

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

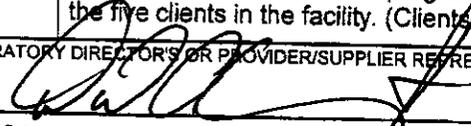
PRINTED: 08/14/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G188	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/20/2009
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NAME OF PROVIDER OR SUPPLIER INNOVATIVE LIFE SOLUTIONS, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3259 'O' ST, SE WASHINGTON, DC 20020
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(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) COMPLETION DATE
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W 000	<p>INITIAL COMMENTS</p> <p>On May 5, 2009 at 7:20 AM, the Health Regulation and Licensing Administration received an unusual incident report from the group home alleging verbal abuse of Client #1 by a nurse contracted to administer medications at the group home. According to the facility's investigative report, on May 5, 2009, at approximately 4:20 PM, a cup of water was spilled on the table during the medication administration. Client #1 said that the nurse spilled the water. The nurse responded by saying that the client had lied about him spilling the water. When the client repeatedly stated that the nurse spilled the water, the nurse allegedly threatened to slap the client, if she continued to lie on him.</p> <p>The investigation conducted by the group home concluded that the allegation was substantiated. An onsite visit was initiated by the Health Regulation and Licensing Administration on May 20, 2009 to examine the facility's incident management system and to verify the corrective action implemented based on the group home's investigative findings.</p>	W 000	<p style="text-align: center;"><i>Received 8/21/09</i></p> <p style="text-align: center;">GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002</p>	
W 159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the Qualified Mental Retardation Professional (QMRP) failed to coordinate, integrate and monitor the active treatment programs of two of the five clients in the facility. (Clients #1 and #2)</p>	W 159	<p>W159</p> <p>The administration acknowledges the rights of #1 & #2 to receive active treatment programs as identified in their ISP. Then GHMRP will ensure that The QMRP will be provided additional training to aide in development and coordination of meaningful active treatment programs for #1 & #2. Additionally the quarterly round table discussion will provide the opportunity to monitor performance of active treatment programs.</p>	8/31/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE *Executive Director* (X6) DATE *8/21/09*

