

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

PRINTED: 02/09/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/22/2010
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NAME OF PROVIDER OR SUPPLIER WESTVIEW 01	STREET ADDRESS, CITY, STATE, ZIP CODE 3200 12TH STREET, NE WASHINGTON, DC 20017
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W 000	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted from January 19, 2010, through January 22, 2010. The fundamental survey process was initiated however due to concerns in Client Protections and Active Treatment, the survey was extended those areas. The extension led to the determination that the facility was not in compliance with the Conditions of Participation in Client Protections and Active Treatment.</p>	W 000	<p style="text-align: center;">MAR 02 2010</p>	
W 100	<p>440.150(c) ICF SERVICES OTHER THAN IN INSTITUTIONS</p> <p>"Intermediate care facility services" may include services in an institution for the mentally retarded (hereafter referred to as intermediate care facilities for persons with mental retardation) or persons with related conditions if:</p> <p>(1) The primary purpose of the institution is to provide health or rehabilitative services for mentally retarded individuals or persons with related conditions;</p> <p>(2) The institution meets the standards in Subpart E of Part 442 of this Chapter, and</p> <p>(3) The mentally retarded recipient for whom payment is requested is receiving active treatment as specified in §483.440.</p> <p>This STANDARD is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to meet the Condition of</p>	W 100		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 100	Continued From page 1 Participation in Client Protections, for two of the six clients residing in the facility and failed to meet the Condition of Participation In Active Treatment, for three of the three clients included in the sample. The finding includes: The facility failed to ensure that Clients #1 and #2 were protected from client to client mistreatment and injuries of unknown origin [See W122, W124, W130, W140, W148, W153, and W156] and Clients #1, #2, and #3 received continuous, aggressive active treatment programming and services. [See W195, W196, W212, W214, W248, W249, W250 and W436]	W 100			
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: The governing body failed to maintain general operating direction over the facility to prevent neglect and abuse. [See W104] The results of these systemic practices revealed that the facility's Governing Body failed to adequately govern the facility in a manner that would ensure client protection [See W122]; and active treatment [See W195].	W 102			
W 114	483.410(c)(4) CLIENT RECORDS Any individual who makes an entry in a client's record must make it legibly, date it, and sign it.	W 114			

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W 114	Continued From page 2 This STANDARD is not met as evidenced by: Based on record review and interview, the facility's nurse failed to ensure entries in the clients record were signed by the person completing the assessments, for two of three clients included in the sample. (Clients #1 and #2) The findings include: 1. Review of Client #1's medical record on January 20, 2010 at 1:53 p.m., revealed nursing quarterly assessments dated September 30, 2009 and December 31, 2009 were not signed. Interview with the qualified mental retardation professional (QMRP) at approximately 11:00 a.m., revealed the RN was not available for interview. Further interview confirmed that the quarterly nursing assessment were not signed. 2. Review of Client #2's medical record on January 19, 2010 at approximately 10:00 a.m., revealed nursing assessments dated October 20, 2009 revealed no signature. Interview with the qualified mental retardation professional (QMRP) at approximately 11:00 a.m., revealed the RN was not available for interview. Further interview confirmed that the nursing assessment were not signed.	W 114			
			W114	1. Person # 1 Nursing assessments are signed by the RN 2-12-10 2. Person # 2 Nursing assessments are signed by there RN 2-12-10	
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by:	W 122	W122	The nursing, clinical and all direct staff are trained on reporting incidents and injuries. 2-26-10	

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W 122	Continued From page 3 Based on interview and record review, [Refer to W130]; the facility failed to ensure a system had been implemented to maintain a complete accounting of clients' personal funds [Refer to W140]; [Refer to W148]; the facility failed to ensure that systems had been developed and implemented to establish and implement policies that ensure each client's health and safety [Refer to W149]; failed to ensure the immediate notification of the State officials of injuries of unknown origin and emergency medical services [Refer to W153]; and failed to thoroughly investigate injuries of unknown origin [Refer to W154]; failed to ensure effectively trained staff to implement emergency measures [Refer to W192]; failed to ensure that restrictive programs were used only with written consents [Refer to W263].	W 122			
W 124	The effects of these systemic practices resulted in the failure of the facility to protect its clients from potential harm and to ensure their general safety and well being. 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, family members or	W 124			

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W 124	<p>Continued From page 4</p> <p>guardians were informed of their risks and benefits of clients restrictive measures, for two of the three clients included in the sample. (Clients #1 and #3)</p> <p>The findings include:</p> <p>1. The facility failed to ensure that informed consent was obtained from Client #3's guardian prior to the administration of his psychotropic medications.</p> <p>During the entrance conference on January 19, 2010, at 8:30 a.m., the Qualified Mental Retardation Professional (QMRP) indicated that Client #3 received psychotropic medications to address his maladaptive behaviors. Further interview revealed the client did not have the capacity to give informed consent for the use of medications and habilitation services.</p> <p>Observation of the evening medication administration on January 19, 2010, at 5:40 p.m., revealed Client #3 was observed receiving Haldol 10 mg, Depakote 500 mg and Risperidone 4 mg. Interview with the trained medication employee (TME) during the medication administration, revealed the aforementioned medications were used to address the client's behaviors.</p> <p>The QMRP's statement was verified on January 20, 2010, at 2:30 p.m., through review of Client #3's psychological assessment. According to the assessment, Client #3 "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</p>	W 124	<p>W124</p> <p>1. Consent for all person including person # and # 2 psychotropic medication will be obtained by guardians</p>	3-6-10	

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W 124	<p>Continued From page 5</p> <p>his habilitation planning and decision making process.</p> <p>Record verification on January 20, 2010, at 2:45 p.m., revealed that Client #3's guardian had given informed consent for the use of Haldol 3 mg QAM and 4 mg QPM, Risperdal 4 mg, twice a day, Cogentin 1 mg QAM and Depakote 500 mg, twice a day dated May 11, 2009. There was no consent signed, however, for the client's current Haldol 10 mg, twice a day.</p> <p>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 the administration of the psychotropic medication.</p> <p>2. The facility failed to ensure that informed consent was obtained from Client #1's guardian prior to the to the implementation of his Behavior Support Plan (BSP).</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on January 19, 2009, at 8:30 a.m., during the entrance conference revealed that Client #1 had a Behavior Support Plan (BSP) to address his maladaptive behaviors. Further interview revealed the client did not have the capacity to give informed consent for the use of medications and habilitation services.</p> <p>The QMRP's statement was verified on January 20, 2010 at 10:30 a.m., through review of Client #1's psychological assessment. According to the assessment, Client #1 "does not show competency or intellectual capacity to make independent decisions regarding his habilitation</p>	W 124	<p>2. Guardians consent and approval are in the process of being obtained</p>	3-6-10	

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W 124	Continued From page 6 plans, medical or psychological issues, residential placement or 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. Review of the incident book on January 19, 2010, at 8:55 a.m., revealed Client #1 was restrained by two direct care support on October 25, 2009. 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 implementing Client # 1's BSP.	W 124			
W 130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure an effective system to protect the clients' right for privacy during medication administration, for one of the six clients residing in the facility. (Client #6) The finding includes: On January 19, 2010, at 6:00 p.m., the trained medication employee(TME) was observed to prepare Client #6's medications, upstairs in the nurse's office. The TME went downstairs, interrupted Client #6's dinner and spoon fed him his medication. Clients #1, #2, #3, #4, and #5	W 130	Medication by our trained medication pass people will be administered in a manner that ensures our individuals privacy	1-22-10	

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W 130	Continued From page 7 were present at the dining room table eating dinner. At the time, direct care staff were assisting clients with eating their dinner. Interview with the house manager on January 19, 2010, at 6:20 p.m., confirmed the observation.	W 130			
W 140	483.420(b)(1)(i) CLIENT FINANCES 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. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure a system had been implemented to maintain a complete accounting of residents' personal funds, for three of the three residents in the sample. (Resident #1, #2 and #3) The findings include: Interview with the qualified mental retardation professional (QMRP), house manager (HM), administrative assistant and review of the facility's financial records on January 21, 2010, beginning at 12:40 p.m., revealed that the facility assisted Residents #1, #2 and #3 with maintaining their finances. Continued interview and record review revealed that the residents received Supplemental Security Income (SSI) in the amount of \$70.00 per month. a. Resident #1's bank statements were reviewed from January 2009 through December 2009 and revealed the following withdrawals: - January 13, 2009, in the amount of \$60.00;	W 140			
		W 140	A., The staff responsible for requesting these funds from the individuals accounts has been removed from her their position.	3-2-10	

