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| W 000 | INITIAL COMMENTS<br><br>A recertification survey was conducted during the evening of July 31, 2007 through August 3, 2007. The survey was initiated using the fundamental survey process. A random sampling of two clients was selected from a residential population of three females with various disabilities. Due to observational findings during the survey the survey was extended, and a focused review was conducted of Client #3 in the areas of active treatment and client behavior and facility practices. The findings of the survey were based on observations, interviews with staff in the home and two day programs, as well as a review of client and administrative records, including incident reports. | W 000 | | |
| W 104 | 483.410(a)(1) GOVERNING BODY<br><br>The governing body must exercise general policy, budget, and operating direction over the facility.<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, interviews and the review of records, the facility's Governing Body failed to provide general operating direction over the facility.<br><br>The findings include:<br><br>1. The facility failed to ensure sufficient trained direct care staff were available to manage and supervise Client #1, #2 and #3 in accordance with their needs.<br><br>Interviews with two direct care staff and the Qualified Mental Retardation Professional and the review of personnel records and scheduling | W 104 | 1. Staff training inclusive of First Aid, CPR, Nutrition, BSP, Client Rights, Active Treatment, and Program Documentation are on going and scheduled monthly. | 9-15-07 |

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

Dr. Roderick Brooks | Adm | 8/28/07

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<br>records revealed recent hiring of staff. The records reflected gaps in the staffing levels, which reportedly were being filled by staff from other agency homes, when needed. The facility lacked evidence that newly hired staff or the staff from other homes had been trained on the active treatment components and special needs of the clients. [See W189]<br><br>2. The facility failed to ensure each client's active treatment program was integrated, coordinated and monitored by the qualified mental retardation professional. [See W159]<br><br>3. The facility failed to ensure Pharmacy Reviews of the client's medications were conducted timely. [See W362]<br><br>4. The facility failed to ensure four of ten staff were currently certified in emergency procedures. [See W192] | W 104 | 2. Program has a new QMRP since 7-1-07. Documentation is reviewed monthly and coaching of counselors is on going.<br><br>3. Pharmacist review of medication will be conducted quarterly.<br><br>4. Training of staff including is on going and will follow a monthly schedule including CPR and First Aid. | 8-13-07<br><br>8-25-07 |
| W 111 | 483.410(c)(1) CLIENT RECORDS<br><br>The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights.<br><br>This STANDARD is not met as evidenced by:<br>Based on interview and record review, the facility failed to ensure treatment records and assessments were maintained in the facility for three of three sampled clients. (Clients #1, #2 and #3)<br><br>The findings include:<br><br>Interviews conducted with the LPN on August 2 | W 111 | 1. Ensure is given as ordered. Documentation of this order will be recorded on MAR. | 8-24-07 |

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| W 111 | Continued From page 2<br>and August 3, 2007 regarding documentation of the health care treatments and assessments for Clients #1, #2 and #3 revealed the following:<br><br>1. Incomplete documentation was noted on the July 2007 Medication Administration Record (MAR) of Ensure Plus provided to Client #3 to prevent weight loss.<br><br>2. Documentation of treatments administered to Client #2 for a vulva lesion was not available.<br><br>3. No documentation was available for the use of Lorazepam a Schedule IV drug for the months prior to May 2007 for Client #3. [See W385]<br><br>4. The facility lacked documentation of a reported September 2006 sexuality assessment for Client #1.<br><br>The LPN revealed that the aforementioned documentation was completed, however the reports had been purged from the client's records.<br><br>5. Interview with the primary LPN on August 2, 2007 at 5:51 PM revealed that the client was receiving Depro-Provera Contraceptive Injections at the health clinic every three months when she was admitted to the group home in September 2006.<br><br>Record review on August 2, 2007 revealed no sexuality assessment was available for the client. According to the primary LPN, the sexuality assessment was completed in September 2006, but was not in the client's record at the time of the survey. | W 111 | 2. Documentation of treatment will be recorded in Nurses progress note.<br><br>3. All controlled substance will be documented and accounted for on a drug count sheet<br><br>4. Annual assessment will be completed and kept.<br><br>5. Annual assessment will be completed and kept. | 8-24-07<br><br>8-14-07<br><br>9-1-07<br><br>8-27-07 |

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| W 111 | Continued From page 3<br>6. The facility's nursing services failed to maintain documentation relating to Client #2's treatment for a vulva ulceration.<br><br>Record review on August 2, 2007 at 9:57 AM revealed that Client #2 had an annual GYN examination on March 15, 2007. According to the consultation report, "a 2 mm small vulva ulceration, labia majora with dry ulceration, and scant discharge" were observed. The client's medical record revealed a prescription for Lotrisome Cream to be applied to her labia majora for 2 weeks. Review of the client's physician's order failed to reflect the prescription for Lotrisome Cream. .<br><br>Interview with the primary LPN on August 3, 1007 at 10:10 AM revealed the prescribed Lotrisome was not ordered because the client was already prescribed a similar medication which was used twice a day as needed. According to the LPN, the direct care staff applied the medication and documented the treatment on the MAR. The nurse indicated that documentation of treatments done by staff for the vulva ulceration was reviewed by the nurse. Further interview with the LPN revealed the documentation of the aforementioned treatment was purged from the client's medical record and was not available at the time of the survey. | W 111 | 6. Physician Orders will be reviewed and updated monthly. All new orders will be added and noted in the MAR | 8-24-07 |
| W 130 | 483.420(a)(7) PROTECTION OF CLIENTS RIGHTS<br><br>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.<br><br>This STANDARD is not met as evidenced by: | W 130 | | |

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| W 130 | Continued From page 4<br>Based on observation and interview, the facility failed to ensure privacy during personal care for three of three clients residing in the facility. (Clients #1, #2, and #3)<br><br>The findings include:<br><br>1. On August 1, 2007 at 8:00 AM, Clients #1, #2, and #3 were observed sitting in the living room after breakfast. A staff was observed with a basket containing hair grooming supplies, and at approximately 8:02 AM, the staff called the clients one by one to the small table near the TV in the living room to groom their hair. While each client was receiving hair grooming, the other two clients continued to sit in the living room where the third client was provided hair care by the staff.<br><br>Interview with the staff revealed the clients must be checked prior to leaving for the day program to ensure their hair was properly groomed. There was no evidence the facility ensured the clients were afforded personal privacy during hair grooming.<br><br>2. The facility failed to ensure that Client #2 exercised personal privacy while dressing in her bedroom. [See W242, 1b] | W 130 | 1. Grooming of each person will occur in their personal rooms. This item will be presented constantly in rights training.<br><br>2. Staff will be trained on rights and privacy. | 8-24-07<br><br>8-24-07 |
| W 140 | 483.420(b)(1)(i) CLIENT FINANCES<br><br>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients.<br><br>This STANDARD is not met as evidenced by:<br>Based on staff interview and record review, the facility failed to maintain a system that ensured a | W 140 | | |

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| W 140 | Continued From page 5<br>full and complete accounting of clients' personal funds entrusted to the facility for one of the two clients in the sample. (Client #1)<br><br>The finding includes:<br><br>Interview with the Qualified Mental Retardation Professional (QMRP) on August 3, 2007 at 2:37 PM revealed the records of the clients' expenditures were primarily maintained by the group home manager who was currently on leave. The review of Client #1's bank statement for May 2007 revealed a $400.00 withdrawal for shopping on May 17, 2007. Further interview with the QMRP revealed the receipts showing how the money was spent were not available for review. There was no evidence of what items were purchased. | W 140 | Funds were given to mother for shopping for her daughter. The receipt for the purchase was misplaced by the home. The mother wrote a statement verifying the purchases was in the amount of $387.00. Purchase of items was verified by home staff. | 8-22-07 |
| W 149 | 483.420(d)(1) STAFF TREATMENT OF CLIENTS<br><br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.<br><br>This STANDARD is not met as evidenced by:<br>Based on staff interview and record review, the facility failed to implement its established policy to ensure the health and safety of one of three clients residing in the facility. (Client #2)<br><br>The finding includes:<br><br>The facility failed to implement its policy on reporting of unusual incidents.<br><br>The review of unusual incidents on August 1, 2007 revealed on December 23, 2006 at 11:59 | W 149 | | |

