STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G055	A. BUILDING _____ B. WING _____	05/13/2010

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BEHAVIOR RESEARCH ASSOCIATES	4288 1/2 SOUTHERN AVE, SE WASHINGTON, DC 20019

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W 000	INITIAL COMMENTS A recertification survey was conducted from May 11, 2010 through May 13, 2010. The survey was initiated using the fundamental survey process. A random sample of two clients was selected from a population of two female client and two male clients with various levels of intellectual disabilities. The findings of the survey was based on observations at the group home and two day programs, interviews with clients and staff and the review of clinical and administrative records including incident reports.	W 000	Received 6/10/10 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
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 observation, staff interview, and record review, the facility failed to establish a system that would ensure clients guardians were informed of their risks and benefits of clients psychotropic medications, for one of two clients included in the sample. (Client #1) The finding includes: The facility failed to ensure that informed consent was obtained from Client #1's guardian prior to the administration of his psychotropic	W 124		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Linda Graham, Program Director 6/10/2010

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 124	Continued From page 1 medications. During the entrance conference on May 11, 2010, beginning at 9:00 a.m., the qualified mental retardation professional (QMRP) indicated that Client #1 received psychotropic medications to address her maladaptive behaviors. Further interview revealed the client did not have the capacity to give informed consent for the use of medications and habilitation services. Medication administration observation on May 11, 2010, at 7:10 p.m., Client #1 was observed receiving Tegretol XR 300 mg. Interview with the Licensed Practical Nurse (LPN) after the medication administration indicated that the client received the aforementioned medication for her maladaptive behaviors. Review of the client's current physician orders dated May 2010, on May 11, 2010, at approximately 7:30 p.m., revealed an order of Tegretol XR 300 mg, twice a day for aggression. The QMRP's statement was verified on May 12, 2010, at approximately 10:00 a.m., through review of Client #1's psychological assessment dated April 30, 2010. According to the assessment, Client #1 "does not evidence the capacity to make decisions on his own behalf in treatment, habilitation, residential placement, and financial matters." Further interview with the QMRP during the survey, revealed that the client had a court appointed guardian who is involved in his habilitation planning and decision making process. Record verification on May 13, 2010, at 10:00 a.m., revealed that Client #1's guardian had given	W 124	W124 The QMRP will insure that the guardian of Client #1 is informed of the increase in the Tegretol dose; that the risks/benefits are explained and that the guardian provides signed consent for the increase...6-28-10. In the future, such proposed increases will be discussed in the routine psychotropic medication reviews and the team leader will insure that consent is discussed and a plan of action is developed in instances where an increase in medication is suggested...6-30-10. Signed consent will be obtained prior to the implementation of any increase in psychotropic medications, including the addition of a new medication...6-30-10. The QMRP will review the psychotropic medication reviews and physician's orders routinely as a part of her internal audit process to insure that consent is obtained for changes in the regimen. The QMRP also serves as a member of the psychotropic medication review team...6-30-10	

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W 124	Continued From page 2 informed consent for the use of Tegretol 200 mg on May 15, 2008. There was no consent signed, however, for the an additional 100 mg of the prescribed Tegretol. At the time of the survey, the facility failed to provide evidence that informed consent was obtained from the client and/or legally authorized representative prior to an increase in the psychotropic medication.	W 124		
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure guardians were notified, for two of four clients residing in the facility. (Clients #1 and #3) The findings include: An interview was conducted with the Qualified Mental Retardation Professional (QMRP) on May 11, 2010, at 9:00 a.m., during the entrance conference, to ascertain information regarding the facility's incident management system. According to the QMRP, all incidents should be reported to the administrator, family members and/or guardians and governmental agencies. Further interview revealed Client's #1 and #3 had legal guardians that were involved in their habilitation and care. The facility's incident reports and	W 148		

