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

RECEIVED 2/26/07

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G053	A. BUILDING B. WING	01/25/2007

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DEPARTMENT OF HEALTH
HEALTH REGULATION
ADMINISTRATION
2007 FEB 26 A 8:03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CMS	2836 MYRTLE AVENUE NE WASHINGTON, DC 20018

(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 January 22, 2007 through January 25, 2007 utilizing the fundamental process. However, due to deficient practices observed during the survey, the survey was extended in Active Treatment. A random sample of two clients was selected from a residential population of four females with various degrees of mental retardation and other disabilities. The findings of the survey were based on observations at the group home and two day programs, interviews with staff and clients, and review of records, including incident reports. The outcome of the survey revealed the facility failed to be in compliance with the Condition of Participation in Active Treatment. NOTE: On November 20, 2006, two months ago, this office conducted a complaint investigation involving client and staff abuse. The investigation substantiated that the facility's governing body failed to provide adequate supervision and effective staff training to prevent client and staff abuse/ physical injuries. Based on the surveyors findings it was determined that the facility failed to comply with the condition of Active Treatment and an enforcement action was proposed. On December 29, 2006, the facility regained compliance by increasing their staff to client ration (two direct care staff per shift). Although the revised staff schedule was verified at the time of the investigation, this recertification survey revealed that the governing body failed to consistently ensure sufficient staffing to address client's behavior management needs and to ensure clients' safety.	W 000		
W 100	440.150(c) ICF SERVICES OTHER THAN IN INSTITUTIONS	W 100		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Constance A. Reese
TITLE: Program Director
(X6) DATE: 2/23/07

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

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W 100	Continued From page 1 "Intermediate care facility services" may include services in an institution for the mentally retarded (hereafter referred to as intermediate care facilities for persons with mental retardation) or persons with related conditions if: (1) The primary purpose of the institution is to provide health or rehabilitative services for mentally retarded individuals or persons with related conditions; (2) The institution meets the standards in Subpart E of Part 442 of this Chapter; and (3) The mentally retarded recipient for whom payment is requested is receiving active treatment as specified in §483.440. This STANDARD is not met as evidenced by: Based on observation, interviews and record review, the facility failed to ensure that each client received continuous active treatment services. [See W196]	W 100		
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, interviews with staff and a client, and the review of records, the facility's governing body failed to consistently provide operational directions over the facility. The findings include: A. The governing body failed to ensure clients' health and safety by failing to provide consistent	W 104		

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W 104	Continued From page 2 client supervision and monitoring, and by failing to provide continuous active treatment services. On November 20, 2006, two months ago, this office conducted a complaint investigation involving client and staff abuse. The investigation substantiated that the facility's governing body failed to provide adequate supervision and effective staff training to prevent client and staff abuse/ physical injuries. Based on the surveyors findings it was determined that the facility failed to comply with the condition of Active Treatment and an enforcement action was proposed. On December 29, 2006, the facility regained compliance by increasing their staff to client ration (two direct care staff per shift). Although the revised staff schedule was verified at the time of the investigation, this recertification survey revealed that the governing body failed to consistently ensure sufficient staffing to address client's behavior management needs and to ensure clients' safety as evidenced by the following: 1. During the recertification survey on January 24 , 2007, the surveyor arrived at the facility at 8:16 AM. Upon entering the facility, a direct care staff greeted the surveyor and stated "I'm glad you're here cause she is acting up." The surveyor asked the staff who she was referring to and the staff identified Client #3. When asked where was Client #3, the staff indicated that she was in her bedroom. The client's bedroom door was observed to be closed; however, she was overheard yelling and screaming in an unintelligible tone of voice. The direct care staff further indicated that the client said she was going to kill one of her peers [Client #4]. Observation and interview with the direct care	W 104	The present staffing schedule reflects that two direct care staff are on duty when all four of the residents are in the facility. However, in the future two staff will be required to remain on duty until all residents have left to go to the day program or until the relief reports for duty. Residential Manager will review schedule daily to ensure that two staff remain on duty at all times while all four clients are in the facility.	3/1/07

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W 104	Continued From page 3 staff revealed that there was no other staff on duty. At 8:21 AM, the Residential Manager (RM) and the Qualified Mental Retardation Professional (QMRP) arrived to the facility. The direct staff informed the RM that Client #3 said she was going to kill (Client #4). At this time, Client #4 was observed to enter the dining room area and appeared as though she was about to cry. The QMRP asked the staff what was going on? The direct care staff indicated that the client was " cursing and fussing." The RM was observed to enter Client #3's bedroom and was overheard asking the client to calm down. 2. At approximately 8:25 AM the QMRP was interviewed and acknowledged that two staff were scheduled to work for each of the three shifts (12 midnight - 8:00 AM, 8:00 AM - 4:00 PM, and 4:00 PM - 12 midnight). The surveyor asked the RM if one of the midnight staff had been instructed to stay until the second person arrived to relieve them? The RM said they had not been instructed to do so. 3. At 8:30 AM, Client #3 beckoned the surveyor to come in her bedroom. Client #3 indicated that she told Client #4 .... "to get out my room, she was in my closet." Client repeated " I tell her get out my room." Interview with the RM at 8:36 AM, confirmed that Client #3 does not like her peers in her room. The RM indicated that Client #4 liked to go in Client #3's bedroom closet to mess with her shoes and that it was difficult to redirect and keep her from going in Client #3's bedroom.	W 104	The facility's Psychologist and Behavior Specialist will provide additional training to staff on how to manage conflict between Client #3 and Client #4.	3/2/07

