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

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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
	09G009		06/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D C HEALTH CARE	414 "N" STREET, NW WASHINGTON, DC 20001

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W 000	INITIAL COMMENTS A recertification survey was conducted from June 6, 2007 through June 8, 2007. The survey was initiated using the fundamental survey process; however, it was determined that an extended process should be implemented under the condition level of participation of Health Care Services. A random sample of four clients were selected from a population of seven males with various disabilities. The findings of this survey were based on observations at the group home, four day programs, interviews at both the group home and day programs, interview with guardians, review of clinical and administrative records to include the facility's unusual incident reports. From the results of this survey, it was determined that the facility was in compliance with Health Care Services.	W 000		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on the review of incident reports, interview with the Qualified Mental Retardation Professional (QMRP), and review of the facility's policy, the facility failed to implement policies that ensured the continuous protection of clients in the facility. The finding includes:	W 149		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mamta Tiwari
TITLE: Deputy Director
(X6) DATE: 6/29/07

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 149	Continued From page 1 The facility failed to implement its policies and procedures for reporting incidents as evidence below: On June 6, 2007, at 1:00 PM an observation was attempted at Client #4's day program. Upon arrival at the day program, the receptionist informed the surveyor that the client was not there. Interview with the Program Manager from Client #4's day treatment program revealed that Client #4 arrived at the day program that morning, however he was unable to stay due to some "abrasions noticed on his face." Further interview revealed that the day program nurse contacted the group home and was informed that the client had bumped his face when transferring from one van to another." Although it was reported that the facility's staff administered first aid to Client #4, she did not inform anyone (QMRP or any medical staff) of the incident, before transporting the client to his day program. Review of the facility's incident reporting policy on June 6, 2007 at 2:44 PM revealed the facility's staff are instructed to notify the Qualified Mental Retardation Professional (QMRP) or a revelevant staff member immediately in the event of an incident. The facility failed to provide evidence that their policy for reporting incidents had been implemented.	W 149	An in-service training was held on 12-15-06, 01-08-07 pertaining to the Agency's "Incident reporting policy". All staff received training on 06/07/07 to re-emphasize effective incident reporting and documentation. DC Health Care will continue to ensure that all agency staff are trained properly in this area on an ongoing basis. Please see attachment "A".	01-08-07 06-07-07
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:	W 159		

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W 159	Continued From page 2 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. The finding includes: 1. The QMRP failed to provide evidence of a comprehensive psychiatric assessment that identified the specific needs for Clients #2, #3, and #4. [See W212]	W 159	Please see answer to W-212	
	2. The QMRP failed to assess a known behavior of inappropriate touching to determine management strategies for Client #3. [See W214]		Please see answer to W-214	
	3. The QMRP failed to ensure that Client #1and #3's Individual Program Plans (IPP) stated specific objectives necessary to meet their needs. [See W227]		Please see answer to W- 227.	
	4. The QMRP failed to ensure that as soon as the Interdisciplinary Team (IDT) formulated each client's Individual Program Plan (IPP), clients received continuous active treatment, consisting of needed interventions and services. [See W249]		Please see answer to W- 249	
	5. The QMRP failed to ensure that a medical care plan for treatment was integrated in an individual program plan for Client #1. [See W321]		Please see answer to W- 321	
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the	W 189		

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W 189	Continued From page 3 employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each employee was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently. The findings include: 1. On the day of the survey, June 6, 2007, Client #4 experienced a fall on the stairs of one of the providers other facilities and injured his face and forehead. Interview with the facility's Program Manager on June 6, 2007 revealed that the client was transported by a different direct care staff than from his own residence. Review of Client #4's record on June 8, 2007 at 11:50 AM revealed a Physical Therapy assessment dated February 19, 2007. The following recommendations were made to ensure that the client was safe when ambulating: a) Supervision when ambulating on level surfaces and stairs. b) When descending the stairs, the staff member should be in front of the client. c) When ascending the stairs, the staff member should be behind him. At the time of the survey there was no documented evidence that this direct care staff had been trained in assisting Client #4's ambulating protocol.	W 189	An in-service training was held by the physical therapist with all staff on 06-27-07 to review client # 4's ambulating protocol to ensure his safety when ascending and descending the stairs inside and outside of the facility. (Please see attachment) "B"	06-27-07

