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

PRINTED: 09/25/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G037		C 09/12/2008

NAME OF PROVIDER OR SUPPLIER: CMS

STREET ADDRESS, CITY, STATE, ZIP CODE: 3815 ALBERMARLE STREET NW, WASHINGTON, DC 20008

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS	W 000		
	A monitoring survey was conducted from September 11, 2008 through September 12, 2008. The Plan of Correction submitted by the facility on May 9, 2008 served as the focus for this monitoring survey. All six of the clients were subject to review, based either on the findings of the April 2, 2008 survey or after new observations were made that were relevant to previously-cited deficient practices.		Received 10/10/09 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
	The findings of the survey were based on observations, interviews with staff in the home and at two day programs, as well as a review of client and administrative records, including incident reports.			
W 104	483.410(a)(1) GOVERNING BODY	W 104		
	The governing body must exercise general policy, budget, and operating direction over the facility.			
	This STANDARD is not met as evidenced by: Based on observation, interview and record review, the governing body exercised general policy and operational direction over the facility, except in the following areas.			
	The findings include:			
	1. Cross-refer to 149.1. The governing body failed to establish policies to provide clear direction to staff as to how to proceed if/when a medication nurse fails to report timely for the administration of clients' medications.		1. Cross reference W149.1	10/28/08
	2. Cross-refer to W149.2. The governing body failed to establish a policy that defined the term		2. Cross reference W149.2	10/28/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Constance A. Reese — TITLE: Program Director — (X6) DATE: 10/9/08

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

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W 104	Continued From page 1 "medication error." The incident management policies, however, did indicate that "administration of medications at the wrong time (early or late)" would constitute a Report Incident.	W 104		
	3. Cross-refer to W153. The governing body failed to ensure that unusual incidents, such as abrasions of unknown etiology and red bumps, were reported in accordance with facility policies. It should be noted that the RN reported having reviewed clients' medical records on the morning of September 11, 2008. On September 12, 2008, however, review of Client #1's chart revealed that an evening nurse had recorded an injury of unknown origin (on September 2, 2008) for which there was no corresponding incident report.		3. Cross reference W153	10/28/08
	4. Cross-refer to W368.2. There was no evidence that the governing body had determined whether the facility had access to pharmacy services on Saturdays, Sundays and holidays, to include filling new prescriptions.		4. Cross reference W368.2	10/28/08
	5. Cross-refer to W368.3. Although the governing body had established a policy whereby medication nurses should be on site between 4:00 PM to 4:45 PM to administer afternoon medications and/or onsite between 8:00 PM and 8:30 PM for the night administration, there was no evidence of a quality assurance system to ensure that nurses established a medication administration schedule to meet client needs (specifically, Client #6's bedtime medications).		5. Cross reference W368.3	10/28/08
	6. Cross-refer to W440. The Federal Deficiency Report dated April 4, 2008 included findings that there had been only one fire drill conducted on the 8:00 AM - 4:00 PM shift (March 4, 2008) over the span of 12 months. Following that survey,		6. The QMRP and Residential Manager will meet monthly and will review documentation such as the fire drill.	10/30/08

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W 104	Continued From page 2 one drill had been conducted on this shift, on May 24, 2008; thereby meeting initial compliance. However, the September 12, 2008 monitoring visit revealed that the facility had not conducted another drill on that shift since May 24, 2008 (more than 90 days earlier). There was no evidence that the governing body had implemented a quality assurance system to monitor the QMRP and Residential Manager's responsibility to ensure that fire drills were conducted at least quarterly on each shift.	W 104	Any incomplete fire drills will be completed within 48 hours.	10/30/08
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observation, interview and record review, one client's freedom of movement was restricted without programmatic justification. (Client #1) The findings include: On September 12, 2008, at approximately 8:10 AM, Client #1 was observed wearing his gait belt, as prescribed. A direct support staff person (S1) held the gait belt from behind as they walked across the living room to the facility's front door. The staff person locked the dead bolt lock and positioned herself so as to block the client's access to the door. The staff person informed the surveyors that the client wished to go outside.	W 125		

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W 125	Continued From page 3 The staff, however, continued to block the door. The client persisted in his attempts to go outside, reaching for the dead bolt and trying to unlock it. The stalemate continued for a few minutes. The client then attempted to look out the window directly next to the front door. The glass, however, was opaque and he quickly stopped trying to see through it. When asked what might happen if the man was allowed to go outside, the staff replied that he "might run." When asked it there were other reasons the client should not go outside, the staff replied "he might fall." She further indicated that staff took him on walks during the evening shift. After trying to exit through the front door for approximately 10 minutes, Client #1 walked back into the living room, with the same staff holding him by the gait belt from behind. The Qualified Mental Retardation Professional (QMRP) was interviewed later that morning, beginning at approximately 10:13 AM. She stated that there were no restrictions on Client #1 going outside (to either the front or back yard). He was more likely to walk quickly, rather than run. Staff were expected to use the gait belt whenever the client was walking and staff "should be at his side at all times." She said she "would expect staff to take him outside if that was what he wished ... depending on the time of day, if it was beautiful outside then take him for a walk." Exceptions might be if there were inclement weather, if it was after nightfall, or if they were about to load the van for departure to day programs. The QMRP confirmed that they took walks in the evenings. She had been told that Client #1 refused to go for a walk on the previous evening. After she was informed that the observations at the front door	W 125	Staff will be trained on Client #1's right to go outside. In the future, staff will be trained on Client Rights quarterly.	10/30/08

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W 125	Continued From page 4 had been at approximately 8:10 AM, and the van was loaded at approximately 8:25 AM, she suggested perhaps the client's interest earlier was "going out to the van ... he was one of the first people in the van" that morning. Later that afternoon, at approximately 5:35 PM, review of Client #1's Behavior Support Plan (BSP), dated November 26, 2007, revealed target behaviors of self-injurious behaviors, property destruction and aggression towards others. The BSP did not instruct staff to restrict his freedom of movement unless he displayed maladaptive behaviors. Further review of the client's records failed to show justification for preventing him from going outdoors with staff supervision.	W 125		
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 observation, interview and record review, the facility failed to establish and/or implement policies designed to ensure the clients' health and safety. The findings include: 1. The facility failed to implement measures to ensure that clients received medications at the scheduled time, as follows: Cross-refer to W368. On September 11, 2008, clients were observed between the hours of 3:20 PM and 7:26 PM. They were not observed to	W 149	The facility will develop a policy regarding medication administration schedule and will be reviewed by all nursing staff.	10/28/08

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W 149	Continued From page 5 receive their evening medications, which according to their Medication Administration Records (MARs) were to be administered at 5:00 PM. On September 12, 2008, at approximately 2:30 PM, interview with the RN indicated that she did not know whether the facility had a policy that outlined how facility staff should proceed if/when a medication nurse did not arrive at the designated time, and did not notify their supervisor. The Director of Nursing (DON) was interviewed by telephone at 3:05 PM, at which time she indicated that the facility was without said policy. 2. With respect to the issue above (late administration of medications), review of the facility's Incident Management Policy on September 12, 2008, at 2:19 PM, revealed that "Medication Errors" should be considered a "Reportable Incident," thereby generating an unusual incident report. Telephone interview with the DON, at approximately 2:30 PM, revealed that she would not consider administration of medications 1 hour after the designated time as a medication error. When asked for further clarification, she stated that she would expect medications to be administered "before 2 hours later." Interviews had also revealed that neither she nor the RN had been informed that the medication nurse had arrived after 7:26 PM the night before. At approximately 3:20 PM, the Residential Manager presented another policy that listed examples of medication errors, which included "administration of medications at the wrong time (early or late)." No incident report had been prepared for the late administration on the evening before.	W 149		