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| W 149 | Continued From page 6<br>AM a neighbor called the police due to an alleged misunderstanding. The neighbor alleged that Client #2 was being mistreated by staff while the client was on the front porch of the group home.<br><br>The investigation of the incident concluded that Client #2 was screaming on the front porch, which was one of her targeted behaviors. During the time the neighbor observed the resident, she had been on the porch with a staff and another resident. The investigative report indicated that the staff walked into the house ahead of the residents and the neighbor thought one of the clients on the porch was a staff.<br><br>According to the agency's incident reporting policy, allegations of mistreatment are required to be reported to the Department of Health. | W 149 | As per agency policy all allegations of mistreatment will be forwarded to the Department of Health | 8- 13-07 |
| W 159 | 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL<br><br>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interview and record verification, the facility failed to ensure each client's active treatment program was integrated, coordinated and monitored by the qualified mental retardation professional (QMRP) for three of three clients residing in the facility. (Clients #1, #2, and #3)<br><br>The findings include:<br><br>1. The QMRP failed to ensure Client #1's communication device was provided to the day | W 159 | | |

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| W 159 | Continued From page 7<br>program timely for implementation of her training objective.<br><br>Review of the April 20, 2007 Speech and Language Pathologist (SLP) progress noted revealed that Client #1's communication device (Mini-Merc), except for the charger, was delivered to the client's day program. The SLP recommended that the group home locate the charger/adapter and charge the battery for two hours daily. Further interview with the SLP and review of progress notes dated April 30, 2007 and May 3, 2007 revealed the requested components ( charger/adapter) of the Mini-Merc had not been received from the group home. Although, at the time of the survey, the Mini Merc communication device for Client #1 was available and being implemented, the QMRP failed to ensure the implementation of the program for several months after the communication device was delivered to the facility<br><br>2. The QMRP failed to coordinate Client #1's behavioral needs with the day program.<br><br>On August 1, 2007 at 11:55 AM, Client #1 was observed throwing a bag of connecting blocks on the floor from a plastic bag located on the table when she was requested to complete a Lock Puzzle. Interview with the classroom instructor revealed the client was sometimes non-compliant and would throw objects on the floor.<br><br>Record verification at the day program revealed incidents of spitting in the water fountain and other locations, throwing objects and attempted property destruction. The classroom instructor acknowledged the client did not have a formal | W 159 | The communication device is currently being used at the Day Program and is charged daily at the person home.<br><br>2. QMRP will monitor day program monthly and review all documentation from day program to ensure proper treatment of person #1 targeted behavior. | 8-13-07<br><br>9-10-07 |

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| W 159 | Continued From page 8<br>behavior management program at the day program; however behaviors were documented on an "Interim Data Sheet" when the client exhibits them. The classroom instructor indicated that quarterly reports were sent to the group home to be monitored by the QMRP.<br><br>Interview with the QMRP on August 1, 2007 revealed Client #1 had a behavior support plan which addressed the following targeted behaviors: (a) Misuse/inappropriate use of toilet paper/napkins; (b) Inappropriate spitting.<br><br>Further interview with the QMRP on August 2, 2007 and the record verification revealed no behavioral data from the day program was available. There was no evidence the QMRP coordinated with Client #1's day program to determine if the targeted or other maladaptive behaviors were exhibited in that setting.<br><br>3. The QMRP failed to coordinate services to ensure Client #2 received a speech assessment and communication objective as ordered by the court.<br><br>Interview with the QMRP on August 2, 2007 revealed that during Client #2's annual court hearing in March 2007 the judge ordered that the facility implement a formal communication training objective for the client. Record verification confirmed the court ordered that the interdisciplinary team (IDT) develop and implement the formal functional language program in the Behavior Support Plan (BSP) which related to identifying the items the client desires and screams about. Although the review of the current BSP dated June 5, 2007 revealed a "Response Guidelines: Screaming as a | W 159 | 3. Speech program to address behavior and court order is currently being reviewed by DDS speech pathologist. Person # 2 is also scheduled for assessment from providers Speech Pathologist 8-31-07 | 9-4-07 |

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| W 159 | Continued From page 9<br>communicative tool", the review of the current IPP implemented after the August 3, 2006 Individual Support Plan (ISP) revealed no objective was developed to address the screaming behavior.<br><br>4. The QMRP failed to ensure each employee was provided with initial and continuing training that enabled them to perform duties effectively, efficiently, and competently. [See W189]<br><br>5. The QMRP failed to coordinate services to ensure Client #3 received a comprehensive functional assessment of her fingerlicking behavior. [See W214]<br><br>6. The QMRP failed to ensure the type of data collected for Client #2's individual program plan (IPP) objective on safety sign identification allowed assessment of the client's progress. [See W237]<br><br>7. The QMRP failed to ensure the individual program plan (IPP) included training in personal skills necessary for privacy for Client #2 and on good hygiene for Client #1. [See W242]<br><br>8. The QMRP failed to ensure as soon as the interdisciplinary team formulated the individual program plan (IPP), Clients #1 and #2 received a continuous active treatment plan consisting of needed interventions to achieve identified objectives. [See w249]<br><br>9. The QMRP failed to ensure data relative to the accomplishment of Client #3's behavioral objectives was documented. [See W252]<br><br>10. The QMRP failed to ensure that significant events (frequent fingerlicking) that were related to | W 159 | Trainings are scheduled monthly and going monitoring of the home and coaching is provided informally at least twice weekly.<br><br>5. Behavior data is kept and presented to behavior therapist and HRC committee for review and further recommendations.<br><br>6. Goal will be modified with new ISP to allow for assessment of person #2 progress/lack of progress of this goal.<br><br>7. Staff Training on persons rights and privacy.<br>8. Staff will in-serviced on person #1 and Person # 2 IPP monitoring and coaching of programs will be completed monthly.<br><br>9. QMRP monthly review will include a review of MAR documentations.<br><br>10. In Service on Program Documentation scheduled for 8-31-07 | 8-24-07<br><br>9-28-07<br><br>8-31-07<br><br>8-24-07<br>8-31-07<br><br>9-4-07<br><br>8-31-07 |

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| W 159 | Continued From page 10<br>the Client #3's individual program plan and assessment were documented. [See W253]<br><br>11. The QMRP failed to ensure the provision of transportation which would enable clients to participate in scheduled evening and weekend recreational activities.<br><br>On August 1, 2007, after dinner Clients #1, #2 and #3 were observed dressed for an outing at a local mall "City Place". Through information obtained during a 7:00 AM interview earlier the same day, the surveyor learned that the clients previously went to a night club on Thursday evenings. Staff also indicated that in the past the clients had been taken to church. According to the staff, the clients could no longer attend the evening outings due to the resignation of the van driver; to date no replacement has been hired.<br><br>The review of the recreation log for Client #2 on August 2, 2007 at 2:27 PM revealed the following activities were provided for the client during June and July 2007:<br><br>a. 6/2/07 - Walk to the drug store<br>b. 6/16/07 - Sightseeing walk to the swimming pool<br>c. 7/1/07 - Walk to grocery store with staff<br>d. 7/14/07 - Walked to the pool<br>e. 7/27/07- Walked to the grocery store with staff<br><br>Additionally, the review of recreation logs indicated that between January 2007 and April 2007 the clients regularly went to the night club on Thursdays. The review of the June and July 2007 activity schedules indicated the clients should go to church every Sunday, go to the Chateau (night club) every Thursday, and also go | W 159 | 11. QMRP has worked for this company as a consultant since May 07. He became a full time employee as of July 07. Variety of activities will/are presented to persons 1, 2, and 3 for choices for monthly outings. Counselor/Driver began employment 8-4-07. | 9-1-07 |

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| W 159 | Continued From page 11<br>to various points of interest in the city on Saturdays.<br><br>The QMRP indicated the clients have participated on community outings since April 2007, however he acknowledged the documentation of the events was not available. Interview with the QMRP revealed he had only been employed at the facility since July 1, 2007. | W 159 | | |
| W 189 | 483.430(e)(1) STAFF TRAINING PROGRAM<br><br>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.<br><br>The findings include:<br><br>1. The facility failed to ensure that group home staff received training on the use of Client #1's electronic communicative device (Mini Merc).<br><br>Interview was conducted with the Speech and Language Pathologist (SLP) at the day program on August 1, 2007 beginning at 11:55 AM. The SLP revealed Client #1 had an electronic communication device (Mini -merc) which she received training daily at her day program. Further interview with the SLP indicated the client did not use the device at her group home. | W 189 | | |

