

RCM

REGISTRATION CONSULTANTS, INC.

Date: 10-23-07

To: Debbie Allen
Department Of Health
825 N. Capitol Street, NE
Second Floor
Washington DC. 20002

RE: Plan of action for the deficiencies at 1131-45th Place SE

Dear Mrs. Allen,

Please find attached the plan of correction for the deficiencies found at the above mentioned location following the monitoring visit conducted by the Department Of Health on September 13, 2007.

Please feel free to contact me if you have any questions or concerns.
(202) 468-0625

Sincerely,


Angèle Eyamba,
Program Director, ICF/MR



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

PRINTED: 10/11/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G085	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2007
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W 000	<p>INITIAL COMMENTS</p> <p>This recertification survey was conducted in conjunction with an investigation from September 11 through September 18, 2007. This survey was initiated as a full survey as determined by the State Agency. The facility's census was four males with varying degrees of mental retardation and psychiatric disorders. A random sample of two males was selected for the purpose of this survey.</p> <p>An incident report received by the State Agency indicated that one of the males had sustained an injury that warranted medical intervention. The incident report was dated September 9, 2007. Telephone contact was initiated by the facility to the State Agency on September 10, 2007.</p> <p>The conclusion of the investigation revealed that the facility failed to protect clients from harm. The injury was being investigated by the facility; however, there had been no immediate measures developed and implemented to ensure the protection from harm for this client or the others residing in the facility. Subsequently, "Immediate jeopardy" was determined on September 12, 2007. The jeopardy determination was removed upon the provider's immediate system changes and staff trainings implementation to protect the clients in the facility.</p> <p>Although the clients were no longer in jeopardy, condition-level deficiencies remained and preclude finding the facility in compliance with the requirements in the condition of Active Treatment, Facility Staffing, and Governing Body.</p> <p>The findings of this survey and investigation were</p>	W 000	<p>The immediate jeopardy was removed</p>	9-12-07
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE COO	(X6) DATE 10/23/07
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 000	Continued From page 1	W 000		
W 100	<p>derived from observations at the facility and two day programs, as well as interviews with clients #1 and #2, several direct care staff, and two administrators. The findings were also derived from the review of clinical and medical records, to include incident and investigative reports.</p> <p>440.150(c) ICF SERVICES OTHER THAN IN INSTITUTIONS</p> <p>"Intermediate care facility services" may include services in an institution for the mentally retarded (hereafter referred to as intermediate care facilities for persons with mental retardation) or persons with related conditions if:</p> <p>(1) The primary purpose of the institution is to provide health or rehabilitative services for mentally retarded individuals or persons with related conditions;</p> <p>(2) The institution meets the standards in Subpart E of Part 442 of this Chapter; and</p> <p>(3) The mentally retarded recipient for whom payment is requested is receiving active treatment as specified in §483.440.</p> <p>This STANDARD is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to meet the Condition of Participation in Active Treatment for two of two clients in the sample.</p> <p>The findings include:</p> <p>The facility failed to ensure that client (s) were provided continuous learning opportunities to enhance and/or maintain their present skills. [Refer to W249 and W197]</p>	W 100		
W 102	483.410 GOVERNING BODY AND	W 102	<p>The facility nurse has revised individuals' #1 & 2 self-medication assessments as well as the data sheets. Client # 1 & #2 will be punching all of their pills during the medication pass. Refer to attachment #1</p> <p>In the future the facility nurse will ensure that clients # 1 & #2 are provided with the opportunities to enhance their present skills.</p>	9-13-07

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W 102	Continued From page 2 MANAGEMENT The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: The facility's governing body failed to maintain general operating direction over the facility to ensure the provisions of health and safety, active treatment and facility staffing for the clients served [Refer W104]. The systemic effect of these practices results in the failure of the governing body to adequately manage and govern the facility and to ensure its compliance with the conditions of Client Protection [See W122]; Active Treatment [See W195]; and Facility Staffing [See W158].	W 102		
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 observations, staff interviews, and record reviews the governing body failed to ensure that the facility exercised general policy, budget, and operating direction over the facility. The findings include: 1. The governing body failed to ensure that policies/rules were established for the protection	W 104	All of the staff were inserviced on the incident reporting, and notification. All goals and objectives were revised by the Qmnp on a quarterly basis. The facility is currently fully staffed. Refer to attachment # 15 All of the facility staff were trained on client supervision, monitoring as well as on the abuse and neglect.	9-13-07 9-13-07 9-13-07

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W 104	Continued From page 4 It could not be determined that training on the disposal of medications had been conducted for the nursing staff.	W 104	The Qmrp has developed a system to secure cigarettes, matches and lighters. All the above named items are locked in the cabinets, and only staff have access to the keys. In the future the facility will ensure that immediate measures are put in place to prevent further potential abuse/neglect during the investigation. Refer to attachment #5	9-13-07
W 122	6. The facility failed to establish immediate measures to prevent further potential abuse/neglect while the internal investigation was in progress. [Refer to W155] 7. The facility failed to maintain a sufficient number of staff and trained staff to ensure that clients were monitored to prevent discovered injuries. [Refer to W192] 483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.	W 122	All staff were inserviced on incident reporting and notification. Refer to attachment # 6 All staff were trained on first aid by the lead LPN Refer to attachment #7 In the future the agency will ensure that the staff immediately report the incident to the appropriate parties.	10-12-07
W 127	This CONDITION is not met as evidenced by: Based on interviews with client #1, direct care staff, and administrator in conjunction with policy reviews and record review the facility failed to ensure that systems were designed and implemented to ensure that clients were not subjected to abuse and neglect [Refer to W127]; failed to establish and/or implement policies that ensured each clients' health and safety. [Refer to W149]; and failed to establish measures to prevent further potential abuse while the investigation was in progress. [Refer to W155]. The effects of these systemic practices resulted in the failure of the facility to protect its clients from harm and neglect while ensuring their health and safety. 483.420(a)(5) PROTECTION OF CLIENTS RIGHTS	W 127		

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W 127	<p>Continued From page 5</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that systems were developed and implemented to ensure clients were not subjected to neglect for four of the four clients that resided in the facility (Client #1, Client #2, Client #3 and Client #4); and the facility failed to ensure that staff were trained to appropriately address clients' injuries.</p> <p>The findings include:</p> <p>According to the State Agency's Intake Information document, the State Agency was contacted via telephone by client #1's Qualified Mental Retardation Professional (QMRP) on September 10, 2007. The QMRP reported that on September 9, 2007, a direct care staff discovered that client #1 had sustained a burn on his lower left forearm. How the injury occurred had not been determined at that time. An onsite investigation was conducted by the State Agency from September 12 through 18, 2007 to verify compliance with federal required conditions of participation. The investigation determined that the facility failed to protect clients from harm as evidenced by the following:</p> <p>I. Client #1 was observed on September 12, 2007 at 4:30 PM with a gauze dressing on his lower left arm. The actual injury was observed at approximately 5:30 PM during medication</p>	W 127	<p>All of the facility staff were trained on client supervision, monitoring as well as on the abuse and neglect. Refert to attachment #2 In the future the agency will ensure that the staff receive the necessary trainings that will enable them to prevent any situation that could be detrimental to the individuals' health and safety.</p> <p>All of the facility staff were trained on client supervision, monitoring as well as on the abuse and neglect. Refert to attachment #2 In the future the agency will ensure that the staff receive the necessary trainings that will enable them to prevent any situation that could be</p>	<p>9-13-07</p> <p>9-13-07</p>

