

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

PRINTED: 09/03/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G141	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/20/2010
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NAME OF PROVIDER OR SUPPLIER METRO HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 1433 NORTHGATE ROAD, NW WASHINGTON, DC 20012
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W 000	<p>INITIAL COMMENTS</p> <p>An recertification survey was conducted from August 18, 2010, through August 20, 2010, utilizing the fundamental survey process. A random sample of three clients was selected from a population of five females with various levels of mental retardation and disabilities.</p> <p>The findings of the survey were based on observations at the group home and three day programs, interviews staff, and the review of clinical and administrative records including incident reports.</p>	W 000	<p><i>Received 9/13/10 DOH-HRUA-10FO</i></p>	
W 156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS</p> <p>The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to report the results of investigations to the administrator or designated representative within five working days of the incidents, for three of the five clients residing in the facility. (Clients #1, #2 and #4)</p> <p>The findings include:</p> <p>Review of the facility's incident and investigative reports on August 18, 2010, beginning at 4:00 p.m., revealed the following incident and investigative reports:</p> <p>1. On September 18, 2009, a direct support staff discovered a bruise on Client # 1's shoulders.</p>	W 156	<p>W 156</p> <p>In the future the Agency IMC will ensure that all investigative reports are submitted to the Administrator within the 5 day designated period as per the Policy and Procedure – Incident Management.</p> <p>The administrator will keep an on-going data system recording dates of incident and dates of submission of reports to the affiliated agencies. The administrator will also ensure that the date of review is recorded on the report.</p> <p>See attached in-service record – Incident Management Policy and Procedure</p>	9/8/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Susan L. Swan</i>	TITLE <i>VP Operations</i>	(X6) DATE <i>9/10/10</i>
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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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W 156	<p>Continued From page 1</p> <p>At the time of the survey, the facility failed to provide evidence that the administrator was notified of the results of the investigative report, as required per agency's policy.</p> <p>2. On July 31, 2009, a direct support staff discovered Client #2 in bed hitting her herself and noticed that her nose was bleeding. The staff attempted to stop the bleeding and was unsuccessful. Emergency medical services was called.</p> <p>Review of the corresponding investigative report revealed that the investigation was completed. Although the administrator signed the investigative report, she failed to date the report.</p> <p>At the time of the survey, the facility failed to provide evidence the administrator was notified, timely of the results of the investigative report, as required per agency's policy.</p> <p>3. Review of the facility's incident reports on August 18, 2010, beginning at 4:00 p.m., revealed an incident involving Client #2 dated August 2, 2010. According to the report, direct care staff discovered swelling to the left side of the client's face with a half inch abrasion. It was also noted that swelling was on the right side of her face with a dark area in front of her right ear. The client's nose was discolored and swollen. The nurse assessed the client and there was no distress noted. Further record review revealed no evidence of an investigation.</p> <p>Interview with the qualified mental retardation professional on August 18, 2010, at approximately 4:50 p.m., revealed that she had</p>	W 156		
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W 156	Continued From page 2 spoken with the incident management coordinator (IMC) and was informed that the investigation was still being conducted. On August 20, 2010, at approximately 11:00 a.m., the QMRP provided the surveyor with the results of the investigation. The investigative report was completed on August 16, 2010 (five days beyond the required time). The QMRP further stated that the administrator was on leave and there was no one assigned in her steadfast. At the time of the survey, the facility failed to provide evidence that the aforementioned incident was investigated, timely. 4. Review of the facility's incident reports on August 18, 2010, beginning at 4:00 p.m., revealed an incident involving Client #4 dated February 2, 2010. According to the report, Client #4 was observed walking with a limp. The client was taken to the hospital for an x-ray of her ankle, no fractures were noted. At the time of the survey, the facility failed to provide evidence that the administrator was notified of the results of the investigative report, as required per agency's policy.	W 156		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure staff received training to address the needs of the clients, for	W 189		