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| W 189 | Continued From page 12<br>An SLP progress note dated April 3, 2007 revealed that the Mini Merc should be sent to the day program and that training should be conducted by the SLP for the residential staff. Review of the SLP April 20, 2007 note revealed that the staff acquired basic training on the use of the device and that a communication goal using the device would be developed. The note reflected that the client should work for 15 minute intervals 4- 5 times a day with 1: 1 staff person trained in operating the device.<br><br>Interview with the Qualified Mental Retardation Professional (QMRP) on August 2, 2007 at approximately 6:15 PM revealed the residential staff had not been trained on how to use the Mini-Merc and therefore, continuous active treatment was no being provided at the residence.<br><br>2. The facility failed to ensure that each staff was trained on infection control measures for hair grooming. [See W340]<br><br>On August 1, 2007 at 8:00 AM, Clients #1, #2, and #3 were observed sitting in the living room after breakfast. Staff was observed with a basket containing hair grooming supplies. Beginning at 8:02 AM, the staff called the clients one by one to the small table near the TV in the living room to groom their hair. The staff was observed to obtain hair grease from the same jar for each client. Using her hand, she rub the hair grease on each clients' hair and proceeded to brush and/or combing the clients' hair. The staff used the same comb and brush to groom/style all three clients. The staff was not observed to wash her hands between the grooming of each client's hair. | W 189 | 1. QMRP will meet with Day Program to arrange training for staff on proper use of communication device.<br><br>2. In- Service on Infection control will be held for all staff<br><br>3. Staff will receive training on meal protocols and program implementation from Consultants.<br><br>4. See response to W189 # 3<br><br>5. See response to W189 # 3<br><br>6. See response to W189 # 3 | 9-14-07<br><br>8-24-07<br><br>9-18-07 |

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| W 189 | Continued From page 13<br>Interview with the QMRP indicated that some of the new staff had not been trained on infection control. Record review failed to provide evidence the staff who was observed combing the clients' hair had received effective training on infection control.<br><br>3. The facility failed to ensure effective training to staff on the meal time supervision needs of clients. [See W485]<br><br>4. The facility failed to ensure each staff was effectively trained on menu substitutions to ensure a variety of foods was served at each meal. [See W478]<br><br>5. The facility failed to ensure effective training to staff on the implementation of Client #1's behavior support plan. [See W249, 2]<br><br>6. The facility failed to ensure effective training to direct staff on documentation of data relative to accomplishment of Client #3's behavioral objectives [See W252] and on the Client #3's fingerlicking/need for frequent hand and face washing. [See W253] | W 189 | | |
| W 192 | 483.430(e)(2) STAFF TRAINING PROGRAM<br><br>For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.<br><br>This STANDARD is not met as evidenced by:<br>Based on interview and record review, the facility failed to ensure each employee who works with the clients received timely training focused on skills and competencies to address the clients' emergency medical needs. | W 192 | | |

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| W 192 | Continued From page 14<br><br>The finding includes:<br><br>The facility failed to ensure current training in cardiopulmonary resuscitation (CPR) was maintained for each employee.<br><br>The review of training records provided to the surveyor for review on August 2, 2007 beginning at 9:30 AM revealed that five of the ten employees working with the residents of the facility lacked current CPR certification. During interview with the Program Manager/Qualified Mental Retardation Professional, he acknowledged that the CPR training/certification for the identified staff had either expired or had not been done. | W 192 | CPR and First Aid Certification and re-certification class scheduled for 9-15-07 | 9-15-07 |
| W 214 | 483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN<br><br>The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interviews and record review, the facility failed to ensure a comprehensive functional assessment of behavioral needs was conducted for one of three clients residing in the facility. (Clients #3)<br><br>The findings include:<br><br>The facility failed to ensure an assessment of Client #3's finger licking/sucking behavior.<br><br>Interview with direct care staff on July 31, 2007 at 7:10 PM revealed the client required verbal prompting to complete the steps of hand washing. | W 214 | Psychologist will develop and train staff on a plan to address person # 3 behavior. | 9-18-07 |

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| W 214 | Continued From page 15<br>On July 31, 2007 at 7:25 PM, Client #3 was observed sitting on the couch, intermittently placing her fingers in her mouth and appeared to be playing in her saliva. The client also seemed to be listening to music on the radio beside her in the corner of the living room.<br><br>Upon observation of the client at 7:30 PM, the Qualified Mental Retardation Professional (QMRP) looked for a washcloth to clean the client hands "because she had been licking her fingers". A direct care staff told the client "put your hand down." At 7:32 PM the client was observed continuously licking her fingers. The staff commented that she had already washed the client's face and hands twice before dinner and once after dinner. Another staff then escorted the client to the bathroom to wash her hands. From 7:41 PM to 7:52 PM Client #3 remained on the couch alone beside the radio and was again licking her fingers. Observations on August 1, 2007 at 4:00 PM also reflected continued fingerlicking behavior.<br><br>Interview with staff on July 31, 2007 and August 1, 2007 revealed the client exhibits the fingerlicking behavior often and must have her hands washed when she was observed doing it. The review of the clinical record revealed the client was a Hepatitis B carrier.<br><br>Record review revealed a psychological assessment and a behavior support plan (BSP) dated February 13, 2007. The fingerlicking behavior was not identified or addressed in either document. | W 214 | | |
| W 237 | 483.440(c)(5)(iv) INDIVIDUAL PROGRAM PLAN<br><br>Each written training program designed to | W 237 | | |

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| W 237 | Continued From page 16<br>implement the objectives in the individual program plan must specify the type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to ensure that each written training program designed to implement the objectives in the individual program plan specified the type of data necessary to be able to assess progress toward the desired objective for one of two clients in the sample. (Client #2)<br><br>The finding includes:<br><br>The facility failed to ensure the type of data collected for Client #2's individual program plan (IPP) on safety sign identification allowed assessment of the client's progress.<br><br>On July 31, 2007 at 6:40 PM staff was observed showing Client #2 safety signs. Staff indicated the client was learning to identify different safety signs which were seen in the community. Record review revealed an objective scheduled to be implemented daily which stated that the client "will identify safety signs found in the community on 80% of trials per month for three months". The review of the instructions for implementing the objective indicated the client will point to what the picture of the sign means. Further review of the instructions revealed the data collection form stated "identifies" and did not mention what the client is to identify. | W 237 | See Response to W 159 # 6 | |
| W 242 | 483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN<br><br>The individual program plan must include, for | W 242 | | |

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| W 242 | Continued From page 17<br>those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to ensure the individual program plan (IPP) included training in personal skills necessary for privacy and hygiene for two of two clients in the sample. [Clients #1 and #2]<br><br>The findings include:<br><br>The facility failed to ensure the individual program plan (IPP) included training on personal privacy behavior for Client #2.<br><br>a. On July 31, 2007 at 6:15 PM Client #2 was observed pulling up her shirt, exposing her body and breast as she sat at the table with Clients #1 and #3. Client #2's breast was observed hanging below her bra. The client then put her breast back into the bra and pulled down her shirt. During this time the two staff, who on duty, were in the room with the clients.<br><br>At 6:35 PM a staff asked Client #2 if she had her breast in her bra. Interview with the staff indicated the client likes to take her breast out of her bra some times. Observation of the client at her day program on August 1, 2007 at 10:22 AM revealed the client's breast protruding above what appeared to be her bra underneath her shirt. The | W 242 | A & B See Response to W 111 # 2 | |

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| W 242 | Continued From page 18<br>review of the IPP on August 2, 2007 revealed no evidence the client received training on personal privacy to address this behavior.<br><br>b. On August 1, 2007 at 6: 48 AM Client #2 was observed in her bedroom wearing only panties. Although she was alone in her room, the door was wide open. While Client #2 was dressing, a staff was observed cleaning Client #3's bedroom, which was adjacent to Client #2's bedroom. There was no evidence the client received training on personal privacy while dressing herself. | W 242 | | |
| W 249 | 483.440(d)(1) PROGRAM IMPLEMENTATION<br><br>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.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to ensure as soon as the interdisciplinary team formulated the individual program plan (IPP), each client received a continuous active treatment plan consisting of needed interventions to achieve identified objectives for two of two clients in the sample. (Clients #1 and #2)<br><br>The findings include:<br><br>1. The facility facility failed to ensure that Client | W 249 | | |