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 159	<p>Continued From page 1</p> <p>The findings include:</p> <p>1. The facility failed to ensure that Client #1 behavior support plan was implemented as written as evidenced below:</p> <p>According to the QMRP, on May 5, 2009 the medication nurse appeared to be in a hurry when he arrived. The QMRP indicated that at approximately 4:20 PM, Client #1 was being supervised by her one on one staff as she was taken to the nursing office. The QMRP indicated that the one on one stood at the door of the medication room to monitor Client #1 as her medications were administered by the nurse. The QMRP indicated that during this time, she and the residential director (RD) were in the administrative office in the basement, which is located just outside the nursing office. The QMRP revealed that she overheard the medication nurse say the client had turned over a cup of water. Reportedly, the client asked the nurse why he turned over the cup of water. The nurse responded that he did not do it and told Client #1 that she turned over the water. The comments continued back and forth between the nurse, with the nurse and the client accusing each other of spilling the water. According to the QMRP, the nurse then told the client he would smack her if she continued to lie on him.</p> <p>Interview with the QMRP during the investigation indicated that Client #1 liked to play, and make false allegations, however was not aggressive on the day of the incident. The QMRP indicated that the door of the nursing office was visible from the administrative office; however, she did not observe how the water was spilled. The QMRP</p>	W 159	<p>W159</p> <p>The administration acknowledges that #1 one on one staff did not provide arms length supervision to her on the day of the incident, however, the one to one was instrumental in providing support and preventing an escalation in individual's behavior in response to the nurses comments. Consequently all staff working with #1 and other individuals will receive additional training on the all the residents BSP as well as one on one job description as it pertains to individual on 8/26/09. The training will be provided by the ILS Behavior specialist. Additionally, monthly BSP training is scheduled to fully equip all staff with basic understanding of the resident's behavior as well as necessary interventions. The Agency management team is scheduled to conduct quarterly round table discussion that will evaluate services provided to all residents including #1.</p>	8/26/09
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W-159	<p>Continued From page 2</p> <p>also stated that prior to the May 5, 2009 incident, she had never observed or overheard the medication nurse become verbally abusive to the clients.</p> <p>Record review revealed Client #1 had a behavior support plan (BSP) dated July 2008, which stated an objective to decrease incidents of making unfounded statements or false accusations to 0 incidents for six consecutive months. Further review of the BSP revealed the client "should be closely monitored by staff to prevent her from engaging in the target behaviors.... As much as possible staff should intervene before Ms.... begins to become verbally aggressive. Staff should make efforts to address the situation or to redirect Ms.... before she escalates to verbal aggression."</p> <p>At the time of the investigation, there was no evidence interventions identified in the behavior support plan were implemented timely, and as written to minimize the client behavior, which occurred during the alleged incident.</p> <p>2. The QMRP failed to ensure the coordination of services to support implementation of the agency 's " Medication Pass Protocol."</p> <p>[Cross refer to W331] Observation of the basement area of the facility on May 20, 2009 at 4:45 PM revealed a table was located in the recreation area of the basement (the common area). Further observation and interview with the QMRP revealed an administrative office and an adjacent nursing office were also located in the basement.</p> <p>Continued interview with the QMRP on May 20,</p>	W 159	<p>W159</p> <p>The administration acknowledges that all medication nurses must observe the rules and regulation regarding medication administration. The Agency RN has put in place the appropriate medication pass protocol and will provide additional training to all nursing staff on 8/26/09. Additionally the quarterly round table discussion would continue to address resident's medical needs to include medication administration.</p>	8/26/09
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W 159	<p>Continued From page 3</p> <p>2009 at 5:24 PM revealed that on May 5, 2009, both she and the residential director (RD) were in the administrative office. The QMRP indicated that the medication nurse was in a hurry that day. She heard him say Client #1 had spilled water on the table. She then heard back and forth comments between the client and the nurse, each accusing the other of spilling the water on the table. According to the QMRP, during that time, both she and the RD overheard the medication nurse verbally threatened to smack Client #1 if she continued to say that he spilled water on the table in the medication room. The QMRP stated that she then confronted the medication nurse informing him of the inappropriateness of his comments to the client. The QMRP revealed that she also asked the nurse to discontinue contact with the clients, and then notified the administrator and the incident management coordinator.</p> <p>The review of the investigation statement (dated 5/5/09) completed by the one on one staff revealed that Client #2 was also in the medication room with Client #1 at the time the incident occurred. According to the facility's " Medication Pass Protocol ", (the nurse should call individuals into the nursing office for med pass one at a time; (2) Clients who are not receiving medication should wait in the common area, outside of the office while medication pass is being performed.</p> <p>At the time of the investigation, there was no evidence the QMRP had collaborated with the nurse for accurate implementation of the medication protocol to ensure the personal privacy of each client and to facilitate a smooth transition during the medication administration.</p>	W 159	<p>W159</p> <p>The administration acknowledges the rights of individual to maintain privacy at all times including medications pass sessions to ensure smooth transition between residents during medication administration times. The Agency RN has addressed the need for privacy in the medication protocol and will provide additional training to nursing staff, direct care staff and individuals on 8/26/09. Additional training will occur at the quarterly roundtable discussions and as the need may arise.</p>	8/26/09
W 240	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN	W 240		

