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

PRINTED: 04/09/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G024		03/23/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C M S	703 RANDOLPH STREET NW WASHINGTON, DC 20011

(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
W 000	INITIAL COMMENTS This recertification survey was conducted concurrently with a complaint investigation. The investigation was the result of the facility notifying the regulatory agency of an alleged act of physical abuse towards a consumer. The survey and investigation was conducted from March 20, 2007 through March 23, 2007. It was determined that the survey would be initiated as a full survey with focus on client protection, staffing, and facility practices. There were six females residing in the facility who range in age from 27 to 61 years of age. The consumers ' levels of mental retardation range from profound to moderate. Six of the consumers have behavioral medications prescribed as part of their behavioral support plans. Four of the six consumers were randomly selected for the sample. The findings of the investigation and of the survey were derived from client interview, staff interviews, observations, record reviews to include: incident reports and an investigation summary, clinical and medical documentation, and policies and procedures. Staff interviews and observations were also conducted at four day programs providing services to clients represented in the sample. The facility was deemed to be not in compliance at the Condition Level of Participation in Governing Body and Client Protection.	W 000	2007 APR 25 P 3:54 RECEIVED DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION	
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.	W 102		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Constance A. Reese — TITLE: Program Director — (X6) DATE: 4/25/07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 102	Continued From page 1	W 102	Cross reference W149.	4/26/07
	This CONDITION is not met as evidenced by: Based on observations, interviews and record review, the facility's governing body failed to exercise general policy, budget, and operating direction over the facility as detailed in W149 and referenced to W104. In review of the systemic practices, it was determined from the results that the governing body failed to govern the facility's programs and practices in a manner that would ensure that its clients' rights from potential harm were protected.			
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.	W 104	Cross reference W149.	4/26/07
	This STANDARD is not met as evidenced by: Based on interviews with the Qualified Mental Retardation Professional (QMRP), written correspondence from the facility's Human Resource representative, and review of incident reports, incident management policies and medication policy, the governing body failed to establish policies and to implement written policies in areas of client protection to ensure clients rights to be free from harm or the potential. The finding includes: 1. An incident report dated February 23, 2007 involved client #1, reflected that the staff who allegedly hit client #1 in the back " was removed from the facility and placed on leave until the			

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W 104	Continued From page 2 investigation has been completed ". The QMRP indicated during an interview conducted on March 20, 2007 at 10:20 AM that the alleged perpetrator was dismissed immediately after notification of the incident. Client #1's behavioral data was reviewed on March 21, 2007 at 2:26 PM. The data collection on February 24, 2007 was initialed with the same initials as the alleged perpetrator. The QMRP was questioned about the initials and provided no support that the initials were not the alleged perpetrator's. The Director of the HR department for the facility forwarded a document to this surveyor reflecting that the employee who was being investigated had been dismissed on February 27, 2007 pending the outcome of the investigation. The facility ' s incident management policy stated " any [facility] employee involved in level 1 (which includes physical abuse, death, neglect, theft physical injury) serious reportable incidents will be placed on administrative leave pending outcome of the investigation. Any form of verbal, physical, mental, or sexual abuse by an employee will not be tolerated and is grounds for immediate termination " . The findings of this investigation concluded that the facility failed to put immediate measures in place to ensure the protection of client #1. There was no supportive evidence that the staff accused had not remained at the facility following the reported incident and continued to work on the following day and with client #1 as reflected by the data collection documents.	W 104		

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W 104	Continued From page 3 2. According to medical records for client #4, Ativan 3 mg was prescribed to be used prior to an Audiology in January 2007. Although the medication was discontinued in February 2007, the facility ' s policy indicated clients would have a "behavioral support plan (BSP) that specify the need to assess the use of sedatives/anti anxiety agents or other psychotropic medications. Prior to medicals/dentals appointments and only after support strategies have been implemented will medications be used". According to interview with the Qualified Mental Retardation Professional (QMRP) on March 23, 2007 at 1:50 PM, the QMRP indicated that the client did not have a written behavioral support plan (BSP) to address the client ' s behavior during medical appointments. Review of medical charts for client #4 conducted on March 23, 2007 at 1:25 PM revealed that the client had been administered Ativan 300 mg on October 10, 2007 for an audiology appointment that she arrived to tardy and subsequently could not be seen. There was no evidence to support that the governing body had established measures to ensure that the governing policy had been implemented.	W 104	2. THe facility will revise the policy regarding the use of sedatives/antianxiety agents for evasive evaluations identified that require it. The policy will also be revised regarding how CMS transportation will be notified in advance to ensure that sedated clients arrive on time for their medical appointments.	4/26/07
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on observations, interviews, and record reviews, it was demonstrated that the facility	W 122		

