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

PRINTED: 11/20/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G005		10/30/2008

NAME OF PROVIDER OR SUPPLIER: MTS

STREET ADDRESS, CITY, STATE, ZIP CODE: 4901 FOOTE STREET, NE, WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS	W 000		
	A recertification survey was conducted from October 28, 2008, through October 30, 2008. Initially, the fundamental survey process was utilized, but on October 28, 2008, the process was extended in the area of Client Protection due to concerns noted as a result of reviewing the facility's incident management system. A random sample of three clients was selected from a residential population of six clients (four males and two females) with mental retardation and other disabilities. The survey findings were based on observations in the group home and at two day programs, interviews, and a review of records, including unusual incident reports.		GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS	W 124		
	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.			
	This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the rights of each client and/or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment, for two of the three clients (Clients #2, and #3) included in the sample.			
	The findings include:			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lette D. Moore, TITLE: Director of Residential Services, (X6) DATE: 12-4-08

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

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W 124	Continued From page 1 The facility failed to ensure that informed consent was obtained from Clients #2 and #3 and/or their legal guardians prior to the administration of their psychotropic medications. a) Observation of the evening medication administration on October 28, 2008, beginning at 5:25 PM revealed Client #2 received medications including Risperdal and Clomipramine HCL. Interview with the medication nurse on October 28, 2008, revealed the aforementioned medications were used to address the client's behaviors. Interview with the Qualified Mental Retardation Professional (QMRP) on October 29, 2008, at 9:11 AM revealed that Client #2 did not have the capacity to give informed consent for the use of medications and habilitation services. The QMRP's statement was verified on October 30, 2008, at 10:12 AM through review of Client 2's psychological assessment dated January 9, 2008. According to the assessment, Client #2 "is not able to make independent decisions concerning her residential or day placements, treatment plan, or financial affairs. She lacks the cognitive skills necessary to understand the implications of such and therefore cannot give her informed consent." The QMRP further revealed the client had a legal guardian to assist her in decision making. At the time of the survey, the facility failed to provide evidence that informed consent was obtained from the client and/or legally authorized representative prior to the administration of the psychotropic medication. b) Observation of the evening medication administration on October 28, 2008, beginning at	W 124	W124 a. Consent for both the BSP strategies and the psychotropic medication regimen for client #2 have been obtained at this point and copies are attached to the responses…12-4-08 MTS will insure that consent is obtained for any proposed changes in the BSP or medication regimen…12-15-08. b. Consent for both the BSP strategies and the psychotropic medication regimen for client #3 have been obtained at this point and copies are attached to the responses…12-4-08 MTS will insure that consent is obtained for any proposed changes in the BSP or medication regimen…12-15-08	

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W 124	Continued From page 2 5:25 PM revealed Client #3 received medications including Chlorpromazine HCL and Prozac. Interview with the medication nurse on October 28, 2008, revealed the aforementioned medications were used to address the client's behaviors. Interview with the Qualified Mental Retardation Professional (QMRP) on October 29, 2008, at 9:11 AM revealed that Client #3 did not have the capacity to give informed consent for the use of medications and habilitation services. The QMRP's statement was verified on October 30, 2008, at 10:12 AM through review of Client 3's psychological assessment dated January 9, 2008. According to the assessment, Client #3 "is not able to make independent decisions concerning her residential or day placements, treatment plans, or financial affairs. She lacks the cognitive skills necessary to understand the implications of such and therefore cannot give her informed consent. She lacks the judgment and insight required to make these decisions independently." At the time of the survey, the facility failed to provide evidence that informed consent was obtained from the client and/or legally authorized representative prior to the administration of the psychotropic medication.	W 124		
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.	W 125		

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W 125	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure each client exercised their rights, for one of the three clients (Client #1) included in the sample. The finding includes : The facility failed to ensure clients' rights were protected by making certain each client had a legally sanctioned representative to assist them with making decisions regarding their treatment. Cross Refer to W322. Interview with the Nurse Coordinator (NC) and review of Client #1's record on October 28, 2008, revealed Client #1 had an open decubitus on his buttocks. According to the NC and continued review of the client's record, the client was seen by a wound care specialist on July 8, 2008. The consultant's findings indicated that the decubitus was "3.5 x 2.0 cm, stage three, right ischioccygeal pressure ulcer, very small amount of microtic tissue." The wound care specialist recommended that the client have the wound excised and closed. Continued interview with the NC and the Qualified Mental Retardation Professional (QMRP) on October 30, 2008, revealed Client #1 would be scheduled for the excision and closure of his decubitus pending guardianship. Interview with the facility's QMRP during the entrance conference on October 28, 2008, revealed Client #1 was not assigned a legal guardian until October 15, 2008. Continued interview with the QMRP was conducted to ascertain information on when the client was initially assessed for the need of a legal guardian.	W 125	W125 MTS was working consistently to obtain a legal guardian for client #1 so that the needed medical procedure could be done and so as to provide the decision-making support needed routinely. Although the process for obtaining legal guardians has been improved, it is still slower than it should be and private providers cannot control that. The two physician certification procedure can only be invoked for situations that have been deemed life threatening emergencies and this situation did not qualify under that criterion although it was explored by MTS. At this point, the legal guardian has been obtained, the risks/benefits discussion concerning this procedure has been completed to the guardian's satisfaction, consent has been obtained and the procedure has been done…11-14-08 Client #1 has been seen for follow up as well. That visit occurred on 11-25-08. The feedback was, "Looks good. No signs of infection…healing well…keep clean…" MTS is insuring that the site is being properly treated, monitored and managed…12-4-08 Future consent situations will be more manageable now that the legal guardian is in place. MTS has decision-making support persons in place at this point for the majority of the individuals it supports and is seeking such support for the small minority who still need them. Progress on such follow up will be evidenced in the QMRP notes…12-20-08.	

