

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

Received

GOVERNMENT OF THE DISTRICT OF COLUMBIA

PRINTED: 03/16/2010
FORM APPROVED
OMB NO. 0938-0

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G136	(X2) DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR B. WING WASHINGTON, D.C. 20002	(X3) DATE SURVEY COMPLETED C 02/26/2010
--	--	---	---

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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

W 000 INITIAL COMMENTS

On February 4, 2010, the State Agency (SA) received written notification of incidents alleging abuse and/or neglect.

1. An incident report dated February 1, 2010, reflected that "while in a behavior," Client #1 grabbed his 1:1 staff's (Staff #1) shirt. Staff #1 allegedly used excessive force by slamming the client against a wall, dragging him on the floor, and placing the client in a head lock. The report further stated that the incident was witnessed by the Supervisor on duty, who informed Staff #1 that he could not use restraints on Client #1. [Incident complaint #1HF10-2447]

2. An incident report dated February 3, 2010, reflected that a shift Supervisor detected an odor of alcohol on Staff #1's breath when he reported for duty. The report further indicated that Staff #1 gave Client #2 cigarettes outside of his designated smoking schedule. According to the report Staff #1 was sent home as a result of his actions. [Incident complaint #1HF10-2446]

Due to the nature of the incidents and information obtained from an administrative review, an onsite investigation was initiated on February 22, 2010, to verify compliance with Federal and local regulatory requirements. The findings of the investigation were based on observations in the group home, interviews with administrative and direct care staff as well as review of clinical, habilitation and administrative

On February 25, 2010, at 9:30 a.m. the facility's Qualified Mental Retardation Professional was informed that the failure to timely report client abuse; and to allow alleged abusers to continue

W 000

Person #1 has a behavior plan to address grabbing and physical aggression. Staff # 1 was assigned to person # 1 after an emergency call off by person # 1 usual 1 to 1 staff. Person 1 grabbed staff # 1 the staff was overly aggressive in response to person #1 aggression. Shift supervisor joined staff 1 and assisted him in proper techniques to address person #1 while in behavior.

Staff # 1 did not follow person # 2 smoking protocol. Staff # 1 was asked to leave the shift when alcohol odor was detected on him.

Westview QMRP was notified that person# 1 grabbed his staff. QMRP went to the home and saw Person # 1 sitting with shift supervisor. Who was cleaning person #1 hand. Person #1 then went to the table and sat with staff # 1. QMRP then asked the shift supervisor was everything ok, and what had happened. She stated that everything was over and that she had assisted Staff #1 address person # 1 physical aggression. QMRP was not made aware of the overly aggressive response to Person #1 behavior. Shift supervisor later expressed the aggressive nature of person #1 response to

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Israel R. West, M.D.</i>	TITLE <i>Administrator</i>	(X6) DATE <i>4-8-10</i>
--	-------------------------------	----------------------------

any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the 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.

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

PRINTED: 03/16/
FORM APPRC
OMB NO. 0938-1
(X3) DATE SURVEY
COMPLETED
C
02/26/2010

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 C 02/26/2010
--	--	--	---

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) COMPLETE DATE
W 000	Continued From page 1 to provide care to clients; to allow witnesses who failed to report abuse to remain on duty which placed all clients' health and safety in jeopardy. Prior to exiting the facility on February 26, 2010, the QMRP implemented the facility's plan to protect clients by removing all staff involved in the incident from the schedule until the internal investigation was completed. Also the QMRP initiated in-service training of all staff on Client #1's Behavior Support Plan. Although her facility removed the serious and immediate threat to Clients' health and safety, the Condition of Governing and Client Protection continued to be in non-compliance.	W 000	the Home Manager and wrote a letter to QMRP that was not given to companies QMRP but the Quality Assurance personnel and sent anonymously to provider DDS Incident management. Home Manager and Shift Supervisor have been disciplined for failure to report incident properly and Home manger also has been disciplined for not removing safety risk from person's home. All staff has received training on person 1 BSP and incident reporting.	
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.	W 102	Please see response to W104, and W 122	
W 104	This CONDITION is not met as evidenced by: Based on observation, interview, and record review, the facility's Governing Body failed to maintain general operating direction over the facility. [See W104]. The effects of these systematic failures resulted in the facility's inability to ensure each clients' health and safety. [See W122] 483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.	W 104		