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W 140	<p>Continued From page 8</p> <ul style="list-style-type: none"> - February 15, 2009, in the amount of \$20.00; - February 25, 2009, in the amount of \$160.00; - March 24, 2009, in the amount of \$70.00; - March 30, 2009, in the amount of \$40.00; - May 2009, (statement did not reflect exact date); - June 2009, (statement did not reflect exact date); - August 7, 2009, in the amount of \$350.00; - December 10, 2009, in the amount of \$24.50; and - December 28, 2009, in the amount of \$200.00. <p>There were no receipts for the aforementioned withdrawals or evidence on how the money was spent.</p> <p>b. Resident #2's bank statements were reviewed from December 2008 through December 2009 and revealed the following withdrawals:</p> <ul style="list-style-type: none"> - December 1, 2009, in the amount of \$340.20. There were no receipts; - February 5, 2009, in the amount of \$20.00. There were no receipts; - March 30, 2009, in the amount of \$25.00. There were no receipts; - May 6, 2009, in the amount of \$45.00. There were no receipts; 	W 140	<p>W140 cont'd</p> <p>The Program has replaced these funds to the individuals accounts and are in the process of completing an internal financial audit to assure all individuals funds are accounted for and reconciled.</p> <p>The system is also implemented that no individuals funds can be distributed until the staff has reconciled previous withdrawals.</p>	3-31-10	

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W 140	Continued From page 9 - June 11, 2009, in the amount of \$210.00. There were no receipts; and - December 28, 2009 in the amount of \$200.00. There were no receipts. c. Resident #3's bank statements were reviewed from January 2008 through December 2009 and revealed the following withdrawals: - January 13, 2009, in the amount of \$117.00. There were no receipts; - February 25, 2009, in the amount of \$200.00. There were no receipts; - February 11, 2009, in the amount of \$260.00. There were no receipts; - March 30, 2009, in the amount of \$60.00. There were no receipts; and - April 10, 2009, in the amount of \$60.00. There were no receipts. At the time of the survey, the facility failed to ensure a complete accounting of the residents personal funds providing evidence to justified the aforementioned withdrawals.	W 140			
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.	W 148			

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W 148	<p>Continued From page 10</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure clients' family members were informed of client to client mistreatment and injuries of unknown origin, for two of the three clients in the sample. (Clients #2 and #6)</p> <p>The finding includes:</p> <p>Review of the facility's incident reports on January 19, 2010, beginning at 8:56 a.m., revealed the following client to client mistreatment and injuries of unknown origin:</p> <p>1. On August 27, 2009, at 2:00 p.m., the Incident Management Coordinator (IMC) received a phone call from Department of Disabilities Services (DDS) investigator on August 27, 2009, at 2:00 p.m., stating that their office received an anonymous fax alleging abuse against Client #1. The statement alleged that the client was "acting out", grabbed a staff and in return the staff used force to release himself.</p> <p>An interview was conducted with the IMC on January 19, 2010, at approximately 10:45 a.m., that revealed that she did not complete an incident report. According to the notification section of the investigative report revealed that the administrator was notified on August 28, 2009, at 2:45 p.m., (24 hours after the phone call). Further interview revealed that all allegations of abuse should be reported to the administrator, immediately.</p> <p>2. Review of the Client #2's nursing notes on January 20, 2010, beginning at 9:51 a.m.,</p>	W 148	<p>1. The program will notify all persons including guardians, attorneys, monitoring agencies on incidents involving our individuals. Staff retrained on this policy</p> <p>2. The program has trained staff on incident reporting policy pertaining to all individuals</p>	2-26-10	

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W 148	<p>Continued From page 11</p> <p>revealed the following client mistreatment and injuries of unknown origin:</p> <p>a. On December 18, 2008, at 6:50 p.m., the registered nurse (RN) noted that Client #2 sustained a bite to her right lower arm by Client #4.</p> <p>b. On September 14, 2009, the RN noted a round bruise on Client #2's right forearm.</p> <p>c. On June 27, 2009, the RN noted a fading bruise on Client #2's left forearm.</p> <p>d. On April 28, 2009, the RN noted that she received a page from the facility at 6:45 a.m. The RN was apprised of a bruise on Client #2's arms. Upon arrival to assess the client, the RN observed a large ecchymosed area on her left forearm. The RN further noted that she had assessed the client's vital signs, placed ear drops in her ears and provided nail care on either April 25, or April 26, 2009, and did not note any bruises or made aware of any incidents that had taken place.</p> <p>An interview was conducted with the RN on January 21, 2010, beginning at 1:15 p.m., via telephone. The RN was aware of the bite incident; however, the other aforementioned bruises were noted during visits to the facility. Inquiry was made of the RN, about the facility's incident reporting procedures. The RN stated, "If a client receives an injury of unknown origin, the direct care staff should report the injury of unknown origin to the QMRP or House Manager and complete an incident report.</p> <p>An interview was conducted with the IMC on</p>	W 148		
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NAME OF PROVIDER OR SUPPLIER WESTVIEW 01			STREET ADDRESS, CITY, STATE, ZIP CODE 3200 12TH STREET, NE WASHINGTON, DC 20017										
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W 148	Continued From page 12 January 19, 2010, at approximately 10:45 a.m., that revealed she was not aware of the injuries of unknown origin for Client #2. Further review of the incident report, however, revealed that there was no documented evidence that indicated Client #5's guardian had been notified.	W 148											
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that staff consistently implemented policies developed to protect client safety, for four of the six clients residing in the facility. (Clients #1, #2, #3, #4 and #6) The findings include: 1. [Cross Refer to See W140]. The facility failed to ensure a system had been implemented to maintain a complete accounting of clients' personal funds. 2. [Cross Refer to W153]. The facility failed to ensure client to client mistreatment and injuries unknown origin were reported immediately to the administrator in accordance with the agency's developed policy. 3. [Cross Refer to W154]. The the facility failed to thoroughly investigate all incidents of client to client mistreatment and injuries unknown origin in accordance with the agency's developed policy.	W 149											
W 153	483.420(d)(2) STAFF TREATMENT OF	W 153	<table border="1"> <tr> <td>W149</td> <td>1. Money management policy has been reviewed with Financial office and Management Staff</td> <td>2-24-10</td> </tr> <tr> <td></td> <td>2. Incident Reporting procedures including policy on injury of unknown origin is trained and implemented</td> <td>2-26-10</td> </tr> <tr> <td></td> <td>3. Program will review all incidents of unknown origin as serious reportable and investigate these injuries in the same manner as all serious reportable incidents</td> <td></td> </tr> </table>	W149	1. Money management policy has been reviewed with Financial office and Management Staff	2-24-10		2. Incident Reporting procedures including policy on injury of unknown origin is trained and implemented	2-26-10		3. Program will review all incidents of unknown origin as serious reportable and investigate these injuries in the same manner as all serious reportable incidents		
W149	1. Money management policy has been reviewed with Financial office and Management Staff	2-24-10											
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W 153	<p>Continued From page 13</p> <p>CLIENTS</p> <p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure client to client mistreatment and injuries unknown origin were reported immediately to the administrator or to other officials in accordance with district law (22 DCMR, Chapter 35, Section 3519.10), for two of the six clients residing in the facility. (Clients #1 and #2)</p> <p>The findings include:</p> <p>1. Review of the facility's incident reports and corresponding investigative reports on January 19, 2010, beginning at 8:56 a.m., revealed the following:</p> <p>On August 27, 2009, at 2:00 p.m., the Incident Management Coordinator (IMC) received a phone call from Department of Disabilities Services (DDS) investigator on August 27, 2009, at 2:00 p.m., stating that their office received an anonymous fax alleging abuse against Client #1. The statement alleged that the client was "acting out", grabbed a staff and in return the staff used force to release himself.</p> <p>An interview was conducted with the IMC on January 19, 2010, at approximately 10:45 a.m.,</p>	W 153		
			W 153	1. All staff are trained on the appropriate manner of reporting incidents including reporting allegations of abuse.