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W 240	<p>Continued From page 4</p> <p>The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interviews and record review, the facility failed to ensure that the behavior support plan (BSP) identified how the one on one supervision was to be provided to Client #1.</p> <p>The finding includes:</p> <p>A site visit was made at the facility on May 20, 2009 at 4:45 PM to investigate an allegation of verbal abuse to Client #1, which occurred on May 5, 2009. During the investigation, Client #1 was observed to be supervised by the Qualified Mental Retardation Professional (QMRP) and a direct care staff.</p> <p>Interview with the QMRP on May 20, 2009 at 5:24 PM revealed Client #1 had a behavior support plan (BSP) which included strategies to increase her level of socially appropriate behavior, and to increase her emotional stability and cooperation. Further interview with the QMRP revealed the client had been approved by the Human Rights Committee (HRC) to be provided one on one supervision to address her maladaptive behaviors for sixteen hours a day (waking hours).</p> <p>On May 20, 2009 at 5:40 PM, an attempt was made by the surveyors to interview Client #1 concerning the alleged incident of verbal abuse. The client appeared sleepy and was slightly drooling. The QMRP verbally prompted the client</p>	W 240	<p>W240</p> <p>The administration will continue to ensure that all staff working with #1 and other residents will continue to receive proper training on their BSP and one on one protocol. Additional training will take place on 8/26/09. The behavior specialist and the ILS IMC will coordinate training to all staff as needed. Additionally, the quarterly round table discussion will continue to address services to all residents and staff to enhance high and quality services at all times.</p>	8/26/09
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W 240	<p>Continued From page 5</p> <p>to wipe her mouth. The QMRP stated that the client liked to play and was pretending to be sleepy. When questioned concerning the incident, the client said that the medication nurse was going to slap her. The client also stated, "She [the QMRP] heard it, and she [Client #2] did too." Client #1 made not further statements, and then started a playful, irrelevant conversation.</p> <p>Subsequent record review on May 20, 2009 at 5:57 PM revealed Client #1's behavior management regimen included medications (Haldol, Lorazepam, Clonazepam, Seroquel, Divalproex, and Haloperidol) to address her diagnoses of Mood Disorder (NOS) and Intermittent Explosive Disorder.</p> <p>The review of Client #1's BSP, dated July 2008, on May 20, 2009 at 6:15 PM, revealed she functions in the mild range of mental retardation. The BSP revealed strategies were being implemented to do the following:</p> <ul style="list-style-type: none"> (a) Reduce incidents of verbal aggression ...* (b) Reduce incidents of leaving staff supervision (eloping)... (c) Consistently take all prescribed medication... (d) Reduce incidents of property destruction... (e) Reduce incidents of agitation ...* (f) Decrease incidents of physical aggression (g) Decrease incidents of making statements or gestures indicating suicidal ideation... (h) Decrease incidents of making unfounded statements or false accusations ...* (i) Maintain at least an average rating of positive mood on the provided scale and decrease incidents of mood instability. <p>According to the BSP, the client may appear to be</p>	W 240		
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W 240	Continued From page 6 joking and being playful at times, but often this escalates to one or more of the identified behaviors of concern. The BSP recommended that Client #1 receive one to one staff supervision. The BSP stated, "This staff person is needed for behavior support plan implementation, and to ensure the safety of Client #1, given the high level of risks of several of her target behaviors ". The review of the job description for the One to One Direct Care Staff revealed (1) Provide ongoing supervision to individuals you are assigned to. (2) Staff must be within arm's length of consumer at all times. The review of the facility internal investigation report dated May 8, 2009, revealed Client #1 " requires one on one supervision at all times. " At the time of the investigation, however the BSP failed to identify the number of hours a day the client was to be provided one on one supervision. Additionally, the BSP failed to identify the distance the staff should be from Client #1 when providing her with one on one supervision.	W 240	W240 The administration acknowledges # 1 rights to receive one on one staff supervision as identified in her ISP The administration will ensure the review of #1 and others residents BSP to specify the number of hours per day the residents are to be provided one on one staff supervision. #1 current BSP dated 7/08 clearly identify one on one staff supervision for 16 hours per day during awaking hours (8am-4pm & 4pm-12am) Further review by the behavior specialist, MC/QA, QMRP would be completed 8/26/09	8/26/09
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's nursing services failed to ensure that its medication administration procedures/policy was effectively implemented for two of the five clients residing in the facility. (Clients #1 and #2) The finding includes:	W 331	to determined that #1 BSP clearly identifies one on one staff supervision hours and staff positions to #1 and other residents (Arms length at all times)	

