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

PRINTED: 02/14/2008
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
	09G190		02/05/2008

NAME OF PROVIDER OR SUPPLIER: C M S

STREET ADDRESS, CITY, STATE, ZIP CODE: 1608 EVARTS ST, NE, WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from February 4, 2008 through February 5, 2008. The survey was initiated using the fundamental survey process. A random sample of two clients were selected from a population of four males with profound mental retardation and various disabilities. The findings of this survey were based on observations at the group home, a day program, 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 000		
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 unusual incidents including injuries of unknown origin were reported immediately to the administrator and other officials according to district law (22 DCMR, Chapter 35, Section 3519.10) one of the four clients in the facility. (Client #4) The finding includes: Review of the incident reports on February 4, 2008 at 9:30 AM revealed the following injury of	W 153	In the future incidents and injuries will be reported and documentation will be made on the incident form that administration was notified.	2/29/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Constance A. Keese — TITLE: Program Director — (X6) DATE: 2/22/08

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 153	Continued From page 1 unknown origin had not been reported to the Administrator as required: On December 5, 2007, staff discovered a cut on the right side of Client #4's forehead.	W 153		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observation, staff i interview, and record review, the facility failed Human Rights Committee (HRC) failed to review and approve the use of restrictive measures for one of the two clients in the sample. (Client #1) The finding includes: On February 4, 2008 at 8:40 AM, Client #1 was observed being administered Tegretol, Prozac, and Zyprexa. Interview with the medication nurse indicated that the client received these medications for his maladaptive behaviors. During the entrance conference on February 4, 2008 at 9:00 AM, the Qualified Mental Retardation Professional (QMRP) stated that Client #1 had a Behavior Support Plan (BSP) and received psychotropic medication as well as one to one support services. During client observation from February 4 - 5, 2008, a direct care staff was observed with the client (at arms length) at all times.	W 262	Client #1s BSP will be revised to include the need for one to one support services during his waking hours. The HRC will be made aware to the one to one staffing used to assist with the management to client #1s behavior.	3/3/08

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W 262	Continued From page 2 Review of the BSP dated November 27, 2007 address targeted behaviors of snatching food, spitting and aggression to others.. The BSP was designed to provide positive approaches to challenging behaviors so a successful home learning environment could be created. The BSP did not indicate a need for one to one support services with the exception of during meal times. Review of the HRC minutes on February 5, 2008 dated November 29, 2007 revealed that the client's BSP was review and approved by the HRC. It should be noted that the BSP approved did not include one to one support services. There no evidence that the HRC was made aware of the one to one staffing used to assist with the management of Client #1's behavior.	W 262		
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 one of the two clients in the sample. (Client #2) The findings include: The facility's Nursing staff failed to ensure recommended laboratory studies were obtained for Client #2 as evidenced by the following:	W 325	Client #2 will receive lab work for depakote and tegretol levels every three months. QMRP and Primary Care Nurse will monitor for completion quarterly.	2/29/08

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W 325	Continued From page 3 a. During the medication observation on February 4, 2008 at 8:35 AM, Client #2 received Depakote ER 250 mg and Tegretol XR 500 mg. Review of the client PO's dating back to September 2007 on February 5, 2008 at 11:00 AM revealed an order for Depakote and Tegretol levels to be obtained every three months. Review of the laboratory results section of the medical record revealed that levels were obtained February 6, 2007, April 3, 2007 and January 4, 2008. The record lacked evidence that the levels were obtained every three months as ordered by the physician. It should be noted that the Depakote levels obtained on April 3, 2007 were below the therapeutic range. (Normal limits 50 - 120)	W 325	The nursing cordinator will make the lab schedule for all the clients, to be forward to the homes.	2/29/08
W 336	483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that a health status was reviewed by the nursing staff on a quarterly or more frequent basis for two of the two clients in the sample. (Clients #1 and #2) The findings include: 1. Review of Client #2's medical record on February 4, 2008 at approximately 12:00 PM revealed an annual nursing assessment was completed on January 19, 2007. Further review	W 336	Client #2 quarterly nursing assessment will be completed. In the future all quarterly assessments will be completed by the due date and reveiwed by the QMRP.	2/5/08

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W 336	Continued From page 4 of the medical record revealed that the first report review was not available for review. Interview with the Licensed Practical Nurse confirmed that the quarterly assessment had not been completed. 2. Review of Client #1's medical record on February 5, 2008 at approximately 12:00 PM revealed an annual nursing assessment dated August 6, 2007. Further review of the medical record revealed a quarterly review dated November 15, 2007. According to the assessment there was no evidence that a comprehensive system check had been conducted on the quarterly review form. At the time of the survey, the facility failed to ensure a comprehensive nursing assessment had been completed for Client #1.	W 336	A comprehensive nursing assess ment will be completed for client #1. In the future all assessments will be completed by the due date.	2/5/08
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT 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. 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) The finding includes: On February 4, 2008, Client #2 was observed with many missing teeth. Review of the dental consultation dated July 23, 2007 revealed that the	W 356		

