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

PRINTED: 01/31/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G097	A. BUILDING B. WING	01/24/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 03	1447 OAK STREET, NW WASHINGTON, DC 20010

(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 re-certification survey was conducted on January 23, 2007, through January 24, 2007 utilizing the fundamental survey process. four clients with varying degrees of disabilities reside in this facility. Two of the four clients were randomly selected for the sample. The findings of the survey were based on observations at the group home and two day programs. Also the findings were based on interviews with the residential staff and the day program staff, and the review records, including unusual incident reports.	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations, interviews and the review of records, the facility's Governing Body failed to provide general operating direction over the facility, as evidenced by the following: The findings include: 1. The Governing Body failed to ensure consistent staffing to facilitate Client #1's participation in programing at the day program as evidenced by the following: On January 23, 2006, at 10:19 AM, the surveyor made an on-cite visit to Client #1's day program. In an interview with the day program staff it was discovered that Client #1 requires one-on-one supervision. The day program staff indicated that the group home provided the staffing for the	W 104	The QMRP and the Director of Disability Services will ensure that all staff at the home are thoroughly trained on supporting every client in the home whether for 1:1 or general staffing requirements. The QMRP will coordinate with the Day Program staff to provide specific program training for all facility staff, thus ensuring that when staff assignments must change, all staff are familiar with and competent to support all clients in the Day Program or in the home.	3/9/2007

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Marsha H. Thompson	Director of Disability Services	2/6/07

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

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W 104	Continued From page 1 one-to one supervision, however the person providing the one to one was very inconsistent. She indicated that Client #1 would be used to one staff and the next week there would be another staff assigned. When asked if the changes in staffing affected the clients behavior or programming, the day program staff indicated that whenever the client was with a new staff person he would refuse to participate in his programs. The day program staff further indicated that it was very difficult to continue to constantly have to train the new staff on the clients programs. 2. The governing body failed to ensure administrative procedures were effectively implemented to obtain surrogate decision makers for Clients #2 and #3. The lack of these procedures resulted in the facility's failure to ensure the timely completion of recommended medical procedures for Clients #2 and #3. [See W124, 2-3)	W 104	The QMRP will submit guardianship application packages for all clients in the home to DDS (MRDDA) per the District's protocol. The QMRP and the Director of Disability Services will track the progress of the guardianship applications with Case Managers until guardians are successfully assigned.	3/9/07
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that a system had been established to obtain consent for treatments that may cause risk to the rights of three clients	W 124	The Director of Disability Services and the QMRP will establish a communication protocol whereby medical decision makers are notified in writing immediately when the need for a medical decision arises. Te QMRP will provide follow up until the written consent is obtained. Copies of the consents for each procedure will be maintained in the clients' medical records.	3/9/07

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W 124	Continued From page 2 residing in the facility. (Clients #1, #2, and #3) The findings include: 1. The facility failed to obtain consent for the use of sedation prior to its administration for Client #1. Review of Client #1's medical record on January 24, 2007, revealed that on February 9, 2006, he received Ativan 3 mg. Interview with the nurse on the 24th revealed the medication was administered prior to the client having his blood drawn. Interview with the Qualified Mental Retardation Professional (QMRP) on January 23, 2007, revealed that Client #1 does not have a guardian, however his sister is involved in his life. Further review of the record failed to evidence informed consent by the sister, additionally, there was no other person or entity identified in the clients record authorized as a surrogate decision maker for the client. 2. Interview with the QMRP on January 23, 2007 revealed Client #1 receives psychotropic medication and has a behavior support plan. Review of the record revealed that Client #1 receives Paxil 37.5 mg daily for depression and anxiety. Further interview with the QMRP revealed Client #1 has no guardian, however, he has a sister who is involved in his life. At the time of the survey, there was no consent for the Behavior management plan or the use of psychotropic medication. Further there was no other person or entity identified as having authority to give substituted consent. 3. Interview with the medication nurse on January 23, 2007 at 5:42 PM revealed that Client #2 receives Abilify 15 mg Tab by mouth each	W 124		