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W 189	Continued From page 3 one of three clients in the sample. (Client #2) The finding include: Evening observations on August 18, 2010, at 5:10 p.m., revealed Client #2 wearing a loose fitted chest harness. At 5:13 p.m., the client was observed hitting her head while moving it back and forth. At 5:14 p.m., the client's left harness strap was observed hanging off her shoulder. Review of Client #2's physician orders (POs) dated August 2010, on August 19, 2010, at 4:20 p.m., revealed Client #2 required a wheelchair with a chest harness for safety. Interview with the license practical nurse on August 19, 2010, at 4:30 p.m., revealed Client #2's chest harness should not fit loosely or hang off the shoulder.	W 189	W 189 In the future the QMRP and nursing staff will ensure that adaptive equipment is monitored on a daily basis for function and efficacy. A daily 'Adaptive Equipment functioning checklist' will be maintained and monitored by the QMRP and nursing staff. See attached – Adaptive Equipment form and in-service record on documentation.	9/8/10
W 193	483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's staff failed to demonstrate competency in implementing clients, behaviors support plans (BSP), for one of the three clients included in the sample. (Client #2) The finding includes: On August 18, 2010, at 5:13 p.m., Client #2 was observed banging her head on her wheelchair. At 5:38 p.m., the client began to bang her head on	W 193		

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W 193	<p>Continued From page 4</p> <p>her wheelchair. At 6:17 p.m., the direct support staff asked Client #2 to stop hitting her head on her wheelchair as she ate her dinner. At 6:31 p.m., the client was observed in the living room rocking and banging her head on her wheelchair. At 6:38 p.m., the qualified mental retardation professional (QMRP) asked the client to stop. At 6:39 p.m., the QMRP told the staff to ask the client to stop hitting her head. At 6:51 p.m. the client continued to bang her head on her wheelchair, shortly after the QMRP placed the client's helmet on her head.</p> <p>On August 19, 2010, at 9:20 a.m., review of Client #1's BSP dated August 14, 2009, revealed "hitting self, scratching self, and rubbing self" were challenging maladaptive behaviors identified in the BSP. Further review revealed a helmet protocol for her self injurious behaviors. Review of the protocol revealed that the client "will not be required to wear her helmet at all times unless the self abuse increases to where she is engaging in ear slapping and side of head banging on a daily basis and at least twice a day. The team, considering the potential danger, recommended that the helmet be worn during meal time or when sitting in the living room."</p> <p>In an interview with the QMRP on August 19, 2010, at approximately 2:30 p.m., confirmed that the staff were required to place the helmet on Client #2's head as recommended.</p>	W 193	<p>W 193</p> <p>In the future the QMRP and nursing staff will ensure that all staff are competently trained to demonstrate skills and techniques to manage inappropriate behaviors. The QMRP and nursing staff will monitor staff at least weekly to ensure that the BSP is being followed and staff are practicing the correct techniques. See attached – in-service record on BSP</p>	9/8/10
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</p>	W 249		

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W 249	<p>Continued From page 5</p> <p>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, staff interview and record review, the facility's qualified mental retardation professional (QMRP) failed to ensure client's received continuous active treatment, for three of the three clients included in the sample. (Clients #1, #2 and #3)</p> <p>The findings include:</p> <p>1. On August 18, 2010, at 5:13 p.m., Client #2 was observed banging her head on her wheelchair. At 5:38 p.m., the client began to bang her head on her wheelchair. At 6:17 p.m., the direct support staff asked Client #2 to stop hitting her head on her wheelchair as she ate her dinner. At 6:31 p.m., the client was observed in the living room rocking and banging her head on her wheelchair. At 6:38 p.m., the QMRP asked the client to stop. At 6:39 p.m., the QMRP told the staff to ask the client to stop hitting her head. At 6:51 p.m. the client continued to bang her head on her wheelchair, shortly after the QMRP placed the client's helmet on her head.</p> <p>On August 19, 2010, at 9:20 a.m., review of Client #1's behavior support plan (BSP) dated August 14, 2009, revealed "hitting self, scratching self, and rubbing self" were challenging maladaptive behaviors identified in the BSP. Further review revealed a helmet protocol for her self injurious behaviors. Review of the protocol revealed that the client "will not be required to wear her helmet</p>	W 249	<p>W 249 – 1, 2&3</p> <p>In the future the QMRP will ensure that the staff are adequately trained and are equipped to provide continuous active treatment and interventions needed to achieve the objectives in each individual's IPP. The QMRP will ensure that she monitors the staff at least weekly to ascertain the efficacy of training and intervention techniques.</p> <p>See attached – in-service record – communication IPP, Adaptive equipment – helmet, harness, BSP</p>	9/8/10	

