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

PRINTED: 09/05/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G031	A. BUILDING _____ B. WING _____	08/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C M S	4314 9TH STREET NW WASHINGTON, DC 20011

(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 August 19, 2008 through August 21, 2008. The survey was initiated using the fundamental survey process. A random sample of three clients was selected from a resident population of six women with various disabilities. In addition, a focused review was conducted of a fourth client's adaptive equipment and mobility/ physical therapy needs. The findings of the survey were based on observations, interviews with clients, interviews with staff in the home and at two day programs, as well as a review of client and administrative records, including incident reports.	W 000		
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to effectively monitor each client's dental services to ensure that needs were met, for one of three clients in the sample. (Client #3) The findings include: 1. On August 20, 2008, at 1:08 PM, review of Client #3's dental records revealed that the dentist failed to provide care and treatment for all assessed needs. On May 2, 2007, the dentist had assessed mobility of tooth #15 and carries in tooth #30. The dentist then recommended "either filling or extraction" of #30. Client #3 returned to the dentist on June 21, 2007 at which time tooth #15 was extracted. There was no mention, however, of tooth #30 and the dentist did not	W 120	2008 Sept 15 P 3:20	RECEIVED DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Constance A. Reese
TITLE: Program Director
(X6) DATE: 9-15-08

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 120	Continued From page 1 indicate how soon or when the client should return for her next appointment. Client #3 returned to the dentist 12 months later. On June 23, 2008, the dentist found "large deposits of plaque and calculus on all remaining tooth surfaces. Most teeth are periodontally involved... recommend repair tooth #30 ... #30 is super-erupted." On August 20, 2008, beginning at 1:32 PM, the Qualified Mental Retardation Professional (QMRP), House Manager and RN were interviewed in the facility. They indicated that the client was mostly independent in tooth brushing. Further interviews revealed that they were previously unaware that tooth #30 had been assessed with carries in May 2007 or that the dentist had not provided all necessary services. Review of the monthly and/or quarterly reports prepared by Client #3's QMRP, nurses and the primary care physician for the period May 2007 - July 2008 revealed no indication that the facility had identified the failure to provide needed dental services prior to this survey. 2. Even though the May 2, 2007 and June 23, 2008 dental evaluations reflected calculus and dental carries, the dentist failed to provide written recommendations or prescribe an appropriate daily oral hygiene/ dental care regimen.	W 120	The nursing Staff will review all consultants recommendations and follow-up. Dental appointment will be scheduled to follow-up with recommendations to repair tooth #30 for Client #3.	10/20/08
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	W 125		

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W 125	Continued From page 2 to due process. This STANDARD is not met as evidenced by: Based on observation, interview and review of staff in-service training records, the facility failed to ensure that all staff consistently allowed clients to exercise their right to access food and nourishment, for one of the three clients in the sample. (Client #1) The findings include: On August 21, 2008, beginning at approximately 8:38 AM, a direct support staff person was observed repeatedly refusing Client #1's request for food, as follows: At 8:38 AM, Client #1 was observed standing in the kitchen, holding a large fruit bowl in her hand. A direct support staff person saw this and instructed her to return the fruit bowl to its proper location. Client #1, who was mostly non-verbal, made a physical gesture indicating that she wanted a piece of fruit. The staff person told her no, the food di not belong to her: "that's not your food, put it back, it's not yours..." etc. The staff person took the bowl from her. While the staff placed the bowl atop the refrigerator, the client reached into a kitchen cabinet and removed a can of fruit cocktail. The staff said "no, you've already had your breakfast. No, that's not yours. Put it back." As the staff person put the fruit cocktail back into the cabinet, the client removed a can of peas. The staff insisted that she put it back in the cabinet as well. Immediately (at approximately 8:42 AM), Client #1 looked in the freezer and then in the refrigerator, reaching for various food items; the staff repeatedly told her to let go of the foods.	W 125		

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W 125	Continued From page 3 The client then went into a cabinet and removed a snack pack of cheese-filled crackers and an individual pudding cup. The staff person took the pudding cup from the client's hand and then followed the client as she quickly left the kitchen, walked through and around the living room. The staff person remained in pursuit and at approximately 8:45 AM, she caught up with the client in the kitchen. The staff insisted that the client give her the crackers. By then, however, the client had opened the package and placed one of the crackers in her mouth. The staff took the package from her hand and threw it into the trash recepticle. She instructed the client to remove the cracker from her mouth and give it to her. The client hesitated and took a bite from the cracker. The staff took what remained of the cracker from the client's mouth and threw it in the trash. While the staff person was asking Client #1 for the crackers, another staff person was asked about the breakfast. She indicated that Client #1 had not eaten her entire breakfast that morning. A surveyor suggested that the client might still be hungry. At that same moment, at approximately 8:56 AM, the Qualified Mental Retardation Professional (QMRP) and the House Manager descended the stairs from the 2nd floor into the living room/ dining room archway. Still in the kitchen nearby, the staff person offered the client water. When the client said "juice," the staff person told her she could not have juice "uh uh, that's not an option." She then repeated her offer of water. The client said "juice" again and the staff responded "no, you can't have it; you want water?" The QMRP heard the discussion and asked the staff if there was juice available. As the staff	W 125		

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W 125	Continued From page 4 person retrieved a pitcher of juice from the refrigerator, Client #1 reached for the pitcher. The staff said "uh uh, I'll pour it, you go sit down." The staff poured some juice, handed her the glass, and watched the client drink the juice rapidly, finishing the glass in a few seconds. Previously, on the first day of survey, staff had indicated that Client #1 was on a regular diet. On August 20, 2008, review of her physician's orders and other records had confirmed that she did not have any dietary restrictions. There was no clinical or other reason evidenced that would explain why staff did not consistently allow and encourage the client to exercise her rights as a resident of the facility. It should be noted that on August 21, 2008, review of staff in-service training records revealed no evidence that the staff person observed that morning denying Client #1's requests had received training on resident rights. On August 20, 2008, at approximately 6:00 PM, the QMRP and House Manager were informed that the staff person's (S4) personnel record had not been made available for review along with the others'. No additional information was made available, including no evidence of orientation training for this staff, before the survey ended approximately 24 hours later.	W 125	The facility will train the staff on the Clients' Rights and Choice Making. In the future, Management and Psychologist will train the staff quarterly on the Clients' Rights, and Behavior Support Plans.	9/12/08
W 261	483.440(f)(3) PROGRAM MONITORING & CHANGE The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate	W 261		