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W 127	Continued From page 9 protect client #1 from harm and neglect as a result of its failure to effectively monitor the clients, failure to take immediate actions to ensure protection of all of the clients; and failure to establish and implement policies for the protection of all clients. As a result of these actions or the lack of, a determination of "Immediate Jeopardy" was made by the State Agency. The Chief Operating Officer for the facility was notified of the "Immediate Jeopardy" status on September 13, 2007 at 2:30 PM.	W 127	All staff were inserviced on the smoking protocol The Qmnp has developed a system to secure cigarettes, matches and lighters. All the above named items are locked in the cabinets, and only staff have access to the keys. In the future the facility will ensure that immediate measures are put in place to prevent further potential abuse/neglect during the investigation. Refer to attachment #5 In the future, the facility will ensure that the staff implement the smoking protocol to prevent future future individuals's injuries or arm.	9-13-07 9-13-07	
W 130	The immediate jeopardy determination was removed upon the provide's immediate systems and staff training was implemented to protect the clients in the facility. Although, the facility made significant improvements in the area of clients' protection a Condition Level deficiency remained. 483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure that clients #1, #2, #3, and #4 were provided privacy during their medication administration. The finding includes: An observation of the facility's medication administration was conducted on September 12, 2007 at approximately 5:30 PM. The clients were called to the designated area (the kitchen) one by one. The area was opened to viewers from the living room and the dining room. The	W 130	It is the policy of this agency that privacy be respected during the medication pass. All agency's nurses were trained on the best practices by the RN, including privacy during medication pass. Refer to attachment #4 In the future the agency nursing department will ensure that privacy is respected during the medication pass. Currently there is a designated medication pass area in the house.	10-16-07 10-12-07	

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W 130	Continued From page 10 medication administration was not conducted as a private matter.	W 130		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on the review of incident reports, interview with the Qualified Mental Retardation Professional (QMRP), and review of the facility's policy, the facility failed to implement policies that ensured the continuous protection from harm and neglect of 4 of the 4 clients who reside in the facility (#1, #2, #3, #4). The findings include: 1. It could not be determined that the facility had established comprehensive policies regarding smoking and the use of lighters, matches, etc to aid in the protection of the clients and/or to teach clients the use and dangers of these items. A. Client #1 was interviewed at his day placement on September 13, 2007 at 12:55 PM. The client confirmed that he smoked and burned his arm using the stove to light his cigarette. He further stated that he used "something and patted his arm and the fire fell on the floor." He reportedly retrieved the cigarette and went outside to smoke it. Client #1 stated that he had been caught "long time ago" trying to smoke in the bathroom.	W 149	Refer to W 127 (1,2,3,4,) PP. 7 & 8 Refer to attachment #5 The Qmrp has developed a system to secure cigarettes, matches and lighters. All the above named items are locked in the cabinets, and only staff have access to the keys. In the future the facility wil ensure that immediate measures are put in place to prevent further potential abuse/neglect during the investigation. Refer to attachment #5	9-13-07 9-13-07

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W 149	<p>Continued From page 11</p> <p>B. A staff interview (#4) was conducted on September 13, 2007 at 5:15 PM. This interview revealed that on September 9, 2007, after the discovery of client #1's burn, another staff (#1) retrieved a pack of cigarettes from client #4 and a lighter from client #1. According to Staff (4) these items were not provided to the clients by staff members. Staff (#1) was interviewed on September 14, 2007 at 12:30 PM and stated that client #4 had the cigarettes and the lighter on the afternoon of September 9, 2007.</p> <p>C. An environmental inspection was conducted on September 17, 2007 at 10:30 AM along with the House Manager. It was observed that near client #1's bed there were six cigarette burns on the carpet. The House Manager also confirmed that these were carpet burns from cigarettes.</p> <p>It could not be determined that the facility had developed a comprehensive policy to address smoking and the use of devices to light cigarettes.</p> <p>II. The facility failed to establish guidelines to ensure effective monitoring of clients in the facility.</p> <p>Interview with client #1 was conducted on September 13, 2007 at 12:55 PM at his/her day program. The client admitted that he burned his arm using the stove to light his cigarette.</p> <p>Staff (#1) indicated in the incident report that the injury was discovered. The QMRP was interviewed regarding the level of monitoring needed for client #1. He stated that client #1 "doesn't require 24 hour supervision; however, the staff is with him when he smokes". During the</p>	W 149	<p>The Qmrp has developed a system to secure cigarettes, matches and lighters. All the above named items are locked in the cabinets, and only staff have access to the keys. In the future the facility will ensure that immediate measures are put in place to prevent further potential abuse/neglect during the investigation. Refer toa attachment #5</p> <p>The carpet was replaced on</p> <p>Refer to W 127 P. 7 & 8</p> <p>Refer to W 104 (1) P. 3</p> <p>Individual #1 is in a facility that requires 24 hours supervision. All staff were trained on the individual supervision and monitoring, Refer to attachment #2 In the future the agency will ensure that the supervise the individuals during the shift</p>	<p>9-13-07</p> <p>10-19-07</p> <p>9-13-07</p> <p>9-13-07</p> <p>9-13-07</p>

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W 149	Continued From page 12 interview, the QMRP reviewed the behavioral support plan. He stated that he was reviewing the plan to verify what level of monitoring may have been identified by the psychologist. The level of monitoring was not identified. Staff (#4) was interviewed on September 13, 2007, at 5:15 PM and indicated that client #1 should have been monitored at all times but the client "is able to sit out back alone but staff is with him most times". Review of the training record failed to identify that staff had received training on the monitoring support for clients in the facility. III. The facility failed to establish policies to ensure prompt and timely reporting of incidents and injuries to prevent neglect and to promote safety. A. On September 14, 2007 at 12:30 PM, Direct Care Staff (#1) was interviewed to ascertain how incidents were reported. The staff revealed that incidents were reported via telephone to the House Manager, incident reports were written and injuries reported to the nurse. The staff recalled that on September 9, 2007, after discovering the client with the burn, left a voice message with the House Manager at 11:00 or 11:30 AM. The House Manager returned the staff's call at 12 Noon. At that time, the House Manager reportedly instructed the staff to contact the Qualified Mental Retardation Professional (QMRP). The staff reportedly called the the QMRP at approximately 1:00 PM and informed her of the incident. According to the staff, the QMRP asked staff #1 about completing the incident report. The report was noted to have been written at 4:30 PM. B. The incident report reflected that client #1's	W 149	Refer to W 104 (1) P.3 Refer to attachment # 2 Refer to W 104 (6) P. 5 Refer to attachment # 6 Refer to W 104 (1) P. 3 Refer to attachment # 2	9-13-07 9-13-07 9-13-07	

