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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G010	A. BUILDING _____ B. WING _____	02/28/2007

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CARECO 01	6417 KANSAS AVE, NE WASHINGTON, DC 20001

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W 000	INITIAL COMMENTS A recertification survey was conducted from February 26, 2007 through February 28, 2007. A random sample of three clients was selected from a client population of five males with varying degrees of disabilities. This survey was initiated utilizing the fundamental survey process. The finding of this survey were based on observations at the group home and three day program, interview with direct care staff and management, and a review of the habilitation and administrative records to include the unusual incident reports on file. Note: It should be noted that the clients residing in this facility were transferred from 1447 Oak Street, NW on Saturday, February 9, 2007.	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 failed to provide general operating direction over outside services: The findings include: The governing body failed to have written policies and procedures for communication with the day program on Client issues as evidenced below: 1. Interview with the day program staff and record review revealed that Client #1, #2 and #3's	W 104	The Governing Body will review and update the policies and procedures for communicating wit outside services. As soon as the policies are updated, the QMRP will train all staff and ensure the policy is implemented. 4/26/2007 SIGN & DATE The QMRP will train staff to properly implement the policy for communication with	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marsha W. Thompson — TITLE: Director of Disability Service — (X6) DATE: 3/27/07

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 104	Continued From page 1 day program had not been provided current physician orders. Further review of each client's physicians order revealed that the orders on file at the day program expired in January 2007. At the time of the survey , the governing body failed to ensure that this facility had an effective system of communication with each client's day program to ensure that current medical information was on file at each day program in case of an emergency situation. Note: It should be further noted that Client #3 is administered a noon dosage of medication from Monday through Friday at his day program. 2. The facility's governing body failed to have a system of accountability in place to protect Client #4's day program stipend payment given to him in cash bi-weekly. (See W140)	W 104	The day program, including provision of current medical information and documentation.	4/26/2007
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 observations, interviews and record review, the facility failed to ensure of each client, parent, or legally authorized party of the client's medical conditions, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment for three of the four clients residing in the facility.	W 124	The QMRP will ensure that the client is assessed by the psychologist to determine his capacity to manage his stipend. The QMRP will coordinate with the day program to ensure that the client receives his stipend in a way that is consistent with the facility's policy on protection and management of client funds. Each client and his/her guardian or legal decision maker will receive written explanation of the therapies recommended to address the client's physical and behavioral/mental health. Explanation will include benefits and risks associated wit the proposed treatment. Copies of the written notifications will be kept in the client's record. Each client will be provided with a copy of the facility's human rights and intake/discharge policies.	4/26/2007 4/26/2007

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W 124	Continued From page 2 (Client #1, #2 and #3) The findings include: The facility failed to ensure clients' #1, #2 and #3 were informed of the risks and benefits of their psychotropic medications and behavior management plans as evidenced below: 1. Observations of the evening medication administration on 2/26/07 at 5:47 PM revealed that Client #1 had received Tegretol 200 mg, Clonazepam 1 mg and Risperdal 1 mg for behavior. Review of the medication administration records and the Physician's orders revealed that Client #1 receives an AM dosage of the same medications as well. Interview with the Licensed Practical Nurse (LPN), Qualified Mental Retardation Professional (QMRP) and the review of the client's Physician's orders revealed the aforementioned medication is used in conjunction with the Behavior Management Plan (BMP) to address maladaptive behaviors. Additional interview conducted with the QMRP on 2/27/07 revealed that Client #1's mother is involved in his life and will consents for necessary medical treatment. Further review of the record and interview with the QMRP failed to evidence that written consent for the use of these medications had been obtained. At the time of the survey, there was no evidence that Client's rights to refuse medications and to be informed of the risk and benefits of behavioral treatment, which includes the behavior support plan and the used of psychotropic medications.	W 124	See response above.	4/26/2007

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W 124	Continued From page 3 The review of the psychological assessment dated 10/15/06 revealed that Client #1 was not able to give informed consent and/or make independent decisions on his behalf regarding his habilitation planning, placements, treatment, financial and medical matters. 2. Observations of the evening medication administration on 2/26/07 at 5:47 PM revealed that Client #2 received Risperdal 3 mg and Buspirone 15 mg for behavior. Record verification of the Medication Administration Record revealed that Client #2 also receives Naltrexone 50 mg in the AM and another dosage of Naltrexone 50 mg twice daily. Additionally, Client #2 received an AM dosage of the Buspirone and Risperdal as well. Interview with the Licensed Practical Nurse (LPN) and further review of the client's Physician orders revealed the aforementioned medications were used in conjunction with the Behavior Management Plan (BMP) to address Client #2's maladaptive behaviors. Interview conducted with the Qualified Mental Retardation Professional (QMRP) on 2/27/07 revealed that Client #2's sister is actively involved in his life and provide signatures for medical procedures. Further review of the record and interview with the QMRP failed to evidence that written consent for the use of these medications had been obtained. At the time of the survey, there was no evidence that Client's rights to refuse medications and to be informed of the risk and benefits of behavioral treatment, which includes the behavior support plan and the used of psychotropic medications.	W 124	See response above.	4/26/2007

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W 124	Continued From page 4 The review of the psychological assessment dated 4/10/06 revealed that Client #2 cannot make independent decisions on his behalf regarding his habilitation planning, placements, treatment, financial and medical matters. 3. Observations of the evening medication administration on 2/26/07 at 5:47 PM revealed that Client #3 received Valproic Acid 15 ml and Dilantin 100 mg for behavior. Record verification of the Medication Administration Record revealed that Client #3 also received Paxil 25 mg in the morning for anxiety/depression. Interview with the Licensed Practical Nurse (LPN) and further review of the client's Physicians order revealed the aforementioned medications were used in conjunction with the Behavior Management Plan (BMP) to address maladaptive behaviors. Interview conducted with the Qualified Mental Retardation Professional (QMRP) on 2/270/07 revealed that Client #3's sister was actively involved in his life and provided signed consents for necessary medical procedures. Further review of the record and interview with the QMRP failed to evidence that written consent for the use of these medications had been obtained. At the time of the survey, there was no evidence that Client's rights to refuse medications and to be informed of the risk and benefits of behavioral treatment, which includes the behavior support plan and the used of psychotropic medications. The review of the psychological assessment dated 1/3/07 revealed that Client #3 cannot make independent decisions on his behalf regarding his habilitation planning, placements, treatment,	W 124	See response above.	4/26/2007

