G. Hope

10/30/2007 04:52 FAX 2024429430 HRA ☑005

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FORM APPROVED
OMB NO. 0938-0391

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

RECEIVED
DEPARTMENT OF HEALTH
HEALTH REGULATION
ADMINISTRATION
2007 NOV 13 A 10:13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G137	A. BUILDING _____ B. WING _____	10/12/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MTS	1528 GOOD HOPE ROAD, SE WASHINGTON, DC 20020

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W 000	INITIAL COMMENTS A recertification survey was conducted from October 9, 2007 through October 12, 2007. The survey was initiated using the fundamental survey process. Due to deficient practices, however, the survey was extended on October 11, 2007 to examine the condition of Health Care Services. A random sampling of three clients was selected from a residential population of five clients, two males and three females with various disabilities. The findings of the survey were based on observations, interviews with clients and staff in the home and at one day program, as well as a review of client and administrative records, including incident reports.	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's governing body provided general operating direction over the facility except for the following deficient practices: The findings include: 1. During the inspection of the environment, the following concerns were identified. a. Nine slate floor tiles were observed to be completely detached from the kitchen floor. b. Observation revealed that the kitchen and the laundry were included in the same room. Further observation revealed there was a small open	W 104	W104 1a. the floor tiles will be secured by...1-30-07. 1b. the space below the door and at the corners will be sealed by...11-30-07. MTS wishes to minimize the resources it puts into this home for upkeep because a new home has been identified to replace it. The move will be completed by...12-30-07.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Linda Graham, QMRP — (X6) DATE: 11-9-07

ly deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ner safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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W 104	Continued From page 1 space at both corners (at the bottom) of the kitchen door which exited to the back yard. It was further noted that space was at the bottom of the exit door from the laundry room to the back yard. 2. The Governing Body failed to have a system to ensure dental services were available to residents while awaiting medicaid approval. [See W356]	W 104	2. See response for W356.	
W 112	483.410(c)(2) CLIENT RECORDS The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to keep confidential all information contained in the clients' record for five of five clients residing in the facility. (Client #1, #2, , #3, #4, and #5) The findings include: 1. Interview with direct care staff concerning the client's dietary requirements on October 10, 2007 at 6:20 PM indicated that each client's diet was on the list in the kitchen. Observation revealed a list on the refrigerator on which the diet order and instructions were written. There was no evidence the facility ensured the clients' dietary information/requirements was kept confidential.	W 112	W112 The diet information was taken off the refrigerator and placed in a menu book that is kept on the kitchen counter…11-1-07.	
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client.	W 120		

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W 120	Continued From page 2 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that outside services met the needs of one of three clients in the sample (Clients #1). The findings include: Meal time observations were conducted for Client #1 at his day program on October 13, 2007 at 12:20 PM. The client was observed feeding himself a pureed casserole and pureed spinach from a three section plate using a regular spoon . At 12:45 PM, he was observed feeding himself a sliced banana for dessert. Interview with staff indicated the client was prescribed a pureed diet but that he was given the banana because it was very soft. The review of the physician's orders at the day program revealed the client was prescribed a pureed texture diet.	W 120	W120 The QMRP will meet with the day program of client #1 to insure that its staff adheres to the prescribed diet without exception...11-20-07. In addition, the QMRP will visit the program monthly to insure consistent compliance ...11-20-07.	
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that a system was established to obtain consent for treatments that may cause risks to the rights of two of three clients in the sample. (Clients #1 and #2)	W 124		

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W 124	Continued From page 3 The finding includes: 1. Medication administration observation on October 9, 2007 at 6:10 PM revealed Client #1 received Risperdal 1 mg by mouth for behavior. Interview with the QMRP and the RN on on October 12, 2007 at 2:45 PM revealed psychological and medical affidavits were submitted to the client's case manager for assistance in obtaining a surrogate decision maker for the client. At the time of the survey, there was no evidence the client had a legally sanctioned advocate to assist him in decisions regarding his treatment and care. 2. Medication administration observation on October 9, 2007 at 6:25 PM revealed Client #2 received Fluphenazine (Prolixin) 8 mg and Clonazepam 1 mg by mouth for behavior. Record review revealed the client was also prescribed Fluphenazine (Prolixin) 4 mg in the AM. Interview with the QMRP on October 9, 2007 at 10:17 AM indicated his sister gave consent for the client medical procedures when needed. Further interview with the QMRP and the RN on on October 12, 2007 at 1:37 PM revealed psychological and medical affidavits were submitted to the client's case manager for assistance in obtaining a surrogate decision maker for the client.	W 124	W124 1. A guardianship package is being assembled for client #1 and will be submitted to the DDS Case manager by...11-20-07. The QMRP will follow up with the case manager routinely thereafter until a guardian is identified. The QMRP's monthly notes will reflect the status of follow up...12-1-07. 2. Client #2 has two brothers who can act as decision making support but have not routinely indicated that they wish to do so. Both have been invited to client #2's upcoming ISP meeting at which time (if one or both attend) they will be asked if they are willing to routinely serve this function for their brother. If one answers yes, the QMRP and DDS case manager will follow up to insure all the necessary paperwork is completed to establish the status...12-15-07. If neither wants to do so, the QMRP will work with the DDS case manager to establish a legal guardian....12-30-07.	
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.	W 125		

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W 125	Continued From page 4 This STANDARD is not met as evidenced by: Based on interview and record review during the re-visit on June 4-8, 2007, the facility failed to ensure each client was encouraged to exercise their rights, for two of three clients in the sample. (Clients #1 and #2) The findings include: The facility failed to ensure the rights of Clients #1 and #2 were protected by making certain each the client had a legally sanctioned representatives to assist them with making decisions regarding their treatment. [See W124]	W 125	W125 See responses for W124 above.	
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 verification, the facility failed to ensure each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP) for one of three clients in the sample. (Clients #1] The finding include: 1. The QMRP failed to ensure coordination of services for the implementation of Client #1's physical fitness objectives at his day program. a. Interview with Client #1's day program case	W 159		