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W 261	Continued From page 5 client behavior, and persons with no ownership or controlling interest in the facility. This STANDARD is not met as evidenced by: Based on interview and review of Human Rights Committee (HRC) minutes, there was no evidence that persons without a controlling interest had attended and participated in the HRC meeting during which Client #1's restrictive plans were reviewed and approved. The finding includes: Client #1 was admitted to the facility on April 19, 2008. On August 21, 2008, at 10:20 AM, interview with the Qualified Mental Retardation Professional revealed that the facility had reviewed the restrictive measures (medications and behavior intervention techniques) that were prescribed and being implemented. Review of the HRC minutes provided showed no indication that meetings were held during the months of April, May, June 2008. Review the minutes of the July 8, 2008 HRC meeting revealed that the committee had approved Client #1's restrictive measures. However, further review of the signature sheet for the meeting revealed that all attendees that day were employed by the agency.	W 261	In the future, the HRC will have a non-employee present at the meeting.	10/20/08
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide medical services timely, for one	W 322		

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W 322	Continued From page 6 of the three clients in the sample. (Client #3) The findings include: 1. Cross-refer to W356.3 and W356.4. On August 20, 2008, review of Client #3's dental records revealed the dentist's repeated findings of calculus and carries (January 2007, May 2007 and June 23, 2008). In addition, she had several teeth extracted and one tooth (tooth #30) had been assessed with carries in May 2, 2007 yet remained without recommended treatment 15 months later. Further review of the client's record, and interviews with the RN and Qualified Mental Retardation Professional, revealed no evidence that the facility sought specific recommendations from the dentist. Review of the client's Health Management Care Plan, dated January 10, 2008, revealed no mention of her assessed calculus and carries and failed to outline a plan to address her dental care needs. 2. The facility failed to provide timely assessment of Client #3's hemorrhoid, as follows: On August 20, 2008, at 2:52 PM, review of nurse progress notes revealed that Client #3 had shown signs/ symptoms of hemorrhoids on April 2, 2008 and again on July 23, 2008. On both occasions, the LPN documented having administered Tylenol 650 mg as needed for pain, in accordance with her physician's orders. In addition, both progress notes indicated that the LPN would notify her supervisor. On August 20, 2008, at 3:38 PM, Client #3 was seated in the dining room with staff, peers and surveyors. Without prompting, she declared "my butt hurts" two times in succession. The House	W 322	Cross reference W120	10/20/08

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W 322	Continued From page 7 Manager instructed direct support staff to take her upstairs to be assessed by the RN, who was in the facility at the time. When asked, the House Manager indicated that she was unaware of any hemorrhoids and there were no special treatments or precautions being implemented to date. While Client #3 was upstairs being assessed, review of her records failed to show evidence that she had been assessed by an RN or her primary care physician since the LPN made her April 2, 2008 progress note. In addition, her HMCP, dated January 10, 2008, did not address hemorrhoids. The RN was interviewed in the living room shortly after she had completed her assessment of Client #3. At 4:02 PM, she reported having observed a hemorrhoid approximately 1 cm in length. She said this was the first time that she had seen a hemorrhoid since she began working in this facility in December 2007. She was previously unaware of the LPN's reported observations. She further indicated that to date, there was no treatment plan prescribed, as she was awaiting assessment by the primary care physician. 3. Cross-refer to W338. There was no evidence that the PCP's order for testing of Client #3's prolactin levels (every 6 months prior to January 29, 2008, and anuually since then) had been implemented.	W 322	The primary nurse will review all nursing entries in all the individuals record and make an appropriate follow up, including arranging the individual to be examined by PCP. Client #3 was evaluated by the PCP on 8/22/08. HMCP will be updated to include the diagnosis of hemorrhoids. Prolactin level was ordered for Client #3.	9/19/08 9/19/08 8/14/08
W 338	483.460(c)(3)(v) 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 result in any necessary action (including referral to a	W 338		

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W 338	Continued From page 8 physician to address client health problems). This STANDARD is not met as evidenced by: Based on record review and interview, facility nurses failed to refer clients to medical specialists (serum labs), for one of the three clients in the sample. (Client #3) The finding includes: On August 20, 2008, at approximately 10:50 AM, review of Client #3's physician's orders (POs) revealed that since January 29, 2008, her serum prolactin levels should be tested annually. Review of her November 2007 POs revealed that prior to that (since November 20, 2006), the orders were to "monitor prolactin level every 6 months." Subsequent review of lab reports in the client's record, however, failed to reveal any findings or test results showing prolactin levels. There was no evidence that nursing staff had scheduled or sought testing of her prolactin levels in accordance with physician's orders. It should be noted that on February 5, 2008, the pharmacist had conducted a quarterly review, at which time he wrote a recommendation to the physician, to "monitor prolactin level." There was no evidence, however, that the medical team had acted upon the pharmacist's recommendation in the 6 months that followed.	W 338	The primary care nurse will be responsible for tests ordered by the physician to be completed on time. Cross reference W322	9/19/08
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	W 356		

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W 356	Continued From page 9 health. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that clients received dental services in a timely manner, for one of the three clients in the sample. (Client #3) The findings include: 1. Cross-refer to W120.1. The facility failed to ensure that Client #3's dentist provided the recommended treatment ("either a filling or extraction") of the client's tooth #30, as per a May 2, 2007 evaluation. On June 23, 2008, the dentist wrote that tooth #30 remained problematic ("super-erupted"), more than 1 year later. As of August 21, 2008, the tooth had not been filled or extracted and a return appointment date had not yet been established. The Qualified Mental Retardation Professional (QMRP) and the registered nurse (RN) both reported that authorization for payment (by Medicaid) was expected within 3 - 6 months after the dentist submitted a form on June 23, 2008, or shortly thereafter. 2. Even though Client #3's May 2, 2007 and June 23, 2008 dental evaluations reflected calculus and dental carries, and she had numerous teeth extracted within the past few years, there was no evidence that the facility sought the dentist's recommendations regarding an appropriate daily oral hygiene/ dental care regimen. 3. The facility's medical team failed to address Client #3's dental needs, as follows:	W 356	Cross reference W120	10/20/08

