

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

PRINTED: 03/06/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/20/2009
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NAME OF PROVIDER OR SUPPLIER R.C.M OF WASHINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1318 45TH PLACE, NE WASHINGTON, DC 20019
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W 000	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted from February 19, 2009 through February 20, 2009. The survey was initiated using the fundamental survey process. A random sample of three clients was selected from a client population of two males and three females with various disabilities.</p> <p>The findings of the survey were based on observations at the group home and three day programs, interviews with day program staff, management and direct care staff in the residence and the review of administrative records, including the facility's incident management system.</p>	W 000	<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> <p>MAR 17 2009</p>	
W 120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>The facility must assure that outside services meet the needs of each client.</p> <p>This STANDARD is not met as evidenced by: Based on observations, staff interview, and record review, the facility failed to ensure that each client's day program met their needs for three of the three clients in the sample. (Clients #1 and #3)</p> <p>The findings include:</p> <ol style="list-style-type: none"> The day program failed to ensure that Client #3 received her diet texture as prescribed as evidenced below. <p>[Cross Reference W474] Observation on February 19, 2009 at 12:15 PM at Client #3's day program, revealed her receiving lunch consisting</p>	W 120	<p>The meeting was held at client #3's day program on 3-12-09 to discuss her diet. A copy of the current diet order was provided to the nurse, and the day program staff was inserviced on the current diet. Refer to attachment #1</p> <p>In the future the facility management will ensure that the day program is provided with the diet order as prescribed. The qmnp will make observation during lunch time to ensure that client #3 receives diet as prescribed;</p>	3-12-09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Angele E. ...</i>	TITLE Program Director	(X6) DATE 3/16/09
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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TRC M OF WASHINGTON

STREET ADDRESS, CITY, STATE, ZIP CODE

1318 45TH PLACE, NE

WASHINGTON, DC 20019

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W 120	<p>Continued From page 1</p> <p>of ground textured foods (hamburger, string beans, sweet potatoes and two slices of whole wheat bread). Interview with the day program staff revealed that the client was prescribed a mechanical soft, low cholesterol, high fiber diet.</p> <p>Interview with the Day Program Coordinator revealed a copy of Client #3's physician's order dated January 31, 2009. Further interview revealed a copy of the physician's order confirmed a mechanical soft texture diet as communicated by the day program staff.</p> <p>Later interview with the License Practical Nurse (LPN) at the group home at approximately 1:50 PM, revealed that the client had been out of the day program since late January 2009. According to the LPN, a case conference was held with the day program before she returned, however, the LPN could not provide any minutes from that meeting. Reportedly, the nurse provided the day program with the new diet order for Client #3 during that meeting. The LPN further commented that Client #3's diet order was changed from a mechanical soft to a pureed texture diet. At no time during the meal observation at the day program was Client #3 provided a pureed texture diet as prescribed.</p> <p>2. The facility failed to ensure that the day program provided Client #3 with her hearing aide as prescribed.</p> <p>On February 19, 2009 from 11:00 AM to 12:20 PM, Client #3 was observed in her classroom at the day program. During that time, she appeared to have difficulty hearing the instructions provided by the direct care staff in her classroom. The day program staff occasionally moved close to the</p>	W 120	<p>The meeting was held at client #3's day program on 3-12-09 to discuss her diet. A copy of the current diet order was provided to the nurse, and the day program staff was inserviced on the current diet. Refer to attachment #1</p> <p>In the future the facility management will ensure that the day program is provided with the diet order as prescribed. The qmnp will make observation during lunch time to ensure that client #3 receives diet as prescribed; additionally, when correspondence i.e Physician Orders are delivered to the day program, the residential facility will ensure that day program personnel signs a receipt to acknowledge reception. The copy will be filed in the resident's medical book.</p>	3-12-09

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W 120	<p>Continued From page 2</p> <p>client when she appeared not to hear the instructions. Interview with the Individual Program Plan (IPP) Coordinator revealed that Client #3 wore a hearing aide. Further interview revealed that the Speech and Language Therapist kept the hearing aide in her office. According to the IPP Coordinator, the Speech and Language Therapist was out of the building at a court hearing and the staff were unable to access Client's #3 hearing aide.</p> <p>Review of the day program IPP book failed to evidence a protocol had been established for the use of Client #3's hearing aide.</p> <p>3. The facility failed to ensure that Client #1's clothes fidgeting behavior was addressed by his day program.</p> <p>Observation of Client #1 on February 19, 2009 at 11:04 AM, revealed the client repeatedly buckling and unbuckling his belt. Additionally, the client was observed to zip and unzip his pants several times. At that time, interview with the day program case manager and the classroom instructor revealed a Behavior Support Plan (BSP) was being implemented at the day program to address his targeted behaviors of Self Injurious Behavior (SIB) and Verbal Outbursts.</p> <p>Again, at 11:12 AM, the client was observed repeatedly buckling and unbuckling his belt, and zipping and unzipping his pants. Interview with day program instructor at 11:19 AM revealed that the client frequently engaged in those behaviors. When verbally prompted to zip his pants at the time, the client complied, but by 11:23 AM had resumed the behavior. The instructor indicated the behavior of buckling/unbuckling and</p>	W 120	<p>Currently, client #3 has two (2) hearing aides one at the day program and another one in the house. A meeting was held at the day program on March 12, 2009 to discuss the adaptive equipment protocol. The day has hired an Adaptive Equipment Assistant to ensure that the individual's adaptive equipment is available regardless of the presence of the Speech Pathologist or not. A protocol has been established by the facility Qmnp to ensure that client #3 wears her hearing aide at home and at the day program as she can tolerate. The protocol was presented, and approved by the HRC. Refer to attachment #2. In the future the facility will ensure that client #3 wears her hearing aid as prescribed.</p> <p>The Behavior Specialist has expanded the target behavior of Disrobing to include Unbuckling of the belt, Unzipping of pants, and possible Self Stimulation. 3-15-09 The revised BSP was approved by the HRC, 3-16-09 the Behavior Specialist will inservice the home as well as the day program staff. Refer to attachment #3</p> <p>The Behavior Specialist has expanded the target behavior of Disrobing to include Unbuckling of the belt, Unzipping of pants, and possible Self Stimulation. 3-15-09 The revised BSP was approved by the HRC 3-16-09 The Behavior Specialist will inservice the home as well as the day program staff.</p>	3-06-09 3-16-09

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W 120	<p>Continued From page 3</p> <p>unzipping/zippping was relatively new, and that the client seemed to enjoy it. During those behaviors, it was difficult to engage him in other activities. Later that day, at 12:10 PM and at 12:25 PM, the client was again observed engaging in the same behavior.</p> <p>During lunch observation at 12:30 PM, the client was served a pureed textured meal. He ate for approximately two minutes, then again became preoccupied with the previously described clothes fidgeting. The client continued the behavior without intervention until 12:42 PM when staff verbally prompted him to eat. The client, however did not eat and continued the clothes fidgeting until 12:47 PM. At that time, the staff zipped the client's pants, secured the belt buckle, and pushed the client's chair closer to the table. Staff again verbally prompted the client to eat. Client #1 overturned his beverage, resumed the fidgeting with the zipper of his pants and his belt buckle until 1:00 PM. The instructor gently slid him closer to the table and instructed him again to eat. Client # 1 consumed approximately 60% of his food during lunch hour.</p> <p>Interview with the instructor at 1:03 PM indicated that he was surprised that the client did not eat. According to the instructor, the clothes fidgeting had not been formally addressed as a concern. At the time of the survey, the records at the day program failed to evidence that Client #1's aforementioned fidgeting with his pants zipper and belt buckle had been effectively addressed.</p>	W 120	<p>Refer to W 120 (3) P 3</p> <p>Refer to W 120 (3) P 3</p>	<p>3-15-09 3-16-09</p> <p>3-15-09 3-16-09</p>
W 125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage</p>	W 125		

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W 125	<p>Continued From page 4</p> <p>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 interview and record review, the facility failed to maintain client rights and/or ensure each client was encouraged to exercise their rights, for one of three clients in the sample. (Clients #1)</p> <p>The finding includes:</p> <p>The facility failed to ensure Client #3's right to have her hearing aids at all times.</p> <p>Interview with the House Manager (HM) on February 20, 2009 at approximately 9:45 AM, revealed that Client #3 was prescribed the use of a hearing aids. Further interview revealed that the staff were required to remove the client's hearing aid prior to her departure from the group home enroute to her day program. Reportedly, the staff were to place the hearing aid on the desk in the nurse's office. The HM was observed to go into the nurse's office and pick up a small plastic bag from the desk. The plastic bag was observed to contain one hearing aid. According to the house manager, the aforementioned process was implemented to ensure that the client's hearing aid was not lost. However, reportedly, Client #3 was not afforded the opportunity to use her hearing aid on the van during transport to her day program. Review of the facility's Human Rights Committee (HRC) minutes for the period of August 2008 to the present failed to reveal that the HRC had reviewed these practices.</p>	W 125	Refer to W.120 (2) P.3	3-06-09 3-16-09