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W 159	Continued From page 5 manager on October 12, 2007 at 12:45 PM revealed Client #1 was recommended to have a physical fitness objective to improve his trunk range of motion to be implemented at the day program. Record review at the day program on October 12, 2007 revealed an objective which stated Client #1 will "tolerate the prone position with a pillow under his abdomen for 15 minutes each day at the day program for 3 consecutive months." According to the day program's monthly progress notes written to document the client's progress and outcomes, the objective was not implemented in September and October 2006. The November 2006 summary indicated that a wedge was brought to the day program to be used instead of the pillow. The December 2006 review of the objective revealed the program remained pending until the QMRP could arrange for the group home Physical Therapist (PT) to provide an in-service training to the day program staff on how to implement the objective. According to the January 2007 day program summary, the objective was suspended until the physical therapy training could be arrange by the group home for the day program staff. At the time of the survey, there was no evidence that the recommended PT objective for prone positioning for 15 minutes daily at the day program had been implemented. b. On October 9, 2007 at Client #1 was observed using his walker to ambulate from the living room to the dining room, and also from the living room to his bedroom with standby assistance. Interview with staff indicated that the client was encouraged to walk and had a training	W 159	W159 MTS' QMRP and PT will visit the day program of client #1 so that the PT can train the day program staff on the physical fitness objective. At that time, the QMRP will supply the program with a pillow for prone positioning...11-20-07. The QMRP will monitor routine compliance during her monthly visits thereafter...12-1-07.	

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W 159	Continued From page 6 program to ambulate daily. Interview with the day program nurse, case manager, and the client's instructor on October 11, 2007 revealed the client no longer walks at the day program because he was considered to be at risk for falls. The day program case manager also indicated that the staff had not received training from the physical therapist on how to assist and monitor the client during ambulation using his walker. Record review revealed the physical therapist dated June 14, 2007 recommended that the client sit for no longer than 30 minutes at a time. The PT also recommended that the client be encouraged to walk at least 30 feet once an hour while at his day program to improve his mobility and endurance. The PT recommended that staff inservice be done on the formal programs. There was no evidence that these programs/services were coordinated by the QMRP to ensure the Client #1's needs were addressed. 2. The QMRP failed to ensure coordination of services for the monitoring of Client #1's nutritional and occupational needs by the designated professional prior to the development of Client #1's individual support plan (ISP). Interview with the Qualified Mental Retardation Professional (QMRP) on October 11, 2007 at 5:17 PM revealed that Client #1's Annual ISP Meeting was held on October 6, 2007. Further interview with the QMRP indicated that the interdisciplinary teams recommendations had been incorporated into the individual program plan. It was noted however that the Annual Occupational Therapy(OT) evaluation was conducted on October 9, 2006 and the annual	W 159	The former QMRP did not receive the OT or nutrition assessments in a timely manner prior to the ISP meeting for client #1. The new QMRP will insure that all needed assessments are completed in a timely manner prior to the team meetings by using MTS tracking tools to systematically track due dates and send proactive reminder notices to the relevant clinical professionals...12-1-07.	

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W 159	Continued From page 7 nutritional assessment was conducted on October 5, 2006. The QMRP indicated and the record review confirmed that updated assessments and corresponding recommendations were not available for the nutritionist and the occupational therapist. 3. The QMRP failed to coordinate services with the Nutritionist to ensure timely follow-up regarding dietary recommendations. [See W460,2]	W 159	See also responses for W460	
W 212	483.440(c)(3)(i) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the presenting problems and disabilities and where possible, their causes. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a comprehensive assessments to identify presenting problems and disabilities for two of three clients in the sample. (Clients #1 and #3) The findings include: 1. On October 9, 2007 from 6:05 PM to 6:40 PM, Client #1 was observed independently eating a finely ground casserole and greens and drinking his beverages. Interview with staff indicated the client diet was prescribed a pureed textured foods because he was edentulous. Staff was observed verbally prompting the client to slow his eating pace during the meal and reported. The staff reported that prompting was necessary to prevent the client from eating too fast. After completing his meal, the client was observed to cough several times.	W 212		

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W 212	Continued From page 8 Record review on October 12, 2007 at 10:15 AM revealed a physician's orders dated February 2007 to obtain a Swallowing Test. Interview with the QMRP and the primary Registered Nurse(RN) on October 12, 2007 revealed that the recommended swallowing study had not been conducted. 2. Interview with the primary RN on October 11, 2007 revealed that Client #3 was a diabetic and that her renal functioning declined during 2007. Record review revealed a hemoglobin on June 2, 2007 of 8.3 g/dL. The review of unusual incidents revealed on June 16, 2007, Client #3 became unresponsive and was transferred to the ER via 911. In the ER, client was noted to have a low blood sugar and was admitted to the hospital for further evaluation. She remained hospitalized until June 26, 2007. During the hospitalization, the client was also assessed to have a low hemoglobin and was treated. The review of a hospital discharge summary revealed on June 18, 2007 revealed the client was administered 2 units of packed cells to improve her low hemoglobin and that her hemoglobin was 9.1 gm/dL (Reference range: 11.6 - 16.0 g/dL). Procrit injections weekly were initiated to treat the client's low iron level. the discharge summary also recommended that the client's hemoglobin be monitored. Further record review revealed hemoglobins of 10.4 gm on August 18, 2007 and 10.3 g/dL on September 15, 2007 respectively. Interview with the primary RN revealed that due to the abnormal lab values, the Primary Care Physician (PCP) recommended a bone marrow	W 212	W212 1. The swallowing study has been scheduled for client #1...11-12-07. 2. The bone marrow aspiration test for client #3 was scheduled as indicated by the monitor and MTS attempted to get signed consent from both brothers in a timely manner. Neither verbally objected to the procedure or raised questions about it but neither signed the needed consent in time to have the procedure scheduled and done. One has provided consent at this point and the procedure is scheduled...11-12-07. As mentioned earlier, MTS will explore with the brothers in the upcoming ISP meeting whether either can consistently provide decision making support for client #3, if both cannot, the QMRP and DDS case manager will move in the direction of an alternate legal guardian to support the decision making process...12-30-07.	