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W 149	<p>Continued From page 13</p> <p>burn injury was discovered by direct care staff at 11:00 AM. The incident report reflected that the nurse was notified at 5:00 PM, six hours after the incident was discovered. Interview with the lead LPN, conducted on September 13, 2007 at 5:30 PM, revealed that the medication nurse was in the facility to administer medications to client #1 at 12 noon. The Medication Administration Records documented that the medications were given to client #1 at 12:00 noon; however, there was no mention of treatment for the client's injury. According to the staff (#1), she was busy and "forgot" to inform the nurse at 12 Noon; therefore, the injury went unnoticed by the nurse.</p> <p>IV. The facility's incident management policy referenced words such as "prompt," "timely," and "as required" without including any specific timeframe. The policy also failed to include who should be contacted.</p> <p>Review of the facilities incident reporting policy conducted on September 12 and 13, 2007 revealed the following:</p> <p>The facility must "ensure prompt staff response and intervention; ensure prompt medical treatment and contact with community support personnel; and ensure timely and accurate notification of appropriate staff, families and agency officials."</p> <p>The policy defined a reportable incident as "a significant event or situation involving a customer that shall be reported to designated authorities within a provider agency for review and internal investigation. All Customer incidents described in this policy are Reportable Incidents." The policy also stated that "any person subject to the scope</p>	W 149	<p>Refer to W 104 (2) P. 4 Also refer to W 104 (7) P.5</p> <p>Refer to W 104 (7) P.5</p>	<p>9-13-07 10-12-07</p> <p>9-13-07</p>

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W 149	Continued From page 14 of this policy who fails to report an incident as required, gives false, misleading, or incomplete information, or otherwise does not participate in the incident management process as outlined in this policy shall be subject to disciplinary measures which may include termination of employment and, where appropriate, civil action or criminal prosecution."	W 149	All staff were inserviced on incident reporting and notification. Refer to attachment # 6 All staff were trained on first aid by the lead LPN Refer to attachment #7 In the future the agency will ensure that the staff immediately report the incident to the appropriate parties.	10-12-07
W 155	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must prevent further potential abuse while the investigation is in progress. This STANDARD is not met as evidenced by: Based on interview with the Qualified Mental Retardation Professional (QMRP) the facility failed to establish immediate measures to prevent further potential abuse/neglect while the internal investigation was in progress for four of four clients in the facility. The finding includes: According to a State Agency Intake Information document, the facility's Qualified Mental Retardation Professional (QMRP) contacted the State Agency via telephone on September 10, 2007. The QMRP reported that on September 9, 2007, that a direct care staff discovered that client #1 had a burn on his lower left forearm. This injury was sustained by the client was attempting to light his cigarette on the kitchen stove. An interview was conducted with the QMRP on September 13, 2007 at 12:55 PM. He stated that "nothing" had been developed or implemented since the incident on September 9, 2007. The	W 155	The Qmrp has developed a system to secure cigarettes, matches and lighters. All the above named items are locked in the cabinets, and only staff have access to the keys. In the future the facility will ensure that immediate measures are put in place to prevent further potential abuse/neglect during the investigation. Refer to attachment #5	9-13-07

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W 155	Continued From page 15 QMRP stated that measures would be taken pending the outcome of the internal investigation. He stated that client #1 had been informed that he should "inform staff when something happens." [Also See W127] It was also shared through this interview that one other client in the facility also smokes.	W 155	Refer to W 149 (cII) P.12	9-13-07	
W 158	483.430 FACILITY STAFFING The facility must ensure that specific facility staffing requirements are met. This CONDITION is not met as evidenced by: Based on Client interviews (#1 and #2), direct care staff interviews at two day program facilities and the facility, and record review, the Qualified Mental Retardation Professional (QMRP) failed to ensure that each client's active treatment program was integrated, coordinated and monitored [Refer to W159]; failed to ensure that staff demonstrated effective training on appropriately implementing active treatment programs [Refer to W189]; failed to maintain a sufficient number of trained staff to ensure that clients were monitored to prevent injuries [Refer to W186]; and failed to effectively train staff to detect the need to administer first aid [Refer to W192]. The effects of these systemic practices results in the failure of the facility to ensure the availability of adequately trained staff to ensure its clients' safety and provide active treatment.	W 158	All staff were trained on the program documentation. Refer to attachment #15 The lead LPN has trained the staff on the first aid. Refer to attachment # 7 The house is currently on ratio Refer to attachment # 14	9-20-07 10-12-07 9-13-07	

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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 with the Qualified Mental Retardation Professional (QMRP), the facility failed to ensure the protection of clients and to coordinate services as identified through the individual support plan and demonstrated abilities.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. [Cross Refer W127] The investigative findings identified that the QMRP failed to establish immediate systems to provide protection to all clients. 2. Review of client #2's clinical records to include monthly notes and quarterly reviews revealed that the QMRP failed to ensure that clients' programs were implemented and documented as identified by the objectives. <ol style="list-style-type: none"> a) Review of client #2's Individual Program Plan (IPP) was conducted on September 17, 2007 at 3:50 PM. According to client #2's IPP dated January 2007, the client had a program to write his address 7/8 consecutive trials with verbal prompting. The client's quarterly report for the period of March through June 2007 reflected that the client had mastered the objective as written and that revisions would be made. The following months data sheets stated "revised". The revision could not be determined and there was 	W 159	<p>Refer to W 127 P. 7</p> <p>All goals were revised on a quarterly basis Refer to attachment # 8, 9, &10</p>	9-13-07	

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W 186	<p>Continued From page 19</p> <p>facility failed to maintain a sufficient number of staff and trained staff to ensure that clients were monitored to prevent discovered injuries.</p> <p>The findings include:</p> <p>According to the State Agency's Intake Information document, the State Agency was contacted via telephone by client #1's Qualified Mental Retardation Professional (QMRP) on September 10, 2007. The QMRP reported that on September 9, 2007, a direct care staff discovered that client #1 had sustained a burn on his lower left forearm. How the injury occurred had not been determined at that time.</p> <p>On September 12, 2007, the surveyor requested that the client demonstrate what happened to his arm. Client #1 stated that he retrieved a cigarette from the cabinet above the stove and turned the stove on. He simulated how he got the light from the stove, and how the fire fell on his arm. Client #1 stated that he was unaware of where the staff was at that time. He identified by name staff members (2) who were allegedly on duty at the time of the incident. Through further questioning, it could not be determined conclusively that client #1 was sure of the timing of the incident or which staff may have been present.</p> <p>According to the written staffing schedule presented to the surveyor on September 13, 2007, the staff members and their designated shifts were identified. The schedule reflected one staff on duty between 11:00 PM and 7:00 AM, and three staff between 3:00 PM and 11:00 PM (including a one to one for client #2) during weekday evenings. The weekend schedule reflected that there were two staff assigned</p>	W 186	Refer to W 104 (1) P 3	9-13-07	

