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

PRINTED: 09/27/2007
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
	09G031		09/14/2007

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 000	INITIAL COMMENTS	W 000		
	A recertification survey was conducted from September 11, 2007 thru September 14, 2007. The survey was initiated using the full survey process. A random sample of four clients was selected from a resident population of seven women with various disabilities. The findings of the survey were based on observations, interviews with clients and staff in the home and at three day programs, interviews with one client's guardian, as well as a review of client and administrative records, including incident reports.			
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the rights of each client and/or their legal guardian to be informed of the client's medical condition, attendant risks of treatment, and the right to refuse treatment, for two of the four clients in the sample. (Clients #3 and #4) The findings include: 1. During the September 11, 2007 Entrance Conference, at approximately 4:45 PM, the Qualified Mental Retardation Professional (QMRP) indicated that Client #3's aunt attended	W 124		

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DEPARTMENT OF HEALTH
HEALTH REGULATION
ADMINISTRATION
2007 OCT -5 P 1:38

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Constance C. Reese | Program Director | 10-5-07

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

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W 124	Continued From page 1 her meetings and served as a surrogate health care decision-maker. Review of the client's Individual Support Plan (ISP), dated August 9, 2006, confirmed this. The client's psychological assessment reflected that "due to cognitive deficits consistent with severe mental retardation... does not evidence the decision-making capacity... in granting, refusing and/or withdrawing consent to medical treatment..." On September 13, 2007, at approximately 9:15 AM, review of the client's gynecology records revealed that she was administered Ativan 2 mg at 12:15 on March 15, 2007 and Ativan 3 mg at 11:30 AM on May 17, 2007 for sedation. The client's records, however, revealed no evidence that her aunt was informed of the need for sedation for gyn evaluations and/or had granted consent for the use of Ativan on either of the two aforementioned appointments. Further review of the gynecology records revealed that even with sedation, the client had been uncooperative. To date, doctors were unable to perform the pap smear, as ordered by the primary care physician. The gynecologist recommended evaluation under full anesthesia. At 10:00 AM, the QMRP did not answer directly the question on whether the client's aunt had been informed of the difficulties in performing a pap smear and/or the gynecologist's recommendation for anesthesia. Instead, she stated that the primary care physician (PCP) was not in favor of using anesthesia due to the inherent risks posed by the client's Downs syndrome. The PCP reportedly was preparing a letter stating that because the client had past pap smears with normal results ("negative") and was not sexually active, he no longer was recommending a pap smear. To date,	W 124	In the future the nursing staff will obtain consent from each individual's family or legal guardian before using sedation for medical appointments. The Human Rights Committee will also review using sedation. client #3 GYN exam will be scheduled to get PAP Smear done under mild sedation. Consent will be obtained for this procedure.	10/31/07

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W 124	Continued From page 2 the letter had not been finalized. At 10:39 AM, a message was left on the aunt's home telephone; however, the call was not returned. No additional information was made available before the end of the survey the next day. There was no documented evidence that Client #3's designated health care decision-maker (aunt) had been apprised of the client's ongoing gynecological assessment needs. It should be noted that the client's record failed to show evidence of any pap smears performed in the past with "negative" or "normal" results/ findings. 2. During the September 11, 2007 Entrance Conference, at approximately 4:45 PM, the QMRP indicated that Client #4 had a court-appointed guardian. The QMRP further stated that the facility maintained frequent contact with the guardian and she was kept informed of the client's treatment issues. Review of the client's Individual Support Plan (ISP), dated May 31, 2007, and court documents confirmed this. a. On September 14, 2007, at 12:56 PM, review of the client's records revealed a consent form that was signed by the guardian on August 31, 2007. The guardian authorized the use of medications in addition to the client's behavior support plan. Review of the medications listed, however, revealed that Geodon was still listed as a current medication. The client's physician's orders, however, reflected orders dated August 27, 2007 that discontinued the Geodon and started Thorazine 200 mg twice daily. When asked, the QMRP could not confirm that the guardian was aware of the recent change in medications. She also acknowledged that the	W 124	The nursing staff will notify the designated health care decision maker about change of medication orders including medication ordered by the physician. Consent for treatment will be obtained with the new changes updated.	10/31/07