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W 212	Continued From page 9 aspiration test. The test was scheduled with the hematologist for October 5, 2007, but was not completed due no consent for procedure. At the time of the survey, consent had not been obtained to perform the procedure.	W 212		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure as soon as the interdisciplinary team formulated the individual program plan (IPP), each client received a continuous active treatment plan consisting of needed interventions to achieve identified objectives for one of three clients in the sample. (Client #1) The findings include: The facility failed to ensure continuous active treatment for Client #1 on his physical fitness objective. [See W159]	W 249	W249 See responses for W159.	
W 263	483.440(f)(3)(II) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a	W 263		

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W 263	Continued From page 10 minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's specially-constituted committee (Human Rights Committee, HRC) failed to ensure that restrictive programs were used only with written consents, for two of three clients (Clients #1 and #2) in the sample who received psychotropic medications. The finding includes: 1. Medication administration observation on October 9, 2007 at 6:25 PM revealed Client #2 received Fluphenazine (Prolixin) 8 mg and Clonazepam 1 mg by mouth. Interview with the medication nurse revealed the medications were prescribed for behaviors. According to the nurse, the client also had a behavior support plan (BSP) to address his targeted behaviors. The review of the medication administration record (MAR) revealed the client is also prescribed to receive Fluphenazine (Prolixin) 4 mg in the morning and confirmed that the client is prescribed to receive the evening behavior medications. According to the Human Rights Committee (HRC) minutes dated April 27, 2007, the use of the medication, side effects and the BSP was reviewed and approved. There was no evidence, however, that the committee had ensured that written consent was obtained prior to the implement the restrictive behavioral strategies. 2. Medication administration observation on October 9, 2007 at 6:10 PM revealed Client #1 received Risperdal 1 mg by mouth. Interview with	W 263	W263 The QMRP will insure that the HRC reviews any changes in the psychotropic drug regimen of any person supported in the home who has such a regimen and changes in the BSPs of such individuals are reviewed by the Human Rights Committee before such changes are initiated in non emergency situations...11-20-07. MTS has established a routine review process that insures that the HRC discusses and reviews such issues each meeting held but emergency meetings will be held as needed to insure that changes proposed are reviewed in a timely manner...11-20-07.	

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W 263	Continued From page 11 the medication nurse revealed the medication was prescribed for behaviors. According to the nurse, the client also had a behavior support plan (BSP) to address his targeted behavior. The review of the medication administration record (MAR) confirmed that the client was prescribed this medication. Review of the HRC minutes dated April 27, 2007 indicated the medication, side effects and the BSP were reviewed and approved. There was no evidence, however, that the committee had ensured that written consent was obtained prior to the use of the restrictive behavioral strategies.	W 263		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to provide preventive and general medical care for three of three clients in the sample. (Clients #1, #2, and #3) The findings include: 1. The facility failed to ensure that Client #1 was provided an assessment for a hearing aide as recommended by the audiologist. [See W212] 2. The facility failed to ensure proactive strategies were effectively and timely implemented to maintain Client #1's skin integrity. [See W331,2] 3. The facility failed to ensure a comprehensive	W 322	W322 1. Client #1's assessment for a hearing aid has been scheduled...11-12-07. 2. See responses for W331 (#2) 3. The pelvic ultrasound for client #3 has been scheduled...11-12-07.	

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W 322	Continued From page 12 assessment of the pelvic calcifications identified during Client #3's abdominal series. The review of an abdominal series dated July 28, 2006 revealed Client #3 had pelvic calcifications which were believed to be fibroids. A pelvic ultrasound was attempted on November 20, 2006 for the client. Review of the consultation report revealed the client was uncooperative and combative, and that the procedure was not completed. Record review revealed a Psychological assessment dated November 27, 2006 which included interventions to address the client's Gyn examinations. Interview with the primary Registered Nurse (RN) on October 12, 2007 revealed the Pelvic Ultrasound had not been done. At the time of the survey, there was no evidence the client's Gyn status had been assessed. 4. The review of physician's order dated February 2007 revealed Client #1 was prescribed to have a swallowing test. Interview with the primary RN and the QMRP on October 12, 2007 revealed the test had not been conducted. [See W212] 5. The facility failed to obtain the results of Client #1's CT scan of the thorax timely . The review of an unusual incident report dated 5/1/07 revealed Client #1 was referred to the emergency room for evaluation of a mass on his left clavicle which direct care staff observed while weighing him. While in the ER on May 2, 2007, an x-ray of the soft tissue of the neck was performed and the client was released to the group home. On May 2, 2007, the provider nurse examined the client and observed the mass to be hard and warm to touch. During medical	W 322	The QMRP and nursing will insure that an action plan is developed to insure the success of the follow up (extra staff support, sedation approved by HRC, etc.)...11-20-07. 4. The swallowing test for client #1 has been scheduled...11-12-07. 5. As indicated, the CT scan for client #1 was obtained but not in a timely manner. The RN will use the MTS appointment tracking forms to insure that consultation reports are obtained routinely in a timely manner. The QMRP and RN will review the medical	