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W 148	Continued From page 3 corresponding investigations were reviewed on the same day, beginning at 8:41 a.m. and revealed the following: - On August 13, 2009 and May 23, 2009, staff discovered a purple bruise on Client #1's thigh; - On August 5, 2009, Client #3 was bitten by another client; - On June 16, 2009, staff discovered a bruise on Client #3's right calf area. Interview with the Incident Management Coordinator (IMC) on May 11, 2010, at approximately 12:30 p.m., indicated that the guardians had been notified, however there was no documented evidence that indicated the client's guardians had been notified.	W 148	W148 In the future, the IMC will document at the bottom of the formal Incident Report Form the notification of involved family and/or legal guardians for all such incidents. These documents will be reviewed by the Program Director prior to being permanently filed to insure that all proper notifications occurred and were documented...6-28-10. The status of incidents will be reviewed routinely in the (minimum) bi-monthly management team meetings (Program Director, QMRP, RN, IMC, managers)...6-30-10	
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to report the results of all investigations to the administrator, designated representative or to other officials in accordance with State Law within five working days of the incident, for three of the four clients residing in the facility. (Clients #1, #2 and #3) The findings include:	W 156		

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W 156	Continued From page 4 Review of the facility's incident and investigative reports on May 11, 2010, beginning at 8:41 a.m., revealed the following incidents and investigative reports: a. On Augst 13, 2009 and May 23, 2009, staff discovered a bruise on Client #1's left thigh. b. On August 9, 2009, Client #2 was hit by another client (across the back of the head). Interview was conducted with the Qualified Mental Retardation Professional (QMRP) on May 12, 2010, at 11:00 a.m., to ascertain information regarding the facility's incident management system. According to the QMRP, all investigative results were completed by the Incident Management Coordinator. Further review of the investigative report revealed that there was no documented evidence that the administrator had been notified of the results of the investigations. At the time of the survey, the facility failed to provide evidence that ensured the administrator was notified of the results of the investigative reports within five working days as required.	W 156	W156 As per W148 above, the IMC will insure that notification of the administrator is documented on the bottom of each incident report form prior to submission and permanent filing...6-28-10. The QMRP will audit reports monthly to insure routine compliance and the issue will be reviewed by the management team during team meetings...6-30-10.	
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, staff interview and record review, the qualified mental retardation professional (QMRP) failed to ensure client's current mealtime protocol was provided to client's	W 159		

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W 159	Continued From page 5 day program, for one of the two clients included in the sample. (Client #2) The findings include: 1. On May 11, 2010, at 12:04 p.m., the day program counselor was observed placing Client #2's lunch in front of him. His lunch consisted of chicken fried rice, mix vegetables, and 1% white milk. Interview with the day program counselor on the same day at 12:16 p.m., revealed Client #2 was on a regular diet. Moments later, record review of the client's mealtime protocol dated August 27, 2006, revealed the client was required to received a 1500 calorie, high fiber, no salt added diet. Further interview confirmed that the day program did not receive an updated mealtime protocol from the facility. On May 12, 2010, at 11:00 a.m., review of the facility's mealtime protocol dated October 22, 2009, revealed Client #2 was required to receive a 1200 calorie, high fiber, no added salt diet. Interview with qualified mental retardation professional (QMRP) on the same day at approximately 3:30 p.m., revealed that she was unaware that the day program did not have a current mealtime protocol. At the time of the survey, there was no evidence that the QMRP provided the day program with a current mealtime protocol for Client #2. 2. On May 11, 2010, at 12:11 p.m., Client #2 was observed eating lunch at his day program. During this observation the client was observed eating large spoonfuls before swallowing at a fast pace.	W 159	W159 The QMRP will insure that the day program for Client #2 receives the most current mealtime protocol...6-15-10	

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W 159	Continued From page 6 The day program counselor did not prompt him to slow down. Review of Client #2's mealtime protocol dated August 27, 2006, at 12:25 p.m., stated the client "feeds himself at a rapid pace, verbally prompt him to slow his eating pace when necessary. Moments later, interview with the day program counselor confirmed that the day program did not receive an updated mealtime protocol from the facility. On May 12, 2010, at 11:00 a.m., review of the facility's mealtime protocol dated October 22, 2009, revealed the following safe feeding techniques: a. May need verbal prompts to slow his eating pace; b. Should encourage him to chew and swallow thoroughly; c. Safe feeding techniques should be used at each meal; Interview with QMRP on the same day at approximately 3:30 p.m., revealed that she was unaware that the day program did not have a current mealtime protocol. At the time of the survey, the QMRP failed to ensure that the day program received and implemented Client #2's current mealtime protocol.	W 159	During monthly visits to the program, the QMRP will routinely inquire as to whether the program has all needed materials (ISP, Physician's orders, and protocols) and will follow up in instances where the program indicates it does not have needed information...6-30-10. BRA will offer to train the day program staff on the protocol...6-15-10.	
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with	W 189		