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W 331	Continued From page 7 An unusual incident report dated May 5, 2009, was received by the Health Regulation and Licensure Administration (HRLA) on May 6, 2009. The incident report revealed that the evening medication nurse threatened to slap Client #1 when she allegedly and repeatedly " lied on him" by saying that he had spilled water on the table during the medication administration. Interview with the Qualified Mental Retardation Professional (QMRP) on May 20, 2009 at 5:05 PM revealed that Client #1 had a behavior support plan that required one on one supervision. The review of the BSP dated July 2008 confirmed that the one on one supervision should be provided. The job description for the one on one staff revealed that Client #1 should be supervised at arm's length. The written statement (dated May 5, 2009) of Client #1's one on one staff, which was completed for the agency's internal investigation, was reviewed on May 20, 2009 during the Department of Health investigation. According to the statement, the one on one staff escorted Client #1 to the nursing office to receive her medication from the evening medication nurse. The staff wrote that the nurse gave Client #1 her medication and a cup of water while she was sitting across from Client #2. Reportedly, during this time, Client #2 was about to check her blood sugar. The statement then revealed that the cup of water was observed to have been over turned on the table, however did not identify who turned over the cup. According to this statement, the medication nurse summoned the house manager	W 331	W 331 Cross-reference W159	8/26/09

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W 331	<p>Continued From page 8</p> <p>to the office to see what Client #1 had allegedly done. He then said that Client #1 had poured water on a napkin placed on the table for Client #2 to use during her finger stick. The one on one's written statement indicated that Client #1 immediately denied pouring the water on the table, told the nurse that he spilled the water, and repeatedly stated that the nurse poured the water on the napkin. The statement further indicated that the nurse then verbally threatened to smack Client #1 if she continued to lie on him.</p> <p>The review of the " Medication Pass Protocol " revealed the following procedures should be implemented to ensure that best practice procedures are followed when administering medications to individuals.</p> <ol style="list-style-type: none"> 1. Call individuals one at a time into the nursing office for medication pass. 2. Waiting individuals are to remain in common area outside of office while medication pass is being performed. 3. The nursing office door, as well as main office door must be closed during medication pass to ensure privacy. 4. Once the individual leaves the office after completing the medication pass, the next individual can be called into the nurse ' s office for their med pass. <p>At the time of the survey, there was no evidence the aforementioned procedures identified in the medication administration policy had been implemented as written on the day of the unusual incident.</p>	W 331	<p>W 331</p> <p>Cross-reference W159</p>	8/26/09
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Health Regulation Administration

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1000	INITIAL COMMENTS On May 5, 2009 at 7:20 AM, the Health Regulation and Licensing Administration received an unusual incident report from the group home alleging verbal abuse of Resident #1 by a nurse contracted to administer medications at the group home. According to the GHMRP's investigative report, on May 5, 2009, at approximately 4:20 PM, a cup of water was spilled on the table during the medication administration. Resident #1 said that the nurse spilled the water. The nurse responded by saying that the resident had lied about him spilling the water. When the resident repeatedly stated that the nurse spilled the water, the nurse allegedly threatened to slap the resident, if she continued to lie on him. The investigation conducted by the group home concluded that the allegation was substantiated. An onsite visit was initiated by the Health Regulation and Licensing Administration on May 20, 2009 to examine the GHMRP's incident management system and to verify the corrective action implemented based on the group home's investigative findings.	1000		
1180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure adequate administrative support to effectively meet the needs identified in the habilitation plans of two residents. (Residents #1 and #2)	1180	1180 The GHMRP acknowledges the rights of #1 & # 2 to receive adequate supports/ services as identified in their ISP. The administration will ensure quarterly round table meeting occur as scheduled to review all services/ needs for all residents. Additionally, the QA director will be conducting quarterly review of records to ensure compliance with all regulations / recommendations to include #1 & #2.	8/26/09