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W 125	Continued From page 4 According to the QMRP, the client was assessed in 2007 and she began the process for filing the necessary documents for guardianship on November 9, 2007. The required documents were submitted to Client #1's case manager but "nothing happened." Further discussion with the QMRP revealed that the facility was informed that Client #1's case manager had resigned and a new case manager was assigned. It should be noted however, that the QMRP could not recall the timeframe in which the facility was notified of the reassignment of case managers. The QMRP reported that it was not until May 5, 2008, (six months later) that another application for guardianship was submitted. At the time of the survey, the facility failed to ensure Client #1's received consistent and timely assistance to obtain a surrogate decision-maker to help him with making habilitation and treatment decisions.	W 125		
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure parents/guardians were notified of serious incidents, for one of the three clients (Client #2) included in the sample. The finding includes: Review of the facility's incident reports on October 28, 2008, beginning at 8:59 AM revealed the	W 148	W148 Client #2's guardian was not notified until a week after the incident occurred. The QMRP received feedback and further training from the executive director to insure that notifications are more timely in the future…12-4-08. The executive director will review the status of all incidents during her routine meetings with the QMRP…12-20-08. Additionally, MTS has increased the hours dedicated to incident management coordination by 20 per month to insure that all necessary follow up occurs as mandated in a timely manner and that proper oversight exists for incident follow up…12-4-08.	

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W 148	Continued From page 5 following: On March 18, 2008, a day program staff contacted the facility's Qualified Mental Retardation Professional (QMRP) to report that Client #2 had fallen and hit her head on the bathroom floor. The client sustained a laceration on the top of her head and was transported to a local emergency room. Interview with the QMRP during the entrance conference on October 28, 2008, at 9:11 AM revealed Client #2 had a legal guardian that was involved in her care. At the time of the survey, however, the facility failed to provide evidence that Client #2's guardian had been notified of the aforementioned incident.	W 148		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to implement policies that ensured the client's health and safety, for one of the three clients (Client #1) included in the sample. The findings include: The facility failed to ensure its incident management policy was developed and/or implemented in accordance with the federal regulations. Interview with the facility's Qualified Mental	W 149	W149 As have many other providers, MTS has adopted the DDA incident management policy as its own but has addendums that insure the ICF/MR regulatory mandates are routinely met (See: attachments)...12-4-08	

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W 149	Continued From page 6 Retardation Professional (QMRP) and review of the facility's incident reports on October 28, 2008, beginning at 8:59 AM revealed an incident report involving Client #1 on February 10, 2008. According to the report, Client #1 was discovered on the floor with a cut on his forehead and his lip was bleeding. Further review of the report revealed the client was transported to the emergency room and was diagnosed with difficulty walking and a head injury. The QMRP was queried on October 28, 2008, to ascertain information regarding the facility's policies and procedures for conducting investigations. The surveyor was provided a copy of the investigation policy for review. Review of the policy revealed the policy was developed by a governmental agency. According to the QMRP, the policy that was presented was the policy that the facility implemented for conducting investigations. Continued review of the policy revealed a recommendation for each provider to initiate an investigation for any serious reportable incidents "immediately and no later than twelve (12) hours of the incident being witnessed/discovered." Additionally, the policy recommended that the investigation be completed within "ten (10) working days of the incident being reported, unless an extension was approved." Interview conducted with the QMRP on October 28, 2008, at 9:20 AM revealed that the provider's policy recommended that the Incident Management Coordinator (IMC) conduct investigations and submit the results of the investigation to the administrator within five working days. At the time of the survey, the facility failed to	W 149		

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W 149	Continued From page 7 provide evidence of the development of their own incident management/investigative policy that maintained compliance with the federal regulations.	W 149		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all injuries of unknown source were immediately reported to the administrator or to other officials in accordance with State law, for one of the three clients (Client #1) included in the sample. The finding includes: Review of the facility's incident reports on October 28, 2008, beginning at 8:59 AM revealed an incident involving Client #1 dated February 10, 2008. According to the report, Client #1 was discovered on the floor with a cut on his forehead and his lip was bleeding. The report further revealed the client was transported to the emergency room and diagnosed with difficulty walking and a head injury. Interview was conducted with the Qualified Mental Retardation Professional (QMRP) on October 28, 2008, at 9:20 AM to ascertain information regarding the facility's incident management	W 153	W153 The administrator was notified but the incident report developer failed to document as such on the incident report form and the QMRP failed to catch the oversight in her review. The QMRP has been reinforced by the executive director to insure that all notifications are documented on the report form...12-4-08 Additionally, the QMRP retrained staff on proper completion of incident report forms with emphasis on the notification issue...12-4-08	

