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

PRINTED: 08/04/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G111	A. BUILDING B. WING	07/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R C M OF WASHINGTON	1326 45TH PLACE, NE WASHINGTON, DC 20019

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W 000	INITIAL COMMENTS A recertification survey was conducted from July 22, 2008 through July 25, 2008. The survey was initiated utilizing the fundamental survey process. A random sample of three clients was selected from a population of six females with varying degrees of mental retardation. The findings of the survey were based on observations at the group home and three day programs. Also the findings were based on interviews with direct care staff and management in both the group home and the day programs, as well as a review of habilitation and administrative records, to include the review of the facility's unusual incident management system.	W 000	Received 8/14/08 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on interviews with direct care staff, and the review of records, the facility's governing body failed to provide general operating directions over the facility as evidenced by the following: The findings include: Cross Reference W436. The Governing Body failed to ensure that the recommended adaptive equipment had been provided and maintained in accordance to their recommended needs for one of three clients in the sample.	W 104	Refer to W 436 P. 10	7-24-08
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES	W 120		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Angela Bjornlia	Program Director	8-14-08

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

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W 120	Continued From page 1 The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure that outside contracted services met the needs of Client #3 in the sample. The finding includes: Observations of the dinner meal on July 22, 2008 at approximately 5:51 PM revealed Client #1 was served onion baked chicken, mashed potatoes, carrots, and bread finely chopped. On July 23, 2008 at 12:16 PM, Client #3 was observed to eat chicken tacos, succotash and bread pureed during her lunch meal. Interview with the program instructor confirmed that Client #3's lunch meal was served pureed when asked by the surveyor. Further interview with the program instructor revealed that Client #3 was on a 1500 calorie diet finely chopped meats and vegetables. Review of the current Physician's Orders (PO's) dated June 30, 2008 and Nutritional Assessment dated October 22, 2008 was conducted on July 23, 2008 at approximately 4:10 PM. According to PO's and assessment, Client #3 was prescribed a 1500 calorie finely chopped meats and vegetables, No Salt Added diet. There was no evidence that Client #3 received her prescribed diet in accordance with the PO's and nutritional assessment.	W 120	The Qmrp reported to the day program, and inserviced the day Program Director on client # 3's diet Refer to attachment #1 In the future the home management will ensure that the client #3's diet is implemented as prescribed at the day program.	7-24-08
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a	W 159		

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W 159	Continued From page 2 qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observations, interviews with the Qualified Mental Retardation Professional (QMRP) and record review, the QMRP failed to ensure integration, coordination and monitoring of client's active treatment regimen. The findings include: 1. The QMRP failed to ensure that Client #3's behavior of spitting at the day program was baselined and incorporated into her Behavior Support Plan (BSP) as evidenced below: On July 23, 2008 at approximately 1:00 PM, Client #3 was observed to clear her throat two times while at her day program. The Program Instructor (PI) quickly removed Client #3 away from her peers at the table and verbally prompted her not to spit. Interview with the PI revealed that when Client #3 cleared her throat, that was an indication that she was getting ready to spit. Further interview with the PI revealed that Client #3 spits almost daily. When asked if spitting was a part of Client #3's BSP, the PI stated that it was not, but should have been included. The PI further stated that the day program had not baselined the data on the behavior and frequency of Client #3's spitting. Review of Client #3's BSP dated August 17, 2007 (expired) at day program revealed that the client had targeted behaviors of rectal digging and placing her hands in in front between her legs. Interview with the Assistant Director/Incident Management Coordinator/ Qualified Mental	W 159	Individual #3's targeted behavior of spitting is incorporated in her current BSP. The Qmrp has provided the day program with client#3's current BSP, and inserviced the day program staff on individual #3's BSP as well. Refer to attachment #2 The Qmrp will also ensure that the day program baseline the data on the behavior and frequency of individual #3 spitting during the monthly site observation. In the future the Qmrp will ensure that client #3 's BSP is implemented at home as well as at the day program.	8-12-08