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| W 249 | Continued From page 19<br>#1 received continuous active treatment using her communication device.<br><br>Interview with the Speech and Language Pathologist (SLP) at Client #1's day program on August 1, 2007 beginning at 11:55 AM revealed that Client #1's noncompliance to task and attempted property destruction may be related to her autism and the way she processes information. According to the SLP, the client expressed a desire for a Mini Merc communication device and was evaluated for it in 2006. Further interview with the SLP revealed the device was received by the group home in April 2007, but was not delivered to the day program until June 2007. The SLP indicated the client brings the Mini Merc to the day program on Monday through Friday with the battery charged so that the communication training can be provided there. The SLP stated that no training using the Mini Merc was being provided at the group home. During the day program observations, the instructor stated the client intentionally knocked the Mini Merc over on July 31, 2007 which caused it to stop functioning. At 7:36 PM on August 2, 2007, the Qualified Mental Retardation Professional (QMRP) at the group home was observed with the Mini Merc. He acknowledged that staff were not trained on its use and that the client did not use it at the group home.<br><br>2. The facility failed to ensure interventions in Client #1's behavior support plan (Behavior Support Plan (BSP) were implemented.<br><br>Observation of the first floor bathroom on August 1, 2007 at 6:46 AM revealed no paper towel and toilet tissue were available. On August 1, 2007 at | W 249 | 1. See Response to W 189 # 1<br><br>2. See Response to W 189 # 3<br><br>3. See response to W159 # 10 | |

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| W 249 | Continued From page 20<br>3:45 PM a staff informed another staff that Client #1 tears off paper towels and puts them in the toilet. At 3:50 PM the staff said the paper towels and toilet paper were being removed from the first floor bathroom because anytime Client #1 sees the paper she would attempt to put the paper in the toilet and this would clog the toilet. At 5:00 PM the commode in the first floor bathroom was observed filled to the water line with what appeared to be paper towels. Staff indicated that Client #1 probably did it because she had a history of putting excess paper in the toilet. At the time of the observation no paper towel or toilet tissue were in the bathroom.<br><br>Interview with staff indicated Client #1 misused paper when in the bathroom and that the paper supplies in the bathroom must be closely monitored. Further interview with staff revealed the removal of the paper supplies from the bathroom had been used as a proactive strategy to prevent Client #1's misuse of toilet tissue/paper.<br><br>The review of Client #1's Behavior Support Plan (BSP) dated November 29, 2006 revealed "The presence of a female staff member is necessitated by M's ... inability to avoid the misuse of toilet paper and in view of her lack of knowledge on how to use toilet paper in a hygienic and correct manner". There was no evidence Client #1's Behavior Support Plan (BSP) was implemented as written.<br><br>3. Interview with the QMRP revealed Client #2 had an Individual Support Plan (Individual Support Plan (ISP) conference on August 4, 2006. Review of Client #2's IPP on August 3, 2007 revealed it included the following objectives: | W 249 | | |

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| W 249 | Continued From page 21<br><br>a. Given verbal assistance M ... will purchase a greeting card for a family member on monthly trials for three months.<br><br>b. Given physical assistance, M .... will mail package (card, photo, drawing) to her brother on monthly sessions for three months.<br><br>Interview with the QMRP revealed the client's brother was her guardian, but the facility was unsuccessful in locating him. The QMRP also acknowledged and the record review revealed no evidence that the aforementioned IPP objectives had been implemented for the client. | W 249 | | |
| W 252 | 483.440(e)(1) PROGRAM DOCUMENTATION<br><br>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to ensure data relative to the accomplishment of the behavioral objective for one of three clients residing in the facility was documented in measurable terms for one of three clients residing in the facility. (Client #3)<br><br>The finding includes:<br><br>Observation of the medication administration on July 31, 2007 at 7:00 PM revealed Client #3 received Lorazepam 1 mg by mouth. Interview with the medication nurse revealed the medication was prescribed for behaviors. | W 252 | | |

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| W 252 | Continued From page 22<br><br>Interview with the primary Licensed Practical Nurse (LPN) revealed psychotropic medication reviews (PMR) were held monthly to monitor the client's response to behavioral interventions. Interview with the LPN revealed the team consisted of the psychiatrist, the psychologist, the nurse and the Qualified Mental Retardation Professional (QMRP).<br><br>The review of psychotropic medication reviews revealed no data was recorded for the periods of February 28, 2007 - March 26, 2007, March 27, 2007 - April 23, 2007 and May 22, 2007 - June 25, 2007. It was noted on these PMRs that no data was available for the aforementioned dates. Interview with the primary LPN on August 3, 2007 at 11:36 AM revealed that the client had some behaviors during these periods. The primary LPN indicated that the QMRP was responsible for documenting the behavioral frequencies on the the PMR forms before the meetings were held. There was no evidence this necessary information was documented as required to ensure accurate monitoring of the client's response to behavioral interventions. | W 252 | Program documentation with frequency of behavior will be presented at monthly psychotropic review meeting. | 8-24-07 |
| W 263 | 483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE<br><br>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.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interview and record review, the facility's specially-constituted committee (Human Rights Committee, HRC) | W 263 | | |

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| W 263 | Continued From page 23<br>failed to ensure that restrictive programs were used only with written consents, for one client residing in the facility who received psychotropic medications. (Client #3)<br><br>The finding includes:<br><br>Medication administration observation on July 31, 2007 at 7:00 PM revealed Client #3 received Lorazepam 1 mg by mouth. Interview with the medication nurse revealed the medication was prescribed twice daily for behaviors. According to the nurse, the client also had a behavior support plan (BSP) to address her targeted behaviors.<br><br>According to the Human Rights Committee (HRC) minutes dated January 16, 2007, the use of the medication and the BSP was reviewed and approved. There was no evidence, however, that the committee had ensured that written consent was obtained prior to the use of the restrictive behavioral strategies. | W 263 | Restrictive procedures will be reviewed by HRC and consent will be obtained from guardian or court designee | 9-27-07 |
| W 322 | 483.460(a)(3) PHYSICIAN SERVICES<br><br>The facility must provide or obtain preventive and general medical care.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, staff interview, and record review the facility failed to provide or obtain preventive care for one of two clients in the sample (Clients #1).<br><br>The findings include:<br><br>1. The facility failed to ensure timely GYN followup as recommended for Client #1. | W 322 | | |

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| W 322 | Continued From page 24<br><br>Interview with the QMRP on July 31, 2007 revealed that Client #1 was admitted to the group home in September 2006. A GYN consultation was recommended. Record review revealed the client went to the GYN clinic on January 18, 2007, but was uncooperative and the pelvic and rectal examinations could not be completed. The consultation report failed to show evidence that it was reviewed by the PCP.<br><br>Record review revealed that during the February 25, 2007 clinic appointment for a Depo-Provera Contraceptive injection, it was recommended that an appointment be scheduled in March 2007 with an OB/GYN for an annual Pap test. There was no evidence that the client attended the March 2007 appointment. Interview with the nurse on August 2, 2007 revealed that the appointment was rescheduled for August 20, 2007.<br><br>2. The facility failed to ensure that Client #1 received her Depo-Provera Injection at the scheduled time.<br><br>Interview with the LPN on August 3, 2007 revealed that Client #1 was recommended and scheduled to have a Depo-Provera Injection every three months. During the February 23, 2007 clinic visit, the nurse scheduled an appointment for the next Depo Provera Injection for May 17, 2007. According to the LPN, the client missed the appointment for the injection on May 17, 2007 because her guardian did not come to carry her to the clinic. The LPN indicated that the injection was rescheduled for August 10, 2007, six months after the last injection. | W 322 | 1. GYN appointment completed 8-10-07<br><br>2. Nurse will monitor and record appointments for this treatment with family to ensure appointment is kept on a timely manner and offer transportation assistance as needed. | |
| W 331 | 483.460(c) NURSING SERVICES | W 331 | | |

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| W 331 | Continued From page 25<br>The facility must provide clients with nursing services in accordance with their needs.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interview and record review, the facility's nursing services failed to ensure that each client received nursing services in accordance with his assessed needs for one of three clients residing in the facility. (Clients #3)<br><br>The finding includes:<br><br>The facility nursing services failed to ensure treatment records documenting Client #3's receipt of prescribed nutritional supplement were maintained.<br><br>Interview with direct care staff on July 31, 2007 at 7:45 PM revealed that Client #3 received a nutritional supplement of Ensure Plus three times a day to maintain her weight. According to the staff, the client took the last available Ensure Plus to his day program; and therefore, the client did not have the Ensure suppliment for the evening of July 31, 2007. Staff indicated that more would be purchased on the next day.<br><br>Interview with the primary LPN on August 3, 2007 indicated direct care staff was responsible for documenting the administration of the Ensure Plus in the treatment book. Record review revealed that the nurse failed to consistently document the administration of Ensure Plus. | W 331 | The nurse will monitor and document the administration of Ensure by residential counselors | 8-24-07 |
| W 340 | 483.460(c)(5)(i) NURSING SERVICES<br><br>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health | W 340 | | |