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W 189	Continued From page 7 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 observation, staff interview and record review, the facility failed to ensure staff received effective training to address the needs of the clients, for one of two clients residing in the facility. (Client #1) The finding includes: The facility failed to ensure staff demonstrated competency in Implementing Client #1's diet order, as evidenced below: On May 11, 2010, at 7:50 a.m., Client #1 was observed as a large framed women. The client was observed wearing support type hose/knee highs. At 6:20 p.m., Client #1 was observed having dinner. The staff prepared the client's plate and sat it in front of her. The meal consisted of three ounces of chicken, a half cup of green beans and mashed potatoes. The client was observed shaking a lot of salt and a small amount of pepper onto her food (chicken and green beans). Interview with staff, during the meal, indicated that the Client #1 likes to add a lot of salt. She has decrease the amount of "salt that she use to use." Further interview revealed that the client is on a "regular chopped texture, and she should add salt to food." Review of Client #1's physician orders (POS) dated May 2010, on May 11, 2010, at 2:00 p.m.,	W 189	W189 All staff will be retained on the implementation of Client #1's diet and mealtime protocol by nursing supports…6-20-10 Nutrition will follow up the training by…7-15-10.	

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W 189	Continued From page 8 revealed a diet order of 1500 calorie, high fiber, fluid restriction (maximum of 1000 cc per day), four ounces of yogurt with breakfast and dinner. Further review of the client's POS from July 2009 through April 2010, revealed a diet order of 1500 calorie, high fiber, fluid restriction (maximum of 1000 cc per day), four ounces of yogurt with breakfast and dinner. Review of the posted menu on May 12, 2010, at 12:30 p.m., indicated that a 1500 calorie meal consisted of two ounces of chicken and a regular diet was three ounces of chicken. There was no evidence that the facility implemented Client #1's diet as ordered.	W 189	The QMRP and nursing supports will observe meals weekly to insure that all staff members implement the diet regimen as prescribed and will provide on-the –spot training to staff when issues are observed…6-20-10.	
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 interview and record review, the facility's qualified mental retardation professional (QMRP) failed to ensure client's received continuous active treatment, for two of the two clients included in the sample. (Client #1 and #2) The findings include: 1. On May 11, 2010, at 8:20 a.m., the one to one	W 249		

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W 249	Continued From page 9 support staff was observed walking in front of Client #1 as she descended down the stairs. Once outside, the staff provided Client #1 with a roller walker. The client was then observed using the walker with stand by assistance. Review of Client #1's individual program plan (IPP) dated May 2, 2010, on May 12, 2010, at approximately 10:30 a.m., revealed a program goal that stated, "[the client] will improve her strength." The client was to perform hip and knee exercises, three times a week, for 10 repetitions at 100% accuracy for six months. Review of the data collection book on May 12, 2010, at 11:30 a.m., reflected no program data sheets. In an interview with the QMRP on the same date, at 11:45 a.m., she acknowledged that the program has not been implemented, "yet." According to the physical therapy assessment dated April 27, 2010, on May 12, 2010, at approximately 12:10 p.m., indicated that the client's mobility has deteriorated and was therefore recommending an exercise program. 2. The facility failed to ensure an effective system that each clients participated in a self-medication training program, for one of the two clients in the sample. (Client #1) Observations during of medication administration on May 11, 2010, at 7:10 p.m., the Licensed Practical Nurse (LPN) was observed placing two pill bottles on a medication tray. The LPN went upstairs and asked staff to bring Client #1 to her bedroom for her medications. The nurse was observed handing the client two pill bottles of medications and holding an empty medication	W 249	W249 1. Client #1's exercise program prescribed by PT will be implemented by...7-1-10. PT will train staff on proper implementation by...6-28-10. The QMRP will monitor implementation via direct observations at minimum weekly and via reviews of the data collected (minimum weekly)...7-1-10. The QMRP will review the status of all recommendations accepted during her monthly audit of the individual records to insure that implementation of each is properly tracked...6-30-10. 2. The RN will train the medication nurses on proper implementation of the self-medication protocol for Client #1...6-20-10. Additionally, the RN will monitor data collection to insure that the objective is routinely implemented with proper, accurate documentation evidenced...6-30-10.	