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W 186	Continued From page 20 throughout all shifts with the exception of the overnight when there was one staff in the facility. The State Agency investigation concluded that the discovered injury likely occurred between 11:00 PM on September 8, 2007 and 11:00 AM on September 9, 2007. For the incident to have been discovered, the staff neglected to provide sufficient monitoring of client #1 to protect him from harm.	W 186	Refer to W 102 (1) P.3	9-13-07	
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on review of the training record, the facility failed to provide documented evidence of staff training to ensure competency in performing their job duties. The finding includes: 1. The facility failed to provide effect training in incident reporting. [Refer to W127] 2. The facility failed to establish and train staff on a smoking protocol. [Refer to W149] 3. The facility failed to provide effective staff training on client monitoring and supervision. [Refer to 127, W149] 4. The facility failed to training nursing staff on medication disposal. [Refer to W104]	W 189	Refer to W 104 (6) P.5 Refer to W 127 (II) P.7 Refer to W 127 P. 10 Also refer to 149 P. 13 Refer W 104 (5) P. 4	9-13-07 9-13-07 9-13-07 9-13-07 9-13-07	

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W 189	Continued From page 21 5. Client #2 had an objective to independently prepare a grocery list in association with his diet on 4/5 trials. The QMRP notes including a quarterly report reflected that client #2 performed with verbal prompting from March 2007 to July 2007 at 100%. Interview with staff on September 17, 2007 at approximately 4:10 PM, revealed that client #2's performance in this objective had been independent following an introduction to initiate the task. The QMRP failed to ensure that staff were trained to recognize the appropriate level of documentation to complete for each client's programs to ensure the accuracy in documentation.	W 189	Staff have been trained on program documentation Refer to attachment #15 In the future the Qmnp will ensure the individual level of performance reflects on the data collection to ensure accuracy.	10-20-07
W 192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to effectively train staff to detect the need to administer first aid to one of four clients in the facility. (Clients #1) The finding includes: Review of the unusual incident report revealed that the client's burn injury was reported on September 9, 2007 at 4:30 PM. The injury was discovered however, at 11:00 AM on September 9, 2007. According to the contact information recorded on the incident report, the nurse was	W 192		

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W 192	Continued From page 22 notified of the client's injury at 5:00 PM (6 hours after the incident). At 6:20 PM the medication LPN documented that the direct care staff had informed him of client #1's injury and the LPN at that time provided treatment. The medication nurse contacted the lead LPN and the Primary Care Physician (PCP). On the next day, September 10, 2007, the client was seen by the PCP and determined to have a "left forearm injury 1x3 cm due to burn." There was no documentation to reflect that first aid had been provided to client #1 by the staff who discovered the injury. On September 17, 2007 at 12:30 PM, an interview was conducted with the staff who discovered the injury. The staff confirmed that first aid was not administered. The staff stated that she recently received her license to practice nursing (LPN); however, she stated that her position at the facility was direct care staff. The staff did not have her first aid card with her at the time of the interview.	W 192		
W 195	483.440 ACTIVE TREATMENT SERVICES The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to provide clients' with continuous active treatment [Refer to W197 and 249]; acility failed to ensure that self medicaton assessments were conducted; [Refer to W214] and failed to revise programs/objectives as needed [Refer to W257]. The cumulative effect of these systemic	W 195	Refer to W 104 (7) P.5 The goals and objectives were revised by the Qmnp on a quarterly basis. The self medication assessments were revised by the LPN to reflect the individuals' level of performance	10-12-07 9-13-07

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W 195	Continued From page 23 practices results in the failure of the facility to deliver statutorily mandated active treatment to its clients.	W 195		
W 197	483.440(e)(2) ACTIVE TREATMENT Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program. This STANDARD is not met as evidenced by: Based on interview with staff and records reviewed, the facility failed to ensure that clients who demonstrated a cognitive and adaptive level of independence and do not required the comprehensive services of an intermediate care facility are placed in lesser restrictive environments for two of two clients in the sample. The findings include: 1. According to the psychology assessment dated August 30, 2006, client #1 "evidences the capacity to provide informed consent regarding decisions on his behalf in medical care, other treatment; habilitation/residential placement, life planning and general financial matters". He demonstrates the capacity to grant, refuse, or withdraw consent to any ongoing medical treatment and has the ability to execute a durable power of attorney. At reviews of his response to psychotropic support he made relevant inquiry of the protocols." Client #1 was diagnosed with mild mental retardation. The assessment reflected that client #1's adaptive skills were recorded to be as follows: Communications 6	W 197	Refer to W 104 (4) P.4	Pending

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W 197	<p>Continued From page 24</p> <p>years; dally living 7 years, and 4 months; and socialization 6 years, 11 months. Client #1 had a psychiatric diagnosis of schizophrenia; however, it could not be determined by the review of records that the client's psychiatric related behaviors interfered with the overall consistency in his independent performance.</p> <p>During observation at client #1's day program on October 13, 2007, the client was demonstrating his ability to complete mathametic problems (addition). The instructor was interviewed and stated that client #1's was 71 years of age and required programs geared towards seniors. Program opportunities would be offered and the client may select from those choices. Reportedly, client #1 goes on community outings frequently, eats independently, and attends to his personal needs independently.</p> <p>Client #1 was interviewed at his day program on September 13, 2007. He stated that he did math, cleaned tables and sweeps. He was able to recall his friends, to tell how much money he had on him, to express his desire to read more, to dress himself, and to make his breakfast drink. Client #1 further stated that staff (naming specific staff) gave him showers and washed his hair, but he independently dressed. He further stated that he was on a smoking schedule and was able to identify the four times of the day that smoking was allowed.</p> <p>Interview with staff revealed that client #1 would sit in the back yard without the staff direct supervision.</p> <p>According to interview with the Administrator that was conducted on September 17, 2007 at 1:30</p>	W 197	<p>Refer to W 104 (4) P. 4</p> <p>Refer to W 104 (4) P. 4</p>	<p>Pending</p> <p>Pending</p>

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W 197	<p>Continued From page 25</p> <p>PM, efforts to seek other funding sources for client #1 had been attempted. The Administrator agreed that client #1 was at a level of independence and did not require the comprehensive program or supervision as provided by an intermediate care facility.</p> <p>2. An interview with client #2 was conducted on September 17, 2007 at 11:00 AM. The client revealed that he independently showers, dressed and selected his clothing. He ambulates and eats meals independently. He stated that he made his bed and took out trash. He goes to the bank every Friday and may go to the movies. The client was able to recall the colors of his medications, the form (pills and liquid), and recall the purpose of his medication in general terms (i.e. "behavior to calm me down").</p> <p>According to direct care staff interview conducted on September 17, 2007 at 11:30 AM, client #2 demonstrated a number of independent skills. Interview confirmed that client #2 performed independently in selecting his clothing, dressing, ambulating, and eating. It was identified that he completes assigned chores with "little assistance". Reportedly, client #2 recognizes danger and was capable of contacting 911 for emergencies and convey the needed information.</p> <p>Client #2's Individual support plan that was reviewed on September 18, 2007 at 9:30 AM revealed that client #2 cursive writes and can write his name and address. The functional assessment indicated that client #2 revealed that client was independent in social graces, counting up to 500, and identifying bills.</p>	W 197	<p>Refer to W 104 (4) P. 4</p> <p>Refer to W 104 (4) P. 4</p> <p>Refer to W 104 (4) P. 4</p>	<p>Pending</p> <p>Pending</p> <p>Pending</p>
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN	W 214		