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W 153	Continued From page 8 system. According to the QMRP, all incidents were to be reported to the administrator. Further review of the incident report, however, revealed that there was no documented evidence that indicated the administrator had been notified. At the time of the survey, the facility failed to provide evidence that the administrator and/or other officials were immediately notified of the incident of unknown origin.	W 153		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP). The findings include: 1. The QMRP failed to ensure Client #1 received a comprehensive psychiatric assessment. [See W214] 2. The QMRP failed to ensure each client was provided with assistance to exercise their rights timely. [See W125] 3. The QMRP failed to ensure written informed consent had been obtained from the client and/or their legal guardian for the use of psychotropic medications and Behavior Support Plans (BSP).	W 159	W159 The issues cited have been addressed as evidenced by the responses for W214, W125, and W436	

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W 189	Continued From page 10 Review of the facility's policy entitled, "Guide To Insure Effective Medication Administration" on October 30, 2008, revealed a section of the policy entitled, "Routine Medication Administration." In that section the first step of administering the client's medications included a "review of the current MARs and Physician's Orders to insure no changes had been made in the drug regimen since the last pass." At the time of the survey, the medication nurse was observed to review the MAR, but, she was not observed to review Client #2's POS. b. Continued review of the policy also revealed to "ensure that water or some other liquid was readily available." During the observation of the medication administration on October 28, 2008, the medication nurse was not observed to offer Clients #2, #3, or #5 water or any other liquid. c. Review of the facility's policy entitled, "Routine Medication Administration" on October 30, 2008, documented "Do not leave medications unattended." The medication nurse was observed on October 28, 2008, at 5:57 PM to leave Client #6's medications on the desk. She left the surveyor in the room and proceeded to go to the kitchen to get Client #6 some water. It should be noted that the client requested to have some water. At the time of the survey, the facility failed to ensure the medication nurse was trained and familiar with the facility's policy for the administration of medications.	W 189		
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must	W 214	W214 1. Client #1 will have a full psychiatric assessment done by…12-16-08. 2. Self medication assessment have been completed for the individuals mentioned (#2, #3, #6)…12-4-08	

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W 159	Continued From page 9 [See W263] 4. The QMRP failed to furnish adaptive equipment (spout cup and plastic, curved coated spoon) for Client #3. [See W436]	W 159		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each employee was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently. The findings include: The facility failed to ensure the medication nurse was trained and familiar with the facility's policy entitled "Guide To Ensure Effective Medication Administration." a. Observation of the evening medication administration on October 28, 2008, beginning at 5:25 PM revealed Client #2 received medications including Risperdal and Clomipramine HCL. Review of the Medication Administration Record (MAR) on October 29, 2008, at 2:40 PM revealed Client #2 also was prescribed Travatan Opth 0.004% drops, instill three drops to each eye every evening. At the time of the survey, however, Client #2 was not observed to receive the prescribed eye drops.	W 189	W189 The medication nurse will be retrained on all of the elements of the MTS medication pass guide…12-15-08. The RN, QMRP and Facility Manager will monitor medication passes periodically to insure that the guide's mandates are routinely followed…12-20-08.	

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W 214	Continued From page 11 identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a comprehensive functional assessment of developmental needs was conducted for four clients (Clients #2, #3, and #6) residing in the facility. The finding includes: 1. Observation of the evening medication administration on October 28, 2008, beginning at 5:25 PM revealed Client #2 received medications including Risperdal and Clomipramine HCL. Interview with the medication nurse during the medication administration, revealed the aforementioned medications were used to address the client's behaviors. Review of the Medication Administration Record (MAR) on October 29, 2008, revealed a Physician's Order dated September 1, 2008. Continued review of the order revealed Client #2 was prescribed Risperdal to address self-injurious behavior (SIB). Interview with Qualified Mental Retardation Professional (QMRP) on October 28, 2008, at 8:45 AM verified that Client #2's medication was used to control behaviors in conjunction with a Behavior Support Plan (BSP). Continued interview with the QMRP on October 29, 2008, was conducted to ascertain if Client #1 had a comprehensive psychiatric assessment to justify the use of the behavior modification drugs and her corresponding psychiatric diagnoses	W 214	Self medication programs that reflect their current skill level and their potential for skill development will be implemented by…12-20-08. The QMRP will perform monthly records audits to insure that all needed assessments, reviews and programs are in place and that all necessary follow up is completed…12-20-08.	

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W 214	Continued From page 12 (Obsessive Compulsive, Stereotyped with Self Injury, and Intermittent Explosive Disorder). At the time of the survey, the facility failed to provide evidence that Client #2 received a comprehensive psychiatric assessment. 2. Observation of the evening medication administration on October 28, 2008 beginning at 5:25 PM revealed Clients 2, #3, and #6 were administered their medications by the medication nurse. The nurse was observed to punch the client's medications from their bubble packs, combine the medications into applesauce, and physically feed/administer the client's their medications. Interview with the Qualified Mental Retardation Professional (QMRP) on October 30, 2008 at 1:15 PM revealed the clients had not been assessed for formal self medication programs. It should be noted that on October 29, 2008, at approximately 1:30 PM Client #2 was observed in the facility's dining room area eating hot dogs and beans independently. Client #3 was observed on October 29, 2008, at 11:34 AM eating her lunch independently at her day program. At the time of the survey, the facility failed to ensure Clients #2, #3, and #6 were assessed in the domain of self-medication administration.	W 214		
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:	W 263	W263 The required consents have been obtained (copies submitted with survey responses)...12-4-08 See also the responses for W124	