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

PRINTED: 03/16
FORM APPRC
OMB NO. 0938-1

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 C 02/28/2010
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) COMPLETE DATE
W 104	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation, interview and record review the Governing Body failed to maintain general operating direction over the facility as evidenced by the deficiencies cited throughout this report and the following. The findings include: 1. The Governing body failed to ensure that staff who are transferred from one facility to another are trained to manage and provide habilitation services to the clients assigned. [See W189] 2. The Governing Body failed to provide specific behavioral techniques to employ when using manual restraints. [See W193 and W149] 3. The governing body failed to ensure the effectiveness of the facility's incident management system. [See W127]	W 104	1. All staff are trained on individuals BSP 2. Staff receive training on release protocols. 3. All staff received training on incident management training will be refreshed quarterly	
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on observation, interviews and record review, the facility failed to ensure the implementation of an effective system of oversight to prevent physical injury (See W127); the facility failed to ensure that client's rights to be free from unnecessary physical restraint (See W128); the facility failed to ensure the development and implementation of written policies and procedures that prohibit mistreatment, neglect or abuse for a client (See W149); the facility failed to ensure allegations of abuse had been immediate reported and investigated (See W153 and W154); failed to protect clients from potential harm while an	W 122	Staff have been retrained on BSP to address antecedents to behaviors and appropriate responses to de-escalate behaviors. Staff and management have been re-trained on incident reporting. Incident Manager is receiving support from DDS coordinator to complete incident investigation within governing agencies guidelines. Incident will also be reported to QMRP and Administrator to assure timely reporting and investigations.	

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

PRINTED: 03/16/2
FORM APPRO'
OMB NO. 0938-0

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 C 02/26/2010
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) COMPLETE DATE

W 122 Continued From page 3
investigation was being conducted (See W155); and failed to ensure the timely reporting of the corresponding investigation in accordance to the law (See W156).

W 122

The effects of these systemic practices resulted in the failure of the facility to protect its clients from abuse, neglect, harm and to ensure their general safety and well being.

W 127 483.420(a)(5) PROTECTION OF CLIENTS RIGHTS

W 127

The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment.

This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to protect 2 of 6 clients from neglect and physical abuse.

The findings include:

1. On February 22, 2010, surveyors initiated an onsite investigation of physical abuse and neglect reported by the facility on February 4, 2010. The report alleged that during an episode of aggression (i.e. grabbing others, kicking and biting self), Client #1 was slammed into a wall, dragged on the floor, and put into a headlock. This incident was observed by three staff to include the staffs' supervisor. According to one witness, Staff #1 used a forceful "karate chop" on the client's arm and hand. Another witness reported that he "clip" him by using his feet to trip the client, causing the client to fall. Further interview with witnesses revealed that Staff #1 and the supervisor escorted the client into the living room and closed the door. After the client

All staff have been re-trained on incident reporting. Any staff involved in allegations of abuse will be removed from client contact until completion of investigation by internal and external investigators.

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

PRINTED: 03/16/20
FORM APPROVE
OMB NO. 0938-031

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 C 02/26/2010
--	--	--	---

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 127 Continued From page 4
was calmed, both Staff #1 and the client accompanied another staff on the van run. Although the incident was witnessed by staff #2 and Staff #3, the incident was not reported to the administrator until 2 days later and not reported to the State Surveying Agency (SSA) until 3 days later. Staff #1 remained on the scheduled and was allowed to return to the facility and instructed to work directly with another client.

2. On February 1, 2010, the House Manager was informed by the Supervisor of the alleged abuse. The House Manager contacted Staff #1 and instructed him to report to work as scheduled (February 3, 2010) but not to work with Client #1. Upon reporting to work on February 3, 2010 at 8:05 a.m., the facility supervisor detected alcohol on the Staff's breath. He was allowed to stay on duty and provide direct care to Client #2. When asked if Client #2 could have a cigarette, Staff #1 was told was no and instructed to follow the client's smoking schedule. The Supervisor however observed the client smoking two cigarettes with Staff #1 within one hour. When the staff was confronted, the staff became loud and disagreeable; and was then instructed by his supervisor to leave the facility.

The client's Health Management Care Plan revealed that smoking was a specific concern as it is a risk factor associated with his diagnoses of hypertension and renal failure. The client has a smoking schedule that limits his cigarette smoking to 4 times a day, approximately 3 1/2 hours between smoking times.