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W 130	<p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure clients were provided privacy during personal needs for one of the three clients in the sample. (Client #1)</p> <p>The finding includes:</p> <p>Observation on the morning of February 19, 2009 at approximately 7:00 AM, revealed Client #1 sitting on the toilet in the bathroom, located next to the office, with the door open. Direct care staff were observed passing the open door on several occasions. Also, during the observation, two clients were observed passing in front of the open door.</p> <p>At approximately 7:08 AM, the House Manager (HM) entered the facility and noticed the bathroom door was open. The HM immediately closed the door. Prior to the house manager's arrival, no direct care staff was observed to encourage Client #1 to exercise his right to privacy during toileting.</p> <p>During observation on February 20, 2009 at approximately 4:15 PM, Client #1 was assisted to the bathroom located next the office. Moments later, the client was observed in the bathroom with the door open. According to interview with the direct care staff, the client opened the bathroom door himself.</p>	W 130	<p>The staff was inserviced on Privacy and Rights by the facility Qmnp on 3-06-09 Additionally, the Qmnp has developed a goal on bathroom privacy. All staff were inserviced 3-06-09 Refer to attachment #4 a, b, c In the future, the facility management and staff will ensure that Client #1 privacy rights is exercised when toileting.</p> <p>The staff was inserviced on Privacy and Rights by the facility Qmnp on 3-06-09 Additionally, the Qmnp has developed a goal on bathroom privacy. All staff were inserviced 3-06-09 Refer to attachment #4 a, b, c In the future, the facility management and staff will ensure that Client #1 privacy rights is exercised when toileting.</p> <p>The staff was inserviced on Privacy and Rights by the facility Qmnp on 3-06-09 Additionally, the Qmnp has developed a goal on bathroom privacy. All staff were inserviced 3-06-09 Refer to attachment #4 a, b, c In the future, the facility management and staff will ensure that Client #1 privacy rights is exercised when toileting.</p>	

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W 130	Continued From page 6 Interview with the HM at 4:17 PM revealed that Client #1 had a training objective to keep the door closed for his privacy. Review of the individual program plan confirmed that the objective should have been implemented. There was no evidence that Client #1 was encouraged to exercise his right to privacy during toileting.	W 130	Refer to W 130 P 6 Attachment # 4 a, b, c	3-06-06 3-06-09
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP). The findings include: 1. [Cross refer to W120.3]. The QMRP failed to monitor, coordinate and integrate services to ensure Client #1's clothes fidgeting was addressed as evidenced below: Observation at the group home on February 19, 2009 at 7:25 AM, revealed Client #1 began to continuously buckle/unbuckle his belt and unzip/zip his pants as he looked down at them. He occasionally raised his hips from the seat and attempted to pull his pants higher on his body. He remained seated on the couch where he continued to engage in this behavior intermittently until 8:18 AM. Staff then asked him if he wanted	W 159	Refer to W 120 (3) P. 3, 4	3-15-09 3-16-09

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W 159	<p>Continued From page 7</p> <p>to use the bathroom and the client stood to his feet. Further observation at his group home at approximately 4:10 PM, revealed the client repeatedly opening his pant as staff attempted to engage him in a variety of table top activities.</p> <p>On February 20, 2009 beginning at 7:58 AM, the client was observed to engage in the behavior until 8:14 AM without intervention, until he prepared to leave for his day program.</p> <p>Interview with the group home staff on February 19, 2009 at 8:15 AM and with day program staff on the same day at 11:22 AM, revealed the client often exhibited the aforementioned behavior and appeared to enjoy it.</p> <p>A review of the Behavior Support Plan (BSP) dated December 5, 2008, on February 20, 2009 at 12:37 PM, revealed an objective which stated he [the client] will decrease incidents of removing his clothing to 2 incidents for 6 consecutive months. Review of corresponding program data for December 2008, January 2009, and February 2009 revealed the client achieving the criteria.</p> <p>Further review of the BSP revealed it identified strategies to address the behavior (removal of clothes and picking of clothes) which included, "Try to shift his attention to an activity that requires him to move about in the home or go outside." There was no evidence the strategy was effectively implemented during the survey, as required by the BSP.</p> <p>Review of the Annual Psychological Assessment dated December 10, 2008, on February 20, 2009, at 12:37 PM, revealed "Very few incidents of the removal of clothing have been observed. When</p>	W 159	<p>Refer to W 120 (3) P. 3, 4 Attachment #3</p> <p>Refer to W 120 (3) P. 3, 4 Attachment #3</p> <p>Refer to W 120 (3) P. 3, 4 Attachment #3</p> <p>Refer to W 120 (3) P. 3, 4 Attachment #3</p> <p>Client #1's revised BSP was approved by the HRC 3-16-09 the Behavior Specialist will inservice the home as well as the day program staff. During the training the Behavioral Specialist will emphasize on the strategy to "try to shift client#1 attention to an activity that requires him to go outside or him to move about in the home.</p>	3-15-09 3-16-09	3-15-09 3-16-09

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W 159	<p>Continued From page 8</p> <p>attempted, the client unzipped his pants and seemed to make the effort to remove them unless it was discouraged". The corresponding data collection system required by the BSP dated December 10, 2008, indicated that the time of the behavior, the behavior and the antecedents must be documented. Additionally, the data collection system required that if a new problem behavior was noted, it should be documented. There was no evidence the client's repeated incidents of unfastening his belt and unzipping his pants had been documented, monitored, or addressed.</p> <p>2. (Cross Refer to W249.2). The QMRP failed to coordinate services to ensure the implementation of the communication training program for Client #1.</p> <p>Interview with the QMRP on February 20, 2009 at approximately 10:00 AM revealed that Client #1 was admitted to his current group home in March 2008. Further interview with the QMRP at 10:07 AM indicated that at that time, the client had a 2007 court hearing recommendation to be provided with an augmentive communication device. According to the QMRP, two "Go Talk" communication devices were purchased for the client, in accordance with the September 29, 2008 recommendation of the Speech and Language Pathologist (SLP). The QMRP stated that the augmentive device was also discussed during the 2008 day program annual Individual Support Plan (ISP) meeting. The home manager indicated that the direct care staff sometimes informally used the "Go Talk" with the client, however no formal training objective had been developed and implemented.</p>	W 159	<p>The Behavior Specialist has expanded the target behavior of Disrobing to include Unbuckling of the belt, Unzipping of pants, and possible Self Stimulation.</p> <p>The revised BSP was approved by the HRC.</p> <p>The Behavior Specialist will inservice the home as well as the day program staff.</p> <p>in the future The Behavior specialist, the Qmrp and house Manager will closely monitor the staff documentation of client #1 repeated incidents of unfastening his belts, unzipping his pants. This emphasis will be addressed during the staff inservice.</p> <p>The Qmrp has inserviced the staff on the use of the "Go Talk" on 3-06-09 in order to ensure that client #1's communication goal is being implemented correctly.</p> <p>The Qmrp went to the day program to inservice the staff on the "Go Talk" as well</p> <p>Refer to attachment #5a & b</p> <p>In the future, the Qmrp will ensure that client #1 use of the Augmentive communication devices is implemented as recommended by the professionals.</p>	<p>3-15-09</p> <p>3-16-09</p> <p>3-06-09</p> <p>3-10-09</p>

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W 159	<p>Continued From page 9</p> <p>Review of the day program IPP reflected an objective that [the client] will communicate his thoughts, ideas and preferences daily through the use of sign language and/or voice output device 60% of the time (Vocabulary: go home; finished, work, more help, lunch, drink, hello, good-bye."). There was no evidence, however that the QMRP had coordinated services with the day program to ensure the training program was implemented at the group home to enhance Client #1's communication skills.</p> <p>3. The QMRP failed to ensure that staff ensure clients exercise their rights to privacy during personal activities. [W130]</p> <p>4. The QMRP failed to ensure that each employee had been provided with adequate training that enabled the employee to perform his or her duties effectively, efficiently and competently. [W189]</p> <p>5. The QMRP failed to ensure that Clients #1, #2 and #3's Activity Schedules were available and incorporated each client's Individual Program Plan. [W250]</p> <p>6. The QMRP failed to ensure data collection was accurate for each client. [W252]</p> <p>7. The QMRP failed to ensure that adaptive equipment was available and maintained in good repair. [W436]</p> <p>8. The QMRP failed to coordinate services that evidenced the results of Client #2's Modified Barium Swallow Study were relayed to the client's Primary Care Physician and addressed.</p>	W 159	<p>The day program staff was inserviced on the use of "Go Talk" communication device by the Qmrp. 3-10-09</p> <p>Additionally, another device was given to the day program to ensure that the goal is being implemented in both places.</p> <p>The day program staff was inserviced in the goal by the Qmrp. 3-10-09</p> <p>Refer to attachment #5b</p> <p>In the future, the Qmrp will ensure that client #1 use of the Augmentive communication devices is implemented as recommended by the professionals.</p> <p>Refer to W 130 P.5 & 6 Attachment #4 a & b 3-06-09</p> <p>Refer to W 189, P.12 &13 Attachment # 5 3-06-09</p> <p>Refer to W 250 P. 16 & 17 Attachment #7 3-06-09</p> <p>Refer to W 252 P. 17 & 18 Attachment #3 3-06-09</p> <p>Refer to W 436 P. 22 & 23 Attachment # 8 3-13-09</p> <p>The PCP was notified by the nursing staff on the SPL evaluation of 9-04-08. All staff were trained on different food textures on 9-19-08;</p>	