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	09G005		10/30/2008

NAME OF PROVIDER OR SUPPLIER: M T S

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W 263	Continued From page 13 Based on interview and record review, the facility's specially-constituted committee failed to ensure that restrictive programs were used only after written consents had been obtained, for three of the three clients (Clients #1, #2, and #3) included in the sample. The findings include: The facility failed to ensure that written informed consent was obtained from Clients #1, #2, and #3 or their legal guardians prior to the implementation of their Behavior Support Plans (BSP). a. Interview with the Qualified Mental Retardation Professional (QMRP) on October 29, 2008, during the entrance conference revealed Client #1's medication was used in conjunction with a BSP to manage the client's behaviors. Review of the client's habilitation record on October 29, 2008 at 7:07 PM, verified that Client #1 had a BSP dated September 15, 2008. According to the BSP, Client #1 received psychotropic medications for Intermittent Explosive Disorder. Continued interview with the QMRP and record review revealed Client #1 was not capable of giving informed consent for the use of medications and habilitation services. The QMRP further revealed the client had a legal guardian to assist him in decision making. At the time of the survey however, there was no evidence that the facility's specially constituted committee ensured that written informed consent had been obtained from Client #1's legal guardian for the use of the BSP that incorporated restrictive techniques.	W 263	prior to the supply expiring so as to insure that an error in delivery can be corrected before a medication must be missed…12-4-08.	

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W 263	Continued From page 14 b. Interview with the QMRP on October 29, 2008, during the entrance conference revealed Client #2's medication was used in conjunction with a BSP to manage the client's behaviors. Review of the client's habilitation record on October 30, 2008 at 12:20 PM, verified that Client #2 had a BSP dated January 9, 2008. According to the BSP, Client #2 received psychotropic medications for Obsessive Compulsive, Stereotyped with Self Injury, and Intermittent Explosive Disorder. Continued interview with the QMRP and record review revealed Client #2 was not capable of giving informed consent for the use of medications and habilitation services. The QMRP further revealed the client had a legal guardian to assist her in decision making. At the time of the survey however, there was no evidence that the facility's specially constituted committee ensured that written informed consent had been obtained from Client #2's legal guardian for the use of the BSP that incorporated restrictive techniques c. Interview with the QMRP on October 29, 2008, during the entrance conference revealed Client #3's medication was used in conjunction with a BSP to manage the client's behaviors. Review of the client's habilitation record on October 30, 2008, verified that Client #3 had a BSP dated November 19, 2007. According to the BSP, Client #3 received psychotropic medications for Bipolar Disorder. Continued interview with the QMRP and record review revealed Client #3 was not capable of giving informed consent for the use of medications and habilitation services. The QMRP further revealed the client did not have a legal guardian to assist her in decision making, but she	W 263		

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W 263	Continued From page 15 did have family involvement. At the time of the survey, there was no evidence that the facility's specially constituted committee ensured that written informed consent had been obtained for the use of Client #3's BSP that incorporated restrictive techniques.	W 263		
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 observation, interview and record review, the facility failed to ensure general and preventative care services, for one of the three clients (Client 1) included in the sample. The findings include: Observation on October 28, 2008, at approximately 8:30 AM, revealed direct care staff were assisting the clients to board the facility's van to be transported to their day programs. It should be noted that Client #1 was observed not to be escorted on the van. Interview with the House Manager on October 28, 2008, at 12:41 PM revealed Client #1 was home from the day program, because he was scheduled for surgery due to a decubitus on his buttocks. Review of the facility's incident reports on October 28, 2008, beginning at 9:02 AM revealed an incident involving Client #1 dated February 1, 2008. The report indicated that during the client's evening care the staff discovered an opening on	W 322	W322 MTS was working consistently to obtain a legal guardian for client #1 so that the needed medical procedure could be done and so as to provide the decision-making support needed routinely. Although the process for obtaining legal guardians has been improved, it is still slower than it should be and private providers cannot control that. The two physician certification procedure can only be invoked for situations that have been deemed life threatening emergencies and this situation did not qualify under that criterion although it was explored by MTS. At this point, the legal guardian has been obtained, the risks/benefits discussion concerning this procedure has been completed to the guardian's satisfaction, consent has been obtained and the procedure has been done...11-14-08 Client #1 has been seen for follow up as well. That visit occurred on 11-25-08. The feedback was, "Looks good. No signs of infection...healing well...keep clean..." MTS is insuring that the site is being properly treated, monitored and managed...12-4-08 Future consent situations will be more manageable now that the legal guardian is in place. MTS has decision-making support persons in place at this point for the majority of the individuals it supports and is seeking such support for the small minority who still need them. Progress on such follow up will be evidenced in the QMRP notes...12-20-08.	