Interviews with direct care staff, the QMRP and the incident manager confirmed that Staff #1 was allowed to continue to provide direct care to

W 127
2. Staff # 1 was removed from duty when alcohol was detected on his breath. Staff # 1 did not follow Person #2 smoking schedule and was redirected by the shift supervisor pertaining to person 2 protocol. All staff were retrained on Person # 2 smoking protocol any staff who is inebriated will be sent immediately from client contact. Westview also randomly test staff for illegal drug usage.

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

PRINTED: 03/16/2
FORM APPROV
OMB NO. 0938-0

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 C 02/26/2010
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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

W 127 Continued From page 5

W 127

clients after he was observed to abuse Client #1 and after he reported to work smelling of alcohol. Interviews with direct care staff, the QMRP and the incident manager, witnesses continue to work with clients after failing to report client abuse timely.

Based on these factors, the SSA determined on February 25, 2010, at 9:30 a.m. that there was a potential for further abuse and neglect; and therefore, clients' health and safety were at risk. The QMRP and the Administrator were informed of the determination and at 11:00 AM the facility implemented a plan to remove the immediate jeopardy.

The facility placed all staff members, who either witnessed or was aware of client abuse and failed to report it timely or according to facility's policies, on administrative leave. The facility also initiated the retraining of staff on incident management policies and procedures, and on all clients' behavioral management plans.

W 128 483.420(a)(6) PROTECTION OF CLIENTS RIGHTS

W 128

The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints.

This STANDARD is not met as evidenced by: Based on interviews, and record review, the facility failed to ensure that client's rights to be free from unnecessary physical restraint for one of six clients residing in the facility. (Client #1)

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

PRINTED: 03/16/2
FORM APPROV
OMB NO. 0938-01

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 C 02/26/2010
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)
W 128	Continued From page 6	W 128	

The finding includes:

On February 1, 2010 Client #1 was reported to exhibit aggressive behaviors, (i.e. grabbing others, kicking and biting self). During the behavior episode, Client #1 was slammed into a wall, dragged on the floor, and put into a headlock by his 1:1 staff. According to one witness (Staff #2), Staff #1 used a forceful "karate chop" on the client's arm and hand. Another witness (Staff #3) reported that he "clip" him by using his foot to trip the client, causing the client to fall. Further interview with witnesses revealed that Staff #1 and the supervisor escorted the client into the living room closed the door.

Staff have been trained on person # 1 BSP. Westview expects all staff to follow techniques taught in this plan.

Review of Client #1's Behavior Support Plan on February 25, 2010 revealed that Client #1 exhibits maladaptive behaviors which are managed by behavioral interventions to include manual restraints. According to the BSP manual restraints were to be employed after verbal redirection was not effective. The restraint techniques, which were not described in the BSP, were to be used by identified and authorized trained staff. The BSP also required that the restraints were preferably to be implemented by more than one staff person

W 148 483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS &

W 148

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.

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

PRINTED: 03/16/2010
FORM APPROVE
OMB NO. 0938-036

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 C 02/26/2010
--	---	--	---

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 148 Continued From page 7

This STANDARD is not met as evidenced by: Based on interview and record verification, the facility failed to notify the family/guardians timely of a incident of alleged abuse for one of the six clients residing in the facility. (Client #1)

W 148

The finding includes:

The facility failed to notify Client #1's family /guardian of an incident timely as evidenced below:

An incident report dated February 1, 2010, revealed that Client #1 was slammed against a wall, dragged him on the floor, and placed in a head lock by his 1:1 staff. [Staff #1]

Further review of the incident report revealed that Client #1's family/guardian was notified on February 4, 2010 (four days after) the alleged incident of abuse that occurred on February 1, 2010. There was no evidence that the facility notified the family/guardian timely of this above mentioned incident.

Guardian and attorney have been informed of this incident. Westview will place emphasis on informing family and guardians of incidents as they occur.

See Incident Management Policy

W 149 483.420(d)(1) STAFF TREATMENT OF CLIENTS

W 149:

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 staff interviews, and record review, the facility's shift Supervisor and House Manager failed to implemented the incident management protocols developed to protect client health and safety for two of two in the investigation. (Clients #1 and #2)

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

PRINTED: 03/16/20
FORM APPROVE
OMB NO. 0938-036

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 C 02/28/2010
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)

W 149 Continued From page 8

W 149

The findings include:

The facility failed to ensure that staff implemented incident management policies and procedures as evidenced by the following:

1. On February 1, 2010 at 12:30 p.m., Client #1 was allegedly physically abused by Staff #1. Although the incident was witnessed by the Supervisor and two other staff, the incident was not reported to the administrator until 2 days later and not reported to the State Surveying Agency (SSA) until 3 days later. Also Staff #1 remained on the scheduled until 2:59 PM February 1, 2010, and was allowed to return to the facility on February 3, 2010 to work directly with another client.