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W 159	<p>Continued From page 10</p> <p>On February 19, 2009 at 5:35 PM, Client #2 was observed being slowly fed finely ground food and being offered intermittent sips of water.</p> <p>Interview with the staff at that time indicated that the aforementioned procedures were outlined in the client's feeding protocol. Interview with the Director of Nursing (DON) on February 20, 2009 at 3:45 PM revealed that the client was prescribed and tolerated a ground textured diet. Further interview with the DON revealed the client was referred for a Modified Barium Swallow Study on September 4, 2008 to determine which food textures she was able to safely eat. The DON indicated that the client was prescribed a ground textured diet at the time she was referred to have the swallowing study conducted. It should be noted, however, that there was no evidence Client #2's tolerance of ground foods was evaluated by the SLP during the study.</p> <p>On February 20, 2009 at 12:19 PM, review of the Modified Barium Swallow Study report dated September 29, 2008 revealed the client was evaluated on September 4, 2008 by the Speech and Language Pathologist (SLP) for speech/dysphagia. Further review of the report revealed it documented that the client was evaluated for diagnoses of severe oral apraxia, severe oral defensiveness, and moderate-severe dysphagia. The report included "the textures administered: Thin liquid, nectar-thick liquid, honey, pudding thick liquid and barium with food.... There was no problem with the tested foods." Finally, the SLP recommended that a pureed diet with thin liquids be provided for the client.</p> <p>Review of the current physician's order dated</p>	W 159	<p>The nursing staff notified the PCP of the 9-04-08 SLP evaluation and recommendations; The staff was trained on the puree diet and other textures by the nutritionist on 9-19-08; however the nutritionist was not notified on the recommendations made by the Speech Pathologist.</p> <p>In the future, the nursing staff will ensure that the recommendations are reviewed, and notify the nutritionist of any changes in the individual's diet.</p> <p>refer to attachment #9</p> <p>The Speech Pathologist evaluated client #2 with a puree diet, and recommended to continue with the same texture.</p> <p>In the future, the nursing staff will ensure that the pos are updated regularly to reflect current dietary order monthly.</p>	2-20-09

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W-159	Continued From page 11 February 1, 2009 revealed a ground textured diet was prescribed instead of the pureed consistency recommended by the SLP. Additionally, there was no evidence the nursing staff followed up to ensure Client #2 received a pureed diet as recommended by the SLP.	W 159	The Speech Pathologist evaluated client #2 with a puree diet, and recommended to continue with the same texture. In the future, the nursing staff will ensure that the pos are updated regularly to reflect current dietary order monthly. Refer to attachment #9	2-20-09
W 189	<p>Surveyor: TORBIT, MARCELLA 483.430(e)(1) STAFF TRAINING PROGRAM</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observations, staff interview, and record verification, the facility failed to provide each employee with initial and continuing training that enabled the employee to perform his or her duties effectively and competently for five of the five clients residing in the facility. (Clients #1, #2, #3, #4, and #5)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The facility failed to ensure each staff was trained to provide personal privacy for each client. [See W130] 2. The facility failed to ensure that staff were effectively trained on food textures. <p>Meal observation on February 19, 2009 at 5:31 PM revealed Client #1 was provided finely ground foods instead of the prescribed pureed texture.</p>	W 189	<p>Refer to W 130 P.5 & 6</p> <p>All staff were trained by the nutritionist on food textures and preparation. Refer to attachment #6. In the future, the facility will ensure that foods are prepared according to the appropriate textures.</p>	<p>3-06-09</p> <p>3-06-09</p>

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W 189	<p>Continued From page 12</p> <p>On February 20, 2009 at approximately 2:15 PM, interview with the QMRP indicated that the nutritionist trained direct care staff on preparing foods of various textures. Subsequent review of the training records revealed that direct care staff received training on food preparation on September 19, 2008. Review of the physician's orders dated February 1, 2009 indicated Client #1 was prescribed a pureed diet. At the time of the survey, however, there was no evidence that staff demonstrated competency to ensure appropriately textured foods were prepared and served.</p> <p>3. The facility failed to ensure that staff were adequately trained to make food substitutions of comparative nutritive value for each client. (Clients #1, #2, #3, #4, and #6)</p> <p>Observation of meal preparation on February 19, 2009 at 5:10 PM revealed staff using the blender to modify the textures of beef cubes, mixed vegetables, coleslaw, and whole wheat rolls which were being prepared for dinner. The clients were observed to receive applesauce in addition to the above foods. Interview with the staff member that prepared the meal revealed that substitutions were made for the unavailable items (fruit salad and cottage cheese) on the menu.</p> <p>On February 20, 2009 at 1:30 PM, review of the printed dinner menu for the previous day revealed that beef stew with vegetables, pineapple/apricot salad, cottage cheese, bread, and margarine were scheduled to be served. There was no evidence that the coleslaw served was of a similar nutritive value to replace the cottage cheese on the menu for the clients' dinner.</p>	W 189	<p>All staff were trained by the nutritionist on food textures and preparation. Refer to attachment #6. In the future, the facility will ensure that foods are prepared according to the appropriate textures, and that all staff are proficient in food preparation and texture.</p> <p>All staff were trained by the nutritionist on food textures and preparation. Refer to attachment #6. In the future, the facility will ensure that foods are prepared according to the appropriate textures</p> <p>All staff were on foods substitutions and textures on 9-19-08 by the nutritionist; however, the training seemed not to be effective. All staff were retrained by the nutritionist on food substitutions In the future the facility will ensure that the staff substitute food according to the substitution list Refer to attachment #6</p>	<p>3-06-09</p> <p>3-06-09</p> <p>3-06-09</p>
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W 189	<p>Continued From page 13</p> <p>4. [Cross Refer to W189.1 and W252]. The facility failed to ensure that direct care staff were effectively trained to monitor, document and provide support to Client #1 when he exhibited maladaptive behavior.</p> <p>On February 19, 2009 and February 20, 2009, Client #1 was observed to repeatedly exhibit incidents of unzipping pants and unbuckling his belt. During these times, staff failed to intervene and/or document the behavior.</p> <p>Interview with the QMRP on February 20, 2009, at approximately 2:30 PM revealed that on February 17, 2009, staff were trained on the implementation of Client #1's behavior support plan. Review of the inservice training log on February 20, 2009 at approximately 2:45 PM, confirmed that the training was conducted by the behavioral specialist. There was no evidence that this training was effective.</p>	W 189	<p>The Behavior Specialist has expanded the target behavior of Disrobing to include Unbuckling of the belt, Unzipping of pants, and possible Self Stimulation.</p> <p>The revised BSP was approved by HRC</p> <p>The Behavior Specialist will inservice the home as well as the day program staff.</p>	<p>3-15-09 3-16-09</p>
W 249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure continuous active treatment consisting of needed interventions and services of sufficient number</p>	W 249		

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W 249	<p>Continued From page 14</p> <p>and frequency to support objectives identified in the individual program plan (IPP) for one of three clients in the sample (Client #1).</p> <p>The findings include:</p> <p>1. [Cross Refer to W130.] The facility failed to effectively implement Client #1's IPP objective to ensure his privacy.</p> <p>On February 20, 2009 at 4:17 PM, interview with the House Manager (HM) revealed that Client #1 had a training objective to keep the door closed for his privacy while using the restroom. Review of the client's IPP at approximately 4:25 PM, revealed an objective which stated, "Please remind (the client) to close the bathroom door and assist (the client) with keeping the door closed for privacy." There was no evidence that Client #1 was continuously reminded to keep the door closed to exercise his right to privacy during toileting.</p> <p>2. On February 20, 2009 at 3:27 PM, interview with the QMRP and the review of the Speech-language assessment dated January 11, 2009 PM revealed "It appeared that the client (Client #1) may benefit from a voice output device coupled with a sign language program." Further record review on the same day revealed a written objective which stated, "Given modeled demonstration, the client will pair manual signs with a picture representation when presented related to daily living activities for 7/10 trials offered per session as measured by program documentation." There was no evidence that this program objective was being implemented at the group home to enhance Client #1's communication skills.</p>	W 249	<p>Refer to W 130 P.5 & 6 Attachment #4 a, b & c</p> <p>Refer to W 159.2 P 9 Attachment #5.a</p>	<p>3-06-09</p> <p>3-06-09</p>