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| W 340 | Continued From page 26<br>measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, the facility failed to ensure each staff was effectively trained on infection control and hygiene methods for three of three clients in the survey. (Clients #1, #2, and #3)<br><br>The finding includes:<br><br>On August 1, 2007 at 8:00 AM, Clients #1, #2, and #3 were observed sitting in the living room after breakfast. Staff was observed with a basket containing hair grooming supplies. Beginning at 8:02 AM, the staff called the clients one by one to the small table near the TV in the living room to groom their hair. The staff was observed to obtain hair grease from the same jar for each client using her hand, then rub it on each clients' hair immediately before brushing and/or combing it. The same comb and brush was used to groom the hair of Clients #2 and #3. The same brush was used to groom Client #1's cornrowed hair. The staff was not observed to wash her hands after grooming any client's hair before going to the next client.<br><br>Interview with the QMRP indicated that some of the new staff had not been trained on infection control. | W 340 | See response for W 189 # 2 | 8-24-07 |
| W 362 | 483.460(j)(1) DRUG REGIMEN REVIEW<br><br>A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. | W 362 | | |

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| W 362 | Continued From page 27<br><br>This STANDARD is not met as evidenced by:<br>Based on interview and record verification, the facility failed to ensure that the pharmacist reviewed drug regimens for three of three clients residing in the facility on a quarterly basis. (Clients #1, #2 and #3)<br><br>The findings include:<br><br>Observation of the medication administration on July 31, 2007 beginning at 6:52 PM revealed Clients #1, #2, and #3 were each administered medications. Interview with the LPN administering the medication and the review of the medication administration record revealed these medications were prescribed by the primary care physician. Interview with nurse and the review of the agency's policy revealed the Pharmacy review should be conducted at least quarterly.<br><br>Review of the documentation on Pharmacy Review forms in the clients' medical records on August 2, 2007 beginning a 3:47 PM, revealed reviews were completed on December 20, 2006 and April 25, 2007. | W 362 | See response for W 104 # 3 | |
| W 381 | 483.460(l)(1) DRUG STORAGE AND RECORDKEEPING<br><br>The facility must store drugs under proper conditions of security.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to store drugs under proper conditions of security. | W 381 | | |

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| W 381 | Continued From page 28<br><br>The findings include:<br><br>On July 31, 2007 at 7:05 PM the medication nurse was observed removing the August 2007 medications from an unlocked yellow box which was on the floor in the dining room. Further observation of the medications revealed a monthly supply of Lorazepam 1 mg BID, a Schedule IV drug (controlled substance) belonging to Client #3. The medications were check by the nurse then locked in the medication closet.<br><br>Interview with the medication nurse concerning why the aforementioned drugs were not initially secured in locked storage revealed they were left in the dining room when the pharmacy employee delivered them at approximately 4:30 PM that afternoon. | W 381 | Pharmacy and Nurse will arrange and meet when medication is delivered. To assure medication is locked upon receipt. | 8-27-07 |
| W 385 | 483.460(l)(3) DRUG STORAGE AND RECORDKEEPING<br><br>The facility must maintain records of the receipt and disposition of all controlled drugs.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, staff interview, and record verification, the facility failed to maintain records of the receipt and disposition of a controlled drug for one client residing in the facility. (Client #3).<br><br>The finding includes:<br><br>The facility failed to provide evidence of the disposition of the Schedule IV Drug (Lorazepam) prescribed for Client #3 as evidenced by: | W 385 | | |

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| W 385 | Continued From page 29<br>Medication administration observation on July 31, 2007 at 7:00 PM revealed Client #3 received Lorazepam 1 mg by mouth.<br>Review of the Medication Administration Record (MAR) revealed that Client #3 was prescribed Lorazepam 1 mg BID for behavior. Further review of the MAR revealed a declining inventory (separate record) showing the receipt and disposition of the drug was maintained for July 2007. Interview with the primary LPN revealed that the separate record was also available for the months prior to May 2007, however they were not available for review at the time of the survey. | W 385 | See response for W 111 # 3 | |
| W 474 | 483.480(b)(2)(iii) MEAL SERVICES<br><br>Food must be served in a form consistent with the developmental level of the client.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, staff interviews and record review, the facility failed to ensure each food was provided in the prescribed texture for two of the three clients residing in the facility. (Clients #2 and #3)<br><br>The findings include:<br><br>1. On July 31, 2007, at 7:40 PM, Client #2 was observed asking the staff for cookies. She was instead given a snack of apple wedges. Further observation of the client revealed no visible teeth. Interview with staff revealed the client had no teeth or dentures The client ate the apple slowly and appeared to be gumming it.<br><br>Record review on August 1, 2007 revealed a dental consultation report dated October 19, 2006 which stated the client was edentulous and did | W 474 | 1.In Service on persons dietary and dental orders will be presented by QMRP | 8-31-07 |

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| W 474 | Continued From page 30<br>not have dentures. According to the current physician's orders, the client was prescribed a chopped textured diet.<br><br>2. At 4:10 PM on August 1, 2007, a staff was observed returning from the store with Clients #1 and #2 with a large can of beverage. Client #3 was given approximately 3 ounces of the beverage that contained no food thickener. The review of the client's prescribed diet revealed all of her liquids should be thickened to a honey consistency. | W 474 | 2. In Service of persons dietary order will be presented by QMRP | |
| W 478 | 483.480(c)(1)(ii) MENUS<br><br>Menus must provide a variety of foods at each meal.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to ensure that a variety of foods was served at each meal for three of three clients residing in the facility.(Clients #1,#2, and #3).<br><br>The findings include:<br><br>Observation of the meal preparation during breakfast on August 1, 2007 at 7:00 AM revealed a pale colored drink. Interview with staff preparing the meal revealed she substituted lemonade for orange juice because the orange juice was not available.<br><br>The review of the menu provided to the surveyor confirmed that orange juice was scheduled to be served to the clients at breakfast. There was no evidence a food of similar nutritive value was substituted for the orange juice for Clients #1, #2, | W 478 | See response to W189 # 3 | |

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| W 478 | Continued From page 31 and #3. | W 478 | | |
| W 485 | 483.480(d)(4) DINING AREAS AND SERVICE<br><br>The facility must supervise and staff dining rooms adequately.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to provide adequate staff supervision in the dining room at mealtime for three of three clients residing in the facility. (Clients #1, #2, and #3)<br><br>The finding includes:<br><br>The breakfast meal observation was conducted on August 1, 2007 beginning at 7:28 AM. Interview with an overnight staff indicated they were running late with breakfast. After all food was placed on the table, one of the two staff on duty was observed to return to the kitchen to clean up. The other staff remained in the dining room to supervise the three clients. The following observations were made:<br><br>a. At 7:41 AM Client #2 got up from her seat at the dining table and grabbed the can of Thicket, which was placed on the table for Client #3's use. Client #2 immediately took a scoop of Thicket and poured it into her coffee and stirred it. Staff instructed the client to give the can of Thicket to her. The client immediately drank the coffee to which she had added the Thicket.<br><br>b. At 7:33 AM Client #1 was observed spooning raisin bran and milk from the bowl onto her plate. At 7:48 AM she was observed spitting food back onto her plate. No staff intervention was | W 485 | A. Staff will be in serviced on active involvement and monitoring mealtime.<br><br>B. Staff will be in-serviced on BSP for person #1 | 8-29-07<br><br>8-29-07 |