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W 153	<p>Continued From page 14</p> <p>that revealed that she did not complete an incident report. According to the notification section of the investigative report revealed that the administrator was notified on August 28, 2009, at 2:45 p.m., (24 hours after the phone call). Further interview revealed that all allegations of abuse should be reported to the administrator, immediately.</p> <p>2. Review of the Client #2's nursing notes on January 20, 2010, beginning at 9:51 a.m., revealed the following client to client mistreatment and injuries of unknown origin:</p> <p>a. On December 18, 2009, at 6:50 p.m., the registered nurse (RN) noted that Client #2 sustained a bite to her right lower arm by Client #4.</p> <p>b. On September 14, 2009, the RN noted a round bruise on Client #2's right forearm.</p> <p>c. On June 27, 2009, the RN noted a fading bruise on Client #2's left forearm.</p> <p>d. On April 28, 2009, the RN noted that she received a page from the facility at 6:45 a.m. The RN was apprised of a bruise on Client #2's arms. Upon arrival to assess the client, the RN observed a large ecchymosed area on her left forearm. The RN further noted that she had assessed the client's vital signs, placed ear drops in her ears and provided nail care on either April 25, or April 28, 2009, and did not note any bruises or made aware of any incidents that had taken place.</p> <p>An interview was conducted with the RN on January 21, 2010, beginning at 1:15 p.m., via</p>	W 153	<p>a. Staff is retrained on incident reporting policy</p> <p>b. Staff is retrained on incident reporting policy</p> <p>c. Staff is retrained on incident reporting policy</p> <p>d. Nurses and staff will report all incidents of unknown origin as serious reportable. These incidents will be given to IMC to investigate these in the same manner as all other serious reportable incidents</p>	2-26-10	2-26-10

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W 153	Continued From page 15 telephone. The RN was aware of the bite incident; however, the other aforementioned bruises were noted during visits to the facility. Inquiry was made of the RN, about the facility's incident reporting procedures. The RN stated, "If a client receives an injury of unknown origin, the direct care staff should report the injury of unknown origin to the QMRP or House Manager and complete an incident report. An interview was conducted with the IMC on January 19, 2010, at approximately 10:45 a.m., that revealed she was not aware of the injuries of unknown origin for Client #2. At the time of the survey, the facility failed to provide evidence that the administrator had been notified of the aforementioned incidents.	W 153			
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to thoroughly investigate all incidents, for two of the six clients residing in the facility. (Clients #2 and #6) The findings include: 1. Review of the facility's unusual incident reports (UIR) and investigative reports on January 19, 2010, beginning at 8:56 a.m., revealed the following client to client mistreatment and injuries of unknown origin:	W 154	1a. Nurses and staff will report all incidents of unknown origin as serious reportable. These incidents will be given to IMC to investigate these in the same manner as all other serious reportable incidents	2-26-10	

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W 154	<p>Continued From page 16</p> <p>Review of the Client #2's nursing notes on January 20, 2010, beginning at 9:51 a.m., revealed the following client to client mistreatment and injuries of unknown origin revealed the following:</p> <p>a. On December 18, 2009, at 6:50 p.m., the registered nurse noted that Client #2 sustained a bite to the right lower arm from Client #4.</p> <p>b. On September 14, 2009, the RN noted a round bruise on the Client #2's right forearm.</p> <p>c. On June 27, 2009, the RN noted a fading bruise on Client #2's left forearm.</p> <p>d. On April 28, 2009, the RN noted that she received a page from the facility at 6:45 a.m. The RN was apprized of a bruise on Client #2's arms. Upon arrive to assess the client, the RN observed a large ecchymosed area on her left forearm. The RN further noted that she had assessed the client's vital signs, placed ear drops in her ears and provided nail care on either April 25, 2009, or April 26, 2009, and did not observe any bruises or made aware of any incidents that took place.</p> <p>Review of the facility's incident reports on January 4, 2010, at 5:00 p.m., revealed no evidence of the aforementioned incident reports.</p> <p>An interview was conducted with the IMC on January 19, 2010, at approximately 10:45 a.m., that revealed that she was not aware of the injuries of unknown origin for Client #2. However she noted that according to the facility's policy, the first person that discovers an injury of unknown origin should complete an incident report and Informed the QMRP and/or the House</p>	W 154	<p>1b. Nurses and staff will report all incidents of unknown origin as serious reportable. These incidents will be given to IMC to investigate these in the same manner as all other serious reportable incidents.</p> <p>1c. Nurses and staff will report all incidents of unknown origin as serious reportable. These incidents will be given to IMC to investigate these in the same manner as all other serious reportable incidents</p> <p>1d Nurses and staff will report all incidents of unknown origin as serious reportable. These incidents will be given to IMC to investigate these in the same manner as all other serious reportable incidents</p>	2-26-10	

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W 154	Continued From page 17 Manager. She further indicated that investigations were not conducted because she was not informed of the injuries of unknown origin. 2. Review of the facility's incident reports and investigative reports on January 21, 2010, at 8:56 p.m., revealed Client #6's investigation report dated March 24, 2009. The investigation report stated, "S/P fall, ... substantiated and resolved." However, the investigative report failed to document how the fall was substantiated and or a conclusion. Review of the recommendations revealed the 1:1 direct support staff needs more training on how to assist his client up and down the stairs. An interview was conducted with the IMC on January 19, 2010, at approximately 10:45 a.m., revealed that Client #6 fell down the stairs while his 1:1 direct support staff was assisting him. Further interview confirmed that she did not include all the findings in her investigative report.	W 154	2. 1 to 1 staff retrained BSP and 1to 1 procedure for person #6	1-28-10	
W 195	483.440 ACTIVE TREATMENT SERVICES The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: Based observations, interviews, and record reviews, the facility failed to provide continuous and aggressive active treatment services and interventions in accordance with recommendations presented by professional staff of the interdisciplinary team (IDT), [Refer to W196, W249]; facility failed to ensure that each clients who received psychotropic medications	W 195			

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W 195	Continued From page 18 had a psychiatric assessment [Refer to W212]; facility failed to ensure that the comprehensive functional assessment identified behavioral need interventions [Refer to W214]; the facility failed to ensure each client's Individual Support Plan (IPP) was available to all relevant staff who work with the client [Refer to W248]; the facility failed to implement clients communication Individual Program Plan (IPP)[Refer to W249]; the facility failed to develop an alternative and a regular active treatment schedule that outlined the current active treatment programs [See W250]; the facility failed to ensure that data was collected in the form and required frequency [See W252]; and the facility failed to furnish and maintain clients adaptive communication device [See W436].	W 195			
	The findings of these systemic practices results in the facility's failure to adequately govern the facility in a manner that would ensure its clients' were provided active treatment to address their identified needs.				
W 196	483.440(a)(1) ACTIVE TREATMENT Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status.	W 196	Current ISP goals and Behavior Sheets are in the Individuals Books for documentation by Staff	2-15-10	

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W 196	<p>Continued From page 19</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interviews, and record review, the facility failed to ensure that clients received continuous active treatment program in accordance with recommendations made by the interdisciplinary team (IDT) for three of the three clients included in the sample. (Clients #1, #2 and #3)</p> <p>The findings include:</p> <p>1. On January 19, 2010, Client #1's home activities beginning at 7:30 a.m., were observed and revealed the following:</p> <p>a) Upon the surveyors' arrival at 7:30 a.m., a direct care support staff was observed talking on his cell phone, outside. Once the surveyor entered the facility, Client #1 was observed eating breakfast with his peers. Further observations revealed staff walking in and out the dining room as the clients ate breakfast. Interview with the direct support staff at approximately 7:50 a.m., revealed Client #1 required a 1:1 direct care support staff (24 hours). There was no evidence that a 1:1 direct care support staff was present during breakfast.</p> <p>b) On January 19, 2010, at 8:30 am., Client #1 was observed entering the facility's van to go to his day program. At 10:00 a.m., Client #1 returned home. Interview with his 1:1 direct support staff revealed the client refused to get off the van because he did not want to go to his day program. From 10:00 a.m., until 10:30 a.m., Client #1 was observed looking out the dining room window. At 11:45 a.m., the client was observed leaving the facility with staff and returned at 12:35 p.m. Interview with his 1:1</p>	W 196			
			W196	<p>1a. 1to 1 Staff has been trained on BSP's and what 1to 1 services expectation they are to meet.</p> <p>1b. Person 1 has his choice of magazines and active treatment materials he prefers including sports magazines. Staff has been trained to offer this person more alternatives and to follow the alternative program schedule of this person when he choices not to go to his program.</p>	<p>1-29-10</p> <p>1-29-10</p>