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W 250	<p>483.440(d)(2) PROGRAM IMPLEMENTATION</p> <p>The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that each client's Individual Program Plan (IPP) objectives were incorporated in their individual activity schedules for three of three clients in the sample. (Clients #1, #2 and #3)</p> <p>The findings include:</p> <p>The facility failed to ensure that the Activity Schedules for Clients #1, #2 and #3 were available and incorporated individual objectives as evidenced below:</p> <p>1. On February 20, 2009 at approximately 10:45 AM, interview with the QMRP and the review of Client #3's IPP failed to evidence a current activity schedule. Further interview with the QMRP revealed the format for the activity scheduled had been revised. Reportedly, the old schedule was to be replaced. According to the QMRP, the new schedule would include the day and time, specified activities and IPP objectives. At the time of the survey, there was no evidence that the schedule had been developed.</p> <p>2. On February 20, 2009 at approximately 11:45 AM, interview with the QMRP and the review of Client #2's IPP failed to evidence a current activity schedule. Further interview with the</p>	W 250	<p>Clients # 3's activity schedule was developed by the Qmnp Refer to attachment #7 a In the future, the Qmnp will ensure that all activity schedules are developed, filed in the the book, and available upon request.</p>	3-06-09

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W 250	<p>Continued From page 16</p> <p>QMRP revealed the format for the activity scheduled had been revised. Reportedly, the old schedule was to be replaced. According to the QMRP, the new schedule would include the day and time, specified activities and IPP objectives. At the time of the survey, there was no evidence that the schedule had been developed.</p> <p>3. On February 20, 2009 at approximately 1:00 PM, interview with the QMRP and the review of Client #1's IPP failed to evidence a current activity schedule. Further interview with the QMRP revealed the format for the activity scheduled had been revised. Reportedly, the old schedule was to be replaced. According to the QMRP, the new schedule would include the day and time, specified activities and IPP objectives. At the time of the survey, there was no evidence that the schedule had been developed.</p>	W 250	<p>Clients # 2's activity schedule was developed by the Qmrp Refer to attachment #7 b In the future, the Qmrp will ensure that all activity schedules are developed, filed in the book, and available upon request.</p> <p>Clients # 1's activity schedule was developed by the Qmrp Refer to attachment #7 c In the future, the Qmrp will ensure that all activity schedules are developed, filed in the book, and available upon request.</p>	3-06-09 3-06-09
W 252	<p>483.440(a)(1) PROGRAM DOCUMENTATION</p> <p>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure accurate documentation of progress on the individual program plan (IPP) objective, for one of the three clients in the sample. (Client #1)</p> <p>The finding includes:</p> <p>[Cross refer to W249]. On February 19, 2009 and again on February 20, 2009, Client #1 was</p>	W 252		

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W 252	<p>Continued From page 17</p> <p>observed to repeatedly unbuckle his belt and unzip his pants throughout the survey. Interview with staff on February 19, 2009 at 8:15 AM indicated that the client frequently engaged in the behavior.</p> <p>Review of the Annual Psychological Assessment dated December 10, 2008 on February 20, 2009 at 12:37 PM, revealed "Very few incidents of the removal of clothing have been observed. When attempted, the client unzipped his pants and seemed to make the effort to remove them unless it was discouraged". The corresponding data collection system required by the Behavior Support Plan (BSP) dated December 10, 2008 indicated that the time of the behavior, the behavior and the antecedents must be documented. Additionally, the data collection system required that if a new problem behavior was noted, it should be documented. There was no evidence the client's repeated incidents of unfastening his belt and unzipping his pants had been documented in accordance with his individual program plan (IPP).</p>	W 252	<p>The Behavior Specialist has expanded the target behavior of Disrobing to include Unbuckling of the belt, Unzipping of pants, and possible Self Stimulation.</p> <p>The revised BSP was approved the HRC 3-15-09</p> <p>Refer to attachment # 4 3-16-09</p> <p>The Behavior Specialist will inservice the home as well as the day program staff.</p> <p>in the future The Behavior specialist, the Qmnp and house Manager will closely monitor the staff documentation of client #1 repeated incidents of unfastening his belts, unzipping his pants. This emphasis will be addressed during the staff inservice.</p>	
W 322	<p>483.460(a)(3) PHYSICIAN SERVICES</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 observation, interview and record review, the facility failed to provide preventive and general medical care, for one of three clients in the sample. (Client #3)</p> <p>The finding includes:</p>	W 322		

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W 322	<p>Continued From page 18</p> <p>[Cross Refer to W331]. The facility's nursing services failed to coordinate services to ensure Client #3 received an evaluation of her right ear to determine if she could benefit from an amplification device as evidenced below:</p> <p>Observations at the day program and the residence on February 19 and 20, 2009, revealed that Client #3 appeared to have difficulty hearing. Interview with the Licensed Practical Nurse revealed that the client had recently been assessed for a hearing aide.</p> <p>The review of a nursing consultation report dated November 21, 2008 for Client #3 revealed an Audiology appointment was completed on that date. The purpose of the visit was to address the question, "Does the client (Client #3) need to wear a hearing aide in both ears?" The recommendation for the next scheduled appointment included, ".....Hearing evaluation also to be performed at that time to obtain a right hearing aide....."</p> <p>Review of the next nursing consultation form dated January 23 2009, indicated that the Client #3 was again scheduled to address the hearing in her right ear. According to the report, there was no evidence that an assessment was performed on the client's right ear during this visit.</p>	W 322	<p>Client # 3 had two (2) audiology evaluations, and the nursing staff inquired if bilateral hearing is required based on client#3's hearing deficit, but the audiologist did not address the nurse's concern; instead, the audiologist recommended BSER with a hearing aid which was completed on 1-29-09, and hearing aid was adjusted to adequate functioning level. Client #3 is scheduled for re-evaluation to determine the need for bilateral hearing aid, and the nurses will ensure that the audiologist addresses this issue on 5-12-09.</p> <p>In the future, the nursing department will ensure that client#3's right ear is examined by the audiologist to determine a need for bilateral hearing aide; furthermore, a copy of the speech evaluation will be sent to the audiologist for review.</p>	
W 331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>This STANDARD is not met as evidenced by: Based observation, interview and record review the facility failed to ensure nursing services in</p>	W 331		

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W 331	<p>Continued From page 19</p> <p>accordance with the needs of one of three clients included in the sample. (Client #2)</p> <p>The finding includes:</p> <p>The facility's nursing services failed to coordinate services to ensure Client #3 received an evaluation of her right ear to determine if she would benefit from an amplification device as evidenced below:</p> <p>Observations at the day program and the residence on February 19 and 20, 2009 revealed that Client #3 appeared to have difficulty hearing. Interview with the staff indicated that the client should wear a hearing aids in her left ear.</p> <p>Interview with the Licensed Practical Nurse (LPN) Coordinator at the group home on February 20, 2009 at approximately 12:00 PM, revealed that the client had recently been assessed for the hearing aids for her left ear, however had not received an evaluation of her right ear. According to the LPN, an assessment of Client #3's right ear was requested to see if she would benefit from an amplification device</p> <p>On February 20, 2009 at approximately 2:50 PM, review of the Speech and Language Evaluation dated January 11, 2009 revealed that Client #3 had a diagnosis of a "severe bilateral hearing loss". Further review of the audiological evaluation section indicated that Client #3's "speech awareness threshold was severely impaired in the right ear."</p> <p>Review of the nursing consultation form dated November 21, 2008 revealed the reason for the assessment was to</p>	W 331	<p>Client # 3 had two (2) audiology evaluations, and the nursing staff inquired if bilateral hearing is required based on client#3's hearing deficit, but the audiologist did not address the nurse's concern; instead, the audiologist recommended BSER with a hearing aid which was completed on 1-29-09, and hearing aid was adjusted to adequate functioning level. Client #3 is scheduled for re-evaluation to determine the need for bilateral hearing aid, and the nurses will ensure that the audiologist addresses this issue on 5-12-09.</p> <p>In the future, the nursing department will ensure that client#3 right ear is examined by the audilogist to determine a need for bilateral hearing aide; furthermore, a copy of the speech evaluation will be sent to the audiologist for review.</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/20/2009
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W 331	<p>Continued From page 20</p> <p>address the question, "Does Client #3 needs to wear a hearing aide in both ears?" The recommendations included the following:</p> <ol style="list-style-type: none"> 1. Cerumen Management 2. If hearing aid is found, contact hearing and speech clinic if the device in not functioning. 3. BSER threshold search to investigate auditory sensitivity for the purpose of obtaining a new hearing aide, assuming that the device is lost. Hearing evaluation also to be performed at that time to obtain a right hearing aide through DC Medicaid. <p>Review of the next nursing consultation form dated January 23 2009, indicated that the reason for the second consultation was to again address the question, "Does Client #3 need to wear a hearing aide in both ears at the same time?" Further review of the consultation report revealed that the clinic only repaired the "Dead" hearing aide for the left ear. According to the report there was no evidence that an assessment was performed on the client's right ear.</p>	W 331	<p>Client # 3 had two (2) audiology evaluations, and the nursing staff inquired if bilateral hearing is required based on client#3's hearing deficit, but the audiologist did not address the nurse's concern; instead, the audiologist recommended BSER with a hearing aid which was completed on 1-29-09, and hearing aid was adjusted to adequate functioning level. Client #3 is scheduled for re-evaluation to determine the need for bilateral hearing aid, and the nurses will ensure that the audiologist addresses this issue on 5-12-09.</p> <p>In the future, the nursing department will ensure that client#3 right ear is examined by the audilogist to determine a need for bilateral hearing aide; furthermore, a copy of the speech evaluation will be sent to the audiologist for review.</p>	
W 436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure necessary adaptive equipment was furnished and/or</p>	W 436		