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W 322	Continued From page 13 follow-up by the Primary Care Physician (PCP) on May 3, 2007 the client was recommended to have a CT scan of the thorax. The scan however was performed May 14, 2007, however, the results of the CT scan were not obtained from the hospital until June 1, 2007. 6. The facility failed to closely monitor Client #1's anticonvulsant level. The review of an unusual incident reports on October 11, 2007 revealed on August 12, 2007 revealed Client #1's had a sudden change in clinical status marked by vomiting and altered mental status. The client had incontinence of bowel and lost consciousness. 911 was called and client was transported to the hospital ER for evaluation. A CT scan was performed and lab values revealed a Depakote level of 10 ug/ml (range: 50 - 100ug/ml). At the time of the incident the client was prescribed Depakote for seizures. Record review revealed the client had a last Depakote level on July 7, 2007 was 42.2 ug/ml. Review of the discharge summary revealed the client was administered a loading dose of Depakote and discharged to the group home at 12:43 AM. The investigative report (dated August 18, 2007) revealed that after the client returned to the group home on August 13, 2007, he had a seizure at 6:52 AM which lasted 4 minutes . The PCP was notified and provided instructions on the care of the client and Valproic 500 mg PO BID was prescribed. The Depakote level was repeated on August 18, 2007 and had increased to 45.6 ug/ml. There was no evidence however the client's Depakote level was repeated since that time. WAS THE PCP AWARE.	W 322	records monthly (separately) to insure routine compliance...12-1-07. 6. Client #1 has had a Depakote level on and it was within the normal range...11-12-07. The RN and QMRP will review the medical records monthly to insure that all needed lab work is scheduled and obtained in a timely manner...11-20-07. Additionally, the QMRP and RN will meet monthly at minimum to review the status of all medical concerns for each person supported in the home...12-1-07. Client #2's PSA level has been scheduled for review...11-12-07.	

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W 322	Continued From page 14 6. The facility failed to follow-up on the Urologist's recommendation that Client #2's Prostatic Specific Antigen (PSA) reassessed. Medication administration observations on October 9, 2007 at 6:15 PM revealed Client #2 received Flomax 0.4 mg, 1 capsule. Interview with the medication nurse revealed the medication was prescribed for incontinence. Client #2 had a urology consultation on March 28, 2007 for urinary incontinence during which the Urologist documented that there was no record of a recent PSA. Record review on October 12, 2007 did reveal that the client had a PSA on March 11, 2006 which was within the reference range. The review of the Annual Medical evaluation dated February 1, 2007 revealed a recommendation that the client have an PSA test. Interview with the nurse and the further record review however failed to provide evidence that a current PSA lab report was provided to the Urologist for the consultation or that the client's PSA had been reassessed.	W 322		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that nursing services were provided in accordance with the needs of two of the five clients residing in the facility. (Clients 1# and #5) The findings include:	W 331		

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W 331	Continued From page 15 1. The facility failed to implement timely and effective measures to ensure prevent Client #5's constipation. Medication administration observations on October 9, 2007 at 6:05 PM revealed Client #5 received Lactulose 30 ml (10 gm/15 gm) with 8 ounces of water. Interview with the medication nurse revealed this medication was prescribed to prevent constipation. Review of the medication administration record (MAR) and the medication container revealed Lactulose was prescribed once a day. Record review revealed the client had experienced untimely reporting of no bowel movements as detailed below: a. According to a nursing progress note dated June 13, 2007 (8:00 PM), a memo was received from the day program which stated the client experienced abdominal discomfort. A group home nursing progress note revealed staff had documented no stools for the client for the last five days. The Primary Care Physician (PCP) was notified and Bisacodyl suppository, 10 mg was prescribed. Additionally extra fluids were given . b. A June 22, 2007 nursing progress note revealed staff reported no stool for the previous week. Fluids and warm prune juice were recommended and reported to have been effective. c. The review of a nursing progress note dated September 28, 2007 revealed Client #5 was assessed and determined to be constipated. Per the PCP's order, the client was administered Bisacodyl suppository. The PCP also so prescribed that the Lactulose (stool softener) be increased from 30 ml QD to BID on September	W 331	W331 In each case cited here, staff notified the team of constipation issues but not in 3 days as required. The QMRP and nursing have developed a protocol that reminds staff in writing to report episodes of constipation that persist for 3 days and to report routinely at the three day mark. Staff has been trained on the new protocol...11-12-07. Additionally, the medication nurses will be alerted to check the bowel movement data daily and to report 3 days of constipation to the RN routinely upon discovery of that status...11-20-07. Pharmacy has modified the orders to reflect the change in the Lactulose regimen...11-1-07. Client #1 is receiving ointment for the skin breakdown, is being repositioned routinely and monitored daily by direct care staff and nursing. His condition has improved significantly. The RN has outlined the routine follow up for this issue on the health management care plan and staff has protocols to follow regarding their roles in routine follow up and have been trained on the protocols...11-12-07. The QMRP and Facility Manager will monitor routine follow up during their home visits at minimum weekly (QMRP) and biweekly (Facility Manager)...12-1-07. The medication (cream) with the unreadable label has been discarded and replaced...11-12-07.	

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W 331	Continued From page 16 28, 2007. The review of the updated health care plan dated September 11, 2007 revealed to monitor and record BM-inform nurse if no BM after three days stool medications as prescribed, and high fiber diet including prunes or prune juice daily. Interview with the QMRP on October 12, 2007 at 3:37 PM indicated that the staff had been retrained on the updated health care plan. There was no evidence that the client's failure to have regular bowel movements had been reported timely and consistently to the nurse. d. Current printed physician's orders dated September 2007 stated "Lactulose 10 gm/15 ml solution, 30 ml (20 gm) by mouth every day for constipation. Review of the medication container during the medication administration observations revealed the medication was prescribed QD. Further record review revealed on September 28, 2007, the Primary Care Physician ordered to increase the Lactulose 10 gm/15 ml solution, 30 ml (20 gm) from by mouth QD to BID. At the time of the survey, there was no evidence the nurse had ensured that the physician's current medication order, Lactulose 10 gm/15 ml solution, 30 ml (20 gm) by mouth BID was transcribed on the current orders by the pharmacy. 2. The facility failed to implement timely protective measures to prevent Client #1's skin breakdown. a. Unusual incident report (UIR) dated March 15, 2007 revealed direct care staff reported a small area of abrasion on Client #1's scrotum. Client referred by PCP to ER for assessment. PCP prescribed antibiotic ointment. Nurse was instructed on skin care and to keep the client dry.	W 331		

