



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

PRINTED: 11/30/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G101	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2007
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NAME OF PROVIDER OR SUPPLIER: MTS	STREET ADDRESS, CITY, STATE, ZIP CODE 6014 32ND STREET, NW WASHINGTON, DC 20015
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OF 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
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W 000	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted from November 13, 2007 through November 14, 2007. The survey was initiated utilizing the fundamental survey process. A random sample of two clients were selected from a population of four males with various degrees of disabilities.</p> <p>The findings of this survey were based on observations at the group home, two day programs, interviews with clients and staff at both the group home and day programs, review of clinical and administrative records to include the facility's unusual incident reports.</p>	W 000		
W 114	<p>483.410(c)(4) CLIENT RECORDS</p> <p>Any individual who makes an entry in a client's record must make it legibly, date it, and sign it.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure persons making entries in the medical record made them legibly and signed them for one of the two clients in the sample. (Client #1)</p> <p>The findings include:</p> <ol style="list-style-type: none"> Review of Client #1's medical record on November 14, 2007, at 11:30 AM revealed a nursing assessment dated July 25, 2007. The document lacked the signature of the person completing the document. The document was confirmed with the Qualified Mental Retardation Professional (QMFP) and Registered Nurse at the exit conference on November 14, 2007 at 3:00 PM. 	W 114	<p>3514.2 Also with 4</p> <p>The RN signed the assessment the day of the survey exit... 11-14-07.</p> <p>The DON will review all nursing annual assessments before they are submitted to insure that they are full and complete, signed and dated... 12-30-07.</p> <p>The QMRP will also audit the assessments prior to submission... 12-30-07.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE <i>Residential Prog. Asst.</i>	(X6) DATE 12/11/07
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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B. WING _____

(X3) DATE SURVEY
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W 000

INITIAL COMMENTS

W 000

A recertification survey was conducted from
November 13, 2007 through November 14, 2007.
The survey was initiated utilizing the fundamental
survey process. A random sample of two clients
were selected from a population of four males
with various degrees of disabilities.

The findings of this survey were based on
observations at the group home, two day
programs, interviews with clients and staff at both
the group home and day programs, review of
clinical and administrative records to include the
facility's unusual incident reports.

W 114

483.410(c)(4) CLIENT RECORDS

W 114

Any individual who makes an entry in a client's
record must make it legibly, date it, and sign it.

This STANDARD is not met as evidenced by:
Based on interview and record review, the facility
failed to ensure persons making entries in the
medical record made them legibly and signed
them for one of the two clients in the sample.
(Client #1)

The findings include:

1. Review of Client #1's medical record on
November 14, 2007, at 11:30 AM revealed a
nursing assessment dated July 25, 2007. The
document lacked the signature of the person
completing the document. The document was
confirmed with the Qualified Mental Retardation
Professional (QMRP) and Registered Nurse at
the exit conference on November 14, 2007 at
3:00 PM.

3514.2

Also W114

The RN signed the assessment the day of the survey exit... 11-14-07.

The DON will review all nursing annual assessments before they
are submitted to insure that they are full and complete, signed and
dated ... 12-30-07.

The QMRP will also audit the assessments prior to
submission ... 12-30-07.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

Residential Prog. Asst. 12/11/07

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W 114 Continued From page 1
2. Review of Client #1's medical record on November 14, 2007 at 2:15 PM revealed that the client was evaluated by the Podiatrist on April 26, 2007. At that time the client was diagnosed with tinea pedis. Cream was prescribed and there was a recommendation for follow-up on August 22, 2007. The chart lacked evidence that the client had seen the podiatrist on the recommended follow-up date. The chart did however reflect that Client #1 was evaluated by the podiatrist on September 12, 2007, however the writing on the consultation was illegible therefore it could not be determined if the tinea pedis was resolved.

W 114
W114
The prescribed cream has helped the foot problem (tinea pedis) significantly but it is not quite fully resolved. The RN will write a follow up note in the record updating the status of resident #1's foot problem... 12-15-07.
The QMRP will contact the podiatrist and reinforce the need to insure that the follow up notes are readable and MTS has developed a guide for physicians also reinforcing that consideration.....12-15-07.

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
3523.1 - W 124 W 263
1. MTS has developed a new consent form specific to psychotropic medication regimens and behavioral support plans. The QMRP will review completed forms with the mother of resident #1, supported by nursing, explain the risks and benefits clearly to her and obtain her consenting signature by ... 12-30-07.

This STANDARD is not met as evidenced by:
Based on observation, interview and record verification, the facility failed to ensure the right of each client 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 two of the two clients in the sample. (Clients #1 and #2)

The findings include:
1. During the medication pass observation on

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W 124

Continued From page 2
November 13, 2007 at 5:30 PM Client #1 received Depakote 500 mg and Klonopin 2 mg. During the entrance conference on the same day at 10:20 AM, the Qualified Mental Retardation Professional (QMRP) indicated that Client #1 received psychotropic medication in conjunction with a Behavior Support Plan (BSP) to address his maladaptive behaviors. The QMRP also indicated that the client's mother was very involved in his life.

Review of Client #1's record on November 14, 2007, lacked evidence that the potential risks involved in using psychotropic medication, the BSP, or his right to refuse treatment had been explained to the client or his/her mother. The client's psychological assessment, indicated the client's cognitive abilities tested in the moderate range of retardation and he lacked the capacity to process information effectively to make sound decisions. The QMRP indicated that the client's mother was willing to sign any necessary consents for restrictive measures. The psychologist assessed the client as not being capable of making informed decisions. However, the facility failed to document attempts to secure informed consent from Client #1's mother with regards to the restrictive measures employed to control his maladaptive behaviors.

2. During the entrance conference on November 13, 2007 at approximately 10:00 AM, the QMRP indicated that Client #2 receives psychotropic medications for his maladaptive behavior. Further interview revealed that the client and does not have a legal guardian. Review of the client's current physician orders revealed that the client received the following psychotropic medications: Luvox 25 mg QPM, Seroquel 100

W 124

2. MTS has submitted the necessary paperwork to obtain a legal guardian for resident #2 but the QMRP notes do not reflect the QMRPs follow up actions and conversations. There have been several. The QMRP will pursue a legal guardian for resident #2 until one is obtained and the QMRP monthly notes will reflect the status of follow up at any given point beginning with the December 2007 notes ... 1-10-07.

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W 124	<p>Continued From page 3 mg QAM and C noon and 150 mg QPM, and Zyprexa 5 mg QPM.</p> <p>On November 13, 2007 at approximately 2:00 PM, further review of Client #2's record failed to show evidence that written informed consent had been obtained for the use of the medication. There was no evidence that the potential risks involved in using this medication, or his right to refuse treatment had been explained to the client. The client's Psychological Assessment, dated May 2, 2007, indicated the client's cognitive abilities tested in the severe range of retardation and he lacked the capacity to process information effectively to make sound decisions.</p> <p>The psychologist had assessed the client as not being capable of making informed decisions, the facility failed to document attempts to secure an appropriate surrogate decision-maker. [See W263]</p>	W 124		
W 125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to demonstrate how the rights of all clients were protected and failed to allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States for one of two clients in the sample. (Client #2)</p>	W 125		

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W 125 Continued From page 4

The finding includes:

Review of the financial records on November 14, 2007, at 1:30 PM, it was discovered that a debit of \$150.00 was made from Client #2's account to pay for a television. The ledger document indicated that the debit was made to pay for a television. Review of the incident reports on November 13, 2007 at 10:00 AM revealed that during a behavior episode, Client #2 destroyed Client #1's television.

