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

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
	09G223		R 10/15/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CMS	6217 16TH STREET, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 000}	INITIAL COMMENTS	{W 000}		
	A re-visit was conducted on October 15, 2008 subsequent to determine the facility's compliance with the Condition level deficiencies cited during the incident investigation on September 5, 2008. The visit was conducted to assess the effectiveness of the corrective actions employed by the facility to address their responses as presented in their Plan of Correction (POC) dated October 8, 2008. The findings of the revisit were based on observation, staff interviews, and the review of the client and administrative records, including the unusual incident reports.		Received 11/13/08 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
	The results of the revisit revealed the facility failed to be in compliance with the Condition of Participation of Client Behaviors and Facility Practices.			
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS	W 124		
	The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.		The QMRP will contact Client #1's legal guardian to obtain consent prior to the administration of his psychotropic medications.	11/14/08
	This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the rights of each client and/or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment, for the client being investigated. (Client #1)			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Constance A. Reese TITLE: Program Director (X6) DATE: 11/12/08

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

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W 124	Continued From page 1 The finding includes: The facility failed to ensure that informed consent was obtained from Client #1 and/or her legal guardian prior to the administration of her psychotropic medications. Review of Client #1's current physician orders on October 15, 2008 at 8:30 AM revealed that the client was prescribed Buspar, Risperdal and Seroquel to address his maladaptive behaviors. Interview with the Qualified Mental Retardation Professional (QMRP) at 9:30 AM indicated the aforementioned medications were used to address the client's behaviors. During the entrance conference on October 15, 2008, an interview was conducted with the QMRP that revealed Client #1 did not have the capacity to give informed consent for the use of medications and habilitation services. The QMRP's statement was verified on October 15, 2008, at 10:00 AM through review of Client #1's current psychological assessment. According to the assessment, Client #1 "is not able to make independent decisions concerning his residential or day placements. He lacks the cognitive skills necessary to understand the implications of such decisions and therefore cannot give her informed consent. He lacks the judgment and insight required to make decisions independently." Review of Client #1's medical record on October 15 2008, at 10:00 AM revealed a a written Physician Orders (POS) dated September 15, 2008, to add "Seroquel XR 300 mg QPM." Interview with the QMRP during the survey on October 15, 2008, revealed Client #1 had a guardian.	W 124		

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W 124	Continued From page 2	W 124		
	Record verification on October 15, 2008, at 11:30 AM revealed although Client #1's guardian had given informed consent for the Buspar and Risperdal there was no evidence that the guardian had consented to the Seroquel.			
	At the time of the survey, the facility failed to provide evidence that informed consent was obtained from the client and/or legally authorized representative prior to the administration of the psychotropic medication.			
{W 227}	483.440(c)(4) INDIVIDUAL PROGRAM PLAN	{W 227}		
	The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.		The BSP for Client #1 will be reviewed and revised to include objectives to address targeted behaviors. Staff will be trained on the revised BSP.	10/24/08
	This STANDARD is not met as evidenced by: Based on interview, and the record review, the facility failed to ensure that the Client #1's individual program plan included objectives to address targeted behaviors.		A meeting was scheduled and the Human Rights Committee approved Client #1's BSP.	10/20/08
	The finding includes:			
	The Plan of Correction (POC) dated October 8, 2008, was reviewed on October 15, 2008, via an onsite visit. According to the POC, Client #1's Behavior Support Plan (BSP) was amended on October 6, 2008, to include objectives to manage all of his targeted behaviors (biting/attempting to bite and pica). Interview with the Qualified Mental Retardation (QMRP) and record review on October 15, 2008, revealed that the facility's Human Rights Committee had not approved the			

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{W 227}	Continued From page 3 usage of the amended BSP and therefore the plan had not been implemented. At the time of the revisit, the facility was implementing a BSP for Client #1 dated July 30, 2008 that failed to identify program objectives to manage each of the client's behaviors.	{W 227}		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's Human Rights Committee (HRC) failed to ensure written informed consent had been obtained from the client and/or their legal guardian for the use of psychotropic medication and Behavior Support Plans (BSP), for one client being investigated. (Client #1) The finding includes: Review of Client #1's current physician orders on October 15, 2008 at 8:30 AM revealed that the client was prescribed Buspar, Risperdal and Seroquel to address his maladaptive behaviors. Interview with the Qualified Mental Retardation Professional (QMRP) at 9:30 AM indicated the aforementioned medications were used to address the client's behaviors. During the entrance conference on October 15, 2008, an interview was conducted with the QMRP that revealed Client #1 did not have the capacity	W 263	Cross reference W124	11/14/08