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W 214	Continued From page 26 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 and review of medical records, the facility failed to ensure that self medication assessments were conducted for one of two clients in the sample. [Client #1] The finding includes: On September 12, 2007, client #1 was observed being verbally prompted to prepare for medication administration. The staff physical assisted the client to punch out the his medications, and the client took his medications (Zyprexa 10 mg and Carbamazepide 200mg) independently. Review of records failed to show evidence that client #1 self medication skills had been assessed.	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 interviews and record review, the facility failed to ensure that clients were provided the opportunities for continuous active treatment in accordance with the individual	W 249	Refer to W 100 P.2 Refer to W 100 P.2	9-13-07 9-13-07

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W 249	<p>Continued From page 27</p> <p>program plans (IPPs) and demonstrated needs for clients #1 and #2 .</p> <p>The findings include:</p> <p>1. During the medication administration observed on September 12, 2007, client #1 administered Zyprexa 10 mg and Carbamazepine 200mg. Client #1 had been encourage with verbal prompting to prepare for taking his medications. With verbal prompting and physical assistance client #1 was allowed to only punch out one of the medications.</p> <p>The nurse failed to allow the client to punch out the second medication that would subsequently encourage consistent performance at every available opportunity.</p> <p>Client #1 demonstrated the ability to identify the date that he was taking the medication. Interview with client #1 on September 13, 2007 at 10:30 AM revealed that client #1 could state the purpose of his medications, however, this was not demonstrated during the medication pass.</p> <p>It could not be determined that client #1 had been encouraged to exercise as much independence as possible in participating in his self medication program and maintaining his current skills.</p> <p>2. Clients #1 and #2 were interviewed on September 17, 2007 at 10:30 AM and 9:30 AM respectively. Both clients indicated that they participated in their finances by going to the bank with staff on Fridays. Both Clients (#1 and #2) were observed leaving the facility on Friday, September 14, 2007 to go the bank. Upon their return the Clients indicated that they had money.</p>	W 249	<p>Refer to W 100 P.2</p> <p>Also refer to W 249 P. 27</p>	<p>9-13-07</p> <p>9-13-07</p>

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W 249	Continued From page 28 During the clients' interview they both indicated that they signed their names for the bank transaction, but did not go into the bank. They stated that the staff went into the back for them. Client #1 further stated that sometimes he would wait in the van until the staff returns from the bank to sign the slip. Client #1 was able to communicate the banking process for withdrawing funds. Both clients had individual program plans programs (IPP) to handle their .	W 249	The staff were trained on how to challenge the individuals on their financial management. Refer to attachment # 16	9-20-07
W 257	Clients #1 and #2 were assessment for handing personal finances had been conducted, and an IPP was developed in September 2006. It could not be determined, however, how clients were to be challenged in their opportunities to engage in their financial management. It also could not be determined how clients were given consistent opportunities to maintain current skills. 483.440(f)(1)(iii) PROGRAM MONITORING & CHANGE The Individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is falling to progress toward identified objectives after reasonable efforts have been made. This STANDARD is not met as evidenced by: Based on record review, the facility failed to ensure that revisions were considered when clients' demonstrated a lack of achievement in attaining the established criterion level (s) . The finding include: On September 17, 2007 at 3:50 PM, QMRP's	W 257	Both individuals have money management goals Refer to attachment # 10	

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W 257	<p>Continued From page 29</p> <p>notes and the IPP for Client #2 were reviewed. Although, the criterion levels for the Client's programs had not been met, the QMRP failed to revised or document justification for continuing the programs.</p> <p>1. Client #2 had an objective to independently prepare a grocery list in association with his diet on 4/5 trials. The QMRP's notes, including a quarterly report, reflected that client #2 performed with verbal prompting from March 2007 to July 2007.</p> <p>2. Client #2's IPP dated January 2006, revealed an IPP objective that the "[client] will independently learn the main street name in his neighborhood on 4/5 consecutive trials". Review of the monthly documentation revealed that the client maintained this skill at the verbal prompting level from March 2007 through August 2007. There was no evidence that revisions had been considered.</p>	W 257	<p>Refer to W 189 P. 22</p> <p>Criteria is not met yet. Objective will be revised once the individual meets the criteria.</p>	
W 331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review the nursing staff failed to recognize and provide services to a client who had sustained an injury.</p> <p>The finding includes:</p> <p>The incident report dated September 9, 2007 (Sunday) reflected that the injury on client #1 was discovered at 11:00 AM. The incident report reflected that the nurse was notified at 5:00 PM.</p>	W 331	<p>Refer to w 104 (2) P.4</p>	9-13-07

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W 331	Continued From page 30 According to interview with the lead LPN, conducted on September 13, 2007 at 5:30 PM, client #1 received medications at 12 Noon on weekends. The nurse documented that the medications were administered; however, there was no mention of treatment for the client's injury. According to the staff who discovered the injury, she forgot to tell the nurse at 12 Noon. There was no evidence that measures had been established to encourage the nursing staff to conduct a brief overview of clients visible areas to identify any unusual changes or injuries when in contact with the client. It could not be determined that the needs of client #1 had been addressed promptly.	W 331	Refer to w 104 (2) P.4	9-13-07
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on review the review of records, the facility failed to provide documented evidence of evacuation drills being conducted at least quarterly for each shift of personnel. The finding includes: During the review of the evacuation log, it was identified that the facility failed to provide evidence that fire drills were conducted during the second shift between 2:00 PM and 10:00 PM. The log was reviewed for the period of November 2006 through August 2007.	W 440	All staff were inserviced on the fire drills schedule Refer to attachment 17	10-05-07
W 443	483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with evacuation drills, including accidents.	W 448		

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W 448	Continued From page 31 This STANDARD is not met as evidenced by: Based on review of records, the facility failed to investigate all problems with evacuation drills, including accidents. The findings include: During the review of the fire drill records on September 14, 2007, it was discovered that "problem" areas identified during evacuation by the direct care staff had not been addressed by the management staff. August 16, 2007's drill revealed "guys need to be alert when the evacuation drill is complete; [client #2] agltated." June 1, 2007's drill report identified no signature of staff, or time in relations to AM and PM. March 18, 2007's fire drill report reflected that there were six consumers and one staff. The drills was noted to have taken place at 12:00 AM. It was documented that two clients refused to move from their bedrooms. One staff is scheduled during the overnight. March 15, 2007 at 12:00 AM, a drill was documented. During the drill, six clients and one staff were documented as present. All bedroom being used currently are on the second floor. The drill report reflected that the clients exited the back door exit which was identified by one of the staff during the survey as the door leading from the dining room. The clients were in bed on the second floor.	W 448	All staff were inserviced on how to complete the drill report including the signature Currently the house in on ratio; There is one staff for four individuals in the house during the night shift. Currently the house in on ratio; There is one staff for four individuals in the house during the night shift.	10-05-07 9-15-07 9-15-07
W 449	483.470(i)(2)(iv) EVACUATION DRILLS	W 449		