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W 124	Continued From page 3 consent form contained incorrect medication information. At 1:20 PM, a message was left on the guardian's answering service. The call was returned (post-survey) and on September 19, 2007, at 3:20 PM, the guardian stated that she was not aware that the client's Geodon was discontinued and Thorazine started. b. Client #4's medication administration records (MARs) indicated that on June 19, 2007, the client began receiving Lamisil for treatment of toe nail fungus. Review of the client's records failed to show evidence that the guardian had been made aware of the fungal condition and/or treatment needs. On September 14, 2007, at approximately 1:05 PM, the QMRP acknowledged that she could not confirm that the potential risks posed by Lamisil treatment had been explained to the client's guardian. At 1:20 PM, a message was left on the guardian's answering service. The call was returned (post-survey) and on September 19, 2007, at 3:22 PM, the guardian stated that she was not aware that the client had foot fungus or that she had begun receiving Lamisil in June. She could not recall anyone discussing potential side effects associated with taking Lamisil.	W 124		
W 151	483.420(d)(1)(ii) STAFF TREATMENT OF CLIENTS Staff must not punish a client by withholding food or hydration that contributes to a nutritionally adequate diet. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that written policies and procedures to protect client's rights were	W 151		

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W 151	Continued From page 4 implemented by all staff, for one of the four clients in the sample. (Client #4) The findings include: On September 14, 2007, at approximately 11:22 AM, review of Client #4's behavior (ABC) data sheets revealed two staff entries that documented the withholding of the client's food and/or threats to do so, as a consequence for not following staff instructions, as follows: - "9/6/07 <client'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 <client'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. At 11:23 AM, review of Client #4's behavior support plan (BSP), dated August 26, 2007, revealed proactive strategies outlined to prevent maladaptive behaviors from occurring. Once a behavior occurs, the approved interventions listed became progressively more restrictive, as follows: tell the client "to stop... provide verbal redirection... touch control, safety zone... not seclusion... business-like manner, emergencies... block a blow... CMS policies and procedures are to be followed for any situations not covered in this plan..." The BSP did not authorize making verbal threats of withholding food as a	W 151		

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W 151	Continued From page 5 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 House Manager further indicated that agency policies regarding those subjects had been reviewed at the time. The Qualified Mental Retardation Professional (QMRP) arrived in the facility shortly after 12:00 noon. She was asked (1) whether clients' snacks are considered part of their overall dietary/ nutritional intake, and (2) whether CMS policies forbid withholding snacks as a means of addressing client 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." She replied "no" when asked if any of her staff ever threatened to withhold a client's snack as a consequence for behavior. After reviewing the staff entries of September 6 and 7, 2007, she said this raised several questions. Client #4 reportedly did not receive afternoon snacks because her finger sticks, scheduled to be performed before dinner, precluded after snacks. The initials were those of	W 151	The facility will have an in-service training on how to refer to the BSP when disciplining clients. The facility will provide on-going training on CMS policy and procedures on disciplining clients. The client Bill of Rights will be reviewed by staff annually.	10/15/07

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W 151	Continued From page 6 a staff who reports for duty in the afternoon. The QMRP acknowledged, however, that the documentation reflected inappropriate behavior intervention technique.	W 151		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to adequately monitor, integrate and coordinate each client's active treatment programs . The findings include: 1. Cross-refer to W124.1. The QMRP failed to document that Client #3's surrogate health care decision-maker (aunt) was informed of the client's gynecology/ pap smear assessment needs and/or concerns regarding sedation and anesthesia. 2. Cross-refer to W124.2. The QMRP failed to ensure that Client #4's court-appointed guardian was informed of recent changes in the client's psychotropic medication regimen and of a June 2007 fungal condition of her toe nails, with ensuing treatment with Lamisil. 3. Cross-refer to W212. The QMRP failed to ensure that Client #1 received a psychiatric assessment. 4. Cross-refer to W225. The QMRP failed to	W 159	1. Cross reference W124. 2. Cross reference W124.2 3. The QMRP will request the Psychiatrist to update Psychiatric Assessments.	10/31/07 10/31/07 10/31/07

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W 159	Continued From page 7 ensure that Clients #3 and #4 received vocational assessments. 5. Cross-refer to W371. The QMRP failed to ensure that four of the four clients in the sample had self-medication training programs developed to enhance their skills in this area. 6. The QMRP failed to ensure that Client $#4's day program received current physician's orders timely, as follows: a. On September 12, 2007, review of Client #4's day program records followed by interview with the day program nurse revealed that she began attending the program on April 24, 2007. At the time, she was living in a hospital. While in the hospital, the client, who was diabetic, received finger sticks three times daily ("am, 12noon and at bedtime") to monitor her blood glucose levels. She was admitted to the ICF/MR on April 26, 2007. The primary care physician assessed the client on April 27, 2007 and entered handwritten treatment orders in the client's residential record. Interviews and record review revealed that the day program had not received a copy of the April 27, 2007 orders. The first physician's orders sent to the day program were for the month of June 2007. Further review of the day program records revealed that Client #4 had received noon finger sticks throughout the month of May 2007. The April 27, 2007 orders, however, only called for finger sticks twice daily, "before breakfast and before dinner" in the home. The day program nurse stated that the client had been resistive to the noon finger sticks but she had performed them anyway, as a precaution since that was what had been happening in the hospital. Based on the April 27, 2007 orders, the noontime finger	W 159	4. Cross reference W225. 5. The nursing staff will make an annual assessment of the self-medication administration process and based on the individual's ability a training program will be developed. In the future this assessement will be done by the ISP date. 6. The Nursing Coordinator will send a copy of current Physician Orders to the day program by the 1st of each month.	10/31/07 10/31/07 10/31/07