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W 436	<p>Continued From page 21</p> <p>maintained for clients and that clients were taught to make informed choices on their use, for two of the five clients residing in the facility. (Client #3 and #5)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The facility failed to ensure that Client #5 was provided eyeglasses as prescribed and failed to ensure that the client was taught to care for them as evidenced below. <p>On February 20, 2009 at 8:10 AM, interview with the Home Manager (HM) indicated that Client #5 sometimes wore eyeglasses when participating in tabletop activities. According to the HM, the client had broken several pairs of eye glasses and currently did not have any glasses available for her use. Further interview with the HM and the Qualified Mental Retardation Professional (QMRP), later that morning failed to determine how long the client's glasses had been without glasses. Additional discussion with the QMRP failed to evidence that the client had received training on how to care for her glasses.</p> <p>Review of a note dated May 28, 2008 on February 20, 2009 at 9:30 AM, written to the optician revealed that Client #5's prescription needed to be reevaluated because she bumped into objects. The same note reflected a request for two pairs of eye glasses with unbreakable frames because she broke her eye glasses. The consultation report revealed on that date that the client was fitted for two pairs of eyeglasses.</p> <p>On February 20, 2009 at approximately 9:45 AM, review of the current physician's orders dated February 1, 2009 an order that Client #5 "May</p>	W 436	<p>A meeting was held on 3-13-09 with members of the IDT; at that time the team agreed to schedule a follow-up visual appointment due to the fact that her last appointment could not be completed. After the appointment is scheduled, and completed, a BSP will be revised to include an eyeglasses desensitization protocol in order to increase her tolerance to wearing her eyeglasses.</p> <p>The Behavioral Specialist will inservice the staff on the protocol once it is completed. Refer to attachment #7</p> <p>In the future, the facility will ensure that client #5's glasses are available, and that the staff receive appropriate training on how to care for them.</p>	3-13-09

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W 438	<p>Continued From page 22</p> <p>wear glasses". Further record review revealed a diagnoses of Keratomas of right eye and myopia. The Annual Nursing Health Management Care Plan dated January 21, 2009 documented a potential for injury related to diagnosis of myopia. The client "wears glasses to improve her vision....Assure that she wears them daily." At the time of the survey, however, there was no evidence the client's glasses were available or that she had received training on how to use/care for them to ensure that they were maintained in good repair.</p> <p>2. The facility failed to ensure that Client #5 was provided a helmet that fit her head as evidenced below:</p> <p>On February 19, 2009 at 3:23 PM, Client 5's protective helmet was observed to hang slightly above her left eye as she sat at the dining table. At 4:20 PM, the helmet continued to slide down on her forehead and she removed it, then put it back on again. At 4:25 PM, staff was observed to remove the helmet and place a folded hand towel inside the helmet. The helmet was observed to sit high when it was put back on the client's head. Staff then adjusted the cloth inside the helmet and placed it back on the client's head. On February 20, 2009 at 8:00 AM, again a cloth was visible through the holes in Client #5's helmet.</p> <p>Interview with staff on February 20, 2009 at 8:00 PM indicated the Physical Therapist mentioned that the use of a towel may improve the comfort of the helmet. Further interview with staff and the Qualified Mental Retardation Professional indicated that the client was provided with this type of helmet because she had previously</p>	W 438	<p>A meeting was held on 3-13-09 with members of the IDT; at that time the team agreed to schedule a follow-up visual appointment due to the fact that her last appointment could not be completed. After the appointment is scheduled, and completed, a BSP will be revised to include an eyeglasses desensitization protocol in order to increase her tolerance to wearing her eyeglasses.</p> <p>The Behavioral Specialist will inservice the staff on the protocol once it is completed. Refer to attachment #8 a</p> <p>In the future, the facility will ensure that client #5's glasses are available, and that the staff receive appropriate training on how to care for them.</p> <p>The PT came to the house on 3-12-09 in order to assess client #5. A new helmet was ordered, and is currently in place. The use of the new helmet was approved by HRC</p> <p>In the future the house management will ensure that client # is provided with the training that will enable her to make choice of to make choice of the proper use of the helmet.</p> <p>The PT came to the house on 3-12-09 in order to assess client #5. A new helmet was ordered, and is currently in place. The use of the new helmet was approved by HRC</p> <p>Refer to attachment #8.b & c</p>	<p>3-13-09</p> <p>3-16-09</p> <p>3-16-09</p>

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W 436	<p>Continued From page 23</p> <p>intentionally damaged other types of helmets that had been provided.</p> <p>Documentation provided during the survey failed to substantiate a recommendation to use a towel in client's helmet. Additionally, there was no evidence the client was offered training to enable her to make an informed choice on the proper use of her helmet.</p> <p>3. [Cross Reference W120] The facility failed to ensure that Client #3's had access to her hearing aids at all times in accordance with her needs as evidenced below:</p> <p>Interview with the House Manager (HM) on February 20, 2009 at approximately 9:45 AM, revealed that Client #3 was prescribed the use of a hearing aid. Further interview revealed that the staff were required to remove the client's hearing aid prior to her departure from the group home in route to her day program. Reportedly, the staff were to place the hearing aid on the desk in the nurses office. The HM was observed to go into the nurses' office and pick up the hearing aid in a plastic bag. According to the HM, that was the procedure to ensure that the client hearing aid was not lost. However, Client #3 was not afforded the opportunity to use her hearing aid while in transit to and from her day program.</p>	W 436	<p>The PT came to the house on 3-12-09 in order to assess client #5. A new helmet was ordered, and is currently in place. The use of the new helmet was approved by HRC Refer to attachment #7.b & c In the future the house management will ensure that client # is provided with the training that will enable her to make choice of to make choice of the proper use of the helmet.</p> <p>Refer to W 120 (2) P.3</p> <p>Attachment #2</p>	<p>3-16-09</p> <p>3-06-09</p> <p>3-16-09</p>
W 455	<p>483.470(l)(1) INFECTION CONTROL</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>This STANDARD is not met as evidenced by:</p>	W 455		

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W 455	Continued From page 25 were implemented. On February 19, 2009 at approximately 5:24 PM, the facility's LPN Coordinator entered the facility and came directly into the dining room. At that time, Client #1, #3 and #5 were eating their dinner at the table. The LPN removed the hat from his head and placed it on the dining room table where the clients were eating their meal.	W 455	The registered nurse has trained the LPN as well as the staff on infection control. Refer to attachment # 10 In the future, the facility will ensure that the nurses demonstrate effective measures to control infection.	3-06-09
W 474	483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to serve foods in a form consistent with dietary orders for three of the three clients in the sample. (Clients #1, #2 and #3) The findings include: 1. The facility failed to ensure that food was prepared in a form consistent with Client #3's prescribed dietary needs as evidenced below: Observation at Client #3's day program on February 19, 2009 at 12:15 PM, revealed the client receiving a ground diet consisting of hamburger, sweet potatoes and green beans. Further observation revealed two slices of whole wheat bread (not ground) were provided. Interview with the day program staff revealed that the client was prescribed a mechanical soft, low cholesterol, high fiber diet. Observation on the same day during dinner at the	W 474	The meeting was held at client #3's day program on 3-12-09 to discuss her diet. A copy of the current diet order was provided to the nurse, and the day program staff was inserviced on the current diet. Refer to attachment #1 a & b In the future the facility management will ensure that the day program is provided with the diet order as prescribed. The qmnp will make observation during lunch time to ensure that client #3 receives diet as prescribed; additionally, when correspondence i.e Physician Orders are delivered to the day program, the residential facility will ensure that day program personnel signs a receipt to acknowledge reception. The copy will be filed in the resident's medical book. The nursing staff will ensure that the day program nurse communicates future dietary changes for client #3 to their food catering company, and comply with her dietary order; in addition, the nurse at the day program will be advised to train the staff on dietary changes.	3-12-09

