

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

PRINTED: 09/28/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G139	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/14/2011
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NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6810 FIRST STREET NW WASHINGTON, DC 20011
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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 INITIAL COMMENTS W 000

A recertification survey was conducted from September 12, 2011 through September 14, 2011. A sample of two clients was selected from a population of four men with various Intellectual and developmental disabilities. This survey was initiated utilizing the fundamental survey process.

The findings of the survey were based on observations and interviews with staff, in the home and one day program, as well as a review of client and administrative records, including incident reports.

[Qualified Mental Retardation Professional (QMRP) will be referred to as Qualified Intellectual Disabilities Professional (QIDP) within this report.]

W 159 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL W 159

Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.

This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the qualified intellectual disabilities professional (QIDP) failed to coordinate, monitor, integrate each client's active treatment, for four of four residents residing in the facility. (Clients #1, #2, #3 and #4)

The findings include:

- 1. Cross refer to W189. The QIDP failed to ensure that each employee was provided with

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Department of Health
Health Regulation & Licensing Administration
Intermediate Care Facilities Division
800 North Capitol St., N.E.
Washington, D.C. 20002

1. Staff will receive continuous training on active treatment goals/ objectives for each individual. QIDP and QA Specialist will monitor performance and documentation monthly.

10/21/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Constantine D. Reese Program Director</i>	DATE 10/30/11
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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<p>W 159 Continued From page 1 initial and continued training that enabled the employee to perform his or her duties effectively, efficiently, and competently for all clients.</p> <p>2. Cross refer to W316. The QIDP failed to coordinate with Client #1's psychiatrist and psychologists to ensure that medications used to support maladaptive behaviors had been gradually withdrawn in over a year.</p> <p>W 189 483.430(e)(1) STAFF TRAINING PROGRAM</p> <p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide each employee with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently, for four of four clients residing in the facility. (Clients #1, #2, #3, and #4)</p> <p>The finding includes:</p> <p>Cross Refer to W454. The qualified intellectual disabilities professional (QIDP) failed to ensure that all current staff had received initial and continued training on infection control. Interview with QIDP on September 13, 2011, at approximately 3:50 p.m., confirmed that the August 20, 2009, infection control training was the most current training located in the training records. The QIDP also added that most of the staff from August 20, 2009, were no longer</p>	<p>W 159</p> <p>W 189</p>	<div data-bbox="829 583 1304 814" style="border: 1px solid black; padding: 5px;"> <p>2. The QIDP and Primary Care Nurse will consult with the psychiatrist and psychologist to discuss a titration plan for Client #1's psychotropic medication. Evaluation of titrations will be discussed at each quarterly psychotropic review and the psychiatrist will document minimum dose based on previous titration efforts.</p> </div> <div data-bbox="829 1287 1287 1413" style="border: 1px solid black; padding: 5px;"> <p>The primary care nurse will provide additional training on infection control. The QIDP will schedule training quarterly and QA Specialist will monitor for compliance.</p> </div>	<p>8/30/11</p> <p>10/21/11</p>

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W 189 W 262	<p>Continued From page 2 employed at this facility.</p> <p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide evidence that restrictive measures had been reviewed and/or approved by the Human Rights Committee (HRC), for one of two clients included in the sample. (Client #2)</p> <p>The findings include:</p> <p>1. The facility failed to provide evidence that its HRC reviewed, monitored and/or approved the use of adaptive equipment for Client #2.</p> <p>On September 12, 2011, at 3:25 p.m., the direct care staff was observed to assist Client #2 with ambulating throughout the facility by holding the back of the client's gait belt.</p> <p>On September 13, 2011, beginning at 3:00 p.m., review of the facility's HRC minutes from October 2010 to present failed to provide evidence that the gait belt had been reviewed and approved to ensure clients' rights were protected. Interview with the facility's qualified intellectual disabilities professional (QIDP) on the same day at approximately 3:34 p.m. revealed that she was</p>	W 189 W 262	<p>1. All individuals' adaptive equipment will be reviewed for approval by the HRC annually. QIDP and Primary Care Nurse will monitor documentation for annual approval.</p> <p>10/31/11</p>