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W 159	Continued From page 8 sticks performed at the day program had been unnecessary. It should be noted that review of Client #4's MARs in the residence revealed numerous documented instances when the client refused to allow the nurse to perform a finger stick. Documentation included but was not limited to May 12, May 13, May 14, May 27, 2007 refusals.	W 159		
	b. On September 12, 2007, review of Client #4's day program records followed by interview with the day program nurse revealed that they had not yet received the current, September 2007 physician's orders. It should be noted that the client's medication regimen had changed in late August. On August 27, 2007, one of the client's psychotropic medications (Geodon) had been discontinued and another psychotropic medication (Thorazine) had been started. As of September 12, 2007, the day program was not aware of the change in medications.		b. Any new orders or changes of medications will be communicated to the day program by the Nursing Coordinator.	10/31/07
	7. Cross-refer to W488. The QMRP failed to ensure clients were taught skills in the area of portion size, in accordance with their individual modified diets.		7. Cross reference W488.	10/15/07
	8. Cross-refer to W472. The QMRP failed to ensure effective staff training in the area of proper quantity/portion size for clients on modified diets.		8. Cross reference W472.	10/15/07
W 192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by:	W 192		

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W 192	Continued From page 9 1. Cross-refer to W472. Based on observation, interview and record review, the facility failed to ensure that food portions served were in accordance with the menu, for four of the four clients in the sample. (Clients #1, #2, #3 and #4)	W 192	Cross reference W472.	10/15/07
	2. Cross-refer to W488. Based on observation, interview and record review, the facility failed to ensure that clients were taught to serve themselves the proper amount of food (based on their dietary requirements) at mealtimes, for four of the four clients in the sample. (Clients #1, #2, #3 and #4)		Cross reference W488.	10/15/07
W 212	483.440(c)(3)(i) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the presenting problems and disabilities and where possible, their causes. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that clients received psychiatric assessments as indicated, for one of the four sample clients who was prescribed psychotropic medications and had a Behavior Management Plan. (Client #1) The findings include: During the medication pass observation on September 11, 2007, at 5:30 PM, Client #1 was observed receiving Risperdal 3 mg. Interview with the QMRP during the entrance conference on the same day revealed that Client #1 received medication to manage inappropriate behaviors. Review of the medical record revealed that the client had an Axis I diagnosis of Behavior Disorder. Review of the client's physicians orders	W 212		

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W 212	Continued From page 10 dated September 2007, on September 12, 2007 at approximately 11:15 AM, revealed that the client received 4 mg of Risperdal in the morning and 3 mg of Risperdal every evening. The use of this medication was incorporated in a Behavior Support Plan (BSP) dated November 16, 2006, to address behaviors associated with spitting, screaming, inappropriate nose blowing, self-injurious behavior and clothes tearing. Further review of her medical record failed to show evidence that a psychiatric assessment had been completed. In an interview with the QMRP on September 14, 2007 at approximately 1:30 PM, she acknowledged that the record did not reflect that the psychiatric assessment had been completed.	W 212	Cross reference 159.3	10/31/07
W 225	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include, as applicable, vocational skills. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that clients received comprehensive vocational assessments as indicated, for two of the four clients in the sample. (Clients #3 and #4) The findings include: 1. On September 11, 2006, beginning at approximately 6:10 PM, Client #3 was observed seated at the dining room table. She independently put together a jigsaw puzzle, with great success. At approximately 6:25 AM the next morning, the client independently walked from window to window in the living room and dining room area, opening the blinds and	W 225		

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W 225	Continued From page 11 curtains. At 8:17 AM, she was observed stringing multi-colored beads in an organized fashion and with no assistance needed from staff. Later that morning, at 11:18 AM, this surveyor arrived at Client #3's day program and was informed that the client was away on a community outing (for an undetermined length of time). Direct observation, therefore, could not be performed. On September 13, 2007, at approximately 10:18 AM, the Qualified Mental Retardation Professional (QMRP) was asked about Client #3's day program. She stated that she was "working with" the current day program to "develop a new program" for her. While the day program reportedly were "doing job readiness," the client was engaged in frequent community outings and it was unclear to the interdisciplinary team whether the was acquiring work skills. The QMRP further indicated that a summary report that the day program submitted for court review had not provided enough information about her strengths, needs and programs. When asked about a vocational assessment, the QMRP stated that she had seen an assessment report in the client's record at the day program; however, the day program reportedly had refused to share a copy of the document with the home. Further review of Client #3's record failed to show evidence that she had received a comprehensive vocational assessment to determine her interests, skills and training needs. It should be noted that on September 13, 2007, at 10:25 AM, the QMRP agreed to locate the written agreement between the facility and Client #3's day program. At 10:32 AM, the QMRP reported having contacted administration No written	W 225	The facility will request in writing a copy of Client #3's Vocational Assessment from the day program. The facility will request in writing that Client #3's day program sign the day program agreement. Day Program Agreements will be reviewed annaully by the QMRP.	10/31/07 10/31/07