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W 149	Continued From page 6	W 149		
	3. Cross-refer to W365. The facility failed to ensure that Client #5 received all prescribed medications, as follows:		The nursing staff and the Trained Medication Employees will receive additional training about documentation. In the future, the primary nurse will monitor the MAR for documentation on a weekly basis.	10/28/08
	a. On September 12, 2008, at 11:10 AM, interview with the facility RN revealed Castellani Paint was applied to Client #5's nails one time daily to deter thumb sucking. Review of the client's July 2008 MAR revealed spaces left blank on July 17, 26 and 27, 2008. Further review of the MAR failed to show documented evidence that the medication had been applied, or an explanation as to why the designated spaces had been left blank.			
	b. In July 2008, Client #5 also had physician's orders to be administered Fluoxetine 20 mg and Zyprexa 5 mg every morning. Review of the July 2008 MAR revealed no evidence that the client received these medications on the morning of July 17, 2008. Further review of the MAR failed to show documentation indicating why the designated spaces had been left blank.			
	Further interview with the RN revealed that she was previously unaware of the missing data and, therefore, had not investigated to determine whether the client had received his prescribed medications as ordered. The facility's medication policy stated that if a medication was not given for any reason, the space on the MAR should be encircled and the reason should be documented on the reverse side.			
	4. Cross-refer to W153. The facility failed to ensure that staff (either nursing staff or direct support staff) prepared incident reports of client injuries, in accordance with facility policies. The		4. Cross reference W153.1	10/30/08

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W 149	Continued From page 7 monitoring visit revealed 2 such injuries that were not reported during September 2008. 5. The facility's RN failed to implement the written "Procedure For Discarding Medications," as follows: On September 11, 2008, at 3:25 PM, a large quantity of pills were observed at the bottom of the toilet bowl. The pills had begun to dissolve. Interview with the direct support staff indicated that the RN had left the facility approximately 10 minutes before the surveyors arrived. The RN was interviewed by telephone later that afternoon, at approximately 5:15 PM. She confirmed that she had tried flushing expired Tylenol down the commode; however, she was unsuccessful after several attempts. On September 12, 2008, at approximately 6:00 PM, review of the facility's "Procedure For Discarding Medications" revealed that "in the event that a medication has expired...the nursing staff will pull applicable medication and write D/C or expired on the label... notify Nursing Coordinator of medication(s) that needs to be picked up promptly." The procedure did not, however, indicate flushing as an alternative disposal procedure. It should be noted that at the time that the pills were discovered in the commode, staff indicated that the clients were due to return home from their day programs momentarily. Indeed, they returned at 3:50 PM, and some individuals were observed to use the toilet in question.	W 149	The nursing staff will receive additional training on the facilities medication discarding procedures.	10/21/08
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of	W 153		

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W 153	Continued From page 8 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, review of incident reports and review of client records, the facility failed to ensure that all injuries of unknown origin were consistently reported immediately to the administrator and to the State agency. The findings include: On September 11, 2008, beginning at 3:36 PM, incident reports were reviewed in the facility. Review of client records later in the monitoring visit, however, revealed the following: 1. On September 12, 2008, at 2:10 PM, review of Client #1's nurse progress notes in the Medication Administration Record (MAR) book revealed that an evening nurse recorded an injury of unknown origin for which there was no corresponding incident report. The nurse's entry, dated September 2, 2008, indicated that Client #1 had sustained a 1-to-2-inch abrasion surrounded by a 3-inch hematoma to the left side of his face while he was at day program. No further information regarding the source of the injury had been documented by the nurse, and there was no evidence that staff had completed a corresponding incident report, in accordance with facility policies. The Residential Manager and the Qualified Mental Retardation Professional (QMRP) were in the facility at the time the nurse's note was discovered. They both denied prior	W 153	1.Staff will be trained on incident reporting and the incident management policy quarterly.	10/30/08

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W 153	Continued From page 9 knowledge of the client's injury. To their knowledge, the injury had not been reported to their administrator. In addition, State agency records had not reflected notification of said injury prior to this monitoring visit. 2. Cross-refer to W331.2. On September 11, 2008, at approximately 7:00 PM, three dime-sized red bumps were observed on Client #6's left arm. Both the Residential Manager and the QMRP were made aware of the observations immediately. At that time, nobody knew the cause of the bumps. The next evening (September 12, 2008), at approximately 5:00 PM, interview with the Residential Manager and QMRP revealed that there had not been an incident report prepared. There was no evidence that the administrator had been notified immediately of the unusual discovery. It should be noted that on September 12, 2008, beginning at approximately 5:00 PM, review of Client #6's nurse progress notes failed to show evidence that the bumps had been brought to the medication nurse's attention on the previous evening, for assessment. In addition, telephone interview with the RN revealed that neither she nor the Director of Nursing had been made aware of bumps and there was no evidence that the bumps had been assessed by a trained medical professional. This is a repeat deficiency. ********** Previously, the Federal Deficiency Report dated April 4, 2008 cited the facility's failure to notify their administrator of an injury of unknown origin	W 153	2. In the future, all health concerns will be communicated to the nurse in writing.	10/30/08

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W 153	Continued From page 10 (cut to the forehead) sustained by a resident on February 11, 2008.	W 153		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on interview, and record review, the Qualified Mental Retardation Professional (QMRP) failed to adequately monitor, integrate, and coordinate the health, safety and active treatment needs, for six of the six clients residing in the facility. (Clients #1, #2, #3, #4, #5 and #6) The findings include:	W 159		
	1. Cross-refer to W125. The QMRP failed to ensure that direct support staff only restricted Client #1's freedom of movement if/when maladaptive behaviors indicated the need to implement restrictive controls, in accordance with his formal behavior support plan (BSP).		1. Cross reference W125	10/30/08
	2. Cross-refer to W153. The QMRP failed to ensure that staff (either nursing staff or direct support staff) prepared incident reports of client injuries, in accordance with facility policies. The monitoring visit revealed 2 such injuries that were not reported to the administrator and government agencies during September 2008. It should be noted that the QMRP informed of the discovery of red bumps on Client #6's arm on the first day of the visit.		2. Cross reference W153	10/30/08
	3. Cross-refer to W249.1. The QMRP failed to		3. Cross reference W249.1	10/30/08

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W 159	Continued From page 11 ensure that direct support staff consistently implemented Client #5's BSP.	W 159		
	4. Cross-refer to W249.2. The QMRP failed to ensure that Client #4 received 1:1 supports in accordance with his BSP. Although interview with the QMRP indicated a recent change to "Acuity Specialist" supervision, Client #4's BSP had not been updated accordingly. In addition, there was no evidence that a written job description had been developed to define the "Acuity Specialist's" role and responsibilities.		4. Cross reference W249.2	10/30/08
	5. Cross-refer to W252. The QMRP failed to ensure that staff were trained to consistently document incidents of Client #5's targeted (thumb sucking) behavior.		5. Cross reference W252	10/30/08
	6. Cross-refer to W440. The facility's May 9, 2008 Plan of Correction included the following: "In the future, the facility will conduct a fire drill quarterly during each shift. The QMRP and the Residential Manager will review fire drill records quarterly and provide training on fire drill safety," with a completion date of June 20, 2008. Since the recertification survey, the facility documented one fire drill on the 8:00 AM - 4:00 PM shift, on May 24, 2008, thereby meeting initial compliance. However, findings of the September 12, 2008 monitoring visit revealed that the QMRP and Residential Manager failed to ensure sustained compliance.		6. Cross reference W104.6	10/30/08
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	W 249		