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W 104	Continued From page 4 B. Cross Refer to W124.1-2. The governing body failed the establishment and implementation of policies and procedures to ensure informed consents for the use of psychotropic medications. C. The governing body failed to ensure that the implementation of policies and procedure to ensure that all drugs administered had proper labeling as evidenced by the following: During the environmental walk-through on January 25, 2007 at approximately 1:17 PM revealed that Client #1's Dental 5000 PPM fluoride Prescription was observed at her bedside in a plastic storage container. Further observation revealed that the treatment medication was not labeled with the client's name, expiration date and treatment administration instructions. Review of the facility's policy for medication labeling on January 25, 2007 revealed that all resident medications, regardless of source, should be properly labeled as follows: a) The name of the drug; if generic, the manufacturer shall be indicated; b) The directions for use; c) The name of the resident; d) The name of the prescriber; e. The date dispensed; f). The name and address of the pharmacy; g) The prescription number; h) The strength and quantity; i) When appropriate, precautionary labels shall be added indicating storage conditions, handling procedures, etc. and j) Expiration dates of drugs.	W 104	B. Cross reference W124, 1-2. The Pharmacist will be requested to label all over the counter medication.	3/1/07 3/1/07

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W 104	Continued From page 5 Further review of the policy revealed that the nurse receiving the drugs assumes responsibility for assuring that all items coming from the pharmacy are properly labeled.	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 outside services met the needs of one of the two clients included in the sample. (Client #1) The findings include: I. The facility failed to ensure that the day program met Client #1's needs due to her refusals to participate in active treatment programming as evidenced below: On January 23, 2007 at 1:37 PM, Client #1 was observed at her day program wearing her coat, hat, and gloves in the classroom. The day program staff reported the client had her coat on since her arrival approximately 10:00 AM that morning. The client was not observed to be engaged in any task. At 1:59 PM the day program staff assisted Client #1 to sit in a circle with her peers. According to the staff the clients sat in a circle to discuss things of interest to them. It should be noted that Client #1 was not observed to engage in the conversation, but was observed to repeat whatever was said. Throughout the observation the day program staff were observed requesting the client to take off	W 120	The QMRP and Behavior Specialist will visit Client #1's day program to make observation of her participation in her daily programming. A case conference will be requested with the day program staff and DDS Case Manager to determine if Client #1 can benefit from her present day program placement or if alternative programs can be explored.	3/1/07

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W 120	Continued From page 6 her coat and hat, but she refused. Review of the client 's day program Behavior Support Plan (BSP)dated September 14, 2006 revealed whenever the client exhibits noncompliance in response to staff directives " staff should give her a verbal prompt to follow the directive e.g. Client's name, please do _____. If the client refuses to comply, staff should repeat the directive in a calm but firm tone of voice. If the client continues to ignore staff, they should allow two-three minutes to lapse and then should repeat the directive again. At the time of the survey, the day program staff were not observed to implement the BSP as written. Interview on the aforementioned date at 1:38 PM with the day program case manager revealed they had concerns regarding Client #1's noncompliance. According to the case manager, on some days the client refuses to come in the classroom. He indicated that they have requested a one to one staff for the safety of the client. The day program case manager further indicated that the client was not aggressive, however sometimes she wants to walk around in the building, and collect cardboard, "we don't have the staff for that." Review of the behavior data revealed that the client has been consistently non-compliant. Further review of the data revealed that from December 12, 2006 through January 9, 2007, Client #1 had displayed eighteen (18)incidents of the non-compliant behavior. An interview was conducted on January 24, 2007 with the group home Residential Manager (RM). According to the RM Client #1 was suspended	W 120		

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W 120	Continued From page 7 from the day program for approximately nineteen days due to her non-compliance. A case conference was held on October 12, 2006 to discuss the client's "non-compliance with daily routines, decrease in compliance with ADLs' (personal hygiene, and suspension due to refusal to engage in any programming). According to the Qualified Mental Retardation (QMRP) a request has been submitted for a one to one staff, however, due to the fact that the client does not exhibit aggressive behaviors, the QMRP indicated that she probably does not qualify for a one to one staff. The QMRP also indicated that once the facility receives the letter denying the one to one staff a referral will be made to another day program for the client.	W 120		
	II. [Cross Refer to W391] Review of the Personnel Records on January 24, 2007 revealed a Pharmacist contract which indicated that the Pharmacist should conduct an inspection of medication storage rooms, if applicable. Additionally, the contract indicated that the audits would consist of appropriate labeling. At the time of the survey, the facility failed to ensure clients medication was labeled.		All medication will be labeled and storage reviewed by the Pharmacist quarterly.	3/1/07
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 observation, staff interview, and record review, the facility failed to establish a system that would ensure clients that were informed of their risks and benefits of their medication for two of the two clients in the sample. (Clients #1 and #2) The findings include: 1. Client #1 was observed during the evening medication pass on January 22, 2007 at 6:59 PM. The client was observed to receive Depakote 500 mg, Revia 50 mg, and Tegretol XRU-D 40 mg. Review of Client #1's physician's orders dated January, 2007, revealed that the client was also prescribed Aricept 10 mg. Interview with the Primary Care Nurse (PCN) and review of the Medication Administration Record (MAR) revealed that the client started this medication on September 28, 2006. Interview with the nursing staff on January 22, 2006 revealed Client #1 was prescribed the aforementioned medications for behavioral support. Interview with the Residential Manager (RM)on January 22, 2007 revealed that Client #1's sister is involved in her life, but that the client does not have a legal guardian. Further interview with the RM revealed that the sister had signed a consent for sedation however, at the time of the survey there was no documented evidence of an informed consent for the use of her psychotropic medications or the use of her corresponding BSP. Review of Client 1#'s, psychological assessment dated October 2, 2006, revealed that the client does not have the ability to make major decisions on her behalf regarding habilitation planning, placement, finances, treatment and medical	W 124	Consent forms for treatment will be obtained from DDS Case Managers. The consent for Psychotropic Medications and use of BSP will be reviewed and signed by Client #1's sister. A telephone conference with Client #1's sister in California will request that she sign and return consent forms.	3/1/07 3/1/07