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W 225	Continued From page 12 agreement was presented for review prior to the end of the survey the next day. 2. Client #4 was observed at her day program on September 12, 2007, beginning at 11:45 AM. For the next 23 minutes, the client refused to perform math problems that were presented to her by day program staff. She also refused to assist staff with putting place mats on the tables prior to lunch. After lunch, at approximately 12:30 PM, she performed her math. Three minutes later, she proudly showed her work; she had correctly added all 8 sets of numbers without staff assistance. She then proceeded to write her first and last names, which she achieved correctly and with no assistance from staff. At approximately 12:42 PM, she and staff began playing Connect Four. Review of her day program plan, beginning at 12:57 PM, revealed the following goals: (1) "... will verbalize her complete address and telephone number" (2) "will pass out snacks among her peers..." and, (3) "...will engage in an activity with a peer of her choice..." She had a behavior support plan to address physical aggression, verbal aggression, taking others' food, elopement, non-compliance, psychotic behaviors and anger and frustration. She had started at the day program on April 24, 2007. A July 2007 progress report indicated that she had refused to participate in any programs. Interview with the Behavior Specialist and Director revealed that she had increased participation in August. Further interview revealed that to date, she had not received a comprehensive vocational assessment. On September 14, 2007, at 10:52 AM, review of Client #4's Psychological Evaluation, dated May 25, 2007, revealed that the psychologist had	W 225		

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W 225	Continued From page 13 recommended the following: "<client's name> should have a vocational assessment and the possibility of supported employment evaluation and participation may be explored." When asked about the psychologist's recommendation, the QMRP said Client #4's current day programming was focused mostly on "ironing out her behaviors." She further explained that prior to her admission to the facility in April 2007, the client, who was 48 years old, had stayed home all day, "slept all day, no structure." The QMRP anticipated that the interdisciplinary team would review her vocational needs at an upcoming 6-month review. The QMRP acknowledged that to date, Client #4 had not received a comprehensive vocational assessment to determine her interests, skills and training needs.	W 225	QMRP will meet and request a vocational assessment from Client #4's day program to determine her interest, skills, and training needs.	10/31/07
W 242	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: Based on observations, staff interview and the review of records, the facility failed to implement an effective system to ensure that each client participated in a self-medication training program, for four of the four clients in the sample. (Client's #1, #2, #3, and #4) The findings include:	W 242	Cross reference 159.5	10/31/07

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W 242	Continued From page 14 1. On September 11, 2007, at approximately 6:00 PM, Client #1 was observed receiving her medication. The nurse punched the medications Carbitrol and Risperdal into a medicine cup. The QMRP was observed pouring her water. The client was handed the medication and she took it. The Nurse and the Qualified Mental Retardation Professional (QMRP) were asked if any of the clients had a self medication training program. They both indicated that none of the clients participated in a self medication training program. Review of Client #1's self medication assessment on September 13, 2007 revealed several areas that she was not able to perform; however, there were no programs designed to improve the client's skills in those areas. 2. On September 11, 2007, at approximately 5:50 PM, Client #2 was observed receiving her medication. The nurse punched the medications Gordon into a medicine cup. The QMRP poured her water. The client was handed the medication and she took it. The Nurse and the QMRP were asked if any of the clients had a self medication training program. They both indicated that none of the clients participated in a self medication training program. Review of Client #2's self medication assessment on September 13, 2007 revealed several areas that she was not able to perform; however, there were no programs designed to improve the client's skills in those areas. 3. On September 11, 2007, at approximately 5:50 PM, Client #3 was observed receiving her medication. The nurse punched the medications	W 242		

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W 242	Continued From page 15 Naltrexone, Haldol and a calcium supplement into a medicine cup. The QMRP was observed pouring her water. The client was handed the medication and she took it. As with Clients #1 and #2, Client #3's self medication assessment revealed several areas that she was not able to perform; however ,there were no programs designed to improve the client's skills in those areas. 4. On September 11, 2007, at approximately 5:55 PM, Client #4 was observed receiving her medication. The nurse punched the medications Thorazine, Depakote and Melatonin into a medicine cup. The QMRP was observed pouring her water. The client was handed the medication and she took it. As with the other three sampled clients, Client #4's self medication assessment revealed several areas that she was not able to perform, such as arriving to the medication area at the proper time or pouring the proper amount of medication into the cup, etc. There were no programs, however, designed to improve the client's skills in those areas.	W 242	Cross reference W159.	10/31/07
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observations, staff interview and record review, the facility failed to provide general and preventive care for one of the four clients included in the sample. (Client #2)	W 322		