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

PRINTED: 09/25/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G037		C 09/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 249	Continued From page 12 and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that clients received continuous active treatment, for two of the six clients residing in the facility. (Clients #4 and #5). The findings include: 1. Facility staff failed to consistently implement Client #5's behavior support plan (BSP), as follows: Client #5 was observed intermittently sucking his thumbs on September 12, 2008, beginning at 8:15 AM. It was noted that his right thumb nail was chipped. He continued to suck his right, then his left thumb intermittently for approximately five minutes. Even though there was one staff present, with other staff occasionally coming through the living room, they did not intervene while he sucked his thumbs. At 8:20 AM, a direct support staff escorted the client upstairs to prepare for his departure to the day program. At approximately 10:30 AM, interview with the Residential Manager revealed the client had a BSP to address thumb sucking/ nail biting behavior. Review of a dermatology consultation report dated June 16, 2008 revealed a conclusion that thumb sucking and nail biting were behavioral in nature. According to Client #5's BSP, dated May 6, 2008, staff should observe the client for thumb sucking and redirect him when it	W 249	1. The staff will be trained on Client #5's BSP. In the future, staff will be trained quarterly on all Clients BSP and documenting behaviors.	10/30/08

PRINTED: 09/25/2008
FORM APPROVED
OMB NO. 0938-0391

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

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	09G037		C 09/12/2008

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W 249	Continued From page 13 occurred. If he put his fingers or thumb into his mouth, staff were to tell him to stop, instruct him to come to them and then immediately redirect him to do something else with his hands. Observations, however, revealed that staff failed to implement Client #5's BSP as written. 2. Client #4 was not receiving 1:1 staff support as prescribed in his BSP, as follows: Even though Client #4's BSP, dated November 26, 2007, included the following: "He is primarily a danger to himself and/or others without a 1:1 staff person at all times... behaviors are unpredictable... day, night, weekends...anywhere, anytime... danger to others when he is not properly redirected by someone such as a 1:1, as he may become more aggressive at these times." Targeted behaviors included: elopement, physical aggression, public masturbation, spitting, touching others and pulling his hair. On September 11, 2008, at approximately 6:45 PM, the Residential Manager stated that 1:1 staffing was provided when Client #4 went to day program only, on Monday - Friday. The client remained without a designated 1:1 on weekends and weekday evenings after the the daytime staff person signed-off of their shift, reportedly due to the lack of funding. On September 12, 2008, at 12:19 PM, the QMRP stated that funding had been secured for an "Accuity Specialist" who she described as having visual observation but not was not required to be in immediate proximity to the client. Further interview, however, revealed that the facility had not yet begun receiving the new funding stream and the client remained without 1:1 or "Acuity Specialist" supervision. The QMRP also acknowledged Client #4's BSP had	W 249	2. The QMRP sent a package to MAA for a Behavioral Acuity in May 2008. Client #4 will receive additional support once MAA approves the behavioral acuity.Currently the package is being processed. The QMRP will follow-up with MAA monthly re:the status of the behavioral acuity. The QMRP will work with the personnel department to develop a job description for the "acuity specialist".	10/31/08

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

PRINTED: 09/25/2008
FORM APPROVED
OMB NO. 0938-0391

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	09G037		C 09/12/2008

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W 249	Continued From page 14 not been revised to reflect the proposed change in level of staff supervision. It should be noted that there was no written job description presented to outline the specific duties and responsibilities of an "Acuity Specialist." This is a repeat deficiency. ********** Client #4's BSP and 1:1 staffing needs were addressed in the April 4, 2008 Statement of Deficiencies. The facility's May 9, 2008 Plan of Correction, included the following: "The facility will increase <his> 1:1 hours from 8 hours Monday through Friday to waking hours Monday through Sunday." Additional funds would be sought.	W 249		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION 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: Based on observation, interview and record review, the facility failed to ensure that data relative to the accomplishment of behavioral objectives was documented in measurable terms, for one of the six clients residing in the facility. (Client #5) The finding includes.	W 252		

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

PRINTED: 09/25/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G037	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 09/12/2008
NAME OF PROVIDER OR SUPPLIER CMS		STREET ADDRESS, CITY, STATE, ZIP CODE 3815 ALBERMARLE STREET NW WASHINGTON, DC 20008	

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W 252	Continued From page 15	W 252		
	Cross-refer to W249.1. On September 12, 2008, Client #5 was observed sucking both of his thumbs, alternately, between 8:15 AM and 8:20 AM. Staff were present on again off again during those 5 minutes. Interview with the Residential Manager, at approximately 10:30 AM, revealed that the client had a behavior support plan (BSP) which addressed thumb sucking/nail biting behavior. According to his BSP, dated May 6, 2008, staff should document the behavior whenever observed. At 1:12 PM, however, review of Client #5's ABC documentation for that morning revealed 0 incidents of thumb sucking. There was no evidence that facility staff maintained accurate data regarding the frequency of Client #5's thumb sucking behavior.		Cross reference W249.1	10/30/08
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 review, the facility failed to provide nursing services for five of the six clients residing in the facility. (Clients #1, #2, #4, #5 and #6) The findings include: 1. On September 12, 2008, beginning at 4:03 PM, review of Resident #1's lab records revealed that on June 10, 2008, he had been unable to void; therefore, the requested urinalysis had not been performed. The resident did, however, provide a urine sample on the next day. Most of the lab reports in the record, including those that were achieved on June 10, 2008, had been	W 331		

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

PRINTED: 09/25/2008
FORM APPROVED
OMB NO. 0938-0391

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	09G037		C 09/12/2008

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W 331	Continued From page 16 signed and dated by the primary care physician (PCP), indicating when he had reviewed the results and noting any additional comments regarding appropriate follow-up. However, review of the urinalysis test report for the sample obtained June 11, 2008 revealed no signatures, dates, initials or other notations that would indicate that the PCP had received the results of the urinalysis. The Director of Nursing was interviewed by telephone that afternoon, beginning at 4:14 PM. She checked their records in the medical office and could not locate a copy of the June 11, 2008 urinalysis test results. She further stated that the absence of notations on the lab report indicated that the PCP had not yet seen the report. 2: The facility failed to ensure that nursing staff assessed raised, red bumps on Client #6's left arm, as follows: On September 11, 2008, at approximately 7:00 PM, this surveyor observed three dime-sized red bumps on Client #6's left arm. There was a raised center part of each bump, resembling those associated with bug bites. Both the Residential Manager and the Qualified Mental Retardation Professional (QMRP) stated that they were previously unaware of any bumps on his arm. [Note: The client and his peers had arrived home from day programs approximately 3 hours earlier.] The next evening (September 12, 2008), at approximately 5:00 PM, review of Client #6's nurse progress notes failed to show evidence that a nurse had assessed the client's arm. A minute later, the RN was contacted by telephone. She said she was previously unaware of any red bumps observed on Client #6. She then asked if	W 331	The primary nurse will ensure that all lab results are reviewed by the PCP. In the future, the primary nurse will review the medical records of the individuals on a monthly basis.	10/28/08

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

PRINTED: 09/25/2008
FORM APPROVED
OMB NO. 0938-0391

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	09G037		C 09/12/2008

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W 331	Continued From page 17 they had been on his head. While maintaining contact with this surveyor, the RN telephoned the Director of Nursing. She too had not been made aware of any bumps. During a conversation earlier (at approximately 2:20 PM) with the Residential Manager and QMRP, it had been determined that a nurse had arrived at the facility at or near 7:28 PM the evening before, to administer medications. There was no evidence that he had assessed the client's arm. [Note: According to the Residential Manager, he did not observe bumps on Client #6's arm the next morning. The client and his peers were away from the facility all afternoon on September 12, 2008. As of 6:56 PM, the client remained out of the facility, and therefore unavailable for verification.]	W 331	2. Cross reference W153.2	10/30/08
	3. Cross-refer to W365. Nursing staff failed to ensure that Medication Administration Records (MARs) were accurately maintained. Data had not been documented consistently on Client #5's July 2008 MAR.		Cross reference W149	10/28/08
	4. Cross-refer to W368. Nursing staff failed to ensure that medications were administered in accordance with physician's orders. (a) On September 11 and 12, 2008, nurses failed to ensure that evening medications were administered during the designated time frame (no more than 1 hour before or 1 hour after 5:00 PM) designated on their MARs. (b) There was a 3-day delay in securing medication that was prescribed for treating a boil on Client #2's head. (c) Two medications that were prescribed for Client #6 at bedtime were being administered at 5:00 PM instead; and, (d) Client #1 did not receive Keflex antibiotic three times daily for 7 days, as prescribed for the treatment of a wound.		Cross reference W149	10/28/08