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W 356	Continued From page 10 a. On June 10, 2007, Client #3's primary care physician (PCP) documented having examined her mouth after she complained of a toothache. The PCP wrote: "no cavity seen but tender over the right lower molar tooth ... toothache - no sign of carries." However, 5 weeks earlier, on May 2, 2007, the client had been to the dentist, at which time the dentist found caries in tooth #30 (a molar on the lower right jaw). There was no evidence that the nursing team and physician were aware of the dentist's May 2, 2007 findings.	W 356	a. In the future, the physician and primary care nurse will review dentist findings and make notation in the medical records.	9/1/08
	b. On August 20, 2008, review of Client #3's annual physical assessments by the (PCP) and RN, dated December 14, 2007 and January 10, 2008 respectively, revealed no evidence that they addressed the dentist's repeated findings of calculus and carries (January 2007 and May 2007). The PCP's annual evaluation did not report any dental findings, and he recommended dental evaluations "as indicated." The RN reported that tooth #15 had been extracted on June 12, 2007; however, she did not mention carries in tooth #30. The RN recommended health assessments/evaluations "as indicated." While both the PCP and RN recommended evaluations "as indicated," the client's dentist had not established a schedule or noted on the consultation forms a recommended return date for future evaluations.		b. The annual physical assessment and the nursing assessment will be revised to include the dentist findings.	9/30/08
	c. Client #3's Health Management Care Plan (HMCP) failed to address her dental needs. On August 20, 2008, at 1:08 PM, review of Client #3's dental records revealed findings of dental caries and/or extractions on January 11, 2007, March 20, 2007, May 2, 2007, June 21, 2007 and June 23, 2008. Moderate to heavy calculus was assessed on January 11, 2007 and again on June		c. Cross reference W322	9/19/08

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W 356	Continued From page 11 23, 2008. Review of the client's HMCP, dated January 10, 2008 revealed no mention of her assessed calculus and caries. Client #3's HMCP also failed to outline a plan to address her dental care needs. 4. Client #3's interdisciplinary team (IDT) failed to address her assessed dental concerns (calculus and caries), as follows: On August 20, 2008, beginning at 1:48 PM, review of Client #3's QMRP monthly and quarterly reports for the period May 2007 - June 2008 revealed no references made to dental findings and/or recommendations. Her dental records, however, revealed findings of calculus and dental caries on January 11, 2007, May 2, 2007 and June 23, 2008. Tooth #30 had reportedly needed "filling or extraction" since May 2, 2007 (more than 15 months earlier). Her IDT met on January 10, 2008 to review and update her annual Individual Support Plan (ISP). Review of the ISP revealed that it reflected the June 12, 2007 extraction of tooth #15. It also indicated that the client "would like to continue to have regular clinical visits as recommended by her PCP." However, while the PCP recommended evaluations "as indicated," neither he nor the client's dentist had established a schedule or noted on the consultation forms a recommended return date for future evaluations. There was no evidence, however, that the IDT discussed her dental status to determine whether or not her needs were being met. 5. The facility failed to re-evaluate Client #3's daily oral care/ tooth brushing needs or otherwise alter her routine after dental evaluations	W 356	Client #3 HMCP will be updated to include the dental care needs	9/19/08

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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
	09G031		08/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C M S	4314 9TH STREET NW WASHINGTON, DC 20011

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W 356	Continued From page 12 repeatedly showed evidence of inadequate care, as follows: On August 20, 2008, at 1:32 PM, the QMRP and House Manager stated that for years, Client #3 routinely brushed her teeth twice daily "during her AM and PM hygiene" care. They further indicated that the client was independent in her brushing; however, direct support staff reportedly prompted her occasionally to complete her brushing if she was in a hurry and stopped too soon. Subsequent review of her record confirmed that she was assessed as "independent" in tooth brushing. As noted above, Client #3's dental records reflected years of calculus build-up, dental caries and tooth extractions. The facility, however, failed to alter Client #3's daily oral care/ tooth brushing routine or verify the accuracy of her skills assessment.	W 356		
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 teach clients to use their prescribed adaptive equipment (i.e. dentures and hearing aids) and to make informed choices about their use, for one of the clients residing in the facility. (Client #4) The findings include:	W 436		

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W 436	Continued From page 13 1. The facility failed to ensure that Client #4 was reassessed to determine how well her dentures fit while consuming her meals, as follows: During the Entrance Conference on August 19, 2008, at approximately 9:00 AM, the Qualified Mental Retardation Professional (QMRP) stated that Client #4 was prescribed full dentures. Client #4 had not, however, been observed wearing dentures earlier that morning, from 6:57 AM until her 8:32 AM departure for day program. However, at approximately 4:20 PM, Client #4, smiled broadly when this surveyor commented that she had beautiful teeth. While eating her dinner, however, at approximately 5:00 PM, the client did not appear to be wearing the dentures. Interview with staff revealed "She always removes her teeth when she gets ready to eat." Further observation revealed the dentures were wrapped in a paper towel and laying on the dining room table, beside her plate. Interview with the QMRP August 21, 2008, at 2:30 PM, revealed that Client #4 had been wearing dentures for approximately two years and was still getting used to them. The QMRP indicated that she was aware that the client usually removed her teeth before eating; however, there were times ("occasionally") when she kept them in her mouth for the meal. The client reportedly was encouraged to wear her dentures while eating. A short while later, during snack time, the QMRP asked the client if she would try to eat her fresh orange wedge while wearing her dentures. The client had trouble biting; however, she sucked on the orange several times. After several minutes, she removed her dentures from her mouth and	W 436		

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W 436	Continued From page 14 finished the orange. The review of Client #4's September 17, 2007 annual nursing assessment revealed that she had "adjusted well" to her dentures. An annual dental examination consultation report dated December 11, 2007 failed to mention dentures. However, further staff interviews could not confirm that the client had worn the dentures when she went to the dentist that day. There was no evidence that Client #4's dentist had been made aware of her refusals to wear the dentures during her meals. At the time of the survey, the reason(s) why the client removed the dentures during meals had not been assessed. 2. The facility failed to ensure that Client #4 was monitored for wearing her bilateral hearing aids as prescribed. Client #4 was observed in the facility on August 19, 2008 and August 20, 2008. At no time was she observed wearing hearing aids. During the August 19, 2008 Entrance Conference, the QMRP indicated that Client #4's dentures were her only adaptive equipment. However, interview with the RN on August 20, 2008, at approximately 3:20 PM, revealed that the Client #4 wore bilateral hearing aids. When the client returned from her day program a short while later, at approximately 3:40 PM, she was not observed wearing hearing aids. When asked, a direct support staff person stated that the client sometimes removed them from her ears. Staff then checked the client's pockets; however, she did not have them with her. Staff escorted the client upstairs and shortly thereafter, she returned to the dining room wearing both hearing aids. Review of the April	W 436	1. An appointment is scheduled on 10/22/08 with Client #4's dentist to communicate her refusals to wear her dentures during meals. The facility will follow the dentist recommendation regarding this issue.	10/22/08