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W 124	Continued From page 5 financial and medical matters.	W 124		
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. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to address the client's needs for advocacy to ensure their rights were protected. The findings include: 1. [Cross Reference W124] Clients #1,#2 and #3's psychological assessment reflect that the clients were unable to make independent decisions. There was no evidence that the facility had ensured a surrogate decision- maker or guardian to ensure each client's rights to be informed and rights to refuse treatment was being protected. 2. Observation on February 26 - 28, 2007, revealed that the facility has door alarms placed on all exits throughout the facility. Further observation revealed that when the door is opened it activated the alarms, which had a loud double tone ring to alert the direct care staff. Interview with the QMRP revealed the alarms were place on the door due to Client #5 elopement behavior and Client #2 history of	W 125	The facility will hold a Residents' Council meeting to discuss door alarms. The Human Rights Committee will review the installation of alarms to determine if it is the least restrictive measure for the client's safety, and ensure it is does not unnecessarily restrict the rights of other clients living in the home. The QMRP will submit guardianship request packages to DDS for the identified clients. The QMRP will track the status of the requests already submitted. The Resident Council will meet to discuss the door alarms and choose a different tone if they do not approve of the tone currently in use. See response to W125 above.	4/26/2007 4/26/2007 4/26/2007

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W 125	Continued From page 6 elopement behavior. Further interview with the QMRP did not evidence that all the client residing in the facility had been involved in the selection of the type of alarm tone and/or participated in exploration of other least restrictive options prior to implementing the door alerts. Review of the records failed to evidence that all the other client's and/or their representative had been informed of their rights prior to the alarms installation. Further review of the records failed to provide evidence that the Human Rights Committee had review and discussed the installation of the door alarms, other least restrictive measures and the rights of all the other client living in the facility. 3. Interview with the facility's nurse on February 28, 2007 at approximately 12:30 PM and record review Human Rights Committee minutes dated 10/26/06 revealed that Client #4 was recommended for baseline colonoscopy. Further interview with the nurse revealed that the colonoscopy had not been completed due to the need for a consent for this procedure. The need for the colonoscopy was delayed due to the consent issue and therefore the facility failed to ensure preventative care. At the time of the survey, four months later, there was no evidence that the facility have a effective system to ensure informed consent for Client #4's colonoscopy.	W 125	The QMRP will follow up with DDS on the assignment of a legal guardian for Client #4 to give consent for medical procedures.	4/26/2007
W 140	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients.	W 140	The QMRP will ensure that copies of bank statements are available in each client's record at the facility. See response to W104 #2.	4/26/2007

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W 140	Continued From page 7 This STANDARD is not met as evidenced by: Based on staff interview and review of records, the facility failed to maintain a system that ensures a complete and accurate accounting of clients' funds that are entrusted to the facility for four of the five clients residing in the facility. (Client #1, #2, and #3) The findings include: Client's #1, #2, and #3 recieve SSI of $70.00 per month for personal expenditures and according to assessments Clients are not able to manage their own finances. 1. Interview the Facility's Director (FD) on February 28, 2007 at approximately 3:00 PM and review of Client #2 and #3's financial records did not evidence any bank statements for the 3rd and 4th quarters. Although a copy of the agencies resident ledger sheet was provided for review, without the current bank statement verification of expenditures and deposits as listed on the ledger could not be verified. 2. Interview with the facility's director on February 28, 2007 at approximately 3:00 PM revealed that CLient #1's finacial records had been left at the main office. The FC further commented that the record would be forwarded, as per his request, from the main office for review. However, Client #1's financial records was not provide at the time of the survey for review.	W 140	See response above. See response above.	4/26/2007 4/26/2007
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be	W 159		

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W 159	Continued From page 8 integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility Qualified Mental Retardation Professional (QMRP), failed to adequately monitor, integrate and coordinate each client's health and safety. The findings include: 1. The QMRP failed to ensure that assessments and/or reassessments of each clients' developmental and behavioral strengths and needs. [See W214]	W 159	The QMRP will ensure that assessmentf for each client's needs are completed.	4/26/2007
	2. The QMRP failed to ensure that each employee had been provided with adequate training that enables the employees to perform his or her duties effectively, efficiently and competently. [See W189]		The QMRP will ensure that each employee is provided with adequate training to perform his/her duties effectively and competently.	4/26/2007
	3. The QMRP failed to ensure that the direct care staff recieve proper training from the nursing staff on implemtation and maintenance of support prescribed by the primary care for Client #1. [See W322, W331]		The QMRP will coordinate with nursing staff to provide employees with the proper training on implementing care prescribed by the primary care physician for Client #1.	4/26/2007
	4. The QMRP failed to ensure that restrictive measures had been approved by the Human Rights Committee (HRC). [See W262]		The QMRP will ensure that restrictive measures are approved by the HRC.	4/26/2007
	5. The QMRP failed to ensure each client's behavior intervention program, including the use of behavior modification drugs, was conducted only with the written informed consent. [See W263]		The QMRP will ensure that clients' behavior intervention programs, including the use of drugs, is conducted only with written informed consent. See response to W124.	4/26/2007

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W 159	Continued From page 9 6. The QMRP failed to ensure facility failed to implement Human Rights Committee (HRC) recommendations failed to review, monitor and make suggestions to the facility about its practices and programs as they relate to protection of client rights. [See W264] 7. The facility failed to ensure that each day program was provided with current medical information for Client #1, #2 and #3's day programs in case of an emergency. (See W104). 8. Interview with the day program case manager on February 8, 2007 at approximately 10:45 AM and review of day program habilitation records failed to evidence that a current copy of Client #1's Individual Support Plan (ISP) was on file. According to the day program staff the ISP meeting was held on October 16, 2006. Interview with the program director revealed that the "ISP planning meeting occurred a couple of months ago, however, they had not received a copy of the plan." Interview with the QMRP revealed that the ISP document was being processed by The Department of Disability Services and the current comprehensive function assesssment was not yet available for distribution.	W 159	See response to W104 #1. See response above. See response above. The QMRP will forward a copy of the completed ISP to the Day Program at the same time it is submitted to DDS for approval. The approved ISP cannot be transmitted until it is received from DDS.	4/26/2007 4/26/2007 4/26/2007
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:	W 189	See response to W159 #2.	4/26/2007