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W 189	Continued From page 4 2. The facility failed to ensure staff were trained in the Incident Reporting Policies and Procedures. [See W149]	W 189		
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 observations, interview and record review, the facility failed to provide evidence of a comprehensive psychiatric assessment that identified the specific needs of three of four clients included in the sample. (Client #2, #3, and #4)	W 212		
	The findings includes: 1. Observation of the evening medication administration conducted on 6/6/07 at 5:51 PM, revealed Client #2 received Seroquel 1/2 tab 50 mg. Interview with the medication nurse staff on the same day revealed that the medication was prescribed for maladaptive behaviors. On 6/7/07 at approximately 3:24 PM the client's physicians orders dated 6/1/07 confirmed the use of Seroquel to address the client's aggression. The client's medical records on 6/7/07 did not include a comprehensive psychiatric assessment. It should be noted that an additional interview with the Quality Assurance staff on 6/8/07 at approximately 1:30 PM acknowledged that the records lack a full comprehensive psychiatric assessment. 2. Observation of the evening medication administration conducted on 6/6/07 at 6:22 PM,		The Program Director will meet with the Psychiatrist on 06-29-07 to discuss the need to provide the agency with a comprehensive Psychiatric assessment inclusive of all past medical diagnosis and needed social history for all targeted individuals. (See W212 #1)	06-29-07

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W 212	Continued From page 5 revealed Client #3 received Seroquel 50 mg QPM . Interview with the medication nurse staff on the same day revealed that the medication was prescribed for maladaptive behaviors. On 6/7/07 at approximately 3:24 PM the client's physicians orders dated 6/1/07 was reviewed and confirmed the use of Seroquel 50 mg to address behaviors associated with aggressive (bitting others, striking out, scratching, turning over furniture, chairs, tables, etc) and banging on objects. Further review of the medical records on the same day did not include a comprehensive psychiatric assessment. It should be noted that an additional interview with the Quality Assurance staff on 6/8/07 at approximately 1:30 PM acknowledged that the records lack a full comprehensive psychiatric assessment.	W 212		
	3. Observation of the evening medication administration conducted on 6/6/07 at 6:30 PM, revealed Client #4 received Depakote 250 mg, Ativan 1mg, and Atarax 50mg. Interview with the medication nurse staff on the same day revealed that the medication was prescribed for maladaptive behaviors. On 6/7/07 at approximately 1:39 PM, the client's physicians orders dated 6/1/07 was reviewed and confirmed the use of the aforementioned medications to address behaviors associated with skin picking, pulling private parts, chewing clothes, and tearing clothes. Further review of the client's medical on 6/7/07 did not include a comprehensive psychiatric assessment. It should be noted that an additional interview with the Quality Assurance staff on 6/8/07 at approximately 1:30 PM acknowledged that the records lack a full comprehensive psychiatric assessment.		Please see answer to W 212 #1	
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN	W 214		

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W 214	Continued From page 6 The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to assess a known behavior of inappropriate touching to determine management strategies for one of four clients in the sample. (Client #3) The finding includes: Evening observations on 6/6/07 beginning at 4:20 PM revealed Client #3 on three different occasions, trying to touch the female staff inappropriately while they socialized with him. Each time, the client was redirected to stop or the staff moved away rapidly. Further observations revealed Client #3 touching the male surveyor on the thigh when sitting next to him. Interview with the House Manager, Quality Assurance staff, and second shift supervisor on 6/6/07, revealed that Client #3 given the opportunity would touch inappropriately. Further interview with the staff revealed that this behavior was not part of Client #3's Behavior Support Plan. (BSP) On 6/7/07, at approximately 12:40 PM, review of Client #1's Individual Support Plan (ISP) dated 4/5/07 revealed a Behavior Support Plan (BSP) dated 5/29/07. The BSP revealed that Client #3 had targeted behaviors of aggression (biting others, striking out, scratching, turning furniture over, and banging objects), none of which addresses inappropriate touching. There was no evidence that Client #3's behavior of inappropriate touching had been assessed.	W 214	Client # 3 who is blind has a tendency to reach out and touch any one who is in his personal space and pat. A meeting was held on 06-27-07 with the QMRP, QA, Program Coordinator and the psychologist to discuss monitoring the frequency of his inappropriate touching to see if a formal program is needed. Baseline data will be collected for 90 days starting 06/27/07. Please see attachment 'C'	06-27-07 06-27-07