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W 436	Continued From page 15 28, 2008 hearing aid evaluation revealed that the client needed the hearing aids due to her bilateral mild-to-moderate hearing loss. There was no evidence that facility staff encouraged/ensured that the client wore her hearing aids in the home and while at day program, as prescribed.	W 436	2. Staff will be trained to check the ears of Client #4 daily to encourage and ensure that she wears her hearing aids. Management will supervise staff weekly to ensure their follow through on Client #4's body check.	9/15/08

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I 000	INITIAL COMMENTS A licensure survey was conducted from August 19, 2008 through August 21, 2008. The survey was initiated using the fundamental survey process. A random sample of three residents was selected from a resident population of six women with various disabilities. In addition, a focused review was conducted of a fourth resident's adaptive equipment and mobility/ physical therapy needs. The findings of the survey were based on observations, interviews with residents, interviews with staff in the home and at two day programs, as well as a review of resident and administrative records, including incident reports.	I 000		
I 047	3502.5 MEAL SERVICE / DINING AREAS Each GHMRP shall be responsible for ensuring that meals, which are served away from the GHMRP, are suited to the dietary needs of residents as indicated in the Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record verification, the GHMRP failed to ensure that meals served away from home suited the dietary needs of the residents as indicated in the individual support plan, for one of two of the six clients residing in the facility. (Residents #3 and #4). The findings include: On August 20, 2008, at 7:45 AM, two lunch boxes were observed on the counter in the kitchen. Interview with staff indicated that they belonged to Residents #3 and #4 who attended the same day	I 047		

Gaetane A. Lewis Program Director
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

(X6) DATE 9-15-08

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I 047	Continued From page 1 program. Both residents were on 1500 calorie diets. Observation of one lunch box revealed it contained tuna salad, 8 crackers, ½ cup pudding and water. The staff indicated that both lunches boxes contained the same food items. Staff indicated that the water and a diet soda were alternated. At 8:22 AM, Resident #3 retrieved an opened bag of pretzels and requested some for her lunch box. The QMRP replied that she would have to substitute the pudding for the pretzels, which she did. Menus for box lunches were reviewed on the next day, August 21, 2008, at 2:05 PM. The menu indicated that on the day before, Residents #3 and #4 should have received 3 ounces of Chicken salad on a bed of lettuce, six saltines, carrot sticks, ½ cup of sugar free yogurt with fruit, and water. Interview with the QMRP revealed that lunch items were subject to change on days when the residents went on community outings (such as on the day before) when there was no refrigeration available. This, however, did not explain the choice of tuna salad in a lunch that would not be refrigerated to ensure safety, or absence of carrot sticks (or an appropriate vegetable substitute). Resident #3 made a choice to substitute pretzels (bread) for the pudding (milk product), without being provided guidance to make a more appropriate choice. In addition, there was no evidence that the GHMRP had informed the nutritionist about the need for non-perishable lunch choices. The lunch menus did not identify suitable food substitutions for those days when residents were without access to a refrigerator. Although there was documented evidence that staff had received training on diets, menus and food preparation, the facility failed to ensure that substitutions	I 047	The facility will request from the Nutritionist a menu with non-perishable lunch choices. The facility will also request an exchange ~~substitution~~ menu.(a list of menu items to substitute) The staff will be trained on how to prepare a nutritious lunch and how to follow~~ing~~ the menu.	

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I 047	Continued From page 2 made for lunches were of a similar nutritive value and that all food categories on the menu were served.	I 047		
I 056	3502.14 MEAL SERVICE / DINING AREAS 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. This Statute is not met as evidenced by: Based on observations, interview and review of staff training records, the GHMRP failed to ensure sanitary food handling and storage practices. The findings include: 1. On August 21, 2008, at 12:35 PM, three food storage containers were observed to have measuring cups/ portion control items stored inside of them. The House Manager, who was present at the time, stated that staff should store these items separately. 2. Trash was observed in a cabinet underneath the sink. 3. The doors on each of the lower cabinet doors in the kitchen were soiled. Even though there was documented evidence that a certified food manager was present on each shift, there was no evidence that their training had been effective to ensure safe food handling and sanitation.	I 056	1. The facility removed the measuring cups and portion control items from the three food storage containers. 2. The trash was removed from underneath the sink. 3. The cabinet doors will be repaired.	9/9/08 9/9/08 10/18/08

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I 075	Continued From page 3	I 075		
I 075	3503.3(d) BEDROOMS AND BATHROOMS Each bedroom shall be equipped with at least the following items for each resident: (d) Night stand. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure that each bedroom was equipped with at least the following items, for six of the six residents. (Residents #1, #2, #3, #4, #5 and #6) (d) Night stand. The finding includes: On August 21, 2008, beginning at 11:29 AM, there were no night stands observed in any of the six residents' bedrooms. Interview with the House Manager revealed that there were no night stands available in the facility.	I 075	The facility will purchase a night stand for Clients #1, #2, #3, #4, #5, and #6.	9/30/08
I 077	3503.5 BEDROOMS AND BATHROOMS Each bedroom shall contain sufficient storage space for each resident ' s seasonal, personal clothing and personal effects. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure that each bedroom contained sufficient storage space for each resident's seasonal, personal clothing and personal effects, for two of the six residents. (Residents #4 and #5) The findings include:	I 077		

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I 077	Continued From page 4	I 077		
	1. On August 21, 2008, at 11:29 AM, there were no clothes belonging to Resident #5 observed in her bedroom. Clothes in the room belonged to another resident who shared that room. The House Manager stated that she would ask her staff about the whereabouts of the resident's clothing. At 2:35 PM, the House Manager showed this surveyor Resident #5's clothing, which was being stored in two large suitcases, in an adjoining room.		1. The facility will purchase a dresser for Resident #5.	10/15/08
	2. At 11:48 AM, Resident #4's television was observed placed on the bedroom floor. The House Manager indicated that the GHMRP planned to purchase a television stand. In the meantime, the resident was not provided with the furniture necessary for comfortable television viewing.		2. The facility will purchase a t.v. stand for Resident #4.	10/15/08
	3. There was clothing hung in a closet located off the hallway on the third floor. Interview with the House Manager revealed that the clothing belonged to Resident #4, whose bedroom was located down the hall. Moments later, observation of the client's bedroom confirmed that she lacked storage space for hanging her clothes.		3. The facility will purchase a storage device to hang Resident #4's clothes.	10/15/08
I 090	3504.1 HOUSEKEEPING	I 090		
	The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.			
	This Statute is not met as evidenced by: Based on observation and interview, the GHMRP			