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W 449	Continued From page 32 The facility must investigate all problems with evacuation drills and take corrective action. This STANDARD is not met as evidenced by. Based on review records, the facility failed to investigate all problems with evacuation drills, including accidents. The findings include: During the review of the fire drill records on September 14, 2007, it was discovered that "problem" areas identified during evacuation by the direct care staff had not been addressed by the management staff. August 16, 2007's drill revealed "guys need to be alert when the evacuation drill is complete; (client #2) agitated." June 1, 2007's drill report identified no signature of staff, or time in relations to AM and PM. March 18, 2007's fire drill report reflected that there were six consumers and one staff. The drills was noted to have taken place at 12:00 AM. It was documented that two clients refused to move from their bedrooms. One staff is scheduled during the overnight. March 15, 2007 at 12:00 AM, a drill was documented. During the drill, six clients and one staff were documented as present. All bedroom being used currently are on the second floor. The drill report reflected that the clients exited the back door exit which was identified by one of the staff during the survey as the door leading from	W 449	The Qmnp and house manager did address the i importance of the drill with client #2 All staff were inserviced on how to complete the drill report including the signature Currently the house in on ratio; There is one staff for four individuals in the house during the night shift.	10-05-07 10-05-07 9-15-07	

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W 449	<p>Continued From page 33</p> <p>the dining room. The clients were in bed on the second floor.</p> <p>At the time of the survey, it could not be determined that a corrective action plan had been established.</p>	W 449		

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000	INITIAL COMMENTS This licensure survey was conducted in conjunction with an investigation from September 11 through September 18, 2007. The facility's consensus was four males with varying degrees of mental retardation and psychiatric disorders. A random sample of two males was selected for the purpose of this survey. An incident report received by the State Agency indicated that one of the males had sustained an injury that warranted medical intervention. The incident report was dated September 9, 2007. Telephone contact was initiated by the facility to the State Agency on September 10, 2007. The conclusion of the investigation revealed that the facility failed to protect clients from harm. The injury was being investigated by the facility; however, there had been no immediate measures developed and implemented to ensure the protection from harm for this client or the others residing in the facility. The findings of this survey and investigation were derived from observations at the facility and two day programs, as well as interviews with clients #1 and #2, several direct care staff, two administrators. The findings were also derived from the review of clinical and medical records, to include incident and investigative reports.	1000		
002	3500.2 GENERAL PROVISIONS Each GHMRP licensee and residence director shall demonstrate that he or she understands that the provisions of D.C. Law 2-137, D.C. Code, Title 6, Chapter 19 govern the care and rights of mentally retarded persons in addition to this chapter.	1002		

Health Regulation Administration

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

STATE FORM

6800

HZBJ11

TITLE

(X5) DATE

10/23/07

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1002	Continued From page 1 This Statute is not met as evidenced by: Based on interview with the facility failed to ensure that the GHMRP licensee and residence director demonstrated that he or she understands the provisions of D.C. Law 2-137, D.C. Code, Title 6, Chapter 19 govern the care and rights of mentally retarded persons. The finding includes: I. The facility failed to demonstrate protection of clients' rights to be free of mistreatment, neglect or abuse. (2-137-6-1970) B. According to the State Agency's Intake Information document, the State Agency was contacted via telephone by client #1's Qualified Mental Retardation Professional (QMRP) on September 10, 2007: The QMRP reported that on September 9, 2007, a direct care staff discovered that client #1 had sustained a burn on his lower left forearm. How the injury occurred had not been determined. An onsite investigation was conducted by the State Agency from September 12 through 14 and September 17 and 18, 2007. This investigation was conducted to verify compliance with 42 CFR Part 489.3 and 42 CFR Part 488.301 of the Federal Regulations. B. Client #1 was observed on September 12, 2007 at 4:30 PM with a gauze dressing on his lower left arm. The actual injury was observed at approximately 5:30 PM during medication administration and treatments. The injury had the appearance of a burn with a layer of skin removed.	1002	All of the facility staff were trained on client supervision, monitoring as well as on the abuse and neglect. Refer to attachment #2 In the future the agency will ensure that the staff receive the necessary trainings that will enable them to prevent any situation that could be detrimental to the individuals' health and safety	9-13-07

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1002	Continued From page 5 first aid had been provided to client #1 by the staff who discovered the injury. Through an interview conducted on September 17, 2007 at 12:30 PM, with the staff who discovered the injury, it was confirmed that first aid was not administered. It should be further mentioned that this employee stated that she had recently received her license practical nursing license; however, her position at the facility was direct care staff. The employee did not have her first aid card with her at the time of the interview. The State Agency determined that the QMRP, the Administration, and the facility's staff failed to protect client #1 from harm and neglect as a result of its failure to effectively monitor the clients, failure to take immediate actions to ensure protect of all of the clients; and failure to establish and implement policies for the protect of all clients. The Chief Operating Officer for the facility was notified of the determination of "Immediate Jeopardy" as identified by federal regulation September 13, 2007 at 2:30 PM.	1002	Refer to W 104 (7) P. 5 Refer to W 104 (1) P. 3 Refer to W 104 (6,7) P.5 Refer to W 27 P.7	10-12-07 9-13-07 9-13-07 9-13-07
1090	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 an environmental inspection conducted on September 14, 2007 at 2:25 PM, the facility failed to ensure that the interior and exterior of the GHMRP had been maintained in a safe,	1090		

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1090	Continued From page 6 clean, orderly, attractive, sanitary condition. The findings include: 1. During the environmental inspection conducted on September 17, 2007, the carpet in client #1's bedroom had six cigarette burns showing. 2. The refrigerator rubber gasket was loose around the door seal that could potentially cause temperature changes to the stored foods. 3. The back porch had unattractive, discolored and peeling wood on the rails and the porch. 4. The carpet in the hall on the second floor in front of the bathroom was torn and could cause a potentially trip hazard.	1090	The carpet was replaced on _____ In the future the facility will ensure that the carpet is maintained in a good condition. A new refrigerator has been ordered, and will be delivered by _____ In the future the facility will ensure that the refrigerator is kept in a good condition. The peeling wood on the back porch has been repaired. The carpet on the second floor of the front bathroom has been repaired.	10-19-07 10-31-07 10-23-07 10-17-07
1160	3507.1 POLICIES AND PROCEDURES Each GHMRP shall have on site a written manual describing the policies and procedures it will follow which shall be as detailed as is necessary to meet the needs of each resident served and provide guidance to each staff member. This Statute is not met as evidenced by: Based on the review of incident reports, interview with the Qualified Mental Retardation Professional (QMRP), and review of the facility's policy, the facility failed to implement policies that ensured the continuous protection from harm and neglect of 4 of the 4 clients who reside in the facility (#1, #2, #3, #4). The findings include: 1. It could not be determined that the facility had established comprehensive policies regarding	1160		