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W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN 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. This STANDARD is not met as evidenced by: Based on staff interview, and record review, the facility failed to ensure each client's Individual Program Plan (IPP) stated specific objectives necessary to meet the needs of twoo of the four clients included in the sample. (Clients #1 and #3) The finding includes:	W 227		
	1. Interview with the facility's nurse, the Qualified Mental Retardation Professional (QMRP) and review of Client #1's medical record on June 7, 2007 revealed "Nursing Care Plans" starting from August 1, 2006 through March 26, 2007." Each of the nursing care plans for Client #1 identified the client's "problem" as "conjunctivitis", and the plan consisted of the following receommendations: a. Encourage client to wash hands frequently. b. Discourage client from rubbing eyes. c. Apply Sodium Sulamyd as ordered. d. Keep eyes clean and moist. Review of Client #1's Individual Program Plan (IPP) failed to provide documented evidence of the client's nursing care plan integrated in an IPP to ensure that the specific program and objectives were implemented.		While preventive measures continue for client # 1 to prevent eye irritation a formal program was implemented on 06-07-07 as a preventive measure to reduce or eliminate eye infections. Please see attachment D.	06-07-07

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W 227	Continued From page 8 2. The facility failed to ensure that Client #3 was furnished with a bib during mealtime as recommended by the interdisciplinary team. Observations of the dinner meal conducted on 6/6/07 at approximately 6:48 PM, Client #3 was observed using a Dycem mat, a built up fork, and eating out of a regular plate with a plate guard attached. The dinner meal consisted of cabbage, roasted turkey, mash sweet potatoes, and diced mixed fruit in a bowl. Interview with the second shift supervisor on 6/7/07 at approximately 2:50 PM revealed that the Human Rights Committee (HRC) had discussed the use of a bib for Client #3. Further interview with the shift supervisor revealed that Client #3 would benefit from wearing a bib during mealtime. Review of the Protocol for Adaptive Equipment (AE) dated 3/5/07 on 6/7/07 at 11:01 AM revealed Client #3 used the following Adaptive Equipment: Dycem mat, bib during mealtime, built-up fork and spoon, plate guard. According to the Occupational Assessment dated 2/18/07 reviewed on 6/7/07 at approximately 12:20 PM, Client #3 would benefit from using a bib during feeding. There was no evidence that an Individual Program Plan (IPP) had been designed to address the client feeding needs.	W 227	An in-service training was held on 06-26-07 with QMRP and all Direct Care Staff to reemphasize the use of all adaptive equipment and mealtime protocols. Please See attachment 'E'	06-26-07
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.	W 249		

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W 249	Continued From page 9 This STANDARD is not met as evidenced by: Based on observations, interviews, and record verification, the facility failed to demonstrate that one out of four clients in the sample are actively and consistently encouraged to engage in learning opportunities to maintain or enhance their skill levels. (Client #1) The findings include: 1. Client #1 was observed on June 6, 2007 at approximately 5:46 PM leaving the facility to take a community walk with the direct care staff. At 5:50 PM he returned to the facility. During the dinner preparation, the client was not observed to participate with his housemate (Client #2) in preparing the meal or setting the table. He was observed in the living room area playing connect four with one of the direct care staff. Interview with the Qualified Mental Retardation Professional (QMRP) and review of Client #1's record on June 7, 2007 revealed the client had an Individual Support Plan (ISP) dated November 1, 2006. According to the QMRP, the client had objectives to choose a shirt that he would like to wear three times weekly and to play a connect four game stacking legos with peers with 50% verbal reminders three times weekly. Further review of the record on June 7, 2007 revealed an Occupational Therapy Assessment dated February 18, 2007. The Occupational Therapist recommended the client to assist in	W 249	Client # 1's mealtime objective to set the table was scheduled for implementation on Mondays and Thursday only. However, client #1 generally engages in table setting activities, but chose to play on board game with his Direct Care Staff. QMRP & QA in-serviced the staff on proper program implementation and documentation on 06-27-07. Please See attachment 'F'	06-27-07

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W 249	Continued From page 10 meal preparation twice weeky with verbal cues on 80% of the trials recorded per month for three consecutive months and set the table with verbal cues prior to mealtime on 95% of the trials recorded per month for three consecutive months. Review of the data collection on June 7, 2007 did not include evidence that the program had been implemented. 2. The facility failed to ensure that a program was developed to train Client #1 to wash his hands frequently as recommended: Interview with the nurse on June 6, 2007 at 12:09 PM and record review revealed Client #1 has a diagnosis of Conjunctivitis S/P. Further review of the client's medical record revealed Nursing care plans from August 1, 2006 through March 26, 2007. Each of the nursing care plans for Client #1 identified the client's "problem" as "conjunctivitis," and recommended the the client to wash his hands frequently, however, there was no Individual Program Plan (IPP) provided. Interview with the Qualified Mental Retardation Professional (QMRP) and review of Client #1' s Individual Program Plan (IPP) dated November 1, 2006 revealed the facility failed to provide evidence that the client was being trained in skills necessary for washing his hands. [Also See W321]	W 249	An in-service training was held on 03-05-07 on proper hand washing during the survey held on 06-07-07 to discuss the importance of implementing good hand washing techniques and to devise a plan to ensure that client # 1 washes his hands more frequently to help reduce the frequency of recurring eye infections and irritations. Please See attachment 'G'	03-05-07 06-07-07
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	W 263		