1. Pleased See response to W127 #1

The facility's incident management policy reflected that an incident report was required to be completed immediately upon identifying an incident. The policy also required any staff member accused or alleged of a serious incident which harm or may potentially harm an individual's health, safety, or well being shall be immediately identified and separated from the individual and suspended pending the outcome of the investigation.

2. On February 1, 2010, the House Manager was informed of the alleged abuse. The House Manager instructed Staff #1 to report to work as scheduled but not to work with Client #1. Upon reporting to work on February 3, 2010 at 8:05 a.m. the facility supervisor detected alcohol on Staff #1's breath. He was allowed to stay on duty and provide direct care to Client #2. When asked if Client #2 could have a cigarette, Staff #1

2. Please see response to W127 #2

The House manager has received disciplinary action for his failure to follow Westview policy on incident reporting.

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

PRINTED: 03/16/2011
FORM APPROVE
OMB NO. 0938-039

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 C 02/26/2010
--	---	--	---

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 149 Continued From page 9

W 149

was told no by the Supervisor and he was instructed to follow the client ' s smoking schedule. The Supervisor however observed the client smoking two cigarettes within one hour. When the staff was confronted, the staff became loud and disagreeable; and was then instructed by the Associate Administrator to leave the facility.

The facility ' s incident management policy reflected that an incident report was required to be completed immediately upon identifying an incident. The policy also required any staff member accused or alleged of a serious incident which harm or may potentially harm an individual ' s health, safety, or well being shall be immediately identified and separated from the individual and " out of client contact " pending the outcome of the investigation.

3. On February 1, 2010 Client #1 was reported to exhibit aggressive behaviors, grabbing a staff ' s arm. During the behavior episode, Client #1 was slammed into a wall, dragged on the floor, and put into a headlock by Staff #1. According to one witness (Staff #2), Staff #1 used a forceful " karate chop " on the client ' s arm and hand. Another witness (Staff #3) reported that he " clip " him by using his foot to trip the client, causing the client to fall. Further interview with witnesses revealed that Staff #1 and the supervisor escorted the client into the living room and closed the door.

3. Please see response to W128

Review of Client #1 ' s Behavior Support Plan dated January 25, 2010, on February 25, 2010, revealed that Client #1 exhibits maladaptive behaviors which are managed by behavioral interventions to include manual restraints. According to the Behavior Support Plan (BSP)

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

PRINTED: 03/16/20
FORM APPROVI
OMB NO. 0938-03

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 C 02/26/2010
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 149 Continued From page 10
manual restraints were to be employed after verbal redirection was not effective. The restraint techniques, which were not described in the BSP, were to be used by identified and authorized trained staff. The BSP also required that the restraints were preferably to be implemented by more than one staff person.

W 149

4. Interview with the Qualified Mental Retardation Professional (QMRP) on February 25, 2010 at 8:30 a.m., revealed that Staff #1 who was alleged to abuse Clients #1 and #2 was a substitute staff who was new to the facility and unfamiliar with Client #1's behaviors techniques and with Client #2's smoking risk and schedule.

4. Please see response to W104 #1

There was no evidence that the facility had established and/or implemented policies and procedure to ensure that specific manual restraint techniques to managed maladaptive behaviors were identified. Also there were no policies to ensure that substitute staff employed to provide one to one staffing were trained on clients' behavior management techniques and supports and incorporated into the client's BSP.

W 153 483.420(d)(2) STAFF TREATMENT OF CLIENTS

W 153

The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.

This STANDARD is not met as evidenced by:
Based on interview and record review, the staff failed to report incidents of abuse and neglect to

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

PRINTED: 03/16/2011
FORM APPROVE
OMB NO. 0938-039

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 C 02/26/2010
--	---	--	---

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 153 Continued From page 11

the facility's administrator and the State Survey Agency (SSA) according to District of Columbia's regulations (Title 22 DCMR Chapter 35).

