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

PRINTED: 04/25/2008
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		04/04/2008

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 A recertification survey was conducted from April 2, 2008 through April 4 2008. The full survey process was utilized. A random sample of four clients was selected from a residential population of seven males with mental retardation and other disabilities. The survey findings were based on observations in the group home and at four day programs, interviews and a review of records, including unusual incident reports. Observations conducted throughout the survey revealed concerns related to the health and safety of Client #1. On April 4, 2008, a determination was made that an immediate jeopardy of Client #1's health and safety existed. The facility's Qualified Mental Retardation Professional (QMRP) and House Manager were notified of the safety concerns regarding the immediate jeopardy at 5:28 PM. The surveyors remained onsite until the facility addressed the serious and immediate jeopardy by initiating a plan that prohibited Client #1's return to the day program until his mealtime service at the program was addressed. The support was designed to protect Client #1 from potential harm. The outcome of the survey resulted in the facility's failure to be in compliance with the Conditions of Participation in Governing Body and Client Protection.	W 000		
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.	W 102		

RECEIVED DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 2008 MAY -9 P 2:06

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Constance A. Reese — TITLE: Program Director — (X6) DATE: 5-8-08

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 102	Continued From page 1 This CONDITION is not met as evidenced by: The facility's governing body failed to maintain general operating direction over the facility to ensure the provision of active treatment and the clients' health and safety [See W104 and W127]. The results of these systemic practices revealed the facility's Governing Body failed to adequately govern the facility in a manner that would ensure clients' were free from neglect. [See also W122]	W 102	Cross reference W104	5/5/08
W 104	483.410(a)(1) GOVERNING BODY 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 facility's Governing Body failed to monitor and/or revise its operation directions to ensure the facility's environment was appropriate and provided for the health and safety as well as active treatment services for one of the four clients (Client #1) included in the sample. The finding includes: Observation at the residential facility on April 2, 2008 at approximately 4:41 PM revealed Client #1 entering the facility. The client required the assistance of two direct care staff (one on each side of the client) to ambulate to the recliner chair that was located in the living room. Interview with staff on April 2, 2008 at approximately 5:02 PM revealed that Client #1 required the support of at least two people to ascend the exterior front stairwell in order to enter the facility. Staff further	W 104		

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W 104	Continued From page 2 revealed that Client #1 sometimes must be carried up the stairwell. Observation of at the residential facility on April 4, 2008 at approximately 3:44 PM revealed Client #1 entering the facility with the assistance of three staff members. The staff were positioned behind, to the right, and in front of Client #1 in order to assist him into the facility. While ambulating from the front entrance to the recliner chair, the client was observed to have the assistance of two staff persons. Interview was conducted with the Qualified Mental Retardation Professional (QMRP) and former House Manager (HM) on April 4, 2008 at 5:26 PM to ascertain information about the aforementioned concern regarding Client #1 's ambulation into/out of and around the facility. According to the interview, Client #1 was being assessed to transition to another residential placement. The QMRP revealed that on March 12, 2008 the Interdisciplinary team initiated a plan that would include Client #1 moving to a more barrier free environment. The plan consisted of acquiring a physical therapy assessment, obtaining a neurological evaluation and a cardiology evaluation. The team further agreed to reconvene regarding the matter in thirty days. It should be further noted that the former HM revealed that the facility had been meeting with the Department of Disability Services (DDS) since 2006 regarding Client #1 transitioning out of the facility. Continued interview with the former HM revealed that since 2006 Client #1's case manager has changed and the change caused a delay in his transition into another home. The former HM also revealed that the client' s functioning had decreased within the past year.	W 104	Client #1's DDS case manager submitted a referral for a barrier free environment on 04/08/08. CMS, Inc. Program Director submitted a letter to Client #1's case manager, attorney, and guardian to identify a barrier free facility for Client #1. The facility will communicate with DDS twice a month to follow-up on Client#1's placement.	5/05/08

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W 104	Continued From page 3 Interview with the nurse on April 3, 2008 at 6:00 PM also revealed that Client #1 needed a more barrier free environment. Review of Client #1' s records on April 4, 2008 at 5:25 PM revealed a social work assessment dated August 2, 2007. According to the review of the assessment, the consultant recommended to "locate a facility that is barrier reduced for his placement." At the time of the survey, the governing body failed to ensure the matter regarding Client #1's new placement had been adequately addressed in order to provide a more barrier free living environment.	W 104		
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that outside services met the needs of two of four clients (Client #1 and Client #4) included in the sample. The findings include: 1. The facility failed to ensure the day program staff provided Client #1 with meals that were prepared in accordance with his prescribed dietary order. Observation of the dinner meal on the evening of April 2, 2008 at approximately 5:47 PM and staff interview revealed Client #1 was served fish sticks, creamed corn, collard greens, milk, water and peaches. Client #1's meal was pureed and	W 120		

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W 120	Continued From page 4 his beverages were thickened. A staff member was further observed to be situated next to the client during his meal. It should be noted that the client was also observed to be edentulous. Review of Client #1's April 2008 Physician's Orders on April 3,2008 at 4:47 PM revealed he was prescribed a low sodium, low fat, low cholesterol pureed diet and thickener was to be added to his liquids. Observation at Client #1's day program on April 4, 2008 at approximately 11:48 AM revealed the client seated at a table in a room eating lunch with his peers. Closer observation and interview with the day program staff revealed the client was eating greens, breaded fish fillet, macaroni and cheese, juice and milk. It should be noted however, that Client #1's fish fillet was cut up into bite sized pieces; the macaroni and cheese and the prepared collard greens were portioned and served without any special modifications to their form and/or consistency as required by Client #1's dietary order. Continued observation revealed that staff were present in the dining room but intermittently left the room. Day program staff was not observed to be continuously by his side during the lunch. While the Client #1 was eating his lunch, the day program staff monitoring the meal was asked if she was aware of the client's dietary order and aware that the client had not received the correct textured diet. The staff person acknowledged the client's dietary order as a pureed diet with thickened beverages, but failed to intervene with the served meal in order to provide the client with the correct textured diet. Due to the staff members failure to address the observed food texture concern, the staff member was asked	W 120		

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W 120	Continued From page 5 who was responsible for preparing the clients' meals at the day program. The staff member replied that it was the responsibility of another staff member at the day program and further indicated that the responsible staff person was in the kitchen. Interview was conducted with the staff person responsible for preparing Client #1's meal on April 4, 2008 at 11:52 AM to ascertain if she was aware of Client #1's prescribed dietary order. According to that staff person Client #1's meal was to be pureed or chopped. The staff member further revealed a document, located in the kitchen, that indicated Client #1 was to receive a No Added Salt (NAS), low fat, low cholesterol pureed diet with thickened liquids. When the staff member was informed of the consistency of the meal that was served to Client #1, she indicated he could eat it in the manner it was served. Interview was conducted with the day program nurse on April 4, 2008 at 12:04 PM that revealed Client #1 was to have a pureed diet due to being at risk for aspiration. When the nurse was informed that Client #1's meal was not served as prescribed, she immediately stopped the client from eating and told the kitchen staff person to prepare another meal for him in accordance with his dietary order (pureed). At the time of the survey, the facility failed to ensure the day program provided Client #1's meal in accordance with his prescribed dietary order. (See also W127) 2. The facility failed to ensure infection control techniques were systematically implemented at the day program.	W 120	1.) A meeting was held at Client #1's day program on 04/10/08. Client #1's diet was reviewed. The facility requested that staff be trained on Client#1's diet, feeding protocol, and one to one supervision prior to Client #1's return to the program. The day program trained their staff and provided an activity schedule for Client #1. In the future, the QMRP will make unannounced visits at Client #1's day program during lunch to ensure they adhere to his diet.	5/05/08

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W 120	Continued From page 6 Observation at Client #4's day program on April 3, 2008, beginning at 10:06 AM revealed the client's fingernails were missing on both of his thumbs. The exposed area on each thumb appeared to be discolored (brownish pink). Staff were interviewed on April 3, 2008 at 10:35 AM to ascertain if they were aware of the aforementioned observation (no thumb nails). The staff revealed that they were not aware that the client had no nails on his thumbs and instructed the surveyor to talk with the day program nurse. Interview with the day program nurse on April 3, 2008 at 10:48 AM revealed that the nurse was not aware of the missing thumb nails. After being notified of the observation, the nurse examined Client #4's thumbs and revealed that they were infected. Continued observation at Client #4's day program on April 3, 2008, at 10:58 AM revealed the client assisting with setting the table for lunch. The client was observed to place plastic bibs, cups and Dycem mats on the table. At 11:00 AM, after setting the items on the table and prior to disseminating them at each place setting, the client was observed to stick his hands in his mouth. Staff witnessed the action and escorted the client to the restroom to wash his hands. The client then returned to the table to place the items at each place setting. It should be noted however, that the day program staff failed to provide any protective covering for the client's hands to prevent the contamination of the items despite the nurse acknowledging the fact that the client's thumbs were infected.	W 120	2. A meeting will be held at Client #4's day program to discuss Infection Control and revising Client #4's goal to prevent contamination.	5/23/08
W 122	483.420 CLIENT PROTECTIONS	W 122		

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W 122	Continued From page 7 The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the health and safety of each client by making certain all meals were served in accordance with prescribed dietary orders [See W127]; failed to ensure parents/guardians were notified of serious incidents [See W148]; failed to implement policies and procedures that ensured clients' health and safety [See W149]; and failed to ensure that all injuries of unknown source were reported [See W153]; failed to ensure that prior to the use of more restrictive techniques, the client's record documented that programs incorporating less intrusive techniques had been attempted and were ineffective [See W278]; failed to provide barrier free environment to ensure client's health and safety risk [W104]; and failed to provide 1:1 supervision to ensure clients' health and safety [W249]. The effects of these systemic practices results in the failure of the facility to protect its clients and to ensure their health and safety.	W 122	Cross reference W120, W148, W149, W249, W104, W249	6/8/08
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.	W 124		