Review of Client #2's Behavior Support Plan dated April 24, 2007, does not address the client having to replace items that he breaks or destroys during behavior episodes.

During the entrance conference on November 13, 2007, the QMRP informed the surveyors that Client #2 did not have family involvement nor a guardian to assist him in making decisions and to protect his rights.

W 125

W125

The BSP of resident #2 will be modified to reflect strategies aimed at preventing property destruction and restitution parameters... 1-15-07.
The TV repayment issue will be taken before the MTS Human Rights Committee for its review. If the committee agrees with the decision it will stand. If not, the account of resident #2 will be reimbursed... 1-30-07.
All future decisions of this type will go before the MTS Human Rights Committee before they are implemented... 1-30-07.
MTS continues to see a legal guardian for resident #2 and the QMRP will continue the follow up until a guardian is obtained... 2-28-07.

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 notify parents and/or guardians of significant incidents for one of the two clients in the sample. (Client #1)

W 148

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W 148 Continued From page 5
The findings include:

Review of the facility's unusual incident reports and investigative reports on November 13, 2007 at approximately 10:00 AM, failed to provide evidence of the prompt notification of family members and/or guardians of the incidents detailed below:

a. On January 3, 2007, Client #1 complained of back pain/flank pain. There was a small amount of blood in his urine. He was transported via the facility's van; to the emergency room (ER). A Cat Scan performed at the ER reflected that there was no stones observed. The ER physician indicated that the pain was likely musculoskeletal. The client was prescribed pain medication.

b. On June 11, 2007, Client #1 was taken to the hospital for a cough. He was treated and released with a diagnosis of upper respiratory infection.

c. On September 24, 2007 Client #1 was transported to the emergency room for a cough. He was treated and released from the ER with a diagnosis of pneumonia/bronchitis.

Interview with the Qualified Mental Retardation Professional (QMRP) on November 14, 2007 at 2:00 PM revealed that the client's mother had been notified of the aforementioned incidents, however could not provide evidence to support his statement.

W 148

3519.5 *W-148*

As the QMRP stated to the surveyor, resident #1's mother was notified in each case but the QMRP failed to document the conversations in his monthly notes. The QMRP will document all such contacts in his monthly notes beginning ... 12-1-07.

W 192 483.430(e)(2) STAFF TRAINING PROGRAM

For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.

W 192

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W 192	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the facility failed to ensure effective training with regard to special diets for one of two clients in the sample. (Client #1) The finding includes: On November 13, 2007, Client #1 was observed at his day placement program. At approximately 11:15 AM, the client indicated to his 1:1 staff that he wanted to take his dentures out. The staff directed the client to the bathroom and instructed him to take the dentures out and place them in a paper towel. The client gave the paper towel with the dentures to the staff who placed them in a denture cup. At 11:45 AM the client was observed eating his lunch. The lunch consisted of a tuna salad sandwich and water. The sandwich was served on a sub-roll. The client gummed the sandwich as he ate. Review of the clients physician's orders on the same day revealed that he is prescribed a chopped texture 1800 calorie diet. At no time during lunch observation did the staff cut the sandwich to ensure a chopped consistency as recommended. Interview with the QMRP on November 14, 2007 at 2:30 PM revealed that the client usually eats without his dentures. The QMRP also acknowledged the need for the chopped diet consistency.	W 192	3502.5 W 192 The QMRP will meet with the day program of resident #1 to insure that all of its staff understand and follow the prescribed diet (1800 calorie, chopped)... 12-30-07. The QMRP will visit the program at minimum monthly to insure that the diet regimen is being implemented on a consistent basis... 12-1-07. At home, resident #1's food is chopped consistently and he has no problem eating in his preferred way (i.e. without his dentures), however the QMRP will coordinate with the speech pathologist to observer resident #1 at mealtime to insure that there is no danger of choking or aspiration because resident #1 prefers to eat without his dentures. The speech pathology notes will reflect her findings... 12-30-07.	
W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific	W 227		

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W 227	<p>Continued From page 7</p> <p>objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>This STANDARD is not met as evidenced by: Based on interview with the observation, staff interview and record review, the facility failed to ensure that an objectives was developed to address self medication training program as identified by the interdisciplinary team (IDT) in the comprehensive assessment for one of the two clients in the sample. (Client #2)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of Client #2's records on September 13, 2007 at 2:00 PM revealed the client's Self-Medication Assessment dated May 2, 2007. According to the assessment, the client was recommended to participate in a self-medication program, and the specific goal and corresponding program objective was documented on the assessment. Interview with the Qualified Mental Retardation Professional (QMRP) and further record review on November 13, 2007 at 3:00 PM revealed Client #2's IPP dated May 2, 2007. Review of the plan and discussion with the QMRP failed to provide evidence of an objective written to assist the client with acquiring skills in the domain of self-medication administration. 2. On November 13 2007 at 7:45 AM, Client #2 was observed as overweight. Interview with the direct care staff revealed that the client receives a restrictive diet. Review of the client's medical 	W 227	<p>3521.1</p> <p>W-227</p> <ol style="list-style-type: none"> 1. Resident number two will have a self-medication program added to his active treatment regimen that reflects his existing skill levels and potential for growth/improvement... 12-24-07. <p>The QMRP will collaborate with nursing to develop and implement the program.</p> <p>W-227</p> <ol style="list-style-type: none"> 2. The QMRP will collaborate with the relevant members of the IDT to establish an exercise regimen for resident #2. However, the regimen may be a structured activity as opposed to a measurable objective. That decision will be made by the team with resident #2's input as to what exercises he desires to do ... 12-30-07. 	

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W 227	Continued From page 8 record indicated a 1500 calorie, no concentrated sweets, no added salt. According to the Nutritionist assessment dated April 28, 2007 indicated that the client is 27 pounds overweight. The Nutritionist recommended that the client participate in physical activity at least two to three times per week for 30-40 minutes. Review of the client's IPP dated May 2, 2007 revealed no training goals or objectives to assist the client in losing or maintain his weight.	W 227		
W 255	483.440(f)(1)(i) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, staff interviews and record review, the Qualified Mental Retardation Professional (QMRP) failed to review and revise the Individual Program Plan (IPP) once the client had successfully completed an objective identified in the IPP for one of the two clients in the sample. (Client #2) The finding includes: The facility's QMRP failed to revise Client #2's program objectives. a. On November 13, 2007 at 8:10 AM, Client #2 was observed assisting the direct care staff with laundry. The client measured the laundry detergent and set the dial requiring verbal	W 255	3521.5 (a) W 255 All three objectives cited will be modified to reflect the progress made... 12-30-07. The QMRP will review the data for each objective monthly and modify programs based on progress or the lack thereof... 12-30-07. MTS will provide further training to the QMRP on modifying programs based on the (data-based) performance of the person and will provide additional standard tools for this QMRP and others to use as models... 1-30-07.	