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W 249	Continued From page 10 cup. The client was observed opening the bottles, taking the pills from each bottle and putting into medications into a cup. The client put the top back on each pill bottle and handed the bottles to the LPN. The LPN was observed handing the medication cup and a cup of water to the client. The client consumed the medication and drank the water. The LPN was observed putting the client's medication cup into the trash can. Interview with LPN, after the medication administration, revealed Client #1 had a self-medication program to administer her psychotropic medication. Review of Client #1's Individual Program Plan (IPP) dated May 3, 2010, on May 13, 2010, at approximately 10:00 a.m., revealed a program objective which stated, "[the client] will require one verbal prompt 100% of the time to complete her medication regimem... Review of Client #1's self-medication program was as follows: - wash hands; - pour water; - recognize name; - remove medication with green dot - remove cap from bottle - remove pill from bottle; - take medication; - drink water; and - dispose of cup There was no evidence that the client was given the opportunity to fully participate in the self-medication program.	W 249		
W 255	483.440(f)(1)(i) PROGRAM MONITORING & CHANGE	W 255		

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W 255	Continued From page 11 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 has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record verification, the facility's qualified mental retardation professional (QMRP) failed to ensure that client individual program plans (IPP) were reviewed and revised once the client had successfully completed an objective identified in the IPP, for one of the two clients in the sample. (Client #1) The finding includes: On May 11, 2010, at approximately 4:30 p.m., Client #1 was observed counting by 5's up to 100. Interview with the client at 4:50 p.m., indicated that she knows how to count and can very well. Minutes later, in a face to face interview with the one to one support staff, she indicated that [Client #1] is really good with math. Review of Client #1's IPP dated May 1, 2009, on May 12, 2010, at approximately 11:00 a.m., revealed a program objective which stated, "Given verbal prompts, [the client] will learn to count by 5's to 100 at 50% accuracy level two times a week for six consecutive months" Review of the QMRP monthly notes from April 2009, through March 2010, revealed that the client met the established criteria by October 2009.	W 255	W255 The QMRP will complete the IPP objective for client #1 and replace it with a new objective for the remainder of the ISP year...7-1-10. The QA Consultant will audit records at minimum quarterly to insure that all measurable objectives are properly implemented; progress is documented and to insure that objectives are modified or completed in a timely manner...6-30-10.	
W 322	483.460(a)(3) PHYSICIAN SERVICES	W 322		

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W 322	Continued From page 12 The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure preventive health services were implemented as recommended, for one of two clients in the sample. (Client #1) The finding includes: On May 11, 2010, at 7:50 a.m., Client #1 was observed wearing support hose/socks. During day program observations on the same day, from 12:40 p.m., until 1:30 p.m., the client was sitting at a table, participating in table top activities. The client arrived home from day program, on the same day, at 4:00 p.m. At 4:10 p.m., Client #1 was observed sitting in her recliner chair with a table in front of her, eating her snack and participating in table top activities until 6:05 p.m. After the client completed her meal and medication administration, at 7:14 p.m., the client was observed sitting in a recliner chair with her feet elevated. Interview with the QMRP, house manager and registered nurse (RN) on May 12, 2010, at approximately 12:15 p.m., indicated that when Client #1 participates in her active treatment programs, she should be sitting in her recliner chair, in front of a table, with her feet elevated. At that time, the surveyor informed the aforementioned parties, that the client was not observed with her feet elevated or standing and	W 322	W322 The RN will again train staff on the mandates of the HMCP for Client #1 and all of her peers to insure that staff members understand their duties and responsibilities in implementing the HMCP…6-28-10.	

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W 322	Continued From page 13 changing positions, the previous evening until 6:05 p.m., and 7:14 p.m. The QMRP indicated that the client's feet should be elevated if sitting longer that 15 minutes. The RN indicated that Client #1's one to one support staff usually following the HMCP (to elevate feet). Review of Client #1's physical therapy assessment dated April 27, 2010, on May 12, 2010, at approximately 11:00 a.m., revealed the following recommendations: - Elevate her lower extremities if sitting longer than 15 minutes. This also applies to her day program; - The client should not sit longer than one hour without standing and changing positions; - Work at the table for fine motor tasks. Do not the allow, client to work with puzzles and books resting on her lap; and - Continue with compression socks. There was no evidence that the facility's staff implemented Client #1's HMCP, as instructed.	W 322	The QMRP and RN will separately observe active treatment implementation on an ongoing (minimum weekly for each shift) basis to insure routine implementation of all HMCP mandates and protocols...6-30-10.	
W 371	483.460(k)(4) DRUG ADMINISTRATION The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observations, staff interviews and the	W 371		