Health Regulation Administration

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

TITLE
EXECUTIVE DIRECTOR

(X6) DATE
8/26/09

Health Regulation Administration

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I 180	<p>Continued From page 1</p> <p>The findings include:</p> <p>1. The QMRP failed to ensure the coordination of services to support implementation of the agency's "Medication Pass Protocol".</p> <p>[Cross refer to I401 (3520.3)] Observation of the basement area of the GHMRP on May 20, 2009 at 4:45 PM, revealed a table was located in the the recreation area of the basement (the common area). Further observation and interview with the QMRP revealed an administrative office and an adjacent nursing office were also located in the basement.</p> <p>Continued interview with the QMRP on May 20, 2009 at 5:24 PM revealed that on May 5, 2009, both she and the residential director (RD) were in the administrative office. The QMRP indicated that the medication nurse was in a hurry that day. She heard him say Resident #1 had spilled water on the table. She then heard back and forth comments between the resident and the nurse, each accusing the other of spilling the water on the table. According to the QMRP, during that time, both she and the RD overheard the medication nurse verbally threatened to smack Resident #1 if she continued to say that he spilled water on the table in the medication room. The QMRP stated that she then confronted the medication nurse informing him of the inappropriateness of his comments to the resident. The QMRP revealed that she also asked the nurse to discontinue contact with the residents, and then notified the administrator and the incident management coordinator.</p> <p>The review of the investigation statement (dated 5/5/09) completed by the one on one staff revealed that Resident #2 was also in the</p>	I 180	<p>I180</p> <p>Cross-reference W159</p>	8/26/09

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I 180	<p>Continued From page 2</p> <p>medication room with Resident #1 at the time the incident occurred. According to the GHMRP's " Medication Pass Protocol ", (1) the nurse should call individuals into the nursing office for med pass one at a time; (2) Residents who are not receiving medication should wait in the common area, outside of the office while medication pass is being performed.</p> <p>At the time of the investigation, there was no evidence the QMRP had collaborated with the nurse for accurate implementation of the medication protocol to ensure the personal privacy of each resident and to facilitate a smooth transition during the medication administration.</p> <p>2. The GHMRP failed to ensure that Resident #1 behavior support plan was implemented as written as evidenced below:</p> <p>(Cross refer to I422 (3521.1)). According to the QMRP, on May 5, 2009 the medication nurse appeared to be in a hurry when he arrived. The QMRP indicated that at approximately 4:20 PM, Resident #1 was being supervised by her one on one staff as she was taken to the nursing office. The QMRP indicated that the one on one stood at the door of the medication room to monitor Resident #1 as her medications were administered by the nurse. The QMRP indicated that during this time, she and the RD were in the administrative office in the basement, which is located just outside the nursing office. The QMRP revealed that she overheard the medication nurse say the resident had turned over a cup of water. Reportedly, the resident asked the nurse why he turned over the cup of water. The nurse responded that he did not do it and told Resident #1 that she turned over the water. The comments continued back and forth between the nurse, with</p>	I 180	<p>I180</p> <p>The administration will continue to ensure that all staff working with #1 and other residents will continue to receive proper training on their BSP and one on one protocol. Additional training will take place on 8/26/09. The behavior specialist and the ILS IMC will coordinate training to all staff as needed. Additionally, the quarterly round table discussion will continue to address services to all residents and staff to enhance high and quality services at all times.</p>	8/26/09