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W 255	<p>Continued From page 9</p> <p>prompts from the staff. Interview with the direct care staff indicated that the client requires minimal verbal assistance. Review of the client's IPP dated May 2, 2007 revealed a program objective which stated, "given verbal directives, the client will complete pour measured laundry detergent into washing machine on 80% of the trials for three consecutive months. Record verification of the Qualified Mental Retardation Professional (QMIRP) and data sheets from March 2007 through October 2007 revealed that the client achieved the established criteria since March 2007.</p> <p>b. On November 14, 2007 at approximately 11:00 AM, in reviewing client's IPP dated May 2, 2007, the client had a program objective which stated, "[the client] will wash his upper body with a washcloth with verbal prompts for 12 consecutive months". Record verification of the data sheets on November 14, 2007 indicated that the client achieved the established criteria since June 2007.</p> <p>c. On November 14, 2007 at approximately 11:00 AM, in reviewing client's IPP dated May 2, 2007, the client had a program objective which stated, "Given verbal directives, [the client] will complete a tabletop activity with one or two of his peers on 80% of the record trials per month for six consecutive months". Review of the data sheets from August 2005 through October 2007 revealed that the client achieved the established criteria since August 2005;</p>	W 255		
W 263	<p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE</p> <p>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a</p>	W 263		

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W 263	<p>Continued From page 10 (minor) or legal guardian.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the facility failed to ensure that informed consent was obtained prior to the implementation of restrictive programs for two of the two clients in the sample. (Clients #1 and #2)</p> <p>The finding includes:</p> <ol style="list-style-type: none"> 1. Although the Qualified Mental retardation Professional (QMRP) indicated that Client #1's mother was very involved in the clients life and was willing to sign any necessary consents for restrictive measures, the facility failed to document attempts to secure informed consent from Client #1's mother with regards to the restrictive measures employed to control his maladaptive behaviors prior it's the implementation. 2. During the entrance conference on November 13, 2007 at approximately 10:00 AM, the QMRP indicated that Client #2 receives psychotropic medications for his maladaptive behavior. Further interview revealed that the client and does not have a legal guardian. Review of the client's current physician orders revealed that the client received the following psychotropic medications: Luvox 25 mg QPM, Seroquel 100 mg QAM and Q noon and 150 mg QPM, and Zyprexa 5 mg QPM. <p>On November 13, 2007 at approximately 2:00 PM, further review of Client #2's record failed to show evidence that written informed consent had been obtained for the use of the medication.</p>	W 263	<p>As the QMRP stated to the surveyor, resident #1's mother was notified in each case but the QMRP failed to document the conversations in his monthly notes. The QMRP will document all such contacts in his monthly notes beginning... 12-1-07.</p> <p>MTS has submitted the necessary paperwork to obtain a legal guardian for resident #2 but the QMRP notes do not reflect the QMRPs follow up actions and conversations. There have been several. The QMRP will pursue a legal guardian for resident #2 until one is obtained and the QMRP monthly notes will reflect the status of follow up at any given point beginning with the December 2007 notes... 1-10-07.</p>		

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W 263	Continued From page 11 There was no evidence that the potential risks involved in using this medication, or his right to refuse treatment had been explained to the client. The client's Psychological Assessment, dated May 2, 2007, indicated the client's cognitive abilities tested in the severe range of retardation and he lacked the capacity to process information effectively to make sound decisions. [See W124]	W 263			
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 observations, staff interview and record verification, the facility failed to provide routine laboratory testing as determined necessary by the physician for two of the two clients in the sample. (Clients #1 and #2) The findings include: The facility's Nursing staff failed to ensure recommended laboratory studies was obtained for Client #1 and Client #2 as evidenced by the following: a. During the medication observation on November 13, 2007 at 5:30 PM, Client #1 received Valproic Acid 500 mg. Review of Client #1's PO's on November 13, 2007 at 2:04 PM revealed an order for his valproic acid levels to be obtained every three months. Review of the laboratory results section of the medical record revealed that levels were obtained February 27,	W 325	W325 1. Resident #1's valproic acid levels will be checked quarterly as prescribed. The RN will use the MTS medical appointment charting tool to proactively track these and all medical appointments for her assigned grouping. The QMRP will meet with the RN monthly to review follow up for the people served in this home and the DON will do likewise for the entire cluster covered by this RN...12-1-07. 2. Same as above (regarding the lyses levels for resident #2).		

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W 325	<p>Continued From page 12</p> <p>2007, August 10, 2007, and August 15, 2007. The record lacked evidence that the levels were obtained every three months as ordered by the physician.</p> <p>It should be noted that the levels obtained on August 10, 2007 and August 15, 2007 were elevated 107.4 and 120.4 respectively (Normal limits 50 - 100)</p> <p>b. Review of Client #2's current physician orders revealed an order for laboratory studies to include Lytes, every three months. Review of the laboratory studies revealed that the client received lytes on May 3, 2007. Interview with the Registered Nurse on November 14, 2007 confirmed the latest laboratory studies.</p>	W 325		
W 331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide nursing services in accordance with the needs of two of the two clients included in the sample. (Clients #1, and #2)</p> <p>The findings include:</p> <p>1. The nursing staff failed to maintain the medication administration record.</p> <p>During the medication pass verification on November 14, 2007 at 1:30 PM, Client #1's Physicians Orders (PO's) and Medication Administration Records (MARS) were reviewed.</p>	W 331		