W 153

The findings include:

1. On February 4, 2010 the SSA received an incident report of two incidents of client abuse by Staff #1. The first abuse, involving Staff #1 occurred on February 1, 2010 and alleged that during a behavioral episode, Client #1 was slammed into a wall, dragged on the floor, and put into a headlock. The second incident involving Staff #1 occurred on February 3, 2010. According to the report, on February 3, 2010 the facility supervisor detected alcohol on Staff #1's breath. He was allowed to stay on duty and provide direct care to Client #2. He supplied cigarettes to and permitted Client #2 to smoke after he was instructed not to by his supervisor. [See W127]

1. Please see response to W127

2. On February 22, 2010 at approximately 9:00 AM, the facility's IMC and QMRP were interviewed about the alleged abuses. They confirmed that the facility failed to report the abuse to the facility's administrator and to the SSA timely. Interview with the administrator/owner of facility on February 23, 2010 at 2:30 p.m., confirmed that the incidents were not reported immediately and he was not made aware of the abuses until February 3, 2010.

2. Staff and management have been re-trained on incident reporting. Incident Manager is receiving support from DDS coordinator to complete incident investigation within governing agencies guidelines. Incident will also be reported to QMRP and Administrator to assure timely reporting and investigations.

W 154 483.420(d)(3) STAFF TREATMENT OF CLIENTS

W 154

The facility must have evidence that all alleged violations are thoroughly investigated.

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

PRINTED: 03/16/2010
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 C 02/26/2010
--	---	--	---

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 154 Continued From page 12

W 154

This STANDARD is not met as evidenced by:
Based on interview and record review the facility failed to ensure that allegations of abuse are thoroughly investigated for 2 of 2 incidents of abused.

The findings include:

[Cross Reference W153] Interviews with witnesses (Staff #2 and #3) revealed that the facility's internal investigative report of one allegation of client abuse failed to be comprehensive; and the report failed to determine who witnessed the abuse as evidence by the following examples:

1. During Client #1's behavioral episode and after the witnessed abuse, the house manager and Staff #1 escorted the client to the living room and closed the door. There was no indication in the investigative report as to what occurred in the living room.

1. Westview Administrator will review all incident investigations before they are submitted. Incident manager is also receiving assistance from DDS incident investigator to improve her investigative skills.

2. The investigative report also failed to examine why the supervisor continue to allow Staff #1 to stay on duty and to have contact with Client #1 after physically abusing him.

2. See Response to W154 #1

3. The investigative report did not examine why the supervisor allowed Staff #1 to return to work (three days later) under the influence of alcohol; especially after the supervisor witnessed the staff's abuse of Client #1 on February 1, 2010.

3. See Response to W154 #1

4. The investigative report failed to examine if Staff #1 abused any other clients prior to February 1, 2010.

4. See Response to W154 #1

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

PRINTED: 03/16/10
FORM APPRO
OMB NO. 0938-C

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 C 02/26/2010
--	---	--	---

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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

W 154 Continued From page 13

W 154

5. The investigative report failed to explain why the Metropolitan Police was not notified immediately about the allegation of abuse.

5. See Response to W154 #1

6. The investigative report failed to detail when a medical assessment of Client #1 was completed to determine if injuries had occurred as a result of the abuse.

6. See Response to W154 #1

W 155 483.420(d)(3) STAFF TREATMENT OF CLIENTS

W 155

The facility must prevent further potential abuse while the investigation is in progress.

This STANDARD is not met as evidenced by:
Based on interview and record review, the facility failed to protect 6 of 6 clients from potential harm while investigating allegations of abuse and neglect.

The findings include:

1. [Cross Reference W127] On February 4, 2010 the SSA received an incident report of two incidents of client abuse by Staff #1. The first abuse, involving Staff #1 occurred on February 1, 2010 and alleged that during a behavioral episode, Client #1 was slammed into a wall, dragged on the floor, and put into a headlock. Although the staff's supervisor witnessed the incident and informed the House Manager of the abuse, they allowed Staff #1 to stay on the work schedule. He returned to the facility two days later on February 3, 2010. According to the internal investigative report and staff interviews,

See response to W127 #2

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

PRINTED: 03/16/
FORM APPRC
OMB NO. 0938-1

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 C 02/26/2010
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)
W 155	Continued From page 14	W 155	(X5) COMPLETE DATE

the facility supervisor detected alcohol on the Staff #1's breath when he arrived to work. He was allowed to stay on duty and provide direct care to Client #2. He supplied cigarettes to and permitted Client #2 to smoke after he was instructed not to by his supervisor. [See W127]

2. On February 22, 2010 at approximately 9:00 a.m., the facility's IMC and QMRP were interviewed about the alleged abuse. They confirmed that the facility failed to protect clients from actual harm by allowing Staff #1 to continue direct care services after being accused of physically abusing Client #1. The facility's management also confirmed that 3 staff members, to include a supervisor, were allowed to provide direct client care after witnessing an abuse of a client and not reporting the abuse as prescribed in the incident management policies and procedures.