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W 196	<p>Continued From page 20</p> <p>direct support staff revealed the client went to lunch at McDonalds. At 12:45 p.m., the 1:1 direct support staff handed the client a magazine and he flipped through the pages briefly then began to watch television. At 1:02 p.m., the 1:1 direct support staff handed him the same magazine. The client flipped through the pages briefly then began to look around the living room. Shortly after he began to look out the window.</p> <p>Interview with the 1:1 direct support staff on January 21, 2010, at 1:20 p.m., revealed "I give him his freedom and space during the day because he is programmed in the evenings." Further interview revealed "If you get into his space too much he will go into his behaviors." Minutes later, the 1:1 direct support staff revealed Client #1 was going to ride on the van to pick the other clients up from their day programs.</p> <p>Review of the client's habilitation record on January 21, 2010, revealed no documented evidence of training programs for January 2010. Further record review revealed the last QMRP monthly notes were dated September 3, 2009.</p> <p>c. Observation on January 19, 2010, at approximately 3:00 p.m., revealed Client #1 looking out the window. At 3:50 p.m., the client was observed leaving the group home. Interview with the direct support staff indicated the client was going to ride on the van to take another client to a medical appointment. At 4:40 p.m., Client #1 arrived home and began to look out the dining room window. The 1:1 direct support staff was in the living room. At 5:00 p.m., the client and his 1:1 direct support staff went into the living room to watch television. At 5:05 p.m., Client #1 began to look out the dining room window again. The</p>	W 196	<p>1c. Staff training on program goal and implementation for this person is completed.</p>	2-19-10	

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W 196	<p>Continued From page 21</p> <p>direct support staff named three things that was out the window. At 5:15 p.m., the 1:1 direct support staff handed Client #1 a magazine and he flipped through the magazine briefly. Interview with the 1:1 direct support staff at 5:53 p.m., revealed, "we usually take him for a ride in the evenings."</p> <p>Record review on January 21, 2010, beginning at 9:10 a.m., revealed an activity schedule included in Client #1's Individual Support Plan (ISP), dated December 12, 2008. Interview with the 1:1 direct support staff on January 21, 2010, at 11:40 a.m., revealed he has not seen Client #1's activity schedule since his last ISP in December 2008.</p> <p>At 6:00 p.m., the direct support staff was observed setting the table for dinner. At 6:05 p.m., Client #1 was observed eating his dinner while wearing his winter coat. After he completed his dinner, staff was observed taking the client's dishes to the kitchen.</p> <p>Review of Client #1's occupational therapy assessment dated December 12, 2009, on January 21, 2010, at 10:00 p.m., revealed Client #1 was able to place "his cup and utensil onto his plate and take his plate to the kitchen when finished eating.</p> <p>Observations on January 19, 2010, at 6:25 p.m., revealed Client #1 watching television in Client #5's bedroom. Interview with the direct support staff revealed Client #1 broke his television last week, therefore he "lets him enjoy himself." The support staff was observed downstairs while Client #1 was upstairs looking out Client #2's bedroom window. At 6:44 p.m., Client #1 was observed walking into the dining room wearing a</p>	W 196	<p>Person 1 television is replaced</p>	2-28-10	

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W 196	<p>Continued From page 22</p> <p>dirty suit jacket (a white substance was all over his jacket). Interview with the 1:1 direct support staff revealed Client #1 "likes to wear that jacket." Further interview revealed he will display his behavior if he is redirected.</p> <p>Review of Client #1's occupational therapy assessment dated December 12, 2009, on January 21, 2010, at 10:00 p.m., revealed Client #1 was able to "place dirty clothing into the hamper and load the washing machine and the dryer with verbal prompting."</p> <p>Review of Client #3's IPP revealed that the recommended training programs were not consistently implemented as evidenced below:</p> <ul style="list-style-type: none"> - The client will independently Say hi to his 1:1 counselor by name, when he arrives to work on 4 out of 4 trials a week. - The client will independently set his place at the dinner table on 3 out of 3 trials a week. - The Client will independently remove his dishes from the table after dinner on 3 out of 3 trials a week. - Given visual demonstration and verbal prompting. The client will participate in structured exercise on 3 out of 3 trials a week. - Given a model, the client will identify the function of 5 community helpers with 80% accuracy per session for six consecutive months. - The client will independently participate in a table top activity for 30 minutes on 4 out of 4 trials a week. 	W 196			

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NAME OF PROVIDER OR SUPPLIER WESTVIEW 01			STREET ADDRESS, CITY, STATE, ZIP CODE 3200 12TH STREET, NE WASHINGTON, DC 20017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 196	Continued From page 23 Interview with the Qualified Mental Retardation Professional (QMRP) on January 21, 2010, at 11:00 a.m., revealed that the program had not been implemented since his Individual Support Plan (ISP) meeting. Further interview revealed that Client #1's ISP meeting was held on December 11, 2009. 2. Observation on the morning of January 19, 2010, from 7:20 a.m. to 8:10 a.m., Client #3 was upstairs in his bedroom watching television. At 8:15 a.m., the client got on the van and was transported to his day program. At 3:40 p.m., Client #3 arrived home from his day program. At 3:50 p.m., the client went on a medical appointment and returned home at 4:40 p.m. Several minutes later, the client was served a snack. After his snack he put his napkin in the trash can. From 4:45 p.m., until 5:30 p.m., Client #3 stood in the living room wearing ear phones, listening and moving to his music. There was no staff intervention. At 5:30 p.m., the trained medication employee (TME) arrived in the facility. The client went upstairs to the nurses' station to get his evening medications. Client #3 was observed retrieving a key, unlocking a box, and retrieving medications in bubble packages, punching his medications from the bubble packs, pouring a cup of water and consuming his medications, independently. After the client consumed his medications, he locked the medication box and put the box back into the cabinet. The TME was observed signing the medication administration record (MAR). Interview with the TME indicated that the client is independent in taking his medications; however, he does not indicate the medication usage or sign the medication administration records (MARs). At	W 196	Medication documentation with TME has occurred with RN	2-1-10	

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W 196	<p>Continued From page 24</p> <p>6:05 p.m., Client #3 was served his dinner which consisted of a chicken leg and thigh, mashed potatoes, mixed vegetables and a small loaf of corn bread. The client was observed picking up the chicken pieces (leg and thigh) and corn bread, with his fingers and biting into it. For the remainder of the evening, Client #3 stood or sat in the living room wearing ear phones, listening and moving to his music. There was no staff intervention.</p> <p>Interview with the staff indicated that Client #3 likes to come home, and relax (listening to his music).</p> <p>Review of Client #3's Individual Program Plan revealed the following program objectives:</p> <p>Review of the Client #3's IPP revealed objectives to improve social awareness in regards to smoking, improve his activities of daily living skills, improve personal management skills, improve physical fitness, improve functional communication skills, improve independent recreational skills and improve money management skills. At no time during the observations did the staff encourage the client to participate in any of the aforementioned program objectives as evidenced below:</p> <p>[The client] will independently iron his shirt for the next day on 3/3 trials a week as recorded per month for three consecutive month by 12/10.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on January 21, 2010, at 10:00 a.m., revealed that the program had not been implemented since his Individual Support Plan (ISP) meeting. Further interview revealed</p>	W 196			