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W 331	<p>Continued From page 13</p> <p>Several spaces were blank on the MAR. Interview with the facility's Registered Nurse (RN) on the same day at approximately 2:30 PM, she acknowledged the lack of documentation on the MAR's.</p> <p>2. The facility's Nursing staff failed to ensure Client #1 was evaluated by the Urologist as recommended as evidenced by the following:</p> <p>Review of Client #1's record on November 13, 2007, at 2:15 PM revealed that he was evaluated by the Urologist on January 30, 2007. A appointment slip was noted to have an August 21, 2007 follow-up date. Further review of the record revealed that the client missed the August appointment (no reason was documented). The RN indicated on November 14, 2007 that the client was evaluated by the Urologist on October 16, 2007, however acknowledged the untimeliness of the appointment.</p> <p>3. The facility's Nursing staff failed to ensure Client #1 received the recommended Neurology evaluation as evidenced by the following:</p> <p>Review of Client #'s record on November 13, 2007, at 2:15 PM revealed that he was evaluated by the Neurologist on June 4, 2007. The consultant recommended that the client return in four to six weeks. The record lacked evidence that the client had returned for the follow-up visit as recommended.</p> <p>4. The facility's Nursing staff failed to ensure recommended laboratory studies was obtained for Client #1 and Client #2. [See W325]</p> <p>5. The facility's nurse failed to schedule an</p>	W 331	<p>W331</p> <ol style="list-style-type: none"> The RN will monitor and review the MARs at minimum weekly to insure that medication administration is implemented and documented consistently as prescribed...12-1-07. <p>The RN will conduct a training session with the medication nurses by...12-24-07.</p> <ol style="list-style-type: none"> Although not documented by nursing in the record, the urology appointment was rescheduled by the specialist. The RN will insure that the reasons for any cancellations or missed appointments are documented in the nursing notes in the future...12-20-07. Neurology will be scheduled for resident #1 by...12-20-07. See responses for W325 above. Urology will be scheduled for resident #2 by...12-20-07. See responses for W114 above. <p>b. Resident #2 will be scheduled for podiatry follow up by...12-20-07.</p> <ol style="list-style-type: none"> The needed Certificate of Waiver has been obtained...12-1-07. <p>The DON will meet with the RN monthly to review follow up for all medical consultations required for each person. The RN will use the MTS consultation tracking tool to insure that all appointments are scheduled in a timely manner and will document any problems incurred...12-15-07.</p> <p>In addition, MTS has revised its nursing supports creating an LPN team charged with scheduling and insuring implementation of all needed medical consultations...12-1-07.</p>	
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W 331	<p>Continued From page 14</p> <p>urology consultation appointments for Client #2, timely.</p> <p>Review of Client #2's medical record on November 13, 2007 revealed that the client has a diagnosis of bladder instability. Further review of the medical record revealed an urology consult on July 25, 2006 with a recommendation to return in one year. According to the consult the client should return in one year. At the time of the survey there was no evidence of urology consult.</p> <p>6. The facility nurse failed to obtain podiatry services for two of the two clients in the sample.</p> <p>a. Review of Client #1's medical record on November 14, 2007 at 2:15 PM revealed that he was evaluated by the Podiatrist on April 26, 2007. At that time the client was diagnosed with tinea pedis. Cream was prescribed and there was a recommendation to follow-up August 22, 2007. The chart lacked evidence that the client had seen the podiatrist on the recommended follow-up date. The chart did however reflect that Client #1 was evaluated by the podiatrist on September 12, 2007, however the writing on the consultation was illegible therefore it could not be determined if the tinea pedis was resolved.</p> <p>b. On November 13, 2007 at approximately 7:45 AM, Client #2 was putting on his shoes. The shoes were observed to have pads in them. Review of Client #2's medical record revealed a podiatry consult dated June 18, 2007. The consultation form recommended extra depth shoes to prevent trauma to the feet and to return in 12 weeks. Further review of the medical record revealed no updated podiatry consult. Interview with the Registered Nurse on November</p>
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W 331	
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W 331	Continued From page 15 14, 2007 at approximately 11:00 AM, confirmed that there was no updated podiatry consult.	W 331		
W 356	<p>7. The facility's nurse failed to obtain a Certificate of Waiver as required under the Clinical Laboratory Improvement Amendments of 1988 Act (CLIA) before administering finger stick tests for blood sugar glucose levels. [See W394]</p> <p>483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT</p> <p>The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure comprehensive treatment services for the maintenance of dental health for one of the two clients in the sample. (Client #2)</p> <p>The finding includes:</p> <p>On November 13, 2007 at approximately 8:00 AM, Client #2 was observed wearing dentures. Record review of the dental consultations dated June 27, 2006 and December 19, 2006. At both times, the dentist diagnosed heavy calculus deposits and recommended scaling. The dentist indicated that a request for pre-authorization would be submitted to Medicaid and that the facility would be contacted to schedule the procedure once pre-authorization was received. At the time of the survey, the facility failed to ensure that the client received his recommended dental services.</p>	W 356	<p>W358</p> <p>MTS nursing has been following up to obtain dental services for resident #2 but has had difficulty as is the case routinely for dental services for all individuals served in our system. This is a serious system issue that must be resolved. MTS will continue to pursue the prior authorization needed and will enlist the aid of the DDS case manager in doing so. The QMRP and nursing notes will reflect the status of progress...12-20-07. An appointment will be scheduled by... 12-28-07.</p>	

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W 394

483.460(n)(2) LABORATORY SERVICES

W 394

If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of service in accordance with the requirements of part 493 of this chapter.

This STANDARD is not met as evidenced by:
Based on observation, interview and record review, the facility failed to obtain a Certificate of Waiver as required under the Clinical Laboratory Improvement Amendments of 1988 Act (CLIA) before administering finger stick tests for blood sugar glucose levels for one of the two clients in the sample. (Client #2)

The finding includes:

Review of Client #2's medical record on November 13, 2007 at approximately 11:30 AM revealed a physician order to monitor the client's blood sugar, four times per day. On November 13, 2007, at approximately 2:25 PM, the facility's Registered Nurse was asked whether the facility had obtained a Certificate of Waiver, as required under the Clinical Laboratory Improvement Amendments of 1988 Act (CLIA). The nurse indicated that she had completed the application, however, completed the form incorrectly and it was returned to the Provider. The nurse indicated that she would re-submit the application. At the time of the survey, the facility did not have a CLIA Certificate of Waiver.

W394

The CLIA waiver has been obtained. Such waivers when needed will be obtained in a timely manner. Neither MTS management nor its DON were aware of this requirement and thanks the surveyor for bringing it to our attention... 12-1-07.

W 426

483.470(d)(3) CLIENT BATHROOMS

W 426

The facility must, in areas of the facility where clients who have not been trained to regulate

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W 426	<p>Continued From page 17</p> <p>water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.</p> <p>This STANDARD is not met as evidenced by: Based on observations, the facility failed to maintain water temperatures at or below 110 degrees Fahrenheit.</p> <p>The finding includes</p> <p>On November 13, 2007 at 4:00 PM, the hot water temperature felt hot to the touch. Readings from the surveyor's thermometer was 118 degrees Fahrenheit in the kitchen. The Qualified Mental Retardation Professional (QMRP) was informed. The maintenance staff was in the facility and adjusted the hot water tank, at which time the reading was 115 degree Fahrenheit. During the environmental inspection on November 14, 2007 at 1:15 PM, the hot water temperature registered at 116 degree Fahrenheit in the kitchen. At 2:30 PM the temperature reading was 120 degrees Fahrenheit. The QMRP was informed at 2:30 PM and instructed the staff to monitor the water temperature very closely and that staff would supervise the clients while bathing. The maintenance staff was called again to make adjustments to the hot water tank.</p>	W 426	<p>W426</p> <p>The hot water was adjusted to maximum 110 degrees by the end of the day it was brought to the attention of staff by the surveyor... 11-15-07.</p> <p>The water temperature will be checked daily and documented to insure that it is routinely at or below 110 degrees. Staff has been instructed to notify supervisors immediately whenever they get a reading above 110 degrees... 12-1-07.</p>	
W 440	<p>483.470(i)(1) EVACUATION DRILLS</p> <p>The facility must hold evacuation drills at least quarterly for each shift of personnel.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to hold evacuation drills quarterly on</p>	W 440		