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I 090	Continued From page 5	I 090		
	failed to maintain the interior of the facility in a safe, clean, orderly, and attractive manner.		1. The facility will purchase an extra trash can.	9/30/08
	The findings include:			
	On August 21, 2008, beginning at 11:20 AM, observation of the environment revealed the following deficiencies:		2. The railing between the second and third floors will be secured. The bolts of the railing will be secured. The vertical supports on the left side of the railing will be secured.	10/15/08
	1. One of the three trash cans in the back yard was filled with garbage such that the lid could not be closed. Another, smaller trash can was without a lid.			
	2. Railings on the steps between the second and third floors were not secured. The bolt at the bottom of the railing on the right hand side had pulled out of the wall, leaving a small hole in the plaster. The railing on the left side was missing three of the vertical supports.		3. The interior floor boards will be replaced. In addition, the small hole at the bottom of the door will be replaced.	10/15/08
	3. At the emergency exit door on the third floor, wooden interior floor boards extended beyond the door, to the exterior. Approximately 2 inches of wood was exposed to the elements when the door was closed. Those portions of wood that were exposed to the elements appeared to be rotted, and sagged when weight was applied. In addition, a small hole was observed at the bottom right corner of the door.		4. A lamp was purchased for the room that Residents #3, and #5 were sharing.	9/10/08
	4. The bedroom shared by Residents #3 and #5 did not have sufficient lighting. A dim ceiling light was the sole electric light and the one small window provided only minimal light during daytime hours.		5. The bathroom tub will be re-caulked B.) The shower curtain will be replaced with a new curtain.	10/15/08
	5. The third floor bathroom had: (a) mildew on the caulking on the bathtub; (b) soap scum and a tear on the shower curtain; (c) no device to hold			

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I 090	Continued From page 6	I 090		
	water in bathtub when required; (d) no holder for disposable towel; (e) a hole in of the bathroom door.		c. A device will be purchased to hold water in the bath tub. d. A holder for the disposable towel will be purchased.	9/30/08
	6. Numerous wrinkles were observed in the wall to wall carpet on the floor in Resident 4's bedroom which was located on the third floor. The wrinkles created potential a potential trip hazard.		The hole in the bathroom door will be restored or a new door will be purchased. 6. Resident #4's carpet will be repaired.	10/15/08
	7. The floor of Resident #1's closet was covered with shoes which were scattered about. Her storage placed near the closet was filled with unfolded and disorganized clothing. Interview with the residential manager revealed that the resident had a targeted behavior of clothes changing and that she often rambled though her clothing storage unit.		7. Resident #1 will be encouraged to organize her shoes and clothes daily. A shoe rack will also be purchased. In addition, Resident #1 will be given a chore to organize her room and belongings.	9/30/08
	8. The door of the bedroom that was shared by Residents #1 and #2 had a plastic plate secured to it. There was a circular hole approximately 2 inches in diameter in the plastic plate. The edges of the hole were sharp to the touch and therefore presented a potential safety hazard. In addition, portions of the paint on the inside of their bedroom door was peeled.		8. Residents#1, and #2 door will be repaired or replaced.	10/15/08
	9. The metal screen on the radiator cover in the bedroom shared by Residents #1 and #2 was not fastened on the left edge, presenting a potential safety hazard In addition, an exposed nail was observed on the radiator cover.		9. Resident #1, and #2 metal screen on the radiator cover will be repaired. The exposed nail will be removed.	10/15/08
	10. Sections of the radiator covers in both the second floor and basement bathrooms were missing. Thin square metal coils of the radiator were exposed, therefore presenting a potential safety hazard.		10. The radiator cover in both bathrooms (2nd Floor and basement) will be repaired.	10/15/08

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I 090	Continued From page 7 11. The metal screen on the radiator cover in Resident #6's bedroom was observed to be rolled outward at the top right side, with a sharp metal edge exposed, presenting a potential safety hazard. 12. The wardrobe in Resident #6's bedroom had a hole and 3-inch long crack in the right side. 13. Residents received their medications in the room on the second floor that was used as an office. The carpet just inside the door was frayed. In addition, there was a hole in the frame of the door leading outside, at the bottom right side. A wash cloth had been stuffed into the hole from the inside. 14. A constant drip of water was observed coming from the faucet of the utility sink located in the basement. 15. The front was missing from a drawer of the right kitchen cabinet. 16. The drawer was missing from the buffet on which the television was displayed in the kitchen. Screws were missing from the metal handles on the doors of the buffet, which caused the handles to be partially detached.	I 090	11. Resident #6's radiator cover will be repaired. 12. Resident #6's wardrobe will be replaced. 13. The carpet will be repaired. 14. The utility sink's constant drip will be fixed. 15. The kitchen drawer will be repaired. 16. The buffet's drawer will be repaired. The metal handles will be reattached.	10/15/08 10/15/08 10/15/08 9/30/08 10/15/08 10/15/08
I 094	3504.5 HOUSEKEEPING Adequate and appropriate storage shall be provided for each food item in accordance with § 3502.17, each piece of cleaning equipment, and each supply, utensil, linen, or other household item. This Statute is not met as evidenced by:	I 094		

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I 094	Continued From page 8 Based on observation and interview, the GHMRP failed to ensure appropriate storage of linens. The finding includes: On August 21, 2008 at 11:34 AM dark stains were observed on the ceiling of the linen closet which was located in middle room on the third floor. The stains appeared to be water damage from above the ceiling. When asked, the House Manager did not know how long ago the stains had appeared or whether the origin of the stains had been investigated.	I 094	The dark stains on the linen closet's ceiling will be removed and ceiling repaired.	10/15/08
I 098	3504.9 HOUSEKEEPING Each GHMRP shall provide appropriate procedures, personnel, and equipment in order to ensure sufficient clean linen supplies and the proper sanitary washing and handling of linen and personal clothing of each resident. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure adequate equipment for the sanitary handling of linen and personal clothing for each resident. The finding includes: On August 19 2008, at 9:37 AM, two plastic baskets with cracked, torn areas were observed near the dryer in the basement. Several items of clothing were observed in one of the baskets. Later that day, at 3:10 PM, a staff person was observed folding freshly-washed clothing at the dryer and placing them into the same baskets that were used to carry dirty laundry to the basement. Interview with the staff person	I 098		