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W 122	Continued From page 4 failed to provide protection to its clients as evidenced by: The facility's failure to establish, evaluate, revise program interventions and to ensure oversight of these programs to ensure the safety of clients [Refer to W149]. In review of the systemic practices, it was determined from the results that the facility failed to adequately govern the facility's programs in a manner that would ensure that its clients' rights from potential harm were protected.	W 122	Cross reference W149.	4/26/07
W 126	483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities. This STANDARD is not met as evidenced by: Based on observation, direct care staff interview and review of program data collection, the Qualified Mental Retardation Professional (QMRP) failed to ensure that clients [#2] received challenging opportunities to enhance their levels in financial management. The findings include: During evening activities on March 20 and 21, 2007, client #2 walked to the store with staff and her housemates. When client #2 returned she had a bag and indicated that she had a diet item. Interview with a direct care staff on March 21, 2007, at 6:10 PM revealed that client #2 made purchases "independently with only a verbal reminder about dietary chooses". The formal program for making purchases was discontinued	W 126		

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W 126	Continued From page 5 in February 2007 and noted by the QMRP to be achieved. It could not be determined that client #2 had achieved all levels of financial management and there was no evidence of further training being implemented with an established goal/objective. There no financial assessment provided at the time of the survey.	W 126	Client #2 will receive a financial assessment and current goal will be revised.	4/26/07
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 interviews with the Qualified Mental Retardation Professional (QMRP), written correspondence from the facility's Human Resource representative, and review of incident reports, incident management and medication policies, the facility failed to establish policies and to implement written policies in areas of client protection to ensure clients' safety from harm or the potential of. The finding includes: 1. A direct care staff failed to implement the facility ' s policy on verbal incident reporting for client #1 regarding an alleged incident occurring February 23, 2007. a. According to an incident report submitted on February 26, 2007, a direct care staff reported that another worker " hit [client #1] in the back. The report reflected that the incident occurred on February 23, 2007 at 8:30 AM. The report noted that the writer wrote the report at 4:04 PM on the	W 149		

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W 149	Continued From page 6 on the day of the alleged incident. According to an interview with the Qualified Mental Retardation Professional (QMRP) conducted on March 20, 2007 at 10:20 AM, the direct care staff reported the alleged incident to the Human Resources Director at approximately 2:00 PM on February 23, 2007. The QMRP indicated in her investigative summary and during interview that she was in the facility on another floor at the time of the alleged incident and was not informed. The QMRP stated that staff persons were trained to inform the supervisor immediately. The facility's policy reads "verbal notification" in hierchy as such: 911 as needed, police department if criminal misconduct is suspected, supervisor or manager on duty and administrator ... ... The policy further reflected that physical abuse incidents " require immediate notification". The facility's policy for reporting incidents was not implemented by the reporting staff. The accused employee remained with the client throughout the day as the assigned one to one staff. b. An incident report dated February 23, 2007 involving client #1 reflected that the staff who allegedly hit client #1 in the back " was removed from the facility and placed on leave until the investigation had been completed " . It was stated as reflected above that the incident was reported at 2:20 PM on February 23, 2007. The QMRP indicated during an interview conducted on March 20, 2007 at 10:20 AM that the alleged perpetrator was dismissed immediately after notification of the incident. Client #1 behavioral data was reviewed on March 21, 2007 at 2:26	W 149	Staff will be required to submit a written Incident Report to CMS Management at the time the abuse occurred. Staff involved in incidents of alleged abuse of a resident will be removed immediatley once the written report is received and sent to CMS Personnel office.	4/26/07