PRINTED: 09/25/2008
FORM APPROVED
OMB NO. 0938-0391

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

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W 331	Continued From page 18 5. On September 11, 2008, review of incident reports revealed that in early August 2008, Client #2 received treatment for a boil on the back of his head. Subsequent review of his medical records revealed a failure by nursing staff to document the condition and/or status of the boil, in accordance with facility policies. On September 12, 2008, at 5:15 PM, review of the facility's Policies and Procedures Manual, revealed a policy titled "Illness/Injury" that requires "daily follow-up by the nurse until the illness/injury is resolved." Nurses had only described the boil sporadically, on 7/29/08, 8/2/08, 8/3/08, 8/4/08 (when antibiotic treatment started), 8/6/08, 8/9/08, 8/15/08 and 8/16/08. Nurses failed to document the status of the illness on other days. There was a note dated 8/17/08 indicating that the antibiotic treatment had been completed. However, the note failed to indicate the status of the boil and the record did not reflect when the boil had actually been resolved. It should be noted that Client #2's record reflected a history or recurring boils.	W 331	The nursing staff will receive additional training in nursing documentation and the primary nurse will review nurses progress notes on a weekly basis.	10/28/08
W 365	483.460(j)(4) DRUG REGIMEN REVIEW An individual medication administration record must be maintained for each client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the individual medication record was accurately maintained, for one of the six clients residing in the facility. (Client #5) The finding includes:	W 365		

PRINTED: 09/25/2008
FORM APPROVED
OMB NO. 0938-0391

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

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	09G037		C 09/12/2008

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W 365	Continued From page 19 1. Client #5 was observed intermittently sucking his thumbs on September 12, 2008 at 8:15 AM. Further observation of the client's thumbs during this time revealed the nail on his right thumb was chipped. He continued to suck his right, then his left thumb intermittently for approximately five minutes, without staff intervention. On September 12, 2008, at 11:10 AM, interview with the nurse revealed that on June 16, 2008, the dermatologist determined that the thumb sucking was probably of a behavioral nature. Further review of the dermatologist's consultation report revealed a recommendation to continue applying Castillani Paint to his nails one time daily to deter thumb sucking. A corresponding physician's order (PO) documented "Castillani Paint Mod Liquid (apply to nails daily)." Further interview with the primary RN revealed that the Castillani Paint was applied to the client's finger nails every morning by a nurse. Review of Client #5's July 2008 medication administration record (MAR) revealed that the nurse failed to document having applied the Castellini Paint to his nails on July 17, 26 and 27, 2008. 2. On September 12, 2008, at 10:35 AM, interview with the primary RN revealed that Client #5 had POs for Fluoxetine 20 mg and Zyprexa 5 mg every morning. Although the POs confirmed that the client was prescribed this medication, further interview with the nurse, as well as the review of the MAR, failed to show evidence to verify that the client had received these medications on July 17, 2008.	W 365	Cross reference W149	10/28/08
W 368	483.460(k)(1) DRUG ADMINISTRATION	W 368		

PRINTED: 09/25/2008
FORM APPROVED
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 368	Continued From page 20 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, interview and record review, the facility failed to ensure that medications were administered in compliance with physician's orders, for five of the six clients residing in the facility. (Clients #1, #2, #4, #5 and #6) The findings include: 1. The facility failed to ensure that evening medications were administered during the designated time frame, as follows: a. Surveyors were in the facility on September 11, 2008, between the hours of 3:20 PM and 7:26 PM. No client was observed receiving his medications during that period. On the next day, September 12, 2008, at approximately 2:30 PM, the Residential Manager reported that the medication nurse had arrived "just 2 or 3 minutes" after the surveyors had departed the previous evening. Immediate review of the clients' Medication Administration Records (MARs) revealed that 5:00 PM was the time designated for evening medications. The RN, who was present during this interview, indicated that she was previously unaware that medications had been passed after 7:26 PM on the night before. The RN immediately telephoned their Director of Nursing (DON), who also stated she was unaware of any late medication administrations in this facility.	W 368	Cross reference W149	10/28/08

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

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W 368	Continued From page 21 b. At approximately 2:30 PM, review of the clients' MARs revealed that the nurse had documented the September 11, 2008 evening medication pass without indicating that he had begun the process 2 1/2 hours after the time specified on the MARs. c. At approximately 2:35 PM, when asked if administering medications beyond 6:00 PM would constitute a "med error," the DON replied "no." When asked "how late would be too late," the DON said she would expect medications to be administered no later than 2 hours after the designated time. She was then informed that the previous evening's medication pass began 2 1/2 hours beyond the 5:00 PM time frame. d. The Exit Conference was held September 12, 2008, between 6:13 PM - 6:56 PM. On that evening, the medication nurse had not arrived at the facility prior to the surveyors' departure shortly thereafter. It should be noted that on September 12, 2008, at 3:05 PM, the DON informed the facility's RN by telephone that the agency was without a written policy on how they should proceed if/when a nurse does not arrive within the time period allowed (<1 hour prior to, or >1 hour after) for a medication pass. It should be further noted that the facility had a policy stating that a nurse should be on site between 4:00 PM to 4:45 PM to administer the afternoon (5:00 PM) medications. The procedure also stated that a nurse should be onsite between 8:00 PM and 8:30 PM for night administration. Interviews and record review had not, however, indicated that a late-evening (8:30 PM)	W 368		

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

PRINTED: 09/25/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G037		C 09/12/2008

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W 368	Continued From page 22 administration was expected for medications designated for a 5:00 PM administration. 2. The facility failed to ensure that Client #2 received medication timely for treatment of a boil on his scalp, as follows: A nursing progress note, dated August 1, 2008, indicated that Client #2 had a pus-filled boil on the back of his head. Staff reportedly had noted the boil 2 days earlier (July 29, 2008). On August 1, 2008, the PCP prescribed Bactrim antibiotic twice daily for "folliculitis/ with abcess - draining, recurrent nature." Review of the client's August 2008 MAR revealed that the Bactrim was started on Monday, August 4, 2008, 3 days later. At approximately 6:10 PM, the Residential Manager and the QMRP both replied "no" when asked if there were any known difficulties accessing pharmacy services during a weekend, to include filling a new prescription.	W 368	The primary nurse will ensure that prescriptions are filled within 24 hours. In the future, the QMRP and/ or the Residential Manager will ensure all orders from consultants be forwarded to the nursing office the same day, so that medication orders will be filled.	10/28/08
	3. Client #6 had not been receiving medications at bedtime, as ordered by the primary care physician (PCP), as follows: On September 12, 2008, at 8:00 AM, Client #6's eyes were closed and his head drooped to the side while he sat in a chair in the living room. For much of the next 25 minutes, he appeared fatigued and/or to be sleeping. This prompted a review of Client #6's medication regimen. His September 2008 physician's orders (POs) included orders to have Paxil 20 mg and Benztropine Mesylate 1 mg administered at bedtime. According to the MARs, however, those medications were being administered along with other medications at 5:00 PM on a routine, daily basis. Subsequent interviews with the RN and		Cross reference W149	10/28/08