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W 262	Continued From page 3 unsure if the HRC had reviewed and approved the equipment (gait belt). She indicated that she would have to call the main office to get clarity. On September 14, 2011, at 9:55 a.m., continued interview with the QIDP confirmed that there were no HRC minutes available that indicated that the client's gait belt had been reviewed and approved prior to its use. 2. Review of Client #2's medical chart on September 13, 2011, beginning at 9:15 a.m., revealed a physician's order (POS) dated November 26, 2010. The POS revealed an order for Ativan 3 mg, by mouth two hours, prior to CT scan of brain. Review of Client #2's medication administration record on September 13, 2011, at approximately 11:00 a.m., confirmed that the client received the aforementioned sedation. Interview with the qualified intellectual disabilities professional (QIDP) on September 13, 2011, at approximately 1:30 p.m., revealed that Client #2 received the sedation to address his non-compliance prior to the medical appointment. On September 14, 2011, at approximately 10:00 a.m., review of the facility's HRC minutes from October 2010 to present, revealed no evidence that the HRC had reviewed and or approved the use of the aforementioned sedation for Client #2. The QIDP confirmed the above findings as stated.	W 262	2. All orders of sedation will be approved by the HRC and a consent form will be signed by the individuals guardian before it is administered. Primary Care Nurse will review orders in advance and obtain consent form before medication is administered. QA Specialist will monitor for compliance.
W 316	483.450(e)(4)(ii) DRUG USAGE Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually.	W 316	Cross reference W159 (2)

9/30/11

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W 316	<p>Continued From page 4</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that medications to control maladaptive behaviors had been gradually withdrawn, for one of two clients included in the sample. (Client #1)</p> <p>The finding includes:</p> <p>On September 12, 2011, at 7:24 p.m., observations of the evening medication administration revealed Client #1 was administered Loxapine Succinate 25 mg by mouth for behaviors. A few minutes later at 7:27 p.m., interview with licensed practical nurse (LPN) confirmed that the medication was prescribed for the client's maladaptive behaviors. Review of Client #1's physician's orders dated September 2011 on September 13, 2011, at 11:43 a.m., revealed that client had a diagnosis of intermittent explosive disorder.</p> <p>On September 13, 2011, at 12:40 p.m., review of the psychotropic medication quarterly review documents dated September 1, 2011, April 1, 2011, January 19, 2011, and December 22, 2010, revealed that Client #1 had zero (0) incidents of targeted behaviors. Further review of the aforementioned reviews failed to evidence a titration plan for the psychotropic medication when the client attained the behavioral objective/goal, as evidenced below:</p> <p>Review of Client #1's behavior support plan (BSP) on September 13, 2011, at 1:53 p.m. revealed that the client had targeted behaviors of self-injurious behaviors (hitting or slapping himself) and agitation (jumping up/down</p>	W 316	<div style="border: 1px solid black; padding: 2px;">Cross reference W159 (2)</div> <div style="border: 1px solid black; padding: 2px; float: right;">8/30/11</div>

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NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5610 FIRST STREET NW WASHINGTON, DC 20011
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W 316 Continued From page 5
screaming). Further review revealed the objectives for the aforementioned behaviors stated, [the client] will decrease SIB and agitation behaviors to zero (0) per month for 6 consecutive months. It should be noted that the BSP also failed to evidence a titration plan for the reduction of Client #1's medications.

Review of the behavior data from October 2010 through August 2011 on September 14, 2011, at 10:23 a.m., revealed that Client #1 had not exhibited any targeted behaviors.

Interview with the qualified intellectual disabilities professional (QIDP) on September 14, 2011, at 10:51 a.m., confirmed that Client #1 had not exhibited any targeted behaviors since in the past ten months. Further interview revealed that there have been no discussion between the psychiatrist and psychologists regarding the reduction of Client #1's medications.

At the time of the survey, there was no documented evidence that Client #1's interdisciplinary team (IDT) had addressed a reduction in psychotropic medications as the client successfully achieved the behavior management objective.

W 316 Cross reference W159 (2) **9/30/11**

W 331 483.460(c) NURSING SERVICES

The facility must provide clients with nursing services in accordance with their needs.

This STANDARD is not met as evidenced by:
Based on observation, staff interview and record review, the facility's nursing staff failed to ensure physician orders (POS) were transcribed, for one

W 331

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W 331 Continued From page 6 of the two clients in the sample. (Client #2)

The finding includes:

Observations on September 12, 2011, at 3:30 p.m., revealed Client #2 was observed with a blue gait belt around his waist. As Client #2 ambulated throughout the facility, the direct support staff was observed to assist the client by holding onto the back of the gait belt. Interview with the direct support staff on September 12, 2011, at approximately 3:33 p.m., indicated that the client had an unsteady gait and required the use of the gait belt for additional support from staff.