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W 322	Continued From page 16	W 322		
	The findings include:			
	1. During the medication pass observation on September 11, 2007 at 5:30 PM, Client #2 received Goedon 20 mg for behavior. Review of the client's medical assessment dated January 26, 2007 revealed a recommendation for the client to receive an EKG every six months while on Geodon. Review of the physician's orders revealed a corresponding order for the EKG. Further review of the medical record revealed an EKG dated September 21, 2006; however, there was no other EKG documented in the record. Interview with the Qualified Mental Retardation Professional on September 14, 2007, at approximately 2:00 PM, acknowledged that Client #2 had not received an EKG every six months as ordered by the physician.		1. Client #2's EKG was done on 6/11/07; however, a copy of the EKG will be kept in the individual's medical record.	10/4/07
	2. Cross-refer to W368. The facility failed to ensure prescribed medications were adminstered as ordered for Client #2.		Cross reference W361.	10/31/07
W 338	483.460(c)(3)(v) NURSING SERVICES	W 338		
	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 physician to address client health problems).			
	This STANDARD is not met as evidenced by: Based on interview and record review, the facility's nurse failed to secure a physician's order prior to the administration of a sedative (Ativan) prior to medical appointments, for one of the four clients in the sample. (Client #3)			

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W 338	Continued From page 17 The findings include: On September 12, 2007, at approximately 5:50 PM, review of Client #3's gynecology records revealed that she was administered Ativan for sedation prior to two gynecology appointments (2 mg on March 15, 2007 and 3 mg on May 17, 2007). The client's records, however, revealed no evidence that a physician's order was obtained prior to the use of Ativan for either of the two gynecology exams. Interview with the Qualified Mental Retardation Professional on September 13, 2007, at approximately 10:00 AM, revealed that she was unaware of the physician's orders and the nurse was unavailable that day for interview. It should be noted that Client #3's records indicated that a previous physician's order for Ativan (2 mg prior to a February 5, 2007 CT scan of the spine) had been discontinued on February 19, 2007.	W 338	The nursing staff will obtain the Physician Order for all medications administered prior to administering the medications.	10/31/07
W 361	483.460(i) PHARMACY SERVICES The facility must provide or make arrangements for the provision of routine and emergency drugs and biologicals to its clients. Drugs and biologicals may be obtained from community or contract pharmacists or the facility may maintain a licensed pharmacy. This STANDARD is not met as evidenced by: Based on interview and the record review, the facility failed to ensure that the pharmacy provided, or made arrangements for, the timely provision of an emergency drug, for one of three clients in the sample. (Client #2)	W 361		

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W 361	Continued From page 18 The finding includes: Client #2's medical record was reviewed on September 12, 2007. The client was prescribed a 90-day course of Lamisil 250 mg for toe fungus. The medication was ordered on April 20, 2007. Review of medication administration records (MAR) for Client #2 revealed that the client did not receive the medication 16 days out of the 90 days. The back of the MARs noted that the medication was not available. In an interview with the facility's Registered Nurse on September 19, 2007, at approximately 2:45 PM, she indicated that the medication had not been received from the pharmacy on the days noted on the MAR. There was no explanation given for why the medication was not available for administration. Review of the medical record failed to show evidence that the Primary Care Physician or the podiatrist was made aware of the breaks in the treatment regimen.	W 361	The nursing staff will communicate with the pharmacy and obtain prior authorization from Medicaid if needed before a new medication is started. The nursing staff will document in the individual's medial record and notify the prescribing physician if the medication is not going to be dispensed as ordered.	10/31/07
W 362	483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the pharmacist reviewed drug regimens quarterly, for one of the four clients in the sample. (Client #3) The finding includes:	W 362		

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W 362	Continued From page 19 During the evening medication pass observed on September 11, 2007, Client #3 received Haldol, Revia and other medications. Review of Client #3's medical records on September 12, 2007 at 4:33 PM revealed a Pharmacy Review form. According to the form, the pharmacist reviewed her drug regimen on November 7, 2006, May 11, 2007 and August 10, 2007. Review of the other three sampled clients revealed the pharmacist had reviewed their regimens in February 2007. During a September 17, 2007 telephone interview, the Qualified Mental Retardation Professional indicated that she was previously unaware that the client's regimen had not been reviewed in February. She did, however, state "that sounds familiar" when asked whether the client's chart might not have been available for review on the day the pharmacist came in February because the record was with the client, on a medical appointment. At the time of the survey, the facility failed to establish a system that ensures clients' drug regimens received quarterly review by the pharmacist.	W 362	The facility will ensure that all clients' drug regimens are reviewed by the pharmacist quarterly. If a client's record is not availabe for review because of a medical appointment, arrangements will be made with the pharmacy consultant to review the record at a later date. The pharmacist will be requested to submit in writing any records not reviewed.	10/31/07
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that medications were	W 368	Cross reference W361.	10/31/07