See response to W127 #1

All staff members involved in the abuse including Staff #1 remained on the staff schedule until the State Surveying Agency (SSA) inquired on February 25, 2010 about their work status. At that time, the House Manager and the Supervisor was placed on administrative leave.

It should be noted that Staff #2 and #3 informed the investigator that they were unaware of their responsibility to write an incident report. However, both staff #2 and #3 reported the incident to the supervisor who was present at the time of the incident.

W 156 483.420(d)(4) STAFF TREATMENT OF CLIENTS

W 156

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

PRINTED: 03/16
FORM APPRC
OMB NO. 0938-1

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 C 02/26/2010
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)

W 156 Continued From page 15

W 156

The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.

This STANDARD is not met as evidenced by: Based on interview and record review, the staff failed to investigate and report the results of 2 of 2 investigations within 5 working days.

See response to W 153 #2 and W154

The findings include:

On February 4, 2010 the SSA received an incident report of two incidents of client abuse by Staff #1. The first abuse, involving Staff #1 occurred on February 1, 2010 and alleged that during a behavioral episode, Client #1 was slammed into a wall, dragged on the floor, and put into a headlock. The second incident involving Staff #1 occurred on February 3, 2010. According to the report, on February 3, 2010 the facility supervisor detected alcohol on Staff #1's breath. He was allowed to stay on duty and provide direct care to Client #2. He supplied cigarettes to and permitted Client #2 to smoke after he was instructed not to by his supervisor. [See W127]

An full internal investigation of the allegation of abuse was not initiated until February 18, 2010 approximately 17 days after the first allegation of abuse. There was no evidence that the administrator/owner of facility was informed of the investigative results timely.

W 159 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL

W 159

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

PRINTED: 03/16/2
FORM APPRO
OMB NO. 0938-0

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 C 02/26/2010
--	--	--	---

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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

W 159 Continued From page 16

W 159

Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.

This STANDARD is not met as evidenced by:
Based on observation, staff interview, and record review, the facility failed to ensure the qualified mental retardation professional (QMRP) coordinated, integrated and monitored services, for two of the six clients residing in this group home. (Clients #1 and #2)

The findings include:

1. [Cross-refer to W189] The facility failed to ensure that each employee had been provided with adequate training that enables the employee to perform his or her duties effectively.

1. See response to W 128

2. [Cross refer to W193] The facility staff failed to demonstrate competency in implementation of the Behavior Support Plan.

2. QMRP and Behavior Therapist will monitor staff for competency in implementation of individuals BSP

W 189 483.430(e)(1) STAFF TRAINING PROGRAM

W 189

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.

This STANDARD is not met as evidenced by:
Based on interviews and record reviews, the facility failed to effectively trained staff on incident management policies and procedures, and behavior management techniques to ensure the

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

PRINTED: 03/18/2010
FORM APPROVED
OMB NO. 0938-0

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 C
--	---	--	--

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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

W 189 Continued From page 17
safety of 1 of 6 clients residing in the facility.
(Client #1) W 189

The findings include:

[Cross refer to W127] Interview with the facility's QMRP revealed that Staff #1 was hired in September 2009 to provide direct care services to client at another facility operator by the Provider. According to the QMRP, Staff #1 was transferred to the facility and was assigned as Client #1's one to one direct case staff. The QMRP confirmed that Staff #1 had not been trained on Client #1's behavior support plan or the techniques to use in applying manual restraints. A review of Staff #1's personnel file failed to include any orientation training as required by DC Title 22 Chapter 35. Also there was no evidence to show that Staff #2, Staff #3 and Staff #4 were trained effectively on the facility's incident management procedures.

See response to W127 and W128

W 193 483.430(e)(3) STAFF TRAINING PROGRAM W 193

Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.

This STANDARD is not met as evidenced by:
Based on staff interview and record verification, the facility staff failed to demonstrate competency in the implementation of the Behavior Support Plan (BSP) for one of two client being investigated. (Client #1)

The finding includes:

On February 1, 2010 Client #1 was reported to exhibit aggressive behaviors, grabbing a staff's

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

PRINTED: 03/16
FORM APPR
OMB NO. 0938-

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 C 02/26/2010
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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

W 193 Continued From page 18
shirt. During the behavior episode, Client #1 was slammed into a wall, dragged on the floor, and put into a headlock. According to one witness, (Staff #2) Staff #1 used a forceful " karate chop " on the client ' s arm and hand. Another witness (staff #2) reported that he " clip " him by using his foot to trip the client, causing the client to fall. Further interview with witnesses revealed that Staff #1 and the supervisor escorted the client into the living room and closed the door.