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| W 485 | Continued From page 32<br>observed.<br><br>c. At 7:50 AM Client #3 was observed eating independently from a high sided plate. She was observed to overfill the spoon while scooping her food from the plate and to attempt to eat rapidly. Staff supervising the client intermittently provided verbal prompts to the client to put her spoon down.<br><br>On August 2, 2007, the review of the client's behavior support plan (BSP) dated February 13, 2007 revealed she had an individual program plan (IPP) objective to improve her socially appropriate behavior. The objective stated the client "will eat her meals at a steady and measured pace under staff supervision". She should be instructed to put her spoon down between mouthfuls to encourage thorough chewing and to prevent her from eating at a rapid pace. | W 485 | C. Staff will receive in service on BSP for person # 3 | 8-29-07 |
| W9999 | FINAL OBSERVATIONS<br><br>The following observations were made during the survey process. It is recommended that this area be reviewed and a determination be made regarding appropriate actions in order to prevent potential non-compliant practices:<br><br>1. Observation of Client #1 at her day program on August 1, 2007, beginning at 11:50 AM revealed the client seated at a table with five peers and the classroom instructor. The client had a puzzle in front of her called a "Lockup Puzzle" which was constructed of wood and various types of locks and latches. When the instructor asked the client to work on the board, the client picked up a bag of connecting blocks from the table and dumped them on the floor. | W9999 | Day program and Residential will improve communication through program visitation. The visitation will occur at least once a month unless more attention is merited. The program monitoring will include sharing of behavioral data, care of communication equipment and personal hygiene concerns. | |

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| W9999 | Continued From page 33<br><br>Interview with the classroom instructor indicated the client is able to release the locks and latches on the Lockup Puzzle, however, she is sometimes non-compliant for performance of various tasks. Interview with the Speech and Language Pathologist (SLP) revealed that the client's noncompliance and attempted property destruction may be related to her autism and the way she processes information. According to the SLP, the client expressed a desire for an special communication device (Mini Merc) and was evaluated for it. The Mini Merc was requisitioned and was initially brought to the day program by the group home staff in June 2007. The day program reported that on July 31, 2007, the client intentionally knocked the Mini Merc over, causing it to stop working. The SLP indicated this incident was reported to the group home on August 2, 2007.<br><br>Further interview with the classroom instructor and record verification at the day program also revealed incidents of spitting in the water fountain and other locations, throwing objects and attempted property destruction. The classroom instructor acknowledged that the client does not have a formal behavior management program at the day program. Behaviors are documented on an "Interim Data Sheet" when they are exhibited. The classroom instructor indicated that quarterly reports were sent to the group home which reflects monitoring of the client's progress in the individual program objectives (IPP). The instructor indicated that the group home had not been notified of the behaviors that were being baselined at the day program.<br><br>Interview with the Qualified Mental Retardation | W9999 | | |

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| W9999 | Continued From page 34<br>Professional (QMRP) on August 2, 2007 revealed no behavioral data was provided to him from the day program. There was no evidence the day program coordinated information on Client #1's maladaptive behaviors with the group home.<br><br>2. The day program failed to ensure the group home was informed of each incident of "poor vaginal hygiene" for Client #1.<br><br>Interview with the classroom instructor on August 1, 2007 and the review of the Interim Data Sheet revealed on July 5, 2007, Client #1 arrived at the day program with "poor vaginal hygiene". Further interview with the classroom instructor revealed this type of information was usually reported to the group home by the day program social worker.<br><br>During an interview with the social worker, she recalled reporting an incident of poor vaginal hygiene to the group home on May 31, 2007; however she indicated that she was unaware of the July 5, 2007 incident. Interview with the QMRP and the review of records revealed no evidence that the July 5, 2007 incident was reported to the group home by the day program. | W9999 | | |

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| I 022 | 3501.5 ENVIRONMENTAL REQ / USE OF SPACE<br><br>Each window shall be supplied with curtains, shades or blinds, which are kept clean, and in good repair.<br><br>This Statute is not met as evidenced by:<br>Based on observation and interview, the facility failed to ensure that window blinds were maintained in good repair in various locations of the GHMRP.<br><br>The findings include:<br><br>Observation of the environment conducted on August 3, 2007 beginning at 3:10 PM revealed broken louvers on the blinds in the locations below:<br><br>a. Resident #3's bedroom (louvers broken on two of four blinds).<br>b. Resident #2's bedroom (louvers broken on two of two blinds). | I 022 | Blinds in the bedroom of person 1 and 2 were replaced | 8-15-07 |
| I 073 | 3503.3(b) BEDROOMS AND BATHROOMS<br><br>Each bedroom shall be equipped with at least the following items for each resident:<br><br>(b) Clean comfortable pillow;<br><br>This Statute is not met as evidenced by:<br>Based on observation, the GHMRP failed to ensure each bedroom was equipped with at least the following items for each resident:<br><br>(b) Clean, comfortable pillow;<br><br>The findings include: | I 073 | | |

Health Regulation Administration

Dr. Rodwell Burgess

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

TITLE Adm.

(X6) DATE 8/28/07

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| I 073 | Continued From page 1<br>Observation of Resident #3's bed pillow on August 3, 2007 at 3:12 PM revealed it was stained. The bed pillow of Resident #1 was observed to be flat. | I 073 | Purchase and replacement of pillows for all persons residing in this home will occur by 8-30 -07 | 8-31-07 |
| I 082 | 3503.10 BEDROOMS AND BATHROOMS<br><br>Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting.<br><br>This Statute is not met as evidenced by:<br>Based on observation and interview, the GHMRP failed to ensure each bathroom that is used by residents was equipped with toilet tissue and paper towel at all times.<br><br>The findings include:<br><br>Observation of the first floor bathroom on August 1, 2007 at 6:46 AM revealed no paper towel and toilet tissue.<br><br>On August 1, 2007 at 3:45 PM a staff informed another staff that Client #1 tears off paper towels and puts them in the toilet. At 3:50 PM the staff indicated the paper towels and toilet paper were being removed from the first floor bathroom because anytime Client #1 sees them she will attempt to put them in the commode and this will clog the toilet. At 5:00 PM the commode in the first floor bathroom was observed filled to the water line with what appeared to be paper towel. Staff indicated that Client #1 probably did it because she has a history of putting excess paper in the commode. At this time no paper towels or toilet tissue was observed in the bathroom. Staff reported that as a precautionary | I 082 | See response to w249 | 8-6-07 |

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| I 082 | Continued From page 2<br>measure paper towels and the toilet tissue were in the closet in the kitchen.<br><br>[See Federal Deficiency Report - Citation W249,2] | I 082 | See response to w249 | 8-6-07 |
| I 090 | 3504.1 HOUSEKEEPING<br><br>The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.<br><br>This Statute is not met as evidenced by:<br>The facility failed to maintained the environment as evidenced by the concerns identified in this section of the report.<br><br>The findings include:<br><br>The surveyor conducted environmental observations on August 3, 2007 beginning at 3:10 PM. She was accompanied through the GHMRP by the Qualified Mental Retardation Professional.<br><br>a. On August 2, 2007 at 6:30 PM. the toilet seat on the commode in the second floor bathroom was not tightly secured to the commode by the supporting screws.<br><br>b. A heavy accumulation of dust was on the carpet at the edges and behind the furniture in Resident #1's bedroom. According to the agency's housekeeping checklist, baseboards in the bedrooms should be swept weekly.<br><br>3. A heavy accumulation of dust was on the floor in the laundry room and other areas of the | I 090 | a. repair of toilet seat was completed on 8-15-07<br><br>b. Person # 1 room was vacuumed and furniture dusted 8- 4-07 this task will be completed weekly<br><br>3. Area cleaned 8-4-07 this task will be completed weekly.<br><br>4. Door maintenance has been ordered and expected remedy of this problem is expected 8-30-07<br><br>5. Shower curtains are washed or replaced weekly<br><br>6. Windows cleaned 8-5-07. Maintenance of cleaning will occur bi-weekly<br><br>7. Clothes hampers replaced 8-25-07<br><br>8. Cover on the rear of the refrigerator was replaced 8-9-07<br><br>9. Stair well bracket support was repaired 8-4-07 | 8-15-07 |

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| I 090 | Continued From page 3<br>basement.<br><br>4. Client #2's closet door was not secured in the tract.<br><br>5. Soap scum was on bottom of the the shower curtain in the bathroom located on the second floor.<br><br>6. Window panes contained soil on the interior throughout the facility.<br><br>7. Client #2's clothes hamper was heavily stained/soiled.<br><br>8. A large black piece was detached from the back of the refrigerator in the kitchen. The piece appeared to be made of rubber.<br><br>9. At the end of the environmental observations, one of the metal braces underneath the right stair railing broke. The brace helps to support the railing to the stairs that lead from the first to the second floor. | I 090 | | |
| I 097 | 3504.8 HOUSEKEEPING<br><br>No cleaning agent, bleach, insecticide or any other poisonous, dangerous, or flammable material shall be accessible to a resident where access to such substance is contraindicated in the resident ' s Individual Habilitation Plan.<br><br>This Statute is not met as evidenced by:<br>Based on observation and interview and record review, the GHMRP failed to ensure that insecticide and potentially poisonous substances were not accessible to the residents. | I 097 | | |