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W 249	<p>Continued From page 6</p> <p>at all times unless the self abuse increases to where she is engaging in ear slapping and side of head banging on a daily basis and at least twice a day. The team, considering the potential danger, recommended that the helmet be worn during meal time or when sitting in the living room." During the aforementioned time, the facility failed to place Client #2's helmet on her head while she was banging her head on her wheelchair.</p> <p>In an interview with the QMRP on August 19, 2010, at approximately 2:30 p.m., confirmed that the staff were required to place the helmet on Client #2's head as recommended.</p> <p>2. Observation on August 18, 2010, at 5:15 p.m., revealed the direct support staff transferred Client #2 from her wheelchair to the recliner chair. At 5:38 p.m., the direct support staff stated to the client, "I'm going to take you to the bathroom to wash your hands." At 5:55 p.m., Client #2 began to eat her dinner.</p> <p>Review of Client #2's individual program plan (IPP) dated August 2010, on August 19, 2010, at 11:08 a.m., revealed an objective for Client #2 to use her low tech communication device to express her wants and needs (eat, drink, out of chair, music and television). On August 20, 2010, at 11:45 a.m., review of the client's speech and language evaluation dated July 29, 2009, revealed a recommendation that "the device may be used to communicate basic wants and needs and to control one's environment." At no time during the survey were any of the direct support staff observed implementing the client's communication goal.</p> <p>Interview with the QMRP on the same day at</p>	W 249		

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W 249	<p>Continued From page 7</p> <p>approximately 2:00 p.m., confirmed that the direct support staff did not implement the Client #2's communication goal.</p> <p>There was no evidence that the facility implemented Client #2's communication program as recommended in the IPP.</p> <p>3. Observation on August 18, 2010, at 4:40 p.m., revealed the direct support staff transferred Client #3 from her wheelchair to the recliner chair. At 5:08 p.m., the direct support staff placed head phones on Client #3's ears. At 5:50 p.m., Client #3 began to eat her dinner.</p> <p>Review of Client #3's IPP dated June 18, 2010, on August 19, 2010, at 1:35 a.m., revealed an objective for Client #3 to use her communication device to express wants and needs (hi, name, eat, drink, music, out of chair, shower and bed). On August 19, 2010, at 1:00 p.m., review of the client's speech and language evaluation dated July 18, 2009, revealed a recommendation that stated, "On a daily basis, given physical guidance, (the client) will use her communication device to communicate with persons in her environment for 4 of 5 days per week, for six consecutive months. At no time during the survey were the direct support staff observed implementing the client's communication goal.</p> <p>Interview with the house manager on the same day at approximately 1:30 p.m., revealed that the staff were required to implement Client #3's communication goal at the day program and at the facility.</p> <p>There was no evidence that the facility implemented Client #3's communication program</p>	W 249			