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W 189	Continued From page 10 Based on observation, interview and record review, the facility failed to ensure that each employee had been provided with adequate training that enables the employees to perform his or her duties effectively, efficiently and competently. The findings include: 1. Observations on January 27, 2007 at approximately 12:38 PM revealed that Client #3 sitting at the table with his lunch in front of him. Further observations revealed Client #3 1:1 Staff #1 standing on his right side with a bib in her hand. The 1:1 staff attempted to place a bib around the Client's neck on several occasion, however, the Client at each attempted pulled the bib from around his neck and threw it on the floor. The 1:1 staff also attempted to place an built up handle spoon in Client #3's right hand, but he refused to hold the spoon. The 1:1 staff repeatedly attempted to place the spoon in the client hand, however, all attempts were unsuccessful. The 1:1 then commented "He does not want to eat?" Observation during the evening meal on the same day with the client was observed at the dinner table different 1:1 staff (Staff #2). The 1:1 staff was implementing different feeding procedures. The 1:1 staff set up the table area with the adaptive equipment. The evening 1:1 never place a bib around the Client #3's neck. Additionally, the evening 1:1 staff provided hand over hand assistance using the built up handle spoon without any difficulty. The 1:1 was also observed to mix small amount of applesauce with each spoonful of food. Client #3 completed a 100% of his meal.	W 189	The QMRP will schedule training for all staff on all diets with the Registered Dietician; the QMRP will provide training to all staff on each client's dining protocols.	4/26/2007

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W 189	Continued From page 11 Interview with the Qualified Mental Retardation Professional (QMRP) revealed that the 1:1 direct care staff at Client #3 day program was not the regular 1:1 assigned. According to the QMRP, the 1:1 observed at the day program had not been trained to the specific practices and procedures with Client #3's feeding protocols prior to being assigned. The regular 1:1 staff called in to work sick the same morning. Reportedly the QMRP stated that the staff #1 observed "will soon be trained as the back up 1:1 staff for Client #3". 2. The facility failed to provide in-service training to the direct care staff on the use and maintenance of the Cervical Collar prescribed for Client #1. [See W322, W331 and W159]	W 189	The QMRP will have the PT complete an assessment. If the collar is recommended and approved by the PCP, the QMRP will train staff on its proper use.	4/26/2007
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to assess and/or reassess clients' developmental and behavioral strengths and needs for three of three clients in the sample. (Client's #1, #2 and #3) The findings include: 1. Observations of the evening medication administration on 2/26/07 at 5:47 PM revealed that Client #1 had received Tegretol 200 mg, Clonazepam 1 mg and Risperdal 1 mg for behavior. Review of the medication	W 214	The QMRP will coordinate with the Interdisciplinary Team to ensure that updated comprehensive functional assessments are completed for all clients, and that programming reflects steps to address each client's specific developmental and behavioral management needs. The QMRP will ensure that a psychiatric assessment is completed and placed in each client's record.	4/26/2007 4/26/2007

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W 214	Continued From page 12 administration records and the Physician's orders revealed that Client #1 receives an AM dosage of the same medications as well. Interview with the Licensed Practical Nurse (LPN), Qualified Mental Retardation Professional (QMRP) and the review of the client's Physician's orders revealed the aforementioned medication is used in conjunction with the Behavior Management Plan (BMP) to address maladaptive behaviors. Review of the habilitation records revealed a diagnosis Atypical psychosis, Onychomycosis-Nal Adapt Behavior and Profound Mental retardation. Further review of the records failed to evidence a psychiatric assessment. 2. Observations of the evening medication administration on 2/26/07 at 5:47 PM revealed that Client #2 received Risperdal 3 mg and Buspirone 15 mg to manage behavior. Record verification of the Medication Administration Record revealed that Client #2 also received Naltrexone 50 mg in the AM and another dosage of Naltrexone 50 mg twice daily. Additionally, Client #2 also receives an AM dosage of the Buspirone and Risperdal. Interview with the Licensed Practical Nurse (LPN) and further review of the client's Physician orders revealed the aforementioned medications was used in conjunction with the Behavior Management Plan (BMP) to address Client #2's maladaptive behaviors. Review of the habilitation records revealed that Client #2 has a diagnosis of Atypical Psychosis/Maladaptive Behaviors, Autism and	W 214	See response above.	4/26/2007

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W 214	Continued From page 13 Profound Mental Retardation. Further review of the records failed to evidence a psychiatric assessment. 3. Observations of the evening medication administration on 2/26/07 at 5:47 PM revealed that Client #3 received Valproic Acid 15 ml and Dilantin 100 mg for behavior. Record verification of the Medication Administration Record revealed that Client #3 also receives Paxil 25 mg in the morning for anxiety/depression. Interview with the Licensed Practical Nurse (LPN) and further review of the client's Physicians order revealed the aforementioned medications were used in conjunction with the Behavior Management Plan (BMP) to address maladaptive behaviors. Review of the habilitation records revealed a diagnosis of Adjustment Disorder Unspecified-Chronic and Profound Mental Retardation. Further review of the records failed to evidence a psychiatric assessment. 4. Interview on 2/28/07 with the QMRP at approximately 3:00 PM and record review revealed that Client #2 last Physical Therapy Assessment was completed on 5/1/05. Review of the habilitation records revealed that Client #2 had a Physical Therapy/Fall Protocol dated 4/26/06. Further review of the protocol did not evidenced that the PT had amended and/or updated these safety procedures to reflect safe ambulating up and down the stairs in the new facility. According to the QMRP no mobility assessment had not been completed for the environment. Additionally, no recommendation	W 214	See response above. The QMRP will have the PT assess ambulation safety for persons with visual impairments in the home. The PT will revise ambulation protocols as needed. The QMRP will train all staff on the revised ambulation protocols.	4/26/2007 4/26/2007