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W 149	Continued From page 7 PM. The data collection on February 24, 2007 was initialed with the same initials as the alleged perpetrator. The QMRP was interviewed and was unable to determine any other employee with the same initials as the alleged perpetrator. The Director of the HR department for the facility forwarded a document to this surveyor reflecting that the employee who was being investigated had been dismissed on February 27, 2007 pending the outcome of the investigation. The facility ' s incident management policy stated " any [facility] employee involved in level 1 (which includes physical abuse, death, neglect, theft physical injury) serious reportable incidents will be placed on administrative leave pending outcome of the investigation. Any form of verbal, physical, mental, or sexual abuse by an employee will not be tolerated and is grounds for immediate termination " . The findings of this investigation concluded that the policy was implemented; however, the written policy and actions of the facility and Human Resouces failed to ensure the immediate protection for client #1. The staff accused remained at the facility following the reported incident and continued to work in the capacity of one to one with client #1. Based on the review of the policy, it could not be determined how clients would be protected until which time the accused employee was placed on administrative leave. 2. The facility's internal investigative report dated February 28, 2007 reflected that the follow up recommendations or actions were that "all staff will receive training on [client's] behavioral support plan (BSP) and the proper care for	W 149	In the future the facility will ensure that all staff involved in alleged abuse will be removed once a written statement is received from the witness. The staff will be removed from the facility pending the outcome of the investigation.	4/11/07

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W 149	Continued From page 8 residents". Although, during an interview with the QMRP on March 20, 2007 at 10:20 AM, she stated that all staff persons were trained to inform the supervisor immediately regarding incidents of this nature. Although reporting of the February 23, 2007's alleged incident was severly delayed, the recommendation summary did not reflect a staff training need on incident reporting . To ascertain if continued deficiencies in training existed since the alleged incident, staff records for the staff working in the capacity of one to one with client #1 were reviewed on March 22, 2007 at 4:10 PM. The training attendance record and agenda reflected that five out of six staff assigned as one to one had received documented training on incident management procedures and client #1's BSP and responsibilities of the one to one staff. It should be noted that client #1 was observed with one to one supervision at the group home on March 20, 21, and 22, 2007 and the BSP was implemented by the one to one staff. Training records for the direct care staff workers (incident reporter and alleged perpetrator) were not made available. The QMRP was unable to provide evidence of staff training and the survey reviewed the annual training and two quarter trainings provided. The QMRP indicated that all staff received training on incident management during orientation and quarterly. Measures to ensure staff training were not included in the policy.	W 149	2. In the future all staff working with client #1 will receive training in incident reporting, incident management, and proper care for Client #1. The policy will be revised to include the frequency training for staff. Staff will receive training quarterly in incident management.	4/26/07
W 155	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must prevent further potential abuse while the investigation is in progress.	W 155		

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W 155	Continued From page 9 This STANDARD is not met as evidenced by: Based on the review of an incident report (2/23/07), investigation summary, documentation from Human Resource, interview with the Qualified Mental Retardation Professional (QMRP), the facililty failed to ensure protection from possible immediate threats of harm. The finding includes: An incident report dated February 23, 2007 involving client #1 reflected that the staff who allegedly hit client #1 in the back " was removed from the facility and placed on leave until the investigation has been completed". The QMRP indicated during an interview conducted on March 20, 2007 at 10:20 AM that the alleged perpetrator was dismissed immediately after notification of the incident. Client #1 behavioral data was reviewed on March 21, 2007 at 2:26 PM. The data collection on February 24, 2007 was initialed with the same initials as the alleged perpetrator. The QMRP was questioned and there was no determination made that any other staff in the facility at that time had the same initials. The Director of the HR department for the facility forwarded a document to this surveyor reflecting that the employee who is being investigated had been dismissed on February 27, 2007 pending the outcome of the investigation. The facility ' s incident management policy states " any [facility] employee involved in level 1 (which includes physical abuse, death, neglect, theft physical injury) serious reportable incidents will be placed on administrative leave pending outcome of the investigation. Any form of verbal, physical,	W 155	Cross reference W149.	4/26/07