W 193

Review of Client #1 ' s Behavior Support Plan dated January 25, 2010, revealed that Client #1 exhibits maladaptive behaviors which are managed by behavioral interventions to include manual restraints. According to the BSP manual restraints were to be employed after verbal redirection was not effective.

Interview with the facility ' s QMRP revealed that Staff #1 was hired in September 2009 to provide direct care services to client at another facility operated by the Provider. According to the QMRP, Staff #1 was transferred to the facility and was assigned as Client #1 ' s one to one direct care staff. The QMRP confirmed that Staff #1 had not been trained on Client #1 ' s behavior support plan or the techniques to use in applying manual restraints.

See response to W128

W 252 483.440(e)(1) PROGRAM DOCUMENTATION

W 252

Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.

This STANDARD is not met as evidenced by:

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

PRINTED: 03/16/10
FORM APPRO
OMB NO. 0938-0

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 C 02/26/2010
--	--	--	---

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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

W 252 Continued From page 19

Based on staff interviews and review of records, the facility failed to ensure the implementation of an effective system of documentation of client's progress of his program objectives for one of the six clients residing in the facility. (Client #1)

The finding includes:

The facility failed to ensure that staff #1 collected consistent data for Client #1's behavioral objectives in accordance with the individual program plan as evidenced below:

On February 1, 2010 Client #1 was reported to exhibit aggressive behaviors, grabbing a staff 's arm. During the behavior episode, Client #1 was slammed into a wall, dragged on the floor, and put into a headlock. According to one witness, Staff #2, Staff #1 used a forceful " karate chop " on the client 's arm and hand. Another witness, Staff #3, reported that he " clip " him by using his foot to trip the client, causing the client to fall. Further interview with witnesses revealed that Staff #1 and the supervisor escorted the client into the living room and closed the door.

Review of Client #1 's Behavior Support Plan dated January 25, 2010 revealed that Client #1 exhibits maladaptive behaviors which are managed by behavioral interventions to include manual restraints. According to the BSP manual restraints were to be employed after verbal redirection was not effective. The restraint techniques, which were not described in the BSP, were to be used by identified and authorized trained staff. The BSP also required that the restraints were preferably to be implemented by more than one staff person.

W 252

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

PRINTED: 03/16/20
FORM APPROVE
OMB NO. 0938-031

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 C 02/26/2010
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESTVIEW 01	STREET ADDRESS, CITY, STATE, ZIP CODE 3200 12TH STREET, NE WASHINGTON, DC 20017
--	---

(X4) IO 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 252	Continued From page 20 The BSP requires that at the end of day the assigned staff person should determine by asking other staff the total frequencies of Client #1 ' s behaviors and frequencies of staff intervention steps. On the client ' s data sheet the staff person should enter the appropriate data. If no behaviors occur, a zero should be inserted on the data sheet. Review of Client #1 ' s data collection revealed inconsistent entries. For example, for the month of February there was only three days of data. In addition, there was no documented evidence of the restraint used during the alleged abuse on February 1, 2010.	W 252	All staff have been trained on program documentation inclusive of behavior data collection	
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 that 2 of 2 clients who were abused/neglected were assessment to determine injuries. (Client #1 and Client #2) The findings include: 1. Interviews with staff on February 22, 2010 revealed that Client #1 was allegedly slammed into a wall, dragged on the floor, and put into a headlock. According to one witness (Staff #2), Staff #1 used a forceful " karate chop " on the client ' s arm and hand. Another witness (Staff #3) reported that he " clip " him by using his foot to trip the client, causing the client to fall. Review of nursing records failed to provide evidence that the client was assessed for injuries	W 322	1. Person #1 was seen by his Nurse	

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

PRINTED: 03/16/
FORM APPRC
OMB NO. 0938-

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 C 02/26/2010
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)
W 322	Continued From page 21	W 322	(X5) COMPLETE DATE

as a result of the above mentioned alleged abuse interview with the staff confirmed that the facility's nurse had not been notified of the incident. Interview with the staff revealed that the shift supervisor after the incident was observed administering first aid (applying an ointment) to Client #1's hand.