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W 124	Continued From page 3 morning for behavior. Record verification on January 23, 2007 confirmed that the client is prescribed and is administered this medication. The review of the Comprehensive Psychiatric Assessment revealed an Axis I diagnosis of Intermittent Explosive Disorder. According to Client #1's Psychological Assessment dated 2006, the client functions in the moderate range of mental retardation cognitively and the profound range adaptively. Further, the psychological assessment revealed the client is not cognitively competent to make independent decisions on her her behalf regarding her habilitation planning, placement, financial, and medical matters. Interview with the QMRP on January 23, 2007, as well as the record review revealed that Client #1 does not have a legally-sanctioned guardian and/ or a surrogate health care decision-maker to review and approve the use of the restrictive interventions. There was no evidence a legally authorized representative had been identified to represent the client in the aforementioned areas identified in the psychological assessment. 4. a. Cross refer to W322, 1 The facility failed to ensure a legally authorized representative to sign the consents for recommended medical and dental procedures for Clients #2 and #3. Interview with the nurse on January 24, 2007 revealed that Client 2 was initially recommended to have an EMB (endometrial biopsy) was on December 29, 2005 however, the procedure had not been performed. Further interview with the nurse and the review of the Human Rights Committee (HRC) minutes dated February 23, 2006 revealed the HRC approved the procedure. The minutes, however indicated the client also	W 124		

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W 124	Continued From page 4 needed to have a signed consent for the procedure to be performed. Interview with the QMRP and the record verification on January 24, 2007 revealed that the procedure had not been completed because the client did not have an authorized representative to sign the consent form. The QMRP indicated numerous efforts made to contact the client's brother to sign the consent were unsuccessful. There was no evidence, however, a guardian/surrogate decision -maker had been obtained to ensure the procedures recommended to assess the client's health were completed. b. Cross Refer to W322, 2. The review of HRC minutes dated February 23, 2006 revealed the committee approved sedation for full mouth dental rehabilitation for Client #3. Interview on January 24, 2007 with the home manager, the nurse and the QMRP indicated initial attempts to contact the brother to sign the consents were unsuccessful. Further interview with the nurse and the QMRP however, indicated the procedure still had not been scheduled or performed due to the lack of a legally authorized representative to sign the consents.	W 124		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and review of the records, the	W 153	The Director of Disability Services will review and revise current facility policies to ensure they meet legal requirements for incident identification, reporting, investigation, and corrective actions. The Director of Disability Services will ensure that all staff are trained on proper policies and protocols in the identification, reporting, investigation, and corrective actions for client incidents.	3/9/07

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W 153	Continued From page 5 facility failed to ensure that outside agencies were informed of injuries of unknown origin in accordance with District Law 22 DCMR, Chapter 35, Section 3519.10 for one two clients in the sample. (Client #2) The finding includes: The facility failed to investigate the origin of Client #2's discomfort which was reported to the group home by the day program. According to a day program quarterly report dated June 13, 2006, day program staff "Observed slight limping on both legs. Upon standing up client held her knees, as though they hurt. No facial grimace noted. Unable to use the treadmill during gross motor. Spoke with the Qualified Mental Retardation Professional (QMRP) about it . Will notify the PCP". Interview with the QMRP and the review of unusual incidents on January 22, 2007 failed to provide evidence the client's discomfort of unknown origin was reported immediately to the administrator or to other officials through established procedures in accordance with State law.	W 153		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to thoroughly investigate Client #2's discomfort or injury unknown origin. The finding includes:	W 154	See response to W153.	3/9/07