Review of Client #2's medical record on September 13, 2011, at 9:15 a.m., revealed a Rheumatology consult dated September 2, 2011. The consult noted a diagnosis of Orthotitrites of the right knee with minimal pain on examination. At that time, the Rheumatologist wrote a prescription. Moments later, review of the medication administration records (MARS), revealed that the client received and order for the Voltaren 1% gel on September 8, 2011; to be administered both in the morning and the evening. Further review of the medical record revealed no evidence that the primary care physician (PCP) had counter-signed the Rheumatologist prescription or the consult sheet.

Interview with the registered nurse (RN) on September 13, 2011, at approximately 11:00 a.m., revealed that the PCP had agreed with the prescription, however failed to write or order the prescribed medication for Client #2.

W 331 The primary care nurse will review all new orders coming from outside medical specialists and will send to primary care physician for review and signature. DON will monitor medical service sheets for compliance.

10/16/11

W 441 483.470(i)(1) EVACUATION DRILLS

W 441

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<p>W 441 Continued From page 7</p> <p>The facility must hold evacuation drills under varied conditions.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and review of the fire drill records, the facility failed to conduct fire drills under varied conditions, for four of four clients residing in the facility. (Clients #1, #2, #3, and #4)</p> <p>The finding includes:</p> <p>On September 12, 2011, at approximately 12:15 p.m., the direct support staff directed the surveyor to bathroom located in the basement. There were two basement exit doors observed in the basement.</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) on September 12, 2011, at 2:46 p.m., revealed that the facility had at least four methods of egress (front door, back door, basement door #1, and basement door #2).</p> <p>Review of the facility's fire drill records on September 12, 2011, beginning at 2:48 p.m., revealed that all of the fire drills were conducted utilizing the front door and back door exits. Further review of the fire drill records revealed that basement door #1 and basement door #2 exit were not used from September 2010 to present. At 2:51 p.m., interview with the qualified intellectual disabilities professional (QIDP) revealed the laundry facilities are located in the basement and the client's actively participate in cleaning their clothes. At 3:07 p.m., the QIDP</p>	W 441	<p>Fire drills will be conducted using all exit doors and under varied conditions. Fire drills will be reviewed quarterly by QIDP and QA Specialist for usage of all exits.</p>	10/21/11

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<p>W 441 Continued From page 8 confirmed that the basement door exits were not utilized during the past year. The QIDP stated that Client #2 had a laundry goal and that other clients were capable of exiting the facility via the basement exit.</p> <p>At the time of the survey, there was no evidence on file at the time of survey to substantiate that all exits were used.</p> <p>W 454 483.470(l)(1) INFECTION CONTROL</p> <p>The facility must provide a sanitary environment to avoid sources and transmission of infections.</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to ensure sanitary conditions at all times, for four of four clients residing in the facility. (Clients #1, #2, #3, and #4)</p> <p>The finding includes:</p> <p>On September, 12, 2011, at 10:48 a.m., while using the bathroom located on the second level of the facility, brown feces was observed on the toilet handle. Further observation revealed there was dried up urine observed underneath the toilet seat. At 10:50 a.m., the house manager (HM) observed the condition of the toilet handle and toilet seat. The HM replied by saying, that this was totally unacceptable. Further interview with the HM revealed that all staff had received training on infection control. At 10:53 a.m., the HM was observed to retrieve cleaning supplies (Clorox) from the supply closet, went upstairs, and cleaned the bathroom.</p>	<p>W 441</p> <p>W 454</p>	<p>The QIDP and Residential Manager will conduct daily group home inspections and check for cleanliness and sanitation of all bathrooms. In addition, staff will receive ongoing training on infection control.</p>	<p>10/21/11</p>

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W 454	<p>Continued From page 9</p> <p>Review of the in service training records on September 13, 2011, beginning at 3:45 p.m., revealed that the last documented training in the records on infection control was dated August 20, 2009. This was confirmed through interview and record review with the qualified intellectual disabilities professional (QIDP) on September 13, 2011, at 3:50 p.m. The QIDP also added that most of the staff from August 20, 2009, were no longer employed at this facility.</p> <p>At the time of the survey, there was no evidence that the facility maintained a sanitary environment to avoid sources and transmission of infection.</p>	W 454	

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R 000 INITIAL COMMENTS

A licensure on survey was conducted from September 12, 2011 through September 14, 2011. A sample of two residents was selected from a population of four men with various intellectual and developmental disabilities.

The findings of the survey were based on observations and interviews with staff, in the home and one day program, as well as a review of client and administrative records, including incident reports.

[Qualified Mental Retardation Professional (QMRP) will be referred to as Qualified Intellectual Disabilities Professional (QIDP) within this report.]