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I 098	Continued From page 9 confirmed that the baskets were used to transport clothing to and from the the basement. On August 21, 2008, at 12:22 PM, the House Manager also confirmed that the two plastic baskets observed were used routinely to transport all six of the residents' laundry. Residents did not have personal hampers. Review of the facilities's policy on laundry revealed that each resident was to be taught to sort and launder her own clothing with staff assistance. The policy, however, failed to provide sufficient guidelines regarding how staff were to ensure sanitary handling of residents' personal clothing.	I 098	The facility will purchase hampers for each of the six residents.	9/30/08
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that all staff obtained annual health certificates/ inventories. The findings include: Review of the personnel records on August 20, 2008, beginning at 5:24 PM, revealed the following:	I 206		

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WASHINGTON, DC 20011

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		I 206		
	n file for the tember 9,		1. The House Manager will get her physical accomplished.	9/12/08
	inventories e 9 direct the		2. S3 is no longer an employee of the facility. The facility will receive S4's employee file.	9/15/08
	3. The health certificates/ inventories on file for an LPN (N2) and an RN (N1) had expired in March 2008.		3. N1 and N2 will accomplish their physicals.	9/20/08
	4. The health certificate/inventory on file for the Nurse Coordinator/RN had expired on September 26, 2004.		4. The Nursing Coordinator will accomplish her physical.	9/15/08
	5. The health certificates/ inventories on file for the consulting Physical Therapist and Pharmacist had expired in April 2008 and June 2007, respectively.		5. The Physical Therapist and Pharmacist will be requested to forward their health certificates to the facility. In the future, the facility will review all personnel records quarterly to ensure that they are active.	9/20/08
I 221	3510.2 STAFF TRAINING	I 221		
	Orientation training shall be the responsibility of each GHMRP and shall be documented in each employee ' s personnel folder.			
	This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to document the provision of orientation training for Staff #4.			
	The finding includes:			
	Observation of Staff #4 during the survey revealed her providing supervision and active treatment to Resident #1 who did not attend a day program (school) on Monday through Friday because her school was closed for the summer.			

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I 221	Continued From page 11 Interview with the staff indicated that she was a student who had worked in the group home during the summer as well as other school breaks. Review of the GHMRP's in-service training records on August 21, 2008 revealed no evidence that Staff #4 had received orientation training and an overview of the special needs of the residents living in the group home. In addition, there was no personnel file made available for this staff person. It should be noted that this staff person (S4) was observed violating Resident #1's right to access food and nutrition in the home on August 21, 2008, beginning at 8:38 AM. [See I500]	I 221	All staff will be required to attend all trainings. In the future, staff who are unable to attend three trainings will be recommended for termination.	9/10/08
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure that staff received effective training in nutrition, therapeutic diets and resident rights. The findings include: 1. On August 19, 2008, at 8:08 AM, staff was observed offering Resident #3 an oatmeal pie. The staff person then asked her to share it with Residents #1, #2 and #6. Resident #3 complied with the staff's instructions. Moments later, the	I 229		

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I 229	Continued From page 12 same staff person gave Resident #4 an oatmeal pie as well and asked her to share it with Resident #1. Resident #4 complied with the request. After Resident #6 finished eating the piece of oatmeal pie, at 8:12 AM, she asked for more. After explaining to her that there were no more oatmeal pies in the facility, the staff gave her (Resident #6) a honey bun. Also on August 19, 2008, at 5:45 PM, Resident #6 was administered Novalog insulin, 8 units after a fingerstick. Interview with the medication nurse confirmed that the resident was diabetic. The amount of insulin administered was based on the result of the blood sugar level at that time. Later that evening, interview with staff revealed that Resident #6 was prescribed a 1500 calorie diet to manage her diabetes and to promote weight loss. Review of records also revealed that Residents #2 and #3 were prescribed 1500 calorie diets for weight reduction. Review of the facility's menus revealed no indication that oatmeal pies and/or honey buns were allowed for individuals on 1500 calorie restricted diets or in accordance with Resident #6's diabetic diet. 2. On August 19, 2008, the residents were observed eating dinner between 5:23 PM - 6:22 PM. After dinner, the residents walked with staff to a convenience store on the corner. They returned to the facility with vanilla cookies and diet sodas. At 7:15 PM, Residents #2 and #5 were observed eating sandwich-type vanilla cookies and drinking diet sodas while seated on the front porch. Review of the facility's menus revealed no indication that creme-filled vanilla cookies were in accordance with 1500 calorie restricted diets. There was no evidence that staff was effectively	I 229	1. The facility will train staff on the resident's diet and the importance of having a balanced diet. 2. Staff will recieve additional training on how to assist each resident in adhering to their diets.	9/30/08 9/30/08

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I 229	Continued From page 13 trained in assisting residents with adhering to their specially prescribed diets and making appropriate choices. 3. Cross-refer to I500. There was no evidence that the staff person (S4) observed violating Resident #1's right to access food and nutrition on August 21, 2008 had received training on resident rights. Interview with the staff indicated that she was a student who worked in the facility during the summer months and on holidays.	I 229	3. Cross reference W125	9/12/08
I 271	3513.1(b) ADMINISTRATIVE RECORDS Each GHMRP shall maintain for each authorized agency ' s inspection, at any time, the following administrative records: (b) Personnel records for all staff including job descriptions either at the GHMRP or in a central office and made available upon request; This Statute is not met as evidenced by: Based on record review, the GHMRP failed to provide evidence of personnel records for all staff. The finding includes: Review of the GHMRP's personnel files on August 20, 2008, beginning at 5:24 PM, revealed no evidence of a personnel record being maintained for one direct support staff person (S4).	I 271	In the future, personnel records will be sent to the facility immediately after hire.	9/30/08
I 291	3514.2 RESIDENT RECORDS Each record shall be kept current, dated, and signed by each individual who makes an entry.	I 291		

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I 291	Continued From page 14 This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each residents record was kept current, for one of the three residents in the GHMRP. (Resident #3) The findings include: 1. On August 20, 2008, beginning at 10:54 AM, review of Resident #3s medical records revealed no written evidence of recent physical examinations by either a registered nurse or the primary care physician (PCP). The most recent PCP documentation was dated December 14, 2007 and the most recent RN quarterly assessment was dated April 10, 2008. The facility's RN was interviewed in the group home later that day, beginning at 3:18 PM. She stated that Resident #3 had been evaluated more recently by the PCP but that the PCP's findings were not yet filed in her record. She described a process by which the PCP used a recording device to dictate his findings and recommendations; these reportedly were then transferred later to a typed report. a. Moments later, the RN presented a handwritten progress note, dated May 2, 2008, in which the PCP documented having evaluated Resident #3's foot after she complained of foot pain. The RN asked this surveyor to place the May 2, 3008 progress note into the resident's record. The RN acknowledged that to date, the May 2, 2008 foot examination had not been reflected in Resident #3's record in the group home. b. Further interview with the RN revealed that Resident #3 and her peers routinely went to the	I 291	PCP's Quarterly Progress Notes will be updated and included in the Client's record. The Nursing Coordinator will ensure the PCP notes are done on a timely manner.	9/30/08