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W 371	Continued From page 14 review of records, the facility failed to ensure an effective system that each clients participated in a self-medication training program, for one of the two clients in the sample. (Client #1) The finding includes: Observations during of medication administration on May 11, 2010, at 7:10 p.m., the Licensed Practical Nurse (LPN) was observed placing two pill bottles on a medication tray. The LPN went upstairs and asked staff to bring Client #1 to her bedroom for her medications. The nurse was observed handing the client two pill bottles of medications and holding an empty medication cup. The client was observed opening the bottles, taking the pills from each bottle and putting into medications into a cup. The client put the top back on each pill bottle and handed the bottles to the LPN. The LPN was observed handing the medication cup and a cup of water to the client. The client consumed the medication and drank the water. The LPN was observed putting the client's medication cup into the trash can. Interview with LPN, after the medication administration, revealed Client #1 had a self-medication program to administer her psychotropic medication. Review of Client #1's Individual Program Plan (IPP) dated May 3, 2010, on May 13, 2010, at approximately 10:00 a.m., revealed a program objective which stated, "[the client] will require one verbal prompt 100% of the time to complete her medication regimem... Review of Client #1's self-medication program was as follows:	W 371	W371 1. The RN will train the medication nurses on proper implementation of the self-medication protocol for Client #1...6-20-10.	

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W 371	Continued From page 15 - wash hands; - pour water; - recognize name; - remove medication with green dot - remove cap from bottle - remove pill from bottle; - take medication; - drink water; and - dispose of cup There was no evidence that the client was given the opportunity to fully participate in the self-medication program.	W 371	Additionally, the RN will monitor data collection to insure that the objective is routinely implemented with proper, accurate documentation evidenced...6-30-10.	
W 390	483.460(m)(2)(i) DRUG LABELING The facility must remove from use outdated drugs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's nurse failed to ensure outdated medications were remove from use, for one of four clients residing in the facility. (Client #4) The finding includes: During the environmental inspection on May 12, 2010, beginning at 2:55 p.m., a bottle of Ketoconazole shampoo 2% was observed in Client #4's topical storage box. The label on the bottle had an expiration date of April 14, 2010. The House Manager on duty at that time reviewed the label and confirmed that the medication had expired.	W 390	W390 The topical cream has been properly discarded...6-8-10 The RN and/or support LPN will audit the topical creams and by mouth medications monthly to insure that expired medications are disposed of properly and in a timely manner...6-28-10. Additionally, pharmacy reviews will be conducted quarterly and audits will occur at that time as supported by the pharmacist...7-1-10.	
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the	W 455		

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W 455	Continued From page 16 prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure an active program for the prevention and control of infection, for one of the two clients included in the sample. (Client #1) The finding includes: 1. The facility failed to ensure proper infection control procedures prior to Client #1 administering her medication. Observations during of medication administration on May 11, 2010, at 7:10 p.m., the Licensed Practical Nurse (LPN) was observed washing her hand and placing two pill bottles on a medication tray. The LPN went upstairs and asked staff to bring Client #1 to her bedroom for her medications. The LPN was observed washing her hand again. The nurse was observed handing the client two pill bottles of medications and holding an empty medication cup. The client was observed opening the bottles, and taking the pills from each bottle and putting into medications into a cup. the client did not wash her hands nor did the LPN give her hand sanitizer prior to administering her medications. The client put the tops back on each pill bottle and handed them to the LPN. The LPN was observed handing the medication cup and a cup of water to the client. The client consumed the medication and drank the water. There was no evidence the facility's nursing staff	W 455	W455 All staff members and medication passing nurses will receive training on infection control procedures/precautions. This re-training will occur by...6-20-10.	