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W 474	<p>Continued From page 26</p> <p>group home revealed at approximately 5:21 PM, the client was given ground beef stew with mixed vegetables and coleslaw. Further observation revealed the client received one wheat roll (not ground). At approximately 5:25 PM, the LPN was observed to direct the staff preparing the food to remove Client #3's plate from the table. The staff then was observed to place the roll into the blender. The staff was then observed to turn on the blender and grind the roll, after which the ground bread was poured onto the client's plate. The staff then mixed applesauce into the ground bread.</p> <p>Interview with the LPN and the RN revealed that Client #3's diet texture was changed to pureed. According to the nurses, the client's food in the day program and the group home should have been prepared in a pureed texture.</p> <p>Review of the nutritional assessment dated January 28, 2009, indicated that the client diet was changed from a Mechanical Soft, Low Cholesterol, High Fiber to Puree, Low Cholesterol, High Fiber diet; serve extra low cholesterol gravy. Further review of the assessment revealed that the "Resident is having difficulty consuming mechanical soft foods." On February 20, 2009 at approximately 2:00 PM, review of the current physician order dated February 1, 2009 revealed a Puree, Low Cholesterol, High Fiber was prescribed. There was no evidence that the day program or the group home provided Client #3 a pureed textured diet as prescribed.</p> <p>This is a repeat deficiency from the February 28, 2008 survey.</p>	W 474	<p>The meeting was held at client #3's day program on 3-12-09 to discuss her diet. A copy of the current diet order was provided to the nurse, and the day program staff was inserviced on the current diet. Refer to attachment #1 a & b</p> <p>In the future the facility management will ensure that the day program is provided with the diet order as prescribed. The qmnp will make observation during lunch time to ensure that client #3 receives diet as prescribed; additionally, when correspondence i.e Physician Orders are delivered to the day program, the residential facility will ensure that day program personnel signs a receipt to acknowledge reception. The copy will be filed in the resident's medical book.</p> <p>The nursing staff will ensure that the day program nurse communicates future dietary changes for client #3 to their food catering company, and comply with her dietary order; in addition, the nurse at the day program will be advised to train the staff on dietary changes.</p>	3-12-09
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0173	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/20/2009
NAME OF PROVIDER OR SUPPLIER R C M OF WASHINGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1318 45TH PLACE, NE WASHINGTON, DC 20019		
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1000	INITIAL COMMENTS A licensure survey was conducted from February 19, 2009 through February 20, 2009. The survey was initiated using the fundamental survey process. A random sample of three residents was selected from a resident population of two males and three females with various disabilities. The findings of the survey were based on observations at the group home and three day programs, interviews with day program staff, management and direct care staff in the residence and the review of administrative records, including the facility's incident management system.	1000		02/20/2009
1047	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 verification, the GHMRP failed to ensure that meals served away from home suited the dietary needs of the residents as indicated in the individual support plan for three of three residents in the sample. (Resident #1, #2, and #3). The findings include: The facility failed to ensure that food was prepared in a form consistent with Resident #3's prescribed dietary needs as evidenced below. Observation at Resident #3's day program on	1047		03/16/09

Health Regulation Administration

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

TITLE
Program Director
(X5) DATE
3/16/09

STATE FORM

YCOK111

If continuation sheet 1 of 20

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1047	Continued From page 1 February 19, 2009 at 12:15 PM, revealed the resident receiving a ground diet consisting of hamburger, sweet potatoes and green beans. Further observation revealed two slices of whole wheat bread (not ground) were provided. Interview with the day program staff revealed that the resident was prescribed a mechanical soft, low cholesterol, high fiber diet. Observation on the same day during dinner at the group home revealed at approximately 5:21 PM, the resident was given ground beef stew with mixed vegetables and coleslaw. Further observation revealed the resident received one wheat roll (not ground). At approximately 5:25 PM, the LPN was observed to direct the staff preparing the food to remove resident #3's plate from the table. The staff then was observed to place the roll into the blender. The staff was then observed to turn on the blender and grind the roll, after which the ground bread was poured onto the resident's plate. The staff then mixed applesauce into the ground bread. Interview with the LPN and the RN revealed that Resident #3's diet texture was changed to pureed. According to the nurses, the resident's food in the day program and the group home should have been prepared in a pureed texture. Review of the nutritional assessment dated January 28, 2009, indicated that the resident diet was changed from a Mechanical Soft, Low Cholesterol, High Fiber to Puree, Low Cholesterol, High Fiber diet; serve extra low cholesterol gravy. Further review of the assessment revealed that the "Resident is having difficulty consuming mechanical soft foods." On February 20, 2009 at approximately 2:00 PM, review of the current physician order dated	1047	All staff were trained by the nutritionist on food textures and preparation. Refer to attachment #6. In the future, the facility will ensure that foods are prepared according to the appropriate textures All staff were trained on foods substitutions and textures on 9-19-08 by the nutritionist; however, the training seemed not to be effective All staff were retrained by the nutritionist nutritionist on food substitutions In the future the facility will ensure that the staff substitute food according to the substitution list. Refer to attachment #6 All staff were trained on foods substitutions and textures on 9-19-08 by the nutritionist; however, the training seemed not to be effective. All staff were retrained by the nutritionist on food substitutions In the future the facility will ensure that the staff substitute food according to the substitution list. Refer to attachment #6	3-06-09 3-06-09 3-06-09

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1047	<p>Continued From page 2</p> <p>February 1, 2009 revealed a Puree, Low Cholesterol, High Fiber was prescribed. There was no evidence that the day program or the group home provided Resident #3's pureed textured diet as prescribed.</p> <p>This is a repeat deficiency from the February 28, 2008 survey.</p>	1047	<p>All staff were trained on foods substitutions and textures on 9-19-08 by the nutritionist; however, the training seemed not to be effective. All staff were retrained by the nutritionist on food substitutions</p> <p>In the future the facility will ensure that the staff substitute food according to the substitution list.</p> <p>Refer to attachment #6</p>	3-06-09
1090	<p>3504.1 HOUSEKEEPING</p> <p>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.</p> <p>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.</p> <p>The findings include:</p> <p>On February 20, 2009, beginning at 3:15 PM, observation of the environment revealed the following concerns:</p> <ol style="list-style-type: none"> 1. When the bathroom light was turned on, a scratchy-like sound was heard coming from the area of the switch plate. (The light switch was located in the bathroom which was beside the nursing office). Interview with staff during the observation revealed the origin of the noise had not been determined. 2. An unsecured floor tile was observed on the floor at the left side of the toilet. 	1090	<p>The noise was coming from the light bulb. The bulb was replaced</p> <p>In the future, the facility management will ensure that all of the house equipment are in a working condition.</p> <p>The floor will be replaced</p> <p>In the future, the facility will ensure that</p>	2-23-09 3-20-09

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NAME OF PROVIDER OR SUPPLIER ERIC M OF WASHINGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1316 45TH PLACE, NE WASHINGTON, DC 20019		
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I 203	Continued From page 3	I 203		
I 203	<p>3609.3 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 interview and record review, the GHMRP failed to have current job descriptions for all employees on file for review.</p> <p>The finding includes:</p> <p>Interview and review of the personnel files conducted on February 20, 2009 revealed that GHMRP failed to provide evidence of current signed job descriptions for the House Manager and the Qualified Mental Retardation Professional.</p>	I 203	<p>The house manager and Qmrp job descriptions are currently on file.</p> <p>In the future, the provider will ensure that the employees files are updated, and that the documents are available upon request.</p>	3-13-09
I 206	<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 interview and record review, the GHMRP failed to ensure that all staff had current health certificates on file.</p> <p>The finding includes:</p>	I 206		

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1208	Continued From page 4 Interview with the Qualified Mental Retardation Professional and review of the personnel files on February 20, 2009, revealed the GHMRP failed to provide evidence of a current health certificate for the Physician, Podiatrist, Social Worker, and one License Practical Nurse.	1208	The health certificates for the Physicain, Social Worker, and LPN are curently on file. In the future, the provider will ensure that the consultant's files are updated, and that the documents are available upon request.	
1222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on observations, interview and record verification, the GHMRP failed to ensure continuous, ongoing in-service training programs were conducted for all personnel. The findings include: 1. The facility failed to ensure each staff was trained to provide personal for each resident. Observation on the morning of February 19, 2009 at approximately 7:00 AM, revealed Resident #1 sitting on the toilet in the bathroom, located next to the office, with the door open. Direct care staff were observed passing the open door on several occasions. Also, during the observation, two residents were observed passing in front of the open door. At approximately 7:08 AM, the House Manager (HM) entered the facility and noticed the bathroom door was open. The HM immediately closed the door. Prior to the house manager's arrival, no direct care staff was observed to encourage Resident #1 to exercise his right to privacy during toileting.	1222	Refer to W 130 P.5 & 6 Attachment #4a & b Refer to W 130 P.5 & 6 Attachment #4a & b	3-06-09 3-06-09

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1222	Continued From page 5 During observation on February 20, 2009 at approximately 4:15 PM, Resident #1 was assisted to the bathroom located next the office. Moments later, the resident was observed in the bathroom with the door open. According to interview with the direct care staff, the resident opened the bathroom door himself. Interview with the HM at 4:17 PM revealed that Resident #1 had a training objective to keep the door closed for his privacy. Review of the individual program plan confirmed that the objective should have been implemented. There was no evidence that Resident #1 was encouraged to exercise his right to privacy during toileting. 2. The facility failed to ensure that staff were effectively trained on food textures. Meal observation on February 19, 2009 at 5:31 PM revealed Resident #1 was provided finely ground foods instead of the prescribed pureed texture. On February 20, 2009 at approximately 2:15 PM, interview with the QMRP indicated that the nutritionist trained direct care staff on preparing foods of various textures. Subsequent review of training record revealed that direct care staff received training on food preparation on September 19, 2008. Review of the physician's orders dated February 1, 2009 indicated Resident #1 was prescribed a pureed diet. At the time of the survey, however, there was no evidence that staff demonstrated competency to ensure appropriately textured foods were prepared and served. 3. The facility failed to ensure that staff were adequately trained to make food substitutions of comparative nutritive value for each resident.	1222	Refer to W 130:P.5 & 6 Attachment #4 a & b Refer to W 130 P.5 & 6 Attachment #4 a & b All staff were inserviced on foods textures and substitutions on 9-19-08 by the nutritionist on 9-19-08 by the nutritionist; however, the training seemed not to be effective. All staff were retrained by the nutritionist on food substitutions In the future the facility will ensure that the staff substitute food according to the substitution list. Refer to attachment #6	3-06-09 3-06-09 3-06-09