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| I 097 | Continued From page 4<br>The finding includes:<br><br>Blue pellets, approximately 1/3 inch in length were underneath the bottom of the rotating corner cabinet in the kitchen where food was stored. Interview with the staff indicated the pellets were probably placed in the cabinet by the exterminator when who was recently in the facility.<br><br>Interview with the QMRP and the record verification revealed individual support plans of the three residents living in the GHMRP did not approve access to the aforementioned substance. | I 097 | Exterminator was informed not to leave pellets or any potentially poisonous substance within reach of any person who resides in this address. | 8-08-07 |
| I 189 | 3508.7 ADMINISTRATIVE SUPPORT<br><br>Each GHMRP shall maintain records of residents ' funds received and disbursed.<br><br>This Statute is not met as evidenced by:<br>Based on staff interview and record review, the facility failed to maintain a system that assures a full and complete accounting of residents'personal funds entrusted to the facility on behalf of one of the two clients in the sample. (Resident #1)<br><br>The finding includes:<br><br>Interview with the Qualified Mental Retardation Professional (QMRP) on August 3, 2007 at 2:37 PM revealed the records of the residents' expenditures are primarily maintained by the group home manager who was currently on leave. The review of resident #1's bank statement for May 2007 revealed a withdrawal for shopping of $400.00 on May 17, 2007. Further interview with the QMRP revealed the receipts | I 189 | Receipt for purchase was turned in by person # 1 parent a certify note to this was sent to the Administrative Assistant for shopping expenses of $ 387.00. All expense withdrawal will be approved by the QMRP and review of receipts before final balancing of records will also be reviewed by the homes QMRP. | 8-31-07 |

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| I 189 | Continued From page 5<br>showing how the money was spent were not available for review and that additional follow-up was needed. | I 189 | | |
| I 206 | 3509.6 PERSONNEL POLICIES<br><br>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.<br><br>This Statute is not met as evidenced by:<br>Based on interview and record review, the facility failed to ensure that all staff and consultants had current health certificates on file.<br><br>The findings include:<br><br>1. Review of 4 of 10 personnel records on August 3, 2007 at approximately 9:20 AM revealed no documented evidence of current health certificates. The individuals who lacked the current health certificates were Staff #2, #5, #9, and #10.<br><br>2. Review of the consultant files on the same date revealed no current health certificates were available for consultants #2, #4, #10, and #12. It was noted that Consultants #2 and #4 had PPDs and no evidence of a health screening.<br><br>The Program Director/QMRP acknowledged on August 3, 2007 during interview that the aforementioned health certificates were not | I 206 | 1. Current health certificates are received for Staff # 2, 5, 9,and 10<br><br>2. Health certificates that include screening have been requested of consultants #2, 4, 10, and 12 and are expected no later than Sept 15. 2007 | 8-27-07<br><br>9-15-07 |

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| I 206 | Continued From page 6<br>available during the survey. | I 206 | | |
| I 222 | 3510.3 STAFF TRAINING<br><br>There shall be continuous, ongoing in-service training programs scheduled for all personnel.<br><br>This Statute is not met as evidenced by:<br>Based on interview and record review, the GHMRP failed to ensure continuous training programs was provided for all personnel<br><br>The findings include:<br><br>1. The GHMRP failed to ensure that group home staff received training to enable them to use Resident #1's electronic communicative device (Mini merc). [See Federal Report - Citation W189,1]<br><br>2. The GHMRP failed to ensure that each staff was trained on infection control measures for hair grooming. [ See Federal Deficiency Report - Citation W340]<br><br>3. The GHMRP failed to ensure each staff received training on sign language to enable them to effectively address Resident #1's health care and active treatment needs. [See Federal Deficiency Report - Citation W189, 3]<br><br>4. The GHMRP failed to ensure effective training to staff on the meal time supervision needs of Residents #1, #2, and #3. [See Federal Report - Citation W485]<br><br>5. The GHMRP failed to ensure each staff was effectively trained on menu substitutions to ensure a variety of foods was served at each meal for Residents #1 #2, and #3. [See Federal | I 222 | 1. Staff will receive training on person # 1 communication device with Day Program Speech Language Specialist on or before September 18, 2007<br><br>2. In –Service for all staff on Universal Precaution and infection control completed 8-24-07<br><br>3. Consultant training for sign language will begin 10-3-07.<br><br>4. Staff training on programming and active treatment to be held 8-30-07<br><br>5. Staff training on meal substitution will be held on or before 8-30-07<br><br>6. Staff training on person #1 and person # 2 BSP will occur 8-29-07<br><br>7. Staff training on program documentation will be held on 8-29-07 | 9-18-07<br><br>8-24-07<br><br>10-3-07<br><br>8-30-07<br><br>8-30-07<br><br>8-29-07<br><br>8-29-07 |

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| I 222 | Continued From page 7<br>Deficiency Report - Citation W478]<br><br>6. The GHMRP failed to ensure effective training to staff on the implementation of Resident #1's and #2's behavior support plan. [See Federal Report - Citation W249,2]<br><br>7. The GHMRP failed to ensure effective training to direct staff on documentation of data relative to accomplishment of Resident #3's behavioral objectives [See Federal Report - W252] and on the Resident #3's fingerlicking/need for frequent hand and face washing. [See Federal Deficiency Report - Citation W253] | I 222 | | |
| I 226 | 3510.5(c) STAFF TRAINING<br><br>This Statute is not met as evidenced by:<br>Based on interview and record review, the GHMRP failed to ensure that current training on cardiopulmonary resuscitation (CPR) was maintained for each employee.<br><br>The finding includes:<br><br>The review of training record provided to the surveyor for review on August 2 and August 3, 2007 revealed that four of the ten employees working with the residents lacked a current CPR certification. The identified staff were Staff #'s 1, 4, 6, 7 and 9.<br><br>During interview with the Program Manager/Qualified Mental Retardation Professional, he acknowledged that the CPR certification for the identified staff had either expired or not been completed. | I 226 | CPR, First Aid training is scheduled for 9-15-07 staff #1, 4, 6, 7, and 9 are signed up for this class. | 9-15-07 |

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| I 229 | Continued From page 8 | I 229 | | |
| I 229 | 3510.5(f) STAFF TRAINING<br><br>Each training program shall include, but not be limited to, the following:<br><br>(f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies;<br><br>This Statute is not met as evidenced by:<br>Based on interview and record review, the GHMRP failed to ensure each training program included specialty areas needed by the residents being served.<br><br>The finding includes:<br><br>The in-service training records on August 2 and August 3, 2007 failed to evidence that training on going training was provided to direct care staff in the following areas:<br><br>(a) behavior management;<br>(b) nutrition;<br>(c) total communication;<br>(d) assistive devices.<br><br>During interview with the QMRP on August 3, 2007. he acknowledged that some training was provided to staff on July 9, 2007, however some of the required subjects had not been covered. | I 229 | Staff training is ongoing on all domains. The consultant training is scheduled for 9-18-2007 the schedule training for this In –service is nutrition, speech, and BSP | 9-18-07 |
| I 291 | 3514.2 RESIDENT RECORDS<br><br>Each record shall be kept current, dated, and signed by each individual who makes an entry.<br><br>This Statute is not met as evidenced by: | I 291 | | |

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| I 291 | Continued From page 9<br>Based on interview and record review, the GHMRP failed to ensure that the record of each resident was kept current dated and signed by all persons making an entry.<br><br>The findings include:<br><br>The facility failed to ensure treatment records and assessments were maintained accessible for Residents #1 and #3.<br>[ See Federal deficiency Report - Citation W111] | I 291 | Documentation of person receiving Ensure will be monitored by Nurse and documented on an MAR sheet | |
| I 293 | 3514.4 RESIDENT RECORDS<br><br>The record for resident ' s prescribed controlled substances shall be in conformance with § 3522.6 of this chapter.<br><br>This Statute is not met as evidenced by:<br>Based on interview and record verification, the GHMRP failed to continuously maintain a record of Resident #3's prescribed controlled substances in conformance with § 3522.6 of this chapter for Resident #3.<br><br>The finding includes:<br><br>Interview with the primary LPN indicated that a separate record was maintained for the Resident #3's controlled substance, Lorazepam 1 mg BID. Record verficationon August 3, 2007 revealed the separate records for the Lorazepam 1 mg BID were not available for the months prior to May 2007. [See Federal Deficiency Report - Citation W385] | I 293 | All controlled substance will be documented and accounted for on a drug count sheet | 8-14-07 |