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W 196	<p>Continued From page 25</p> <p>that Client #3's ISP meeting was held on December 13, 2009.</p> <p>3. Review of Client #2's records on January 20, 2010, at 10:00 a.m., revealed the client had an Individual Support Plan (ISP) dated November 23, 2009. Interview with the Qualified Mental Retardation Professional (QMRP) on January 20, 2010, at 10:30 AM and further review of Client #2's record revealed that at the time of the ISP meeting, the Interdisciplinary Team (IDT) recommended the following program objectives:</p> <p>a. The [client], will participate in a structured exercise program on three days a week as recorded per month for three consecutive months by 10/10;</p> <p>b. The [client], will talk to her mother on the telephone for 5 minutes once a week as recorded per month for three consecutive months by 10/10;</p> <p>c. The [client], will wash her back using a long handle back brush on three days a week as recorded per month for three consecutive months by 10/10;</p> <p>d. The [client], will apply deodorant under her arms on three days a week as recorded per month for three consecutive months by 10/10;</p> <p>e. The [client], will sort her laundry two days a week as recorded per month for three consecutive months by 10/10; and</p> <p>f. The [client] will play the game "Trouble" on three days a week for three consecutive months by 10/10.</p>	W 196			

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W 196	Continued From page 26 Interview with the QMRP and review of the client's records on January 21, 2010, at approximately 11:00 AM, revealed there was no evidence that the aforementioned program objectives had been implemented.	W 196	Staff training on Program goals and documentation	2-19-10	
W 212	483.440(c)(3)(i) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the presenting problems and disabilities and where possible, their causes. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that clients received comprehensive functional assessments, for three of the three clients in the sample. (Clients #1, #2 and #3) The findings include: 1. The facility failed to ensure that Client #1 received a psychological assessment. Observation of the evening medication administration on January 19, 2010, at 6:00 p.m., revealed Client #1 received Tegretol 500 mg, and Risperdal 3 mg. Interview with the trained medication employee (TME) on January 19, 2010, during the medication administration indicated that the medication was prescribed for behavior management. Review of the client's physicians orders (POS) dated January 2010, on January 20, 2010 at 10:30 a.m., revealed that the aforementioned medications were prescribed for the client's psychotic disorder. Review of Client #1's psychological assessment dated December 6, 2008 on January 21, 2010, at	W 212	Psychological Assessment has been obtained and BSP implemented	2-7-10	

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W 212	<p>Continued From page 27</p> <p>10:15 a.m., stated, "complete an annual psychological assessment update within one year." Interview with the qualified mental retardation professional (QMRP) on January 21, 2010, at approximately 3:00 p.m., indicated that Client #1's psychological assessment had not been completed. There was no evidence of a current psychological assessment.</p> <p>2. The facility failed to ensure clients who received psychotropic medication had a psychiatric assessment, for two of the three clients in the sample. (Clients #2 and #3)</p> <p>a. Observation of the evening medication administration on January 19, 2010, at 5:45 p.m., revealed Client #2 received Risperdal and Tegretol. Interview with the trained medication employee (TME) on January 19, 2010, during the medication administration indicated that the medication was prescribed for behavior management. Review of the client's physicians orders dated January 2010, on January 20, 2010 at 10:30 a.m., revealed that the aforementioned medications were incorporated in a Personal Behavior Support Plan (PBSP) dated November 4, 2009.</p> <p>Review of Client #2's medical evaluation dated October 29, 2009, on January 19, 2010, at approximately 10:00 AM, revealed that the psychotropic medications were prescribed to address behaviors associated with a diagnosis of bipolar disorder.</p> <p>Further review of the client's medical record revealed no documented evidence of a psychiatric assessment.</p>	W 212		

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W 212	<p>Continued From page 28</p> <p>b. Observation of the evening medication administration on January 19, 2010, at 5:40 p.m., revealed Client #3 received Haldol, Depakote and Risperdal. Interview with the trained medication employee (TME) on January 19, 2010, during the medication administration indicated that the medication was prescribed for behavior management. Review of the client's physicians orders dated January 2010, on January 20, 2010 at 1:34 p.m., revealed that the aforementioned medications were incorporated in a Personal Behavior Support Plan (PBSP) dated December 10, 2008.</p> <p>Review of Client #3's medical evaluation dated December 2008, on January 20, 2010 at approximately 2:00 p.m., revealed that the psychotropic medications were prescribed to address behaviors associated with a diagnosis of chronic schizophrenia paranoid.</p> <p>Further review of the client's medical record revealed no documented evidence of a psychiatric assessment.</p> <p>3. The facility failed to assess Clients #1 and #2 to determine their need to participate in a self medication program.</p> <p>a. Observation of the medication administration on January 19, 2010, at 6:02 p.m., the trained medication employee (TME) was observed preparing and spoon feeding the client his medications, pouring Client #1's cup of water. Observations throughout the survey from January 19, 2010, through January 22, 2010, revealed that the client was independent in feeding himself.</p> <p>Interview with the TME during the medication</p>	W 212			

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W 212	Continued From page 29 observation indicated that the client did not participate in a self medication training program. Review of the medical record revealed no self medication assessment. Further interview with the QMRP on January 21, 2010, at approximately 10:00 a.m., confirmed that there was no self medication assessment. b. Observation of the medication administration on January 19, 2010, at 5:45 p.m., the TME was observed preparing Client #2's medications. The TME punched the pills into a medication cup, put the pills in a cup of applesauce, spoon fed it to the client and poured the client a cup of water. Observations throughout the survey from January 19, 2010, through January 22, 2010, revealed that Client #2 pouring water into a cup and feeding herself independently. Interview with the TME during the medication observation indicated that the client did not participate in a self medication training program. Review of the medical record revealed no self medication assessment. Further interview with the QMRP on January 21, 2010, at approximately 10:00 a.m., confirmed that there was no self medication assessment.	W 212			
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by. Based on interview and record review, the facility failed to ensure that the comprehensive functional assessment identified behavioral need interventions, for one of the three clients included	W 214			

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W 214	Continued From page 30 in the sample. (Client #1) The finding includes: Interview with the direct care support staff on January 19, 2010, at 1:20 p.m., revealed Client #1 will get upset and display his maladaptive behaviors "if your in his space" or try to redirect him. Review of Client #1's behavior support plan (BSP) dated December 8, 2008, on January 21, 2010, at 10:30 a.m., revealed his BSP was not current. Interview with the QMRP on January 21, 2010, at approximately 3:00 p.m., indicated that the client's BSP had not been completed. There was no evidence of a current BSP.	W 214	W214 BSP is current and implemented	2-14-10	
W 248	483.440(c)(7) INDIVIDUAL PROGRAM PLAN A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure each client's Individual Support Plan (ISP) was available to all relevant staff who work with the client, for three of the three clients residing in the sample. (Clients #1, #2 and #3) The findings include: 1. Review of Client #1's records on January 21, 2010, at 9:00 a.m., revealed a copy of his ISP	W 248	I. A Current Copy of ISP is in individual record	2-9-10	

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W 248	Continued From page 31 dated December 12, 2008. Interview with the Qualified Mental Retardation Professional (QMRP) on January 21, 2010, at approximately 9:30 a.m., revealed that the facility did not have a current copy of Client #1's ISP. Further interview with the QMRP revealed that Client #1's ISP meeting was held on December 2009. 2. Interview with the day program Individual Program Plan (IPP) Coordinator on January 19, 2010 at approximately 11:00 a.m., revealed that the day program did not have a current copy of the Client #2's current ISP. Review of the records revealed a copy of the ISP dated October 24, 2008. Interview with the QMRP on January 20, 2010, at approximately 4:00 p.m., indicated that the client's ISP meeting was held on November 23, 2009. 3. Interview with the day program Social Worker on January 19, 2010, at approximately 11:00 a.m., revealed that the day program did not have a current copy of the Client #3's current ISP. Review of the records revealed a copy of the ISP dated December 12, 2008. Interview with the QMRP on January 20, 2010, at approximately 4:00 p.m., indicated that the client's ISP meeting was held on December 13, 2010 (over thirty days).	W 248	2. A Current Copy of ISP is in the individuals record 3. A current copy of ISP is in the individuals record	2-9-10 2-9-10	
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.	W 249			