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If continuation sheet 6 of 20

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1222	<p>Continued From page 6 (Residents #1, #2, #3, #4, and #5)</p> <p>Observation of meal preparation on February 19, 2009 at 5:10 PM revealed staff using the blender to modify the textures of beef cubes, mixed vegetables, coleslaw, and whole wheat rolls which were being prepared for dinner. The residents were observed to receive applause in addition to the above foods. Interview with the staff member that prepared the meal revealed that substitutions were made for the unavailable items (fruit salad and cottage cheese) on the menu.</p> <p>On February 20, 2009 at 1:30 PM, the review of the printed dinner menu for the previous day revealed that beef stew with vegetables, pineapple/apricot salad, cottage cheese, bread, and margarine were scheduled to be served. There was no evidence that the coleslaw served was of a similar nutritive value to replace the cottage cheese on the menu for the residents' dinner.</p> <p>4. [Cross Refer to 3521.1]. The facility failed to ensure that direct care staff were effectively trained to monitor, document and provide support to Resident #1 when he exhibited maladaptive behavior.</p> <p>On February 19, 2009 and February 20, 2009, Resident #1 was observed to repeatedly exhibit incidents of unzipping pants and unbuckling his belt. During these times, staff failed to intervene and/or document the behavior.</p> <p>Interview with the QMRP on February 20, 2009, at approximately 2:30 PM revealed that on February 17, 2009, staff were trained on the implementation of Resident #1's behavior support</p>	1222	<p>All staff were trained on foods substitutions and textures on 9-19-08 by the nutritionist on 9-19-08 by the nutritionist; however, the training seemed not to be effective. All staff were retrained by the nutritionist on food substitutions In the future the facility will ensure that the staff substitute food according to the substitution list. Refer to attachment #6</p> <p>All staff were trained on foods substitutions and textures on 9-19-08 by the nutritionist on 9-19-08 by the nutritionist; however, the training seemed not to be effective. All staff were retrained by the nutritionist on food substitutions In the future the facility will ensure that the staff substitute food according to the substitution list. Refer to attachment #6</p> <p>Refer to W 120 (3) P. 3, 4, 7</p>	<p>3-06-09</p> <p>3-06-09</p> <p>3-15-09 3-16-09</p>

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1401	<p>Continued From page 8</p> <p>Coordinator at the group home on February 20, 2009 at approximately 12:00 PM, revealed that the resident had recently been assessed for the hearing aide for her left ear, however had not received an evaluation of her right ear. According to the LPN, an assessment of Resident #3's right ear was requested to see if she would benefit from an amplification device</p> <p>On February 20, 2009 at approximately 2:50 PM, review of the Speech and Language Evaluation dated January 11, 2009 revealed that Resident #3 had a diagnosis of a "severe bilateral hearing loss". Further review of the audiological evaluation section indicated that Resident #3's "speech awareness threshold was severely impaired in the right ear."</p> <p>Review of the nursing consultation form dated November 21, 2008 revealed the reason for the assessment was to address the question, "Does Resident #3 needs to wear a hearing aide in both ears?" The recommendations included the following:</p> <ol style="list-style-type: none"> 1. Carumen Management 2. If hearing aid is found, contact hearing and speech clinic if the device in not functioning. 3. BSER threshold search to investigate auditory sensitivity for the purpose of obtaining a new hearing aide, assuming that the device is lost. Hearing evaluation also to be performed at that time to obtain a right hearing aide through DC Medicaid. <p>Review of the next nursing consultation form dated January 23 2009, indicated that the reason for the second consultation was to again address the question, "Does Resident #3 need to wear a hearing aide in both ears at the same time?"</p>	1401	<p>Refer to attachmentto W 322 P. 19 & 20</p> <p>Refer to attachmentto W 322 P. 19 & 20</p> <p>Refer to attachmentto W 322 P. 19 & 20</p>	

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1401	<p>Continued From page 9</p> <p>Further review of the consultation report revealed that the clinic only repaired the "Dead" hearing aide for the left ear. According to the report there was no evidence that an assessment was performed on the resident's right ear.</p> <p>2. The GHMRP nursing services failed to ensure follow-up on the results of Resident #2's Modified Barium Swallow Study.</p> <p>On February 19, 2009 at 5:35 PM, Resident #2 was observed being slowly fed finely ground food and being offered intermittent sips of water.</p> <p>Interview with the staff at that time indicated that the aforementioned procedures were outlined in the resident's feeding protocol. Interview with the Director of Nursing (DON) on February 20, 2009 at 3:45 PM revealed that the resident was prescribed and tolerated a ground textured diet. Further interview with the DON revealed the resident was referred for a Modified Barium Swallow Study on September 4, 2008 to determine which food textures she was able to safely eat. The DON indicated that the resident was prescribed a ground textured diet at the time she was referred to have the swallowing study conducted. It should be noted, however, that there was no evidence Resident #2's tolerance of ground foods was evaluated by the SLP during the study.</p> <p>On February 20, 2009 at 12:19 PM, review of the Modified Barium Swallow Study report dated September 29, 2008 revealed the resident was evaluated on September 4, 2008 by the Speech and Language Pathologist (SLP) for speech/dysphagia. Further review of the report revealed it documented that the resident was evaluated for diagnoses of severe oral apraxia,</p>	1401	<p>Refer to attachment to W 322 P. 19 & 20</p> <p>The nursing staff notified the PCP of the 9-04-08 SLP evaluation and recommendations. The staff was trained on the puree diet and other textures by the nutritionist on 9-19-08; however the nutritionist was not notified on the recommendations made by the Speech Pathologist. In the future, the nursing staff will ensure that the recommendations are reviewed, and notify the nutritionist of any changes in the individual's diet.</p> <p>The Speech Pathologist evaluated client #2 with a puree diet, and recommended to continue with the same texture. In the future, the nursing staff will ensure that the pos are updated regularly to reflect current dietary order monthly.</p>	2-20-09

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1401	<p>Continued From page 10</p> <p>severe oral defensiveness, and moderate-severe dysphagia. The report included "the textures administered: Thin liquid, nectar-thick liquid, honey, pudding thick liquid and barium with food.... There was no problem with the tested foods." Finally, the SLP recommended that a pureed diet with thin liquids be provided for the resident.</p> <p>Review of the current physician's order dated February 1, 2009 revealed a ground textured diet was prescribed instead of the pureed consistency recommended by the SLP. Additionally, there was no evidence the nursing staff followed up to ensure the Resident #2 received a pureed diet as recommended by the SLP.</p> <p>3. The GHMRP failed to ensure necessary adaptive equipment was furnished and/or maintained for Resident #5, and that she was taught to make informed choices on their use.</p> <p>a. The GHMRP failed to ensure that Resident #5 was provided eyeglasses as prescribed and failed to ensure that the resident was taught to care for them as evidenced below:</p> <p>On February 20, 2009 at 8:10 AM, interview with the Home Manager (HM) indicated that Resident #5 sometimes wore eyeglasses when participating in tabletop activities. According to the HM, the resident had broken several pairs of eye glasses and currently did not have any glasses available for her use. Further interview with the HM and the Qualified Mental Retardation Professional (QMRP), later that morning failed to determine how long the resident's glasses had been without glasses. Additional discussion with the QMRP failed to evidence that the resident had received training on how to care for her</p>	1401	<p>The Speech Pathologist evaluated client #2 with a puree diet, and recommended to continue with the same texture. In the future, the nursing staff will ensure that the pos are updated regularly to reflect current dietary order monthly.</p> <p>The Speech Pathologist evaluated client #2 with a puree diet, and recommended to continue with the same texture. In the future, the nursing staff will ensure that the pos are updated regularly to reflect current dietary order monthly.</p>	<p>2-20-09</p> <p>2-20-09</p>

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1401	<p>Continued From page 11 glasses.</p> <p>Review of a note dated May 28, 2008 on February 20, 2009 at 9:30 AM, written to the optician revealed that Resident #5's prescription needed to be reevaluated because she bumped into objects. The same note reflected a request for two pairs of eye glasses with unbreakable frames because she broke her eye glasses. The consultation report revealed on that date that the resident was fitted for two pairs of eyeglasses.</p> <p>On February 20, 2009 at approximately 9:45 AM, review of the current physician's orders dated February 1, 2009 an order that Resident #5 "May wear glasses". Further record review revealed a diagnoses of Keratomas of right eye and myopia. The Annual Nursing Health Management Care Plan dated January 21, 2009 documented a potential for injury related to diagnosis of myopia. The resident "wears glasses to improve her vision... Assure that she wears them daily." At the time of the survey, however, there was no evidence the resident's glasses were available or that she had received training on how to use/care for them to ensure that they were maintained in good repair.</p> <p>b. The GHMRP failed to ensure that Resident #5 was provided a helmet that fit her head as evidenced below:</p> <p>On February 19, 2009 at 3:23 PM, Resident 5's protective helmet was observed to hang slightly above her left eye as she sat at the dining table. At 4:20 PM, the helmet continued to slide down on her forehead and she removed it, then put it back on again. At 4:25 PM, staff was observed to remove the helmet and place a folded hand towel inside the helmet. The helmet was observed to sit</p>	1401	<p>A meeting was held on 3-12-09 with members of the IDT; at that time the team agreed to schedule a follow-up visual appointment due to the fact that her last appointment could not be completed. After the appointment is scheduled, and completed, a BSP will be revised to include an eyeglasses desensitization protocol in order to increase her tolerance to wearing her eyeglasses.</p> <p>The Behavioral Specialist will inservice the staff on the protocol once it is completed. Refer to attachment #8 a</p> <p>In the future, the facility will ensure that client #5 glasses are available, and that the staff receive appropriate training on how to care for them.</p> <p>The PT came to the house on 3-12-09 in order to assess client #5. A new helmet was ordered, and is currently in place. The use of the new helmet was approved by HRC</p> <p>Refer to attachment #8.b & c</p> <p>In the future the house management will ensure that client # is provided with the training that will enable her to make choice of to make choice of the proper use of the helmet.</p>	<p>3-13-09</p> <p>3-16-09</p>