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W 331	Continued From page 17 b. According to an UIR dated May 7, 2007 direct care staff observed a change in the appearance of Client 31's buttocks during personal care. Nurse notified and DuoDerm was also initiated. Repositioning and treatment to relieve pressure to the site to be implemented. Staff inserviced by the nurse on skin care and positioning. There was no evidence that proactive strategies were effectively implemented to prevent the client's skin breakdown. 4. The facility's nursing services failed to remove medications from use that had a worn label for Client #5. [See W391]	W 331		
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on interview and the record review, the facility failed to ensure that comprehensive dental services were provided timely, for one of the five clients residing in the facility. (Client #4) The finding includes: The review of a Dental Assessment dated October 4, 2006 revealed Client #4 had heavy calculus deposits and scaling was recommended. The dentist noted that a request would be submitted to the funding agency to obtain authorization to perform the treatment. Interview with the primary Registered Nurse (RN) on	W 356		

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W 356	Continued From page 18 October 12, 2007 at 2:30 PM revealed four unsuccessful attempts to reach the dental provider to ascertain if the authorization had been obtained to provide treatment services to Client #4. For example, the record review revealed a call to the dentist on April 30, 2007 during which the nurse was informed that the authorization still had not been received. Interview with the Qualified Mental Retardation Professional(QMRP) revealed the client went back to the dentist on June 19, 2007. On this date the consultation report again documented a finding of heavy calculus deposits. The dentist noted that authorization would be requested from the funding agency to provide dental treatment services to the client. Interview with the primary RN and record review failed to provide evidence that the dental maintenance recommended on October 4, 2006 had been received by the client. [Note: Further Interview with the nurse and the QMRP revealed no documentation was available to confirm that the client had received the dental treatment services recommended on February 17,2005. On that date, the dentist recommended root planing/scaling with prophylaxis and indicated the provider would be called to schedule the appointment. It should be noted that this is a repeat deficiency for Client #4. Findings from the October 12, 2006 recertification survey also revealed no evidence that the client received the dental treatment services recommended on February 17, 2005.]	W 356	W356 MTS has acquired the consultation record from the June 19, 2007 visit to the dentist by client #4. Dental follow up has been problematic in the industry for some time now but seems to be improving as of late. MTS will insure that dental follow up is scheduled in a timely manner and will work with DDS to insure that needed approvals are obtained in a timely manner...11-12-07.	
W 391	483.460(m)(2)(ii) DRUG LABELING The facility must remove from use drug containers with worn, illegible, or missing labels.	W 391		

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W 391	Continued From page 19 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to remove medications that had a worn label from use for Client #5. The finding includes: On October 12, 2007, at approximately 5:25 PM, during the environmental observations conducted with the Qualified Mental Retardation Professional (QMRP), a tube of Ciclopirox Cream was noted to be stored in in Client #5's personal hygiene box. The print on the label was legible. Interview with direct care staff and the physician's orders revealed the cream was prescribed to be applied to the client's feet.	W 391	W391 The cited cream was discarded and replaced...11-12-07.	
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. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure devices and aids identified by the interdisciplinary team as needed by the client were maintained in good repair for two of the five clients residing in the facility. (Client #2 and #5) The findings include: 1. On each day of the survey Client #5 was observed using her rolling walker to ambulate	W 436		

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W 436	Continued From page 20 about in the facility. Interview with staff revealed she also uses it at her day program. Observation of the rubber tips on the rear legs of the walker revealed they were worn completely through and the metal was exposed through the rubber tips. Record review revealed a Physical Therapy recommendation dated September 24, 2007 which recommended that the rubber tips at the base of the rear legs be replaced because they were worn. There was no evidence the rubber tips on the clients walker were maintained in good repair. 2. The review of a nursing progress note dated June 8, 2007 revealed that Client #5 received her new eyeglasses. A follow-up nursing progress note dated June 11, 2007 revealed that staff reported that the client broke her new glasses. Interview with the Qualified Mental Retardation Professional (QMRP) on October 10, 2007 revealed the client broke her glasses while she was provided privacy in the bathroom. The QMRP stated that the client's glasses were taken to be repaired but the client had not yet received them. The QMRP also indicated that a referral was submitted to the client's case manager to assist in the procurement of another pair of glasses. At the time of the survey, the client's glasses had not been replaced or repaired. There was also no evidence that the client had been trained to care for her glasses. 3. Throughout the survey, Client #2 was observed ambulating at near a 45 degree angle and appeared to have difficulty holding his upper body in an upright position. During this time, he was also observed wear his bifocal eyeglasses approximately 1 inch from the end of his nose. Staff was observed to ask the client occasionally	W 436	W436 1. A new walker has been ordered for client #5 and should be obtained by...11-20-07. 2. Client #5 has another new pair of glasses...11-12-07. She will be routinely monitored and trained on the upkeep of her glasses and MTS will explore the possibility of obtaining a sturdy pair of back up glasses for her...11-30-07. 3. Client #2 enjoys having his glasses down on the lower portion of his nose and will return them there if he is prompted to move them up. However, the vision appointment has been scheduled to determine if any adjustments should be made...11-12-07. MTS will insure that the ophthalmology recommendations are followed...11-30-07. 4. New shoes were ordered for client #2 prior to the start of the survey and will be obtained by 11-30-07. In addition, MTS will seek a second pair of back up shoes for client #2...12-30-07.	