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W 124	Continued From page 9 matters. There was no evidence to determine that the facility had established a system to ensure that legally sanctioned advocacy was made available for clients identified as incapable of comprehending their treatments and the risk and benefits associated. 2. Client #2 was observed during the evening medication pass on January 22, 2007 at 7:11PM. The client was observed to receive Depakote 250 mg and Seroquel 200 mg. Review of Client #2's physician's orders dated January, 2007, revealed that the client was also prescribed Seroquel 100 mg to be administered at 12 noon and 300 mg every evening. Further review of the order revealed that the client was also prescribed Prozac 20 mg. Interview with the nursing staff on January 22, 2006 revealed Client #2 was prescribed these medications for behavioral support. Interview with the Residential Manager (RM) and record verification revealed that Client #2 had a limited guardian, however, at the time of the survey there was no documented evidence of an informed consent for the use of her psychotropic medications or the use of her corresponding BSP. Review of Client #2's, psychological assessment revealed that the client does not have the ability to make major decisions on her behalf regarding habilitation planning, placement, finances, treatment and medical matters. There was no evidence to determine that the facility had established a system to ensure that legally sanctioned advocacy was made available for clients identified as incapable of comprehending their treatments and the risk and benefits associated.	W 124	A signed consent form for Client #2 will be obtained for the use of her psychotropic medications and BSP.	3/1/07

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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 interview and record review, the facility failed to ensure each client was encouraged to exercise their rights, for two of the two clients included in the sample (Clients #1 and #2). The finding includes: The facility failed to ensure Client #1's and #2's rights were protected by making certain the clients had a legally sanction representative to assist them with making decisions regarding their treatment. [See W124]	W 125	The QMRP will contact Client #1 and #2's DDS Case Managers and Court Appointed Attorneys to assist with obtaining consent for use of psychotropic medication and BSP.	3/1/07
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 staff interview and record review, the facility's Qualified Mental retardation Professional (QMRP), failed to adequately monitor, integrate and coordinate each client's health and safety. The finding includes:	W 159		

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W 159	Continued From page 11 1. On January 23, 2007 at 1:37 PM Client #1 was observed at her day program wearing her coat, hat, and gloves in the classroom. The day program staff reported the client had her coat on since her arrival approximately 10:00 AM that morning. The client was not observed to be engaged in any task. At 1:59 PM the day program staff assisted Client #1 to sit in a circle with her peers. According to the staff the clients sat in a circle to discuss things of interest to them. It should noted that Client #1 was not observed to engage in the conversation, but was observed to repeat whatever was said. Throughout the observation the day program staff were observed requesting the client to take off her coat and hat off, but she refused.	W 159		
	Interview with the client's day program case manager on January 23, 2007 at 1:38 PM revealed that they had concerns regarding Client #1's behavior of noncompliance. According to the case manager, on occasions the client would refuse to come in the classroom and would walk around in the building and collect cardboard. Although the case manager reported that the client was not aggressive, case manger indicated that the program did not have the available staff to provide supervision when the client was not in class. Although a behavior support plan was designed to address the client's non-complaint behaviors, the staff indicated that the plan was not effective as the data collection revealed from December 12, 2006 through January 9, 2007 eighteen (18) incidents of the behaviors. There was no evidence that this data and the day program's concerns were communicated to or addressed by the Interdisciplinary team or the psychotropic medication committee.		The BSP for Client #1 will be reviewed and revised. A case conference will be scheduled with IDT to review day program concerns for Client #1.	3/1/07

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W 159	Continued From page 12 An interview with the group home Residential Manager (RM) on January 24, 2007 revealed that in September/October 2006, the client was suspended from her day program for approximately nineteen days due to behaviors of non-compliance. A case conference was held on October 12, 2006 to discuss the client's increase non-compliance with daily routines, lack of participation in day program activities, and decrease compliance with ADLs' (personal hygiene). Residential data collection at that time revealed an increase in the non-compliance from an average of 35 in July and August to 177 in September, 2006. In response to the increase in the behavior, the facility's psychiatric recommended that the client be assessed for dementia and/or begin a diagnostic therapeutic trial of Aricept 10 mg be added to his drug regime. The psychological assessment dated October 2, 2006 recommended that the client be assessed for possible dementia prior to making any changes in the client's psychotropic medications, including starting Aricept. Review of the social worker assessment also recommended that the client be assessed for dementia prior to the trial of Aricept. However, the Aricept was ordered, and initiated on September 28, 2006 without any evidence that the Interdisciplinary team recommendations were addressed or that the human rights committee had reviewed or approved its usage. Review of the data collection since the initiation of the Aricept, the client has not been assessed for dementia. Although the client's behavior of non-compliance at the residence decreased to 41 incidents in November (2006), the behavior increase to 98 incidents in December (2006). It	W 159		

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W 159	Continued From page 13 should be noted that in addition to the increase in behaviors of non-compliance, the client demonstrated an increase in skin picking, and pica (from zero to 60 incidents of eating feces).	W 159		
	2. The QMRP failed to ensure that a system had been developed to inform each client, parent or legal guardian of the client's behavioral status, risks of treatment, and the right to refuse treatment. [See W124]		2. Cross reference W124.	3/1/07
	3. The QMRP failed to ensure Client #1 was provided with continuous active treatment. [See W196]		3. Cross reference W196.	3/1/07
	4. The QMRP failed to ensure outside services met the needs of each client. [See W120]		4. Cross reference W120.	3/1/07
	5. The QMRP failed to develop Individual Program Plans (IPP) to address assessed needs. [See W226]		5. Cross reference W226.	3/1/07
	6. The QMRP failed to state clients behavioral objectives in a single behavioral outcome. [See W229]		6. Cross reference W229.	3/1/07
	7. The QMRP failed to allow clients the opportunity to exercise their right to choice and self management. [See W247]		7. Cross reference W247.	3/1/07
	8. The QMRP failed to develop an active treatment schedule that outlined the current active treatment programs. [See W250]		8. Cross reference W250.	3/1/07
W 186	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.	W 186		