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W 322	Continued From page 16 the client's buttocks. Interview with the facility's Nurse Coordinator on October 30, 2008, beginning at 10:43 AM revealed the aforementioned area on Client #1's buttocks was initially the size of a quarter. According to the nurse the decubitus would heal and then it would break down again. The nurse coordinator revealed that she discovered the wound was not healing at all on April 8, 2008. Additionally, she indicated Client #1's decubitus was monitored on a monthly basis. Further interview with the Nurse Coordinator revealed a meeting was held on April 11, 2008, to discuss the concerns for Client #1's wound care. A decision was made that it might be beneficial for Client #1 to remain home from the day program due to the length of time he sat in his wheelchair. The decision for the client to remain home was discussed and approved by the client's Primary Care Physician (PCP). The Nurse Coordinator indicated that once Client #1 remained home from his day program the decubitus began healing. Continued interview with the Nurse Coordinator and review of the client's medical record revealed Client #1 developed another medical concern. The nurse reported that the client had a diagnoses that included a history (HX) of Prostrate Cancer with Prostatectomy. The nurse informed the surveyor that Client #1's penis was continuously dripping, making the healing process difficult for the client's decubitus. The direct care staff was instructed to change the client's diaper frequently to attempt to keep him dry. Furthermore, the nurse revealed that Client #1's	W 322		

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W 322	Continued From page 17 PCP was contacted on April 23, 2008, to obtain instruction regarding the aforementioned medical concern. According to the Nurse Coordinator, the client's PCP ordered an external catheter to be placed on the client's penis. The nurse indicated that the client was reported to be dry for several days. On April 27, 2008, Client #1's penis was observed to be swollen. The catheter was removed for approximately four days and the swelling was reported to go down. On May 8, 2008, the external catheter was tried again but to no avail, it was determined that Client #1 was allergic to the material of the catheter. The client's PCP discontinued the catheter on May 8, 2008. Continued discussion with the nurse and verification of a nursing note dated May 15, 2008, revealed the decubitus was the size of a half a dollar. Additional interview with the nurse coordinator and review of a nursing note dated May 27, 2008, revealed she assessed Client #1 and reported that the decubitus was not healing. The client's PCP was notified and recommended that the client be seen by a wound care specialist. Review of Client #1's medical record on October 30, 2008, revealed that on June 12, 2008, Client #1 was seen by a wound care specialist who noted that the wound was "3 x 2.5 cm partial thickness" and that it was a "stage two ulcer of right ischiocoygeal." Further review of the client's medical record revealed that the wound care specialist debrided the area and ordered to "cleanse with soap and water, saline rinse and then silvadene/sugar occlusive dressing twice daily." Continued review of Client #1's medical record revealed the client was seen again by the wound care specialist on July 8, 2008. The consult	W 322		

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W 322	Continued From page 18 revealed that the special findings indicated that the decubitus was "3.5 x 2.0 cm, stage three, right ischioccygeal pressure ulcer, very small amount of microtic tissue." The wound care specialist recommended "patient need excision and closure pending recent history and physical examination." (Cross refer to W125) Interview with the Nurse Coordinator and the Qualified Mental Retardation Professional (QMRP) on October 30, 2008, revealed Client #1 would be scheduled for the excision and closure of his decubitus pending guardianship. At the time of the survey, the facility failed to ensure Client #1 received timely services to close the wound	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 observation, interview, and record review, the facility's nursing services failed to ensure that each client received nursing services in accordance with their needs, for two of the three clients (Clients #2 and #6) residing in the facility. The finding includes: 1. [Cross refer to W368] The facility's nursing services failed to ensure all drugs were administered in compliance with the physician's orders. 2. Observation of the evening medication administration on October 28, 2008, at 5:25 PM	W 331	W331 1. See responses for W368 2. Client #6's medication was ordered but was not sent by pharmacy in a timely manner. This was a pharmacy error that has been discussed with the pharmacy. This is not a routine problem although there was an error on this occasion. MTS' support nurses will order medication3-5 days	

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W 331	Continued From page 19 revealed Client #6 received medications including Clonazepam and Fluphenazine HCL. According to each of the medication labels, the medications were prescribed for Schizophrenia. Review of the MAR on October 29, 2008, at 2:40 PM failed to provide evidence that Client #6 was administered his Clonazepam on October 16, 2008. Continued review of the MAR revealed the medication nurse documented on the reverse side of the MAR that the medication was "not available, not given." Interview with the facility's Registered Nurse (RN) on October 29, 2008 revealed that the Clonazepam for Client #6 was not delivered with the "cycle medication." Continued interview with the RN revealed that the pharmacy was contacted to request a "stat" for the medication, however, the medication was not delivered on October 16, 2008. According to the RN, the medication nurse was responsible for communicating to her if a client medications need to be refilled. Interview with the RN and review of the facility's "Missed Medication" policy on October 29, 2008 revealed a section entitled "Preventative Measures. According to the policy, the facility's nursing personnel was responsible for coordinating with the pharmacy to insure that medications were maintained in adequate supply at all times. At the time of the survey, the facility failed to ensure medication the availability of Client #6's medication.	W 331		
W 368	483.460(k)(1) DRUG ADMINISTRATION	W 368		

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

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W 368	Continued From page 20 The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that medications were administered in compliance with the physician's orders, for one of three clients (Client #2) included in the sample. The findings include: 1. Observation of the evening medication administration on October 28, 2008, beginning at 5:25 PM revealed Client #2 received medications including Risperdal, Clomipramine HCL, and Polyethylene. It should be noted that all the medications were administered with applesauce. Review of Client #2's medical record on October 29, 2008, beginning at 2:40 PM revealed a Physician's Order dated September 2008. Review of the order revealed the client was also prescribed Travatan Opth 0.004% drops, instill three drops to each eye every evening. At the time of the medication administration, however, Client #2 was not observed to receive the prescribed eye drops. The Registered Nurse (RN) was queried on October 29, 2008, to ascertain information about the availability of the eye drops for Client #2. The (RN) checked the medication cabinet and presented the surveyor with Client #2's prescribed eye drops (for review). Additionally, the RN verified that Client #2's MAR had not been initialed indicating that the eye drops had been administered on October 28, 2008.	W 368	W368 1. As mentioned earlier in the responses, the medication nurse in question will be retrained on all aspects of the MTS medication pass guide and will be monitored more extensively to insure routine compliance and proper medication passes. If problems persist, a change in personnel will occur…12 20-08.	