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W 436	Continued From page 21 to pull his glasses up on his face. Interview with the QMRP revealed that although the client was prompted to pull his glasses up on his face, they were soon observed back on his nose. Record review on October 11, 2007 revealed an annual ophthalmology consultation referral dated September 28, 2007. The referral by the primary RN acknowledged that the client wore his bifocals glasses near the end of his nose and questioned whether that affected his vision. The ophthalmologist did not respond but stated "Patient needs to return in six months after his last visit (which was May 23, 2007). Interview with the primary RN on October 12, 2007 revealed she had been unsuccessful in rescheduling the client's ophthalmology appointment to have his vision assessed. [Note: Client #2 had a diagnosis of cataract (rt. eye) and and refractive error.] 4. Throughout the survey, Client #2 was observed ambulating in a stooped position. Client #2 was observed to be wearing run-over orthopedic shoes. Interview with the primary RN revealed the client received the shoes in 2005. The RN stated that she submitted a request to obtained orthopedic shoes for the client in late 2006 however the request was denied. Record revealed a Physical Therapy recommendation dated August 1, 2007 for new orthopedic shoes. The review of a physician's order dated August 31, 2007 revealed the client was prescribed custom molded shoes with inserts as recommended by the physical therapist. Interview with the Primary RN and the QMRP on October 13, 2007 revealed the 719A had been	W 436		

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W 436	Continued From page 22 recently been submitted to obtain the prescribed shoes. At the time of the survey, there was no evidence the client was provided shoes in accordance with his assessed need.	W 436		
W 460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure therapeutic diets addressed the nutritional needs of three of three clients in the sample. (Clients #1, #2, #3 and #4). The finding includes: 1. Nutritionist failed to update the "Client Diet order Sheet" provided for direct care staff to follow when preparing and serving Client #3's therapeutic diet. Interview with staff on October 10, 2007 at revealed that Client #3 received a renal calorie restricted diet due to her diagnoses of diabetic renal failure. Observation of a Client Diet order sheet dated June 1, 2007 which was posted in the kitchen revealed a "Renal/Avoid Concentrated Sweets/Low Cholesterol/ No Added Salt; 1 can Glucema daily no Seafood Fluid restriction, Cut food to bite size pieces was prescribed for the client. The review of the physician's orders revealed at the time of the client's readmission from the hospital on June 26, 2007, her diet order was changed to 1800 calorie ADA, No Added Salt	W 460		

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W 460	Continued From page 23 (NAS), Low Fat, 80 MeQ Potassium, May have 5 cans of Glucerna daily if she refuses to eat. There was no evidence the Client Diet Order Sheet had been updated to reflect the client's current dietary orders. (Note: Interview with the nurse and the record review revealed the client was being closely monitored with fingersticks daily to ensure that her blood glucose remained with the range prescribed by the PCP.) 2. The nutritionist failed to ensure timely follow-up on a recommendation that Client #1 be provided a modular high protein supplement. The review of a unusual incident reports dated dated March 15, 2007 and May 5, 2007 revealed direct care staff informed the nurse of observed alterations in Client #1's skin integrity on his scrotum and buttocks during personal care. The nurse initiated treatment (DuoDerm), turning and position/pressure relief to the site, and inserviced the staff as ordered by the primary care physician. A lab report dated March 14, 2007 revealed a serum albumin of 2.7 gm./dl. (Reference range: 3.2 -5.0 gm/dl). The review of the second quarterly nutrition report dated April 5, 2007 identified the 2.7 gm./dl as a health problem and referred to a recommendation to see a diet change note. Review of the third quarterly nutritional assessment for Client #1 dated July 5, 2007 indicated the client was receiving ProMod, a high protein nutritional supplement to increase his protein. Interview with the Primary RN and the record review on October 11, 2007 however indicated that the ProMod was not prescribed	W 460	W460 1. The Diet Order Sheet will be updated by...11-20-07. Client #3 is receiving the proper diet at present and the physician's orders and menus reflect this. 2. Client #1 is receiving ProMod at present as indicated by the surveyor but the change did not occur in a timely manner. The RN will insure that such changes occur in a timely manner by reviewing the medical records monthly and adjusting the Health Management Care Plans to reflect such changes...11-22-07.	

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W 460	Continued From page 24 until October 2, 2007. There was no evidence the nutritionist conducted timely follow-up to ascertain the client was receiving the ProMod as recommended to increase his dietary protein intake.	W 460		
W 474	483.460(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 ensure each food was provided in the prescribed texture for one of the three clients in the sample. (Client #1) The findings include: 1. On October 10, 2007 at PM, at 6:00 PM, Client #1 was observed independently eating finely ground collard greens and casserole at dinner. Interview with the staff revealed the client was eating his prescribed pureed diet. The review of the "Client Diet order Sheet" in the kitchen for direct care staff to follow when preparing and preparing and serving food on the posted menu revealed the client is prescribed a pureed textured diet. The client's current diet order, dated September 1, 2007 was Regular, Pureed - May have seconds. May add salt at the table. Ensure 1 can three times a day. Meal time observations were conducted for Client #1 at his day program on October 13, 2007. At 12:20 PM. the client was observed feeding himself a pureed casserole and pureed spinach with a regular spoon from a three section plate. He was observed feeding himself sliced banana	W 474	W474 1. The QMRP will meet with the day program of client #1 to address the diet issue. 2. The RN will train staff on the special diets of each person supported by... 11-20-07 And the Nutritionist will provide further training by... 12-15-07.	

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W 474	Continued From page 25 at 12:45 PM. Interview with the day program staff indicated the banana was not pureed because it was very soft. There was no evidence Client #1 was provided the prescribed texture of diet at the aforementioned times. 2. On October 10, 2007 at PM, at 6:10 PM, Client #2 was observed independently eating a noodle casserole and collard greens with a fork. Interview with direct care staff revealed the client's food should be chopped to the size of a dime. The collard greens were quarter-sized and the client was appeared to be gumming his food as he ate slowly. Record review on October 12, 2007 revealed the client is edentulous. The record review revealed a September 2007 diet order of Regular - Large Portions chopped, Ensure , 1 can TID. There was no evidence that each food served to the client was textured as prescribed.	W 474		
W 489	483.480(d)(5) DINING AREAS AND SERVICE The facility must ensure that each client eats in an upright position, unless otherwise specified by the interdisciplinary team or a physician. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure Client #2 sat in an upright position while eating his meal, unless otherwise specified by the interdisciplinary team or a physician. The finding includes; On October 9, 2007 at 6:20 PM, Client #2's dinner plate was observed on an elevated block which	W 489	W489 The speech pathologist will observe client #2 at mealtime to determine if there is a need to modify the way he eats for safety's sake. The QMRP will insure that the recommendations of the speech pathologist are implemented on a routine basis...11-30-07.	