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W 249	Continued From page 8 as recommended in the IPP.	W 249		
W 252	<p>483.440(e)(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 staff interview and record review, the facility failed to consistently document the client's progress in achieving a programmatic objective, for one of the three sampled clients. (Client #2)</p> <p>The finding includes:</p> <p>Record review on August 19, 2010, at 11:08 a.m., revealed Client #2's Individual Program Plan (IPP) dated August 2010. Review of the social skill objective revealed, "[the client] will participate in group activities (puzzles, bingo, storybook, etc) with one verbal cue on three out of four trials on 8 days per month for twelve consecutive months. Further review revealed no data was collected for August 2010.</p> <p>Interview with the facility's qualified mental retardation professional (QMRP) on August 19, 2010, at approximately 12:00 p.m., revealed that the weekend staff were responsible for implementing and documenting Client #2's IPP progress.</p> <p>The facility failed to ensure consistent documentation of Client #2's social skill objective as recommended by the interdisciplinary team.</p>	W 252	<p>W 252</p> <p>In the future the QMRP and nursing staff will ensure that staff are trained and monitored to consistently provide active treatment and documentation for all IPPs. The QMRP and Residential Coordinator – will monitor the staff at least weekly while they provide the individuals with active treatment and documentation.</p> <p>See attached – in-service record for IPP documentation</p>	9/8/10
W 390	483.460(m)(2)(i) DRUG LABELING	W 390		

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W 390	Continued From page 9 The facility must remove from use outdated drugs. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to remove from it's use, out dated medications, for one of three clients included in the sample. (Client #3) The finding includes: During medication administration on August 19, 2010, at approximately 7:25 p.m., Licensed Practical Nurse #1 (LPN #1) stated Client #3 was to be administered one drop to each eye as ordered by the Primary Care Physician (PCP). Review of the label on the bottle of Client's #3's "Refresh Tears" on August 19, 2010, at approximately 7:27 p.m. revealed the bottle of "Refresh Tears" expired May 10, 2010. In an interview with LPN #1 on August 19, 2010, at approximately 7:30 p.m., it was acknowledged Client #3's artificial tears had expired on May 10, 2010.	W 390	W 390 Inadvertently the date seen by DOH surveyor was the 'date to be discarded' and not expiration date which was '2011' as per the nursing staff. The DON met with the Pharmacy rep. to discuss pharmacy labels and expiration dates posted. In the future the nursing staff along with the consultant pharmacy will ensure that all medications are current and all expired meds are disposed. See attached nursing staff /TME in-service record – Medication Policy and Procedure	9/8/10
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.	W 436		

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W 436	<p>Continued From page 10</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain in good repair client's wheelchair foot box, for one of the three clients included in the sample. (Client #5)</p> <p>The finding includes:</p> <p>On August 18, 2010, at 4:50 p.m., Client #5's foot box on her wheelchair was observed with tape wrapped around the edges of the foot box, holding it together. Interview with the qualified mental retardation professional (QMRP) on August 19, 2010, at approximately 2:30 p.m., indicated that the foot box needs replaced and has been torn for "sometime."</p> <p>Record review revealed a physical therapy assessment dated December 9, 2009, on August 20, 2010, at approximately 11:45 a.m., revealed that the wheelchair was assessed on March 2, 2010. However there were no results of the assessment. Further record review revealed that the wheelchair repair provider indicated that Client #5 needed a new foot box on August 16, 2010. According to the QMRP's quarterly reviews dated March 18, 2010, and June 20, 2010, indicated that staff will continue to monitor and ensure that [the clients] adaptive equipment is in good working.</p>	W 436	<p>W 436</p> <p>The individual had received a new foot box along with a new wheelchair 5 mths ago. Due to the constant wear and tear the leather gets damaged. The QMRP has sent a 719A form requesting a replacement of the foot box.</p> <p>In the future the QMRP will ensure that all adaptive equipment is monitored daily to maintain in good repair.</p> <p>See attached – Adaptive Equipment functioning checklist, 719A form</p>	9/8/10