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

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W 368	Continued From page 23 the DON (via telephone) revealed that no additional medication passes were scheduled beyond 5:00 PM. In addition, they acknowledged that the discrepancy between administering the 2 medications at 5:00 PM instead of bedtime had not been addressed. It should be noted that the agency's written policies recognized the possibility that some clients might require medications at night. According to the policy, the nurse should be on site between 4:00 PM to 4:45 PM to administer afternoon medication. A nurse should also be onsite between 8:00 PM and 8:30 PM for the night administration. There was no evidence, however, that the facility's nursing staff had established a schedule to meet Client #6's medication needs.	W 368	Cross reference W149	10/28/08
	4. Client #1 did not receive an antibiotic three times daily for 7 days, as prescribed, as follows: On September 12, 2008, at 5:18 PM, review of Client #1's Medication Administration Record (MAR) for the month (September 2008) revealed that he was not administered Keflex antibiotic in accordance with his physician's orders (POs). According to the September 2008 POs, he was prescribed "Keflex 500 mg by mouth 3 times daily for 7 days for wound." Review of the MAR revealed that he received 3 doses of Keflex on September 1, 2008. He did not receive the noon dose on September 2, 3 or 4, 2008. Further review of the MAR revealed that he received the noon dose on September 5, 6 and 7; however, he then missed the noon administration on September 8, 9 and 10, 2008. In total, he missed 6 noontime doses. This resulted in the Keflex being administered over an 11-day period instead		In the future, the primary nurse will ensure a Nurse or a Trained Medication Employee is available to administer noon meds.	10/28/08

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G037		C 09/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CMS	3815 ALBERMARLE STREET NW WASHINGTON, DC 20008

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W 368	Continued From page 24 of 7 days. Follow-up interview with the Residential Manager revealed that the staff person who had initialed the MAR on the dates that he received his medication at noon was a trained Medication Employee (TME). That employee had accompanied him to his day program. The Residential Manager confirmed that on the 6 days that Client #1 missed the noontime medication, there was another staff person assigned who was not a TME. It should be noted that the Keflex was initially prescribed on August 29, 2008. However, Client #1's August MARs were not in his record and, therefore, the precise date that the Keflex was started could not be verified. There was no evidence that the facility established and maintained a system to ensure that clients received medications in accordance with physician's orders.	W 368		
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 quarterly on all shifts. The finding includes: Review of the facility's fire drill records on September 12, 2008, beginning at 4:17 PM, revealed that for the 8:00 AM - 4:00 PM shift, there had been one fire drill documented on May 24, 2008. There was no evidence that another	W 440	Cross reference W104.6	10/30/08

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

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W 440	Continued From page 25 drill had been conducted during the 90 days that followed. When interviewed shortly thereafter, the Residential Manager acknowledged that there had been no drills conducted on that shift since May 24, 2008. This is a repeat deficiency. ********** Previously, the April 4, 2008 Federal Deficiency Report included the following: "Review of the fire drill records on April 2, 2008, revealed that there was only one fire drill conducted on the 8:00 AM - 4:00 PM shift (March 4, 2008) for the entire year." The facility submitted a Plan of Correction, dated May 9, 2008, in which the following was written: "In the future, the facility will conduct a fire drill quarterly during each shift. The QMRP and the Residential Manager will review fire drill records quarterly and provide training on fire drill safety," with a completion date on June 20, 2008.	W 440		

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Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0095	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 09/12/2008
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I 000	INITIAL COMMENTS A monitoring survey was conducted from September 11, 2008 through September 12, 2008. The Plan of Correction submitted by the facility on May 9, 2008 served as the focus for this monitoring survey. All six of the residents were subject to review, based either on the findings of the April 2, 2008 survey or after new observations were made that were relevant to previously-cited deficient practices. The findings of the survey were based on observations, interviews with staff in the home and at two day programs, as well as a review of resident and administrative records, including incident reports.	I 000	Received 10/10/08 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to maintain the interior and exterior of the facility in a safe and attractive manner. The findings include: 1. At the beginning of the monitoring visit, on September 11, 2008, at 3:20 PM, the green carpet on the front steps had long tears on three (3) of the steps. The tears were unattractive and presented a trip hazard. The carpet had been removed by September 12, 2008, at 1:30 PM; thereby abating the trip hazard. Interview with the	I 090	The QMRP will do weekly walk-through's of the facility's environment and will document all maintenance concerns. The Residential Manager will follow-up with the QMRP's walk-through to ensure safety.	10/30/08

Health Regulation Administration

Constance A. Reese Program Director 10/9/08

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

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I 090	Continued From page 1 Qualified Mental Retardation Professional a few minutes later revealed that they planned to replace it with new carpet in order to hide the newly-exposed concrete that that was cracked and discolored. 2. On September 11, 2008, at 3:50 PM, it was observed that the handle used to flush the toilet in the second floor bathroom was broken, leaving a sharp, jagged edge. The exposed edge presented an immediate hazard to anyone trying to flush the toilet. The discovery was made at the same time that the residents were coming in the front door, returning from their day programs, with the Residential Manager and other staff. The Residential Manager indicated that he was aware that the handle had broken earlier that day and he had already informed their maintenance department. He did not, however, know when the handle might be repaired. The Residential Manager was informed that the facility must implement immediate measures to ensure the residents' health and safety. In response, he instructed staff to prevent residents from using that particular toilet and to direct them instead to use other bathrooms in the facility. The immediate threat to safety had therefore been abated. The toilet handle was replaced before 7:00 PM that evening and residents were again free to use that bathroom. 3. On September 4, 2008, at approximately 8:30 AM, the view out of the kitchen window revealed a red recliner chair was observed in the back yard. The chair's back was broken backwards and one of the arm rests also was dislodged. Next to the recliner was a wooden piece of bedroom furniture, with its three (3) drawers removed from their tracks and placed on the grass next to the furniture. The broken furniture	I 090		

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Health Regulation Administration

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I 090	Continued From page 2 was within view of neighbors. At the same time, a kitchen drawer was observed to be missing its front panel. The blade of a large kitchen knife was visible inside the drawer (but not protruding). Interview with the Residential Manager a few minutes later revealed that the broken furniture had belonged to former resident who had been discharged from the facility in June. He said the furniture had been out in the yard for approximately one (1) week. The kitchen drawer had been broken "a couple of days" before the monitoring visit. A maintenance person was observed removing the furniture from the yard later that same morning. The kitchen drawer was repaired before 1:30 PM.	I 090		
I 135	3505.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to hold evacuation drills quarterly on all shifts. The finding includes: Review of the facility's fire drill records on September 12, 2008, beginning at 4:17 PM, revealed that for the 8:00 AM - 4:00 PM shift, there had been one fire drill documented on May 24, 2008. The May 24, 2008 drill brought the facility back into compliance. The findings of this monitoring visit, however, revealed the failure of sustained compliance. There was no evidence that another drill had been conducted during the 90 days that followed. When interviewed shortly	I 135	Cross reference W104.6	10/30/08

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Health Regulation Administration

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I 135	Continued From page 3 thereafter, the Residential Manager acknowledged that there had been no drills conducted on that shift since May 24, 2008. This is a repeat deficiency and will be referred to the Office of the Fire Marshall. ********** Previously, the April 4, 2008 Federal Deficiency Report included the following: "Review of the fire drill records on April 2, 2008, revealed that there was only one fire drill conducted on the 8:00 AM - 4:00 PM shift (March 4, 2008) for the entire year." The facility submitted a Plan of Correction, dated May 9, 2008, in which the following was written: "In the future, the facility will conduct a fire drill quarterly during each shift. The QMRP and the Residential Manager will review fire drill records quarterly and provide training on fire drill safety," with a completion date on June 20, 2008.	I 135		
I 160	3507.1 POLICIES AND PROCEDURES Each GHMRP shall have on site a written manual describing the policies and procedures it will follow which shall be as detailed as is necessary to meet the needs of each resident served and provide guidance to each staff member. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to have written policies and procedures that were sufficiently detailed to meet the residents' needs. The findings include: 1. The facility failed to develop a policy to ensure	I 160		

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Health Regulation Administration