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W 489	Continued From page 26 was approximately four inches tall. The client was observed feeding himself with a fork and had his mouth intermittently one to two inches above the food. During this time, the client's bifocal glasses were observed hanging near the end of his nose. At 6:25 PM staff providing meal supervision was observed asking the client to hold up his head so he could get the food into his mouth better. Staff intermittently verbally prompt the client to hold his head up throughout the meal. Interview with staff revealed the client is able to feed himself but due to his medical condition requires prompting and encouragement to hold his body upright as much as possible. The review of the Physical Therapy Assessment dated August 1, 2007 revealed the client requires constant, repeated verbal and physical cues to extend his body in sitting and standing. Further record review revealed no evidence the client had been approved to eat in the observed manner, with his head bent forward and his mouth near his plate.	W 489		

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I 022	3501.5 ENVIRONMENTAL REQ / USE OF SPACE Each window shall be supplied with curtains, shades or blinds, which are kept clean, and in good repair. This Statute is not met as evidenced by: Based on observation and interview, the facility failed to ensure that window blinds were maintained in good repair in various locations of the GHMRP. The findings include: Observation of the environment conducted on October 12, 2007 beginning at 5:15 PM revealed the windows were dirty throughout the facility.	I 022	3501.5 All of the windows and blinds have been cleaned...11-1-07. A thorough house cleaning was completed while the individuals supported were on vacation. The QMRP has developed a housekeeping schedule that will be implemented routinely by staff and the individuals supported and as monitored by the facility manager...12-1-07.	
I 047	3502.5 MEAL SERVICE / DINING AREAS Each GHMRP shall be responsible for ensuring that meals, which are served away from the GHMRP, are suited to the dietary needs of residents as indicated in the Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation interview and record review, the GHMRP failed to ensure that Resident #1 received the prescribed texture of diet at his day program and his group home. The finding includes: [See Federal Deficiency Report-Citation W120 and W474]	I 047	3502.5 See responses for W120	
I 090	3504.1 HOUSEKEEPING	I 090		

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I 090	Continued From page 1 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: The facility failed to maintained the environment as evidenced by the concerns identified in this section of the report. The findings include: The surveyor conducted environmental observations environmental rounds on October 12, 2007 at 5:15 PM. The surveyor was accompanied through the facility by the Qualified Mental Retardation Professional (QMRP). Interview with the QMRP indicated that the governing body was making plans to relocate the residents to another group home within the next several weeks. 1. Interior a. Nine slate floor tiles were observed to be completely detached from the kitchen floor. b. A small open space was observed at the bottom of the kitchen exit door on each side. Space was also observed at the bottom of the exit door from the laundry room, which was adjacent to the kitchen. c. A large area of scaling plaster was observed on the ceiling in the bathroom on the second floor which was used by Resident #3. d. Water was observed running continuously in the toilet bathroom next Resident #3's bedroom.	I 090	3504.1 MTS will make the repairs necessary as indicated in this citation to insure the home is safe and presentable but does not wish to invest significant resources in this facility. It is a high maintenance facility that MTS has made plans to replace. The individuals supported in this home should be relocated by...12-30-07. The van door will be repaired by 11-30-07.	

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I 090	Continued From page 2 This bathroom also lacked sufficient lighting. e. The back of Client #4's chest of drawers had become detached, exposing the ends of the staples. f. One of two mirror was not secure in the cabinet above the sink in the bathroom used by Resident #4. g. There was no holder for the toilet tissues in the second floor bathroom. h. Several partially detached carpet threads were observed on the carpet on the floor in Resident #5's room. i. The carpet was frayed at the entrance to the half bathroom on the located on the first floor. j. The carpet on the living room floor was heavily soiled. k. Scaling paint was observe on the hood installed above the kitchen range. The light underneath the hood lacked a protective covering. The fan underneath the hood was not operable. Heavy soil was observed on the wall beside the range. l. The metal plated attached to the outside of the kitchen door was not secured on the right side. j. A arm chair in the living room was observed to have the right arm broken off. 2. Exterior a. The doorbell was not operable. b. Screws attaching the mailbox to the exterior of	I 090		

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I 090	Continued From page 3 the front door were loose. 3. Other a. The interior of the van door was observed to have a section of the partition missing from the door which caused the metal to be exposed.	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 facility failed to ensure that all staff and consultants had current health certificates on file. The findings include: 1. Review of personnel records on October 12, 2007, 2007 at approximately 4:30 PM revealed the GHMRP failed to have a current health certificate for the following individuals: a. Occupational Therapist b. Consultant Pharmacist c. S5 d. S7 e. S8 f. S6 had a current Tuberculin screening, but no health certificate.	I 206	3509.6 The needed health certificates will be obtained by...11-30-07. MTS is tracking all such issues routinely at this point and notifying all staff and professional consultants about deficiencies proactively...1-12-07. Failure to correct file deficiencies in a timely manner will result in follow up action by MTS.	

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I 229	Continued From page 4	I 229		
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 interview and record review, the GHMRP failed to ensure each training program included specialty areas needed by the residents being served. The finding includes: The review of in-service training records on October 12, 2007 beginning at approximately 4:00 PM revealed the following information concerning training to direct care staff in the following areas: (a) behavior management; Interview with the Qualified Mental Retardation Professional (QMRP) and the record verification indicated the she reviewed the residents' behavioral objectives in the individual program plans with direct care staff. Observation during the medication administration on October 9, 2007 between the hours of 6:03 PM and 6:55 PM revealed Residents #1, #2, #4 and#5 received psychotic medications. Record verification revealed Residents #1, #2, #3, ,#4, and #5 all had behavior support plans. The QMRP further indicated that the Psychologist is	I 229	3510.5 (f) BSP training will be scheduled by 11-20-07. Total communications training will be scheduled by...11-20-07. The QMRP will develop a six-month training calendar for January through June of 2008 reflecting all of the needed trainings...11-30-07.	