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W 154	Continued From page 6 1. [Cross Refer to W153] The facility failed to investigate the origin of Client #2's discomfort which was reported by the day program. Interview with the QMRP and the review of unusual incidents on January 22, 2007 failed to provide evidence the origin of the client's discomfort/change in mobility status was investigated.	W 154		
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 observation, interview and record review, the facility failed to ensure active treatment programs were integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP) for three of the four clients residing in the facility. (Clients #1, #2 and #3. The findings include: 1. The QMRP failed to ensure that active treatment interventions and recommendations were employed at every available opportunity in the natural setting for Client #1. [See W249] 2. The QMRP failed to effectively coordinate services necessary to obtain consents for Clients #1 and #2. [See W124]	W 159	The Director of Disability Services will ensure the QMRP is fully inserviced and supported in all aspects of developing and implementing active treatment at every opportunity for all clients served. The Director of Disability Services will hold weekly individual two-hour sessions with the QMRP to develop, train, implement, document, and revise formal and informal active treatment interventions and recommendations.	3/9/07
W 192	483.430(e)(2) STAFF TRAINING PROGRAM	W 192		

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W 192	Continued From page 7 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 interview and record review, the facility failed to ensure health care interventions in accordance with each client's needs, for one of the two clients in the sample. (Client #1) The findings include: 1. On January 23, 2007, the surveyor observed Client #1 eating his lunch. The staff encouraged the client to drink water and juice. The client reluctantly drank the water and was noted to drink approximately 75% of it. He also drank 75% of the juice. The surveyor observed the client receiving Diocto 25 ml. Interview with the nurse and record review verified that he received the medication for constipation. Review of the Health Management Care Plan revealed the client's fluid intake should be monitored. Review of the fluid intake record failed to evidence documentation of the amount of fluids the client consumed. Interview with the nurse verified that this information should have been documented by the direct care staff. 2. On January 23, 2007, the surveyor observed Client #1 eating his lunch. The staff fed the client a pureed grilled cheese sandwich and tomato soup. The client consumed 100% of the sandwich and approximately 75% of the soup. The surveyor observed the client receiving Diocto 25 ml. Interview with the nurse and record review verified that he received the medication for	W 192	The Director of Disability Services will coordinate with the Director of Nursing, the QMRP, and outside supports such as the DC Health Resources Partnership, to develop health support protocols and train/mentor all facility staff to implement them. The Director of Disability Services will also perform weekly Quality Assurance checks, and the facility's Quality Assurance Department will provide monthly monitoring to ensure that staff are well versed in all procedures and are implementing and documenting accurately and appropriately. 3/9/07	

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W 192	Continued From page 8 constipation. Review of the Health Management Care Plan revealed the client's fluid intake should be monitored. Review of the fluid intake record failed to evidence documentation of the amount of fluids the client consumed. Interview with the nurse verified that this information should have been documented.	W 192		
W 212	483.440(c)(3)(i) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the presenting problems and disabilities and where possible, their causes. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure a psychiatric assessment was documented in the record for one (Client #1) of two clients in the sample receiving psychotropic medications; and failed to include the diagnoses of constipation and depression for one client (Client #1) receiving medication to treat the conditions. The finding includes: Interview with the Qualified Mental Retardation Professional(QMRP) on January 23, 2007 revealed Client #1 received psychotropic medication and had a behavior support plan. Review of the record revealed that Client #1 receives Paxil 37.5 mg daily for depression and anxiety. Further record review, however revealed no documented evidence that a psychiatric assessment was conducted to determine an Axis I diagnosis for which the medication was indicated.	W 212	The Director of Disability Services and the Director of Nursing will review the client records to ensure that all assessments and individual program plans are coordinated and consistent with the needs identified in the Comprehensive Functional Assessment and other clinical assessments. The Director of Nursing will ensure that all Health Care Management Plans are reviewed and updated appropriately. The Director of Nursing will conduct "grand rounds" at least monthly to ensure that medical and health supports and follow up are coordinated and properly implemented and documented. Also see response to W159.	3/9/07