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I 160	Continued From page 4 that residents received medications at the scheduled time, as follows: On September 11, 2008, residents were observed between the hours of 3:20 PM and 7:26 PM. They were not observed to receive their evening medications, which according to their Medication Administration Records (MARs) were to be administered at 5:00 PM. On September 12, 2008, at approximately 2:30 PM, interview with the RN indicated that she did not know whether the facility had a policy that outlined how facility staff should proceed if/when a medication nurse did not arrive at the designated time, and did not notify their supervisor. The Director of Nursing (DON) was interviewed by telephone at 3:05 PM, at which time she indicated that the facility was without said policy. 2. With respect to the issue above (late administration of medications), review of the facility's Incident Management Policy on September 12, 2008, at 2:19 PM, revealed that "Medication Errors" should be considered a "Reportable Incident," thereby generating an unusual incident report. Telephone interview with the DON, at approximately 2:30 PM, revealed that she would not consider administration of medications 1 hour after the designated time as a medication error. When asked for further clarification, she stated that she would expect medications to be administered "before 2 hours later." Interviews had also revealed that neither she nor the RN had been informed that the medication nurse had arrived after 7:26 PM the night before. At approximately 3:20 PM, the Residential Manager presented another policy that listed examples of medication errors, which included	I 160	Cross reference W149	10/28/08

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Health Regulation Administration

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I 160	Continued From page 5 "administration of medications at the wrong time (early or late)." No incident report had been prepared for the late administration on the evening before. 3. The facility failed to ensure that Resident #5 received all prescribed medications, as follows: a. On September 12, 2008, at 11:10 AM, interview with the facility RN revealed Castellani Paint was applied to Resident #5's nails one time daily to deter thumb sucking. Review of the resident's July 2008 MAR revealed spaces left blank on July 17, 26 and 27, 2008. Further review of the MAR failed to show documented evidence that the medication had been applied, or an explanation as to why the designated spaces had been left blank. b. In July 2008, Resident #5 also had physician's orders to be administered Fluoxetine 20 mg and Zyprexa 5 mg every morning. Review of the July 2008 MAR revealed no evidence that the resident received these medications on the morning of July 17, 2008. Further review of the MAR failed to show documentation indicating why the designated spaces had been left blank. Further interview with the RN revealed that she was previously unaware of the missing data and, therefore, had not investigated to determine whether the resident had received his prescribed medications as ordered. The facility's medication policy stated that if a medication was not given for any reason, the space on the MAR should be encircled and the reason should be documented on the reverse side. 4. Cross-refer to I379. The facility failed to ensure that staff (either nursing staff or direct	I 160	Cross reference W149	10/28/08

PRINTED: 09/25/2008
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Health Regulation Administration

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	HFD03-0095		C 09/12/2008

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I 160	Continued From page 6 support staff) prepared incident reports of resident injuries, in accordance with facility policies. The monitoring visit revealed 2 such injuries that were not reported during September 2008.	I 160	The nursing staff will receive additional training on documentation of illnesses and injuries. In the future, the primary nurse will review individuals medical records to ensure all concerns are being addressed and monitored	10/28/08
I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on observation, interview and record review, the governing body exercised general policy and operational direction over the facility, except in the following areas. The findings include: 1. Cross-refer to I160.1. The governing body failed to establish policies to provide clear direction to staff as to how to proceed if/when a medication nurse fails to report timely for the administration of residents' medications. 2. Cross-refer to Federal Deficiency Report - Citation W149.2. The governing body failed to establish a policy that defined the term "medication error." The incident management policies, however, did indicate that "administration of medications at the wrong time (early or late)" would constitute a Reportable Incident. 3. Cross-refer to I379. The governing body failed to ensure that unusual incidents, such as abrasions of unknown etiology and red bumps, were reported in accordance with facility policies. It should be noted that the RN reported having	I 180		

PRINTED: 09/25/2008
FORM APPROVED

Health Regulation Administration

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I 180	Continued From page 7 reviewed residents' medical records on the morning of September 11, 2008. On September 12, 2008, however, review of Resident #1's chart revealed that an evening nurse had recorded an injury of unknown origin (on September 2, 2008) for which there was no corresponding incident report.	I 180	Cross reference W160	10/28/08
	4. Cross-refer to Federal Deficiency Report - Citation W368.2. The September 12, 2008 monitoring visit findings revealed a 3-day delay in securing medication that was prescribed for treating a boil on Resident #2's head. There was no evidence that the governing body had determined whether the facility had access to pharmacy services on Saturdays, Sundays and holidays, to include filling new prescriptions.		The Director of Nursing or the weekend/ holidays on call RN will be responsible to use other pharmacies on weekends/ holidays & ensure medication order is initiated within 24 hours.	10/28/08
	5. The governing body failed to ensure that nurses implemented a medication administration schedule to meet resident needs, as indicated by the following: The September 12, 2008 monitoring visit findings revealed that Resident #6's September 2008 physician's orders (POs) included orders to have Paxil 20 mg and Benztropine Mesylate 1 mg administered at bedtime. According to his MARs, however, those medications were being administered along with other medications at 5:00 PM on a routine, daily basis. Interviews with the RN and the Director of Nursing (via telephone) revealed that no additional medication passes were scheduled beyond 5:00 PM. In addition, they acknowledged that the discrepancy between administering the 2 medications at 5:00 PM instead of bedtime had not been addressed previously. The findings also revealed that the agency's		Cross reference W149	10/28/08

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I 180	Continued From page 8 written policies recognized the possibility that some residents might require medications at night. According to the policy, the nurse should be on site between 4:00 PM to 4:45 PM to administer afternoon medications and/or onsite between 8:00 PM and 8:30 PM for the night administration. There was no evidence of a quality assurance system to ensure that nurses established a medication administration schedule to meet resident needs.	I 180		
	6. Cross-refer to I135. There was no evidence that the governing body had implemented a quality assurance system to monitor the QMRP and Residential Manager's responsibility to ensure that fire drills were conducted at least quarterly on each shift.		6. Cross reference W104.6	10/30/08
	7. The governing body failed to ensure that the RN implemented the written "Procedure For Discarding Medications" policy, as follows: On September 11, 2008, at 3:25 PM, a large quantity of pills were observed at the bottom of the bowl of the toilet in a half-bathroom located near the laundry room. The pills had begun to dissolve. Interview with the direct support staff indicated that the RN had left the facility approximately 10 minutes before the surveyors arrived. The RN was interviewed by telephone later that afternoon, at approximately 5:15 PM. She confirmed that she had tried flushing expired Tylenol down the commode; however, she was unsuccessful after several attempts. On September 12, 2008, at approximately 6:00 PM, review of the facility's "Procedure For Discarding Medications" revealed that "in the event that a medication has expired...the nursing staff will pull applicable medication and write D/C or expired on the label... notify Nursing Coordinator of			

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I 180	Continued From page 9 medication(s) that needs to be picked up promptly." The procedure did not, however, indicate flushing as an alternative disposal procedure. It should be noted that at the time that the pills were discovered in the commode, staff indicated that the residents were due to return home from their day programs momentarily. Indeed, they returned at 3:50 PM, and some individuals were observed to use the toilet in question.	I 180		
I 291	3514.2 RESIDENT RECORDS Each record shall be kept current, dated, and signed by each individual who makes an entry. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each resident's record was kept current, for two of the six residents in the GHMRP. (Residents #1 and #5) The findings include: 1. On September 12, 2008, at approximately 4:35 PM, review of Resident #1's medical records revealed a seizure chart indicating that he had experienced a seizure on August 7, 2008. However, there was no corresponding Seizure Activity Report form in the resident's record. Further review of the medical chart revealed a nurse progress note, dated August 8, 2008, indicating that he (the nurse) had seen a Seizure Activity Report form for that event. A subsequent onsite interview with the Qualified Mental Retardation Professional revealed that she could not explain why the form was not in the medical record. At 5:00 PM, telephone interview with the RN revealed that she did not have the Seizure	I 291	The primary nurse will review all health related documents and file them in the medical book. The primary nurse will monitor residents medical record on a weekly basis.	10/28/08

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Health Regulation Administration