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W 214	Continued From page 14 had been made and no new assessment of the group homes environment had been update and included on the Fall Protocol/Fall Prevention to ensure that Client #2 safe mobility in the new group home. 5. Observation on February 26 and 27, 2007 revealed the 1:1 direct care staff assigned to Client #1, stood behind the client at the top of the basement stairwell and positioned the clients hand on the rails. The 1:1 one staff then encourage the client to proceed down the steps and continued to stand behind the client as he proceeds down the basement stairwell. Interview on 2/28/07 with the QMRP at approximately 3:00 PM and review of the habilitation records revealed that Client #1 is blind and has a Fall protocol/Fall Prevention in place for safe mobility within the group home. Review of the Fall Protocol/Fall Prevention dated 4/26/06 did not reflect how the direct care staff was to assist Client #1 to safely ambulate on stairwells at the new group home. According to the QMRP the protocol had been developed for use at the previous facility which did not have stairs. Further review of the protocol did not evidenced that the PT had amended and/or updated these safety procedures to reflect safe ambulation up and down the stairs in the new facility. According to the QMRP no new safety protocol was available for review. Note: It should be noted that no blind mobility assessment had been completed and at the time of the survey the maintenance staff were installing safety rails for the second level of the group home.	W 214	See response above.	4/26/2007

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W 214	Continued From page 15 6. Interview with the FD on February 28, 2007 at approximately 3:00 PM revealed that Client #3 receives a bi-weekly stipend from his day program in cash. Further interview with the (FD) revealed that the the agency was not aware of the amount of money given Client #3 and/or when these funds were given to the client. According to the FD the day program indicated that it was his right to get his money directly. Interview with the FD and review of the habilitation records and financial records revealed that the facility has made several attempts to establish a system ensure disbursement and the amount of the disbursement bi-weekly. The agency's governing body has not established a effective system of accountability to ensure when and the amount of cash given to Client #4 was actually being consistent paid by the day program. Further review of the record did not reveal a money management assessment to determine Client #4's ability to manage his own personal funds. There was no evidence that the client was fully assessed to handle his cash stipend received from his day program. The facility's management and staff was unaware of how much and when the Client #4 was spending his personal funds. 7. Observation on February 27, 2007 at the day program lunch at approximately 12:40 PM and at the facility dinner at approximately revealed that Client #3 is prescribed a Pureed, Regular diet. Interview with QMRP revealed that Client #3 "hard to work with when he eats", however, the	W 214	See response to W104 #2 The QMRP will have the Registered Dietician re-evaluate client #3's nutritional needs and supports. See response to W189 #1	4/20/2007 4/20/2007

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W 214	Continued From page 16 PM 1:1 had no difficulty assisting him with hand over hand feeding. Additionally, the 1:1 staff during the dinner mixed applesauce periodically with his meal and Client #3 consumed 100% of his food. Review of the physician order dated February 1, 2007, revealed the diet order as "Pureed - Do Not Feed In Bed". Review of the Nutritional Assessment revealed that the assessment had expired 12/7/07. Further review did not evidence that the Nutritionist had reevaluated Client #3's nutritional needs and nutritional supports.	W 214		
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, staff interview, and record review, the facility failed to ensure that one out of the three clients in the sample received continuos active treatment programs to address their needs. The finding includes: The facility's direct care staff failed to consistently implement Client #1 Behavior support plan as written as evidenced below: During observation of the medication	W 249	The QMRP will ensure that all direct support staff are trained to correctly implement client programming as soon as the interdisciplinary team has formulated it. 4/26/2007 The QMRP will request the psychologist to train direct care staff on the proper implementation of the behavior support plan. 4/26/2007	

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W 249	Continued From page 17 administration on February 26, 2007 at approximately 5:47 PM, Client #1, while in the medication room exhibited a spitting behavior. He repeatedly spit in his hands. The 1:1 assigned to the client repeatedly gave him a dry paper towel to wipe his hand, and encouraged the nurse to speed up the medication administration process. The medication nurse administered the client medication and the 1:1 staff proceeded to take the client to the dining room table for his dinner. At no time was staff observed to take the client into the bathroom to wash his hand. Interview with the QMRP on the same day, revealed that one of Client #1's target behaviors was to decrease spitting and the behavior support plan outlined procedure to wash his hand on each occasion in which he spits in his hands.	W 249		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to ensure that restrictive measures had been approved by the Human Rights Committee (HRC) for three of the three clients in the sample. (Client #1, #2 and #3) The findings include:	W 262	The QMRP will ensure that the Human Rights Committee reviews and approves individual programs that involve risks to client protection and rights.	4/26/2007

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W 262	Continued From page 18 1. There was no evidence that the HRC reviewed and monitored Client #1, #2 and #3's psychotropic medication and Behavior management Program that included the use of behavioral support interventions. (See W124)	W 262		
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 minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that each client's behavior intervention program, including the use of behavior modification drugs, was conducted only with the written informed consent of a legal guardian, for three of the three clients in the sample (Client #1, #2 and #3) The findings include: 1. Observations of the evening medication administration on 2/26/07 at 5:47 PM revealed that Client #1 had received Tegretol 200 mg, Clonazepam 1 mg and Risperdal 1 mg for behavior. Review of the medication administration records and the Physician's orders revealed that Client #1 receives an AM dosage of the same medications as well. Interview with the Licensed Practical Nurse (LPN), Qualified Mental Retardation Professional (QMRP) and the review of the client's Physician's orders revealed the aforementioned medication was used in conjunction with the Behavior	W 263	The QMRP will track submissions to DDS requesting legal guardians for clients who do not have the capacity to make decisions themselves. See response to W124. Client #1 will be assessed by the psychologist to determine his need for a legal guardian. See response to W124 and W125 #1	4/26/2007 4/26/2007

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W 263	Continued From page 19 Management Plan (BMP) to address maladaptive behaviors (i.e. physical aggression, property destruction, noncompliance, SIB, clothes stripping, public masturbation, smearing feces and spitting). Further Interview with the nurse conducted on the same day indicated that Client #1 is cognitively capable of comprehending the side effects of his psychotropic medication regimen and required full assistance to comprehend risk and treatment options. Additionally this clients is unable to make independent decisions without assistance. Interview with the QMRP revealed that Clients #1 has family involvement in their habilitation; however, there was no evidence that an individual or a family member was involved in providing signed informed consents for the use of psychoactive medications and restrictive behavior management programs. In addition, the had not been assessed for the need of legal guardianship to assist them with the decision making as it relates to their habilitation. There was no evidence that the facility had ensure that surrogate decision maker were available to assist Client #1 with written informed consent as it relates to the treatment and habilitation needs prior to prescribing each clients psychotropic mediation regimen and implementation of their behavior support plans. 2. Observations of the evening medication administration on 2/26/07 at 5:47 PM revealed that Client #2 received Risperdal 3 mg and Buspirone 15 mg for behavior. Record verification of the Medication Administration Record revealed that Client #2 also received	W 263	See response above.	4/26/2007