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1401	<p>Continued From page 12</p> <p>high when it was put back on the resident's head. Staff then adjusted the cloth inside the helmet and placed it back on the resident's head. On February 20, 2009 at 8:00 AM, again a cloth was visible through the holes in Resident #5's helmet.</p> <p>Interview with staff on February 20, 2009 at 8:00 PM indicated the Physical Therapist mentioned that the use of a towel may improve the comfort of the helmet. Further interview with staff and the Qualified Mental Retardation Professional indicated that the resident was provided with this type of helmet because she had previously intentionally damaged other types of helmets that had been provided.</p> <p>Documentation provided during the survey failed to substantiate a recommendation to use a towel in resident's helmet. Additionally, there was no evidence the resident was offered training to enable her to make an informed choice on the proper use of her helmet.</p>	1401	<p>The PT came to the house on 3-12-09 in order to assess client #5. A new helmet was ordered, and is currently in place. The use of the new helmet was approved by HRC 3-16-09</p> <p>Refer to attachment #8.b & c In the future the house management will ensure that client # is provided with the training that will enable her to make choice of to make choice of the proper use of the helmet.</p>	
1420	<p>3521.1 HABILITATION AND TRAINING</p> <p>Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure habilitation and training to acquire life skill needed to cope more effectively with the demands of the environment was provided for two of five individuals residing in the GHMRP. (Residents #1 and #5)</p>	1420		

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1420	<p>Continued From page 15</p> <p>communication devices were purchased for the resident, in accordance with the September 29, 2008 recommendation of the Speech and Language Pathologist (SLP). The QMRP stated that the argumentive device was also discussed during the 2008 day program annual individual support plan (ISP) meeting. The home manager indicated that the direct care staff sometimes informally uses the "Go Talk" with the resident, however no formal training objective had been developed and implemented.</p> <p>Review of the day program IPP reflected an objective that [the resident] will communicate his thoughts, ideas and preferences daily through the use of sign language and/or voice output device 60% of the time. Vocabulary: go home; finished, work, more help, lunch, drink, hello, good-bye."). There was no evidence, however that the QMRP had coordinated services with the day program to ensure the training program was implemented at the group home to enhance Resident #1's communication skills.</p>	1420	<p>Refer to W.159 (2) P.9 Attachment # 5.a</p> <p>Refer to W 159 (2) P. 9,10 Refer to attachment 5.b</p>	<p>3-06-09</p> <p>3-10-09</p>
1458	<p>3521.11 HABILITATION AND TRAINING</p> <p>Each resident 's activity schedule shall be available to direct care staff and be carried out daily.</p> <p>This Statute is not met as evidenced by: Based on interview and record review the GHMRP failed to ensure a current daily activity schedule was available to direct staff for three of the three residents in the sample. (Residents #1, #2 and #3)</p> <p>The findings include:</p> <p>The GHMRP failed to ensure that the Activity</p>	1458	<p>Refer to W 159 (5) P 10 Attachments 7, a, b,c</p>	<p>3-06-09</p>

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1458	<p>Continued From page 16</p> <p>Schedules for Residents #1, #2 and #3 were available and incorporated in the residents' Individual Program Plan (IPP) objectives as evidenced below:</p> <ol style="list-style-type: none"> On February 20, 2009 at approximately 10:45 AM, interview with the Qualified Mental Retardation Professional (QMRP) and a the review of Resident #3's IPP failed to evidence a current activity schedule. Further interview with the QMRP revealed the format for the activity scheduled had been revised. Reportedly, the old schedule was to be replaced. According to the QMRP, the new schedule would include the day and time, specified activities and IPP objectives. At the time of the survey, there was no evidence that the schedule had been developed. On February 20, 2009 at approximately 11:45 AM, interview with the QMRP and a the review of Resident #2's IPP failed to evidence a current activity schedule. Further interview with the QMRP revealed the format for the activity scheduled had been revised. Reportedly, the old schedule was to be replaced. According to the QMRP, the new schedule would include the day and time, specified activities and IPP objectives. At the time of the survey, there was no evidence that the schedule had been developed. On February 20, 2009 at approximately 1:00 PM, interview with the QMRP and a the review of Resident #1's IPP failed to evidence a current activity schedule. Further interview with the QMRP revealed the format for the activity scheduled had been revised. Reportedly, the old schedule was to be replaced. According to the QMRP, the new schedule would include the day and time, specified activities and IPP objectives. At the time of the survey, there was no evidence 	1458	<p>Refer to W 159 (5) P 10 Attachments 7 a</p> <p>Refer to W 159 (5) P 10 Attachments 7 b</p> <p>Refer to W 159 (5) P 10 Attachments 7 c</p>	<p>3-06-09</p> <p>3-06-09</p> <p>3-06-09</p>

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0173	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/20/2009
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NAME OF PROVIDER OR SUPPLIER R C M OF WASHINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1318 45TH PLACE, NE WASHINGTON, DC 20019
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1458	Continued From page 17 that the schedule had been developed.	1458		
1500	<p>3523.1 RESIDENT'S RIGHTS</p> <p>Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws.</p> <p>This Statute is not met as evidenced by: Based on interviews and record review, the GHMRP failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) that governs the care and rights of persons with mental retardation for two of three residents in the sample. (Resident #1 and Resident #3)</p> <p>The findings include:</p> <p>1. Observation on February 19, 2009 at approximately 7:00 AM, revealed Resident #1 sitting on the toilet in the bathroom, located next to the office, with the door open. Direct care staff were observed passing the open door several several times. Also during the observation, two residents went pass the open door.</p> <p>At approximately 7:08 AM, the House Manager (HM) entered the GHMRP and noticed the bathroom door was open. The HM immediately closed the door. Prior to the house manager's arrival, no direct care staff were observed to encourage Resident #1 to exercise his right to privacy during toileting.</p> <p>Observation on February 20, 2009 at</p>	1500	<p>Refer to W 130 P. 5,6 Attachment # 4</p> <p>Refer to W 130 P. 5,6 Attachment # 4</p>	<p>3-06-09</p> <p>3-06-09</p>

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1500	<p>Continued From page 18</p> <p>approximately 4:15 PM, revealed staff assisted Resident #1 to the bathroom next the office, which was located off the hallway. Moments later, the resident was observed in the bathroom with the door open. According to interview with the direct care staff, the resident opened the bathroom door himself.</p> <p>Interview with the HM at 4:17 PM revealed that Resident #1 had a training objective to keep the door closed for his privacy. Review of the individual program plan confirmed that that this objective should have been implemented. There was no evidence that Resident #1 was encouraged to exercise his right to privacy during toileting.</p> <p>2. Interview with the House Manager (HM) on February 20, 2009 at approximately 9:45 AM, revealed that Resident #3 was prescribed to wear a hearing aide. Further interview revealed that the staff were required to remove the resident's hearing aide prior to her departure from the group home enroute to her day program. Reportedly, the staff was to place the hearing aide on the desk in the nurse's office. The HM was observed to go into the nurse's office and get a small plastic bag from the desk which was observed to contain one hearing aide. According to the house manager, the aforementioned process was implemented to ensure that the resident's hearing aide was not lost.</p> <p>Record review failed to provided evidence that a written protocol has been developed and was being implemented to ensure that Resident #3's rights were not being violated. Review of the Human Rights Committee (HRC) minutes for the period of August 2009 to the present failed to revealed that the HRC had reviewed these</p>	1500	<p>Refer to W 130 P. 5,6 Attachment # 4</p> <p>Refer to W 130 P. 5,6 Attachment # 4</p> <p>Refer to W 120 (2) P.3 Refer to attachment # 2</p> <p>Refer to W 120 (2) P.3</p>	<p>3-06-09</p> <p>3-06-09</p> <p>3-06-09 3-16-09</p> <p>3-06-09 3-16-09</p>

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NAME OF PROVIDER OR SUPPLIER R C III OF WASHINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1318 46TH PLACE, NE WASHINGTON, DC 20019
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1500	Continued From page 19 practices.	1500		

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