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W 368	Continued From page 21 At the time of the survey, the facility failed to provide evidence that the medication nurse administered Client #2's eye drops in accordance with the physician's orders. 2. Observation of the medication administration on October 28, 2008 revealed Client #2 received her Polyethylene in applesauce. Review of Client #2's Physician's Order on October 29, 2008, revealed Polyethylene was prescribed to be dissolved in "8 ounces of water twice daily." At the time of the survey, the medication nurse failed to administer Client #2's Polyethylene in accordance with the physician's orders.	W 368		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to furnish adaptive equipment (spout cup and plastic, curved coated spoon) for one of the three clients (Client #3) included in the sample. The finding includes: The facility failed to furnish recommended adaptive equipment for Client #3 as evidenced below:	W 436	W436 MTS will purchase and supply the day program with the built up spoon and divided plate client #3 needs to eat efficiently...12-15-08. The QMRP will monitor lunch meals during her routine monthly visits to the program...12-4-08	

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W 436	Continued From page 22 Client #3 was observed on October 29, 2008, at 11:01 AM in her day program classroom. The day program staff was overheard announcing that it was lunch time and proceeded to escort Client #3 to the day program's lunch room. Observation during lunch revealed the client was served her lunch on a paper plate. Additionally, she was given plastic utensils to use while eating her lunch. Throughout the observation, Client #3's paper plate was observed to slide while she attempted to eat her food. Interview with the direct care staff on October 29, 2008, at 2:09 PM revealed Client #3 used adaptive equipment in the home that included a built-up spoon and a divided plate. The Qualified Mental Retardation Professional (QMRP) verified the use of the aforementioned adaptive equipment and indicated that she would order it for the day program's use. At time of the survey, the facility failed to ensure Client #3 was provided with the necessary adaptive equipment while at the day program.	W 436		

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I 000	INITIAL COMMENTS A licensure survey was conducted from October 28, 2008, through October 30, 2008. A random sample of three clients was selected from a residential population of six clients (four males and two females) with mental retardation and other disabilities. The survey findings were based on observations in the group home and at two day programs, interviews, and a review of records, including unusual incident reports.	I 000		
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that each employee, prior to employment and annually thereafter, provided evidence of a physician's certification that documented a health inventory had been performed and that the employee's health status would allow him or her to perform the required duties. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) on October 28, 2008, and review of the GHMRP's personnel records at approximately 12:20 PM revealed that the GHMRP failed to provide evidence that current	I 206	Chapter 35 3509.6 Only one staff member is without a valid health certificate at this point (see attached copies) and that person has been instructed to submit by…12-30-08. Consultants have also been instructed to submit by…12-30-08 Staff will be pulled from the work schedule and consultant checks held for failure to comply…….12-30-08. The Facility Manager will audit the personnel records quarterly to insure routine submission of updated documents and to notify staff proactively of upcoming expiration dates…12-30-08	

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I 206	Continued From page 1 health certificates were on file for eight direct care staff and five consultants.	I 206		
I 354	3518.3(c) DISCHARGE / TRANSFER POLICIES PROCEDURES Reasons for transfer from a group home shall include, but not be limited to, the following: (c) The determination by the interdisciplinary team that the resident ' s habilitative needs would be better met by another setting. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide documentation that determined the need for residents to transfer was available for three of the three residents (Residents #1, #2, and #3) included in the sample. The finding includes: During the entrance conference on October 28, 2008, beginning at 8:45 AM interview with the Qualified Mental Retardation Professional (QMRP) revealed that Residents #1, #2, and #3 had be transferred from another group home operated by the same provider. Continued interview with the QMRP revealed that the decision had been made to move the residents last year in November 2007. At the time of the survey, however, there was no documented evidence provided for review that indicated information about the reason each resident's moved and regarding their habilitation needs being met in their new setting.	I 354		

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I 379	Continued From page 2	I 379		
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure the Department of Health (DOH), Health Facilities Division was immediately notified, followed by written notification within 24 hours, of unusual incidents that substantially interfered with a resident's health, for one of the three residents (Resident #1) included in the sample. The finding includes: Review of the facility's incident reports on October 28, 2008, beginning at 8:59 AM revealed an incident involving Client #1 dated February 10, 2008. According to the report, Client #1 was discovered on the floor with a cut on his forehead and his lip was bleeding. Additionally, the client was transported to the emergency room and diagnosed with difficulty walking and a head injury. The GHMRP failed to provide evidence that DOH was notified of the aforementioned incident as required.	I 379	3519.10 DOH was notified but not within 24 hours. MTS has increased the man hours dedicated to incident management coordination so as to insure timely follow up…12-4-08.	