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W 263	Continued From page 20 Naltrexone 50 mg in the AM and another dosage of Naltrexone 50 mg twice daily. Additionally, Client #2 receives an AM dosage of the Buspirone and Risperdal as well. Interview with the Licensed Practical Nurse (LPN) and further review of the client's Physician orders revealed the aforementioned medications were used in conjunction with the Behavior Management Plan (BMP) to address Client #2's maladaptive behaviors (i.e. physical aggression, Self-injurious behaviors, property destruction, public masturbation, refusing meals and playing in urine. Further Interview with the nurse conducted on the same day indicated that Client #2 is cognitively capable of comprehending the side effects of his psychotropic medication regimen and required full assistance to comprehend risk and treatment options. Additionally this client is unable to make independent decisions without assistance. Interview with the QMRP revealed that Clients #2 has family involvement in their habilitation; however, there was no evidence that an individual or a family member was involved in providing signed informed consents for the use of psychoactive medications and restrictive behavior management programs. In addition, the clients had not been assessed for the need of legal guardianship to assist them with the decision making as it relates to their habilitation. There was no evidence that the facility had ensure that surrogate decision maker were available to assist Client #2 with written informed consent as it relates to the treatment and habilitation needs prior to prescribing each clients	W 263		

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W 263	Continued From page 21 psychotropic mediation regimen and implementation of their behavior support plans. 3. Observations of the evening medication administration on 2/26/07 at 5:47 PM revealed that Client #3 received Valproic Acid 15 ml and Dilantin 100 mg for behavior. Record verification of the Medication Administration Record revealed that Client #3 also receives Paxil 25 mg in the morning for anxiety/depression. Interview with the Licensed Practical Nurse (LPN) and further review of the client's Physicians order revealed the aforementioned medications were used in conjunction with the Behavior Management Plan (BMP) to address maladaptive behaviors (i.e. Self-Injurious Behaviors and Bruxism). Further interview with the nurse conducted on the same day indicated that Client #3 is cognitively capable of comprehending the side effects of his psychotropic medication regimen and required full assistance to comprehend risk and treatment options. Additionally this client is unable to make independent decisions without assistance. Interview with the QMRP revealed that Clients #3 has family involvement in their habilitation; however, there was no evidence that an individual or a family member was involved in providing signed informed consents for the use of psychoactive medications and restrictive behavior management programs. In addition, the clients had not been assessed for the need of legal guardianship to assist them with the decision making as it relates to their habilitation. There was no evidence that the facility had	W 263	See response above.	4/26/2007

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W 263	Continued From page 22 ensure that surrogate decision maker were available to assist Client #3 with written informed consent as it relates to the treatment and habilitation needs prior to prescribing each clients psychotropic mediation regimen and implementation of their behavior support plans.	W 263		
W 264	483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. This STANDARD is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to implement Human Rights Committee (HRC) recommendations failed to review, monitor and make suggestions to the facility about its practices and programs as they relate to protection of client rights and funds, and any other areas that the committee believes that could be an infringement of the clients' rights. The findings include: The HRC failed to review and approved the use of a restrictive measure prior to its implementation in the facility as a daily practice as evidenced below: 1. Observation on February 26 - 28, 2007,	W 264	The Human Rights Committee will be restructured to include clients and additional community members. Policies and procedures will be updated to ensure through review of facility practices and programs relating to protection of client rights and funds, and any other areas that could include infringement of clients' rights. See response to W125 and W124.	4/26/2007 4/26/2007

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W 264	Continued From page 23 revealed that the facility has door alarms placed on all exits throughout the facility. Further observation revealed that when the door was opened it activated the alarms, which had a double tone ring to alert the direct care staff. Interview with the QMRP revealed the alarms were place on the door due to Client #5's elopement behavior and Client #2 history of elopement behavior. Further interview with the QMRP did not evidence that all the client residing in the facility had been included in the selection of the type of alarm tone and/or participated in exploration of other least restrictive options prior to implementing the door alerts. Review of the records failed to evidence that all the other client's and/or their representative had been informed of their rights prior to the alarms installation. Further review of the records failed to provide evidence that the Human Rights Committee had review and discussed the installation of the door alarms, other least restrictive measures and the rights of all the other client living in the facility.	W 264		
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 observation, interview and record review, the facility failed to ensure general and preventive care for three of the five residing in the facility. (Client #1, #3 and #4) The findings include:	W 322	The facility will provide preventive and general medical care by complying with DDS policies on providing each client with an accurate, regularly reviewed, and updated Health Care Management Plan. The HCMP is produced by the RN and approved by the PCP. The HCMP contains those medical supports and interventions deemed necessary by the physician for the acquisition and maintenance of optimal health for each client served. The RN will transpose the protocols required in the HCMP to a 24-hour medical shift log that provides directives to staff on each support they are to provide, and contains areas for nursing to staff communication and vice versa.	4/26/2007

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W 322	Continued From page 24 1. Interview direct care staff and record review of the physician order on February 28, 2007 at approximately 11:30 AM, revealed that Client #3 was prescribed a "Mid-day Nap". Interview with the QMRP revealed that Client #3 is usually tired from his travel on the van. According to the QMRP, when the client retruns hoome from the day program , the 1:1 provide personal hygiene Care and places the Client on the bed to rest. Further interview with the direct care staff revealed that the client doesn't actually tack the nap at the day program, but usually lays own in his bed to rest in the afternoon when he returns from the day program. Reportedly the client does not take a nap at the day program due to the difficulty of waking him in preparation for transported from the day program. 2. Interview QMRP and record review of the physicians's order on February 28, 2007 at approximately 10:15 AM, revealed that Client #1 was prescribed a "Cervical Collar" as a piece of adaptive equipment. Further interview with the QMRP revealed that when Client #1 was transferred to the agency two years ago "the collar came with him". According ti interview with the QMRP, the client is to wear the collar at night to provide him neck. Review of the Physical Therapy assessment dated 10/13/06 failed to reflect the purpose, recommendations and length of time for the use of the collar, as well, did not provide instruction for direct care staff to ensure appropriate implementation for this prescribed support. Further review failed to revealed that a protocol had been developed by the nursing staff and that	W 322	The RN will confirm the physician order for a mid-day nap for Client #3 and obtain clarification of the term "mid-day" to see if taking the nap upon return from the day program meets the PCP's intent. See response to W189 #2.	4/26/2007 4/26/2007