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W 124	Continued From page 8 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the rights of each client and/or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment, for one of the four clients (Client #3) included in the sample. The finding includes: The facility failed to provide evidence that informed consent was obtained from Client #3 and/or his legal guardian for an increase in dosage of his psychotropic medication. Observation of the evening medication administration on April 2, 2008 at approximately 7:15 PM revealed Client #3 received medications including Seroquel FC 400 mg and Naltrexone Hydrochloride 50 mg. Interview with the medication nurse during the medication administration revealed the aforementioned medications were used to address the client's behaviors. Interview with the former House Manager (HM) on April 2, 2008 at 9:40 AM revealed that Client #3 did not have the capacity to give informed consent for the use of medications and habilitation services. The former HM's statement was verified on April 4, 2008 at 12:39 PM through review of Client #3's psychological assessment dated July 9, 2007. According to the assessment, Client #3 "does not evidence the capacity to make decisions on his own behalf regarding granting, refusing, and/or withdrawing consent to medical	W 124		

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W 124	Continued From page 9 treatments; regarding treatments other than medical, regarding habilitation, day programming or work; regarding type and place of residence; regarding finances; and/or regarding life planning; and he does not have the capacity to execute a durable power of attorney." Additionally, continued interview with the HM on April 2, 2008 revealed that Client #3 did not have a legal guardian. Review of Client #3's medical record on April 3, 2008 at 5:30 PM revealed a written physician's order dated July 12, 2007 that documented to increase the client's Seroquel to 300 mg twice a day (previous order indicated Client #3 received Seroquel 100 mg in the morning and 200 mg in the evening). Continued review of Client #3's written physician's orders revealed an additional increase in the the client's Seroquel on October 11, 2007 to 400 mg twice daily. Interview was conducted with the Qualified Mental Retardation Professional (QMRP) on April 3, 2008 at 5:40 PM that revealed that Client #3's medication was increased due to an increase in the client's exhibited behaviors. The QMRP was then queried to ascertain if Client #3 and/or his legally authorized representative was informed of the medication increases and to determine if consent was obtained for the medication changes. The QMRP revealed that there were consents obtained from Client #3's father located in his record. However, review of Client #3's record and further discussion with the QMRP failed to provide evidence that any type of consent (written and/or informed) had been obtained prior to the aforementioned psychotropic medication increases. At the time of the survey, the facility failed to provide evidence that informed consent was obtained from the Client #3 and/or legally	W 124	The ~~facility~~ is currently awaiting for a limited guardianship hearing for Client #3. At the hearing a limited guardian will be identified. The QMRP will continue to follow-up with Client #3's case manager weekly regarding the status. Meanwhile, the QMRP will contact Client #3's father to get consent for the use of psychotropic medication.	5/14/08

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W 124	Continued From page 10 authorized representative for the increase in his psychotropic medications.	W 124		
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 staff interview and record review, the facility failed to ensure that a system had been developed to inform each client, parent or legal guardian of the client's behavioral status, risk of treatment, and the right to refuse treatment for one of four clients (Client #3) in the sample. The finding includes: The facility failed to ensure clients' rights were protected by making certain each client had a legally sanctioned representative to assist them with making decisions regarding their treatment. [See W124]	W 125	Cross reference W124	5/14/08
W 127	483.420(a)(5) PROTECTION OF CLIENTS RIGHTS 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 observation, interview and record	W 127		

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W 127	Continued From page 11 review, the facility failed to ensure the health and safety of one client by making certain all meals were served in accordance with prescribed dietary orders, for one of the four clients (Client #1) included in the sample. The facility failed to ensure Client #1's day program provided Client #1 with meals that were prepared in accordance with his prescribed dietary order. The finding includes: A. Observation of the dinner meal on the evening of April 2, 2008 at approximately 5:47 PM and staff interview revealed Client #1 was served fishsticks, creamed corn, collard greens, milk, water and peaches. Client #1's meal was pureed and his beverages were thickened. A staff member was further observed to be situated next to the client during his meal. It should be noted that the client was also observed to be edentulous. Review of Client #1's April 2008 Physician's Orders on April 3,2008 at 4:47 PM revealed he was prescribed a low sodium, low fat, low cholesterol pureed diet and thickener was to be added to his liquids. Observation at Client #1's day program on April 4, 2008 at approximately 11:48 AM revealed the client seated at a table in a room eating lunch with his peers. Closer observation and interview with the day program staff revealed the client was eating greens, breaded fish fillet, macaroni and cheese, juice and milk. It should be noted however, that Client #1's fish fillet was cut up into bite sized pieces; the macaroni and cheese and the prepared collard greens were portioned and served without any special modifications to their	W 127	Cross reference W120 #1	05/05/08

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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 04/04/2008
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W 127	Continued From page 12 form and/or consistency as required by Client #1's dietary order. Continued observation revealed that staff were present in the dining room but intermittently left the room. Day program staff was not observed to be continuously by his side during the lunch. While the Client #1 was eating his lunch, the day program staff monitoring the meal was asked if she was aware of the client's dietary order and aware that the client had not received the correct textured diet. The staff person acknowledged the client's dietary order as a pureed diet with thickened beverages, but failed to intervene with the served meal in order to provide the client with the correct textured diet. Due to the staff members failure to address the observed food texture concern, the staff member was asked who was responsible for preparing the clients' meals at the day program. The staff member replied that it was the responsibility of another staff member at the day program and further indicated that the responsible staff person was in the kitchen. Interview was conducted with the staff person responsible for preparing Client #1's meal on April 4, 2008 at 11:52 AM to ascertain if she was aware of Client #1's prescribed dietary order. According to that staff person Client #1's meal was to be pureed or chopped. The staff member further revealed a document, located in the kitchen, that indicated Client #1 was to receive a No Added Salt (NAS), low fat, low cholesterol pureed diet with thickened liquids. When the staff member was informed of the consistency of the meal that was served to Client #1, she indicated he could eat it in the manner it was served.	W 127		

PRINTED: 04/25/2008
FORM APPROVED
OMB NO. 0938-0391

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

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W 127	Continued From page 13 Interview was conducted with the day program nurse on April 4, 2008 at 12:04 PM that revealed Client #1 was to have a pureed diet due to being at risk for aspiration. When the nurse was informed that Client #1's meal was not served as prescribed, she immediately stopped the client from eating and told the kitchen staff person to prepare another meal for him in accordance with his dietary order (pureed). B. Interview was conducted with the residential facility's former House Manager (HM) and Qualified Mental Retardation Professional (QMRP) on April 4, 2008 at 5:13 PM to verify Client #1's dietary order and ascertain the reason why the client was prescribed his pureed diet with thickened beverages. According to the HM, Client #1 received a pureed diet with thickened liquids due his risk for aspiration. Review of Client #1's records on April 4, 2008, at approximately 7:35 PM revealed a speech and language evaluation dated August 1, 2007. According to the assessment, "Client #1 has a history of aspiration of thin liquids. A Modified Barium Swallow study was last conducted in May 2001 at Washington Hospital Center. A moderate to severe oral phase of swallow was detected. Coughing and choking were noted to occur after swallow initiation." Continued review of the assessment revealed a recommendation that documented , "one to one supervision at mealtimes is needed." The assessment also documented that Client #1 tolerated a "blenderized pureed diet with thickened liquids (pudding consistency)." It further described his eating at mealtimes and indicated that he had "the tendency to shovel his food..."	W 127		

PRINTED: 04/25/2008
FORM APPROVED
OMB NO. 0938-0391

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

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W 127	Continued From page 14 Note: The QMRP was notified on April 4, 2008 at 5:28 PM of the State Agency's determination that the day program's failure to provide Client #1 with meals in accordance with his prescribed dietary order. This failure resulted in neglect which posed a serious and immediate threat to Client #1's health and safety. The surveyors remained onsite until the facility addressed the serious and immediate jeopardy by initiating a plan that prohibited Client #1's return to the day program until his mealtime service at the program was addressed. The support was designed to protect Client #1 from potential harm.	W 127	Cross reference W120 #1	5/5/08
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure parents/guardians were notified of serious incidents, for one of four clients (Client #6) residing in the facility. The finding includes: Review of the facility's incident reports on April 2, 2008 beginning at 10:23 AM revealed an incident involving Client #6 dated June 29, 2007. According to the report, Client #6 was administered Client #7's medications. Interview was conducted with the former House Manager (HM) on April 2, 2008 at 9:40 AM that revealed that Client #6 had a brother that was his legal	W 148	In the future, Client #6's guardian will be notified when there is an incident involving the facility. The facility will contact the individuals' guardian/ family when there is an incident.	5/6/08

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

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FORM APPROVED
OMB NO. 0938-0391

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	09G037		04/04/2008

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W 148	Continued From page 15 guardian and was involved with his care. At the time of the survey, however, there was no documented evidence that revealed Client #6's brother was notified of the aforementioned incident.	W 148		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to implement policies that ensured the client's health and safety, for one of the four clients (Client #1) included in the sample. The findings include: The facility failed to ensure the timely reporting of incidents as documented in its "Incident Management" policy. Review of the facility's incident reports on April 2, 2008 beginning at 10:23 AM revealed an incident involving Client #7 dated February 11, 2008. According to the report, Client #7 was discovered with a cut on his forehead. Interview was conducted with the former House Manager (HM) on April 2, 2008 at 10:35 AM to ascertain information regarding the facility's incident management system. According to the former HM, incidents were to be reported to the administrator. The former HM's statement was verified on April 2, 2008 at approximately 11:00 AM when the facility's incident management policy and corresponding protocol were reviewed.	W 149	In the future, the facility will ensure that all incidents are reported in a timely manner. The management staff will recieve additional training on the incident management policy.	6/3/08