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I 160	Continued From page 7 smoking and the use of lighters, matches, etc to aid in the protection of the clients and/or to teach clients the use and dangers of these items. A. Client #1 was interviewed at his day placement on September 13, 2007 at 12:55 PM. The client confirmed that he smoked and burned his arm using the stove to light his cigarette. He further stated that he used "something and patted his arm and the fire fell on the floor." He reportedly retrieved the cigarette and went outside to smoke it. Client #1 stated that he had been caught "long time ago" trying to smoke in the bathroom. B. A staff interview (#4) was conducted on September 13, 2007 at 5:15 PM. This interview revealed that on September 9, 2007, after the discovery of client #1's burn, another staff (#1) retrieved a pack of cigarettes from client #4 and a lighter from client #1. According to Staff (4) these items were not provided to the clients by staff members. Staff (#1) was interviewed on September 14, 2007 at 12:30 PM and stated that client #4 had the cigarettes and the lighter on the afternoon of September 9, 2007. C. An environmental inspection was conducted on September 17, 2007 at 10:30 AM along with the House Manager. It was observed that near client #1's bed there were six cigarette burns on the carpet. The House Manager also confirmed that these were carpet burns from cigarettes. It could not be determined that the facility had developed a comprehensive policy to address smoking and the use of devices to light cigarettes.	I 160	Refer to W. 104 P. 7 Refer to W 104 (1) P. 3 Refer to W 127 P. 8 Refer to 1090 (1) P.7	9-13-07 9-13-07 9-13-07 10-19-07

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I 160	Continued From page 9 discovering the client with the burn, left a voice message with the House Manager at 11:00 or 11:30 AM. The House Manager returned the staff's call at 12 Noon. At that time, the House Manager reportedly instructed the staff to contact the Qualified Mental Retardation Professional (QMRP). The staff reportedly called the the QMRP at approximately 1:00 PM and informed her of the incident. According to the staff, the QMRP asked staff #1 about completing the incident report. The report was noted to have been written at 4:30 PM. B. The incident report reflected that client #1's burn injury was discovered by direct care staff at 11:00 AM. The incident report reflected that the nurse was notified at 5:00 PM, six hours after the incident was discovered. Interview with the lead LPN, conducted on September 13, 2007 at 5:30 PM, revealed that the medication nurse was in the facility to administer medications to client #1 at 12 noon. The Medication Administration Records documented that the medications were given to client #1 at 12:00 noon; however, there was no mention of treatment for the client's injury. According to the staff (#1), she was busy and "forgot" to inform the nurse at 12 Noon; therefore, the injury went unnoticed by the nurse. IV. The facility's incident management policy referenced words such as "prompt," "timely," and "as required" without including any specific timeframe. The policy also failed to include who should be contacted. Review of the facilities incident reporting policy conducted on September 12 and 13, 2007 revealed the following: The facility must "ensure prompt staff response	I 160	Refer to W 104 (7) P. 5	9-13-07

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I 160	Continued From page 10 and intervention; ensure prompt medical treatment and contact with community support personnel; and ensure timely and accurate notification of appropriate staff, families and agency officials." The policy defined a reportable Incident as "a significant event or situation involving a customer that shall be reported to designated authorities within a provider agency for review and internal investigation. All Customer incidents described in this policy are Reportable Incidents." The policy also stated that "any person subject to the scope of this policy who fails to report an incident as required, gives false, misleading, or incomplete information, or otherwise does not participate in the incident management process as outlined in this policy shall be subject to disciplinary measures which may include termination of employment and, where appropriate, civil action or criminal prosecution."	I 160	Refer to W 104 (7) P.5	9-13-07
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 review of personnel files on September 18, 2007, the GHMRP failed to demonstrate that each supervisor had discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. The finding includes: Six of the fifteen staff did not have signed annual job descriptions on file.	I 203	All of the staff job descriptions are on file. In the future the agency will ensure that all of the personal records are on file, and available upon request.	10-19-07

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I 222	Continued From page 11	I 222		
I 222	<p>3510.3 STAFF TRAINING</p> <p>There shall be continuous, ongoing in-service training programs scheduled for all personnel.</p> <p>This Statute is not met as evidenced by: Based on review of the training record, the facility failed to provide documented evidence of continuous, ongoing in-service staff training to ensure competency in performing their job duties.</p> <p>The finding includes:</p> <p>Throughout this report, the facility demonstrated non-compliance in staff training to meet the needs of the clients.</p> <ol style="list-style-type: none"> 1. The facility failed to provide effect training in incident reporting. 2. The facility failed to establish and train staff on a smoking protocol. 3. The facility failed to provide effective staff training on client monitoring and supervision. 4. The facility failed to training nursing staff on medication disposal. 5. Client #2 had an objective to independently prepare a grocery list in association with his diet on 4/5 trials. The QMRP notes including a quarterly report reflected that client #2 performed with verbal prompting from March 2007 to July 2007 at 100%. <p>Interview with staff on September 17, 2007 at approximately 4:10 PM, revealed that client #2's performance in this objective had been independent following an introduction to initiate</p>	I 222	<p>Refer to W 104 (6) P.5</p> <p>Refer to W 127 (II) P.7</p> <p>Refer to W 127 P. 10 Also refer to 149 P. 13</p> <p>Refer W 104 (5) P. 4 & 5</p> <p>Refer to W 189 P. 22</p>	<p>9-13-07</p> <p>9-13-07</p> <p>9-13-07 9-13-07</p> <p>9-13-07</p> <p>10-20-07</p>

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NAME OF PROVIDER OR SUPPLIER M OF WASHINGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1131 45TH PLACE, SE WASHINGTON, DC 20019		
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I 222	Continued From page 12 the task. The QMRP failed to ensure that staff were trained to recognize the appropriate level of documentation to complete for each client's programs to ensure the accuracy in documentation.	I 222	Staff have been trained on program documentation Refer to attachment #15 In the future the Qmrp will ensure the individual level of performance reflects on the data collection to ensure accuracy.	10-20-07
I 232	3510.5(I) STAFF TRAINING Each training program shall include, but not be limited to, the following: (i) Training of the residents in the maintenance of oral health and hygiene. This Statute is not met as evidenced by: Based on review of the inservice training documents, client were not included in the provided trainings. The finding includes: There was no documented evidence that clients #1 and #2 were receiving training at least annually regarding their oral health and hygiene.	I 232		
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	I 395	Individuals #1 #2 received training ragarding their oral health and hygiene. Refer toa attachment # 17	10-20-07

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1395	Continued From page 13 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 nursing staff failed to recognize and provide services to a client who had sustained an injury. The finding includes: The incident report dated September 9, 2007 (Sunday) reflected that the injury on client #1 was discovered at 11:00 AM. The incident report reflected that the nurse was notified at 5:00 PM. According to interview with the lead LPN, conducted on September 13, 2007 at 5:30 PM, client #1 received medications at 12 Noon on weekends. The nurse documented that the medications were administered; however, there was no mention of treatment for the client's injury. According to the staff who discovered the injury, she forgot to tell the nurse at 12 Noon. There was no evidence that measures had been established to encourage the nursing staff to conduct a brief overview of clients visible areas to identify any unusual changes or injuries when in contact with the client. It could not be determined that the needs of client #1 had been addressed promptly.	1395		
1421	3521.2 HABILITATION AND TRAINING Each GHMRP shall provide habilitation and training to residents in the most normalizing environment and the least restrictive circumstances. This Statute is not met as evidenced by:	1421	Refer to W 104 (1) P.4	9-20-07