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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 client interviews, observation, and record review, the facility failed to ensure that active treatment interventions and recommendations were employed at every available opportunity in the natural setting for Client #1. The finding includes: 1. On January 23, 2007, at 11:50 AM, Client #1 was observed eating his lunch. The direct care staff fed the client. The surveyor asked the staff if Client #1 had a feeding protocol. The staff presented a document titled "How to assist (client's name) during meals." The client should have received hand over hand assistance to "pick up his weighted spoon, and to feed himself 3 - 4 spoons of food. Further review of the client's individual program plan (IPP) objectives for the current year indicated the same. At no time during the lunch observation was hand over hand assistance employed by the staff during the meal. 2. The "How to assist (client's name) during meals." document further indicated that the client should receive verbal and hand over hand	W 249	See response to W159. The Director of Disability Services will ensure that QMRP and program staff implement continuous active treatment as soon as the interdisciplinary team has formulated the clients' program plans.	3/9/07

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W 249	Continued From page 10 directives about what needs to take place for every step. At no time during the lunch observation was verbal directives given to the client. It should be noted that during the snack observation on January 23, 2007, the staff did provide the recommended hand over hand assistance to the client.	W 249		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that each client's behavior intervention technique, including the use of behavior modification drugs was conducted with the written informed consent of the client, parents (if the client is a minor) or legal guardian for two of two clients in the sample (Clients #1 and #2). The findings include: 1. Cross Refer to W124. The facility failed to obtain informed consent prior to the use of restrictive measures (psychotropic medications) as described in Client #1's behavior support plan. 2. Cross Refer to W 312. The facility failed to ensure that informed consent was obtained prior to the administration of sedation for Client #1.	W 263	See response to W124.	3/9/07

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W 263	Continued From page 11 3. Cross Refer to W124, 2. The facility failed to obtain informed consent prior to the use of restrictive measures (psychotropic medication and behavior support plan for Client #2.	W 263		
W 312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the use of behavior modification medications prescribed to complete medical appointments was incorporated in the individual program plan (IPP) for one of the two clients in the sample (Client #1). The findings include: Review of Client #1's medical records on January 24, 2007 revealed that on February 9, 2006, Client #1 received Ativan 3 mg prior to having blood drawn. Interview with the Licensed Practical Nurse (LPN) on January 24, 2007, revealed that Client #1 did not have a desensitization program for medical appointments. Review of Client #1's Behavior Support Plan dated January 3, 2007, on January 24, 2007, failed to evidence a program that addresses the client's non-compliant behaviors at medical appointments to justify the use of the sedative medication. There was no evidence that the use of behavior modification medications	W 312	See response to W212.	3/9/07

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	09G097	A. BUILDING _____ B. WING _____	01/24/2007

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W 312	Continued From page 12 prescribed to complete medical appointments was incorporated in the individual program plan (IPP).	W 312		
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 staff interview, and record review the facility failed provide preventive and general care for three of four clients residing in the facility. (Client #1, #2 and #3) The findings include: 1. On January 23, 2007,at staff indicated that Client #1 received an upper GI study. Review of the record on January 24, 2007, at 10:40 a.m. revealed that on October 6, 2006, the client was evaluated by his primary care physician (PCP) for "not eating well for the past two (2) days." The PCP recommended that the client receive an upper GI study and an abdominal sonogram. He was also prescribed Pepcid. Interview with the nurse to ascertain if the client received the abdominal sonogram, revealed that he had not. The facility failed to ensure that Client #1 received the recommended procedure timely. 2. Review of Client #1's Medical records on January 24, 2007, at 11:00 a.m. revealed Client # 1 was evaluated by the Urologist on May 12, 2005 . It was recommended that the client be re-evaluated in one year. Further review of the chart	W 322	See responses to W104, W124, and W212.	3/9/07