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W 186	Continued From page 14 Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on observation, staff interviews, and review of staffing schedule, the facility failed to ensure that sufficient direct care staff to manage and supervise clients in accordance with their individual program plans were available. The finding includes: 1. The facility failed to provide adequate client to staff ratio to ensure supervision to address the behavioral management needs of Client #1. [Cross refer to W104.1] During the survey on January 24, 2007, the surveyor arrived at the facility at 8:16 AM. Upon entering the facility, a direct care staff greeted the surveyor and stated " I'm glad you're here cause she is acting up." The surveyor asked the staff who she was referring to and the staff identified Client #3. When asked where was Client #3, the staff indicated that she was in her bedroom. The client's bedroom door was observed to be closed; however, she was overheard yelling and screaming in an unintelligible tone of voice. The direct care staff further indicated that the client said she was going to kill one of her peers [Client #4]. Observation and interview with the direct care staff revealed that there was no other staff on duty. At 8:21 AM, the Residential Manager (RM) and the Qualified Mental Retardation Professional (QMRP) arrived to the facility. The direct staff	W 186	cross reference W104.	3/1/07

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W 186	Continued From page 15 informed the RM that Client #3 said she was going to kill (Client #4). At this time, Client #4 was observed to enter the dining room area and appeared as though she was about to cry. The QMRP asked the staff what was going on? The direct care staff indicated that the client was " cursing and fussing". The RM was observed to enter Client #3's bedroom and was overheard asking the client to calm down. At approximately 8:25 AM the QMRP was interviewed and acknowledged that two staff were scheduled to work for each of the three shifts (12 midnight - 8:00 AM, 8:00 AM - 4:00 PM, and 4:00 PM - 12 midnight). The surveyor asked the RM if one of the midnight staff had been instructed to stay until the second person arrived to relieve them? The RM said they had not been instructed to do so. At 8:30 AM, Client #3 beckoned the surveyor to come in her bedroom. Client #3 indicated that she told Client #4 .... "to get out my room, she was in my closet." Client repeated " I tell her get out my room." Interview with the RM at 8:36 AM, confirmed that Client #3 does not like her peers in her room. The RM indicated that Client #4 liked to go in Client #3's bedroom closet to mess with her shoes and that it was difficult to redirect and keep her from going in Client #3's bedroom. Interview with the direct care staff and record verification revealed Client #3 has a Behavior Support Plan (BSP) to address verbal abuse and physical aggression. Review of the plan revealed that when the client begins to display agitated or verbally abusive behavior, a staff	W 186		

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W 186	Continued From page 16 member will discuss with her the reason for her agitation. Additionally, the plan recommended to use a safety zone when the client does not respond to verbal instructions. Although the client was in her bedroom, she continued to talk loudly in an agitated tone. The direct care staff on duty was not observed to intervene by implementing the behavioral strategies as recommended in her BSP, because she was trying to attend to the other housemates. 2. On January 23, 2007 at 1:37 PM Client #1 was observed at her day program wearing her coat, hat, and gloves in the classroom. The day program staff reported the client had her coat on since her arrival approximately 10:00 AM that morning. The client was not observed to be engaged in any task. At 1:59 PM the day program staff assisted Client #1 to sit in a circle with her peers. According to the staff the clients sat in a circle to discuss things of interest to them. It should noted that Client #1 was not observed to engage in the conversation, but was observed to repeat whatever was said. Throughout the observation the day program staff were observed requesting the client to take off her coat and hat off, but she refused. Interview with the client's day program case manager on January 23, 2007 at 1:38 PM revealed that they had concerns regarding Client #1's behavior of noncompliance. According to the case manager, on occasions the client would refuse to come in the classroom and would walk around in the building and collect cardboard. Although the case manager reported that the client was not aggressive, case manger indicated that the program did not have the available staff to provide supervision when the client was not in	W 186		

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W 186	Continued From page 17 class. Although a behavior support plan was designed to address the client's non-complaint behaviors, the staff indicated that the plan was not effective as the data collection revealed from December 12, 2006 through January 9, 2007 eighteen (18) incidents of the behaviors. There was no evidence that this data and the day program's concerns were communicated to or addressed by the Interdisciplinary team or the psychotropic medication committee. An interview with the group home Residential Manager (RM) on January 24, 2007 revealed that in September/October 2006, the client was suspended from her day program for approximately nineteen days due to behaviors of non-compliance. A case conference was held on October 12, 2006 to discuss the client's increase non-compliance with daily routines, lack of participation in day program activities, and decrease compliance with ADLs' (personal hygiene). Residential data collection at that time revealed an increase in the non-compliance from an average of 35 in July and August to 177 in September, 2006. In response to the increase in the behavior, the facility's psychiatric recommended that the client be assessed for dementia and/or begin a diagnostic therapeutic trial of Aricept 10 mg be added to his drug regime. The psychological assessment dated October 2, 2006 recommended that the client be assessed for possible dementia prior to making any changes in the client's psychotropic medications, including starting Aricept. Review of the social worker assessment also recommended that the client be assessed for dementia prior to the trial of Aricept. However, the Aricept was ordered, and initiated	W 186		

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W 186	Continued From page 18 on September 28, 2006 without any evidence that the Interdisciplinary team recommendations were addressed or that the human rights committee had reviewed or approved its usage. Review of the data collection since the initiation of the Aricept, the client has not been assessed for dementia. Although the client's behavior of non-compliance at the residence decreased to 41 incidents in November (2006), the behavior increase to 98 incidents in December (2006). It should be noted that in addition to the increase in behaviors of non-compliance, the client demonstrated an increase in skin picking, and pica (from zero to 60 incidents of eating feces).	W 186		
W 195	483.440 ACTIVE TREATMENT SERVICES The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure each client received continuous active treatment [See W196]; the facility failed to develop Individual Program Plans (IPP) to address assessed needs [See W 226]; failed to state clients behavioral objectives in a single behavioral outcome [See W229]; failed to allow clients the opportunity to exercise their right to choice and self management [See W247]; and failed to develop an active treatment schedule that outlined the current active treatment programs.[See W250] The effects of these systemic practices resulted in the facility's failure to adequately govern the facility in a manner that would ensure its clients'	W 195	Cross reference W196, W226, W229, W247, W250.	3/1/07