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| I 379 | Continued From page 10 | I 379 | | |
| I 379 | 3519.10 EMERGENCIES<br><br>In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day.<br><br>This Statute is not met as evidenced by:<br>Based on interview and record review, the GHMRP failed to report significant incidents to the Department of Health, (DOH) Health Regulation Administration within twenty-four (24) hours or the next work day.<br><br>The finding includes:<br><br>Interview with the Qualified Mental Retardation Professional on July 31, 2007 revealed unusual incident reports were kept at the administrative and would be provided on August 1, 2007. The review of unusual incidents, interview and record review revealed the following information:<br><br>1. The review of unusual incidents on August 1, 2007 revealed on December 23, 2006 at 11:59 AM a neighbor called the police due to a misunderstanding. The neighbor alleged that Resident #2 was being mistreated by a staff while she was on the front porch of the group home. The police came to the facility to investigation after the neighbored complaint. | I 379 | 1. Any Incident that alleges mistreatment of person will be reported to DOH.<br><br>2. Any Incident involving emergency room treatment will be reported to DOH<br><br>3. Any Incident involving emergency room treatment will be reported to DOH | 8-15-07 |

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| I 379 | Continued From page 11<br>The GHMRP's investigation of the incident indicated that Resident #2 was screaming on the front porch. During the time the neighbor observed the resident, she had been on the porch with a staff and another resident. The investigative report indicated that the staff walked into the house ahead of the residents and the neighbor thought one of the residents on the porch was a staff. There was no evidence the incident was reported to the DOH.<br><br>2. Record review on August 2, 2007 revealed on February 17, 2007 staff reported to th nurse that Resident #2 had a swollen left eye. The Primary Care Physician (PCP) was notified and referred the resident to the emergency rom (ER) where she was treated for an eye rash. On February 19, 2007, the PCP prescribed Erythromycin Ointment.<br><br>Interview with the QMRP and the record review revealed no unusual incident report was available.<br><br>3. The review of Resident #2's clinical record on August 2, 2007 revealed a nursing progress note which stated that the resident was involved in a minor motor vehicle accident on March 6, 2007. Interview with the primary LPN indicated that the resident was not injured. Further review of the clinical record revealed an ER examinations was completed for the resident on the day of the accident which stated no specific injuries.<br><br>According to the review of the clinical records, Residents #1 and #3 were also riding in the van when the accident occurred, were assessed at the ER, and determined to have no specific injuries.<br>The agency's Policy on Incident Management | I 379 | | |

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| I 379 | Continued From page 12<br>states "Any vehicular accident involving a customer, regardless of the severity shall be considered as a reportable incident. There was no evidence this incident was reported to the DOH. | I 379 | | |
| I 391 | 3520.2(a) PROFESSION SERVICES: GENERAL PROVISIONS<br><br>Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services:<br><br>(a) Medicine;<br><br>This Statute is not met as evidenced by:<br>Based on interview and record review, the GHMRP failed to provided evidence that the primary care physician was licensed as required by District of Columbia law.<br><br>The finding includes:<br><br>The review of consultants records provided by the GHMRP for review by the surveyor on August 2, 2007 revealed the license for the primary care physician was not available. Interview with the Qualified Mental Retardation Professional (QMRP) indicated the license had not been provided by the administrative office for review. | I 391 | The record for primary care physician has been requested and will be submitted by 8-31-07 | 8-31-07 |

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| I 401 | Continued From page 13 | I 401 | | |
| I 401 | 3520.3 PROFESSION SERVICES: GENERAL PROVISIONS<br><br>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.<br><br>This Statute is not met as evidenced by:<br>Based on observation, interview and record verification, the GHMRP failed to ensure professional services were provided to three of three residents in the survey. (Residents #1, #2, and #3)<br><br>The findings include:<br><br>1. The GHMRP failed to ensure the active treatment programs for Residents #1, #2, and #3 were integrated, coordinated and monitored by the qualified mental retardation professional (QMRP). [See Federal Deficiency Report - Citation W159]<br><br>2. The GHMRP failed to ensure that comprehensive functional assessments was conducted for Resident #3's fingerlicking behavior and of Resident #1's sexuality. [See Federal Deficiency Report - Citation W214]<br><br>3. The GHMRP failed to ensure that the residents' medications delivered by the pharmacy were stored under proper security. [See Federal Deficiency Report - Citation W381]<br><br>4. The GHMRP failed to ensure pharmacy reviews were conducted timely for Residents #1, #2, and #3. [See Federal Deficiency Report - | I 401 | 1. Person 1, 2, and 3 program are/will be monitored and reviewed monthly by QMRP. Documentation, active treatment, coaching, nutrition, psychology or any other in-service will be completed per need following monitoring.<br><br>2. Universal precaution in service and OSHA overview was completed 8-24-07 and will continue to be presented monthly in orientation and training review. Person # 3 assessment is completed and is attached to this POC<br><br>3. Pharmacy and Nurse will communicate delivery time so that medication will be accepted in person and locked away at that time.<br><br>4. Pharmacy review will occur every 90 days per policy.<br><br>5. Nurse will monitor and record appointments for this treatment with family to ensure appointment is kept on a timely manner and offer transportation assistance as needed.<br><br>The nurse will monitor and document the administration of Ensure by residential counselors<br><br>7. Nutrition recommendation has been reviewed with staff. Follow up training with Nutritionist to occur 9-18-07 | 9-15-07 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 09G152 | A. BUILDING _____ B. WING _____ | 08/03/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COMP CARE I I | 1000 NEWTON STREET NE WASHINGTON, DC 20019 |

| (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 401 | Continued From page 14<br>Citation W362]<br><br>5. The GHMRP failed to ensure health services were provided in accordance with the needs of Residents #1, #2 and #3. [See Federal Deficiency Report - Citations W322 and W331]<br><br>6. The GHMRP failed to ensure oversight regarding food textures and food preparation. [See Federal Deficiency Report - Citations W474 and W478] | I 401 | | |
| I 420 | 3521.1 HABILITATION AND TRAINING<br><br>Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning.<br><br>This Statute is not met as evidenced by:<br>Based on observation, interview and record review, the GHMRP failed to ensure habilitation and training for three of three residents residing in the facility. (Residents #1, #2, and #3)<br><br>The findings include:<br><br>[See Federal Deficiency Report - Citations W120, W130, W159, , W237, 242, W249, W252, and W253] | I 420 | See response to W 130, W159, W 252, and W 253 | |
| I 500 | 3523.1 RESIDENT'S RIGHTS<br><br>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 | I 500 | Se response to W 130, W 149 and W159 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| I 500 | Continued From page 15<br>laws.<br><br>This Statute is not met as evidenced by:<br>Based on observation, interview and record review, the GHMRP failed to ensure the protections of each clients rights.<br><br>The finding includes:<br><br>[See Federal Deficiency Report - Citations W130, W149, 159, W227, W242, W249, and W263.] | I 500 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| R 000 | INITIAL COMMENTS<br><br>A recertification survey was conducted from the evening of July 31, 2007 through August 3, 2007. A random sampling of two residents was selected from a residential population of three females with mental retardation and other disabilities. The findings of the survey were based on observations, interviews, and the review of resident and administrative records including incident reports. | R 000 | | |
| R 125 | 4701.5 BACKGROUND CHECK REQUIREMENT<br><br>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.<br><br>This Statute is not met as evidenced by:<br>Based on the review of records, the GHMRP failed to ensure criminal background checks for the previous seven (7) years, in all jurisdictions where staff had worked or resided within the seven (7) years prior to the check for two of ten staff.<br><br>The finding includes:<br><br>Review of the review of personnel files on August 3, 2007 at 9:20 AM revealed the GHMRP failed to evidence criminal background checks for the previous seven years in all jurisdiction where two staff had worked or resided. The review of criminal background checks provided for Staff #6 and #8 were noted to not be for the jurisdiction in which they currently reside. | R 125 | Global background check for employee # 6 and employee # 8 is currently being conducted result of this check is expected by 9-15-07 | 9-15-07 |