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I 291	Continued From page 10 Activity Report form in question, and said forms should always be kept in the residents' chart. 2. On September 12, 2008, at approximately 4:45 PM, review of Resident #1's record revealed that the Medication Administration Record (MAR) for the month of August 2008 was not in his records. At 5:00 PM, telephone interview with the RN revealed that she did not have the MARs in question, and in general, MARs should always be kept in the residents' chart. 3. On September 12, 2008, at 11:10 AM, interview with the nurse revealed that on June 16, 2008, the dermatologist determined that Resident #5's thumb sucking was probably of a behavioral nature. Further review of the dermatologist's consultation report revealed a recommendation to continue applying Castellani Paint to his nails one time daily to deter thumb sucking. A corresponding physician's order (PO) documented "Castellani Paint Mod Liquid (apply to nails daily)." Further interview with the primary RN revealed that the Castellani Paint was applied to the resident's finger nails every morning by a nurse. Review of Resident #5's July 2008 MAR revealed that the nurse failed to document having applied the Castellani Paint to his nails on July 17, 26 and 27, 2008 and there was no documentation indicating that it had not been administered.	I 291	Cross reference W149	10/28/08
I 292	3514.3 RESIDENT RECORDS Each record shall include, but not be limited to, the requirements of D.C. Law 2-137, D.C. Code § 6-1972 (1989 Repl. Vol.). This Statute is not met as evidenced by: Based on interview and record review, the	I 292		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0095	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 09/12/2008
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I 292	Continued From page 11 GHMRP failed to maintain resident records to include Seizure Activity Report forms, Medication Administration Records and/or Incident Report forms, in accordance with facility policies, for three of the six residents of the facility. (Residents #1, #5 and #6) The findings include: 1. D.C. Law 2-137, Section 7-1305.12 (formerly 6-1972) "Complete records for each customer shall be maintained and shall be readily available to professional persons and to the staff workers who are directly involved... These records shall include: (8) A medication history and status; See Citations I160.3 and I291 above.	I 292	Cross reference W291	10/28/08
	2. D.C. Law 2-137, Section 7-1305.12 (formerly 6-1972) "Complete records for each customer shall be maintained and shall be readily available to professional persons and to the staff workers who are directly involved... These records shall include: (13) A description of any extraordinary incident or accident in the facility involving the customer, to be entered by a staff member noting personal knowledge of the incident or accident or other source of information, including any reports of investigations of customer's mistreatment." See Citations I379.		Cross reference W153	10/28/08
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of	I 379		

PRINTED: 09/25/2008
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Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	HFD03-0095		C 09/12/2008

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I 379	Continued From page 12 Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview, review of incident reports and review of resident records, the GHMRP failed to ensure that all injuries of unknown origin were consistently reported to the Department of Health (DOH). The findings include: On September 11, 2008, beginning at 3:36 PM, incident reports were reviewed in the facility. Review of resident records later in the monitoring visit, however, revealed the following: 1. On September 12, 2008, at 2:10 PM, review of Resident #1's nurse progress notes in the Medication Administration Record (MAR) book revealed that an evening nurse recorded an injury of unknown origin for which there was no corresponding incident report. The nurse's entry, dated September 2, 2008, indicated that Resident #1 had sustained a 1-to-2 inch abrasion surrounded by a 3-inch hematoma to the left side of his face while he was at day program. No further information regarding the source of the injury had been documented by the nurse and there was no evidence that staff had prepared a corresponding incident report, in accordance with facility policies. The Residential Manager and the	I 379	Cross reference W153.1	10/30/08

PRINTED: 09/25/2008
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0095	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 09/12/2008
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I 379	Continued From page 13 Qualified Mental Retardation Professional (QMRP) were in the facility at the time the nurse's note was discovered by surveyors. They both denied prior knowledge of the resident's injury. They acknowledged that the injury had not been reported to their administrator or to the Department of Health. DOH records did not reflect notification of said injury prior to this monitoring visit. 2. Cross-refer to W331.2. On September 11, 2008, at approximately 7:00 PM, three dime-sized red bumps were observed on Resident #6's left arm. Immediately, both the Residential Manager and the QMRP were made aware of the observations. At that time, nobody present knew the cause of the bumps. The next evening (September 12, 2008), at approximately 5:00 PM, interview with the Residential Manager and QMRP revealed that there had not been an incident report prepared, in accordance with facility policies. It should be noted that on September 12, 2008, beginning at approximately 5:00 PM, review of Resident #6's nurse progress notes failed to show evidence that the bumps had been brought to a nurse's attention. In addition, telephone interview with the RN revealed that neither she nor the Director of Nursing had been made aware of the bumps of unknown origin. This is a repeat deficiency. ********** Previously, the State Licensure Report, dated April 4, 2008, cited the facility's failure to notify the DOH immediately after an individual was taken to a hospital emergency room. According	I 379		

PRINTED: 09/25/2008
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Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0095	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 09/12/2008
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I 379	Continued From page 14 to a February 27, 2008 incident report, the resident was described as being non-responsive. The DOH was notified more than 24 hours later (on February 29, 2008). In addition, the Federal Deficiency Report, also dated April 4, 2008, cited the facility's failure to notify their administrator of an injury of unknown origin (cut to the forehead) sustained by a resident on February 11, 2008.	I 379		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to provide nursing services for five of the six residents residing in the facility. (Residents #1, #2, #4, #5 and #6) The findings include: 1. On September 12, 2008, beginning at 4:03 PM, review of Resident #1's lab records revealed that on June 10, 2008, he had been unable to void; therefore, the requested urinalysis had not been performed. The resident did, however, provide a urine sample on the next day. Most of the lab reports in the record, including those that were achieved on June 10, 2008, had been signed and dated by the primary care physician (PCP), indicating when he had reviewed the results and noting any additional comments	I 401	Cross reference W331	10/28/08

PRINTED: 09/25/2008
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Health Regulation Administration

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I 401	Continued From page 15 regarding appropriate follow-up. However, review of the urinalysis test report for the sample obtained June 11, 2008 revealed no signatures, dates, initials or other notations that would indicate that the PCP had received the results of the urinalysis. The Director of Nursing was interviewed by telephone that afternoon, beginning at 4:14 PM. She checked their records in the medical office and could not locate a copy of the June 11, 2008 urinalysis test results. She further stated that the absence of notations on the lab report indicated that the PCP had not yet seen the report.	I 401		
	2. The facility failed to ensure that nursing staff assessed raised, red bumps on Resident #6's left arm, as follows: On September 11, 2008, at approximately 7:00 PM, this surveyor observed three dime-sized red bumps on Resident #6's left arm. There was a raised center part of each bump, resembling those associated with bug bites. Both the Residential Manager and the Qualified Mental Retardation Professional (QMRP) stated that they were previously unaware of any bumps on his arm. [Note: The resident and his peers had arrived home from day programs approximately 3 hours earlier.] The next evening (September 12, 2008), at approximately 5:00 PM, review of Resident #6's nurse progress notes failed to show evidence that a nurse had assessed the resident's arm. A minute later, the RN was contacted by telephone. She said she was previously unaware of any red bumps observed on Resident #6. She then asked if they had been on his head. While maintaining contact with this surveyor, the RN telephoned the Director of Nursing. She too had not been made aware of		Cross reference W331	10/28/08