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W 263	Continued From page 4 to give informed consent for the use of medications and habilitation services. The QMRP's statement was verified on October 15, 2008, at 10:00 AM through review of Client #1's current psychological assessment. According to the assessment, Client #1 "is not able to make independent decisions concerning his residential or day placements. He lacks the cognitive skills necessary to understand the implications of such decisions and therefore cannot give her informed consent. He lacks the judgment and insight required to make decisions independently." Review of Client #1's medical record on October 15 2008, at 10:00 AM revealed a a written Physician Orders (POS) dated September 15, 2008, to add "Seroquel XR 300 mg QPM." Interview with the QMRP during the survey on October 15, 2008, revealed Client #1 had a guardian. Record verification on October 15, 2008, at 11:30 AM revealed although Client #1's guardian had given informed consent for the Buspar and Risperdal there was no evidence that the guardian had consented to the Seroquel. At the time of the survey, the facility failed to provide evidence that informed consent was obtained from the client and/or legally authorized representative prior to the administration of the psychotropic medication.	W 263		
{W 266}	483.450 CLIENT BEHAVIOR & FACILITY PRACTICES The facility must ensure that specific client behavior and facility practices requirements are met.	{W 266}	Cross-reference W124, W227	11/14/08

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{W 266}	Continued From page 5	{W 266}		
	This CONDITION is not met as evidenced by: Based interview and the review of records, the facility failed to ensure that prior to the implementation of more restrictive techniques, less intrusive techniques had been tried [See W278] and failed to ensure that interventions to manage inappropriate client behavior had been employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients were adequately protected [See W285].			
	The effects of these systemic practices resulted in the failure of the facility to adequately govern the facility, making certain to protect its clients from potential harm and to ensure the clients' general safety and well being.			
{W 278}	483.450(b)(1)(iii) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR	{W 278}		
	Procedures that govern the management of inappropriate client behavior must insure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective.		Cross reference W124, W227	11/14/08
	This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that prior to the implementation of more restrictive techniques, less intrusive techniques had been tried to address Client #1's behaviors.			
	The finding includes:			

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{W 278}	Continued From page 6 The Plan of Correction (POC) dated October 8, 2008, was reviewed on October 15, 2008, via an onsite visit. According to the POC, Client #1's Behavior Support Plan (BSP) was amended on October 6, 2008, to include objectives to manage all of his targeted behaviors (biting/attempting to bite and pica), The plan also included the use of physical restraints to manage the client's behaviors. It should be noted however, that at the time of the revisit, the new BSP had not been implemented due to not having been approved by the facilty's Human Rights Committee. [Cross Refer W124] Review of Client #1's medical record on October 15 2008, at 10:00 AM revealed a a written Physician Orders (POS) dated September 15, 2008, to add "Seroquel XR 300 mg QPM." Interview with the QMRP on October 15, 2008, revealed the psychotropic medication was added to the client's medication regimine to address the client's behaviors. Review of Client #1's current BSP dated July 30, 2008, on October 15, 2008 failed to identify any program objectives to manage the client's targeted behaviors. Additionally, the plan failed to identify a less restrictive technique prior to implementing the usage more restrictive techniques (implementation of Seroquel).	{W 278}		
{W 285}	483.450(b)(2) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected.	{W 285}	Cross-reference W227, W124	11/14/08