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

PRINTED: 04/25/2008
FORM APPROVED
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W 149	Continued From page 16 According to the protocol entitled "Serious Reportable Incidents," immediate verbal notifications were to be completed for incidents that documented injuries of unknown origin. Review of the facility's incident management policy documented that the administrator was to be verbally notified. At the time of the survey however, the facility failed to provide evidence that the administrator was notified of the aformentioned incident (See W153). Additionally, the facility failed to provide evidence that the incident management policy and protocol were implemented as outlined.	W 149		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS 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 facility failed to ensure that all injurious of unknown source were immediately reported to the administrator or to other officials in accordance with State law, for one of the seven clients (Client #6) that resided in the facility. The finding includes: Review of the facility's incident reports on April 2, 2008, beginning at 10:23 AM revealed an incident involving Client #7 dated February 11, 2008. According to the report, Client #7 was discovered	W 153	Cross reference W149	06/3/08

PRINTED: 04/25/2008
FORM APPROVED
OMB NO. 0938-0391

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

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	09G037		04/04/2008

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W 153	Continued From page 17 with a cut on his forehead. Interview was conducted with the former House Manager (HM) on April 2, 2008 at 10:35 AM to ascertain information regarding the facility's incident management system. According to the former HM, all incidents were to be reported to the administrator. Further review of the incident report however, revealed that there was no documented evidence that indicated the administrator had been notified. At the time of the survey, the facility failed to provide evidence that ensured the administrator was immediately notified of the aforementioned incident.	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 observation, interview and record review, the facility failed to ensure each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP), for three of the four clients (Clients #1, #2, and #4) that resided in the facility. The findings include: 1. The QMRP failed to ensure staff were effectively trained to implement Client #3's Behavior Support Plan. [See W194] 2. The QMRP failed to ensure a comprehensive functional assessment of behavioral needs was	W 159	1. The facility will train the staff on Client #3's BSP, intervention strategies, and documentation on 5/23/08. 2. Cross reference W214	5/23/08 5/14/08

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OMB NO. 0938-0391

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W 159	Continued From page 18 conducted for Client #4. [See W214] 3. The QMRP failed to ensure objectives documented in the Individual Program Plan (IPP) were stated separately, in terms of a single behavioral outcome for Client #3. [See W229] 4. The QMRP failed to ensure that Client #3 received continuous active treatment services and needed interventions. [See W249] 5. The QMRP failed to ensure that prior to the use of more restrictive techniques, the client's record documented that programs incorporating less intrusive techniques had been attempted and were ineffective. [See W278] 6. The QMRP failed to ensure Client #3's behavior support plan and corresponding data collection forms were effectively monitored. Interview with the QMRP and review of Client #3's records on April 4, 2008 at 12:39 PM revealed the client had a Behavior Support Plan (BSP) dated November 26, 2007. The plan documented that Client #3 had challenging behaviors of non-compliance, physical aggression, eloping, spitting, hoarding, masturbation, repetitive fiddling, touching others and pulling his hair. Continued review of the BSP on April 4, 2008 revealed intervention strategies (verbal redirection and touch control) were used to assist Client #3 with his challenging behaviors. According to the plan, verbal redirection was to be used by staff whenever Client #3 was about to engage in and/or engaged in any one of his targeted behaviors. The plan further indicated that touch control was to be utilized if the verbal	W 159	3. Cross reference W229 4. Cross reference W249 5. Cross reference W249 6. The facility will train the staff on Client #3's BSP, intervention strategies, and documentation on 5/23/08. In the future, the QMRP will review the Clients' data monthly to ensure proper documentation.	5/14/08 5/14/08 5/14/08 5/23/08

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W 159	Continued From page 19 redirection did not work and only if the situation was serious or important. The plan cautioned that touch control "should be a last resort" and used "only if quick action is required." The plan additionally documented that staff were responsible for documenting the "total frequencies of [Client #3's] behaviors and the frequencies of staff intervention steps" on the behavioral data sheet. Review of the corresponding data collection forms on April 4, 2008 at 10:32 AM revealed evidence that Client #3 exhibited challenging behaviors monthly. The data collection form was designed for staff to document the frequency that each behavior occurred and the intervention strategy (either verbal redirection or touch control) that was used. Continued review of the data collection forms however, revealed several occasions where intervention strategies were not utilized in accordance with Client #3's BSP when targeted behaviors were exhibited. For example: a. May 7, 2007 (12:00 AM to 8:00 AM shift) - The data collection form documented that Client #3 engaged in 1 incident of hoarding items, 2 incidents of pulling his hair, 1 incident of repetitive fiddling with objects, 2 incidents of non-compliance, and 3 incidents of inappropriate masturbation. Review of the intervention strategy documentation for the aforementioned date revealed that one instance of touch control was the only intervention utilized. b. May 12, 2007 (12:00 AM to 8:00 AM shift) - The data collection form documented that Client #3 engaged in 1 incident of repetitive fiddling with objects, 1 incident of spitting on people and 3 incidents of inappropriate masturbation. Review	W 159		

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W 159	Continued From page 20 of the intervention strategy documentation for the aforementioned date revealed no intervention strategies were implemented. c. May 22, 2007 (12:00 AM to 8:00 AM shift) - The data collection form documented that Client #3 engaged in 3 incidents of pulling his hair, 3 incidents of spitting on people and 2 incidents of inappropriate masturbation. Review of the intervention strategy documentation for the aforementioned date revealed that touch control (two times) was the only intervention utilized. d. May 23, 2007 (12:00 AM to 8:00 AM shift) - The data collection form documented that Client #3 engaged in 1 incident of spitting on people and 3 incidents of inappropriate masturbation. Review of the intervention strategy documentation for the aforementioned date revealed that touch control (three times) was the only intervention utilized. e. May 25, 2007 (12:00 AM to 8:00 AM shift) - The data collection form documented that Client #3 engaged in 3 incidents of spitting on people and 3 incidents of inappropriate masturbation. Review of the intervention strategy documentation for the aforementioned date revealed no intervention strategies were implemented. f. May 26, 2007 (8:00 AM to 4:00 PM shift) - The data collection form documented that Client #3 engaged in 3 incidents of hoarding items, 4 incidents of pulling his hair, 1 incident of repetitive fiddling with objects, 4 incidents of non-compliance, 3 incidents of aggression to others and 3 incidents of elopement related behavior. Review of the intervention strategy documentation for the aforementioned date	W 159		

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W 159	Continued From page 21 revealed no intervention strategies were implemented. g. May 31, 2007 (12:00 AM to 8:00 AM shift) - The data collection form documented that Client #3 engaged in 1 incidents of hoarding items. Review of the intervention strategy documentation for the aforementioned date revealed no intervention strategies were implemented. h. May 31, 2007 (8:00 AM to 4:00 PM shift) - The data collection form documented that Client #3 engaged in 3 incidents of inappropriate masturbation. Review of the intervention strategy documentation for the aforementioned date revealed no intervention strategies were implemented. i. June 12, 2007 (12:00 AM to 8:00 AM shift) - The data collection form documented that Client #3 did not engage in any of his targeted behaviors but touch control was used as an intervention strategy twice. j. June 16, 2007 (12:00 AM to 8:00 AM shift) - The data collection form documented that Client #3 did not engaged in 8 incidents of spitting on people. Review of the intervention strategy documentation for the aforementioned date revealed no intervention strategies were implemented. At the time of the survey, the facility failed to provide evidence that the QMRP effectively monitored Client #3's BSP to ensure that the data collection and/or the implementation of intervention strategies were completed/conducted in accordance with the BSP.	W 159		
W 194	483.430(e)(4) STAFF TRAINING PROGRAM	W 194		

PRINTED: 04/25/2008
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W 194	Continued From page 22 Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible. This STANDARD is not met as evidenced by: Based on observation, interviews and the review of records, the facility's staff failed to demonstrate competency in the implementation of each clients Individual Program Plan (IPP) for one of the four clients included in the sample. (Client #3) The finding includes: The facility failed to provide evidence that the direct care staff were able to demonstrate competency in the implementation of Client #3's Behavior Support Plan (BSP). Observation on Client #3 on April 2, 2008 at 5:12 PM revealed the client standing in the dining room with a plastic egg in his hand. The client was observed to open and close the egg several times. The client was also observed inserting his index finger in the egg then rubbing his finger across his lower lip on several occasions. It should be noted that at least one direct care staff was present and witnessed the activity. Interview with the Qualified Mental Retardation Professional (QMRP) and review of Client #3's records on April 4, 2008 at 12:39 PM revealed the client had a BSP dated November 26, 2007. The plan documented that Client #3 had several challenging behaviors including repetitive fiddling. The plan further documented strategies that incorporated the use of verbal redirection and/or if	W 194		

PRINTED: 04/25/2008
FORM APPROVED
OMB NO. 0938-0391

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W 194	Continued From page 23 necessary touch control whenever Client #3 engaged in any of his targeted behaviors. Additionally, the plan included the use of 1:1 staffing supports at all times to assist the client with addressing all of his targeted behaviors During the aforementioned observation, staff was not observed to intervene and/or address the client's fiddling. Furthermore, throughout the survey, Client #3 was not observed to have 1:1 staffing supports at all times.(See also W249). At the time of the survey, the facility failed to ensure staff were able to demonstrate skills necessary to implement Client #3's behavior support plan consistently and as outlined.	W 194	Cross reference W249	5/14/08
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure a comprehensive functional assessment of behavioral needs was conducted for one of four clients (Client #4) included in the sample. The finding includes: The facility failed to assess Client #4's thumb-sucking behavior. On April 2, 2008, Client #4 was observed in the home between 4:46 PM and 6:31 PM. At 5:14 PM and 5:28 PM, the client was observed sucking his thumb. The client was observed on April 3, 2008 in his	W 214		