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W 155	Continued From page 10 mental, or sexual abuse by an employee will not be tolerated and is grounds for immediate termination " . The findings of this investigation concluded that the staff accused remained at the facility following the reported incident and continued to work in the capacity of one to one with client #1. Subsequently, the facility failed to ensure the immediate protection of client #1.	W 155		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on client interview, observation, staff interviews, and record review the Qualified Mental Retardation Professional (QMRP) failed to ensure that client #2's vocational needs had been identified and coordinated. The finding include: During an interview conducted on March 20, 2007 at 8:45 AM, Client #2 stated that she attended a day program and gave the name of the program. The client expressed her enjoyment with coloring and with the program. Client #2 was observed at her day program on March 21, 2007, from 10:15 AM to 11:45 AM. Client #2 was observed initiating conversation with a peer. She was initially placing "lego shapes" away in a container. The client then initiated changing her table and group. She engaged in picture bingo and demonstrated the ability to inform the others what	W 159		

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W 159	Continued From page 11 the picture identified. Interviews with the Day Program Coordinator and the Instructor were conducted during the period of observation. According to the Coordinator, client #2 was attending the community volunteer work group. The group that was based outside of the main facility. It was stated that client #2 requested to return to the main program area. Reportedly, the client indicated that she did not like it. It was also indicated that client #2 was engaging in aggressive behaviors towards others (i.e. screaming, hitting, and bossiness) at an increasing rate. According to the Coordinator, since her return to the main facility in June 2006, the client had not demonstrated the behaviors. The Instructor stated that client #2 enjoyed puzzles, matching items/pictures, ball games, ring toss, and talking. The client was described as independent and takes initiative to clear the table after activities. It was stated that client #2 "may refuse to follow instructions when she is requested to because she prefers to initiate what she chooses to do". The Coordinator stated that client #2's program also consisted of her going on community outings and involvement with fitness. Review of client #2's clinical record to include the individual program plan (IPP) was conducted during the day program visit on March 21, 2007 at 11:25 AM. The IPP reflected objectives to include: "Will complete a helper task with no more than 4 prompts; Will complete exercises 4/4 each trial". The helper task explained consisted of setting up and replacing items used by the client or following group activities. According to the day program Instructor who had worked with client #2 for approximately two months, the client achieved the helper task objective independently	W 159		

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W 159	Continued From page 12 but may sometimes require verbal prompting. It was further revealed that the client completes two of four exercises using her limbs with physical assistance and enjoys walking. According to the QMRP interview conducted on March 23, 2007 at 11:36 AM, she visited the client's day program on October 2, 2006 and was informed that the client's community work group involvement had been discontinued since August 2006. The QMRP stated that during the conference held at the day program, client did express the desire to remain at the main building but did not specify why the desire to change after over a year. The QMRP stated that she observed client #2 being engaged in putting items away, participating in simulated store purchasing, and arts and craft activities. It could not be determined that the QMRP had taken measures to ascertain the cause of the client's desire for change and to ensure that the day program continued to train client #2 in skills areas that would promote her return to community work opportunities.	W 159	The QMRP met with Client #2's day program and it was agreed upon that the day program would provide counseling to Client #2 regarding being re-introduced to into the community work program. Client #2 will be gradually placed back into the community 1-2 days a week. Currently Client #2 is partcicipating in weekly activities within the community without refusal.	4/20/07
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on observation, interviews with the Qualified Mental Retardation Professional (QMRP) and review of medical records and individual support plans, the facility failed to ensure that comprehensive functional assessments were conducted for two of four	W 214		