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W 455	Continued From page 17 provided an active program for the prevention and control of infection. 2. The facility failed to ensure that Client#1 washed her hands prior to her snack. On May 11, 2010, at 4:10 p.m., Client #1 was observed exiting the bathroom with a paper towel in her hand. At 4:15 p.m., the client was observed playing cards. At 4:20 p.m., the direct staff offered the client a snack of cottage cheese with strawberries. Minutes later, the client was observed eating and enjoying her snack. Interview with the Client #1's one to one support staff on May 11, 2010, at 4:26 p.m., revealed that Client #1 washed her hands when she came from the bathroom. Interview with a direct care staff, minutes later, revealed that she did not assist the client with washing her hands, prior to the snack. There was no evidence that the staff provided proper infection control procedures prior the client's meal time.	W 455	Special attention will be given to medication pass situations and snack time.	

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I 000	INITIAL COMMENTS A recertification survey was conducted from May 11, 2010 through May 13, 2010. The survey was initiated using the fundamental survey process. A random sample of two residents was selected from a population of two female residents and two male residents with various levels of intellectual disabilities. The findings of the survey was based on observations at the group home and two day programs, interviews with residents and staff and the review of clinical and administrative records including incident reports.	I 000		
I 161	3507.2 POLICIES AND PROCEDURES The manual shall be approved by the governing body of the GHMRP and shall be reviewed at least annually. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide evidence that the governing body approved and reviewed its policies and procedures annually. The finding includes: Interview with the qualified mental retardation professional (QMRP) and review of the policy and procedures manual on May 11, 2010, at approximately 10:30 a.m., failed to provide evidence that the policy manual had been reviewed and approved by the governing body as required, since Janaury 1, 2009.	I 161	3507.2 A January 2010 review of the policy manual occurred but has not been properly documented. This review will be updated and documented by...6-30-10. All staff will have policy manual changes reviewed with them as evidence by their signatures by...7-15-10.	
I 206	3509.6 PERSONNEL POLICIES	I 206		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Linda Carson, Program Director TITLE (X6) DATE 6/10/2010

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I 206	Continued From page 1 Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure each staff and consultant had a current health certificate, for three of the twelve consultants. The finding includes: Interview with the qualified mental retardation professional (QMRP) and review of the personnel records on May 12, 2010,beginning at 2:00 p.m., revealed the GHMRP failed to provide evidence that current health certificates were on file for three of the twelve consultant (primary care physician, psychologist, and occupational therapist).	I 206	3509.6 Health Certificates will be obtained for the cited professionals by...7-15-10. BRA tracks personnel file compliance and routinely notifies staff and consultants in a proactive manner to address upcoming concerns. This process will continue quarterly. BRA will follow up with sanctions as required when follow up is not timely...7-1-10.	
I 422	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, interview and record review, the Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure habilitation, training and assistance were provided to its residents in accordance with their individual Habilitation Plan(s), for one of the two	I 422		

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I 422	Continued From page 2 residents included in the sample. (Resident #1) The findings include: 1. On May 11, 2010, at 8:20 a.m., the one to one support staff was observed was walking in front of Resident #1 as she descended down the stairs. Once outside the staff provided Resident #1 with a roller walker. The resident was then observed using the walker with stand by assistance. Review of Resident #1's individual program plan (IPP) dated May 2, 2010, on May 12, 2010, at approximately 10:30 a.m., revealed a program goal that stated, "[the resident] will improve her strength." The resident was to perform hip and knee exercises, three times a week, for 10 repetitions at 100% accuracy for six months. Review of the Resident #1's data collection book on May 12, 2010, at 11:30 a.m., reflected no program data sheets. In an interview with the QMRP on the same date, at 11:45 a.m., she acknowledged that the program has not been implemented, "yet." According to the physical therapy assessment dated April 27, 2010, on May 12, 2010, at approximately 12:10 p.m., indicated that the resident's mobility has deteriorated and was therefore recommending an exercise program. 2. The facility failed to ensure an effective system that each residents participated in a self-medication training program, for one of the two residents in the sample. (Resident #1) Observations during of medication administration on May 11, 2010, at 7:10 p.m., the Licensed	I 422	1. Client #1's exercise program prescribed by PT will be implemented by...7-1-10. PT will train staff on proper implementation by...6-28-10. The QMRP will monitor implementation via direct observations at minimum weekly and via reviews of the data collected (minimum weekly)...7-1-10. The QMRP will review the status of all recommendations accepted during her monthly audit of the individual records to insure that implementation of each is properly tracked...6-30-10. 2. The RN will train the medication nurses on proper implementation of the self-medication protocol for Client #1...6-20-10. Additionally, the RN will monitor data collection to insure that the objective is routinely implemented with proper, accurate documentation evidenced...6-30-10.	