PRINTED: 04/25/2008
FORM APPROVED
OMB NO. 0938-0391

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W 214	Continued From page 24 day program between 10:02 AM and 11:06 AM. At 10:11 AM, an interview was conducted with the client's day program case manager and classroom coordinator. According to the day program case manager, Client #4 had a Behavior Support Plan (BSP) that included targeted behaviors of aggression and self-injurious behavior (handbiting). When further queried regarding the client's exhibited behavior of thumbsucking, the case manager and the classroom coordinator both reported that they had not observed the client sucking his thumbs. It should be noted however, that continued observation of the client at the day program on April 3, 2008 between 10:42 AM and 10:56 AM revealed the client sucked his right thumb on several occasions. At 11:00 AM, while assisting staff in the lunch room, Client #4 was not only observed to suck his thumbs but he was observed with several fingers in his mouth. An interview was conducted on April 2, 2008 at 6:42 PM with the facility's former house manager who confirmed that the client routinely sucked his thumb, however, thumb sucking was not among the behaviors targeted in his BSP. Furthermore, interview with the facility's Registered Nurse verified that Client #4's thumbsucking was a behavior. At the time of the survey, the facility failed to provide evidence that Client #4's observed thumbsucking behavior had been assessed and addressed as warranted.	W 214	The facility psychologist will clarify, revise, and expand Client #4's BSP of thumbsucking.	5/14/08
W 229	483.440(c)(4)(i) INDIVIDUAL PROGRAM PLAN The objectives of the individual program plan must be stated separately, in terms of a single	W 229		

PRINTED: 04/25/2008
FORM APPROVED
OMB NO. 0938-0391

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

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 04/04/2008
NAME OF PROVIDER OR SUPPLIER CMS		STREET ADDRESS, CITY, STATE, ZIP CODE 3815 ALBERMARLE STREET NW WASHINGTON, DC 20008	

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W 229	Continued From page 25 behavioral outcome. This STANDARD is not met as evidenced by: Based on observation and record review, the facility failed to ensure objectives documented in the Individual Program Plan (IPP) were stated separately, in terms of a single behavioral outcome, for one of the four clients (Client #3) included in the sample. The finding includes: Observation of Client #3 on April 2, 2008 at 5:19 PM revealed the client exhibited repetitive fiddling behavior. Review of Client #3's habilitation record on April 4, 2008 at 10:04 AM revealed a Behavior Support Plan (BSP) dated November 26, 2007. According to the BSP Client #3 had challenging behaviors that included touching others, hoarding, pulling his hair, aggression to others, repetitive fiddling, noncompliance, spitting on people, and inappropriate masturbation. Continued review of the BSP revealed there was only one objective documented in the plan. The objective was documented as "reduce inappropriate behaviors to zero per month." Interview with the Qualified Mental Retardation Professional (QMRP) on April 4, 2008 at 10:32 AM revealed that the one objective (reduce inappropriate behaviors) was used to measure each of the aforementioned challenging behaviors. At the time of the survey, the facility failed to ensure that Client #3's BSP documented objectives separately, making certain that each objective identified a single behavioral outcome.	W 229	The facility's psychologist will revise Client #3's Behavioral objective to list it separately therefore it could be measured.	5/14/08
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION	W 249		

PRINTED: 04/25/2008
FORM APPROVED
OMB NO. 0938-0391

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

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 04/04/2008
NAME OF PROVIDER OR SUPPLIER C M S		STREET ADDRESS, CITY, STATE, ZIP CODE 3815 ALBERMARLE STREET NW WASHINGTON, DC 20008	

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W 249	Continued From page 26 As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure each client received continuous active treatment services, including needed interventions, for one of the four clients (Client #3) included in the sample. The finding includes: The facility failed to implement Client #3's Behavior Support Plan (BSP) as evidenced below: During the entrance conference on April 2, 2008, at approximately 9:40 AM, interview with the former House Manager (HM) revealed that Client #3 received 1:1 supervision for eight (8) hours daily. The former HM further revealed that Client #3 received the 1:1 staffing supports only while at the day program. The special staffing support was implemented to assist Client #3 with addressing maladaptive behaviors of elopement, aggression and self injurious behaviors. Observation of Client #3 on the evening of April 2, 2008 (between 4:31 PM and 6:35 PM) and observation of Client #3 on April 3, 2008 at his	W 249		

PRINTED: 04/25/2008
FORM APPROVED
OMB NO. 0938-0391

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

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 04/04/2008
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W 249	Continued From page 27 day program (from 11:56 AM-12:14 PM) verified the aforementioned staffing supports. Client #3 was not observed to have a 1:1 staff while in the residential facility but was observed to have the assistance of the 1:1 staff person while at the day program. Interview was conducted with Client #3's 1:1 staff on April 3, 2008 at 12:08 PM to ascertain information regarding the 1:1's responsibilities. According to the interview, the 1:1 staff revealed that he/she provided 1:1 support for Client #3 Monday through Friday. The 1:1 further indicated that Client #3 had behaviors of elopement and aggression and having 1:1 supports assisted the client with addressing those behaviors. Interview with the Qualified Mental Retardation Professional (QMRP) and review of Client #3's records on April 4, 2008 at 12:39 PM revealed the client had a Behavior Support Plan (BSP) dated November 26, 2007. The plan documented that Client #3 had challenging behaviors of non-compliance, physical aggression, eloping, spitting, hoarding, masturbation, repetitive fiddling, touching others and pulling his hair. Continued review of the plan revealed a section entitled, "Need for 1:1 Staffing." According to that section, the plan documented that "Client #3 is primarily a danger to himself and/or others without a 1:1 staff person at all times. He has a psychiatric Axis I: Impulse Control Disorder and his behaviors are unpredictable day, night, weekends, upstairs, downstairs, on the van and anywhere at anytime. For example, [Client #3] may at any moment suddenly attempt to elope or he may grab another person sexually. To a less dangerous extent he may embarrass himself or	W 249		

PRINTED: 04/25/2008
FORM APPROVED
OMB NO. 0938-0391

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

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 04/04/2008
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W 249	Continued From page 28	W 249		

others by acting out sexually or inappropriately at anytime without a 1:1 staff person monitoring his behaviors around others, in front of windows, etc... [Client#3] does much better when a familiar staff person is next to him, immediately next to him." The plan further documented that the "[Client #3] is also a danger to others when he is not properly redirected by someone such as a 1:1, as he may be more aggressive at these times. It should be noted that the aforementioned information was found not only in the BSP dated November 26, 2007 but also in Client #3's previous BSP's dated February 21, 2007 and August 9, 2007.

Review of the corresponding data sheets between the months of April 2007 and June 2007 revealed the following information regarding the frequency of Client #3's exhibited challenging behaviors of elopement, inappropriately touching others, pulling his hair and aggression. For example;

April 2007 - 1 incident of touching others and 78 incidents of pulling his hair.
May 2007 - 3 incidents of elopement, 3 touching others, 73 incidents of pulling his hair, 7 incidents of aggression.
June 2007 - 1 incident of elopement, 11 incidents of touching others, 70 incidents of pulling his hair, and 21 incidents of aggression.

Review of the facility Psychotropic Medication Review forms on April 3, 2008 at 5:31 PM revealed the client engaged in incidents of the aforementioned challenging behaviors as detailed below:

July 2007 - 1 incident of elopement related

PRINTED: 04/25/2008
FORM APPROVED
OMB NO. 0938-0391

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

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	09G037		04/04/2008

NAME OF PROVIDER OR SUPPLIER: C M S

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W 249	Continued From page 29 behavior, 1 incident of touching others, 158 incidents of pulling his hair, and 8 incidents of aggression. August 2007 - 1 incident of touching others, 69 incidents of pulling his hair, and 11 incidents of aggression. September 2007 -2 incidents of elopement behavior, 4 incidents of touching others, 185 incidents of pulling his hair, and 7 incidents of aggression. NOTE: Review of Client #3's records on April 3, 2008, at approximately 5:31 PM revealed a written physician's order (dated July 12, 2007) that documented the client was to increase his Seroquel from 100 mg every morning and Seroquel 200 mg every evening to Seroquel 300 mg twice daily. Continued review of the client's record on April 3, 2008, at 5:40 PM revealed another written physician's order dated October 11, 2007. The order documented that the client was prescribed to start Seroquel 400 mg twice a day. Interview with the Licensed Practical Nurse (LPN) on April 3, 2008 at 9:25 AM verified that the client's medication had been increased due to an increase in exhibited behaviors. It should be also noted that review of the client's records revealed the client continued to engage in the aforementioned challenging behaviors through March 2008. October 2007 - 0 incident of elopement related behavior, 0 incident of touching others, 43 incidents of pulling his hair, and 0 incidents of aggression. November 2007 - 8 incident of touching others, 55 incidents of pulling his hair, and 1incidents of aggression.	W 249	QMRP will submit a package to MAA requesting additional hours for one-to-one services for Client #3. The facility will increase Client #3's one-to-one hours from 8 hours Monday-Friday to waking hours Monday-Sunday.	5/14/08

PRINTED: 04/25/2008
FORM APPROVED
OMB NO. 0938-0391

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

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 04/04/2008
NAME OF PROVIDER OR SUPPLIER CMS		STREET ADDRESS, CITY, STATE, ZIP CODE 3815 ALBERMARLE STREET NW WASHINGTON, DC 20008	

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W 249	Continued From page 30 December 2007 -0 incidents of elopement behavior, 2 incidents of touching others, 55 incidents of pulling his hair, and 4 incidents of aggression. January 2008 - 1 incident of elopement related behavior, 1 incident of touching others, 158 incidents of pulling his hair, and 8 incidents of aggression. February 2008 - 1 incident of touching others, 69 incidents of pulling his hair, and 11 incidents of aggression. March 2008 - 0 incidents of elopement behavior, 1 incidents of touching others, 61 incidents of pulling his hair, and 0 incidents of aggression. At the time of the survey, the facility failed to ensure Client #3 was provided with continuous active treatment including needed supports to address his challenging behaviors.	W 249		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that Client #3's increase in psychotropic medication had been reviewed and approved by their Human Rights Committee (HRC). The finding includes:	W 262		