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W 322	Continued From page 25 no documentation was availble to support the nursing staff monitoring of the implemtation of this neck support for Client #1. Review training manual failed to evidence that direct care staff had been in-serviced on the proper use and the maintenance of this soft cervical collar prescribed for Client #1. 3. Interview with the nurse and review of medical records on February 28, 2007 at approximately 11:30 AM, revealed that Client #1 had a GI consult on 6/1/06. The finding of this exam indicated a "Left breast mass, surgical evaluation-Lt breast mass". Further review of the records revealed that a mammogram was completed 8 months late on 1/10/07, however, the medical record did not evidence a copy of the results of the mammogram. Interview with the facility's director, on the sam day, revealed that Providence Hospital was to have mailed the test result to the facility. Interview with the nurse revealed that Client #1 has a follow-up appointment scheduled for surgical consult "sometime" in March and will need the mammogram results prior to the follow-up visit for the surgical consultation. 4. Interview with the QMRP on February 28, 2007 at approximately 1:35 PM and review of Human Rights Committee (HRC) Minutes dated 10/26/06 revealed that Client #4 was recommended for a baseline Colonoscopy. The HRC approved the use of sedation for this procedure for Client #4 at that same meeting. According to the minutes Client #4 requested the use of sedation for the procedure. Further interview with the QMRP revealed that the	W 322	The Facility Director will obtain the results of the mammogram. Grand Rounds in the facility will be led by the Registered Nurse, who will ensure that medical reports are received as soon as they are completed and are filed in each client's record. See response to W125 #'s 1 and 3.	4/26/2007 4/26/2007

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W 322	Continued From page 26 consent for the procedure had not been obtained.	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 interview and record review, the facility failed to provide each client with nursing services in accordance with their needs. The findings include: 1. Interview and record review revealed that Client #1 had a dermatology appointment on 10/17/06 and was scheduled to return 1 month later for a follow-up appointment. At the time of the survey, the nursing staff failed to provide evidence that Client #1 return in November as recommended. 2. Interview and record review revealed that Client #1 had a Urology appointment on 5/12/05 and was scheduled to return 1 year later for a follow-up appointment. At the time of the survey, 19 months later, there was no evidence that the nursing staff ensure timely follow-up as recommended. 3. Interview with the nurse and review of the Medication Administration Records on February 26, 2007, revealed an order for Minerin Cream to be applied three times a day to the buttocks and inner right thigh in the diaper area of Client #3. Further review of the MAR revealed that the MAR had not been signed. Interview with the DON indicated that the staff	W 331	The Director of Nursing will ensure Grand Rounds are held at least monthly and are attended by an RN, the Designated LPN, and the QMRP. All health issues and required follow up will be completed in accordance with physician's orders and referrals. 4/26/2007 The DON will coordinate with the QMRP to ensure that the client returns for the follow up appointment. 4/26/2007 See response above. 4/26/2007 The DON reviews medication records weekly, and will provide training and follow up to nurses on medication and/or documentation errors. 4/26/2007 The DON will coordinate with the Director of Disability Services to establish a system for documenting topicals and rinses. 4/26/2007	

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W 331	Continued From page 27 may may applied this cream during diaper changes. Further interview revealed that the direct care staff have no access to a MAR for them to document administration of Client #3's topical treatment. There was no evidence of a system had been established and was being implemented to ensure implementation of Client #3's prescribed topical treatment. 4. Interview with the nurse and review of the Medication Administration Records on February 26, 2007, revealed an order for Chlorhexidine 0.12% rinse. According to the order this rinse with 15 cc twice daily after brushing for Client #5. Further review of the MAR revealed that the MAR had not been signed for administration. Interview with the DON indicated that the direct care staff give this rinse during toothbrushing. Further interview revealed that the direct care staff have no access to a MAR for them to document administration of Client #5's mouth treatment. There was no evidence of a effective system had been established and implemented to ensure implementation of Client #3's gum treatment. 5. Observation of the medication administration on February 26, 2007 at approximately 5:47 PM, revealed that Client #3 receives the following medication in the PM: Valproic Acid 15 ml, Diocto 25 ml, Simethicone 40 mg, Zyrtec tablet, Dilantin 100 mg, Dilantin 50 mg and Constulose 10 mg/15 ml as described below: a.) During the administration of Diocto, the Client hit the nurse hand and approximately half of the drug dosage spilled from the cup onto the floor.	W 331	See response above. See response above. The DON will provide additional training to medication nurses on the facility policy and procedure for documenting amounts of medication not administered and disposal of medication not administered.	4/26/2007 4/26/2007

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W 331	Continued From page 28 b.) After the Administration of the Dilantinand Zypreza (crushed and placed in aplesauce) Approximatley 20% of the mixture remained in the cup and was discarded in the kitchen trashcan. Interview with the nurse revealed that when a client refuse their medication and portion of the medication are not administered, a note is placed on the MAR and in the nursing notes detailing the percentage amount of the medication not administered. Additionally, any medication not administered is to be flushed down the sewage system and documented. The records are to be documented with the date and time the medication was destroyed and signed by the nurse. Review of the medication administration records and the nursing notes failed to evidence any documentation for the percentage amount of medication not administered and that the medication had been destroyed as required by the agency's policy and procedures. 6. Interview QMRP and record review of the physicians's order on February 28, 2007 at approximately 10:15 AM, revealed that Client #1 was prescribed a "Cervical Collar" as a piece of adaptive equipment. Further interview with the QMRP revealed that when Client #1 was transferred to the agency two years ago "the collar came with him". According ti interview with the QMRP, the client is to wear the collar at night to provide him neck. Review of the medial record failed to evidence a written protocol for the direct care staff	W 331	See response to W189 #2.	4/26/2007