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{W 285}	Continued From page 7 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that interventions to manage inappropriate client behavior had been employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients were adequately protected for Client #1. The finding includes: The Plan of Correction (POC) dated October 8, 2008, was reviewed on October 15, 2008, via an onsite visit. According to the POC, Client #1's Behavior Support Plan (BSP) was amended on October 6, 2008, to include objectives to manage all of his targeted behaviors (biting/attempting to bite and pica), The plan also included the use of physical restraints to manage the client's behaviors. It should be noted however, that at the time of the revisit, the new BSP had not been implemented due to not having been approved by the facilty's Human Rights Committee. [Cross Refer W124] Review of Client #1's medical record on October 15 2008, at 10:00 AM revealed a written Physician's Order (PO) dated September 15, 2008, to add "Seroquel XR 300 mg QPM." Interview with the QMRP on October 15, 2008, revealed the psychotropic medication was added to the client's medication regimine to address the client's behaviors. Further discussion with the QMRP and review of Client #1's medical record revealed that the administration of the newly prescribed psychotropic medication (Seroquel) had been conducted without the informed consent of the client's legal guardian. At the time of the survey,	{W 285}		

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{W 285}	Continued From page 8 the facility failed to ensure Client #1's rights were protected as it related to the usage of the aforementioned medication.	{W 285}		

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{I 000}	INITIAL COMMENTS A re-visit was conducted on October 15, 2008 subsequent to determine the facility's compliance with the Condition level deficiencies cited during the incident investigation on September 5, 2008. The visit was conducted to assess the effectiveness of the corrective actions employed by the facility to address their responses as presented in their Plan of Correction (POC) dated October 8, 2008. The findings of the revisit were based on observation, staff interviews, and the review of the client and administrative records, including the unusual incident reports. The results of the revisit revealed the facility failed to be in compliance with the Condition of Participation of Client Behaviors and Facility Practices.	{I 000}		
I 420	3521.1 HABILITATION AND TRAINING Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to provide habilitation and training to its residents that would enable them to acquire and maintain life skills needed to cope with their environments and achieve optimum levels of physical, mental and social functioning for one of the residents included in the investigation. (Resident #2) The finding includes:	I 420	Cross reference W227	11/14/08

Health Regulation Administration

Constance A. Reese Program Director

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE 11/12/08

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I 420	Continued From page 1 The Plan of Correction (POC) dated October 8, 2008, was reviewed on October 15, 2008, via an onsite visit. According to the POC, Resident #1's Behavior Support Plan (BSP) was amended on October 6, 2008, to include objectives to manage all of his targeted behaviors (biting/attempting to bite and pica). Interview with the Qualified Mental Retardation (QMRP) and record review on October 15, 2008, revealed that the facility's Human Rights Committee had not approved the usage of the amended BSP and therefore the plan had not been implemented. At the time of the revisit, the facility was implementing a BSP for Resident #1 dated July 30, 2008 that failed to identify program objectives to manage each of the resident's behaviors.	I 420		
I 438	3521.7(h) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (h) Interpersonal and social skills (including sharing, courtesy, cooperation, responsibility and age-appropriate and culturally normative social behaviors and relationships involving peers of the same and different sex, younger and older persons and person in authority); This Statute is not met as evidenced by: Based on observation, interview and record review the GHMRP failed to ensure training for social and adaptive behaviors were measurable for one residents in the investigation. (Resident #1) The findings includes: The Plan of Correction (POC) dated October 8,	I 438	Cross reference W124, W227	11/14/08

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I 438	Continued From page 2 2008, was reviewed on October 15, 2008, via an onsite visit. According to the POC, Resident #1's Behavior Support Plan (BSP) was amended on October 6, 2008, to include objectives to manage all of his targeted behaviors (biting/attempting to bite and pica). The plan also included the use of physical restraints to manage the resident's behaviors. It should be noted however, that at the time of the revisit, the new BSP had not been implemented due to not having been approved by the facilty's Human Rights Committee. [Cross Refer W124] Review of Resident #1's medical record on October 15 2008, at 10:00 AM revealed a written Physician's Order (PO) dated September 15, 2008, to add "Seroquel XR 300 mg QPM." Interview with the QMRP on October 15, 2008, revealed the psychotropic medication was added to the client's medication regimine to address the resident's behaviors. Further discussion with the QMRP and review of Resident #1's medical record revealed that the administration of the newly prescribed psychotropic medication (Seroquel) had been conducted without the informed consent of the resident's legal guardian. At the time of the survey, the facility failed to ensure Resident #1's rights were protected as it related to the usage of the aforementioned medication.	I 438		