PRINTED: 04/25/2008
FORM APPROVED
OMB NO. 0938-0391

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

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 04/04/2008
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W 262	Continued From page 31 Observation of the evening medication administration on April 2, 2008 at approximately 7:15 PM revealed Client #3 received medications including Seroquel FC 400 mg and Naltrexone Hydrochloride 50 mg. Interview with the medication nurse during the medication administration revealed the aforementioned medications were used to address the client's behaviors. Review of Client #3's records on April 3, 2007, at approximately 5:31 PM revealed a written physician's order (dated July 12, 2007) that documented the client was to increase his Seroquel from 100 mg every morning and Seroquel 200 mg every evening to Seroquel 300 mg twice daily. Continued review of the client's record on April 3, 2008, at 5:40 PM revealed another written physician's order dated October 11, 2007. The order documented that the client was prescribed to start Seroquel 400 mg twice a day. Interview with the Licensed Practical Nurse (LPN) on April 3, 2008 at 9:25 AM verified that the client's medication had been increased due to an increase in exhibited behaviors. Interview with the Qualified Mental Retardation Professional (QMRP) and review of the facility's Human Rights Committee (HRC) meeting minutes on April 4, 2008 at 9:48 AM revealed HRC meetings dated were held July 2, 2007, August 6, 2007, October 8, 2007 and November 29, 2007. Review of the corresponding meeting minutes for the aforementioned dates failed to provide evidence that the increases in Client #3's Seroquel had been reviewed and approved. At the time of the survey, the facility failed to ensure its HRC reviewed and approved Client #3's psychotropic medication increase prior to its	W 262	In the future, the QMRP will ensure that Client #3's increase of psychotropic medication will be approved by the HRC prior to it's administration. The HRC will be present at the medication review to review Clients' change of medication.	5/23/08

PRINTED: 04/25/2008
FORM APPROVED
OMB NO. 0938-0391

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

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W 262	Continued From page 32	W 262		
	administration.			
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's Human Rights Committee (HRC) failed to ensure written informed consent had been obtained from the client and/or their legal guardian for the use of behavior support plans, for one of the four clients (Client #3) included in the sample. The finding includes: Observation of the evening medication administration on April 2, 2008 at approximately 7:15 PM revealed Client #3 received medications including Seroquel FC 400 mg and Naltrexone Hydrochloride 50 mg. Interview with the medication nurse during the medication administration revealed the aforementioned medications were used to address the client's behaviors. Review of Client #3's record on on April 4, 2008 at 12:39 PM revealed the client had a Behavior Support Plan (BSP) dated November 26, 2007. The plan documented restrictive techniques that included 1:1 staffing supports, touch control and the use of psychotropic medications (Revia and Seroquel). It should be noted that interview with the former House Manager (HM) on April 2, 2008	W 263		

PRINTED: 04/25/2008
FORM APPROVED
OMB NO. 0938-0391

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

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W 263	Continued From page 33 at 9:40 AM revealed that Client #3 did not have the capacity to give informed consent for the use of medications and habilitation services. The former HM's statement was verified on April 4, 2008 at 12:39 PM through review of Client #3's psychological assessment dated July 9, 2007. Additionally, continued interview with the former HM on April 2, 2008 revealed that Client #3 did not have a legal guardian. At the time of the survey, the facility failed to provide evidence that its Human Rights Committee had obtained written informed consent for the use of Client #3's behavior support plan from a legally authorized representative. [See also W124]	W 263	Cross reference W124	5/14/08
W 278	483.450(b)(1)(iii) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Procedures that govern the management of inappropriate client behavior must insure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective. This STANDARD is not met as evidenced by: Based on interview, observation, and record review, the facility failed to ensure that prior to the use of more restrictive techniques, the client's record documented that programs incorporating less intrusive techniques had been attempted and were ineffective, for one of the four clients (Client #3) included in the sample. The finding includes: Review of Client #3's records on April 3, 2008, at approximately 5:31 PM revealed a written	W 278		

PRINTED: 04/25/2008
FORM APPROVED
OMB NO. 0938-0391

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		04/04/2008

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

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W 278	Continued From page 34 physician's order (dated July 12, 2007) that documented the client was to increase his Seroquel from 100 mg every morning and Seroquel 200 mg every evening to Seroquel 300 mg twice daily. Continued review of the client's record on April 3, 2008, at 5:40 PM revealed another written physician's order dated October 11, 2007. The order documented that the client was prescribed to start Seroquel 400 mg twice a day. Interview with the Licensed Practical Nurse (LPN) on April 3, 2008 at 9:25 AM verified that the client's medication had been increased due to an increase in exhibited behaviors. (Cross Refer W249) Interview with the former House Manager (HM)on April 2, 2008, at approximately 9:40 AM revealed that Client #3 received 1:1 supervision for eight (8) hours daily. The former HM further revealed that Client #3 received the 1:1 staffing supports only while at the day program. The special staffing support was implemented to assist Client #3 with addressing maladaptive behaviors of elopement, aggression and self injurious behaviors. The former HM's statement was verified through observation on April 2, 2008 and April 3, 2008. Interview with the Qualified Mental Retardation Professional (QMRP) and review of Client #3's records on April 4, 2008 at 12:39 PM revealed the client had a Behavior Support Plan (BSP) dated November 26, 2007. The plan documented that Client #3 had challenging behaviors of non-compliance, physical aggression, eloping, spitting, hoarding, masturbation, repetitive fiddling, touching others and pulling his hair. Continued review of the plan revealed a section entitled, "Need for 1:1 Staffing." According to that section, the plan documented that "Client #3 is	W 278		

PRINTED: 04/25/2008
FORM APPROVED
OMB NO. 0938-0391

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		04/04/2008

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

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W 278	Continued From page 35 primarily a danger to himself and/or others without a 1:1 staff person at all times. He has a psychiatric Axis I: Impulse Control Disorder and his behaviors are unpredictable day, night, weekends, upstairs, downstairs, on the van and anywhere at anytime... [Client #3] does much better when a familiar staff person is next to him, immediately next to him." It should be noted that the aforementioned information was found not only in the BSP dated November 26, 2007 but also in Client #3's previous BSP's dated February 21, 2007 and August 9, 2007. Continued interview with the former HM on April 2, 2008 revealed that the facility had not been approved by the Medicaid Assistance Administration (MAA) for the cost of providing Client #3 with 1:1 staffing supports at all times and therefore, the special staffing supports had not been implemented as outlined. At the time of the survey, the facility failed to provide evidence that prior to the use of a more restrictive technique, a less restrictive technique had been implemented and proven to be ineffective in order to address Client #3's challenging behaviors. (See also W249)	W 278	Cross reference W249	5/14/08
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure general and preventative care services, for two of the four clients (Clients #2 and #4) included in the sample.	W 322		

PRINTED: 04/25/2008
FORM APPROVED
OMB NO. 0938-0391

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

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 04/04/2008
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W 322	Continued From page 36 The finding includes: 1. Observation of Client #4 at the residential facility on April 2, 2008, at 5:14 PM revealed the client was sucking his thumb. Closer observation revealed the client's fingernails were missing on both of his thumbs. The exposed area on each thumb appeared to be discolored (brownish pink). Interview with the former House Manager (HM) at 6:42 PM revealed that the client had an infection on both thumbs that would not heal because of the client's continuous thumb sucking behavior. Additionally, the former HM revealed that the client thumbs were being treated for an infection. Review of Client #4's medical record on April 4, 2008 at 5:17 revealed the client was seen by the dermatologist on July 17, 2007. According to the dermatological consultation form, the client was diagnosed with chronic paronychia affecting both thumbs that was secondary to his thumb sucking and behavioral nail trauma. The dermatologist prescribed Triamcinoloone Cream to be applied on the client's thumbs twice daily for three weeks. Additionally, the dermatologist recommended Castellani Paint to be applied once daily to deter the client from sucking his thumbs. Continued review of the consultation form revealed that the dermatologist documented that the Castellani Paint "would not initiate systemic antifungals as the problem is caused by a behavior. The foul taste of the Castellani Paint will deter thumb sucking and be therapeutic due to antifungal properties." It should be noted that interview with the nurse verified that Client #4's thumb sucking was a behavior and his nails would not heal until the thumb sucking ceased. At the time of the survey, the facility failed to provide evidence that services were being provided to effectively treat	W 322		

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OMB NO. 0938-0391

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

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 04/04/2008
NAME OF PROVIDER OR SUPPLIER CMS		STREET ADDRESS, CITY, STATE, ZIP CODE 3815 ALBERMARLE STREET NW WASHINGTON, DC 20008	

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W 322	Continued From page 37 Client #4's thumbs. (See also W214) 2. Review of Client #2's record on April 4, 2008 at 7:04 PM revealed the client was seen by an audiologist. Review of the consultation form revealed the client was recommended to return after his ears were cleared. Interview was conducted with the Qualified Mental Retardation Professional (QMRP) at approximately 7:10 PM to ascertain if the client had returned for the audiological revisit and/or find out if the revisit was scheduled. At the time of the survey, the facility failed to provide evidence that Client #2 was seen for a follow up audiological visit.	W 322	Client #2 is scheduled to follow-up with audiologist on 5/15/08. The primary nurse and the QMRP will meet monthly to review and ensure that medical appointments are scheduled ~~in a timely~~ manner.	5/15/08
W 325	482.460(a)(3)(iii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure routine laboratory studies were conducted, for one of the four clients (Client #1) included in the sample. The finding includes: 1. Review of Client #1's April 2008 Physician's Orders on April 3, 2008 at 4:47 PM revealed orders that documented the client receive laboratory tests including HBA1C every 3 months and a Liver Function Test (LFT) every 6 month. Interview with the nurse via telephone on April 4, 2008 and continued review of Client #1's record failed to provide evidence that the aforementioned recommended tests were	W 325	Client #1's LFT and HgbA1C was done on 4/24/08. The primary nurse ~~will~~ be responsible for scheduling bloodwork per physician order.	4/24/08