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I 229	Continued From page 5 often in the group home to monitor them. There was however no documented evidence that the psychologist had reviewed the Behavior Management Plans with the direct care staff. (b) total communication; Observation during the survey revealed Residents #1 and #4 were able to talk, but at times were unable to clearly articulate their wants and needs. Resident #5 was observed to be non-verbal, but using signs and gestures to communicate her wants and needs to direct care staff. During interview with the QMRP on October 12, 2007 she acknowledged that she trained direct care staff on the individual program objectives. There was no evidence however that training had been provided to staff on the clients' communication needs to enable them to function more effectively in their environment.	I 229		
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to report significant incidents concerning the health and well being of Residents	I 379		

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I 379	Continued From page 6 #1 and #3 to the Department of Health (DOH), Health Regulation Administration within twenty-four (24) hours or the next work day. The finding includes: 1. The review of unusual incidents on October 10, 2007 revealed that the three incident involving a significant change in the residents health and welfare had not been reported to the DOH as documented below: a. Review of unusual incidents revealed that on October 10, 2007, Client #3 was hospitalized on October 1, 2007 with a primary diagnosis of shortness of breath. Further record review revealed the client was presented at the specialist's office with a prescription to be evaluated for cerebrovascular disease and dementia. She had dyspnea with rales when she was evaluated by the doctor. Her diagnoses included anemia, renal and adeno-insufficiency. b. Review of unusual incidents revealed that on October 10, 2007, Client #4 was treated at the emergency room on December 8, 2006 with a primary diagnosis of gastroenteritis. - non infectious. The resident was treated and released. c. The review of unusual incidents on on October 10, 2007 revealed Client #4 was treated at the ER on January 30, 2007 for a cough and was diagnosed with an upper respiratory infection. Interview with the QMRP revealed that all unusual incident reports are completed at the group home and sent to the agency's incident management coordinator. Record review at the time of the survey revealed the unusual incident reports	I 379	3519.10 The residential director met with the IMC to insure that incident reports are submitted to DOH within prescribed time parameters and will follow up via monthly tracking and reporting to insure this occurs...11-30-07.	

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I 379	Continued From page 7 notifying DOH of the change in the clients' health status had not been received. 2. The review of unusual incidents on October 10, 2007 also revealed that the unusual incident reports submitted to DOH by the incident management coordinator revealed that seven of ten emergency room visits had not been reported to DOH within 24 hours. Further review of the referenced incident reports revealed they were reported to DOH via fax between three and fifteen days of the incident.	I 379		
I 396	3520.2(f) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (f) Occupational Therapy; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that the Occupational Therapist was licensed as required by the District of Columbia law. The finding is: The review of the consultants files on October 12, 2007 at approximately 4:30 PM revealed the	I 396	3520.2 (f) OT has a current license (see attachment)...11-1-07.	

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I 396	Continued From page 8 Occupational Therapist expired on September 30, 2007. Interview with the Qualified Mental Retardation Professional indicated the current license had been requested from the consultant.	I 396		
I 397	3520.2(g) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (g) Psychology; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that the Psychologist was licensed as required by District of Columbia law. The finding is: The review of the consultants files on October 12, 2007 beginning at approximately 4:30 PM revealed that a current license was not on file for the Psychologist. Interview with the Qualified Mental Retardation Professional indicated the current license had been requested from the consultant.	I 397	3520.2 (g) Psychology has a current license (see attachment)...11-1-07.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G137	A. BUILDING _____ B. WING _____	10/12/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M T S	1528 GOOD HOPE ROAD, SE WASHINGTON, DC 20020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 401	Continued From page 9	I 401		
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: Based on observation, interview and record verification, the GHMRP failed to ensure professional services were provided timely for four of the five residents residing in the facility. (Residents #1, #2, #3 and #5) The findings include: 1. The GHMRP failed to ensure health services were provided in accordance with the needs of Residents #1 and #3. [See Federal Deficiency Report - Citations W120, W212, W214, W322, W331, W356 and W391] 2. The GHMRP failed failed to ensure assistive devices designed to improve the mobility of Residents #2 and #5 were maintained in good repair. [See Federal Deficiency Report - Citation W436]	I 401	3520.3 See responses for W436	
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure Resident #1	I 422	3521.3 See responses for W120 and W159	

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I 422	Continued From page 10 was provided habilitation, training and assistance with their Individual Support Plan (ISP). [See Federal Deficiency Report - Citation W120, W159, and W249]	I 422		
I 484	3522.11 MEDICATIONS Each GHMRP shall promptly destroy prescribed medication that is discontinued by the physician or has reached the expiration date, or has a worn, illegible, or missing label. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to promptly destroy medication that had a illegible. The finding includes: [See Federal Deficiency Report - Citation W391	I 484	3522.11 See responses for W391	
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to 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. The findings include:	I 500		

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I 500	Continued From page 11 [See Federal Deficiency Report - Citations W104, W112, W124, W263, W322, W331, W436, and W460]	I 500	3523.1 See responses for W104, W112, W124, W263, W322, W331, W436 and W460.	

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R 000	INITIAL COMMENTS The re-licensure survey was conducted from October 9, 2007 through October 12, 2007. A random sample of two residents was selected from a residential population of three females with mental retardation and other disabilities. The survey findings were based on observations in the group home and at two day programs, interviews and a review of records including unusual incidents.	R 000		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on the review of records, the GHMRP failed to ensure criminal background checks for the previous seven (7) years, in all jurisdictions where staff had worked or resided within the seven (7) years prior to the check for one of ten staff. The finding includes: Review of the review of personnel files on October 12, 2007 at approximately 4:30 PM revealed the GHMRP failed provide evidence of a criminal background checks for the previous seven years in all jurisdiction where one direct care staff (S9) had worked or resided.	R 125	R125 The cited staff member has a criminal background check (see attachment)...11-1-07.	

alth Regulation Administration

TITLE (X6) DATE

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