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W 195	Continued From page 19 habilitation needs.	W 195		
W 196	483.440(a)(1) ACTIVE TREATMENT Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. 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, for three clients residing in the facility. (Clients #1, #2 and #3) The findings include: A. The facility failed to ensure staff were able to implement Client #3's Behavior Support Plan (BSP) as evidenced below: On January 24, 2007, the surveyor arrived at the facility at 8:16 AM. Upon entering the facility, a direct care staff greeted the surveyor and stated " I'm glad you're here cause she is acting up." The surveyor asked the staff who she was referring to and the staff identified Client #3. When asked where was Client #3, the staff indicated that she was in her bedroom. The client's bedroom door was observed to be closed; however, she was	W 196	Additional training will be provided to the facility's Direct Care Staff to ensure implementation of Client #3's BSP.	3/1/07

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W 196	Continued From page 20 overheard yelling and screaming in an unintelligible tone of voice. The direct care staff further indicated that the client said she was going to kill one of her peers [Client #4]. Observation and interview with the direct care staff revealed that there was no other staff on duty. At 8:21 AM, the Residential Manager (RM) and the Qualified Mental Retardation Professional (QMRP) arrived to the facility. The direct staff informed the RM that Client #3 said she was going to kill (Client #4). At this time, Client #4 was observed to enter the dining room area and appeared as though she was about to cry. The QMRP asked the staff what was going on? The direct care staff indicated that the client was " cursing and fussing". The RM was observed to enter Client #3's bedroom and was overheard asking the client to calm down. At approximately 8:25 AM the QMRP was interviewed and acknowledged that two staff were scheduled to work for each of the three shifts (12 midnight - 8:00 AM, 8:00 AM - 4:00 PM, and 4:00 PM - 12 midnight). The surveyor asked the RM if one of the midnight staff had been instructed to stay until the second person arrived to relieve them? The RM said they had not been instructed to do so. At 8:30 AM, Client #3 beckoned the surveyor to come in her bedroom. Client #3 indicated that she told Client #4 .... "to get out my room, she was in my closet." Client repeated " I tell her get out my room." Interview with the RM at 8:36 AM, confirmed that Client #3 does not like her peers in her room.	W 196		

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W 196	Continued From page 21 The RM indicated that Client #4 liked to go in Client #3's bedroom closet to mess with her shoes and that it was difficult to redirect and keep her from going in Client #3's bedroom. Interview with the direct care staff and record verification revealed Client #3 has a Behavior Support Plan (BSP) to address verbal abuse and physical aggression. Review of the plan revealed that when the client begins to display agitated or verbally abusive behavior, a staff member will discuss with her the reason for her agitation. Additionally, the plan recommended to use a safety zone when the client does not respond to verbal instructions. Although the client was in her bedroom, she continued to talk loudly in an agitated tone. The direct care staff on duty was not observed to intervene by implementing the behavioral strategies as recommended in her BSP, because she was trying to attend to the other housemates. B. The facility failed to ensure Client #2 was provided with continuous informal and formal learning opportunities as evidenced below: Observation on January 23, 2007 revealed Client #2 arriving home from her day treatment program at 3:12 PM. The direct care staff provided a sugar free vanilla pudding for the client's snack. She was observed to sit at the dinning room table to eat her pudding. Client #2's housemates were not observed to eat their snacks at the same time . Interview with the Residential Manager (RM)on January 24, 2007 at 3:50 PM revealed that Client #2 had an objective to prepare a snack for her peers.	W 196	Staff will receive adequate training from QMRP and Residential Manager on Client #2's program objectives on how to provide opportunities for Client #2 to select a snack and prepare a snack for her peers.	3/1/07

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W 196	Continued From page 22 Review of the "Training Book" revealed that Client #2 had an objective to prepare a simple snack with a peer and serve prior to the structure group home activity twice per week with minimal physical assistance. At the time of the survey the facility failed to ensure that Client #2 to had the opportunity to participate in preparing a snack for one of her peers. Further review of Client #2's "Training Book" on January 25, 2007 revealed that there was no data for the month of September 2006. C. The facility failed to ensure Client #1 and #2's social activity objectives were implemented as evidenced below: 1. Observation on January 22, 2007 revealed Client #1 sitting at the dinning room table. One of the direct care staff sat with her and encouraged her to place checkers in a connect four rack without purpose from 5:58 PM until 6:25 PM. The staff was observed to empty the rack each time the client filled it with the checkers. An interview with the staff at 6:02 PM, revealed that the client knows how to play the game " Connect Four", however, at the time of the survey,the staff was never observed to encourage the client or offer her an opportunity to play the game. 2. Review of Client #1's Active Treatment Record on January 23, 2007 revealed the client had an Individual Support Plan dated October 3, 2006. Further review of the record revealed the client had an objective to attend holiday/or theme activities two times per month with moderate	W 196	Staff will receive additional training in implementation of Client #1 and #2's social activity objectives.	3/1/07

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W 196	Continued From page 23 physical assistance and minimum verbal prompts with peers. An interview was also conducted with the Residential Manager(RM) and record verification on January on 24, 2007 revealed that the program data sheet was in the training book, however, at the time of the survey, there was no documented evidence of the aforementioned program being implemented.	W 196		
W 226	483.440(c)(4) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must prepare, for each client, an individual program plan. This STANDARD is not met as evidenced by: Based on observation,staff interview, and record review, the facility failed to develop Individual Program Plans (IPP) to address assessed needs for two of the two clients in the sample. (Clients # 1 and #2) The findings include: 1. Client #1 was observed during the evening medication pass on January 22, 2007 at 6:59 PM. The nurse called the client to the dinning room area to be administered her medication. The nurse was observed to hand the client her medication and and a glass of water. Client #1 was observed to take the medication and drink her water independently. The client was then observed to take her glass to the kitchen without prompting or assistance. Interview with the Primary Care Nurse (PCM) and	W 226	The facility's Primary Care Nurse will review Client #1's Self-Medication Program. The a.m. and p.m. medication nurses will receive additional training on how to assist Client #1 with her Self-Medication Program.	3/1/07