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I 421	<p>Continued From page 14</p> <p>Based on interview with staff and records reviewed, the facility failed to ensure that clients who demonstrated a cognitive and adaptive level of independence and do not required the comprehensive services of an intermediate care facility are placed in lesser restrictive environments for two of two clients in the sample.</p> <p>The findings include:</p> <p>1. According to the psychology assessment dated August 30, 2006, client #1 "evidences the capacity to provide informed consent regarding decisions on his behalf in medical care, other treatment, habilitation/residential placement, life planning and general financial matters". He demonstrates the capacity to grant, refuse, or withdraw consent to any ongoing medical treatment and has the ability to execute a durable power of attorney. At reviews of his responsa to psychotropic support he made relevant inquiry of the protocols. " Client #1 was diagnosed with mild mental retardation. The assessment reflected that client #1's adaptive skills were recorded to be as follows: Communications 6 years; daily living 7 years, and 4 months; and socialization 6 years, 11 months. Client #1 had a psychiatric diagnosis of schizophrenia; however, it could not be determined by the review of records that the client's psychiatric related behaviors interfered with the overall consistency in his independent performance.</p> <p>During observation at client #1's day program on October 13, 2007, the client was demonstrating his ability to complete mathametic problems (addition). The instructor was interviewed and stated that client #1's was 71 years of age and required programs geared towards seniors. Program opportunities would be offered and the</p>	I 421	Refer to W 104 (4)	Pending

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1421	Continued From page 16 the purpose of his medication in general terms (i.e. "behavior to calm me down"). According to direct care staff interview conducted on September 17, 2007 at 11:30 AM, client #2 demonstrated a number of independent skills. Interview confirmed that client #2 performed independently in selecting his clothing, dressing, ambulating, and eating. It was identified that he completes assigned chores with "little assistance". Reportedly, client #2 recognizes danger and was capable of contacting 911 for emergencies and convey the needed information. Client #2's individual support plan that was reviewed on September 18, 2007 at 9:30 AM revealed that client #2 cursive writes and can write his name and address. The functional assessment indicated that client #2 revealed that client was independent in social graces, counting up to 500, and identifying bills.	1421	Refer to W 104 94) P. 4 Also W 197 (1) P. 24	Pending
1422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to ensure that clients were provided the opportunities for continuous active treatment in accordance with the individual program plans (IPPs) and demonstrated needs for clients #1 and #2. The findings include: 1. During the medication administration observed on September 12, 2007, client #1 administered	1422		

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1422	Continued From page 17 Zyprexa 10 mg and Carbamazepine 200mg. Client #1 had been encourage with verbal prompting to prepare for taking his medications. With verbal prompting and physical assistance client #1 was allowed to only punch out one of the medications. The nurse failed to allow the client to punch out the second medication that would subsequently encourage consistent performance at every available opportunity. Client #1 demonstrated the ability to identify the date that he was taking the medication. Interview with client #1 on September 13, 2007 at 10:30 AM revealed that client #1 could state the purpose of his medications, however, this was not demonstrated during the medication pass. It could not be determined that client #1 had been encouraged to exercise as much independence as possible in participating in his self medication program and maintaining his current skills. 2. Clients #1 and #2 were interviewed on September 17, 2007 at 10:30 AM and 9:30 AM respectively. Both clients indicated that they participated in their finances by going to the bank with staff on Fridays. Both Clients (#1 and #2) were observed leaving the facility on Friday, September 14, 2007 to go the bank. Upon their return the Clients indicated that they had money. During the clients' interview they both indicated that they signed their names for the bank transaction, but did not go into the bank. They stated that the staff went into the back for them. Client #1 further stated that sometimes he would wait in the van until the staff returns from the bank to signs the slip. Client #1 was able to communicate the banking process for	1422	Refer to W 100 P. 2 Refer to W 100 P. 2 Refer to Refer to W 100 P. 2 Refer to W 100 P. 2	9-13-07 9-13-07 9-13-07 9-13-07

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I 422	Continued From page 18 withdrawing funds. Both clients had individual program plans programs (IPP) to handle their . Clients #1 and #2 were assessment for handing personal finances had been conducted, and an IPP was developed in September 2006. It could not be determined, however, how clients were to be challenged in their opportunities to engage in their financial management. It also could not be determined how clients were given consistent opportunities to maintain current skills.	I 422	The staff were trained on how to challenge the individuals on their financial management. Refer to attachment # 16	10-20-07
I 426	3521.5(c) HABILITATION AND TRAINING Each GHMRP shall make modifications to the resident ' s program at least every six (6) months or when the client (c) Is failing to progress toward identified objectives after reasonable efforts have been made; This Statute is not met as evidenced by: Based on record review, the facility failed to ensure that revisions were considered when clients' demonstrated a lack of achievement in attaining the established criterion level (s) . The finding include: On September 17, 2007 at 3:50 PM, QMRP's notes and the IPP for Client #2 were reviewed. Although, the criterion levels for the Client's programs had not been met, the QMRP failed to revised or document justification for continuing the programs. 1. Client #2 had an objective to independently prepare a grocery list in association with his diet on 4/5 trials. The QMRP's notes, including a	I 426	A program was developped for individual #2 to make a grocery list, according to his diet. Refer to attachment # 13	10-20-07

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1426	Continued From page 19 quarterly report, reflected that client #2 performed with verbal prompting from March 2007 to July 2007. 2. Client #2's IPP dated January 2006, revealed an IPP objective that the "[client] will independently learn the main street name in his neighborhood on 4/5 consecutive trials". Review of the monthly documentation revealed that the client maintained this skill at the verbal prompting level from March 2007 through August 2007. There was no evidence that revisions had been considered.	1426	Refer to W 169 (2.a) P.17	
1500	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 interview and record review, the facility failed to ensure that systems were developed and implemented to ensure clients were not subjected to neglect for four of the four clients that resided in the facility (Client #1, Client #2, Client #3 and Client #4); and the facility failed to ensure that staff were trained to appropriately address clients' injuries. The findings include: According to the State Agency's Intake Information document, the State Agency was contacted via telephone by client #1's Qualified Mental Retardation Professional (QMRP) on September 10, 2007. The QMRP reported that	1500	Refer to W 104 (6) P. 5	9-13-07

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I 500	Continued From page 23 practice nursing (LPN); however, she stated that her position at the facility was as a direct care staff. The staff did not have her first aid card with her at the time of the interview. VI. The facility's incident management policy failed to provide specific direction as to when incidents should be reported to the management staff and the nursing staff. [Refer W149] The State Agency determined that the QMRP, the Administration, and the facility's staff failed to protect client #1 from harm and neglect as a result of its failure to effectively monitor the clients, failure to take immediate actions to ensure protection of all of the clients; and failure to establish and implement policies for the protection of all clients. As a result of these actions or the lack of, a determination of "Immediate Jeopardy" was made by the State Agency. The Chief Operating Officer for the facility was notified of the "Immediate Jeopardy" status on September 13, 2007 at 2:30 PM. The immediate jeopardy determination was removed upon the provide's immediate systems and staff training was implemented to protect the clients in the facility. Although, the facility made significant improvements in the area of clients' protection a Condition Level deficiency remained.	I 500	The immediate jeorpay was removed on	9-13-07