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I 291	Continued From page 15 PCP's office for quarterly examinations. The examinations reportedly were performed jointly by the PCP and the Nursing Coordinator. At 3:31 PM, the RN was observed speaking by telephone with the Nursing Coordinator, requesting copies of the PCP's most recent quarterly assessments. On the next day (August 21, 2008), at 12:20 PM, the RN presented two PCP quarterly examination reports, dated March 13, 2008 and June 13, 2008. Both quarterly reports were handwritten. The RN acknowledged that the results of the examinations had not been in the resident's record previously and then asked this surveyor to place the documents in the record. 2. While reviewing Resident #3's medical chart on August 20, 2008, the most recent nurse progress note observed in the record was from March 2008. At 2:52 PM, review of a separate binder, the Medication Administration Record (MAR) book, revealed that nurses had made numerous progress notes in the five months since March 2008. The progress notes documented Resident #3's complaints of pain (examples: 4/2/08 c/o pain in anal area; 6/10/08 toothache; and, 7/23/08 c/o hemorrhoid pain), assessment of vital signs and the administration of Tylenol "as needed" for pain. There were similar nurse progress notes observed in the MAR for the other 5 residents. The MAR book routinely was kept locked in a file cabinet that was accessible only to nurses. On August 21, 2008, at 2:29 PM, when asked if the MAR book accompanied residents to their PCP's office, or to other outside clinics, the Qualified Mental Retardation Professional replied "no"... direct support staff routinely took the residents medical charts but not the MAR. There was no evidence that residents' records were kept	I 291	In the future, the nurses' progress notes (currently in the MAR Book) will be placed in the Clients' medical book at the end of each month, to make it available to the PCP to review.	9/30/08

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I 291	Continued From page 16 current.	I 291		
I 325	3517.6(a) ADMISSION POLICIES PROCEDURES Each resident, prior to admission if possible or within ten (10) days of admission shall receive a health inventory, screening and immunizations which may include the following and any other tests as determined appropriate by the examining physician: (a) A complete medical history including vaccination history, immune status and any condition that may predispose the resident to acquiring or transmitting infectious diseases; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that prior to admission or within ten days of admission, Resident #2 received the following: (a) a complete medical history including vaccination history The finding includes: Interview with the QMRP on August 19, 2008 revealed that Resident #2 was admitted to the GHMRP on June 16, 2008 from her natural home to receive temporary respite services. Review of the medical record revealed laboratory reports for Hepatitis screening on June 17, 2008 (negative) and a PPD had been performed previously, on January 2, 2008 (negative). As per the interdisciplinary team recommendation, Resident #2 was officially admitted as an ICF/MR resident on July 22, 2008. Review of the resident's records, however, revealed that the medical history did not included a history of the	I 325		

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I 325	Continued From page 17 immunization (vaccination) record. Further interview with the QMRP confirmed that her vaccination and immunization history had not been available at the time of her admission. In the month that followed, the GHMRP had not been able to confirm that she had ever received standard childhood immunizations. As of August 21, 2008, there was no evidence that the current primary care physician determined what, if any, immunization schedule might be indicated to protect the resident and her new housemates.	I 325	The primary physician will address the need for immunization, since no immunization record is available.	9/26/08
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observation, interview and review of staff in-service training records, the facility failed to ensure that all staff consistently allowed residents to exercise their right to access food and nourishment, for one of the three residents in the sample. (Resident #1) The findings include: On August 21, 2008, beginning at approximately 8:38 AM, a direct support staff person was observed repeatedly refusing Resident #1's request for food, as follows: At 8:38 AM, Resident #1 was observed standing in the kitchen, holding a large fruit bowl in her hand. A direct support staff person saw this and instructed her to return the fruit bowl to its proper location. Resident #1, who was mostly non-verbal, made a	I 500		

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I 500	Continued From page 18 physical gesture indicating that she wanted a piece of fruit. The staff person told her no, the food di not belong to her: "that's not your food, put it back, it's not yours..." etc. The staff person took the bowl from her. While the staff placed the bowl atop the refrigerator, the resident reached into a kitchen cabinet and removed a can of fruit cocktail. The staff said "no, you've already had your breakfast. No, that's not yours. Put it back." As the staff person put the fruit cocktail back into the cabinet, the resident removed a can of peas. The staff insisted that she put it back in the cabinet as well. Immediately (at approximately 8:42 AM), Resident #1 looked in the freezer and then in the refrigerator, reaching for various food items; the staff repeatedly told her to let go of the foods. The resident then went into a cabinet and removed a snack pack of cheese-filled crackers and an individual pudding cup. The staff person took the pudding cup from the resident's hand and then followed the resident as she quickly left the kitchen, walked through and around the living room. The staff person remained in pursuit and at approximately 8:45 AM, she caught up with the resident in the kitchen. The staff insisted that the resident give her the crackers. By then, however, the resident had opened the package and placed one of the crackers in her mouth. The staff took the package from her hand and threw it into the trash recepticle. She instructed the resident to remove the cracker from her mouth and give it to her. The resident hesitated and took a bite from the cracker. The staff took what remained of the cracker from the resident's mouth and threw it in the trash. While the staff person was asking Resident #1 for the crackers, another staff person was asked about the breakfast. She indicated that Resident #1 had not eaten her entire	I 500		

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I 500	Continued From page 19 breakfast that morning. A surveyor suggested that the resident might still be hungry. At that same moment, at approximately 8:56 AM, the Qualified Mental Retardation Professional (QMRP) and the House Manager descended the stairs from the 2nd floor into the living room/ dining room archway. Still in the kitchen nearby, the staff person offered the resident water. When the resident said "juice," the staff person told her she could not have juice "uh uh, that's not an option." She then repeated her offer of water. The resident said "juice" again and the staff responded "no, you can't have it; you want water?" The QMRP heard the discussion and asked the staff if there was juice available. As the staff person retrieved a pitcher of juice from the refrigerator, Resident #1 reached for the pitcher. The staff said "uh uh, I'll pour it, you go sit down." The staff poured some juice, handed her the glass, and watched the resident drink the juice rapidly, finishing the glass in a few seconds. Previously, on the first day of survey, staff had indicated that Resident #1 was on a regular diet. On August 20, 2008, review of her physician's orders and other records had confirmed that she did not have any dietary restrictions. There was no clinical or other reason evidenced that would explain why staff did not consistently allow and encourage the resident to exercise her rights as a resident of the facility. It should be noted that on August 21, 2008, review of staff in-service training records revealed no evidence that the staff person observed that morning denying Resident #1's requests had received training on resident rights. On August	I 500		