Health Regulation Administration

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NAME OF PROVIDER OR SUPPLIER METRO HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 1433 NORTHGATE ROAD, NW WASHINGTON, DC 20012
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I 000	INITIAL COMMENTS An licensure survey was conducted from August 18, 2010, through August 20, 2010. A random sample of three clients was selected from a population of five females with various levels of mental retardation and disabilities. The findings of the survey were based on observations at the group home and three day programs, interviews staff, and the review of clinical and administrative records including incident reports.	I 000		
I 058	3502.16 MEAL SERVICE / DINING AREAS A review and consultation by a dietitian or nutritionist shall be conducted at least quarterly to ensure that each resident who has been prescribed a modified diet receives adequate nutrition according to his or her Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observations and record review, the the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that residents with modified diets had been reviewed at least quarterly by the consulting dietitian, for one of the three residents. (Resident #3) The finding includes: During dinner observations, on August 18, 2010, at 5:50 p.m., revealed Resident #3 being fed by staff. Her meal consisted of finely chopped meatballs, noodles, green beans and peaches. The liquid was of a nectar consistency. Review of Resident #3's current physician orders on August 19, 2010, revealed a diet order of a 1200	I 058	I 058 In the future the QMRP and Nursing staff will ensure that the individuals' who are on modified diets are reviewed by a nutritionist at least quarterly. The QMRP and nursing staff will make sure this is completed as part of the monthly record audits. See attached QA audit record	9/9/10

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Susan J. Sloan* TITLE: *VP Operations* (X6) DATE: *9/10/10*

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I 058	Continued From page 1 calorie, high fiber, ground solids and nectar thick liquids. Further review of the medical records revealed a nutrition assessment dated June 6, 2010. The record failed to show evidence that the resident's modified diet had been reviewed by the dietitian, quarterly.	I 058		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure the interior of the GHMRP was maintained in a safe, orderly, and attractive manner, for five of five residents residing in the facility. (Residents #1, #2, #3, #4 and #5) The findings include: An inspection of the environment was conducted on August 20, 2010, beginning at 9:40 a.m. During the inspection, the surveyor was accompanied by the house manager (HM) and the following concerns were identified: Interior: 1. The living room sofa had plastic on it that was torn. 2. The headrest on the chair next to the sofa was soiled.	I 090	I 090 1. The plastic on the sofa has been replaced as the individuals are incontinent 2. The headrest has been shampooed and is no longer soiled. The DDS Case manager has been requested to provide funds from her Trust Fund, to purchase a new recliner for this individual. This process will take at least 2 mths. 3. The ceiling has been fixed 4. The faucet has been fixed and there is hot water. The crack above the wall has been fixed. The individual has new bed rail padding. 5. New bed rail padding has been purchased. In the future the QMRP and the Maintenance manager will ensure that all environmental issues are addressed and fixed expeditiously and a monthly Environmental audit is completed. See attached Environmental QA record	9/9/10

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I 090	Continued From page 2 3. There was a water pocket in the living room ceiling on the right side. 4. In Resident #1's bathroom, the sink did not have hot water and the cold water faucet was leaking around the top. There was also a crack in the wall over the door. The venetian blinds have a blade missing. The bed rail cover guard had holes in it. 5. In Resident #3's bedroom, the bed rail cover had noticeable holes in it. The House Manager (HM) confirmed the findings at approximately 11:00 a.m., on the same day.	I 090		
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been performed and that the employee's health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Persons with Mental Retardation (GHMRP) failed to ensure that all employees had current health certificates, for two of the ten consultants (Psychiatrist and Podiatrist). The finding includes: On August 20, 2010, beginning at approximately 1:30 p.m., review of the personnel records revealed the GHMRP failed to provide evidence	I 206	I 206 The Health Certificate was in the Personnel Record but inadvertently the surveyor did not see it. The Podiatrist is not a consultant contracted by Metro Homes, Inc. He sees individuals at his office. See attached – Health Certificate – psychiatrist	9/9/10

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I 206	Continued From page 3 that current health certificates were on file for the psychiatrist and the podiatrist. The House Manager (HM) acknowledged the findings at approximately 3:00 p.m.	I 206		
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that all staff were trained and competent to provide assistance in accordance with the residents adaptive equipment needs, for one of the three residents in the sample. (Resident #2) The finding includes: Evening observations on August 18, 2010, at 5:10 p.m., revealed Resident #2 wearing a loose fitted chest harness. At 5:13 p.m., the client was observed hitting her head while moving it back and forth. At 5:14 p.m., the client's left harness strap was observed hanging off her shoulder. Review of Resident #2's physician orders (POs) dated August 2010, on August 19, 2010, at 4:20 p.m., revealed that the resident required a wheelchair with a chest harness for safety.	I 229	I 229 In the future the QMRP and nursing staff will ensure that adaptive equipment is monitored on a daily basis for function and efficacy. A daily 'Adaptive Equipment functioning checklist' will be maintained and monitored by the QMRP and nursing staff. See attached – Adaptive Equipment form and in-service record on documentation.	9/8/10