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W 440	Continued From page 18 all shifts. The finding includes: Based on staff interview and record review, the facility failed to hold evacuation drills quarterly on all shifts. The finding includes: On November 13, 2007, interview with the Qualified Mental Retardation Professional and review of the weekly staffing schedule indicated that on Monday-Friday there are three designated shifts (7:00 AM - 3:00 PM; 3:00 PM - 11 PM; and 11:00 PM - 7:00 AM) and on Saturday and Sunday, there are two designated shifts (7:00 AM - 7:00 PM and 7:00 PM - 7:00 AM). There was no evidence that the facility conducted simulated fire drills at least four times a year for each shift. The facility's documentation reflected that only one fire drill had been conducted during the 7:00 AM - 3:00 PM, two on the 3:00 PM - 11:00 PM - 8:00 AM, two on the 11:00 PM - 7:00 AM (Monday - Friday) two fire drills on the 7:00 AM - 7:00 PM and two on the 7:00 PM - 7:00 AM (Saturday - Sunday) shift for the year.	W 440	3505.5 W-440 In December of 2007, the home will hold one fire drill for each shift... 12-30-07. MTS will develop a mandatory fire drill schedule for 2008 that reflects at least on drill being held per quarter for each work shift. This schedule will be distributed by... 12-30-07. The Assistant to the Residential Director will proactively monitor implementation of the mandatory fire drill schedule routinely to insure all homes and all staffs comply consistently. Shifts that miss a prescribed fire drill will have a make-up drill scheduled within 7 days... 12-30-07.		
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to properly defrost meats in preparation for dinner.	W 455			

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W 455	Continued From page 19 The finding includes: Upon entering the the kitchen on November 14, 2007 at approximately 1:30 PM, a package of turkey wings was observed in the sink. The meat was in the sink without water running over it to assist in defrosting. Review of the dinner menu indicated that chicken was on the menu for dinner. The observation was brought to the attention of the Qualified Mental Retardation Professional at 2:40 PM	W 455	Nursing and nutrition will cover proper defrosting of food in their training sessions when they discuss meal preparation overall... 12-30-07.	W-455
W 472	483.480(b)(2)(I) MEAL SERVICES Food must be served in appropriate quantity. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that food portions were served in accordance with the clients diet for two of two clients in the sample. (Clients #1 and #2) The findings include: Observation of the dinner meal on November 13, 2005 at 6:35 PM revealed the clients received Hamburger Helper, mixed vegetables, salad, pineapple, diet soda and water. Review of the posted menu revealed sloppy joe, hamburger bun, mixed vegetables crushed pineapple, beverage/water. Direct care staff were observed to serve all of the food with a large spoon. Review of the diet orders for Clients #1 revealed that he is prescribed a regular 1800 calorie chopped diet and Client #2 is prescribed a 1500 calorie, no concentrated sweets, no added salt diet. The menu was reviewed and revealed that	W 472	3502.14 W-471 W-472 1. The QMRP will coordinate with the nutritionist to insure that the home has proper tools for measuring food portions. Suggested tools will be purchased by ... 12-15-07. In addition, staff will be trained on the use of the tool(s) by ... 12-20-07. The QMRP and facility manager will observe at least one meal weekly (QMRP) or two weekly (facility manager) to insure staff follow the prescribed diets and use the tool(s) appropriately ... 12-30-07. Nursing will provide training on preparing diets according to prescribed menus by 12-20-07. Nutrition will follow up that training by ... 12-30-07. Both will cover menu-matched shopping to reduce the need to substitute items prescribed.	

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

09G101

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY
COMPLETED

11/14/2007

NAME OF PROVIDER OR SUPPLIER

MTS

STREET ADDRESS, CITY, STATE, ZIP CODE

6014 32ND STREET, NW

WASHINGTON, DC 20015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR I.S.C 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 472	<p>Continued From page 20</p> <p>Client #1 was to receive three ounces of the sloppy joe, one whole bun, 1/2 cup of mixed vegetables and pineapple. Client #2 was to receive two ounces of sloppy joe, one whole bun 1/2 cup of mixed vegetables and pineapple.</p> <p>There was no way to determine if the clients received the prescribed portion of the meat and vegetables. The observed amount of food on the clients' plates appeared to be more than the prescribed portions required for their diets. The QMRP also acknowledged that the staff failed to use proper measuring utensils.</p>	W 472		
W 481	<p>483.480(c)(2) MENUS</p> <p>Menus for food actually served must be kept on file for 30 days.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that menu substitutions were documented for four of the four clients residing in the facility (Clients #1, #2, #3, and #4).</p> <p>The finding includes:</p> <p>Observation of the dinner meal on November 13, 2005 at 6:35 PM clients were served Hamburger Helper, mixed vegetables, salad, crushed pineapple, diet soda and water. The review of the posted menu revealed sloppy joe, hamburger bun, mixed vegetables crushed pineapple, beverage/water were on the printed dinner menu.</p> <p>Interview with the Qualified Mental Retardation Professional on November 14, 2007 at 1:00 PM revealed that the facility did not have a system/procedure for documenting meal</p>	W 481	<p style="text-align: center;">W-481</p> <p>The nutritionist will provide a substitution list for all menu items that staff will follow if the need to substitute arises... 12-30-07.</p>	

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PREFIX
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PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

(X5)
COMPLETION
DATE

W 481

Continued From page 21
substitutions and that he was not aware that the
substitution had to be documented.

W 481

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1000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from November 13, 2007 through November 14, 2007. A random sample of two residents were selected from a population of four males with various degrees of disabilities.</p> <p>The findings of this survey were based on observations at the group home, two day programs, interviews with residents and staff at both the group home and day programs, review of clinical and administrative records to include the facility's unusual incident reports.</p>	1000		
1047	<p>3502.5 MEAL SERVICE / DINING AREAS</p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to ensure that meals served away from the GHMRP suited the residents dietary needs for one of the two residents in the facility. (Resident #1)</p> <p>The finding includes:</p> <p>On November 13, 2007, Resident #1 was observed at his day placement program. At approximately 11:15 AM, the resident indicated to his 1:1 staff that he wanted to take his dentures out. The staff directed the resident to the bathroom and instructed him to take the dentures out and place them in a paper towel. The Resident gave the paper towel with the dentures</p>	1047	<p>3502.5</p> <p>The QMRP will meet with the day program of resident #1 to insure that all of its staff understand and follow the prescribed diet (1800 calorie, chopped)... 12-30-07.</p> <p>The QMRP will visit the program at minimum monthly to insure that the diet regimen is being implemented on a consistent basis... 12-1-07.</p> <p>At home, resident #1's food is chopped consistently and he has no problem eating in his preferred way (i.e. without his dentures), however the QMRP will coordinate with the speech pathologist to observe resident #1 at mealtime to insure that there is no danger of choking or aspiration because resident #1 prefers to eat without his dentures. The speech pathology notes will reflect her findings... 12-30-07.</p>	