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W 331	Continued From page 29 implemtation of Client #1's Cervical Collar prescribed by the primary care physician. Further review failed to evidence that the nursing staff had trained the direct care on the proper use and maintenance of the Cervical Collar.	W 331		
W 362	483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that each client's medication regimen was reviewed by the pharmacist quarterly, for three of the three clients in the sample. (Client #1, #2 and #3) The findings include: Interview with the nurse and review of the medical records revealed that Client #1, #2 and #3's last pharmacological review occurred on 10/30/06. According to the nurse, the next review was to have occurred in January, 2007. Although, at the time of survey, the pharmacist arrived at the facility to review the medications regimen of each client, the review had not occurred timely as required by this regulations. Note: It should be further noted that Client #1, #2 and #3 are prescribed psychotropic medication to manage each their clients's identified maladaptive behaviors.	W 362	The QMRP and the DON will ensure that pharmacy reviews occur on a quarterly schedule.	4/26/2007
W 365	483.460(j)(4) DRUG REGIMEN REVIEW An individual medication administration record must be maintained for each client.	W 365	See response to W331.	4/26/2007

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W 365	Continued From page 30 This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to maintain medication administration records (MAR) for one of the two client in the sample. (Clients #1) The finding includes : 1.) During the verification of the medication pass and review Medication Administration Record (MAR) the medication nurse failed to sign in the MAR after administration of the following clients medications: Interview with the nurse and review of the Medication Administration Records on February 26, 2007, revealed an order for Minerin Cream to be applied three times a day to the buttocks and inner right thigh in the diaper area of Client #3. Further review of the MAR revealed that the MAR had not been signed. Interview with the DON indicated that the staff may may applied this cream during diaper changes. Further interview revealed that the direct care staff have no access to a MAR for them to document administration of Client #3's topical treatment. There was no evidence of a system had been established and was being implemented to ensure implementation of Client #3's prescribed topical treatment. 2.) Interview with the nurse and review of the Medication Administration Records on February 26, 2007, revealed an order for Chlorhexidine 0.12% rinse. According to the order this rinse with 15 cc twice daily after brushing for Client #5.	W 365	See response to W331 #3.	4/26/2007
W			See response above.	4/26/2007

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W 365	Continued From page 31 Further review of the MAR revealed that the MAR had not been signed for administration. Interview with the DON indicated that the direct care staff give this rinse during toothbrushing. Further interview revealed that the direct care staff have no access to a MAR for them to document administration of Client #5's mouth treatment. There was no evidence of a effective system had been established and implemented to ensure implementation of Client #3's gum treatment.	W 365		
W 389	483.460(m)(1)(il) DRUG LABELING Labeling for drugs and biologicals must include the appropriate accessory and cautionary instructions, as well as the expiration date, if applicable. This STANDARD is not met as evidenced by: Based on observation of the medication administration, the facility failed to ensure that medications were labeled with the appropriate information for one of the three client's in the sample. (Client #1) The finding includes: The facility failed to ensure that Client #3's topical treatment medication was property labeled as evidence below: Interview with the nurse and review of the Medication Administration Records on February 26, 2007, at approximatley 6:00 PM revealed an order for Minerin Cream to be applied three times a day to the buttocks and inner right thigh in the diaper area of Client #3.	W 389	The DON will coordinate with the Pharmacist to ensure proper labeling of medications.	4/26/2007

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W 389	Continued From page 32 Review of the Minerin cream stored in the bedside table in Client #3's bedroom failed to have a label with Client #3's name, expiration date and administration instructions.	W 389		
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, interview and record review, the facility failed to maintain adaptive equipment in good repair for two of three clients in the sample . (Client #1 and #3) The findings includes: Observation on February 26, 2007 at approximately 6:00 PM revealed the 1:1 assigned to Client #3 having difficulty rolling the client wheelchair. Interview with the QMRP and the review of records revealed a recommendation had been made for the purchase of an adaptive wheelchair on 2/21/05 for the client. Further interview with the QMRP revealed that the wheelchair had been ordered and that the PT needed to follow-up on the purchase order and the 719A. According to the QMRP the 719A had been approved and forwarded to the appropriate parties for approval and forwarded to the vendor several months ago.	W 436	The QMRP will follow up with the PT to ensure his notes reflect purchase requests for adaptive equipment. The QMRP and PT will follow up with the adaptive equipment vendor to ensure that equipment is delivered timely.	4/26/2007

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W 436	Continued From page 33 Review of the PT notes indicated that his last quarterly note dated 8/30/06 made no mention of the purchase of Client #3's new wheelchair. Review of the HRC minutes dated 10/26/06 indicated that Client #3's new wheelchair was ordered.	W 436		
W 454	483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a sanitary environment to avoid sources and transmission of infection. The finding include: During observation of the medication administration on February 26, 2007 at approximately 5:47 PM, Client #1, while in the medication room exhibited a spitting behavior. He repeatedly spit in his hands. The 1:1 assigned to the client repeatedly gave him a dry paper towel to wipe his hand, and encouraged the nurse to speed up the medication administration process. The medication nurse administered the client medication and the 1:1 staff proceeded to take the client to the dining room table for his dinner. At no time was staff observed to take the client into the bathroom to wash his hand. Interview with the QMRP on the same day, revealed that one of Client #1's target behaviors was to decrease spitting and the behavior support	W 454	See response to W249.The QMRP will schedule all staff to complete additional refresher training in infection control procedures.	4/26/2007

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W 454	Continued From page 34 plan outlined procedure to wash his hand on each occasion in which he spits in his hands. Review of the medical records and physician's orders revealed that Client #1 is a Hepatitis B carrier.	W 454		
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure that procedures for prevention of communicable disease were implemented for two of three clients in the sample. (Client #1) The finding includes: The facility failed 1:1 staff assigned to Client #1 failed to ensure infection control practices were implemented. [See W454]	W 455	The QMRP will ensure that all staff receive refresher training on infection control procedures, and that where necessary, habilitation programs reflect appropriate infection control protocols. See response to W454.	4/26/2007
W 474	483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to serve foods in a form consistent with dietary orders for two of the three included in the sample. (Clients #1 and #2) The finding includes: The findings include:	W 474	See response to W189 #1.	4/26/2007