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W 368	Continued From page 20 given in compliance with the physician's orders for one of two clients in the sample. (Client #2) The finding includes: Client #2's medical record was reviewed on September 12, 2007. The Client was Prescribed a 90 day course of Lamisil 250 mg for toe fungus. The medication was ordered on April 20, 2007. Review of medication administration records for Client #2 revealed that the client did not receive the medication 16 days out of the 90 days. The back of the MAR's noted that the medication was not available. In an interview with the facility's Registered Nurse on September 19, 2007, at approximately 2:45 p.m., she indicated that the medication had not been received from the pharmacy on the days noted on the MAR. There was no explanation given for why the medication was not available for administration. Review of the medical record failed to show evidence that the Primary Care Physician or the podiatrist was made aware of the breaks in the treatment regimen.	W 368		
W 391	483.460(m)(2)(ii) DRUG LABELING The facility must remove from use drug containers with worn, illegible, or missing labels. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to remove medications that had a worn label from use . The finding includes:	W 391		

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W 391	Continued From page 21 On September 14, 2007, at approximately 11:40 AM, during the environmental inspection, a bottle of Ammonium Lactate 12% was located in Client #4's personal hygiene box. The bottle had a worn label. The Qualified Mental Retardation Professional was present at the time this was discovered.	W 391	The nursing staff, QMRP, and Residential Manager will monitor the availability of prescribed topical medications and the nursing staff will check all labels are clear on a monthly basis.	10/31/07
W 393	483.460(n)(1) LABORATORY SERVICES If a facility chooses to provide laboratory services, the laboratory must meet the requirements specified in part 493 of this chapter. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure it met the requirements for performing glucose monitoring testing, for one of one clients who required glucose testing. (Client #4) The finding includes: On September 11, 2007, at approximately 5:55 PM, the evening nurse performed a fingerstick glucose test on Client #4. The nurse was asked on the same day what procedure was in place to ensure quality control of the glucometer. He indicated that there was no policy/procedure in place.	W 393	The nursing staff will receive in-service training regarding Quality Control of the Glucometer. A written policy/procedure will be developed and implemented.	10/31/07
W 472	483.480(b)(2)(i) MEAL SERVICES Food must be served in appropriate quantity. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that food	W 472		

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W 472	Continued From page 22 portions served were in accordance with the menu, for four of the four clients in the sample. (Client's #1, #2, #3 and #4) The findings include: The dinner meal was observed on September 11, 2007, at approximately 5:20 p.m. The meal consisted of baked chicken (drum stick and/or thigh), mixed vegetables, bread and noodles. Direct care staff was observed to serve all of the food with a large spoon. Review of the diet orders for Clients #1 and #2 revealed they were prescribed 1500 calorie, low fat, low cholesterol diets. Clients #3 and #4 also were prescribed calorie-restricted, low fat low cholesterol diets. The menu was reviewed and revealed that the clients were to receive 4 oz rosemary ranch chicken kabobs, 1/2 cup pasta, 1/2 cup oven roasted vegetables, 1 slice bread, 1 tsp margarine, cup water and 1/2 cup frozen yogurt. There was no way to determine if the clients received the prescribed portion of the meat and vegetables. Interview with the house manager revealed that the "staff knows how much food to put on the spoon to equal the proper portion of food", however, the observed amount of food on the clients' plates appeared to be much more than the prescribed portions required for their diets. In an interview with the Qualified Mental Retardation Professional (QMRP) on September 14, 2007, at approximately 1:30 PM, stated that the nutritionist indicated that the clients could have seconds of vegetables. There was no documented evidence, however, of the recommendation. The QMRP also acknowledged that the staff failed to use proper measuring utensils.	W 472	An In-service training will be held for staff to ensure proper training in portion control. All clients will receive training in portion control. The facility will provide on-going training in portion control. Each client will receive training on how to follow their prescribed diets. Staff will also be trained on how to use proper measuring utensils.	10/15/07