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W 226	Continued From page 24 record verification on January 24, 2006 at 1:42 PM revealed Client #1 had a Self-Medication Assessment dated April 6, 2006. Further review of the assessment documented that the client had the ability to "pick up a glass without verbal prompts, put hand out to receive the medication in it and open her mouth, take the glass of water off of the counter, lift the glass of water to her mouth and put the glass down." The assessment indicated a need for training. Although the PCN stated that the client had an IPP for self-medication. Review of the Individual Support Plan (ISP) failed to identify a self medication program. 2. Client #2 was observed during the evening medication pass on January 22, 2007 at 7:11PM. The nurse called the client to the dinning room area to be administered her medication. The nurse was observed to hand the client her medication and and a glass of water. Client #1 was observed to take the medication and drink her water independently. Additionally, the client was observed to take her glass to the kitchen without prompting or assistance. Interview with the Primary Care Nurse (PCM) and record verification on January 24, 2006 at 1:42 PM revealed Client #1 had a Self-Medication Assessment dated April 6, 2006. Further review of the assessment documented that the client had the ability to "pick up a glass without verbal prompts, put hand out to receive medication in it and open her mouth, take the glass of water off of the counter, lift the glass of water to her mouth and put the glass down." According to the PCN Client #2 had an IPP	W 226		

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W 226	Continued From page 25 objective for self-medication. Review of the corresponding IPP failed to identify a program objective associated with Client 2's identified need for training in self-medication. 3. Record review on January 24, 2007 revealed that Client #1 was seen by the Dentist on June 6, 2006. The Dentist recommended a electric toothbrush and for the client to brush her teeth 3 times a day. Interview with the Residential Manager (RM) on January 24, 2006 at 2:06 PM and review of the corresponding IPP failed to identify a program objective associated with Client 1's identified need for brushing her teeth.	W 226	QMRP will develop a toothbrushing objective for Client #1. The toothbrushing program will be implemented at the day program and group home.	3/1/07
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 behavioral outcome. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to state clients behavioral objectives in a single behavioral outcome for two of the two clients in the sample. (Clients #1 and # 2) The findings include: The facility failed to state Client #1 and #2's behavioral objectives in a single behavioral outcome as evidenced below: 1. Interview with staff on January 23, 2007 revealed Client #1 had a behavior support plan which addresses pica, skin picking/scratching, tearing and shredding, hair pulling, and non-	W 229	The behavioral objective for Client #1 and #2 will address each target behavior separately with measurable outcomes.	3/1/07

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W 229	Continued From page 26 compliance. The review of Client #1's Individual Support Plan (ISP)revealed the following behavioral objectives: Ms. [Client #1] will decrease incidents of pica, skin picking/scratching, non-compliance, shouting /yelling, property destruction, and hair pulling to zero incidents per month. There was no evidence these objectives were stated in measurable indices for monitoring of the client's behaviors. 2. Interview with staff on January 23, 2007 revealed Client #2 had a behavior support plan which addresses physical aggression towards others and self, and property destruction. The review of Client #2's Individual Support Plan (ISP) revealed the following behavioral objectives: Ms. [Client #2] will reduce frequency of challenging behaviors,i.e. stealing, skin picking, scratching forehead, hair pulling, wrist biting, hitting others scratching others, biting others, whining, verbal tantrums, and non-aggressive physical tantrums. There was no evidence these objectives were stated in measurable indices for monitoring of the client's behaviors.	W 229	Client #1's behavioral objectives will be revised and stated in measurable terms.	3/1/07
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management.	W 247		

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W 247	Continued From page 27 This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to allow clients the opportunity to exercise their right to choice and self management for two of the two clients included in the sample. (Clients #1 and #2) The findings include: 1. Observation on January 23, 2007 revealed Client #2 arriving home from her day treatment program at 3:12 PM. The direct care staff provided a sugar free vanilla pudding for the client's snack. She was observed to sit at the dinning room table to eat her pudding. There was no evidence that the staff offered the client a choice of snack. At the time of the survey, the facility failed to ensure the client 's right to select a snack of her choice had been exercised.	W 247	1. Client #2 will be given the opportunity to select a snack from several choices.	3/1/07
	2. Interview with the Residential Manager (RM)on January 24, 2007 at 3:50 PM revealed that Client #2 had an objective to prepare and snack. Record verification revealed that the client had an objective to prepare a simple snack with a peer and serve prior to the structured group home activity twice per week with minimal physical assistance. At the time of the survey, the facility failed to ensure that Client #2 had the opportunity to participate in preparing a snack for one of her peers.		2. Client #2 will be given the opportunity to prepare a snack for her peers as stated in her objective.	3/1/07
	3. Observation on January 24, 2007 revealed Clients #1 and #2 arriving home from their day treatment programs at 2:30 PM. The direct care staff provided the clients with a snack-sized box of raisins. There was no evidence that the staff offered the client a choice of snack. At the time		3. During snack time residents will be given an opportunity to select a snack.	3/1/07

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W 247	Continued From page 28 of the survey, the facility failed to ensure the client's right to select a snack of her choice had been exercised.	W 247		
W 250	483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to develop an active treatment schedule that outlined the current active treatment programs, for one of the two clients included in the sample. (Client #1) Interview with the RM on January 23, 2007 at 2:46 PM revealed that Client #1 did not have an alternative schedule when suspended from the day program. According to the RM, Client #1 was suspended from her day program for non-compliance. Further interview with RM revealed the client was absent from the day program for approximately 19 days. At the time of the survey, the client had returned to her day program. The QMRP was asked if the client had an alternative schedule during the time she was at home. Interview with the Qualified Mental Retardation Professional (QMRP) on January 23, 2007 revealed that she was assigned to the facility approximately two weeks ago and she did not know if she had an alternative schedule at that time.	W 250	An active treatment schedule will be developed and implemented for any client that is not attending a day program.	3/1/07