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W 263	Continued From page 11 minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observations, interview and record review during the re-visit on June 8, 2007, 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 behavior support plans, for one of the three clients included in the sample. (Client #1) The finding includes: Observation of the evening medication administration on June 6, 2007 beginning at 6:30 PM revealed Client #4 received medications including Depakote, Atarax and Ativan. Interview with the medication nurse during the medication administration revealed the medications were used to control behaviors. Interview with the Qualified Mental Retardation Professional (QMRP) during the entrance conference on June 6, 2007 at 10:05 AM revealed Client #4 received psychotropic medications and had a Behavior Support Plan (BSP). Review of Client #4's medical record on the same day revealed a revised BSP dated February 28, 2007. The plan addressed targeted behaviors that included self-injurious behaviors, chewing clothes, tearing clothes, and pulling private parts. Further interview with the QMRP during the entrance conference on June 6, 2007 revealed Client #4 had a legal guardian and could not give informed consent for the use of his medications and/or the corresponding BSP. Additionally, review of the plan revealed it utilized a restrictive	W 263	A telephone conversation was held on 06-27-07 with the legal guardian to discuss and review the BSP for client # 4 to obtain consent for the implementation of the plan. The use of the BSP was reviewed on 06-27-07. Please see attachment "H"	06-27-07 06-27-07

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W 263	Continued From page 12 technique to hold the client's hand to inhibit him if he hits himself hard and repeatedly . At the time of the survey, the facility failed to provide evidence that the facility had obtained written informed consent from Client #4 's legal guardian for the use of his behavior support plan.	W 263		
W 321	483.460(a)(2) PHYSICIAN SERVICES The medical care plan of treatment must be integrated in the individual program plan. This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to ensure that a medical care plan for treatment was integrated in the individual program plan for one of the four clients in the sample. (Client #1) The finding includes: An interview was conducted on June 6, 2007 at 10:45 AM, with the day program's Case Manager (CM). When questioned regarding if there had been any incident reports, the CM submitted a "Further Evaluation Required" (F.E.R.) form to the surveyor. Review of the form dated February 12, 2007 revealed a medical/health concern regarding Client #1's eye. Further review of the F.E.R. revealed the client was observed on the aforementioned date with "pink and a dark scaly area around his left eye." The evaluation form also indicated that the client was constantly rubbing his eye. According to the day program's CM the F.E.R. form is completed and forwarded to the residence for further observation of a medical/health	W 321	Please see the answer to W 227	

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	09G009		06/08/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D C HEALTH CARE	414 "N" STREET, NW WASHINGTON, DC 20001

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W 321	Continued From page 13 concern by a physician. Interview with the facility's nurse, Qualified Mental Retardation Professional (QMRP) and review of Client #1's medical record on June 7, 2007 revealed "Nursing Care Plans" starting from August 1, 2006 through March 26, 2007." Each of the nursing care plans for Client #1 identified the client's "problem" as "conjunctivitis", and the plan consisted of the following instructions: 1. Encourage client to wash hands frequently. 2. Discourage client from rubbing eyes. 3. Apply Sodium Sulamyd as ordered. 4. Keep eyes clean and moist. Review of Client #1's Individual Program Plan (IPP) failed to provide documented evidence of the client's nursing care plan integrated in an IPP to ensure that the specific programs and objectives were implemented.	W 321		
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the implementation of infection control procedures to prevent communicable infectious diseases for one of four clients included in the sample. (Clients #3) The finding includes: Evening observations on 6/6/07 at 6:35 PM	W 455	An in-service training was held during the survey on 06-07-07 to discuss the importance of implementing good hand washing techniques of all clients, especially client # 3. Please See attachment 'I'	06-07-07