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W 322	Continued From page 13 failed to evidence that the client was evaluated by the urologist in 2006. Interview with the nurse on January 24, 2006, acknowledged that the client had not been scheduled for a urology visit in 2006 . The facility failed to ensure recommended follow-up timely . 3. The review of Client #2's medical record on January 24, 2007 revealed she had a GYN for evaluation on December 29, 2005 for persistent heavy bleeding that occurred more than one time a month continuously. According to the consultation report, the client was uncooperative, therefore could not be examined on that date. The gynecologist recommend that the client have an EMB (endometrial biopsy). The gynecologist further documented that the client would need consent for the procedure, likely under anesthesia . A GYN consultation report dated December 6, 2006 revealed the client went for a PAP due to abnormal uteral bleeding. The specialist indicated "Patient refused prior Pelvic- Please provide some sort of PO sedative prior to next visit. If Pap available, please forward results. Have durable power of attorney or family for sign consent for the EMBx (endometrial biopsy). Interview with the QMRP and the nurse indicated the procedure had not be completed due to the lack of an authorized representative to sign the consent for the anesthesia and the procedure. There was no evidence Client #2 received health care services in accordance with her assessed needs. 4. Cross refer to W356. The facility failed to ensure treatment services for the maintenance of the dental health of Clients #2 and #3.	W 322		
W 331	483.460(c) NURSING SERVICES	W 331	~~See responses to W104, W124, and W212~~	

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W 331	Continued From page 14 The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to ensure nursing services in accordance with the needs of one of two clients in the sample. (Client #2) The findings include: 1. The facility's nursing services failed to ensure Client #2's body weights were monitored weekly as prescribed. Observation of the medication administration on January 22,2007 review of current physician's order revealed an order which states "Check weight each week at 7:00 AM". Review of the March 14, 2006 Individual Support Plan (ISP) recommendations revealed a goal of "Weight loss ...Weigh Weekly". The review of the resident's Weight Record revealed the last documented weight (169 pounds) available was dated November 23, 2006. Interview with the nurse indicated all weekly weights should be documented on the aforementioned form. There was no evidence Client #2's weight were monitored weekly as recommended by the Interdisciplinary Team (IDT) and as prescribed by the primary care physician (PCP). 2. The facility's nursing services failed to monitor physician's orders to ensure that all approved changes in the physician's orders were documented.	W 331		

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W 331	Continued From page 15 On January 23, 2007 at 10:17 AM, Client #2 was observed to be overweight for height. Interview with direct care staff on January 23, 2007 revealed that Client #2 is prescribed a 1500 diet to control her diabetes and to encourage weight loss. The staff showed the surveyor the 1500 calorie meal pattern which she stated is being followed for meals and snacks provided to Client #2. According to Client #2's annual nutrition assessment dated March 1, 2006, the client was 65 inches tall. The client's ideal body weight range was assessed by the nutritionist to be 130 to 156 pounds. Further record review revealed the nutritionist recommended a reduction in the calories level of the diet from 1800 to 1500 calories. According to the March 14, 2006 approved Individual Support Plan (ISP) recommendations, the intervention for weight loss should be a Diet: 1500 calorie diet/Avoid Concentrated Sweets/cut food into bite size; Review Quarterly. The review of physician's order however, failed provide evidence a change in the diet order from 1800 to 1500 calories was made. 3. The facility's nursing services failed to ensure that Client #2 Health Risk Management Plan documented interventions to address her diabetes mellitus. Medication administration observations on January 22, 2007 at 5:40 PM revealed Client #2 received a fingerstick. Interview with the medication nurse indicated the finger stick is performed before breakfast and dinner to assess her blood glucose. The client was also observed to be administered Glucophage 500 mg. Record verification revealed the client is prescribed the aforementioned blood sugar monitoring and the medication to treat her diabetes. The review of	W 331		