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W 159	Continued From page 3 Retardation Professional (QMRP) on July 23, 2008 at approximately 3:00 PM revealed that he had met with the day program on several occasions to discuss spitting as part of Client #3's BSP. According to the QMRP, the day program staff indicated to him that Client #3 was easily redirected regarding her spitting. Therefore, spitting was not an issue. 2. Cross refer to W436. The QMRP failed to ensure necessary adaptive equipment was furnished for Client #3. [See W436] 3. Cross refer to W189. The QMRP failed to ensure that staff were provided with adequate training that enables the employee to perform his or her duties effectively, efficiently and competently. 4. Cross refer to W120. The QMRP failed to ensure that outside contracted services met the needs of Client #3. 5. Cross refer to W193. The QMRP failed to ensure that staff demonstrated competency in the implementing Client #3's Behavior Support Plan. 6. Cross refer to W247. The QMRP failed to ensure that staff provided Client #3 with opportunities for making choices as part of their self-management. 7. Cross refer to W252. The QMRP failed to ensure that each client's Individual Program Plan (IPP) objectives were documented consistently and accurately.	W 159	The sippy cup is currently in the home. In the future, the facility will ensure that individual #1 adaptive equipment is available in the facility, and used as prescribed. All staff were trained on the implementation of individual #3 meal protocol on 7-25-08; however the training has not been effective. all staff were retrained on individual #3's meal protocol. Refer to attachment # 3 In the future the facility will ensure that the staff implement client #3 meal time protocol as recommended. Refer to W 120 P.2 Staff were retrained on individual # 3' BSP Refer to attachment #4.1 In the future the Qmrp will ensure that the staff implement individual #3's BSP proactive procedures. The staff were inserviced on individual #3 self-management. The training emphasis was on the opportunity to promote independence, and growth through self -management. In the future the management will ensure that the staff provide individual #3 with the opportunity for self management to the extend of her capabilities. Staff were retrained on individual # 3' BSP (data collection on ABC data sheet) Refer to attachment #4.2 In the future the Qmrp will ensure that the staff collect data on the ABC data sheet consistently and	7-24-08 8-12-08 7-24-08 8-12-08 8-12-08 8-12-08
W 189	483.430(e)(1) STAFF TRAINING PROGRAM	W 189		

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W 189	Continued From page 4 The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that each employee had been provided with adequate training that enables the employee to perform his or her duties effectively, efficiently and competently. The findings include: 1. The facility failed to ensure that direct care staff followed the recommendations made by the nutritionist as evidenced below: On July 22, 2008 at 5:51 PM, Client #3 was observed to stuff large amounts of food in her mouth during the dinner meal. Direct care staff was observed approximately two feet away from Client #3. At no time did the direct care staff redirect Client #3 to stop over-stuffing her mouth. Interview with the direct care staff on the same day at approximately 5:58 PM revealed that Client #3 requires hand over hand assistance while feeding to prevent her from over-stuffing her mouth. Record review conducted on July 23, 2008 at 4:10 PM revealed a Nutritional Assessment dated October 17, 2007. According to the assessment, it was recommended that staff should "continue to promote eating small bites of food and rest eating utensils on plate between bites and encourage sips of beverage throughout the meal for Client	W 189	All staff were trained on the implementation of individual #3 meal protocol on 7-25-08; however the training has not been effective. all staff were retrained on individual #3's meal protocol. Refer to attachment # 3 In the future the facility will ensure that the staff implement client #3 meal time protocol as recommended.	8-12-08