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W 250	Continued From page 29 Interview and review of the client's record revealed that she did not have an alternative schedule during her absence from the day program. According to the direct care staff, she worked with Client #1 during the time the client stayed home from the day program. The staff indicated that the client worked on her puzzles and she would take her out sometimes. When asked if she had a schedule to follow she stated " no."	W 250		
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 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 medication, for one of the two clients included in the sample. (Client #1)	W 263	Cross reference W124.	3/1/07
W 264	The facility's Human Rights Committee (HRC) failed to ensure informed consent was given in the use of Aricept in the management of Client #1 's non-compliant behaviors. [See W159, #1] 483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful	W 264	the HRC will review data on the use of Aricept in the management of non-compliant behaviors for Client #1.	3/1/07

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W 264	Continued From page 30 or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. This STANDARD is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to implement Human Rights Committee (HRC) recommendations to review, monitor and make suggestions to the facility about its practices and programs as they relate to protection of client rights ,and any other areas that the committee believes that could be an infringement of the clients' rights. The finding includes: [Cross Reference W159] Client #1 was observed during the evening medication pass on January 22, 2007 at 6:59 PM. The client was observed to receive Depakote 500 mg, Revia 50 mg, and Tegretol XRU-D 40 mg. Review of Client #1's physician's orders dated January, 2007, revealed that the client was prescribed Aricept 10 mg. Interview with the Primary Care Nurse (PCN) and review of the Medication Administration Record (MAR) revealed that the client started this medication on September 28, 2006. The facility's Human Rights Committee (HRC) minutes was reviewed on January 25, 2007. Review of the HRC minutes for September and October 2006 failed to evidence that the recommended medication (Aricept) was	W 264	In the future the HRC will review and approve all Psychotropic Medications including medication for dementia.	3/1/07

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W 264	Continued From page 31 reviewed and approved for Client #1. The facility's HRC minutes reflected a statement that indicated the use of all medication included in the client's Behavior Support Plan (BSP) was reviewed and approved on November 16, 2006, however, the Aricept was not reviewed/approved.	W 264	In the future the HRC will review and approve all Psychotropic Medications including medication for Dementia.	2/26/07
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 observations, staff interview, and record review the facility failed provide recommended assessment for preventive and general care for one of two clients in the sample. (Client #1) The finding includes: An interview with the group home Residential Manager (RM) on January 24, 2007 revealed that in September/October 2006, the client was suspended from her day program for approximately nineteen days due to behaviors of non-compliance. A case conference was held on October 12, 2006 to discuss the client's increase of non-compliant with daily routines, lack of participation in day program activities, and decrease compliance with ADLs' (personal hygiene). Residential data collection at that time revealed an increase in the non-compliance from an average of 35 in July and August to 177 in September, 2006. In response to the increase in the behavior, the	W 322	In the future the Psychiatrist will consult with the Inter-disciplinary Team before initiating new psychotropic medication and/or medication used for Dementia.	3/1/07

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W 322	Continued From page 32 facility's psychiatrist recommended that the client be assessed for dementia and/or begin a diagnostic therapeutic trial of Aricept 10 mg to be added to her drug regime. The psychological assessment dated October 2, 2006 recommended that the client be assessed for possible dementia prior to making any changes in the client's psychotropic medications, including starting Aricept. Review of the social worker assessment dated October 1, 2006 also recommended that the client be assessed for dementia prior to the trial of Aricept. However, the Aricept was ordered, and initiated on September 28, 2006 without any evidence that the Interdisciplinary team recommendations were addressed or that the human rights committee had reviewed or approved its usage. Review of the data collection since the initiation of the Aricept, revealed that the client had not been assessed for dementia. Although the client's behavior of non-compliance at the residence decreased to 41 incidents in November (2006), this behavior increase to 98 incidents in December (2006). It should be noted that in addition to the increase in behaviors of non-compliance, also in December (2006) the client demonstrated an increase in skin picking, and pica (from zero to 60 incidents of eating feces).	W 322		
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 staff interview and record review the facility failed to ensure nursing services in accordance with the needs of one of two clients	W 331		

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W 331	Continued From page 33 included in the sample. (Client #1) The finding includes: The facility's nursing services failed to ensure that medications were labeled with the client's name, expiration date and treatment administration instructions. [See W391]	W 331	All over the counter medication will have a pharmacy label with the Client's name, instruction, and expiration date.	2/26/07
W 391	483.460(m)(2)(ii) DRUG LABELING The facility must remove from use drug containers with worn, illegible, or missing labels. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to remove drug containers with missing labels and/or ensure that clients only received medications from containers with individualized prescription labels, for one of the two clients in the facility. [Client #1] The findings include: 1. During the medication pass observation on Jan 22, 2007 at approximately 6:59 PM Client #1 was administered Caltrate 600 +D and Zinc Dietary Supplement 50 mg. Further observations revealed that the medication was not labeled with the client's name, expiration date and treatment administration instructions. Interview with the nurse revealed that the medication is an over the counter medication. An interview was conducted on January 24, 2007 with the Primary Care Nurse (PCN) to confirm that the medications did not have the appropriate labeling, because the over the counter medications were ordered in bulk, due to the fact that client's Medicaid Insurance does not cover over the counter medications.	W 391	Cross reference W331.	2/26/07