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W 331	Continued From page 16 the Health Risk Management Plan failed to provide evidence that interventions to address the client's diabetes mellitus were documented. 4. The facility's nursing services failed to ensure Client #2's audiological assessment was completed timely. Interview with the nurse on January 24, 2007 revealed that Client #2 has an audiological examination scheduled during February 2007. Record review indicated that an audiological examination was initiated on October 20, 2006. Due to wax accumulation in the client's ears, the audiologist referred the client to ENT for removal of the wax. The audiologist requested the client to return for completion of the audiological examination and recommendations as soon as possible after the ENT visit. Record review revealed the recommended ENT visit was completed on November 6, 2006. At that visit, the specialist diagnosed and removed a severe impaction of cerumen. There was no evidence the recommended ENT appointment was conducted timely to ensure the completion of Client #2's audiological examination as soon as possible as recommended by the audiologist. 5. Cross Refer to W124, 3. The facility's nursing services failed to follow-up timely on the status of guardianship paperwork needed for the completion of Client #2 GYN procedure. According to the March 3, 2006 nursing review, Client #2's Health Risk Management Plan includes interventions to address her alteration in comfort related to dysmenorrhea. Further record review revealed Gyn follow-up for a endometrial biopsy (EMB) was recommended during the	W 331		

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W 331	Continued From page 17 December 29, 2005 consultation. The June 10, 2006 and September 14, 2006 nursing quarterlies reflected the need to follow-up on the guardianship paperwork. The review of nursing documentation however, failed to reveal the details regarding the nurses efforts to obtain follow-up information concerning the client's guardianship. Interview with the home manager indicated the facility and been unsuccessful in locating the client's brother to sign the necessary forms. Interview with the nurse and record review on January 24, 2007 revealed evidence that Client #2's MB had not been completed due to the lack of an authorized representative to provide written informed consent for the procedure.	W 331		
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure treatment services for the maintenance of dental health for two of the four clients residing in the facility. (Clients #2 and #3) The finding includes: 1. Observation of Client #2's teeth on January 22 , 2006 revealed the front teeth protruded forward. Interview with staff and record review indicated the client is able to brush her teeth, however requires supervision for thoroughness. Record	W 356	The Director of Disability Services and the Director of Nursing will ensure that staff and clients are trained in providing daily dental care for each client. See responses to W104, W124, and W212. 3/9/07	

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W 356	Continued From page 18 review revealed Client #2 had a dental recall assessment on October 12, 2006. The dentist diagnosed heavy calculus deposits, generalized. The dentist indicated that the client would be called to schedule an appointment to perform the needed treatment services after preauthoriztion was obtained from Medicaid. Record review to ascertain the date of the last completed dental services revealed Client #2 had a dental recall examination on October 25, 2005. At that time, the client was diagnoses with moderate to heavy calculus deposits. Scaling was recommended. The dentist indicated the client would be called to schedule an appointment to perform the needed treatment services after preauthoriztion was obtained from Medicaid. Interview with the nurse and further record revealed no evidence the client was given an appointment to complete the dental cleaning recommended during either of the appointments. There was no evidence Client #2 received services as needed for the maintenance of her dental health. 2. Cross refer to W124.3. Interview with the Qualified Mental Retardation Professional (QMRP) and the record verification revealed Human Rights Committee (HRC) Meetings are held regularly to review issues related to client rights and services. The review of HRC minutes dated February 23, 2006 revealed the committee approved sedation as recommended for Client #3 during dental appointments. The review of Client #3's clinical record revealed he had a dental consultation on October 3, 2005 for extraction of a lower tooth. The dentist indicated he was unable to obtain the radiograph	W 356		

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W 356	Continued From page 19 of the tooth due to the client's failure to cooperate . The dentist's limited examination of the client's mouth however, revealed a buccal mucosa lesion /laceration and moderate plaque/calculus deposits. Tooth #17 was assessed to have a partial bony impaction. Full mouth rehabilitation in the operating room with extraction of the indicated teeth was recommended. The dentist however, stated that medical clearance must be obtained prior to the treatment being performed. Tylenol 650 mg by mouth ever 6 hours prn was recommended for pain. Interview with the home manager and the nurse on January 24, 2007 at 2: 47 PM indicated that the client had not returned to the dentist for the procedure due to the lack of written consent to complete the procedure. There was no evidence #3 received timely dental treatments services for the maintenance of his dental health.	W 356		
W 441	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. This STANDARD Is not met as evidenced by: Based on staff interview and record verification, the facility failed to hold evacuation drills using different egress areas as a part of the evacuation procedures. The finding includes: Observation of the facility on January 24, 2007, revealed that there was three methods of egress from the facility. On January 24, 2007, review of fire drill records revealed that the primary exits used were the back and side doors of the facility. In an interview with the House Manager, on the	W 441	The Director of Disability Services and the QMRP will devise the evacuation strategy and drill schedule such that drills occur under varied conditions. The QMRP will also ensure that unscheduled drills take place in varied conditions.	3/9/07