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I 500	Continued From page 20 20, 2008, at approximately 6:00 PM, the QMRP and House Manager were informed that the staff person's (S4) personnel record had not been made available for review along with the others'. No additional information was made available, including no evidence of orientation training for this staff, before the survey ended approximately 24 hours later. This is a repeat deficiency. See the State Licensure Deficiency Report, dated September 14 2007, citations I048 and I500. There was documented evidence that staff withheld a resident's food, or threatened to do so, as a consequence for not following staff instructions, as follows: On September 14, 2007, at approximately 11:22 AM, review of Resident #4's behavior (ABC) data sheets revealed two staff entries that documented the withholding of the resident's food and/or threats to do so by staff, as a consequence for not following staff instructions, as follows: - "9/6/07 <resident's name> asked me for a banana and I told her she couldn't have it. She ran and stole the banana off the refrigerator. I told her no snack for tomorrow because she doesn't listen." - 9/7/07 <resident's name> ran out of the house because she didn't want to listen to staff. She cussed out staff and ran out the door." Under C, for "consequence" the staff wrote "no snack." The exact time of occurrence was not documented on either of the aforementioned entries.	I 500		

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I 500	Continued From page 21 At 11:23 AM, review of Resident #4's behavior support plan (BSP), dated August 26, 2007, revealed proactive strategies ... The BSP did not authorize making verbal threats of withholding food as a consequence for behaviors. At 11:46 AM, the House Manager was asked if agency policies allowed for staff to withhold food or make verbal threats to do so. She said this would not be appropriate. Food was only held "if the client has a medical appointment, otherwise, no." Documentation of recent staff in-service training records revealed that the Program Director had presented training on June 28, 2007 for all agency staff. The agenda indicated that topics had included "discipline of residents... preventive techniques for handling aggressive behavior... nutrition... and human rights." The Qualified Mental Retardation Professional (QMRP) arrived in the facility shortly after 12:00 noon. She was asked (1) whether residents' snacks are considered part of their overall dietary/ nutritional intake, and (2) whether CMS policies forbid withholding snacks as a means of addressing resident behavior. She stated that snacks were indeed a part of their dietary intake "not an extra" and she did not know whether the facility had a written policy that expressly prohibited withholding of food. However, she stated that "it's nothing that I would allow... withholding food."	I 500	Cross reference W125	9/12/08

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0052	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2008
NAME OF PROVIDER OR SUPPLIER C M S	STREET ADDRESS, CITY, STATE, ZIP CODE 4314 9TH STREET NW WASHINGTON, DC 20011		

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R 000	INITIAL COMMENTS A licensure survey was conducted from August 19, 2008 through August 21, 2008. The survey was initiated using the fundamental survey process. A random sample of three residents was selected from a resident population of six women with various disabilities. In addition, a focused review was conducted of a fourth resident's adaptive equipment and mobility/ physical therapy needs. The findings of the survey were based on observations, interviews with residents, interviews with staff in the home and at two day programs, as well as a review of resident and administrative records, including incident reports.	R 000		
R 122	4701.2 BACKGROUND CHECK REQUIREMENT Except as provided in section 4701.6, each facility shall obtain a criminal background check, and shall either obtain or conduct a check of the District of Columbia Nurse Aide Abuse Registry, before employing or using the contract services of an unlicensed person. This Statute is not met as evidenced by: Based on interview and review of personnel records, the GHMRP failed to ensure criminal background checks had been obtained before employing or using the contract services of an unlicensed person. The findings include: On August 19, 2008, the Qualified Mental Retardation Professional (QMRP) agreed to provide documentation needed to show evidence of criminal background checks for all staff employed in the facility. On August 20, 2008, beginning at 5:24 PM, review of the materials	R 122		

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R 122	Continued From page 1 presented revealed the following: 1. Review of one direct support staff person's personnel record (S1) revealed no documentation available to verify that a background check had been obtained prior to employment. Note: her employment application form, signed and dated on April 3, 2008, listed one former employer with a telephone number in the 347 area code. 2. There was no personnel information made available for one direct support staff person (S4); therefore, there was no evidence of that a background check had been obtained prior to employment. It should be noted that there were two other staff (S2 and S3) for which there was no evidence of comprehensive criminal background checks, to include all jurisdictions in which he/she lived or worked (see R125).	R 122	1. In the future, background checks will be required from staff prior to employment. 2. All personnel files will be sent to the facility immediately after hire.	9/30/08 9/30/08
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 personnel records, the GHMRP failed to ensure criminal background checks for all jurisdictions in which the employees had worked or resided within the seven (7) years prior to the check. The findings include:	R 125		

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NAME OF PROVIDER OR SUPPLIER CMS	STREET ADDRESS, CITY, STATE, ZIP CODE 4314 9TH STREET NW WASHINGTON, DC 20011		

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R 125	Continued From page 2 On August 19, 2008, the Qualified Mental Retardation Professional (QMRP) agreed to provide documentation needed to show evidence of criminal background checks for all staff employed in the facility. On August 20, 2008, beginning at 5:24 PM, review of the personnel materials presented revealed the following: 1. There was no evidence of comprehensive criminal backgrounds checks for two direct support staff (S2 and S3). a. A Maryland (statewide) background check had been documented for S2. Her personnel records indicated that she had been employed in elder care in the District of Columbia in 2005 and 2006. There was no evidence, however, that a background check had been obtained in the District of Columbia. b. Similarly, there was no evidence that background checks had been obtained for S3 in Maryland, her state of residence at the time she applied for employment, and New York state, where records indicated she had been employed from 1998 until 2008. The sole background check that was documented in her personnel record was for the District of Columbia only. 2. Review of a third direct support staff person's personnel record (S1) revealed no documentation available to verify that a background check had been obtained. Note: her employment application form, signed and dated on April 3, 2008, listed one former employer with a telephone number in the 347 area code. 3. In addition, there was no personnel information made available for another direct	R 125	In the future, staff will be required to get background checks in the state where they reside and states where they have worked prior to employment.	9/30/08

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R 125	Continued From page 3 support staff person (S4); therefore, there was no evidence that a background check had been obtained.	R 125		