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W 391	Continued From page 34 2. During the environmental walk-through on January 25, 2007, at approximately 1:17 PM revealed that Client #1's Dental 5000 PPM fluoride Prescription was observed at her bedside in a plastic storage container. Further observation revealed that the treatment medication was not labeled with the client's name, expiration date and treatment administration instructions.	W 391		
W 441	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on review of the fire drill records, the facility failed to consistently conduct emergency evacuation drills under varied conditions. The finding includes: Review of the facility's fire drill records on January 25, 2006 at approximately 2:53 PM for the period September 2006 - December 2006, there was no evidence that the facility was documenting the environmental weather conditions during the drills .	W 441	The QMRP and Residential Manager will schedule fire evacuation drills to be conducted under varied weather conditions.	3/1/07
W 454	483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a sanitary environment to avoid sources and transmissions of infection.	W 454		

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W 454	Continued From page 35 The finding includes: During the environmental walk-through on January 25, 2007 at 1:17 PM, revealed that Client #1 had an electric toothbrush. The toothbrush was observed sitting on her dresser without a protective covering.	W 454	A protective cover for Client #1's electric toothbrush will be purchased.	3/1/07

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I 000	INITIAL COMMENTS A licensing survey was conducted from January 22, 2007 through January 25, 2007. A random sample of two clients was selected from a residential population of four females with various degrees of mental retardation and other disabilities. The findings of the survey were based on observations at the group home and two day programs, interviews with staff and clients, and review of records, including incident reports.	I 000		
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, GHMRP failed to ensure adequate administrative support had been provided to efficiently meet the needs of the residents as required by their habilitation plans. The finding includes: (See Federal Deficiency Report Citations W104 and W159)	I 180	Cross reference W104 and W159.	3/1/07
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: Based on the review of records, the GHMRP failed to provide evidence that the supervisor	I 203		

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I 203	Continued From page 1 discussed the contents of job descriptions with each employee at the beginning of their employment and annually thereafter. The finding includes: Review of the personnel files on January 24, 2007 revealed the GHMRP failed to provide evidence of a current signed job description for one staff.	I 203	The facility will have each employee to review and sign job descriptions annually.	3/1/07
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.	I 206	All employees will have current health certificates in their personnel files.	3/1/07
	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: Review of the personnel records on January 24, 2007 revealed that the GHMRP failed to ensure that current health certificates were on file for five consultants.		All consultants will be requested to obtain current health certificates.	3/1/07

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I 229	Continued From page 2	I 229		
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 staff interview and record review, the GHMRP failed to ensure each employee with initial and continuing training that enables the employee to perform duties competently for one of four clients residing in the facility. The finding includes: Review of the training records on January 24, 2007 The GHMRP failed to provide documented evidence of training on human sexuality and recreation.	I 229	Training will be provided for staff in human sexuality and recreation.	3/2/07
I 247	3511.5 DIRECT CARE STAFF RATIOS Staffing ratios may be changed during the period of licensure if, in DHS ' determination, the needs of residents require a different staffing pattern, but in no event shall the number of staff per resident be less than established in these chapter . This Statute is not met as evidenced by: Based on observation, staff interviews, and review of staffing schedule, the facility failed to ensure that sufficient direct care staff to manage and supervise clients in accordance with their	I 247	Cross reference W104.	3/1/07

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I 247	Continued From page 3 individual program plans were available. The finding includes: [See W104 #1, W159, W186 and W196]	I 247		
I 274	3513.1(e) ADMINISTRATIVE RECORDS Each GHMRP shall maintain for each authorized agency ' s inspection, at any time, the following administrative records: (e) Signed agreements or contracts for professional services; This Statute is not met as evidenced by: Based on record review, the GHMRP failed to maintain signed contractual agreements for outside services. The finding includes: Review of the personnel records on January 24, 2007 revealed that the GHMRP failed to provide documented evidence of contractual agreements for consultants C1, C2, C10, C21.	I 274	All consultants will have signed contractual agreements in their personnel file.	3/1/07
I 390	3520.1 PROFESSION SERVICES: GENERAL PROVISIONS Each resident of a GHMRP, regardless of his or her age or degree of disability, shall receive the professional services required to meet his or her needs as identified in his or her individual habilitation plan in accordance with the current " Outcome Performance Measures " from the " Council on Quality and Leadership in Support for People With Disabilities " (Council) and to the extent of funds appropriated for purposes of D.C.	I 390	Cross reference W226, W229.	3/1/07

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I 390	Continued From page 4	I 390		
	Law 2-137, as amended.			
	This Statute 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 coordinated, integrated and monitored by the Qualified Mental Retardation Professional (QMRP).			
	The findings include:			
	1. Cross Refer to W196,W247. The QMRP failed to ensure clients received continuous informal and formal learning opportunities.		1. Cross reference W196, W247.	3/1/07
	2. Cross Refer to W125 and W247. The QMRP failed to ensure clients rights were being taught and encouraged.		2. Cross reference W125, W247.	3/1/97
	3. Cross Refer to W124. The QMRP failed to ensure clients were assessed or that persons to advocate for them had been identified.		3. Cross reference W!24.	3/1/07
	4. Cross refer to W454. The QMRP failed to maintain a sanitary environment to avoid sources and transmissions of infection.		4. Cross reference W454.	3/1/07
	5. Cross refer to W441. The QMRP failed to ensure that each employee had initial and continuing training in conducting fire drills under varied conditions.		5. Cross reference W441.	3/1/07
	6. Cross Refer to W322. The QMRP failed to coordinate with the Neurologist to assess Client # 2 for Dementia.		6. Cross reference W322.	3/1/07
I 500	3523.1 RESIDENT'S RIGHTS	I 500		
	Each GHMRP residence director shall ensure			

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G053	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/25/2007
NAME OF PROVIDER OR SUPPLIER C M S	STREET ADDRESS, CITY, STATE, ZIP CODE 2836 MYRTLE AVENUE NE WASHINGTON, DC 20018		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 500	Continued From page 5 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, staff interview and record review, the GHMRP failed to ensure habilitation and training was provided to its residents that would enable them to acquire and maintain life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning. The finding includes: See Federal Deficiency Report - Citations W124, W125, and W263.	I 500	Cross reference W124, W125, and W263.	3/1/07