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W 249	Continued From page 32 This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to implement clients communication Individual Program Plan (IPP), for one of the three clients included in the sample. (Client #3) The finding includes: 1. The trained medication employee (TME) arrived in the facility 5:30 p.m., and explain to Client #3 that he needed to take his medications to control his maladaptive behaviors. Observation of the medication administration on January 19, 2010, at 5:40 p.m., Client #3 was observed locating a key, unlocking his medication box, punching his medications from the bubble packs, pouring a cup of water and consuming his medications, independently. After the client consumed his medications, he locked the medication box and put the box back into the cabinet. The TME was observed signing the medication administration record (MAR). Interview with the TME indicated that the client is independent in taking his medications, however, he does not indicate the medication usage or sign the MARs. Review of the client's IPP dated December 13, 2009, revealed a program objective which stated, "given a description of a medicine and/or warning label, [the client] will identify the label for 10/12 trials offered for six consecutive months as measured by program documentation. Interview with the Qualified Mental Retardation Professional (QMRP) on January 21, 2010, at 10:00 a.m., revealed that the program had not been implemented since his	W 249			
		W249	Medication documenting training has occurred with TME	2-1-10	

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W 249	Continued From page 33 Individual Support Plan (ISP) meeting was held on December 13, 2009.	W 249			
W 250	483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop an alternative and a regular active treatment schedule that outlined the current active treatment programs, for three of the three clients in the sample. (Clients #1, #2 and #3) The findings include: 1. The facility failed to ensure an alternative activity schedule was developed for Client #1 as evidenced below: On January 19, 2010, at 8:30 am., Client #1 was observed entering the facility's van to go to his day program. At 10:00 a.m., Client #1 returned home. Interview with his 1:1 direct support staff revealed the client refused to get off the van because he did not want to go to his day program. From 10:00 a.m., until 10:30 a.m., Client #1 was observed looking out the dining room window. At 11:45 a.m., the client was observed leaving the facility with staff and returned at 12:35 p.m. Interview with his 1:1 direct support staff revealed the client went to lunch at McDonalds. At 12:45 p.m., the 1:1 direct support staff handed the client a magazine and	W 250	1. QMRP quarterly and Monthly notes will be place in record	3-5-10	

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W 250	<p>Continued From page 34</p> <p>he flipped through the pages briefly then began to watch television. At 1:02 p.m., the 1:1 direct support staff handed him the same magazine. The client flipped through the pages briefly then began to look around the living room. Shortly after he began to look out the window.</p> <p>Interview with the 1:1 direct support staff on January 21, 2010, at 1:20 p.m., revealed "I give him his freedom and space during the day because he is programmed in the evenings." Further interview revealed "If you get into his space too much he will go into his behaviors." Minutes later, the 1:1 direct support staff revealed Client #1 was going to ride on the van to pick the other clients up from their day programs.</p> <p>Review of the client's habilitation record on January 21, 2010, revealed no documented evidence of training programs for January 2010. Further record review revealed the last QMRP monthly notes were dated September 3, 2009.</p> <p>2. The facility failed to develop an active treatment scheduled that outlines the current active treatment programs, for three of the three clients included in the sample.</p> <p>a. Observation on January 19, 2010, at approximately 3:00 p.m., revealed Client #1 looking out the window. At 3:50 p.m., the client was observed leaving the group home. Interview with the direct support staff indicated the client was going to ride on the van to take another client to a medical appointment.</p> <p>Record review on January 21, 2010, beginning at 9:10 a.m., revealed an activity schedule included</p>	W 250	<p>2. Current ISP and Schedule are developed and staff trained for person #1</p>	2-5-10	

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W 250	<p>Continued From page 35</p> <p>in Client #1's Individual Support Plan (ISP), dated December 12, 2008. Interview with the 1:1 direct support staff on January 21, 2010, at 11:40 a.m., revealed he has not seen Client #1's activity schedule since his last ISP in December 2009.</p> <p>Interview with the qualified mental retardation professional (QMRP) on January 19, 2010, at approximately 12:05 p.m., indicated that Client #1 had an ISP meeting on December 11, 2009. The client's individual program plan (IPP) goals and objectives were developed and approved by the interdisciplinary team. The client's habilitation records were reviewed on the same day at approximately 12:30 p.m., to determine if the records contained an activity schedule. Although the records revealed a schedule, the clients' IPP or training programs were not included in the schedule. The QMRP was made aware on the same day that the activity schedule lacked information regarding the days and timeframe for the implementation of the client's IPP goals and objectives.</p> <p>b. Interview with the QMRP on January 19, 2010, at approximately 12:05 p.m., indicated that Client #2 had an ISP meeting on November 23, 2009. The client's IPP goals and objectives were developed and approved by the interdisciplinary team. The client's habilitation records were reviewed on the same day at approximately 12:30 p.m., to determine if the records contained an activity schedule. Although the records revealed a schedule, the clients' IPP or training programs were not included in the schedule. The QMRP was made aware on the same day that the activity schedule lacked information regarding the days and timeframe for the implementation of the client's IPP goals and objectives.</p>	W 250	<p>2b. Current ISP and Schedule are developed and staff trained for person #1</p> <p>3b. Current ISP and Schedule are developed and staff trained for person #1</p>	2-5-10	2-5-10

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W 250	Continued From page 36	W 250			
W 252	<p>c. Interview with the QMRP on January 19, 2010, at approximately 12:05 p.m., indicated that Client #3 had an ISP meeting on December 13, 2009. The client's IPP goals and objectives were developed and approved by the interdisciplinary team. The client's habilitation records were reviewed on the same day at approximately 12:30 p.m., to determine if the records contained an activity schedule. Although the records revealed a schedule, the clients' IPP or training programs were not included in the schedule. The QMRP was made aware on the same day that the activity schedule lacked information regarding the days and timeframe for the implementation of the client's IPP goals and objectives.</p> <p>483.440(e)(1) PROGRAM DOCUMENTATION</p> <p>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that data was collected in the form and required frequency, for one of the three clients in the sample. (Client #1)</p> <p>The finding includes:</p> <p>Interview with Client #1's guardian on January 21, 2010, at approximately 4:30 p.m., revealed, sometime in June or July 2009, while Client #1 was outside his home, he became aggressive and began to hit others around him. Further interview indicated the client took a while to calm</p>	W 252			

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W 252	Continued From page 37 down. Review of Client #1's Behavior Support Plan (BSP) dated December 10, 2008, on January 21, 2010 at 10:30 a.m., revealed "hitting others" and "aggression" were two of the client's targeted behaviors. Further review of the BSP revealed that all incidents of targeted behaviors should be recorded at the end of each shift. At approximately 2:00 p.m., review of the data collection sheets from June 2009 and July 2009, revealed no evidence of targeted behaviors (aggression and/or hitting of others). Interview with the incident management coordinator and qualified mental retardation professional (QMRP) on January 22, 2010, at approximately 11:30 a.m., revealed they were not aware of the incident.	W 252			
W 261	483.440(f)(3) PROGRAM MONITORING & CHANGE The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility. This STANDARD is not met as evidenced by: Based on observation, interview and review of the Human Rights Committee (HRC) minutes, the facility failed to ensure that persons with no ownership or controlling interest in the facility reviewed and approved clients Behavior Support Plans (BSP), for one of the three clients included	W 261	Staff are trained on Person 31 behaviors and all incidents will be recorded in person behavior documentation or incident report for medication and/or incident review	2-26-10	

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W 261	Continued From page 38 in the sample. (Client #3) The finding includes: During the entrance conference on January 19, 2010, beginning on at 8:30 a.m., the qualified mental retardation professional (QMRP) revealed that Client #3 received psychotropic medications for his maladaptive behaviors. Observations during the medication administration on January 19, 2010, at 5:40 p.m., revealed Client #3 received Haldol, Risperdal and Depakote. Review of the HRC meeting minutes was conducted on January 22, 2010, at 10:22 a.m. According to the HRC minutes dated April 2, 2009, Client #3's BSP to include psychotropic medications were reviewed and approved. Further review of the corresponding signature sheet attached to the minutes failed to evidence that the facility's HRC committee included persons with no ownership or controlling interest in the facility.	W 261	Human Rights committee meetings are held in conjunction with two other providers who have no stakes in Westview Medical & Rehabilitation, Inc	On-going	
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure restrictive measures were being implemented with the written consent of the client's court appointed legal guardian, for two of three clients included in the sample. (Client #1 and Client #3)	W 263			