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W 325	Continued From page 38 conducted as ordered. 2. Review of Client #1's record on April 4, 2008 at 2:19 PM revealed the client had a urinalysis on October 23, 2007. Further review of the urinalysis results revealed the primary care physician signed the test and wrote a note indicating a urine culture and sensitivity test should be done. Interview was conducted with the Qualified Mental Retardation Professional (QMRP) on April 4, 2008 to ascertain if the urine culture and sensitivity had been completed. At the time of the survey, the facility failed to provide evidence that the urine culture and sensitivity test had been completed.	W 325	Client #1's urine specimen will be collected. The primary nurse will ensure specimen is collected and sent to the laboratory.	5/16/08
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 interview and record review, the facility's nursing services failed to ensure that each client received nursing services in accordance with their needs, for one of the four clients (Clients #1) included in the sample. The finding includes: (Cross Refer W127) Observation at Client #1's day program on April 4, 2008 revealed the client did not receive his meal in accordance with his prescribed dietary order (pureed with thickened beverages). Review of Client #1's records on April 4, 2008, at approximately 7:35 PM revealed a speech and language evaluation dated August 1, 2007. According to the assessment, "Client #1 has a history of aspiration of thin liquids. A	W 331		

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W 331	Continued From page 39 Modified Barium Swallow study was last conducted in May 2001 at Washington Hospital Center. A moderate to severe oral phase of swallow was detected. Coughing and choking were noted to occur after swallow initiation." Continued review of the assessment revealed a recommendation that documented , "one to one supervision at mealtimes is needed." The assessment also documented that Client #1 tolerated a "blenderized pureed diet with thickened liquids (pudding consistency)." It further described his eating at mealtimes and indicated that he had "the tendency to shovel his food..." Review of Client #1's Health Management Care Plan dated July 7, 2007 on April 3, 2008 at 6:23 PM revealed several documented risk areas/conditions. Further review of the care plan failed to indicate any information regarding the client being at risk for aspiration. Additionally, the care plan failed to document any risk management procedures to be utilized to assist Client #1 during meals.	W 331	Client #1's Health Management Care Plan will be updated to include the risk for aspiration.	5/16/08
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that medications were administered in compliance with the physician's orders, for one of four clients (Client #3) included in the sample. The finding includes:	W 368		

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W 368	Continued From page 40 Review of Client #3's medical record on April 3, 2008 beginning at 5:30 PM revealed a Physician's Order (POS) dated March 2008. Further review of the POS revealed that the client was prescribed Vitamin E Softgel 400 Unit Capsules twice daily for nutritional supplement. At 5:44 PM, review of the client's Medication Administration Record (MAR) revealed the Vitamin E was not administered from August 16, 2007, through August 23, 2007. Continued review of the MAR (on the back side) revealed on that the Vitamin E had not been administered because it was "not available." Interview was conducted with the facility's Registered Nurse to ascertain information regarding why the resident did not get the medication. The RN indicated that she could not remember why the medication was not administered. She further revealed that the Vitamin E was purchased over- the - counter and it was the responsibility of the primary nurse to make certain the medication was available. At the time of the survey, the facility failed to provide evidence that the medication prescribed by the physician for Client #3 was consistently given in compliance with the physician's orders.	W 368	Client #3 Vitamin E will be dispensed from the pharmacy with his other medications on a monthly basis. The primary nurse will ensure that all medications are delivered on a regular basis.	5/16/08
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.	W 440		

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W 440	Continued From page 41 The finding includes: Interview with the House Manager on April 2, 2008 at 1:10 PM revealed the direct care staff were assigned the following shifts of duty: Weekends/Weekdays 8:00 AM - 4:00 PM 4:00 PM - 12:00 AM 12:00 AM - 8:00 AM Weekends for 1:1 staff 8:00 AM - 8:00 PM 8:00 PM - 8:00 AM 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. At the time of the survey, the facility failed to provide evidence that evacuation drills were conducted quarterly for each shift of personnel.	W 440	In the future, the facility will conduct a fire drill quarterly during each shift. The QMRP and Residential Manager will review fire drill records quarterly and provide training on fire safety.	6/20/08

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I 000	INITIAL COMMENTS An annual relicensure survey was conducted from April 2, 2008 through April 4 2008. A random sample of four residents was selected from a residential population of seven males with mental retardation and other disabilities. The survey findings were based on observations in the group home and at four day programs, interviews and a review of records, including unusual incident reports.	I 000		
I 047	3502.5 MEAL SERVICE / DINING AREAS Each GHMRP shall be responsible for ensuring that meals, which are served away from the GHMRP, are suited to the dietary needs of residents as indicated in the Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure that meals served away from the GHMRP suited the residents dietary needs, for one of four residents (Resident #1) included in the sample. The finding includes: The facility failed to ensure the day program staff provided Resident #1 with meals that were prepared in accordance with his prescribed dietary order. Observation of the dinner meal on the evening of April 2, 2008 at approximately 5:47 PM and staff interview revealed Resident #1 was served fish sticks, creamed corn, collard greens, milk, water and peaches. Resident #1's meal was pureed and his beverages were thickened. A staff	I 047		

Health Regulation Administration

Constance A. Reese Program Director 5-9-08

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

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I 047	Continued From page 1 member was further observed to be situated next to the client during his meal. It should be noted that the resident was also observed to be edentulous. Review of Resident #1's April 2008 Physician's Orders on April 3,2008 at 4:47 PM revealed he was prescribed a low sodium, low fat, low cholesterol pureed diet and thickener was to be added to his liquids. Observation at Resident #1's day program on April 4, 2008 at approximately 11:48 AM revealed the client seated at a table in a room eating lunch with his peers. Closer observation and interview with the day program staff revealed the resident was eating greens, breaded fish fillet, macaroni and cheese, juice and milk. It should be noted however, that Resident #1's fish fillet was cut up into bite sized pieces; the macaroni and cheese and the prepared collard greens were portioned and served without any special modifications to their form and/or consistency as required by Resident #1's dietary order. Continued observation revealed that staff were present in the dining room but intermittently left the room. Day program staff was not observed to be continuously by his side during the lunch. While the Resident #1 was eating his lunch, the day program staff monitoring the meal was asked if she was aware of the client's dietary order and aware that the resident had not received the correct textured diet. The staff person acknowledged the client's dietary order as a pureed diet with thickened beverages, but failed to intervene with the served meal in order to provide the client with the correct textured diet. Due to the staff members failure to address the observed food texture concern, the staff member was asked who was responsible for preparing the residents' meals at the day program. The staff	I 047		

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I 047	Continued From page 2 member replied that it was the responsibility of another staff member at the day program and further indicated that the responsible staff person was in the kitchen. Interview was conducted with the staff person responsible for preparing Resident #1's meal on April 4, 2008 at 11:52 AM to ascertain if she was aware of Resident #1's prescribed dietary order. According to that staff person Resident #1's meal was to be pureed or chopped. The staff member further revealed a document, located in the kitchen, that indicated Resident #1 was to receive a No Added Salt (NAS), low fat, low cholesterol pureed diet with thickened liquids. When the staff member was informed of the consistency of the meal that was served to Resident #1, she indicated he could eat it in the manner it was served. Interview was conducted with the day program nurse on April 4, 2008 at 12:04 PM that revealed Resident #1 was to have a pureed diet due to being at risk for aspiration. When the nurse was informed that Resident #1's meal was not served as prescribed, she immediately stopped the resident from eating and told the kitchen staff person to prepare another meal for him in accordance with his dietary order (pureed). At the time of the survey, the facility failed to ensure the day program provided Resident #1's meal in accordance with his prescribed dietary order. (See also Federal Deficiency Report Citation W127)	I 047	Cross reference W120	5/5/08
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.	I 135		

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I 135	Continued From page 3 This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide evidence that simulated fire drills were conducted at least four times a year for each shift. The finding includes: Interview with the House Manager on April 2, 2008 at 1:10 PM revealed the direct care staff were assigned the following shifts of duty: Weekends/Weekdays 8:00 AM - 4:00 PM 4:00 PM - 12:00 AM 12:00 AM - 8:00 AM Weekends for 1:1 staff 8:00 AM - 8:00 PM 8:00 PM - 8:00 AM 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. At the time of the survey, the facility failed to provide evidence that evacuation drills were conducted quarterly for each shift of personnel. (See also Federal Deficiency Report Citation W440)	I 135	Cross reference W440	6/20/08
I 161	3507.2 POLICIES AND PROCEDURES The manual shall be approved by the governing body of the GHMRP and shall be reviewed at least annually.	I 161	In the future, the facility will ensure that the policy and procedure manual be reviewed	

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I 161	Continued From page 4	I 161	annually by the Program Director.	5/23/08
	This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide evidence that its governing body reviewed its policies and procedures annually. The finding includes: Interview with the former House Manager and review of the policy and procedure manual on April 2, 2008 at 3:46 failed to provide evidence that the governing body reviewed its policies and procedures annually. According to the policy and procedure manual the last date the governing body reviewed the manual was on November 21, 2006.			
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 GHMRP failed to ensure adequate administrative support had been provided to efficiently meet the needs of the residents as required by their habilitation plans, for three of the four residents (Residents #1, #3, and #4) included in the sample. The finding includes: 1. The QMRP failed to ensure staff were effectively trained to implement Client #3's Behavior Support Plan. [See W194]	I 180	1. Cross reference W159	5/23/08

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I 180	Continued From page 5	I 180		
	2. The QMRP failed to ensure a comprehensive functional assessment of behavioral needs was conducted for Client #4. [See W214]		2. Cross reference W214	5/14/08
	3. The QMRP failed to ensure objectives documented in the Individual Program Plan (IPP) were stated separately, in terms of a single behavioral outcome for Client #3. [See W229]		3. Cross reference W229	5/14/08
	4. The QMRP failed to ensure that Client #3 received continuous active treatment services and needed interventions. [See W249]		4. Cross reference W249	5/14/08
	5. The QMRP failed to ensure that prior to the use of more restrictive techniques, the client's record documented that programs incorporating less intrusive techniques had been attempted and were ineffective. [See W278]		5. Cross reference W249	5/14/08
	6. The QMRP failed to ensure Client #3's behavior support plan and corresponding data collection forms were effectively monitored.		6. Cross reference W159 #6	5/23/08
	Interview with the QMRP and review of Client #3's records on April 4, 2008 at 12:39 PM revealed the client had a Behavior Support Plan (BSP) dated November 26, 2007. The plan documented that Client #3 had challenging behaviors of non-compliance, physical aggression, eloping, spitting, hoarding, masturbation, repetitive fiddling, touching others and pulling his hair.			
	Continued review of the BSP on April 4, 2008 revealed intervention strategies (verbal redirection and touch control) were used to assist Client #3 with his challenging behaviors. According to the plan, verbal redirection was to be used by staff whenever Client #3 was about to engage in and/or engaged in any one of his			