2. Upon Staff #1 reporting to work on February 3, 2010, the facility supervisor detected alcohol on the Staff's breath. Reportedly he was allowed to stay on duty and provided direct care to Client #2. When asked if Client #2 could have a cigarette, Staff #1 was told no and instructed to follow the client's smoking schedule. The Supervisor however observed the client smoking a cigarette on two separate occasions within one hour. On the first occasion, staff #1 was observed smoking a cigarette in the front of the facility with Client #2. On the second occasion Client #2 was discovered by the supervisor, on the back porch on the second level of the facility, smoking alone. At that time, the supervisor asked Client #2 who gave him the cigarette. Reportedly, Client #2 commented, Staff #1. When Staff #1 was confronted, he became loud and disagreeable, and was then instructed by the Associate Administrator to leave the facility.

2. Staff will follow person #2 smoking protocol. If he receive cigarettes out of this protocol he will be examined by medical personnel

Review of Client #2's Health Management Care Plan (HMCP) on the same day, revealed that smoking was a specific concern as it is a risk factor associated with his diagnoses of hypertension and chronic renal failure. Further review of HMCP, revealed the client had a designated smoking schedule that limits his cigarette smoking to 4 times a day, approximately

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

PRINTED: 03/16
FORM APPRC
OMB NO. 0938-

(X3) DATE SURVEY COMPLETED

C

02/26/2010

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

09G136

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

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) COMPLETE DATE

W 322 Continued From page 22

3 ½ hours between smoking times.

W 322

Review of nursing records failed to provide evidence that the client was assessed by the nursing staff for elevations in his blood pressure and/or renal failure as a result of staff 's non-compliance with his smoking regimen.

It should be further noted that the staff confirmed that nurse had not been notified of the incident. Interview with the nurse confirmed that she had not been notified of the incident and had not assessed the client.

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0093	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/28/2010
--	--	--	---

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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

R 000	<p>INITIAL COMMENTS</p> <p>On February 4, 2010, the State Agency received written notification of an incident from this agency. According to the notification two incidents alleged occurred as follows:</p> <ol style="list-style-type: none"> 1. On 2/4/10 DOH recieved an incident report from the facility's Incident Coordinator allegeing that Resident#1 grabbed Staff #1's shirt. Staff #1 used excessive force and slammed the resident against the wall, dragged him on the floor and placed him in a head lock. According to the report the Supervisor witnessed this incident and informed the staff that he could not use restraint on Resident#1. 2. On 2/4/10 DOH recieved an incident report from the facility's Incident Coordinator allegeing that Staff #1 smelled of alcohol. This report was made by the Supervisor. Additionally, the report described that Staff #1 gave Resident #2 cigarettas outside of his scheduled smoking time. According to the report Staff #1 repeated this activity and was sent home for this inappropriate behavior. <p>Due to the nature of the incident and the information obtained from the administrative review, an onsite Investigations [#] was initiated on Febraury 22, 2010 to verify compliance with federal and local regulatory requirements. Findings of the investigation were based on observations in the group home, interviews with the group home management, direct care staff, and the review of Administrative and Habilitation records to include the agency's incident management system.</p> <p>Based on the nature of the incidents and the information obtained from the administrative</p>	R 000	<p>ATTACHED PLEASE FIND JOB DESCRIPTIONS</p>	
-------	--	-------	--	--

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Scott R West MD* TITLE: *Administrator*

STATE FORM (X6) DATE: *4-8-10*

QNC11

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0093	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/28/2010
--	--	--	---

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) COMPLETE DATE
R 000	Continued From page 1 review, the DOH Health Regulation and Licensing Administration (HRLA) assigned a surveyor to investigate this incident. As a result of this investigation, the State agency substantiated that Staff #1 was involved in the unauthorized use of restraint /abuse in both Resident #1 and #2's incidents. This allegation of abuse was substantiated.	R 000		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on the interview and review of records, the GHMRP failed to ensure criminal background checks disclosed the criminal history of any 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 or one of the three personnel files reviewed. The finding includes: On February 22, 2010 at approximately 10:50 a.m. interview with the Incident Management Coordinator and the Qualified Mental Retardation Professional (QMRP) and the review of the personnel records revealed that the GHMRP failed to provide evidence that ensured criminal background checks were on file for one (2) direct	R 125		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0093	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/28/2010
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) COMPLETE DATE	
R 125	Continued From page 2 care staff. (Staff #4 and Staff #5)	R 125			