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W 474	Continued From page 35 1. Observation of the dinner on February 27, 2007 at approximately 6:13 PM, revealed very large chucks of beef stew on Client #1's plate. The direct care was observed to repeatedly look at the meat on the plate and commented on "the size of the beef chucks on his plate to be to large." Interview with the QMRP revealed that she gave the staff the okay to serve the stew beef without chopping it as prescribed. However, the QMRP state she never went back to actually look at the size of the beef chucks to ensure that direct care staff provided the correct texture. Review of the diet order revealed that Client 1 is prescribed a 1800 calorie Low Fat/Low Cholesterol chopped texture diet. 2. Observation of the dinner on February 27, 2007 at approximately 6:13 PM, revealed very large chucks of beef stew on Client #2's plate. The direct care was look at the meat on the plate, however, did not comment on the size of the beef chucks on the plate. The direct care staff picked up Client #2's spoon and began to cut the chuck up with the spoon. Interview with the QMRP revealed that she gave the staff the okay to serve the stew beef without chopping it as prescribed. However, the QMRP state she never went back to actually look at the size of the beef chucks to ensure that direct care staff provided the correct texture. Review of the diet order revealed that Client 1 is prescribed a Regular, Chopped meat, No concentrated Sweets/No Caffeine - No Grapefruit.	W 474	See response above. See response above.	4/26/2007 4/26/2007

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

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	09G010	A. BUILDING _____ B. WING _____	02/28/2007

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I 000	INITIAL COMMENTS A licensure survey was conducted from February 26, 2007 through February 28, 2007. A random sample of three clients was selected from a client population of five males with varying degrees of disabilities. The finding of this survey were based on observations at the group home and three day program, interview with direct care staff and management, and a review of the habilitation and administrative records to include the unusual incident reports on file.	I 000		
I 040	3502.1 MEAL SERVICE / DINING AREAS Each GHMRP shall provide each resident with a nourishing, well-balanced diet. This Statute is not met as evidenced by: Based on observation, interview, and record review the GHMRP failed to serve each resident with a nourishing, well-balanced diet. The finding includes: See Federal Deficiency Report Citation ~~W450~~ error SMM and W474	I 040	The QMRP will ensure that the Registered Dietician provides a refresher training on client diets for all facility staff.	4/26/2007
I 082	3503.10 BEDROOMS AND BATHROOMS Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting. This Statute is not met as evidenced by: Based on observations observation and interview	I 082	SIGN & DATE The QMRP will ensure that all bathrooms are properly equipped with cups, toilet paper, soap and paper towels, and that light bulbs are replaced timely.	4/26/2007

Health Regulation Administration

Marsha H. Thompson Director of Disability Services 3/29/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATE FORM 6899 970J11 If continuation sheet 1 of 7

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I 082	Continued From page 1 at the GHMRP failed properly equip each bathroom with the appropriate items to meet each residents need. The findings include: During the environmental walk-through on February 28, 2007 at approximately 11:15 AM revealed the following; 1. The bathroom on the basement level had no cups and cup dispenser and no paper towels for the residents use. 2. The main level bathroom adjacent to Resident #3's bedroom had no paper towels, cups and cup dispenser. 3. The second level bathroom #3 and #4 had no cups and cup dispensers. 4. Bathroom #2 and #3 had bulbs which were not working.	I 082		
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 during the environmental walk-through the GHMRP failed to maintain the facility in a safe,clean,orderly and sanitary manner as evidence by: The findings include:	I 090	The QMRP will ensure that all unused furnishings are properly and safely stored, and that a working thermometer is in the freezer.	4/26/2007

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I 090	Continued From page 2 INTERIOR 1. A mattress and box spring was being stored next to the furnace. 2. A broken head board and a pile of coat hangers were being stored across from the bathroom. 3. No thermometer was being stored in the refrigerator freezer. EXTERIOR	I 090		
I 095	3504.6 HOUSEKEEPING Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach of each resident. This Statute is not met as evidenced by: Based on observation and interview the GHMRP failed to lock caustic agents being stored. The findings include: During the environmental walk-through on February 28, 2007 at approximately 11:30 PM revealed the following; 1. Caustic agents were being stored underneath the basement bathroom sink unlocked.	I 095	The QMRP will ensure that poisons and caustic agents are properly stored and locked.	4/26/2007

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I 095	Continued From page 3 2. Caustic agents were being stored underneath the main level bathroom sink unlocked.	I 095		
I 188	3508.6 ADMINISTRATIVE SUPPORT Documentation that services have been provided as required by each resident ' s Individual Habilitation Plan including contracts, vendor agreements, receipts, and paid bills shall be available for review by authorized regulatory personnel. This Statute is not met as evidenced by: Based on interview and record review the GHMRP failed to ensure that contract for outside services are on file for the regulatory agency's review. The finding includes: Interview with the QMRP and a review of the available outside contract failed to show evidence contractual agreement for the day programs in which the resident's attend.	I 188	The Director of Operations will ensure signed contracts with day programs are on file with the facility.	4/26/2007
I 189	3508.7 ADMINISTRATIVE SUPPORT Each GHMRP shall maintain records of residents ' funds received and disbursed. This Statute is not met as evidenced by: Based on interview and record review the GHMRP failed to maintained each resident's funds received and disbursed. The finding includes: See Federal Deficiency Report Citation W140	I 189	The QMRP will ensure that updated, signed job descriptions are on file for each staff person, and that annual reviews of the job description are conducted with each employee.	4/26/2007

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I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current job descriptions for all employees annually. The finding includes: Review of the personnel files conducted on February 28, 2007, revealed that GHMRP failed to provide evidence of current signed job descriptions for three (3) direct care staff ([redacted] and [redacted]).	I 203		
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 record review, the GHMRP failed to have on file for review current health certificates for all employees annually. The finding includes: Review of the personnel files on February 28, 2007, the GHMRP failed to provide current health certification for two(2) direct care staff [redacted].	I 206	The Director of Disability Services will ensure that each employee of the facility has a current health certification.	4/26/2007

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I 206	Continued From page 5 QMRP- [redacted], one (1) nurse consultants [redacted], DON- [redacted] and Podiatrist.	I 206		
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on observations, interview and record verification, the GHMRP failed to ensure continuous, ongoing in-service training programs were conducted for all personnel. The finding includes: See Federal Deficiency Report Citation W189	I 222	The Director of Disability Services will draft the in-service training schedule and ensure that it is carried out for all facility staff.	4/26/2007
I 395	3520.2(e) 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: (e) Nursing; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure its nurses had current licenses on file.	I 395	The Director of Disability Services will ensure that all licensed personnel have current licenses on file with the facility.	4/26/2007

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I 395	Continued From page 6 The finding includes: Review of the personnel records on February 28, 2007 revealed that the GHMRP failed to have current license on file for one Registered Nurse(RN) employed by the agency. ([redacted])	I 395		