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I 180	Continued From page 6 targeted behaviors. The plan further indicated that touch control was to be utilized if the verbal redirection did not work and only if the situation was serious or important. The plan cautioned that touch control "should be a last resort" and used "only if quick action is required." The plan additionally documented that staff were responsible for documenting the "total frequencies of [Client #3's] behaviors and the frequencies of staff intervention steps" on the behavioral data sheet. Review of the corresponding data collection forms on April 4, 2008 at 10:32 AM revealed evidence that Client #3 exhibited challenging behaviors monthly. The data collection form was designed for staff to document the frequency that each behavior occurred and the intervention strategy (either verbal redirection or touch control) that was used. Continued review of the data collection forms however, revealed several occasions where intervention strategies were not utilized in accordance with Client #3's BSP when targeted behaviors were exhibited. For example: a. May 7, 2007 (12:00 AM to 8:00 AM shift) - The data collection form documented that Client #3 engaged in 1 incident of hoarding items, 2 incidents of pulling his hair, 1 incident of repetitive fiddling with objects, 2 incidents of non-compliance, and 3 incidents of inappropriate masturbation. Review of the intervention strategy documentation for the aforementioned date revealed that one instance of touch control was the only intervention utilized. b. May 12, 2007 (12:00 AM to 8:00 AM shift) - The data collection form documented that Client #3 engaged in 1 incident of repetitive fiddling with objects, 1 incident of spitting on people and 3	I 180		

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I 180	Continued From page 7 incidents of inappropriate masturbation. Review of the intervention strategy documentation for the aforementioned date revealed no intervention strategies were implemented. c. May 22, 2007 (12:00 AM to 8:00 AM shift) - The data collection form documented that Client #3 engaged in 3 incidents of pulling his hair, 3 incidents of spitting on people and 2 incidents of inappropriate masturbation. Review of the intervention strategy documentation for the aforementioned date revealed that touch control (two times) was the only intervention utilized. d. May 23, 2007 (12:00 AM to 8:00 AM shift) - The data collection form documented that Client #3 engaged in 1 incident of spitting on people and 3 incidents of inappropriate masturbation. Review of the intervention strategy documentation for the aforementioned date revealed that touch control (three times) was the only intervention utilized. e. May 25, 2007 (12:00 AM to 8:00 AM shift) - The data collection form documented that Client #3 engaged in 3 incidents of spitting on people and 3 incidents of inappropriate masturbation. Review of the intervention strategy documentation for the aforementioned date revealed no intervention strategies were implemented. f. May 26, 2007 (8:00 AM to 4:00 PM shift) - The data collection form documented that Client #3 engaged in 3 incidents of hoarding items, 4 incidents of pulling his hair, 1 incident of repetitive fiddling with objects, 4 incidents of non-compliance, 3 incidents of aggression to others and 3 incidents of elopement related behavior. Review of the intervention strategy	I 180		

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I 180	Continued From page 8 documentation for the aforementioned date revealed no intervention strategies were implemented. g. May 31, 2007 (12:00 AM to 8:00 AM shift) - The data collection form documented that Client #3 engaged in 1 incidents of hoarding items. Review of the intervention strategy documentation for the aforementioned date revealed no intervention strategies were implemented. h. May 31, 2007 (8:00 AM to 4:00 PM shift) - The data collection form documented that Client #3 engaged in 3 incidents of inappropriate masturbation. Review of the intervention strategy documentation for the aforementioned date revealed no intervention strategies were implemented. i. June 12, 2007 (12:00 AM to 8:00 AM shift) - The data collection form documented that Client #3 did not engage in any of his targeted behaviors but touch control was used as an intervention strategy twice. j. June 16, 2007 (12:00 AM to 8:00 AM shift) - The data collection form documented that Client #3 did not engaged in 8 incidents of spitting on people. Review of the intervention strategy documentation for the aforementioned date revealed no intervention strategies were implemented. At the time of the survey, the facility failed to provide evidence that the QMRP effectively monitored Client #3's BSP to ensure that the data collection and/or the implementation of intervention strategies were completed/conducted in accordance with the BSP. (See also Federal	I 180		

PRINTED: 04/25/2008
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I 180	Continued From page 9 Deficiency Report Citation W159) 7. The facility's Governing Body failed to monitor and/or revise its operation directions to ensure the facility's environment was appropriate and provided for the health and safety as well as active treatment services for Client #1. Observation at the residential facility on April 2, 2008 at approximately 4:41 PM revealed Client #1 entering the facility. The client required the assistance of two direct care staff (one on each side of the client) to ambulate to the recliner chair that was located in the living room. Interview with staff on April 2, 2008 at approximately 5:02 PM revealed that Client #1 required the support of at least two people to ascend the exterior front stairwell in order to enter the facility. Staff further revealed that Client #1 sometimes must be carried up the stairwell. Observation of at the residential facility on April 4, 2008 at approximately 3:44 PM revealed Client #1 entering the facility with the assistance of three staff members. The staff were positioned behind, to the right, and in front of Client #1 in order to assist him into the facility. While ambulating from the front entrance to the recliner chair, the client was observed to have the assistance of two staff persons. Interview was conducted with the Qualified Mental Retardation Professional (QMRP) and former House Manager (HM) on April 4, 2008 at 5:26 PM to ascertain information about the aforementioned concern regarding Client #1 ' s ambulation into/out of and around the facility. According to the interview, Client #1 was being assessed to transition to another residential placement. The QMRP revealed that on March	I 180		

PRINTED: 04/25/2008
FORM APPROVED

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I 180	Continued From page 10 12, 2008 the interdisciplinary team initiated a plan that would include Client #1 moving to a more barrier free environment. The plan consisted of acquiring a physical therapy assessment, obtaining a neurological evaluation and a cardiology evaluation. The team further agreed to reconvene regarding the matter in thirty days. It should be further noted that the former HM revealed that the facility had been meeting with the Department of Disability Services (DDS) since 2006 regarding Client #1 transitioning out of the facility. Continued interview with the former HM revealed that since 2006 Client #1's case manager has changed and the change caused a delay in his transition into another home. The former HM also revealed that the client' s functioning had decreased with in the past year. Interview with the nurse on April 3, 2008 at 6:00 PM also revealed that Client #1 needed a more barrier free environment. Review of Client #1' s records on April 4, 2008 at 5:25 PM revealed a social work assessment dated August 2, 2007. According to the review of the assessment, the consultant recommended to "locate a facility that is barrier reduced for his placement." At the time of the survey, the governing body failed to ensure the matter regarding Client #1's new placement had been adequately addressed in order to provide a more barrier free living environment. (See also Federal Deficiency Report Citation W104)	I 180		
I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by:	I 203		

PRINTED: 04/25/2008
FORM APPROVED

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I 203	Continued From page 11 Based on interview and record review, the GHMRP failed to provide evidence that the supervisor discussed the contents of job descriptions with each employee at the beginning of their employment and annually thereafter. The finding includes: Interview with the former House Manager and review of the GHMRP's personnel files on April 2, 2008 at 12:00 PM revealed the GHMRP failed to provide evidence that eight direct care staff had the contents of their job descriptions discussed with them at the beginning of their employment and/or annually thereafter.	I 203	The facility will ensure that all staff's job descriptions are discussed and reviewed annually. In the future, Management will review employee files monthly.	5/23/08
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that each employee, prior to employment and annually thereafter, provided evidence of a physician's certification that documented a health inventory had been performed and that the employee's health status would allow him or her to perform the required duties. The finding includes:	I 206	In the future, the facility will ensure that all employees maintain a current health status. In the future, Management will review employee files monthly.	5/23/08

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I 206	Continued From page 12 Interview with the former House Manager and review of the GHMRP's personnel files on April 2, 2008 at 12:00 PM revealed the GHMRP failed to provide evidence that current health certificates were on file for four staff.	I 206		
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure staff were effectively trained on the implementation and documentation of each resident's behavior support plan for one of the four residents (Residents #3) included in the sample. The finding includes: The facility failed to provide evidence that the direct care staff were able to demonstrate competency in the implementation of Client #3's Behavior Support Plan (BSP). Observation on Client #3 on April 2, 2008 at 5:12 PM revealed the client standing in the dining room with a plastic egg in his hand. The client was observed to open and close the egg several times. The client was also observed inserting his index finger in the egg then rubbing his finger across his lower lip on several occasions. It should be noted that at least one direct care staff	I 229	Cross reference W159, W249	5/23/08

PRINTED: 04/25/2008
FORM APPROVED

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I 229	Continued From page 13 was present and witnessed the activity. Interview with the Qualified Mental Retardation Professional (QMRP) and review of Client #3's records on April 4, 2008 at 12:39 PM revealed the client had a BSP dated November 26, 2007. The plan documented that Client #3 had several challenging behaviors including repetitive fiddling. The plan further documented strategies that incorporated the use of verbal redirection and/or if necessary touch control whenever Client #3 engaged in any of his targeted behaviors. Additionally, the plan included the use of 1:1 staffing supports at all times to assist the client with addressing all of his targeted behaviors During the aforementioned observation, staff was not observed to intervene and/or address the client's fiddling. Furthermore, throughout the survey, Client #3 was not observed to have 1:1 staffing supports at all times.(See also W249). At the time of the survey, the facility failed to ensure staff were able to demonstrate skills necessary to implement Client #3's behavior support plan consistently and as outlined. (See Federal Deficiency Report Citation W194)	I 229		
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day.	I 379		