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I 422	Continued From page 3 Practical Nurse (LPN) was observed placing two pill bottles on a medication tray. The LPN went upstairs and asked staff to bring Resident #1 to her bedroom for her medications. The nurse was observed handing the resident two pill bottles of medications and holding an empty medication cup. The resident was observed opening the bottles, taking the pills from each bottle and putting into medications into a cup. The resident put the top back on each pill bottle and handed the bottles to the LPN. The LPN was observed handing the medication cup and a cup of water to the resident. The resident consumed the medication and drank the water. The LPN was observed putting the resident's medication cup into the trash can. Interview with LPN, after the medication administration, revealed Resident #1 had a self-medication program to administer her psychotropic medication. Review of Resident #1's Individual Program Plan (IPP) dated May 3, 2010, on May 13, 2010, at approximately 10:00 a.m., revealed a program objective which stated, "[the resident] will require one verbal prompt 100% of the time to complete her medication regimen... Review of Resident #1's self-medication program was as follows: - wash hands; - pour water; - recognize name; - remove medication with green dot - remove cap from bottle - remove pill from bottle; - take medication; - drink water; and - dispose of cup	I 422	1. The RN will train the medication nurses on proper implementation of the self-medication protocol for Client #1...6-20-10. Additionally, the RN will monitor data collection to insure that the objective is routinely implemented with proper, accurate documentation evidenced...6-30-10.	

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I 422	Continued From page 4 There was no evidence that the resident was given the opportunity to fully participate in the self-medication program.	I 422		
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: Based on staff interviews and record review, the Group Home for the Mentally Retarded Persons (GHMRP's) Qualified Mental Retardation Professional (QMRP) failed to review and revise the Individual Program Plan (IPP) once the resident had successfully completed an objective identified in the IPP, for two of the three residents in the sample. (Residents #2 and #3) The finding includes: On May 11, 2010, at approximately 4:30 p.m., Resident #1 was observed counting by 5's up to 100. Interview with the resident at 4:50 p.m., indicated that she knows how to count and can very well. Minutes later, in a face to face interview with the one to one support staff, she indicated that [Resident #1] is really good with math. Review of Resident #1's IPP dated May 1, 2009, on May 12, 2010, at approximately 11:00 a.m., revealed a program objective which stated, "Given verbal prompts, [the resident] will learn to count by 5's to 100 at 50% accuracy level two	I 424	W255 The QMRP will complete the IPP objective for client #1 and replace it with a new objective for the remainder of the ISP year...7-1-10. The QA Consultant will audit records at minimum quarterly to insure that all measurable objectives are properly implemented; progress is documented and to insure that objectives are modified or completed in a timely manner...6-30-10.	

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I 424	Continued From page 5 times a week for six consecutive months" Review of the QMRP monthly notes from April 2009, through March 2010, revealed that the resident met the established criteria by October 2009.	I 424		
I 436	3521.7(f) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (f) Health care (including skills related to nutrition, use and self-administration of medication, first aid, care and use of prosthetic and orthotic devices, preventive health care, and safety); This Statute is not met as evidenced by: Based on observations, interviews and the review of records, the Group Home for Mentally Retarded Persons (GHMRP) failed to implement an effective system to ensure that each resident participated in a self-medication training program, for one of the two residents in the sample. (Resident #1) The findings include: Observations during of medication administration on May 11, 2010, at 7:10 p.m., the Licensed Practical Nurse (LPN) was observed placing two pill bottles on a medication tray. The LPN went upstairs and asked staff to bring Resident #1 to her bedroom for her medications. The nurse was observed handing the resident two pill bottles of medications and holding an empty medication cup. The resident was observed opening the bottles, taking the pills from each bottle and putting into medications into a cup. The client put the tops back on each pill bottle and handed	I 436		