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6889

X9IV11

If continuation sheet 1 of 15

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1047	<p>Continued From page 1</p> <p>to the staff who placed them in a denture cup. At 11:45 AM, the resident was observed eating his lunch. The lunch consisted of a tuna salad sandwich and water. The sandwich was served on a sub-roll. The client gummed the sandwich as he ate it without his dentures.</p> <p>Review of the residents physician's orders on the same day revealed that he is prescribed a chopped texture 1300 calorie diet. At no time during the lunch observation did the staff cut the sandwich to ensure a chopped consistency as recommended.</p> <p>Interview with the QMRP on November 14, 2007 at 2:30 PM revealed that the resident usually eats without his dentures. The QMRP also acknowledged the need for the chopped diet consistency.</p>	1047		
1056	<p>3502.14 MEAL SERVICE / DINING AREAS</p> <p>Each GHMRP shall train staff in the storage, preparation and serving of food, the cleaning and care of equipment, and food preparation in order to maintain sanitary conditions at all times.</p> <p>This Statute is not met as evidenced by: Based on review of the training records and interview with the Qualified Mental Retardation Professional (QMRP) the GHMRP failed to ensure that staff had been provided training in the serving of food and food preparation in order to maintain sanitary conditions at all times.</p> <p>The findings include:</p> <p>1. Observation of the dinner meal on November 13, 2005 at 6:35 PM revealed the residents</p>	1056	<p>3502.14</p> <p>1. The QMRP will coordinate with the nutritionist to insure that the home has proper tools for measuring food portions. Suggested tools will be purchased by...12-15-07.</p> <p>In addition, staff will be trained on the use of the tool(s) by...12-20-07.</p> <p>The QMRP and facility manager will observe at least one meal weekly (QMRP) or two weekly (facility manager) to insure staff follow the prescribed diets and use the tool(s) appropriately.....12-30-07.</p> <p>Nursing will provide training on preparing diets according to prescribed menus by 12-20-07.</p> <p>Nutrition will follow up that training by...12-30-07.</p> <p>Both will cover menu-matched shopping to reduce the need to substitute items prescribed.</p> <p>The nutritionist will provide a substitution list for all menu items that staff will follow if the need to substitute arises...12-30-07.</p> <p>2. See 3502.5 responses above.</p> <p>3. Nursing and nutrition will cover proper defrosting of food in their training sessions when they discuss meal preparation overall... 12-30-07.</p>	

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1056	<p>Continued From page 2</p> <p>received Hamburger Helper, mixed vegetables, salad, pineapple, diet soda and water. Review of the posted menu revealed sloppy joe, hamburger bun, mixed vegetables crushed pineapple, beverage/water. Direct care staff were observed to serve all of the food with a large spoon. Review of the diet orders for Residents #1 revealed that he is prescribed a regular 1800 calorie chopped diet and Resident #2 is prescribed a 1500 calorie, no concentrated sweets, no added salt diet. The menu was reviewed and revealed that Resident #1 was to receive three ounces of the sloppy joe, one whole bun, 1/2 cup of mixed vegetables and pineapple. Resident #2 was to receive two ounces of sloppy joe, one whole bun 1/2 cup of mixed vegetables and pineapple.</p> <p>There was no way to determine if the residents received the prescribed portion of the meat and vegetables. The observed amount of food on the clients' plates appeared to be more than the prescribed portions required for their diets. The QMRP also acknowledged that the staff failed to use proper measuring utensils.</p> <p>2. On November 13, 2007, Resident #1 was observed at his day placement program. At approximately 11:15 AM, the client indicated to his one to one support staff that he wanted to take his dentures out. The staff directed the client to the bathroom and instructed him to take the dentures out and place them in a paper towel. The resident gave the paper towel with the dentures to the staff who placed them in a denture cup. At 11:45 AM the client was observed eating his lunch. The lunch consisted of a tuna salad sandwich and water. The sandwich was served on a sub-roll. The resident gummed the sandwich as he ate.</p>	1058		
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1056	Continued From page 3 Review of the residents physician's orders on the same day revealed that he is prescribed a chopped texture 800 calorie diet. At no time during lunch observation did the staff cut the sandwich to ensure a chopped consistency as recommended. Interview with the QMRP on November 14, 2007 at 2:30 PM revealed that the client usually eats without his dentures. The QMRP also acknowledged the need for the chopped diet consistency. 3. Upon entering the kitchen on November 14, 2007 at approximately 1:30 PM, a package of turkey wings was observed in the sink. The meat was in the sink without water running over it to assist in defrosting. Review of the dinner menu indicated that chicken was on the menu for dinner. The observation was brought to the attention of the Qualified Mental Retardation Professional at 2:40 PM	1056		
1135	3505.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift. This Statute is not met as evidenced by: Based on interview and record review the GHMRP failed to ensure that each shift conducted a fire drill four times a year. The finding includes: On November 13, 2007, interview with the Qualified Mental Retardation Professional and	1135	3505.5 In December of 2007, the home will hold one fire drill for each shift...12-30-07. MTS will develop a mandatory fire drill schedule for 2008 that reflects at least on drill being held per quarter for each work shift. This schedule will be distributed by...12-30-07. The Assistant to the Residential Director will proactively monitor implementation of the mandatory fire drill schedule routinely to insure all homes and all staffs comply consistently. Shifts that miss a prescribed fire drill will have a make-up drill scheduled within 7 days.....12-30-07.	

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I 135	Continued From page 4 review of the weekly staffing schedule indicated that on Monday-Friday there are three designated shifts (7:00 AM - 3:00 PM; 3:00 PM - 11 PM; and 11:00 PM - 7:00 AM) and on Saturday and Sunday, there are two designated shifts (7:00 AM - 7:00 PM and 7:00 PM - 7:00 AM). There was no evidence that the facility conducted simulated fire drills at least four times a year for each shift. The facility's documentation reflected that only one fire drill had been conducted during the 7:00 AM - 3:00 PM, two on the 3:00 PM - 11:00 PM - 8:00 AM, two on the 11:00 PM - 7:00 AM (Monday - Friday) two fire drills on the 7:00 AM - 7:00 PM and two on the 7:00 PM - 7:00 AM (Saturday - Sunday) shift for the year.	I 135		
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 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: Review of the personnel files on November 14, 2007 failed to provide evidence that direct care staff #8, and #9 job descriptions had been reviewed.	I 203	3509.3 The QMRP has reviewed job descriptions with staff members #8 and #9. An updated, signed and dated job description is now in the personnel file of both employees... 12-10-07. The QMRP will use the MTS personnel file tracking tool to insure that all staff have current, signed job descriptions at all times and to insure that he reviews the job descriptions with each staff member at minimum annually as required... 12-30-07.	
I 206	3509.6 PERSONNEL POLICIES	I 206		

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1206	Continued From page 5 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 interviews and record review, the facility failed to achieve compliance with State regulations pertaining to health (22 DCMR Chapter 35, Section 3509.6). The finding includes: The State regulatory agency conducted a review of personnel records; on November 14, 2007, at which time there was no evidence that five direct care staff had current health certificates. (Staff #1, #2, #7, #10, #11, and #12)	1206		
1229	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 verification, the facility failed to ensure effective training with regard to special diets for one of two residents in the sample. (Resident #1)	1229	3509.6 The cited staff members have been given a deadline to obtain updated health certificates or they will come off the work schedule. Updated health certificates will be obtained for the cited staff by... 12-30-07. The QMRP and Assistant to the Residential Director separately will conduct periodic audits of the personnel files to insure that staff are notified proactively about upcoming file issues.....12-30-07.	