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W 263	<p>Continued From page 39</p> <p>The findings include:</p> <p>1. The facility failed to ensure that informed consent was obtained from Client #1's guardian prior to the to the implementation of his Behavior Support Plan (BSP).</p> <p>Interview with the qualified mental retardation professional (QMRP) on January 19, 2009, at 8:30 a.m., during the entrance conference revealed that Client #1 had a BSP to address his maladaptive behaviors. Further interview revealed the client did not have the capacity to give informed consent for the use of medications and habilitation services.</p> <p>The QMRP's statement was verified on January 20, 2010 at 10:30 a.m., through review of Client #1's psychological assessment. According to the assessment, Client #1 "does not show competency or intellectual capacity to make independent decisions regarding his habilitation plans, medical or psychological issues, residential placement or 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.</p> <p>Review of the incident book on January 19, 2010, at 8:55 a.m., revealed Client #1 was restrained by two direct care support on October 25, 2009.</p> <p>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 implementing Client #1's BSP.</p>	W 263	<p>Consent are being obtained for all individuals BSP's</p>	3-10-10	

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W 263	<p>Continued From page 40</p> <p>2. The facility failed to ensure that informed consent was obtained from Client #3 court appointed legal guardian prior to the administration of his psychotropic medications.</p> <p>Interview with the QMRP on January 19, 2009, beginning at 8:30 a.m., during the entrance conference indicated Client #3 received psychotropic medications to address his maladaptive behaviors. Further interview revealed the client did not have the capacity to give informed consent for the use of medications and habilitation services.</p> <p>Observation of the evening medication administration on January 19, 2010, at 5:40 p.m., revealed Client #3 received Haldol 10 mg, Depakote 500 mg and Risperidone 4 mg. Interview with the trained medication employee (TME) during the medication administration revealed the aforementioned medications were used to address the client's behaviors.</p> <p>The QMRP's statement was verified on January 20, 2010, at approximately 2:30 p.m., through review of Client #3's psychological assessment. According to the assessment, Client #3 "does not show competency or intellectual capacity to make independent decisions regarding his habilitation plans, medical or psychological issues, residential placement or 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.</p> <p>Record verification on January 20, 2010, at 2:45 p.m., revealed that Client #3's guardian had given informed consent for the use of Haldol 3 mg QAM</p>	W 263			

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W 263	Continued From page 41 and 4 mg QPM, Risperdal 4 mg, twice a day, Cogentin 1 mg QAM and Depakote 500 mg, twice a day dated May 11, 2009. However there was no consent signed for the client's current Haldol 10 mg, twice a day.	W 263			
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure general and preventive care, for two of three clients included in the sample. (Client #1 and #2) The findings include: 1. The facility's primary care physician (PCP) failed to address Client #1's recommended diet change. Review of Client #1's medical record on January 20, 2010, at approximately 1:00 p.m., revealed a nutrition quarterly review dated March 13, 2009. The nutritionist recommended to discontinue the no concentrated sweets diet. Further review of the medical record revealed no evidence that the PCP had addressed the nutritionist recommendation. 2. The facility's PCP failed to ensure that Client	W 322	W322 Physicians Order and Nutritionist recommendation will be reflect the same on both reports Purchase of insole will be purchased	3-1-10 3-15-10	

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W 322	Continued From page 42 #1 received a new extra-depth shoe as recommended by the podiatrist.	W 322			
W 325	Record review of Client #1 medical records on January 20, 2010, at 1:30 p.m., revealed a diagnosis of club feet. The client had been seen by a podiatrist on May 12, 2009. It was recommended that the facility "call the office if it is time to order new extra-depth shoe." Interview with the qualified mental retardation professional (QMRP) revealed Client #1 wore orthopedic insoles inside his shoes. Further interview revealed the client needed new shoes and new insoles. The QMRP also stated that he was unaware of the podiatrist recommendation. 482.460(a)(3)(iii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide routine laboratory testing as orded by the physician, for three of the three clients included in the sample. (Clients #1, #2 and #3) The findings include: 1. On January 19, 2010, at 6:00 p.m., Client #1 was administered Tegretol 500 mg by mouth. Interview with the Trained Medication Employee (TME) revealed that the medication was prescribed for the client's maladaptive behaviors.	W 325	Labs were completed and will be quarterly or as prescribed	1-27-10	

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W 325	Continued From page 44 January 21, 2010, at 10:00 a.m., revealed an order for the client to receive Depakote levels, liver function test (LFT), and electrolyte panel, every 90 days. Review of the laboratory tests at 10:30 a.m., revealed Client #3 received laboratory studies in December 2008, April 2009 and July 2009. Further record review and interview with the facility's QMRP on the same day at approximately 11:00 a.m., acknowledged that the client's laboratory studies were not obtained as ordered by the physician.	W 325		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the facility's nursing staff failed to ensure clients received annual nursing assessments for two of three clients included in the sample. (Client #1 and #3) The findings include: 1. Review of Client #1's medical record on January 20, 2010 at 1:53 p.m., revealed an annual nursing assessment dated December 8, 2008. Interview with the qualified mental retardation professional (QMRP) at approximately 11:00 a.m., revealed the RN was not available for interview. Further interview confirmed the facility did not have a current annual nursing assessment. 2. Review of Client #3 medical record on January 20, 2010, at 1:35 p.m., revealed an annual nursing assessment dated December 8, 2008.	W 331	1. Current nursing assessments are obtained and signed for this person 2. Current nursing assessments are obtained and signed for this person	1-27-10 1-27-10

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W 336	Continued From page 46 2009, and June 2009. Interview with the RN on January 21, 2010, at 1:15 p.m., revealed that direct physical examinations should be completed every quarter (3 months).	W 336		
W 362	483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each client's medication regimen was reviewed by the pharmacist quarterly, for three of three clients included in the sample. (Client #1 #2 and #3) The findings include: 1. Observations of the medication administration on January 19, 2010, at 6:00 p.m., revealed that Client #1 received Buspar 15 mg, Colace 100 mg, Tegretol 500 mg, Risperdal 3 mg and Consuls 30 cc's. Interview with the qualified mental retardation professional (QMRP) on January 20, 2010, at approximately 4:00 p.m., and the review of the medical record revealed a pharmacy review dated August 31, 2009. The QMRP indicated that he was not sure of the last date the pharmacist reviewed the client's medication. At the time of the survey, there was no evidence that Client #1's drug regimen had been reviewed at least quarterly by the pharmacist as required. 2. Medication administration observation on January 19, 2010, at 5:45 p.m., revealed that Client #2 received Risperdal, Tegretol and Atarax, Docusate Sodium and Lactulose. Review of	W 362	Pharmaceutical review was scheduled 2-5-10 was rescheduled per weather and will be held quarterly 3-9-10 Pharmaceutical review was scheduled 2-5-10 was rescheduled per weather and will be held quarterly 3-9-10	

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W 362	Continued From page 47 Client #2's medical record on January 20, 2010, at approximately 10:00 a.m., revealed a pharmacy review dated August 31, 2009. Interview with the QMRP on January 20, 2010, at 10:20 a.m., indicated that the pharmacy reviews should be held at least quarterly. At the time of the survey, the facility failed to provide evidence that a pharmacist conducted a quarterly review of Client #1' s record as required.	W 362			
	3. Similarity, medication administration observation on January 19, 2010, at 5:40 p.m., revealed that Client #3 received Haldol, Depakote, Risperdal, Reglan, Procardia XL, Bethanechol CL, Terazosin HCL and Docusate Sodium. Review of Client #3's medical record on January 20, 2010, at approximately 2:00 p.m., revealed a pharmacy review dated August 31, 2009. Interview with the QMRP on January 20, 2010, at 2:20 p.m., indicated that the pharmacy reviews should be held at least quarterly. At the time of the survey, the facility failed to provide evidence that a pharmacist conducted a quarterly review of Client #3's record as required.		Pharmaceutical review was scheduled 2-5-10 was rescheduled per weather and will be held quarterly	3-9-10	
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that all drugs were administered in compliance with the physician's orders, for one of three clients included in the sample. (Client #2)	W 368			