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I 229	Continued From page 4 Interview with the license practical nurse on August 19, 2010, at 4:30 p.m., revealed Resident #2's chest harness should not fit loosely or hang off the shoulder.	I 229		
I 274	3513.1(e) ADMINISTRATIVE RECORDS Each GHMRP shall maintain for each authorized agency ' s inspection, at any time, the following administrative records: (e) Signed agreements or contracts for professional services; This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to provide evidence of signed agreement, for one of ten consultant staff. (Psychiatrist) The finding includes: Review of the personnel records and interview with the House Manager (HM) on August 20, 2010 at approximately 1:30 p.m., revealed there was no signed contract on file for the Psychiatrist.	I 274	I 274 The contract for the psychiatrist was in the personnel file – it was inadvertently overseen by the surveyor. See attached – psychiatrist contract	9/10/10
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by:	I 401		

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I 401	<p>Continued From page 5</p> <p>Based on interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure professional services were provided in accordance with the needs, for three of three residents included in the sample. (Residents #1, #2 and #3)</p> <p>The finding includes:</p> <p>1. On August 18, 2010, at 5:13 p.m., Resident #2 was observed banging her head on her wheelchair. At 5:38 p.m., the client began to bang her head on her wheelchair. At 6:17 p.m., the direct support staff asked Resident #2 to stop hitting her head on her wheelchair as she ate her dinner. At 6:31 p.m., the resident was observed in the living room rocking and banging her head on her wheelchair. At 6:38 p.m., the QMRP asked the resident to stop. At 6:39 p.m., the QMRP told the staff to ask the resident to stop hitting her head. At 6:51 p.m. the client continued to bang her head on her wheelchair, shortly after the QMRP placed the resident's helmet on her head.</p> <p>On August 19, 2010, at 9:20 a.m., review of Resident #1's behavior support plan (BSP) dated August 14, 2009, revealed "hitting self, scratching self, and rubbing self" were challenging maladaptive behaviors identified in the BSP. Further review revealed a helmet protocol for her self injurious behaviors. Review of the protocol revealed that the resident "will not be required to wear her helmet at all times unless the self abuse increases to where she is engaging in ear slapping and side of head banging on a daily basis and at least twice a day. The team, considering the potential danger, recommends that the helmet be worn during meal time or when sitting in the living room." During the</p>	I 401	<p>I401 – 1,2&3</p> <p>1. In the future the QMRP and nursing staff will ensure that all staff are competently trained to demonstrate skills and techniques to manage inappropriate behaviors. The QMRP and nursing staff will monitor staff at least weekly to ensure that the BSP is being followed and staff are practicing the correct techniques. See attached – in-service record on BSP</p> <p>2. In the future the QMRP and nursing staff will ensure that staff are trained and monitored to consistently provide active treatment and documentation for all IPPs. The QMRP and Residential Coordinator – will monitor the staff at least weekly while they provide the individuals with active treatment and documentation. See attached – in-service record for IPP documentation</p>	