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I 180	Continued From page 3 the nurse and the resident accusing each other of spilling the water. According to the QMRP, the nurse then told the resident he would smack her if she continued to lie on him. Interview with the QMRP during the investigation indicated that Resident #1 liked to play, and make false allegations, however was not aggressive on the day of the incident. The QMRP indicated that the door of the nursing office was visible from the administrative office; however, she did not observe how the water was spilled. The QMRP also stated that prior to the May 5, 2009 incident; she had never observed or overheard the medication nurse become verbally abusive to the residents. Record review revealed Resident #1 had a behavior support plan (BSP) dated July 2008, which stated an objective to decrease incidents of making unfounded statements or false accusations to 0 incidents for six consecutive months. Further review of the BSP revealed the resident "should be closely monitored by staff to prevent her from engaging in the target behaviors.... As much as possible staff should intervene before Ms.... begins to become verbally aggressive. Staff should make efforts to address the situation or to redirect Ms.... before she escalates to verbal aggression." At the time of the investigation, there was no evidence interventions identified in the behavior support plan were implemented timely, and as written to minimize the resident behavior, which occurred during the alleged incident.	I 180	I180 Cross-reference W159	8/26/09
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS	I 401		

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I 401	Continued From page 4 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 interview and record review, the GHMRP's nursing services failed to ensure that its medication administration procedures/policy was effectively implemented for two of the five residents residing in the GHMRP. (Residents #1 and #2) The finding includes: An unusual incident report dated May 5, 2009, was received by the Health Regulation and Licensure Administration (HRLA) on May 6, 2009. The incident report revealed that the evening medication nurse threatened to slap Resident #1 when she allegedly and repeatedly " lied on him" by saying that he had spilled water on the table during the medication administration. Interview with the Qualified Mental Retardation Professional (QMRP) on May 20, 2009 at 5:05 PM revealed that Resident #1 had a behavior support plan that required one on one supervision. The review of the BSP dated July 2008 confirmed that the one on one supervision should be provided. The job description for the one on one staff revealed that Resident #1 should be supervised at arm's length. The written statement (dated May 5, 2009) of Resident #1's one on one staff, which was completed for the agency's internal investigation, was reviewed on May 20, 2009 during the	I 401	I140 Cross reference W 159	8/26/09

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I 401	<p>Continued From page 5</p> <p>Department of Health investigation. According to the statement, the one on one staff escorted Resident #1 to the nursing office to receive her medication from the evening medication nurse. The staff wrote that the nurse gave Resident #1 her medication and a cup of water while she was sitting across from Resident #2. Reportedly, during this time, Resident #2 was about to check her blood sugar.</p> <p>The statement then revealed that the cup of water was observed to have been over turned on the table, however did not identify who turned over the cup. According to this statement, the medication nurse summoned the house manager to the office to see what Resident #1 had allegedly done. He then said that Resident #1 had poured water on a napkin placed on the table for Resident #2 to use during her finger stick. The one on one's written statement indicated that Resident #1 immediately denied pouring the water on the table, told the nurse that he spilled the water, and repeatedly stated that the nurse poured the water on the napkin. The statement further indicated that the nurse then verbally threatened to smack Resident #1 if she continued to lie on him.</p> <p>The review of the " Medication Pass Protocol " revealed the following procedures should be implemented to ensure that best practice procedures are followed when administering medications to individuals.</p> <ol style="list-style-type: none"> 1. Call individuals one at a time into the nursing office for medication pass. 2. Waiting individuals are to remain in common area outside of office while medication pass is being performed. 3. The nursing office door, as well as main office 	I 401		

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I 401	Continued From page 6 door must be closed during medication pass to ensure privacy. 4. Once the individual leaves the office after completing the medication pass, the next individual can be called into the nurse ' s office for their med pass. At the time of the survey, there was no evidence the aforementioned procedures identified in the medication administration policy had been implemented as written on the day of the unusual incident.	I 401		
I 420	3521.1 HABILITATION AND TRAINING Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning. This Statute is not met as evidenced by: Based on interview and record review, the Qualified Mental Retardation Professional (QMRP) failed to ensure training to a resident to enable her to effectively cope with the demands of their environment. (Resident #1) The finding includes: The GHMRP failed to ensure that the behavior support plan (BSP) identified how the one on one supervision was to be provided to Resident #1. A site visit was made the GHMRP on May 20, 2009 at 4:45 PM to investigate an allegation of verbal abuse to Resident #1, which occurred on May 5, 2009. During the investigation, Resident #1 was observed to be supervised by the	I 420	I420 The GHMRP recognizes the need for the individual to cope with environmental demands. The GHMRP will ensure that direct care staff and individuals receive training by the Behavioral Specialist on the BSP and coping strategies set forth by BSP on 8/26/09.	8/26/09