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W 368	<p>Continued From page 48</p> <p>The finding includes:</p> <p>Observation of the medication administration on January 19, 2010, at 5:45 p.m., revealed the trained medication employee (TME) administered Client #2, Atarax 25 mg, one tablet by mouth.</p> <p>Review of Client #2's physician's orders (POS) dated January 2010, on January 20, 2010, at approximately 10:00 a.m., revealed an order to administer Atarax 25 mg, one tablet at bedtime.</p> <p>During an interview with qualified mental retardation professional (QMRP) on January 20, 2010, at approximately 10:15 a.m., revealed that the client's medications are administered twice a day (approximately 6:00 a.m., and 6:00 p.m.)</p> <p>There was no documented evidence all drugs were administered in compliance with the physician's orders.</p>	W 368	<p>Nurse will train TME on medication pass and contact Physician to assure PO are correct and administration of medication are completed as outlined on Persons MAR</p>	2-1-10
W 369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that the clients received all prescribed medications without error, for one of the three clients in the sample. (Client #3)</p> <p>The finding includes:</p> <p>Observation of the medication administration on</p>	W 369	<p>All expired medication was disposed and replaced with unexpired medication.</p>	1-22-10

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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) COMPLETION DATE
W 390	Continued From page 50 2009. The House Manager on duty at that time reviewed the label and confirmed that the medication had expired.	W 390	All expired medication was disposed and replaced with unexpired medication.	1-22-10
W 425	At the time of the survey, there was no evidence that the facility's nursing staff ensured that expired medications were removed from the clients' supplies after the expiration date. 483.470(d)(2) CLIENT BATHROOMS The facility must provide for individual privacy in toilets, bathtubs, and showers.	W 425	Curtain is in place in this room to ensure person's privacy	1-24-10
W 436	This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that clients total privacy while in his bedroom, for one of the six clients residing in the facility. (Client #4) The finding includes: During the environmental inspection on January 22, 2010, at 10:50 a.m., the window in Client #4's bedroom had a valence only on it's window. There was no curtains were observed. This window faces the side of the neighbors house and is in direct view of the neighbor's property/windows. 483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.	W 436		

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NAME OF PROVIDER OR SUPPLIER WESTVIEW 01	STREET ADDRESS, CITY, STATE, ZIP CODE 3200 12TH STREET, NE WASHINGTON, DC 20017
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W 436	<p>Continued From page 51</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to furnish and maintain clients adaptive communication device, for one of the three clients included in the sample. (Client #2)</p> <p>The finding includes:</p> <p>On January 19, 2010, at approximately 7:45 a.m., direct care staff introduced Client #2 to the surveyor. The client was observed waving her hand and speaking in a low voice, requiring three verbal prompts. Observations at Client #2's day program on January 19, 2010, beginning at 12:30 p.m., revealed the client's individual program plan (IPP) dated November 1, 2009. Further review of the IPP indicated an objective which required, "[the client] to increase her communication skills via an augmentative alternative communication (ACC) device with verbal prompts each day she is present for eight sessions within a month."</p> <p>Interview with the day program staff on January 19, 2010, at approximately 12:55 p.m., indicated that the client's communication device was in the shop and had been for a long time. Interview with the Speech Pathologist on January 19, 2010, at approximately 1:10 p.m., indicated that the client's ACC device had not been available to her for over a year. Review of the Speech Pathologist notes dated December 15, 2009, indicated that Client #2's AAC device was picked up by the Provider on July 31, 2008. Contact was made on February 20, 2009, and the Provider indicated that the AAC device would be ready and delivered in one week and by August 21, 2009, the AAC device still had not been delivered. According the</p>	W 436	<p>Person's mini-merc was repaired and is used at her day program and home.</p>	2-12-10
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W 436	Continued From page 52 Speech Pathologist note, the Developmental Disability Services, Case Manager (DDS,CM) contacted the Provider on November 25, 2009, and made inquiry about Client #2's ACC device, to no avail. Interview with the qualified mental retardation professional (QMRP) on January 20, 2010, at approximately 10:30 a.m., revealed Client #2 had a communication device and it was in the shop, for repairs. Further interview the QMRP stated, "since my employment (October 2009), I have not seen [the client's] communication device." Interview with the DDS CM on January 21, 2010, at approximately 11:00 a.m., revealed that the AAC device had been delivered to the client's day program, yesterday. Interview with the Speech Pathologist on January 21, 2010, at approximately 4:30 p.m., confirmed that Client #2's AAC device had been delivered.	W 436		
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to hold evacuation drills at least quarterly for each shift of personnel, for one (1) of the three (3) shifts of duty reviewed. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the staffing pattern on January 21, 2010, at 3:40 p.m., revealed the following staffing pattern:	W 440	Fire Drills are scheduled and done monthly this is monitored by facility administrator and QMRP	2-15-10

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W 440	Continued From page 53 Sunday - Saturday 7:00 a.m. - 3:00 p.m.; 3:00 p.m. -11:00 p.m.; and 11:00 p.m. - 7:00 a.m. Review of the fire drill log revealed that the 7:00 a.m. - 3:00 p.m. shift last fire drill was held on October 11, 2009 and the 3:00 p.m. - 11:00 p.m. shift, last drill was held on September 20, 2009, and the 11:00 p.m. - 7:00 a.m., shift the last drill was held on September 10, 2009. Interview with the qualified mental retardation professional (QMRP) on January 21, 2010, at approximately 4:30 p.m., indicated that a schedule was developed and the staff failed to hold fire evacuation drills on the assigned dates.	W 440		
W 455	483.470(1)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure proper infection control procedres for six of the six clients residing in the facility. (Clients #1, #2, #3, #4, #5 and #6) The findings include: 1. Evening observation on January 19, 2010, at 5:30 p.m., revealed the direct care staff was removing chicken from the bone and placing chicken on Clients #1, #2, #3, #4, #5 and #6 plates, with the use of gloves. Further observations revealed the direct care staff opening a dirty trash can wearing the same	W 455	Staff have been trained in Universal Precaution this training will be followed by OSHA training	2-24-10 3-15-10

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W 455	<p>Continued From page 54 gloves she wore to handle the chicken.</p> <p>Review of the training records on January 22, 2010, at approximately 11:00 a.m., revealed that staff was trained on infection control on May 7, 2009.</p> <p>Interview with the house manager on January 22, 2010, at approximately 11:30 a.m., revealed that hand washing was required when handling food.</p> <p>There was no evidence that proper infection control procedures were implemented during dinner preparation.</p> <p>2. Observation on January 19, 2010, at 6:00 p.m., revealed that Client #1, #2, #3, #4, #5, and #6 at the table being served dinner (chicken, mashed potatoes, mixed vegetables and corn bread). None of the clients were observed to be asked to or independently washed their hands prior to consuming their their dinner.</p> <p>Review of the training records on January 22, 2010, at approximately 11:00 a.m., revealed that staff was trained on infection control on May 7, 2009.</p> <p>There was no evidence that proper infection control procedures were implemented prior to the clients having dinner.</p>	W 455		
W 474	<p>483.480(b)(2)(iii) MEAL SERVICES</p> <p>Food must be served in a form consistent with the developmental level of the client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record</p>	W 474		

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W 474	<p>Continued From page 55</p> <p>review, the facility failed to ensure each food was provided in the prescribed texture, for one of the three clients included in the sample. (Client #3)</p> <p>The finding includes:</p> <p>On January 19, 2010, at approximately 6:00 p.m., staff was observed to serve Client #3 a chicken leg and thigh, mashed potatoes, mixed vegetables and a small loaf of corn bread. The client was observed picking up the chicken pieces (leg and thigh) and corn bread, with his fingers and biting into it.</p> <p>Record review of the Client #3's physician orders dated January 2010, on January 20, 2010, at 1:34 p.m. revealed that the client was prescribed a regular bite size, no added salt diet. There was no evidence that the food provided to the client was in the texture prescribed by the physician.</p>	W 474	Staff training on Diet texture and individual diets orders	3-3-010