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I 401	<p>Continued From page 6</p> <p>aformentioned time, the facility failed to place Client #2's helmet on her head while she was banging her head on her wheelchair.</p> <p>In an interview with the QMRP on August 19, 2010, at approximately 2:30 p.m., confirmed that the staff were required to place the helmet on Resident #2's head as recommended.</p> <p>2. Observation on August 18, 2010, at 5:15 p.m., revealed the direct support staff transferred Resident #2 from her wheelchair to the recliner chair. At 5:38 p.m., the direct support staff stated to the client, "I'm going to take you to the bathroom to wash your hands." At 5:55 p.m., Resident #2 began to eat her dinner.</p> <p>Review of Resident #2's individual program plan (IPP) dated August 2010, on August 19, 2010, at 11:08 a.m., revealed an objective for Resident #2 to use her low tech communication device to express her wants and needs (eat, drink, out of chair, music and television). On August 20, 2010, at 11:45 a.m., review of the resident's speech and language evaluation dated July 29, 2009, revealed a recommendation that "the device may be used to communicate basic wants and needs and to control one's environment." At no time during the survey were any of the direct support staff observed implementing the resident's communication goal.</p> <p>Interview with the QMRP on the same day at approximately 2:00 p.m., confirmed that the direct support staff did not implement the Resident #2's communication goal.</p> <p>There was no evidence that the facility implemented Resident #2's communication</p>	I 401	<p>3. In the future the QMRP and nursing staff will ensure that staff are trained and monitored to consistently provide active treatment and documentation for all IPPs. The QMRP and Residential Coordinator – will monitor the staff at least weekly while they provide the individuals with active treatment and documentation.</p> <p>See attached – in-service record for IPP documentation</p>	9/8/10

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I 401	Continued From page 7 program as recommended in the IPP. 3. Observation on August 18, 2010, at 4:40 p.m., revealed the direct support staff transferred Resident #3 from her wheelchair to the recliner chair. At 5:08 p.m., the direct support staff placed head phones on Resident #3's ears. At 5:50 p.m., Resident #3 began to eat her dinner. Review of Resident #3's IPP dated June 18, 2010, on August 19, 2010, at 1:35 a.m., revealed an objective for Resident #3 to use her communication device to express wants and needs (hi, name, eat, drink, music, out of chair, shower and bed). On August 19, 2010, at 1:00 p.m., review of the resident's speech and language evaluation dated July 18, 2009, revealed a recommendation that stated, "On a daily basis, given physical guidance, (the resident) will use her communication device to communicate with persons in her environment for 4 of 5 days per week, for six consecutive months. At no time during the survey were the direct support staff observed implementing the resident's communication goal. Interview with the house manager on the same day at approximately 1:30 p.m., revealed that the staff were required to implement Resident #3's communication goal at the day program and at the facility. There was no evidence that the facility implemented Resident #3's communication program as recommended in the IPP.	I 401		
I 484	3522.11 MEDICATIONS Each GHMRP shall promptly destroy prescribed medication that is discontinued by the physician	I 484		

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I 484	<p>Continued From page 8</p> <p>or has reached the expiration date, or has a worn, illegible, or missing label.</p> <p>This Statute is not met as evidenced by: Based on observation and interview, the Group Home for Mentally Retarded Persons (GHMRP) nursing staff failed to remove from it's use, out dated medications, for one of three residents included in the sample. (Resident# 3)</p> <p>The finding includes:</p> <p>During medication administration on August 19, 2010, at approximately 7:25 p.m., Licensed Practical Nurse #1 (LPN #1) stated Resident #3 was to be administered one drop to each eye as ordered by the Primary Care Physician (PCP).</p> <p>Review of the label on the bottle of Resident #3's "Refresh Tears" on August 19, 2010, at approximately 7:27 p.m. revealed the bottle of "Refresh Tears" expired May 10, 2010.</p> <p>In an interview with LPN #1 on August 19, 2010, at approximately 7:30 p.m., it was acknowledged Resident #3's artificial tears had expired on May 10, 2010.</p> <p>There was no evidence the facility removed from use all out dated medications.</p>	I 484	<p>I 484</p> <p>Inadvertently the date seen by DOH surveyor was the 'date to be discarded' and not expiration date which was '2011' as per the nursing staff. The DON met with the Pharmacy rep. to discuss pharmacy labels and expiration dates posted. In the future the nursing staff along with the consultant pharmacy will ensure that all medications are current and all expired meds are disposed. See attached nursing staff /TME in-service record – Medication Policy and Procedure</p>	9/8/10