R 000

R 125 4701.5 BACKGROUND CHECK REQUIREMENT

The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check.

This Statute is not met as evidenced by: Based on interview and review of personnel records, the group home for persons with intellectual disabilities (GHPID) failed to ensure criminal background checks were obtained for all jurisdictions in which the employees had worked or resided within the 7 years prior to the check, for two of the ten direct support staff. (Staff #2 and #4)

The findings include:

R 125

Health Regulation & Licensing Administration
Christine C. Rees - Program Director TITLE
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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R 125	<p>Continued From page 1</p> <p>1. On September 14, 2011, beginning at 2:00 p.m., review of the personnel record for Staff #2 revealed that a District of Columbia police clearance was documented. However, his application indicated that he lives in Montgomery County, Maryland within the past seven years. There was no evidence that a background check had been obtained in Maryland.</p> <p>2. On September 14, 2011, beginning at 2:00 p.m., review of the personnel record for Staff #4 revealed that a District of Columbia police clearance was documented in June 2005. However, his application indicated that he lived in Monterey, CA from June 2003 through December 2004. There was no evidence that a background check had been obtained in the state of California.</p> <p>At 3:00 p.m., the qualified intellectual disabilities professional confirmed the aforementioned findings.</p>	R 125	<p>1. Staff #2 will be requested to provide documentation of background check for Maryland.</p> <p>2. Staff #4 will be requested to provide documentation for background check for Monterey, Ca.</p>	<p>10/15/11</p> <p>10/15/11</p>
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NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5610 FIRST STREET NW WASHINGTON, DC 20011
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I 000 INITIAL COMMENTS

I 000

A licensure on survey was conducted from September 12, 2011 through September 14, 2011. A sample of two residents was selected from a population of four men with various intellectual and developmental disabilities.

The findings of the survey were based on observations and interviews with staff, in the home and one day program, as well as a review of client and administrative records, including incident reports.

[Qualified Mental Retardation Professional (QMRP) will be referred to as Qualified Intellectual Disabilities Professional (QIDP) within this report.]

I 180 3508.1 ADMINISTRATIVE SUPPORT

I 180

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 observation, interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure adequate administrative support had been provided to effectively meet the needs, for three of three residents in the sample. (Resident #2, #3 and #4)

The findings include:

1. Cross refer to W189. The QIDP failed to ensure that each employee was provided with initial and continued training that enabled the

1. Cross reference W159 (2)

10/21/11

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Constantine C. Reese - Program Director TITLE

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

(X6) DATE

9/30/11

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I 180	Continued From page 1 employee to perform his or her duties effectively, efficiently, and competently for all residents. 2. Cross refer to W316. The QIDP failed to coordinate with Resident #1's psychiatrist and psychologists to ensure that medications used to support control of maladaptive behaviors had been gradually withdrawn in over a year. 3. Cross refer to W441. The QIDP failed to ensure staff conducted fire drills under varied conditions.	I 180	2. Cross reference W159 (2) 3. Cross reference W441	9/30/11 10/21/11
I 207	3509.7 PERSONNEL POLICIES A new employee ' s physical examination shall have been performed within ninety (90) days prior to employment. This Statute is not met as evidenced by: Based on record review and interview, the group home for persons with intellectual disabilities (GHPID) failed to ensure new employee's physical examination was performed within ninety (90) days prior to employment, for one of the ten staff. (Staff #4) The finding includes: Review of the personnel records on September 13, 2011, at approximately 2:00 p.m., revealed that Staff #4 began employment with the GHPID in August 2011. Further review of the staff personnel record revealed that his PPD was completed on September 10, 2010 (eleven months) prior to employment with the GHPID. On September 13, 2011, at approximately 2:40 p.m., the qualified intellectual disabilities professional confirmed that the PPD was	I 207		

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I 207	Continued From page 2 completed more than 90 days prior to employment with the GHPID.	I 207		
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 observation, interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure a continuous, ongoing in-service training program to address the needs, for four of four residents residing in the GHPID. (Residents #1, #2, #3, and #4) The finding includes: Cross refer to Federal Deficiency Citations W189 and W454. On September, 12, 2011, at 10:48 a.m., while using the bathroom located on the second level of the GHPID, brown feces was observed on the toilet handle. Further observation revealed there was dried up urine observed underneath the toilet seat. At 10:50 a.m., the house manager (HM) observed the condition of the toilet handle and toilet seat. The HM replied by saying, that this was totally unacceptable. Further interview with the HM revealed that all staff had received training on infection control. At 10:53 a.m., the HM was observed to retrieve cleaning supplies (Clorox) from the supply closet, went upstairs, and cleaned the bathroom. Review of the in service training records on September 13, 2011, beginning at 3:45 p.m., revealed that last documented training in the records on infection control was dated August 20,	I 222	Cross reference W454	10/21/11