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NAME OF PROVIDER OR SUPPLIER M T S	STREET ADDRESS, CITY, STATE, ZIP CODE 4901 FOOTE STREET, NE WASHINGTON, DC 20019		

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I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure timely treatment services were conducted for one resident (Resident #1) residing in the facility. The findings include: Observation on October 28, 2008, at approximately 8:30 AM, revealed direct care staff were assisting the residents to board the facility's van to be transported to their day programs. It should be noted that Resident #1 was observed not to be escorted on the van. Interview with the House Manager on October 28, 2008, at 12:41 PM revealed Resident #1 was home from the day program, because he was scheduled for surgery due to a decubitus on his buttocks. Review of the facility's incident reports on October 28, 2008, beginning at 9:02 AM revealed an incident involving Resident #1 dated February 1, 2008. The report indicated that during the resident's evening care the staff discovered an opening on the resident's buttocks. Interview with the facility's Nurse Coordinator on October 30, 2008, beginning at 10:43 AM revealed the aforementioned area on Resident	I 401	3520.3 MTS was working consistently to obtain a legal guardian for client #1 so that the needed medical procedure could be done and so as to provide the decision-making support needed routinely. Although the process for obtaining legal guardians has been improved, it is still slower than it should be and private providers cannot control that. The two physician certification procedure can only be invoked for situations that have been deemed life threatening emergencies and this situation did not qualify under that criterion although it was explored by MTS. At this point, the legal guardian has been obtained, the risks/benefits discussion concerning this procedure has been completed to the guardian's satisfaction, consent has been obtained and the procedure has been done…11-14-08 Client #1 has been seen for follow up as well. That visit occurred on 11-25-08. The feedback was, "Looks good. No signs of infection…healing well…keep clean…" MTS is insuring that the site is being properly treated, monitored and managed…12-4-08 Future consent situations will be more manageable now that the legal guardian is in place. MTS has decision-making support persons in place at this point for the majority of the individuals it supports and is seeking such support for the small minority who still need them. Progress on such follow up will be evidenced in the QMRP notes…12-20-08.	

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I 401	Continued From page 4 #1's buttocks was initially the size of a quarter. According to the nurse the decubitus would heal and then it would break down again. The nurse coordinator revealed that she discovered the wound was not healing at all on April 8, 2008. Additionally, she indicated Resident #1's decubitus was monitored on a monthly basis. Further interview with the Nurse Coordinator revealed a meeting was held on April 11, 2008, to discuss the concerns for Resident #1's wound care. A decision was made that it might be beneficial for Resident #1 to remain home from the day program due to the length of time he sat in his wheelchair. The decision for the Resident to remain home was discussed and approved by the resident's Primary Care Physician (PCP). The Nurse Coordinator indicated that once Resident #1 remained home from his day program the decubitus began healing. Continued interview with the Nurse Coordinator and review of the resident's medical record revealed Resident #1 developed another medical concern. The nurse reported that the Resident had a diagnoses that included a history (HX) of Prostrate Cancer with Prostatectomy. The nurse informed the surveyor that Resident #1's penis was continuously dripping, making the healing process difficult for the resident's decubitus. The direct care staff was instructed to change the resident's diaper frequently to attempt to keep him dry. Furthermore, the nurse revealed that Resident #1's PCP was contacted on April 23, 2008, to obtain instruction regarding the aforementioned medical concern. According to the Nurse Coordinator, the resident's PCP ordered an external catheter to be placed on the resident's	I 401		

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I 401	Continued From page 5 penis. The nurse indicated that the Resident was reported to be dry for several days. On April 27, 2008, Resident #1's penis was observed to be swollen. The catheter was removed for approximately four days and the swelling was reported to go down. On May 8, 2008, the external catheter was tried again but to no avail, it was determined that Resident #1 was allergic to the material of the catheter. The resident's PCP discontinued the catheter on May 8, 2008. Continued discussion with the nurse and verification of a nursing note dated May 15, 2008, revealed the decubitus was the size of a half a dollar. Additional interview with the nurse coordinator and review of a nursing note dated May 27, 2008, revealed she assessed Resident #1 and reported that the decubitus was not healing. The resident's PCP was notified and recommended that the resident be seen by a wound care specialist. Review of Resident #1's medical record on October 30, 2008, revealed that on June 12, 2008, Resident #1 was seen by a wound care specialist who noted that the wound was "3 x 2.5 cm partial thickness" and that it was a "stage two ulcer of right ischiocoygeal." Further review of the resident's medical record revealed that the wound care specialist debrided the area and ordered to "cleanse with soap and water, saline rinse and then silvadene/sugar occlusive dressing twice daily." Continued review of Resident #1's medical record revealed the Resident was seen again by the wound care specialist on July 8, 2008. The consult revealed that the special findings indicated that the decubitus was "3.5 x 2.0 cm, stage three, right ischioccygeal pressure ulcer, very small amount of microtic tissue." The wound care specialist	I 401		

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I 401	Continued From page 6 recommended "patient need excision and closure pending recent history and physical examination." (Cross refer to W3523.1) Interview with the Nurse Coordinator and the Qualified Mental Retardation Professional (QMRP) on October 30, 2008, revealed Resident #1 would be scheduled for the excision and closure of his decubitus pending guardianship. At the time of the survey, the facility failed to ensure Resident #1 received timely services to close the wound.	I 401		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Persons with Mental Retardation (GHMRP) failed to observe and protect the rights of a resident, in accordance with D.C. Law 2-137 (now Title 7, Chapter 13), and this chapter. The findings include: Section 7-1305.05 (g). [Formerly 6-1965] The facility failed to ensure the resident's right to receive prompt and adequate medical attention, as evidenced below: Observation on October 28, 2008, at approximately 8:30 AM, revealed direct care staff were assisting the clients to board the facility's van to be transported to their day programs. It	I 500	3523.1 See responses for 3520.3 above.	