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W 356	Continued From page 5 client needs scaling and polishing of all teeth surfaces; and the client appears to be a good candidate for upper and lower dentrues to replace his missing teeth. On June 27, 2007, a dental consutation revealed "two teeth were grossly decayed. Partially edentulous of both arches. The dentist office wil submit preauthorization to Medicaid for approval. Will call to schedule once returned". Interview with the LPN indicated that the home was awaiting approval from Medicaid. There was no evidence that the client received the recommended dental care since December 21, 2006.	W 356	The QMRP will contact the dentist to find out if preauthorization for client #2 partial denture is approved.	2/29/08
W 392	483.460(m)(3) DRUG LABELING Drugs and biologicals packaged in containers designated for a particular client must be immediately removed from the client's current medication supply if discontinued by the physician. This STANDARD is not met as evidenced by: Based on observation, interview and review of records, the facility failed to remove from the current medication supply, medications that had been discontinued by the physician for one of the two clients in the sample. (Client #1) The finding include: During the environmental inspection on February 5, 2008 at 3:00 PM a bottle of Clindamycin Topical 1% lotion was observed in Client #1's personal hygiene kit. The bottle contained a small amount of lotion. Review of Client #1's current physician order revealed no evidence of an order for Clindamycin Topical 1% lotion. According to the October 2007 physician orders	W 392	The nursing staff will monitor the medications to check for expirations date, and the order to discontinue it. All discontinued and expired medications will be removed from the facility.	2/5/08

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W 392	Continued From page 6 indicated that the Clindamycin Topical 1% lotion had been discontinued by the primary care physician at that time.	W 392		
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, staff interview and record review, the facility failed to furnish the recommended feeding equipment for one of the two clients in the sample. (Client #1) The finding includes: On February 4, 2008 at 6:10 PM, Client #1 was observed eating dinner using an divided plate and weighted spoon. After the client completed his meal, food was observed on the table and floor. Review of the Occupational Therapy assessment and Individual Support Plan (ISP) dated August 22, 2007 revealed that the client was recommended to use a plate guard and weighted spoon. Interview with the Qualified Mental Retardation Professional (QMRP) on February 5, 2008 at approximately 1:00 PM indicated that the client used a divided plate due to prevent spillage however, there was no information to support the use of a divided plate.	W 436	Client #1 will use a plate guard and a weighted spoon during his meal time. Staff will monitor client #1 for spillage.	2/5/08
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least	W 440		

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W 440	Continued From page 7 quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to hold evacuation drills at least quarterly for each shift of personnel. The finding includes: Interview with the Qualified Mental Retardation Professional and review of the staff pattern on February 5, 2008 at 11:40 AM revealed the following schedule staffing pattern: Monday - Friday 8:00 AM - 4:00 PM; 4:00 PM -12:00 AM; and 12:00 AM - 8:00 AM. Review of the fire drills log revealed that the 8:00 AM - 4:00 PM failed to hold evacuation drills per shift per quarter. A fire drill was held on February 4, 2007 and the next fire drills was completed on July 21, 2007 on the same shift.	W 440	Fire evacuation drills will be held quarterly for each shift	2/29/08

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I 000	INITIAL COMMENTS A licensure survey was conducted from February 4, 2008 through February 5, 2008. The survey was initiated using the fundamental survey process. A random sample of two residents were selected from a population of four males with profound mental retardation and various disabilities. The findings of this survey were based on observations at the group home, a day program, 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.	I 000		
I 095	3504.6 HOUSEKEEPING Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach of each resident. This Statute is not met as evidenced by: Observation and interview revealed that the GHMRP failed to ensure that caustic agents were stored in the food preparation and serviced area. The finding includes: During the environmental inspection on February 5, 2008 at approximately 3:00 PM, caustic agents were observed stored in a the downstairs bathroom vanity.	I 095	All poison and caustic agents will be stored in a locked cabinet. The QMRP and residential manager will provide training and monitor staff to ensure that all caustic agents are stored in a locked cabinet.	2/5/08
I 135	3505.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift.	I 135		

Health Regulation Administration
Constance A. Reese
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
TITLE Program Director
(X6) DATE 2/22/08

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I 135	Continued From page 1 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: Interview with the Qualified Mental Retardation Professional and review of the staff pattern on February 5, 2008 at 11:40 AM revealed the following schedule staffing pattern: Monday - Friday 8:00 AM - 4:00 PM; 4:00 PM -12:00 AM; and 12:00 AM - 8:00 AM. Review of the fire drills log revealed that the 8:00 AM - 4:00 PM failed to hold evacuation drills per shift per quarter. A fire drill was held on February 4, 2007 and the next fire drills was completed on July 21, 2007 on the same shift.	I 135	Cross reference w440	2/29/08
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:	I 203	The QMRP will meet with staff and review job descriptions. In the future this review will be completed annually.	2/29/08