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W 488	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the facility failed to ensure clients were taught to serve themselves the proper amount of food (based on their dietary requirements) at meal times, for four of the four clients in the sample. (Clients #1, #2, #3 and #4) The findings include: On September 11, 2007, at 5:30 PM, direct care staff was observed bringing the dinner foods to the table. The meal consisted of baked chicken, mixed vegetables, noodles and bread. The direct care staff served each client either a drumstick or a thigh, and scooped up the mixed vegetables in a large serving spoon. The direct care staff handed the spoon to each client so that she could place the vegetables onto her plate. The staff did the same for the noodles. The clients served themselves double and even triple the amounts of vegetables indicated on the menu. Staff, however, did not intervene or otherwise provide instruction to clients regarding proper portion control. Interview with the Qualified Mental Retardation Professional on September 19, 2007, revealed that the clients had not been taught how to portion out their meal.	W 488	An In-service training will be held for staff to ensure proper training in portion control for Clients #1,2,3,and 4. In the future the facility will provide on-going trainings on portion control. The QMRP and Residential Manager will monitor meals for correct portions.	10/15/07

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I 000	INITIAL COMMENTS A licensure survey was conducted from September 11, 2007 through September 14, 2007. A random sample of four residents was selected from a resident population of seven women with various degrees of disabilities. The findings of this survey were based on observations at the group home and three day programs, interviews with residents and staff and one resident's guardian, as well as the review of clinical and administrative records, including incident reports.	I 000		
I 048	3502.6 MEAL SERVICE / DINING AREAS No resident may be denied a meal as a form of punishment. This Statute is not met as evidenced by: The GHMRP failed to prevent staff from denying Resident #4 a meal/ snack as a form of punishment, 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	I 048	Cross reference W151.	10/15/07

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I 048	Continued From page 1 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. At 11:23 AM, review of Resident #4's behavior support plan (BSP), dated August 26, 2007, revealed proactive strategies outlined to prevent maladaptive behaviors from occurring. Once a behavior occurs, the approved interventions listed became progressively more restrictive, as follows: tell the client "to stop... provide verbal redirection... touch control, safety zone... not seclusion... business-like manner, emergencies... block a blow... CMS policies and procedures are to be followed for any situations not covered in this plan..." 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	I 048		

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I 048	Continued From page 2 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." She replied "no" when asked if any of her staff ever threatened to withhold a resident's snack as a consequence for behavior. After reviewing the staff entries of September 6 and 7, 2007, she said this raised several questions. Resident #4 reportedly did not receive afternoon snacks because her finger sticks, scheduled to be performed before dinner, precluded after snacks. The initials were those of a staff who reports for duty in the afternoon. The QMRP acknowledged, however, that the documentation reflected inappropriate behavior intervention technique.	I 048		
I 090	3504.1 HOUSEKEEPING 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: The findings include: During the environmental inspection conducted on September 14, 2007, at 11:05 AM, the following observations were made: 1. Client #4's room had a strong urine odor. 2. There were black marks on the wall and closet	I 090	1. The tile on the floor from Client #4's room will be removed and replaced. 2. Black marks on the wall and closet door in Client #4's room will be removed and areas cleaned.	10/2/07 10/2/07

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FORM APPROVED

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I 090	Continued From page 3 door in Client #4's bedroom. 3. The bathrooms on the second and third floors had caulking around the tubs that was dark in color. The third floor bathroom had a missing tile around the tub. 4. There was a large vent fan in the ceiling on the third floor. The cover of the fan and the fan itself had a thick layer of dust on them. 5. The floor boards leading from the third floor to the second floor had heavy dust. 6. The floor boards throughout the house were dusty. 7. The laundry vent leading to the outside of the house had lint buildup on the outside wall and on the nearby ground.	I 090	3. The caulking around the tubs on the 2nd and 3rd floors will be removed and recaulked.	10/19/07
			4. The dust on the ceiling vent fan will be removed and fan will be cleaned.	10/19/07
			5. The floor boards leading from the third floor to second floor will be cleaned.	10/19/07
			6. All floor boards throughout the home will be cleaned. Staff will be instructed to clean all floor boards monthly to prevent dust build-up.	10/19/07
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: The GHMRP failed to provide training for its residents on proper table manners and the use of eating utensils, as follows: 1. On September 11, 2007, at 5:30 PM, direct care staff was observed bringing the dinner foods to the table. The meal consisted of baked chicken, mixed vegetables, noodles and bread.	I 430	7. The lint will be removed from the laundry vent leading to the outside wall and nearby ground.	10/19/07
			The QMRP will complete a weekly thorough walk-thru inspection of the facility's maintenance and housekeeping. In the future, the QMRP will ensure that the staff complete all housekeeping tasks on the inspection document. The maintenance department will receive a copy of the weekly inspection to make all repairs.	10/19/07