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W 441	Continued From page 20 same day; it was acknowledged that all areas egresses had not been used during the fire drills. At the time of the survey, there was no evidence that evacuation drills were being held under varied conditions.	W 441		

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R 000	INITIAL COMMENTS This re-licensure survey was conducted on January 23, 2007, through January 24, 2007. Four clients with varying degrees of disabilities reside in this facility. Two of the four clients were randomly selected for the sample. The findings of the survey were based on observations at the group home and two day programs. Also the findings were based on interviews with the residential staff and the day program staff, and the review records, including unusual incident reports.	R 000		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: The finding includes: Review of the personnel records on January 24, 2007 revealed the GHMRP failed to provide evidence of a criminal background check for one direct care staff ([redacted]).	R 125	The Director of Disability Services will ensure that all potential employees submit a valid criminal background check prior to official hire. 3/9/07	

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I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: The finding includes: See Federal Deficiency Report - W192.	I 180	The Director of Disability Services will coordinate with the Director of Nursing, the QMRP, and outside supports such as the DC Health Resources Partnership, to develop health support protocols and train/mentor all facility staff to implement them. The Director of Disability Services will also perform weekly Quality Assurance checks, and the facility's Quality Assurance Department will provide monthly monitoring to ensure that staff are well versed in all procedures and are implementing and documenting accurately and appropriately.	3/9/07
I 188	3508.6 ADMINISTRATIVE SUPPORT Documentation that services have been provided as required by each resident ' s Individual Habilitation Plan including contracts, vendor agreements, receipts, and paid bills shall be available for review by authorized regulatory personnel. This Statute is not met as evidenced by: The findings include: The facility filed to provide evidence of a vendor agreement for the pharmacist, the behavior specialist. and the RN sex therapist.	I 188	The Director of Operations will ensure that all vendors have formalized agreements on file at the GHMRP.	3/9/07

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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 findings include: Information was provided to the surveyors on Mental Retardation Overview. Additionally information was provided on the following agency policies: Emergency Preparedness/Disaster Plan, MR Overview, Human Development, Client Rights, Human Sexuality and Recreation. The facility failed to provide sign-in sheets of training provided in these areas to verify a continuous ongoing in-service program.	I 222	The Director of Disability Services will provide training and evidence of such training on Emergency Preparedness/Disaster Plan, MR Overview, Human Development, Client Rights, Human Sexuality and Recreation.	3/9/07
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: The findings include: See Federal Deficiency Report - Citations W212, W312, W322, and W331	I 401	The Director of Disability Services and the Director of Nursing will review the client records to ensure that all assessments and individual program plans are coordinated and consistent with the needs identified in the Comprehensive Functional Assessment and other clinical assessments. The Director of Nursing will ensure that all Health Care Management Plans are reviewed and updated appropriately. The Director of Nursing will conduct "grand rounds" at least monthly to ensure that medical and health supports and follow up are coordinated and properly implemented and documented.	
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training	I 422		

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I 422	Continued From page 2 and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: The finding includes: See Federal Deficiency Report - Citation W249	I 422		
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 findings include See Federal Deficiency Report - Citation W124, W153, W154, W212, W263, W312, W322, and W331	I 500	The Director of Disability Services will ensure that all staff ensure the rights of clients are protected and promoted in accordance with District and Federal laws, and the facility's policies. The Director of Disability Services will provide training on rights protection and promotion, and will ensure all facility policies are in compliance with District and Federal Laws and Basic Assurances as defined by the Council on Quality and Leadership and MRDDA.	3/9/07