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I 229	<p>Continued From page 6</p> <p>The finding includes:</p> <p>On November 13, 2007, Resident #1 was observed at his day placement program. At approximately 11:15 AM, the client indicated to his one to one support staff that he wanted to take his dentures out. The staff directed the resident to the bathroom and instructed him to take the dentures out and place them in a paper towel. The Resident gave the paper towel with the dentures to the staff who placed them in a denture cup. At 11:45 AM the resident was observed eating his lunch. The lunch consisted of a tuna salad sandwich and water. The sandwich was served on a sub-roll. The resident gummed the sandwich as he ate it without his dentures.</p> <p>Review of the residents physician's orders on the same day revealed that he is prescribed a chopped texture 1800 calorie diet. At no time during the lunch observation did the staff cut the sandwich to ensure a chopped consistency as recommended.</p> <p>Interview with the QMRP on November 14, 2007 at 2:30 PM revealed that the resident usually eats without his dentures. The QMRP also acknowledged the need for the chopped diet consistency.</p>	I 229	<p>3510.5 (f)</p> <p>See responses for 3502,5</p>	
I 291	<p>3514.2 RESIDENT RECORDS</p> <p>Each record shall be kept current, dated, and signed by each individual who makes an entry.</p> <p>This Statute is not met as evidenced by: Based on record review the GHMRP failed to ensure each residents records were dated and</p>	I 291		

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1291	Continued From page 7 signed by the individual completing the assessment or monitoring the lab profiles. The finding includes: Review of Resident #1's medical record on November 14, 2007, at 11:30 AM revealed a nursing assessment dated July 25, 2007. The document lacked the signature of the person completing the document. The document was reviewed with the Qualified Mental Retardation Professional and Registered Nurse at the exit conference on November 14, 2007 at 3:00 PM.	1291	3514.2 The RN signed the assessment the day of the survey exit...11-14-07. The DON will review all nursing annual assessments before they are submitted to insure that they are full and complete, signed and dated...12-30-07. The QMRP will also audit the assessments prior to submission...12-30-07.	
1374	3519.5 EMERGENCIES After medical services have been secured, each GHMRP shall promptly notify the resident's guardian, his or her next of kin if the resident has no guardian, or the representative of the sponsoring agency of the resident's status as soon as possible, followed by written notice and documentation no later than forty-eight (48) hours after the incident. This Statute is not met as evidenced by: Based on staff interview and record review, the GHMRP failed to provide evidence of the prompt notification of parents or guardians of significant incidents for one of the three residents in the sample. The finding includes: Review of the facility's unusual incident reports and investigations on November 13, 2007 at approximately 10:00 AM, failed to provide evidence of the prompt notification of family members and/or guardians of the incidents detailed below:	1374		

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1374	Continued From page 8 a. On January 3, 2007, Resident #1 complained of back pain/flank pain. There was a small amount of blood in his urine. He was taken to the emergency room. A CT scan performed at the ER reflected that there was no stones observed. The ER physician dincicated that the pain was likely muskuloskeletal. b. On June 11, 2007, Resident #1 was taken to the hospital for a cough. He was treated and released with a diagnosis of upper respiratory infection. c. On September 24, 2007 Resident #1 was transported to the emergency room for a cough. He was treated and released from the ER with a diagnosis of pneumonia/bronchitis. Interview with the Qualified Mental Retardation Professional (QMFP) on November 14, 2007 at 2:00 PM revealed that the Resident's mother had been notified of the aforementioned incidents, however could not provide evidence to support his statement.	1374	3519.5 As the QMRP stated to the surveyor, resident #1's mother was notified in each case but the QMRP failed to document the conversations in his monthly notes. The QMRP will document all such contacts in his monthly notes beginning...12-1-07.	
1420	3521.1 HABILITATION AND TRAINING Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those 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. 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	1420		

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NAME OF PROVIDER OR SUPPLIER MTS		STREET ADDRESS, CITY, STATE, ZIP CODE 6014 32ND STREET, NW WASHINGTON, DC 20015		
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1420	<p>Continued From page 9</p> <p>skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning for one of the two residents in the sample. (Resident #2)</p> <p>The findings include:</p> <p>1. Review of Resident #2's records on September 13, 2007 at 2:00 PM revealed the resident's Self-Medication Assessment dated May 2, 2007. According to the assessment, the resident was recommended to participate in a self-medication program, and the specific goal and corresponding program objective was documented on the assessment. Interview with the Qualified Mental Retardation Professional (QMRP) and further record review on November 13, 2007 at 3:00 PM revealed Resident #2's IPP dated May 2, 2007. Review of the plan and discussion with the QMRP failed to provide evidence of an objective written to assist the resident with acquiring skills in the domain of self-medication administration.</p> <p>2. On November 13, 2007 at 7:45 AM, Resident #2 was observed as overweight. Interview with the direct care staff revealed that the resident receives a restrictive diet. Review of the resident's medical record indicated a 1500 calorie, no concentrated sweets, no added salt. According to the Nutritionist assessment dated April 28, 2007 indicated that the client is 27 pounds overweight. The Nutritionist recommended that the resident participate in physical activity at least two to three times per week for 30-40 minutes. Review of the client's IPP dated May 2, 2007 revealed no training goals or objectives to assist the resident in losing or</p>	1420	<p>3521.1</p> <p>1. Resident number two will have a self-medication program added to his active treatment regimen that reflects his existing skill levels and potential for growth/improvement.....12-24-07.</p> <p>The QMRP will collaborate with nursing to develop and implement the program.</p> <p>2. The QMRP will collaborate with the relevant members of the IDT to establish an exercise regimen for resident #2. However, the regimen may be a structured activity as opposed to a measurable objective. That decision will be made by the team with resident #2's input as to what exercises he desires to do...12-30-07.</p>	

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1420	Continued From page 10 maintain his weight	1420		
1424	3521.5(a) HABILITATION AND TRAINING Each GHMRP shall make modifications to the resident's program at least every six (6) months or when the client: (a) Has successfully completed an objective or objectives identified in the Individual Habilitation Plan; This Statute is not met as evidenced by: Based on observation, staff interview and record review, the GHMRP failed to make modifications to the residents's program at least every six months when the resident has successfully completed an objective identified in the Individual Program Plan for one of the two residents in the sample. (Resident #2) The findings include: The facility's QMRP failed to revise Resident #2's program objectives. a. On November 13, 2007 at 8:10 AM, Resident #2 was observed assisting the direct care staff with laundry. The resident measured the laundry detergent and set the dial requiring verbal prompts from the staff. Interview with the direct care staff indicated that the resident requires minimal verbal assistance. Review of the resident's IPP dated May 2, 2007 revealed a program objective which stated, "given verbal directives, the resident will complete pour measured laundry detergent into washing machine on 80% of the trials for three consecutive months. Record verification of the Qualified Mental Retardation Professional	1424	3521.5 (a) All three objectives cited will be modified to reflect the progress made...12-30-07. The QMRP will review the data for each objective monthly and modify programs based on progress or the lack thereof...12-30-07. MTS will provide further training to the QMRP on modifying programs based on the (data-based) performance of the person and will provide additional standard tools for this QMRP and others to use as models...1-30-07.	