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I 430	Continued From page 4 The direct care staff served each resident either a drumstick or a thigh, and scooped up the mixed vegetables in a large serving spoon. The direct care staff then handed the spoon to the resident so that the resident could place the vegetables onto her plate. The staff did the same for the noodles. The residents served themselves double and even triple the amounts of vegetables indicated on the menu. Staff, however, did not intervene or otherwise provide instruction to residents regarding proper portion control. Interview with the Qualified Mental Retardation Professional on September 19, 2007, revealed that the residents had not been taught how to portion out their meal.	I 430	1. The facility will have an in-service training for the residents and staff regarding using eating utensils properly and portion control.	10/15/07
	2. During the September 11, 2007 dinner observation, at 5:31 PM, Resident #3 was observed using her right thumb to push food onto the fork she held in her left hand. She did this numerous times during the meal yet staff did not intervene or otherwise provide instruction regarding table etiquette. At 5:40 PM, Resident #1 also was observed using her left hand to push food onto her fork. Staff did not instruct the resident or otherwise provide guidance on proper table manners.		2. The facility will have an in-service for staff and clients on proper table manners.	10/15/07
I 479	3522.6(e) MEDICATIONS The record for a resident ' s prescribed controlled substances shall include the following: (e) Each time the controlled substance is to be taken or administered. This Statute is not met as evidenced by: The GHMRP failed to maintain resident Medication Administration Records (MARs) to accurately reflect all medications being	I 479		

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I 479	Continued From page 5 administered, as evidenced by the following: On September 12, 2007, at approximately 5:50 PM, review of Resident #3's gynecology records revealed that she was administered Ativan 2 mg on March 15, 2007 for sedation prior to a gynecology appointment. Subsequent review of the resident's March 2007 MAR revealed no evidence that the administration of Ativan had been documented on the MAR, in accordance with standard nursing practices.	I 479	All medications administered will be documented on the MAR. The primary nurse will review the MAR on a monthly basis to ensure all medications given are documented on the MAR.	10/31/07
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: The finding includes: On September 14, 2007 at approximately 11:40 AM, a bottle of Ammonium Lactate 12% was observed in Client #4's personal hygiene box. The bottle had a worn label. The Qualified Mental Retardation Professional was present at the time this was discovered.	I 484	Cross reference W391.	10/31/07
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:	I 500		

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I 500	Continued From page 6 The GHMRP failed to ensure residents' rights as evidenced by the following: 1. Cross-refer to I048. There was documented evidence that staff withheld Resident #4's food, or threatened to do so, as a consequence for not following staff instructions.	I 500	Cross reference W151.	10/15/07
	2. Based on observation, interview and record review, the facility failed to ensure the rights of each resident and/or their legal guardian to be informed of the resident's medical condition, attendant risks of treatment, and the right to refuse treatment, as follows: a. Cross-refer to Federal Deficiency Report - Citation W124.1. Review of Resident #3's gynecology records revealed that she was administered Ativan 2 mg at 12:15 on March 15, 2007 and Ativan 3 mg at 11:30 AM on May 17, 2007 for sedation. The resident's records, however, revealed no evidence that her aunt, who was the designated surrogate health care decision-maker, was informed of the need for sedation for gyn evaluations and/or had granted consent for the use of Ativan on either of the two aforementioned appointments. There was no documented evidence that Resident #3's aunt had been apprised of the resident's ongoing gynecological assessment needs.		Cross reference W124.	10/31/07
	b. Cross-refer to Federal Deficiency Report - Citation W124.2. Resident #4 had a court-appointed guardian. Review of the resident's physician's orders reflected orders dated August 27, 2007 that discontinued the psychotropic medication Geodon and the start of Thorazine 200 mg twice daily. When asked, the QMRP could not confirm that the guardian was aware of the recent change in medications. She		Cross reference W124.	10/31/07

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I 500	Continued From page 7 also acknowledged that a consent form that was signed on August 31, 2007 contained incorrect medication information. At 1:20 PM, a message was left on the guardian's answering service. The call was returned (post-survey) and on September 19, 2007, at 3:20 PM, the guardian stated that she was not aware that the resident's Geodon was discontinued and Thorazine had been added.	I 500		
	c. In addition, Resident #4's medication administration records (MARs) indicated that on June 19, 2007, she began receiving Lamisil for treatment of toe nail fungus. Review of the resident's records failed to show evidence that the guardian had been made aware of the fungal condition and/or treatment needs. On September 14, 2007, at approximately 1:05 PM, the QMRP acknowledged that she could not confirm that the potential risks posed by Lamisil treatment had been explained to the client's guardian. On September 19, 2007, at 3:22 PM, the guardian stated over the telephone that she was not aware that the client had foot fungus or that she had begun receiving Lamisil in June. She could not recall anyone discussing potential side effects associated with taking Lamisil. 3. Also see Federal Deficiency Report - Citations W124, W151, W212 and W225.		Cross reference W124.	10/31/07