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W 214	Continued From page 13 clients in the sample. The findings include: 1. On March 20, 2007 at 6:00 PM, client #2 self administered, with nursing supervision, Mellaril, Cogentin, and Revia. There was no evidence that client #2 had been provided an updated psychiatric assessment to determine changes from the March 25, 2002 ' s assessment. The last assessment reflected that the client should be reassessed in four years (2006).	W 214	Client #2 will receive an updated Psychiatric assessment.	4/26/07
	2. Client #3's physician order reflected orders to include psychotropic medications (Neurontin 600 mg twice daily, Loxitane 100 mg twice daily, and Revia 50 mg twice daily. Client #3 most recent psychiatric assessment was dated March 25, 2002. At that time, the client was prescribed Mellaril and was noted to suffer with intermittent explosive behavior. It should be mentioned that client #3 ' s psychological assessment dated October 9, 2006 reflected that the client scored in the " mild autistic range " . There was no evidence that client #3 had been provided an updated comprehensive assessment to determine if there are changes in diagnosis or treatment needs.		Client #3 will receive an updated Psychiatric assessment.	4/26/07
	3. Interview with the Qualified Mental Retardation Professional (QMRP), with day program representatives, and record review, there was no evidence that client #2 had been provided a vocational assessment to determine her skill level or her needs. (Refer to W255)		A vocational assessment was completed by the day program that was reviewed and discussed with the QMRP.	4/26/07
W 255	483.440(f)(1)(i) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at	W 255		

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W 255	Continued From page 14 least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on interview with the day program representative, and review of client #2's clinical record, the Qualified Mental Retardation Professional (QMRP) failed to ensure that programs that had been attained by the client [#2] had been considered for revision to challenge the client. The finding includes: Review of client #2's clinical record to include the individual program plan (IPP) was conducted during the day program visit on March 21, 2007 at 11:25 AM. The IPP reflected objectives to include: "Will complete a helper task with no more than 4 prompts; Will complete exercises 4/4 each trial ". According to the direct care staff, the "helper task" involved setting up and replacing items used by the client or following group activities. According to the day program Instructor, who had worked with client #2 for approximately two months, the client achieved the helper task objective independently. It was further stated that sometimes the client requires verbal prompting because she may refuse if not allowed to initiate the task. It was further revealed that the client completes two of four exercises using her limbs with physical assistance; however, she enjoys walking for fitness which also fits the purpose of fitness.	W 255	Client #2's day program will revise her criterion level for her objectives that she has successfully achieved.	4/26/07

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W 255	Continued From page 15 It could not be determined that the two current objectives had not been revised or reviewed although the verbal and written reports reflectd that the client had attained the criterion of the objectives.	W 255		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation and interview with the Qualified Mental Retardation Professional (QMRP), the facility failed to obtain written informed consent for the use of behavioral control medications for two of four clients (#1, #3) in the sample. The findings include: 1. On March 20, 2007 at 6:00 PM, client #2 self administered, with nursing supervision, Mellaril, Cogentin, and Revia . There was no evidence of written informed consent for the behavioral support plan (BSP) which included prescribed psychotropic medications. 2. There was no evidence that written informed consent had been obtained for client #3 ' s behavioral support plan (BSP) which included prescribed psychotropic medications (Neurontin, Loxitane, Revia). The QMRP confirmed during interview on March 23, 2007 at 1:00 PM that these clients did not	W 263	1. The facility will continue to contact Client #2's mother regarding giving consent for the Behavioral Support Plan and prescribed psychotropic medications. 2. Client #3's legal guardian gave consent for the implementation of her BSP and use of prescribed medications.	4/26/07 1/30/07

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W 263	Continued From page 16 have written informed consents signed by guardians or any other persons identified as responsible. The facility's policy on use of restrictive measures was reviewed on March 22, 2007 at 5:15 PM. The policy indicated that prior to the use of restrictive measures that written informed consent would be provided by the competent individual and otherwise by a guardian.	W 263		
W 278	483.450(b)(1)(iii) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Procedures that govern the management of inappropriate client behavior must insure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective. This STANDARD is not met as evidenced by: Based on the review of medical records and behavioral management policy, the facility failed to ensure that prior to the use of sedation to address client behavior that programs incorporating the use of less intrusive or more positive techniques had been tried systematically and demonstrated to be ineffective. The findings include: According to client #4's March 2007 physician's orders, the medication Ativan had been discontinued as of February 19, 2007. It was reflected that the Ativan 3 mg was prescribed to be used prior to and Audiology in January 2007. Although the medication was discontinued, the facility ' s policy indicated that the client would	W 278		

