protocol to provide staff with strategies on how to effectively persuade Resident #1 to adhere to his diet. The staff training will occur by...12-30-08. The new counseling protocol will be developed and implemented by...12-30-08. Staff will be reinforced that Resident #1 has the right to make personal decisions about what to eat and many other fundamental things so it is recognized that they cannot impose their will on him. However, effective counseling, role modeling and mentoring can be effective in helping him recognize the importance of sticking to his diet regimen...12-30-08.</p>	

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1 090	Continued From page 2	1 090		
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 observation and interview, the GHMRP failed to maintain the interior of the facility in a safe, clean, orderly, and attractive manner. The findings include: On November 13, 2008, at approximately 2:30 PM observation of the environment revealed the following deficiencies: 1. Resident #2's bedroom door was soiled and had peeling paint. 2. The kitchen drawer adjacent to the entrance was off track. 3. The washing machine was operable, however, observation revealed a towel on the floor in front of the machine. Interview with the staff revealed that a towel was placed on the floor, because the washing machine was leaking water. 4. The dining room wall and the door frame was soiled. Additionally, the wall had peeling paint.	1 090 1 090	3504.1 1. Resident #2's bedroom door was cleaned...11-16-08. Scraping and touch up painting will be completed by... 12-30-08. 2. The kitchen drawer will be placed back on its track and maintained as such by...12-18-08 3. The washing machine leak will be repaired by...12-20-08 4. The dining room wall and dining room door frame will be cleaned, scraped and repainted by...12-30-08 The facility manager will conduct weekly environmental audits to identify such concerns and will report them to MTS management for timely follow up or implement follow up via the support staff...12-19-08.	
1 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been	1 206		

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1206	Continued From page 3 performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that each employee, prior to employment and annually thereafter, provided evidence of a physician's certification that documented a health inventory had been performed and that the employee's health status would allow him or her to perform the required duties. The finding includes: Interview with the Facility's Manager on November 13, 2008, and review of the GHMRP's personnel records at 1:36 PM revealed that the GHMRP failed to provide evidence that current health certificates were on file for two direct care staff and three consultants.	1206	3509.6 The cited health certificates will be obtained by... 12-30-08. Staff that fail to meet the deadline will be removed from the schedule and consultants will have holds put on their payments. The QMRP will audit the personnel records quarterly to insure proactive notifications are sent out so as to obtain updated information in a timely manner on a consistent basis... 12-30-08.	
1374	3519.5 EMERGENCIES 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. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that after medical	1374		

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1379	<p>Continued From page 5</p> <p>followed up by written notification within twenty-four (24) hours or the next work day.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure the Department of Health (DOH), Health Facilities Division was immediately notified, followed by written notification within 24 hours, of unusual incidents that substantially interfered with a resident's health, for four of the six residents (Residents #2, #3, #4, and #5) residing in the facility.</p> <p>The findings include:</p> <p>Review of the facility's incident reports on November 12, 2008, beginning at 9:23 AM revealed the following incidents were not reported as required:</p> <ol style="list-style-type: none"> 1. On February 5, 2008, staff reported that Resident #2 bit the staff's hand. The police was notified and the resident was transported to CPAP and administered Klonopin 2 mg. Continued review of the report revealed that the Department of Health (DOH) was notified on February 27, 2008, (three weeks after the incident). 2. On September 22, 2008, staff reported that Resident #3 hit Resident #4 in his eye. Resident #4 sustained a laceration and was transported to the emergency room. Continued review of the report revealed that DOH was notified of the incident on September 24, 2008, (two days after the incident). 3. On November 6, 2008, staff reported that 	1379		

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1379	<p>Continued From page 6</p> <p>Resident #3 walked up to Resident #4 and hit him his mouth three consecutive times. Additionally, Resident #3 hit Resident #2 in his mouth. Continued review of the incident report revealed Residents #2 and #3 started fighting and Resident #3 sustained a "busted nose." At the time of the survey, there was no documented evidence that DOH was notified of this incident.</p> <p>4. On October 5, 2008, staff reported that Resident #4 and Resident #2 were fighting. Continued review of the incident report revealed that Resident #2 pushed the back of Resident #4's head into the wall in the living room area, causing a small dent into the wall. Resident #4 was transported to the ER for further evaluation.</p> <p>Note: The unusual incident report reflected that DOH was notified of this incident on October 7, 2008, however, DOH was not notified of the incident until October 19, 2008.</p> <p>5. On March 21, 2008, staff reported that Resident #5 reported that he accidentally hit his toe and was transported to the emergency room for further evaluation. Continued review of the report revealed that DOH was notified of the incident on March 27, 2008, six days after the incident.</p>	1379	<p>3519.10</p> <p>The IMC will conduct a training session with all staff of this home to insure that all understand the incident management policy mandates and particularly the notification requirements. This training will occur by... 12-30-08.</p> <p>As mentioned, MTS has increased incident management staff to better address incident and investigation follow up requirements... 12-1-08.</p>	
1401	<p>3520.3 PROFESSION SERVICES: GENERAL PROVISIONS</p> <p>Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident.</p>	1401		

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I 401	<p>Continued From page 7</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure timely treatment services were conducted for one of the three residents (Resident #3) included in the sample.</p> <p>The finding includes:</p> <p>Observation on November 12, 2008, revealed Resident #3 had right spastic hemiplegia. Interview with the facility's Nurse Coordinator on the same day was conducted to ascertain if Resident #3 had any medical concerns. Continued interview with the nurse revealed Resident #3 had been evaluated by a neurologist and ordered to receive Botox injections.</p> <p>Review of Resident #3's habilitation record on November 13, 2008, revealed a Physical Therapy Evaluation dated March 10, 2008. Review of the evaluation revealed the physical therapist recommended Botox injections to decrease the tone of the resident's elbow and wrist flexors.</p> <p>Additionally, the physical therapist recommended an evaluation to be conducted by an occupational therapist for bracing and exercises to increase his elbow, wrist, and finger extension which would improve the functional use of his right upper extremity.</p> <p>At the time of the survey, (eight months later), there was no documented evidence that an arrangement had been made for the resident to start the Botox injections or evidence of an occupational therapy evaluation.</p>	I 401	<p>3520.3</p> <p>The Botox injections needed for Resident #3 will be initiated by...12-30-08 The OT evaluation will be completed by...12-30-08</p> <p>The QMRP and RN separately will audit the medical records monthly to insure that all recommended follow up occurs in a timely manner and as prescribed. In addition, the QMRP, Facility Manager and RN will meet monthly to review medical follow concerns for each person supported...12-20-08.</p>	