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I 203	Continued From page 2 Review of the personnel files on February 4, 2008 failed to provide evidence that five direct care staff (Staff #1, #3, #4, #6, and #7) job descriptions had been reviewed.	I 203		
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 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 February 4, 2008, at which time there was no evidence that a direct care staff (Staff #9), Psyciatrist, Social Worker and Occupational Therapist had current health certificates.	I 206	Updated health certificate will be obtained and placed in personnel records.	2/29/08
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	I 379		

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I 379	Continued From page 3 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 record review, the GHMRP failed to ensure that the Aminstrator, was notified of unusual incidents or events that substantially interfered with each resident's health and welfare within twenty-four hours or the next work day. The finding includes: Review of the incident reports on February 4, 2008 at 9:30 AM revealed the following injury of unknown origin had not been reported to the Administrator as required: On December 5, 2007, staff discovered a cut on the right side of Resident #4's forehead.	I 379	Cross reference w153	2/29/08
I 430	3521.7(a) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (a) Eating and drinking (including table manners, use of adaptive equipment, and use of appropriate utensils); This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to train residents to use adaptive feeding equipment for one of the two residents in the sample. (Resident #1)	I 430		

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I 430	Continued From page 4 The finding includes: On February 4, 2008 at 6:10 PM, Resident #1 was observed eating dinner using an divided plate and weighted spoon. After the client completed his meal, food was observed on the table and floor. Review of the Occupational Therapy assessment and Individual Support Plan (ISP) dated August 22, 2007 revealed that the resident was recommended to use a plate guard and weighted spoon. Interview with the Qualified Mental Retardation Professional (QMRP) on February 5, 2008 at approximately 1:00 PM indicated that the resident used a divided plate due to prevent spillage however, there was no information to support the use of a divided plate.	I 430	Cross Reference w436	2/29/08
I 484	3522.11 MEDICATIONS Each GHMRP shall promptly destroy prescribed medication that is discontinued by the physician or has reached the expiration date, or has a worn, illegible, or missing label. This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to promptly destroy prescribed medication that was discontinued by the primary care physician for one of the two residents in the facility. (Resident #1) The finding includes: During the environmental inspection on February 5, 2008 at 3:00 PM a bottle of Clindamycin Topical 1% lotion was observed in Resident #1's personal hygiene kit. The bottle contained very little lotion. Review of Resident #1's current physician order revealed no evidence of an order	I 484	Cross Reference w392	2/5/08

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G190	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/05/2008
NAME OF PROVIDER OR SUPPLIER: C M S	STREET ADDRESS, CITY, STATE, ZIP CODE: 1608 EVARTS ST, NE WASHINGTON, DC 20018		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 484	Continued From page 5 for Clindamycin Topical 1% lotion. According to the October 2007 physician orders indicated that the Clindamycin Topical 1% lotion had been discontinued by the primary care physician at that time.	I 484		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure the protections of each resident's rights for one of the two residents in the sample. (Resident #1) The finding includes: On February 4, 2008 at 8:40 AM, Resident #1 was observed being administered Tegretol, Prozac, and Zyprexa. Interview with the medication nurse indicated that the resident receives these medications for his maladaptive behaviors. During the entrance conference on February 4, 2008 at 9:00 AM, the Qualified Mental Retardation Professional (QMRP) stated that Resident #1 had a Behavior Support Plan (BSP) and received psychotropic medication as well as one to one support services. During resident observation from February 4 - 5, 2008, a direct care staff was observed with the resident (at arms length) at all times. Review of the BSP dated November 27, 2007 address targeted behaviors of snatching food,	I 500	Cross reference W262	3/03/08

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I 500	Continued From page 6 spitting and aggression to others. The BSP was designed to provide positive approaches to challenging behaviors so a successful home learning environment could be created. The BSP did not indicate a need for one to one support services with the exception of during meal times. Review of the HRC minutes on February 5, 2008 dated November 29, 2007 revealed that the resident's BSP was review and approved by the HRC. It should be noted that the BSP approved did not include one to one support services. There no evidence that the HRC was made aware of the one to one staffing used to assist with the management of Resident #1's behavior.	I 500		

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R 000	INITIAL COMMENTS A licensure survey was conducted from February 4, 2008 through February 5, 2008. The survey was initiated using the fundamental survey process. A random sample of two residents were selected from a population of four males with profound mental retardation and various disabilities. The findings of this survey were based on observations at the group home, a day program, 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 February 5, 2008 revealed the GHMRP failed to provide evidence	R 125	Criminal background checks will be completed for staff #2 and #4 In the future new staff will be required to submit background checks before working in the facility. CMS personnel dept. will oversee this procedure.	2/29/08

Health Regulation Administration
Constance A. Reese
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
TITLE Program Director
(X6) DATE 2/29/08

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R 125	Continued From page 1 of criminal background checks for two direct care staff (Staff #2 and #4).	R 125		