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1424	Continued From page 11 (QMRP) and data sheets from March 2007 through October 2007 revealed that the client achieved the established criteria since March 2007. b. On November 14, 2007 at approximately 11:00 AM, in reviewing resident's IPP dated May 2, 2007, the resident had a program objective which stated, "[the resident] will wash his upper body with a washcloth with verbal prompts for 12 consecutive months". Record verification of the data sheets on November 14, 2007 indicated that the resident achieved the established criteria since June 2007. c. On November 14, 2007 at approximately 11:00 AM, in reviewing residents IPP dated May 2, 2007, the resident had a program objective which stated, "Given verbal directives, [the resident] will complete a tabletop activity with one or two of his peers on 80% of the record trials per month for six consecutive months". Review of the data sheets from August 2005 through October 2007 revealed that the resident achieved the established criteria since August 2005.	1424		
1500	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 resident rights.	1500		

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1500	<p>Continued From page 12</p> <p>The finding includes:</p> <p>1. During the medication pass observation on November 13, 2007 at 5:30 PM, Resident #1 received Depakole 500 mg and Klonopin 2 mg. During the entrance conference on the same day at 10:20 AM, the Qualified Mental Retardation Professional (QMRP) indicated that Resident #1 received psychotropic medication in conjunction with a Behavior Support Plan (BSP) to address his maladaptive behaviors. The QMRP also indicated that the client's mother was very involved in his life.</p> <p>Review of Resident #1's record on November 14, 2007, lacked evidence that the potential risks involved in using psychotropic medication, the BSP, or his right to refuse treatment had been explained to the resident or his/her mother. The client's psychological assessment, indicated the resident's cognitive abilities tested in the moderate range of retardation and he lacked the capacity to process information effectively to make sound decisions. The QMRP indicated that the resident's mother was willing to sign any necessary consents for restrictive measures. The psychologist assessed the resident as not being capable of making informed decisions. However, the facility failed to document attempts to secure informed consent from Resident #1's mother with regards to the restrictive measures employed to control his maladaptive behaviors.</p> <p>2. During the entrance conference on November 13, 2007 at approximately 10:00 AM, the QMRP indicated that Resident #2 receives psychotropic medications for his maladaptive behavior. Further interview revealed that the resident and does not have a legal guardian. Review of the resident's current physician orders revealed that</p>	1500	<p>3523.1</p> <p>1. MTS has developed a new consent form specific to psychotropic medication regimens and behavioral support plans. The QMRP will review completed forms with the mother of resident #1, supported by nursing, explain the risks and benefits clearly to her and obtain her consenting signature by...12-30-07.</p> <p>2. MTS has submitted the necessary paperwork to obtain a legal guardian for resident #2 but the QMRP notes do not reflect the QMRPs follow up actions and conversations. There have been several. The QMRP will pursue a legal guardian for resident #2 until one is obtained and the QMRP monthly notes will reflect the status of follow up at any given point beginning with the December 2007 notes...1-10-07.</p>	

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1500	<p>Continued From page 13</p> <p>the resident received the following psychotropic medications: Luvox 25 mg QPM, Seroquel 100 mg QAM and Q noon and 150 mg QPM, and Zyprexa 5 mg QPM.</p> <p>On November 13, 2007 at approximately 2:00 PM, further review of Resident #2's record failed to show evidence that written informed consent had been obtained for the use of the medication. There was no evidence that the potential risks involved in using this medication, or his right to refuse treatment had been explained to the resident. The client's Psychological Assessment, dated May 2, 2007, indicated the resident's cognitive abilities tested in the severe range of retardation and he lacked the capacity to process information effectively to make sound decisions.</p> <p>The psychologist had assessed the resident as not being capable of making informed decisions, the facility failed to document attempts to secure an appropriate surrogate decision-maker.</p> <p>3. Review of the financial records on November 14, 2007, at 1:30 PM, it was discovered that a debit of \$150.00 was made from Resident #2's account to pay for a television. The ledger document indicated that the debit was made to pay for a television. Review of the incident reports on November 13, 2007 at 10:00 AM revealed that during a behavior episode, Resident #2 destroyed Resident #1's television.</p> <p>Review of Resident #2's Behavior Support Plan dated April 24, 2007, does not address the resident having to replace items that he breaks or destroys during behavior episodes.</p> <p>During the entrance conference on November 13, 2007, the QMRP informed the surveyors that</p>	1500	<p>3. The decision to have resident #2 pay for the TV he destroyed belonging to resident #1 was made at an IDT meeting with the DDS case manager present and in agreement. The annual Individual Financial Plan reflects this decision...12-1-07.</p> <p>The BSP of resident #2 will be modified to reflect strategies aimed at preventing property destruction and restitution parameters.....1-15-07.</p> <p>The TV repayment issue will be taken before the MTS Human Rights Committee for its review. If the committee agrees with the decision it will stand. If not, the account of resident #2 will be reimbursed...1-30-07.</p> <p>All future decisions of this type will go before the MTS Human Rights Committee before they are implemented...1-30-07.</p> <p>MTS continues to see a legal guardian for resident #2 and the QMRP will continue the follow up until a guardian is obtained.....2-28-07.</p>	

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1500	Continued From page 14 Resident #2 did not have family involvement nor a guardian to assist him in making decisions and to protect his rights. 4. Also See W263	1500		

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R 000	INITIAL COMMENTS A licensure survey was conducted from November 13, 2007 through November 14, 2007. A random sample of two residents were selected from a population of four males with various degrees of disabilities. The findings of this survey were based on observations at the group home, two day programs, interviews with residents and staff at both the group home and day programs, review of clinical and administrative records to include the facility's unusual incident reports.	R 000		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on the review of records, the GHMRP failed to ensure criminal background checks disclosed the criminal history of any prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. The finding includes: Review of the personnel files on November 14, 2007 revealed the GHMRP failed to provide evidence of criminal background checks for three direct care staff (Staff #6, #8, and #9).	R 125	R125 All staff will have current criminal background check by 12/1/07 MTS has a new system to check criminal records and will continue to implement this system to eliminate the issue of no background check-12/1/07	

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

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