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W 455	Continued From page 14 revealed Client #3 placed his hands in the back of his pants after washing his hands prior to dinner. Although the direct care staff #1 redirected the client to take his hands from inside his pants, the staff did not encourage the client to go back to the bathroom and wash his hands. Interview with the direct care staff on the same day at approximately 6:45 PM revealed that she had training on infection control. Review of the staff in service training book on 6/6/07 at approximately 4:06 PM revealed that all staff had received infection control training on 5/27/07. There was no evidence that training to prevent infectious diseases was effective.	W 455		
W 473	483.480(b)(2)(ii) MEAL SERVICES Food must be served at appropriate temperature.	W 473		
	This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that food was served at the appropriate temperature for seven of seven clients residing in the facility. (Clients #1, #2, #3, #4, #5, #6, and #7) The finding includes: Evening observations conducted on 6/6/07 at 6:10 PM revealed bowls of salad with dressing on the dinner table uncovered. Further observations revealed Client #2 placing his peers dinner that consisted of cabbage, roasted turkey, and mash sweet potatoes on the table at 6:30 PM. The clients did not start eating until 6:50 PM. Interview with the Program Manager and direct care staff revealed on 6/8/07 at approximately 2:30 PM revealed that residents should be served their food within 10 minutes of removal from the		In-service training was held on 06-27-07 to re-emphasis the importance of serving all foods at the proper time and temperature. The QMRP and Nutritionist will monitor closely to ensure that all shifts prepare food properly. Please See attachment 'J'	06-27-07

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W 473	Continued From page 15 stove top and/or oven. There was no evidence that the facility staff served the clients their dinner meal and salad with dressing on top within the fifteen (15) minutes after removal from the temperature control device.	W 473		

Health Regulation Administration

ORIGINAL

PRINTED: 06/21/2007
FORM APPROVED

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	09G009		06/08/2007

RECEIVED 7/10/07

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I 000	INITIAL COMMENTS A licensure survey was conducted from Junes 6, 2007 through June 8, 2007. The survey was initiated using the fundamental survey process; however, it was determined that an extended process should be implemented under the conditions levels of participation of Health care services. A random sample of four clients were selected from a population of seven males with various disabilities. The findings of this survey were based on observations at the group home, four day programs, interviews at both the group home and day program, interview with guardians, review of clinical and administrative records to include the facility's unusual incident reports. From the results of this survey, it was determined that the facility was in compliance with Health Care Services.	I 000		
I 049	3502.7 MEAL SERVICE / DINING AREAS Each GHMRP shall serve meals at proper temperatures. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure food prepared for residents consumption was served promptly within 15 minutes of removal from heat source. The finding includes: Evening observations conducted on 6/6/07 at 6:10 PM revealed Resident #2 placing bowls of salads with dressing on top on the dinner table uncovered. Further observations revealed	I 049	Please the answer for W- 473 here.	

Health Regulation Administration

Mamta Gwani

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE Deputy Director D.C.H.C. (X6) DATE 6/29/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G009	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/08/2007
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I 049	Continued From page 1 Resident #2 placing his peers dinner that consisted of cabbage, roasted turkey, and mash sweet potatoes on the table at 6:30 PM. The residents did not start eating until 6:50 PM. Interview with the Program Manager and direct care staff revealed on 6/8/07 at approximately 2:30 PM revealed that residents should be served their food within 10 minutes of removal from the stove top and/or oven. There was no evidence that the facility staff served the residents their dinner meal and salad with dressing on top within the fifteen (15) minutes after removal from the temperature control device.	I 049		
I 095	3504.6 HOUSEKEEPING Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach of each resident. This Statute is not met as evidenced by: Based on observation the GHMRP failed to lock caustic agents stored in the bathroom. The finding includes: During the use of the facility's bathroom on June 6, 2007 at approximately 4:06 PM, caustic agents were observed stored in the bathroom cabinet. Although a lock was observed hanging on the door, it was not observed to be secured.	I 095	Training was held for all staff on 06-26-07 on the proper storage and usage of caustic agents please see attachment.	06-26-07
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	I 229		

Health Regulation Administration

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I 229	Continued From page 2 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 interview and record review, the facility failed to ensure that each employee was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently. The finding includes: Interview with the Program Manager and record review on June 6, 2007 at approximately 4:16 PM revealed no documented evidence that the staff received sexuality training. Also [See W189]	I 229	An in-service training was held for all staff on 06-27-07 by the psychologist on Human sexuality. Please see attachment. #1	6-27-07
I 432	3521.7(c) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (c) Personal hygiene (including washing, bathing, shampooing, brushing teeth, and menstrual care); This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group Home for the Mentally Retarded (GHMRP) failed to ensure a resident be provided the habilitation to effectively wash his hands for one of four residents. [Resident #1] The finding includes: [See Federal Deficiency Report - Citation W227]	I 432	Please See W-227	

Health Regulation Administration

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