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W 278	Continued From page 17 have a " behavioral support plan (BSP) that will specify the need to assess the use of sedatives/anti anxiety agents or other psychotropic medications. Prior to medication use for medical/dental, support strategies will have been implemented." There was no evidence that alternative strategies and less intrusive measure had been developed or implemented for client #4 prior to the use of Ativan in January 2007. The Qualified Mental Retardation Professional (QMRP) confirmed on March 23, 2007, that no strategies to assist client #4 with medical appointments had been established.	W 278	Cross reference W104.	4/26/07
W 289	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. This STANDARD is not met as evidenced by: Based on interview with the Qualified Mental Retardation Professional (QMRP), review of the medical records to include the physician's orders, the medical administration records, and review of the individual support plan (ISP) recommendations, the facility failed to ensure that the use of behavioral control medications for use during medical appointments had been approved by the Interdisciplinary Team and incorporated in the clients ISPs. The finding includes:	W 289		

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W 289	Continued From page 18 It could not be determined that the use of sedatives to address behaviors during medical appointments for client #4 had been reviewed by the Interdisciplinary Team and cooperated in the client's individual support plan (ISP). According to client #4's March 2007 physician's orders, the medication Ativan had been discontinued as of February 19, 2007. It was reflected that the Ativan 3 mg was prescribed to be used prior to an Audiology in January 2007. The MAR was signed as having been administered. It should be mentioned that the review of medical charts for client #4 reflected that the client had been administered Ativan 2 mg on October 10, 2007 for an audiological appointment that she arrived to tardy and was not seen by the physician.	W 289	Cross reference W104.	4/26/07
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observation, client interview [#2], and medical record review, the facility failed to ensure medical preventivion and general medical care. The finding includes: 1. During the dinner meal observed on March 20, 2007 at 6:00 PM, staff was observed encouraging client #2 to measure her food. Client #2 ' s physician ' s order for March 2007 reflected a diet	W 322		

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W 322	Continued From page 19 order of 1500 calorie diet. Client #2 had informed the surveyor during an interview that morning at 8:20 AM that she could not have certain foods because she was to lose weight. According to client #2 ' s weight chart in her medical file reviewed on March 21, 2007 and 3:40 PM, the client ' s weight had increased by nine pounds since March 2006. Client #2 was observed March 20 and March 21, 2007 walking with her housemates to the corner store. She was also observed being encouraged to using the exercise bike in the basement. Client #2 agreed to ride the bike for approximately 2 minutes before getting off. Participation in weight reduction activities for brief periods were observed; however, it could not be determined that the exercises and/or the times were effective in addressing client #2 ' s weight reduction needs.	W 322	1. Client #2's exercise program will be revised to include a variation of exercises and to increase her frequency level.	4/26/07
	2. According to medical records reviewed on March 23, 2007 at 10:40 AM, client #4 had a swallowing function study on May 15, 2006. It was recommended that the client be referred for an appropriate exam of the esophagus as deemed by the referring physician if the symptoms continue to be present. Need to rule out an esophageal motility disorder. It was recommended by the primary physician on the annual physical dated June 23, 2006 that client #4 receive an esophagoscopy to look for esophageal cause of swallowing problem. There was no evidence that this recommended testing had been done.		The Esophagoscopy will be scheduled 4/27/07. In the future the Nursing Coordinator will meet with the Primary Nurse to ensure follow-ups and recommendations from the Primary Physician and outside consultants are being implemented.	4/27/07

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I 000	INITIAL COMMENTS This licensure survey was conducted concurrently with a complaint investigation. The investigation was the result of the facility notifying the regulatory agency of an alleged act of physical abuse towards a consumer. The survey and investigation was conducted from March 20, 2007 through March 23, 2007. There were six females residing in the facility who range in age from 27 to 61 years of age. The consumers ' levels of mental retardation range from profound to moderate. Six of the consumers have behavioral medications prescribed as part of their behavioral support plans. Four of the six consumers were randomly selected for the sample. The findings of the investigation and of the survey were derived from client interview, staff interviews, observations, record reviews to include: incident reports and an investigation summary, clinical and medical documentation, and policies and procedures. Staff interviews and observations were also conducted at four day programs providing services to clients represented in the sample.	I 000		
I 160	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: The finding includes: Refer to federal deficiency report W149 and	I 160		