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I 500	Continued From page 7 should be noted that Client #1 was observed not to be escorted on the van. Interview with the House Manager on October 28, 2008, at 12:41 PM revealed Client #1 was home from the day program, because he was scheduled for surgery due to a decubitus on his buttocks. Review of the facility's incident reports on October 28, 2008, beginning at 9:02 AM revealed an incident involving Client #1 dated February 1, 2008. The report indicated that during the client's evening care the staff discovered an opening on the client's buttocks. Interview with the facility's Nurse Coordinator on October 30, 2008, beginning at 10:43 AM revealed the aforementioned area on Client #1's buttocks was initially the size of a quarter. According to the nurse the decubitus would heal and then it would break down again. The nurse coordinator revealed that she discovered the wound was not healing at all on April 8, 2008. Additionally, she indicated Client #1's decubitus was monitored on a monthly basis. Further interview with the Nurse Coordinator revealed a meeting was held on April 11, 2008, to discuss the concerns for Client #1's wound care. A decision was made that it might be beneficial for Client #1 to remain home from the day program due to the length of time he sat in his wheelchair. The decision for the client to remain home was discussed and approved by the client's Primary Care Physician (PCP). The Nurse Coordinator indicated that once Client #1 remained home from his day program the decubitus began healing.	I 500		

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I 500	Continued From page 8 Continued interview with the Nurse Coordinator and review of the client's medical record revealed Client #1 developed another medical concern. The nurse reported that the client had a diagnoses that included a history (HX) of Prostrate Cancer with Prostatectomy. The nurse informed the surveyor that Client #1's penis was continuously dripping, making the healing process difficult for the client's decubitus. The direct care staff was instructed to change the client's diaper frequently to attempt to keep him dry. Furthermore, the nurse revealed that Client #1's PCP was contacted on April 23, 2008, to obtain instruction regarding the aforementioned medical concern. According to the Nurse Coordinator, the client's PCP ordered an external catheter to be placed on the client's penis. The nurse indicated that the client was reported to be dry for several days. On April 27, 2008, Client #1's penis was observed to be swollen. The catheter was removed for approximately four days and the swelling was reported to go down. On May 8, 2008, the external catheter was tried again but to no avail, it was determined that Client #1 was allergic to the material of the catheter. The client's PCP discontinued the catheter on May 8, 2008. Continued discussion with the nurse and verification of a nursing note dated May 15, 2008, revealed the decubitus was the size of a half a dollar. Additional interview with the nurse coordinator and review of a nursing note dated May 27, 2008, revealed she assessed Client #1 and reported that the decubitus was not healing. The client's PCP was notified and recommended that the client be seen by a wound care specialist. Review of Client #1's	I 500		

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I 500	Continued From page 9 medical record on October 30, 2008, revealed that on June 12, 2008, Client #1 was seen by a wound care specialist who noted that the wound was "3 x 2.5 cm partial thickness" and that it was a "stage two ulcer of right ischiocoygeal." Further review of the client's medical record revealed that the wound care specialist debrided the area and ordered to "cleanse with soap and water, saline rinse and then silvadene/sugar occlusive dressing twice daily." Continued review of Client #1's medical record revealed the client was seen again by the wound care specialist on July 8, 2008. The consult revealed that the special findings indicated that the decubitus was "3.5 x 2.0 cm, stage three, right ischioccygeal pressure ulcer, very small amount of microtic tissue." The wound care specialist recommended "patient need excision and closure pending recent history and physical examination." (Cross refer to W125) Interview with the Nurse Coordinator and the Qualified Mental Retardation Professional (QMRP) on October 30, 2008, revealed Client #1 would be scheduled for the excision and closure of his decubitus pending guardianship. Interview with the facility's QMRP during the entrance conference on October 28, 2008, revealed Client #1 was not assigned a legal guardian until October 15, 2008. Continued interview with the QMRP was conducted to ascertain information on when the client was initially assessed for the need of a legal guardian. According to the QMRP, the client was assessed in 2007 and she began the process for filing the necessary documents for guardianship on November 9, 2007. The required documents	I 500		

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I 500	Continued From page 10 were submitted to Client #1's case manager but "nothing happened." Further discussion with the QMRP revealed that the facility was informed that Client #1's case manager had resigned and a new case manager was assigned. It should be noted however, that the QMRP could not recall the timeframe in which the facility was notified of the reassignment of case managers. The QMRP reported that it was not until May 5, 2008, (six months later) that another application for guardianship was submitted. At the time of the survey, the facility failed to ensure Client #1's received consistent and timely assistance to obtain a surrogate decision-maker to help him with making habilitation/treatment decisions and make certain he received timely medical services. (See Federal Deficiency Report Citations W125 and W322)	I 500		