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I 420	Continued From page 7 Qualified Mental Retardation Professional (QMRP) and a direct care staff. Interview with the QMRP on May 20, 2009 at 5:24 PM revealed Resident #1 had a behavior support plan (BSP) which included strategies to increase her level of socially appropriate behavior, and to increase her emotional stability and cooperation. Further interview with the QMRP revealed the resident had been approved by the Human Rights Committee (HRC) to be provided one on one supervision to address her maladaptive behaviors for sixteen hours a day (waking hours). On May 20, 2009 at 5:40 PM, an attempt was made by the surveyors to interview Resident #1 concerning the alleged incident of verbal abuse. The resident appeared sleepy and was slightly drooling. The QMRP verbally prompted the resident to wipe her mouth. The QMRP stated that the resident liked to play and was pretending to be sleepy. When questioned concerning the incident, the resident said that the medication nurse was going to slap her. The resident also stated, "She [the QMRP] heard it and she [Resident #2] did too." Resident #1 made no further statements, and then started a playful, irrelevant conversation. Subsequent record review on May 20, 2009 at 5:57 PM revealed Resident #1's behavior management regimen included medications (Haldol, Lorazepam, Clonazepam, Seroquel, Divalproex, and Haloperidol) to address her diagnoses of Mood Disorder (NOS) and Intermittent Explosive Disorder. The review of Resident #1's BSP, dated July 2008, on May 20, 2009 at 6:15 PM, revealed she functions in the mild range of mental retardation.	I 420	I 420 Cross reference W240	8/26/09

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I 420	Continued From page 8 The BSP revealed strategies were being implemented to do the following: (a) Reduce incidents of verbal aggression ...* (b) Reduce incidents of leaving staff supervision (eloping)... (c) Consistently take all prescribed medication... (d) Reduce incidents of property destruction... (e) Reduce incidents of agitation ...* (f) Decrease incidents of physical aggression (g) Decrease incidents of making statements or gestures indicating suicidal ideation... (h) Decrease incidents of making unfounded statements or false accusations ...* (i) Maintain at least an average rating of positive mood on the provided scale and decrease incidents of mood instability. According to the BSP, the resident may appear to be joking and being playful at time, but often this escalates to one or more of the identified behaviors of concern. The BSP recommended that Resident #1 receive one to one staff supervision. The BSP stated, "This staff person is needed for behavior support plan implementation, and to ensure the safety of Resident #1, given the high level of risks of several of her target behaviors " The review of the job description for the One to One Direct Care Staff revealed (1) Provide ongoing supervision to individuals you are assigned to. (2) Staff must be within arm's length of consumer at all times. The review of the GHMRP internal investigation report dated May 8, 2009, revealed Resident #1 " requires one on one supervision at all times. " At the time of the investigation, however the BSP failed to identify the number of hours a day the	I 420		

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I 420	Continued From page 9 resident was to be provided one on one supervision. Additionally, the BSP failed to identify the distance the staff should be from Resident #1 when providing her with one on one supervision.	I 420	1420 The administration acknowledges # 1 rights to receive one on one staff supervision as identified in her ISP The administration will ensure the review of #1 and others residents BSP to specify the number of hours per day the residents are to be provided one on one staff supervision. #1 current BSP dated 7/08 clearly identify one on one staff supervision for 16 hours per day during awaking hours (8am-4pm & 4pm-12am) Further review by the behavior specialist, MC/QA, QMRP would be completed 8/26/09 to determined that #1 BSP clearly identifies one on one staff supervision hours and staff positions to #1 and other residents (Arms length at all times)	8/26/09