PRINTED: 04/25/2008
FORM APPROVED

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I 379	Continued From page 14 This Statute is not met as evidenced by: Based on record review, the GHMRP failed to ensure the Department of Health, Health Facilities Division was immediately notified, followed by written notification within 24 hours, of unusual incidents that substantially interfered with a resident's health, for one of the four residents (Resident #1) included in the sample. The finding includes: Review of the facility's incident reports on April 2, 2008, beginning at 10:23 AM revealed an incident involving Resident #1 dated February 27, 2008. According to the report, Resident #1 was observed to be non responsive and was transferred via ambulance to the emergency room. Further review of the incident report revealed the GHMRP notified the Department of Health about the aforementioned incident on February 29, 2008 (two days after the incident). At the time of the survey, the GHMRP failed to ensure the Department of Health was notified of #1's incident immediately and followed by written notification within 24 hours as required.	I 379	Cross reference W149	6/3/08
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 interview and record review, the GHMRP failed to ensure general and	I 401		

PRINTED: 04/25/2008
FORM APPROVED

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I 401	Continued From page 15 preventative care services, for two of the four residents (Resident #2 and #4) included in the sample. The finding includes: 1. Observation of Client #4 at the residential facility on April 2, 2008, at 5:14 PM revealed the client was sucking his thumb. Closer observation revealed the client's fingernails were missing on both of his thumbs. The exposed area on each thumb appeared to be discolored (brownish pink). Interview with the former House Manager (HM) at 6:42 PM revealed that the client had an infection on both thumbs that would not heal because of the client's continuous thumb sucking behavior. Additionally, the former HM revealed that the client thumbs were being treated for an infection. Review of Client #4's medical record on April 4, 2008 at 5:17 revealed the client was seen by the dermatologist on July 17, 2007. According to the dermatological consultation form, the client was diagnosed with chronic paronychia affecting both thumbs that was secondary to his thumb sucking and behavioral nail trauma. The dermatologist prescribed Triamcinoloone Cream to be applied on the client's thumbs twice daily for three weeks. Additionally, the dermatologist recommended Castellani Paint to be applied once daily to deter the client from sucking his thumbs. Continued review of the consultation form revealed that the dermatologist documented that the Castellani Paint "would not initiate systemic antifungals as the problem is caused by a behavior. The foul taste of the Castellani Paint will deter thumb sucking and be therapeutic due to antifungal properties." It should be noted that interview with the nurse verified that Client #4's thumb sucking was a behavior and his nails would not heal until	I 401	1. The facility's psychologist will clarify, revise, and expand Client #4's BSP of SIB to include thumbsucking. An inservice will be held on 5/23/08 to train the employees on the revised BSP.	5/14/08

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I 401	Continued From page 16	I 401		
	the thumb sucking ceased. At the time of the survey, the facility failed to provide evidence that services were being provided to effectively treat Client #4's thumbs.			
	2. Review of Client #2's record on April 4, 2008 at 7:04 PM revealed the client was seen by an audiologist. Review of the consultation form revealed the client was recommended to return after his ears were cleared. Interview was conducted with the Qualified Mental Retardation Professional (QMRP) at approximately 7:10 PM to ascertain if the client had returned for the audiological revisit and/or find out if the revisit was scheduled. At the time of the survey, the facility failed to provide evidence that Client #2 was seen for a follow up audiological visit. (See also Federal Deficiency Report Citation W322)		2. Cross reference W322	5/15/08
	3. The facility failed to ensure Resident #1 received routine laboratory studies.			
	a. Review of Client #1's April 2008 Physician's Orders on April 3, 2008 at 4:47 PM revealed orders that documented the client receive laboratory tests including HBA1C every 3 months and a Liver Function Test (LFT) every 6 month. Interview with the nurse via telephone on April 4, 2008 and continued review of Client #1's record failed to provide evidence that the aforementioned recommended tests were conducted as ordered.		3a. Cross reference W325 #1	4/24/08
	b. Review of Client #1's record on April 4, 2008 at 2:19 PM revealed the client had a urinalysis on October 23, 2007. Further review of the urinalysis results revealed the primary care physician signed the test and wrote a note indicating a urine culture and sensitivity test should be done. Interview was conducted with		3b. Cross reference W325 #2	5/16/08

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I 401	Continued From page 17 the Qualified Mental Retardation Professional (QMRP) on April 4, 2008 to ascertain if the urine culture and sensitivity had been completed. At the time of the survey, the facility failed to provide evidence that the urine culture and sensitivity test had been completed. (See also Federal Deficiency Report Citation W325)	I 401		
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation interview and record review, the GHMRP failed to ensure habilitation, training and assistance was provided to its residents in accordance with their Individual Habilitation Plan(s), for one of the four residents (Resident #3) included in the sample. The finding includes: During the entrance conference on April 2, 2008, at approximately 9:40 AM, interview with the former House Manager (HM) revealed that Client #3 received 1:1 supervision for eight (8) hours daily. The former HM further revealed that Client #3 received the 1:1 staffing supports only while at the day program. The special staffing support was implemented to assist Client #3 with addressing maladaptive behaviors of elopement, aggression and self injurious behaviors. Observation of Client #3 on the evening of April 2, 2008 (between 4:31 PM and 6:35 PM) and observation of Client #3 on April 3, 2008 at his	I 422		

PRINTED: 04/25/2008
FORM APPROVED

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I 422	Continued From page 18 day program (from 11:56 AM-12:14 PM) verified the aforementioned staffing supports. Client #3 was not observed to have a 1:1 staff while in the residential facility but was observed to have the assistance of the 1:1 staff person while at the day program. Interview was conducted with Client #3's 1:1 staff on April 3, 2008 at 12:08 PM to ascertain information regarding the 1:1's responsibilities. According to the interview, the 1:1 staff revealed that he/she provided 1:1 support for Client #3 Monday through Friday. The 1:1 further indicated that Client #3 had behaviors of elopement and aggression and having 1:1 supports assisted the client with addressing those behaviors. Interview with the Qualified Mental Retardation Professional (QMRP) and review of Client #3's records on April 4, 2008 at 12:39 PM revealed the client had a Behavior Support Plan (BSP) dated November 26, 2007. The plan documented that Client #3 had challenging behaviors of non-compliance, physical aggression, eloping, spitting, hoarding, masturbation, repetitive fiddling, touching others and pulling his hair. Continued review of the plan revealed a section entitled, "Need for 1:1 Staffing." According to that section, the plan documented that "Client #3 is primarily a danger to himself and/or others without a 1:1 staff person at all times. He has a psychiatric Axis I: Impulse Control Disorder and his behaviors are unpredictable day, night, weekends, upstairs, downstairs, on the van and anywhere at anytime. For example, [Client #3] may at any moment suddenly attempt to elope or he may grab another person sexually. To a less dangerous extent he may embarrass himself or others by acting out sexually or inappropriately at	I 422		

PRINTED: 04/25/2008
FORM APPROVED

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I 422	Continued From page 19 anytime without a 1:1 staff person monitoring his behaviors around others, in front of windows, etc... [Client #3] does much better when a familiar staff person is next to him, immediately next to him." The plan further documented that the "[Client #3] is also a danger to others when he is not properly redirected by someone such as a 1:1, as he may be more aggressive at these times. It should be noted that the aforementioned information was found not only in the BSP dated November 26, 2007 but also in Client #3's previous BSP's dated February 21, 2007 and August 9, 2007. Review of the corresponding data sheets between the months of April 2007 and June 2007 revealed the following information regarding the frequency of Client #3's exhibited challenging behaviors of elopement, inappropriately touching others, pulling his hair and aggression. For example: April 2007 - 1 incident of touching others and 78 incidents of pulling his hair. May 2007 - 3 incidents of elopement, 3 touching others, 73 incidents of pulling his hair, 7 incidents of aggression. June 2007 - 1 incident of elopement, 11 incidents of touching others, 70 incidents of pulling his hair, and 21 incidents of aggression. Review of the facility Psychotropic Medication Review forms on April 3, 2008 at 5:31 PM revealed the client engaged in incidents of the aforementioned challenging behaviors as detailed below: July 2007 - 1 incident of elopement related behavior, 1 incident of touching others, 158 incidents of pulling his hair, and 8 incidents of	I 422		

PRINTED: 04/25/2008
FORM APPROVED

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I 422	Continued From page 20 aggression. August 2007 - 1 incident of touching others, 69 incidents of pulling his hair, and 11 incidents of aggression. September 2007 -2 incidents of elopement behavior, 4 incidents of touching others, 185 incidents of pulling his hair, and 7 incidents of aggression. It should be noted that review of the client's records revealed the client continued to engage in the aforementioned challenging behaviors through March 2008. At the time of the survey, the facility failed to ensure Client #3 was provided with continuous active treatment including needed supports to address his challenging behaviors. (See also Federal Deficiency Report Citation W249)	I 422	Cross reference W249	5/14/08
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, the GHMRP failed to ensure the protections of each client's rights. The findings include: (See Federal Deficiency Report Citations W102, W122, W124, W249, W262, W263)	I 500	Cross reference W104, W124, W120 #1, W249, W262	5/23/08

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FORM APPROVED

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R 000	INITIAL COMMENTS An annual relicensure survey was conducted from April 2, 2008 through April 4 2008. A random sample of four residents was selected from a residential population of seven males with mental retardation and other disabilities. The survey findings were based on observations in the group home and at four day programs, interviews and a review of records, including unusual incident reports.	R 000		
R 122	4701.2 BACKGROUND CHECK REQUIREMENT Except as provided in section 4701.6, each facility shall obtain a criminal background check, and shall either obtain or conduct a check of the District of Columbia Nurse Aide Abuse Registry, before employing or using the contract services of an unlicensed person. This Statute is not met as evidenced by: Based on interview and the review of records, the GHMRP failed to ensure criminal background checks had been obtained before employing or using the contract services of an unlicensed person. The finding includes: Interview with the former House Manager (HM) and review of the personnel records on April 2, 2008 at 12:00 PM revealed that the GHMRP failed to provide evidence that a criminal background checks had been obtained prior to employing and using the services of the new house manager.	R 122	CMS Personnel Dept. will review all records to ensure that all employees have criminal background checks prior to working in this facility.	5/23/08

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Santana A. Reese TITLE: Program Director (X6) DATE: 5-9-08

STATE FORM 6899 QX201 If continuation sheet 1 of 1