PRINTED: 09/25/2008
FORM APPROVED

Health Regulation Administration

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I 401	Continued From page 16 any bumps. During a conversation earlier (at approximately 2:20 PM) with the Residential Manager and QMRP, it had been determined that a nurse had arrived at the facility at or near 7:28 PM the evening before, to administer medications. There was no evidence that he had assessed the resident's arm. [Note: According to the Residential Manager, he did not observe bumps on Resident #6's arm the next morning. The resident and his peers were away from the facility all afternoon on September 12, 2008. As of 6:56 PM, the resident remained out of the facility, and therefore unavailable for verification.] 3. Cross-refer to Federal Deficiency Report - Citation W365. Nursing staff failed to ensure that Medication Administration Records (MARs) were accurately maintained. Data had not been documented consistently on Resident #5's July 2008 MAR. 4. Cross-refer to Federal Deficiency Report - Citation W368. Nursing staff failed to ensure that medications were administered in accordance with physician's orders. (a) On September 11 and 12, 2008, nurses failed to ensure that evening medications were administered during the designated time frame (no more than 1 hour before or 1 hour after 5:00 PM) designated on their MARs. (b) There was a 3-day delay in securing medication that was prescribed for treating a boil on Resident #2's head. (c) Two medications that were prescribed for Resident #6 at bedtime were being adminnistered at 5:00 PM instead; and, (d) Resident #1 did not receive Keflex antibiotic three times daily for 7 days, as prescribed for the treatment of a wound. 5. On September 11, 2008, review of incident reports revealed that in early August 2008,	I 401	Cross reference W149	10/28/08

PRINTED: 09/25/2008
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Health Regulation Administration

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	HFD03-0095		C 09/12/2008

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I 401	Continued From page 17 Resident #2 received treatment for a boil on the back of his head. Subsequent review of his medical records revealed a failure by nursing staff to document the condition and/or status of the boil, in accordance with facility policies. On September 12, 2008, at 5:15 PM, review of the facility's Policies and Procedures Manual, revealed a policy titled "Illness/Injury" that requires "daily follow-up by the nurse until the illness/injury is resolved." Nurses had only described the boil sporadically, on 7/29/08, 8/2/08, 8/3/08, 8/4/08 (when antibiotic treatment started), 8/6/08, 8/9/08, 8/15/08 and 8/16/08. Nurses failed to document the status of the illness on other days. There was a note dated 8/17/08 indicating that the antibiotic treatment had been completed. However, the note failed to indicate the status of the boil and the record did not reflect when the boil had actually been resolved. It should be noted that Resident #2's record reflected a history or recurring boils.	I 401	Cross reference W331	10/28/08
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that residents received continuous active treatment, for two of the six residents residing in the facility. (Residents #4 and #5) The findings include: 1. Facility staff failed to consistently implement	I 422		

PRINTED: 09/25/2008
FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	HFD03-0095		C 09/12/2008

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I 422	Continued From page 18	I 422		
	Resident #5's behavior support plan (BSP), as follows:		Cross reference W249.1	10/30/08
	Resident #5 was observed intermittently sucking his thumbs on September 12, 2008, beginning at 8:15 AM. It was noted that his right thumb nail was chipped. He continued to suck his right, then his left thumb intermittently for approximately five minutes. Even though there was one staff present, with other staff occasionally coming through the living room, they did not intervene while he sucked his thumbs. At 8:20 AM, a direct support staff escorted the resident upstairs to prepare for his departure to the day program.			
	At approximately 10:30 AM, interview with the Residential Manager revealed the resident had a BSP to address thumb sucking/ nail biting behavior. Review of a dermatology consultation report dated June 16, 2008 revealed a conclusion that thumb sucking and nail biting were behavioral in nature. According to Resident #5's BSP, dated May 6, 2008, staff should observe the resident for thumb sucking and redirect him when it occurred. If he put his fingers or thumb into his mouth, staff were to tell him to stop, instruct him to come to them and then immediately redirect him to do something else with his hands. Observations, however, revealed that staff failed to implement Resident #5's BSP as written.			
	2. Resident #4 was not receiving 1:1 staff support as prescribed in his BSP, as follows:		Cross reference W249.2	10/30/08
	Even though Resident #4's BSP, dated November 26, 2007, included the following: "He is primarily a danger to himself and/or others without a 1:1 staff person at all times... behaviors are unpredictable... day, night, weekends...anywhere, anytime... danger to			

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I 422	Continued From page 19 others when he is not properly redirected by someone such as a 1:1, as he may become more aggressive at these times." Targeted behaviors included: elopement, physical aggression, public masturbation, spitting, touching others and pulling his hair. On September 11, 2008, at approximately 6:45 PM, the Residential Manager stated that 1:1 staffing was provided when Resident #4 went to day program only, on Monday - Friday. The resident remained without a designated 1:1 on weekends and weekday evenings after the the daytime staff person signed-off of their shift, reportedly due to the lack of funding. On September 12, 2008, at 12:19 PM, the QMRP stated that funding had been secured for an "Acuity Specialist" whom she described as having visual observation but not was not required to be in immediate proximity to the resident. Further interview, however, revealed that the facility had not yet begun receiving the new funding stream and the resident remained without 1:1 or "Acuity Specialist" supervision. The QMRP also acknowledged Resident #4's BSP had not been revised to reflect the proposed change in level of staff supervision. It should be noted that there was no written job description presented to outline the specific duties and responsibilities of an "Acuity Specialist." This is a repeat deficiency. ********** Resident #4's BSP and 1:1 staffing needs had been addressed in the April 4, 2008 Federal Deficiency Report - Citation W249, and State	I 422		

PRINTED: 09/25/2008
FORM APPROVED

Health Regulation Administration

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I 422	Continued From page 20 Licensure Report - Citation I422. The facility's May 9, 2008 Plan of Correction, included the following: "The facility will increase <his> 1:1 hours from 8 hours Monday through Friday to waking hours Monday through Sunday." Additional funds would be sought.	I 422		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observation, interview and record review, one resident's freedom of movement was restricted without programmatic justification. (Resident #1) The findings include: On September 12, 2008, at approximately 8:10 AM, Resident #1 was observed wearing his gait belt, as prescribed. A direct support staff person (S1) held the gait belt from behind as they walked across the living room to the facility's front door. The staff person locked the dead bolt lock and positioned herself so as to block the resident's access to the door. The staff person informed the surveyors that the resident wished to go outside. The staff, however, continued to block the door. The resident persisted in his attempts to go outside, reaching for the dead bolt and trying to unlock it. The stalemate continued for a few minutes. The resident then attempted to look out the	I 500	Cross reference W125	10/30/08

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	HFD03-0095		C 09/12/2008

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I 500	Continued From page 21 window directly next to the front door. The glass, however, was opaque and he quickly stopped trying to see through it. When asked what might happen if the man was allowed to go outside, the staff replied that he "might run." When asked it there were other reasons the resident should not go outside, the staff replied "he might fall." She further indicated that staff took him on walks during the evening shift. After trying to exit through the front door for approximately 10 minutes, Resident #1 walked back into the living room, with the same staff holding him by the gait belt from behind. The Qualified Mental Retardation Professional (QMRP) was interviewed later that morning, beginning at approximately 10:13 AM. She stated that there were no restrictions on Resident #1 going outside (to either the front or back yard). He was more likely to walk quickly, rather than run. Staff were expected to use the gait belt whenever the resident was walking and staff "should be at his side at all times." She said she "would expect staff to take him outside if that was what he wished ... depending on the time of day, if it was beautiful outside then take him for a walk." Exceptions might be if there were inclement weather, if it was after nightfall, or if they were about to load the van for departure to day programs. The QMRP confirmed that they took walks in the evenings. She had been told that Resident #1 refused to go for a walk on the previous evening. After she was informed that the observations at the front door had been at approximately 8:10 AM, and the van was loaded at approximately 8:25 AM, she suggested perhaps the resident's interest earlier was "going out to the van ... he was one of the first people in the van" that morning.	I 500		

PRINTED: 09/25/2008
FORM APPROVED

Health Regulation Administration

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I 500	Continued From page 22 Later that afternoon, at approximately 5:35 PM, review of Resident #1's Behavior Support Plan (BSP), dated November 26, 2007, revealed target behaviors of self-injurious behaviors, property destruction and aggression towards others. The BSP did not instruct staff to restrict his freedom of movement unless he displayed maladaptive behaviors. Further review of the resident's records failed to show justification for preventing him from going outdoors with staff supervision.	I 500		