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I 160	Continued From page 1 W155 regarding client protection policies. The client's need for prtoection was not provided in the current policy. For example, the incident allegedly occurred on February 23, 2007 and the staff allegedly involved was dismissed pending the investigation on February 27, 2007. Meanwhile, there was evidence that was not refuted that the alleged perpetrator was in the facility and working one to one with client #1 on February 24, 2007. It could not be determined that the facility took measures to immediately protect client #1.	I 160	Cross reference W149.	4/26/07
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: The finding includes: Training records for the direct care staff workers (incident reporter and alleged perpetrator) were not made available. The QMRP was unable to provide evidence of staff training and the survey reviewed the annual training and two quarter trainings provided. Refer to federal deficiency report W149 #2 regarding staff training.	I 222	Cross reference W149.	4/26/07
I 371	3519.2 EMERGENCIES Each GHMRP shall maintain written documentation that each employee has been trained in carrying out the policies and procedures set forth in § 3519.1 of this section. This Statute is not met as evidenced by:	I 371		

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I 371	Continued From page 2 The finding includes: Training records for the direct care staff workers (incident reporter and alleged perpetrator) were not made available. The QMRP was unable to provide evidence of staff training and the survey reviewed the annual training and two quarter trainings provided. Refer to federal deficiency report W149 #2 and W155 regarding staff training.	I 371	Cross reference W149.	4/26/07
I 391	3520.2(a) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (a) Medicine; This Statute is not met as evidenced by: The finding includes: Refer to federal deficiency report W322.	I 391	Cross reference W322 #2.	4/26/07
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of	I 401		

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I 401	Continued From page 3 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: The finding includes: Refer to federal deficiency report W214. The facility failed to provide clients with current psychiatric assessments that may support the psychotropic medications prescribed for three clients in the sample.	I 401	Cross reference W214 1.2.	4/26/07
I 424	3521.5(a) HABILITATION AND TRAINING Each GHMRP shall make modifications to the resident ' s program at least every six (6) months or when the client: (a) Has successfully completed an objective or objectives identified in the Individual Habilitation Plan; This Statute is not met as evidenced by: The finding includes: Refer to federal deficiency report W255.	I 424	Cross reference W255.	4/26/07
I 443	3521.7(m) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (m) Financial management (including budgeting and banking);	I 443		

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I 443	Continued From page 4 This Statute is not met as evidenced by: The finding includes: Refer to federal deficiency report W126.	I 443	Cross reference W126.	4/26/07
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: The finding includes: 1. According to client #4's March 2007 physician's orders, the medication Ativan had been discontinued as of February 19, 2007. It was reflected that the Ativan 3 mg was prescribed to be used prior to and Audiology in January 2007. Although the medication was discontinued, the facility ' s policy indicated that the client would have a " behavioral support plan (BSP) that will specify the need to assess the use of sedatives/anti anxiety agents or other psychotropic medications. Prior to medication use for medical/dental, support strategies will have been implemented." There was no evidence that alternative strategies and less intrusive measure had been developed or implemented for client #4 prior to the use of Ativan in January 2007. The Qualified Mental Retardation Professional (QMRP) confirmed on March 23, 2007, that no strategies to assist client #4 with medical appointments had been established.	I 500	Cross reference W104.	4/26/07

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I 500	Continued From page 5 Clients have the rights to have less intrusive measures implemented prior to measures that could pose potential harm (i.e. sedations) 2. It could not be determined that the use of sedatives to address behaviors during medical appointments for client #4 had been reviewed by the Interdisciplinary Team and cooperated in the client's individual support plan (ISP). According to client #4's March 2007 physician's orders, the medication Ativan had been discontinued as of February 19, 2007. It was reflected that the Ativan 3 mg was prescribed to be used prior to an Audiology in January 2007. The MAR was signed has having been administered. It should be mentioned that the review of medical charts for client #4 reflected that the client had been administered Ativan 2 mg on October 10, 2007 for an audiological appointment that she arrived to tardy and was not seen by the physician.	I 500	Cross reference W104.	4/26/07