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I 436	Continued From page 6 them to the LPN. The LPN was observed handing the medication cup and a cup of water to the client. The client consumed the medication and drank the water. The LPN was observed putting the resident's medication cup into the trash can. Interview with LPN, after the medication administration, revealed Resident #1 had a self-medication program to administer her psychotropic medication. Review of Resident #1's Individual Program Plan (IPP) dated May 3, 2010, on May 13, 2010, at approximately 10:00 a.m., revealed a program objective which stated, "[the resident] will require one verbal prompt 100% of the time to complete her medication regime... Review of Resident #1's self-medication program was as follows: - wash hands; - pour water; - recognize name; - remove medication with green dot - remove cap from bottle - remove pill from bottle; - take medication; - drink water; and - dispose of cup There was no evidence that the resident was given the opportunity to fully participate in the self-medication program.	I 436	1. The RN will train the medication nurses on proper implementation of the self-medication protocol for Client #1…6-20-10. Additionally, the RN will monitor data collection to insure that the objective is routinely implemented with proper, accurate documentation evidenced…6-30-10.	
I 484	3522.11 MEDICATIONS Each GHMRP shall promptly destroy prescribed medication that is discontinued by the physician or has reached the expiration date, or has a worn, illegible, or missing label.	I 484		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 484	Continued From page 7 This Statute is not met as evidenced by: Based on observation and record review, the Group Home for Mentally Retarded Persons (GHMRP) nurse failed to remove from use, out dated medications, for one of two residents residing in the facility. (Resident #4) The finding includes: During the environmental inspection on May 12, 2010, beginning at 2:55 p.m., a bottle of Ketoconazole shampoo 2% was observed in Resident #4's topical storage box. The label on the bottle had an expiration date of April 14, 2010. The House Manager on duty at that time reviewed the label and confirmed that the medication had expired.	I 484	The topical cream has been properly discarded...6-8-10 The RN and/or support LPN will audit the topical creams and by mouth medications monthly to insure that expired medications are disposed of properly and in a timely manner...6-28-10. Additionally, pharmacy reviews will be conducted quarterly and audits will occur at that time as supported by the pharmacist...7-1-10.	
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observations, interviews and record review, the the Group Home for the Mentally Retardate Persons (GHMRP) failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and other District and federal laws that govern the care and rights of persons with mental retardation, for one of the two residents included in the sample. (Resident #1)	I 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0084	A. BUILDING _____ B. WING _____	05/13/2010

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I 500	Continued From page 8 The finding includes: The facility failed to ensure that informed consent was obtained from Resident #1's guardian prior to the administration of his psychotropic medications. During the entrance conference on May 11, 2010, beginning at 9:00 a.m., the qualified mental retardation professional (QMRP) indicated that Resident #1 received psychotropic medications to address her maladaptive behaviors. Further interview revealed the resident did not have the capacity to give informed consent for the use of medications and habilitation services. Medication administration observation on May 11, 2010, at 7:10 p.m., Resident #1 was observed receiving Tegretol XR 300 mg. Interview with the Licensed Practical Nurse (LPN) after the medication administration indicated that the resident received the aforementioned medication for her maladaptive behaviors. Review of the resident's current physician orders dated May 2010, on May 11, 2010, at approximately 7:30 p.m., revealed an order of Tegretol XR 300 mg, twice a day for aggression. The QMRP's statement was verified on May 12, 2010, at approximately 10:00 a.m., through review of Resident #1's psychological assessment dated April 30, 2010. According to the assessment, Resident #1 "does not evidence the capacity to make decisions on his own behalf in treatment, habilitation, residential placement, and financial matters." Further interview with the QMRP during the survey, revealed that the resident had a court appointed guardian who is involved in his habilitation planning and decision	I 500	W124 The QMRP will insure that the guardian of Client #1 is informed of the increase in the Tegretol dose; that the risks/benefits are explained and that the guardian provides signed consent for the increase…6-28-10. In the future, such proposed increases will be discussed in the routine psychotropic medication reviews and the team leader will insure that consent is discussed and a plan of action is developed in instances where an increase in medication is suggested…6-30-10. Signed consent will be obtained prior to the implementation of any increase in psychotropic medications, including the addition of a new medication…6-30-10. The QMRP will review the psychotropic medication reviews and physician's orders routinely as a part of her internal audit process to insure that consent is obtained for changes in the regimen. The QMRP also serves as a member of the psychotropic medication review team…6-30-10	

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I 500	Continued From page 9 making process. Record verification on May 13, 2010, at 10:00 a.m., revealed that Resident #1's guardian had given informed consent for the use of Tegretol 200 mg on May 15, 2008. There was no consent signed, however, for the an additional 100 mg of the prescribed Tegretol. At the time of the survey, the facility failed to provide evidence that informed consent was obtained from the Resident and/or legally authorized representative prior to an increase in the psychotropic medication.	I 500		