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I 222	Continued From page 3 2009. This was confirmed through interview and record review with the qualified Intellectual disabilities professional (QIDP) on September 13, 2011, at 3:50 p.m. The QIDP also added that most of the staff from August 20, 2009, was no longer employed at this GHPID. At the time of the survey, there was no evidence that the GHPID maintained a sanitary environment to avoid sources and transmission of infection.	I 222		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for with Intellectually Disabilities (GHPID) failed to ensure professional services were provided in accordance with the recommended needs, for one of the residents in the sample. (Resident #2) The finding includes: Observations on September 12, 2011, at 3:30 p.m., revealed Resident #2 was observed with a blue gait belt around his waist. As Resident #2 ambulated throughout the facility, the direct support staff was observed to assist the resident by holding onto the back of the gait belt. Interview with the direct support staff on September 12, 2011, at approximately 3:33 p.m.,	I 401		

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I 401	Continued From page 4 indicated that the resident had an unsteady gait and required the use of the gait belt for additional support from staff. Review of Resident #2's medical record on September 13, 2011, at 9:15 a.m., revealed a Rheumatology consult dated September 2, 2011. The consult noted a diagnosis of Orthotitrites of the right knee with minimal pain on examination. At that time, the Rheumatologist wrote a prescription. Moments later, review of the medication administration records (MARS), revealed that the resident received and order for the Voltaren 1% gel on September 8, 2011; to be administered both in the morning and the evening. Further review of the medical record revealed no evidence that the primary care physician (PCP) had counter-signed the Rheumatologist prescription or the consult sheet. Interview with the registered nurse (RN) on September 13, 2011, at approximately 11:00 a.m., revealed that the PCP had agreed with the prescription, however failed to write or order the prescribed medication for Resident #2.	I 401	Cross reference W331	10/15/11
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observations, interviews and record review, the Group Home for Persons with Intellectually Disabilities (GHPID) failed to observe and protect residents' rights in	I 500		

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I 500	<p>Continued From page 5</p> <p>accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and other District and federal laws that govern the care and rights of persons with intellectually disabilities, for two of the two residents in the sample. (Residents #1 and #2)</p> <p>The findings include:</p> <p>1. The GHPID failed to provide evidence that its HRC reviewed, monitored and/or approved the use of adaptive equipment for Resident #2.</p> <p>On September 12, 2011, at 3:25 p.m., the direct care staff was observed to assist Resident #2 with ambulating throughout the GHPID by holding the back of the resident's gait belt.</p> <p>On September 13, 2011, beginning at 3:00 p.m., review of the GHPID's HRC minutes from October 2010 to present failed to provide evidence that the gait belt had been reviewed and approved to ensure residents' rights were protected. Interview with the GHPID's qualified intellectual disabilities professional (QIDP) on the same day at approximately 3:34 p.m. revealed that she was unsure if the HRC had reviewed and approved the equipment (gait belt). She indicated that she would have to call the main office to get clarity. On September 14, 2011, at 9:55 a.m., continued interview with the QIDP confirmed that there were no HRC minutes available that indicated that the client's gait belt had been reviewed and approved prior to its use.</p> <p>2. Review of Resident #2's medical chart on September 13, 2011, beginning at 9:15 a.m., revealed a physician's order (POS) dated November 26, 2010. The POS revealed an order</p>	I 500	<p>1. Cross reference W262 (1) 10/31/11</p> <p>2. Cross reference W262 (2) 9/30/11</p>

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I 500	<p>Continued From page 6</p> <p>for Ativan 3 mg, by mouth two hours, prior to CT scan of brain. Review of Resident #2's medication administration record on September 13, 2011, at approximately 11:00 a.m., confirmed that the resident received the aforementioned sedation.</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) on September 13, 2011, at approximately 1:30 p.m., revealed that Resident #2 received the sedation to address his non-compliance prior to the medical appointment.</p> <p>On September 14, 2011, at approximately 10:00 a.m., review of the GHPID's HRC minutes from October 2010 to present, revealed no evidence that the HRC had reviewed and or approved the use of the aforementioned sedation for Resident #2. The QIDP confirmed the above findings as stated.</p>	I 500		