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W 189	Continued From page 5 #3. Monitor pace of eating and encourage the client to eat slower." Review of the staff in service training book on July 25, 2008 at approximately 2:10 PM revealed all staffs had received training on nutrition dated July 22, 2008. There was no evidence that the training had been effective.	W 189	All staff were trained on the implementation of ndividual #3 meal protocol on 7-25-08; however the training has not been effective. all staff were retrained on individual #3's meal protocol. Refer to attachment # 3 In the future the facility will ensure that the staff implement client #3 meal time protocol as recommended.	8-12-08
W 193	483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on observations, staff interviews and the review of records, the facility staff failed to demonstrate competency in the implementation of Client #3's Behavior Support Plan (BSP). The finding includes: On July 22, 2008 at approximately 5:20 PM, Client #3 was observed to spit while sitting at the dining table waiting for her dinner meal. The client was further observed to wipe the saliva attached from her mouth with her hands onto her shirt. Two direct care staff were within two feet from Client #3. Interview with the direct care staff on the same day at approximately 6:05 PM revealed that Client #3 has behaviors of rectal digging, spitting, and physical aggression. Review of Client #3's Behavior Support Plan (BSP) dated May 28, 2008 on July 24, 2008 at approximately 1:16 PM revealed the following targeted behaviors: 1) Spitting on herself, at others, or on the furniture; 2) Rectal Digging; 3) mild physical aggression (i.e. deliberately	W 193	Staff were retrained on individual # 3' BSP Refer to attachment #4.1 In the future the Qmrp will ensure that the staff implement individual #3's BSP proactive procedures. Staff were retrained on individual # 3' BSP Refer to attachment #4.1 In the future the Qmrp will ensure that the staff implement individual #3's BSP proactive procedures.	8-12-08 8-12-08

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W 193	Continued From page 6 coughing on others, pushing or hitting staff/peers, tossing the personal items of others (belonging to her home) to the floor or into the street and stuffing food. Further review of the BSP revealed the following proactive procedures to address the spitting as detailed below:	W 193		
	1). Should the client spit on herself or a piece of furniture, immediately intervene. Direct her to stop and go over to her.		Staff were retrained on individual # 3' BSP Refer to attachment #4.1 In the future the Qmrp will ensure that the staff implement individual #3's BSP proactive procedures.	8-13-08
	2). Provide her with an antibacterial (hand) wipe to use on her clothing. One for other surfaces should be provided for cleansing those.		Staff were retrained on individual # 3' BSP Refer to attachment #4.1 In the future the Qmrp will ensure that the staff implement individual #3's BSP proactive procedures.	8-12-08
	3). Either independently or with manual assistance, the client shares the responsibility (with a staff member) for cleaning herself and the surface on which she spat.		Staff were retrained on individual # 3' BSP Refer to attachment #4.1 In the future the Qmrp will ensure that the staff implement individual #3's BSP proactive procedures.	8-12-08
	There was no evidence that staff demonstrated competency in the implementation of Client #3's BSP.			
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that Client #3 was provided the opportunities for making choices as part of their self-management. The finding includes: On July 22, 2008 at approximately 4:31 PM, direct	W 247		

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W 247	Continued From page 7 care staff was observed to place napkins, cups, bowls, eating utensils, and mats in front of Client #3 while she sat at the dining table. The direct care staff was further observed to break Client #3's graham crackers into bitesize pieces. Client #3 drank and ate her snack independently. During the dinner meal at approximately 5:50 PM, direct care staff was observed to assist Client #3 with hand over hand assistance while feeding and drinking. Interview with the direct care staff revealed that Client #3 feeds and drinks independently, but needs close supervision not to over stuff her mouth. At no time did the direct care staff allow Client #3 to feed herself independently during her dinner meal. There was no evidence that Client #3 was afforded the opportunity for self-management to the extent of her capabilities.	W 247	The staff were inserviced on individual #3 self-management. The training emphasis was on the opportunity to promote independence, and growth through self -management. In the future the management will ensure that the staff provide individual #3 with the opportunity for self management to the extend of her capabilities.	8-12-08
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure that each client's Individual Program Plan (IPP) objectives are documented consistently and accurately for one of three clients in the sample. (Client #3) The finding includes: Observations conducted on July 22, 2008 at approximately 5:20 PM revealed Client #1 spat while sitting at the dining table waiting for her	W 252		

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W 252	Continued From page 8 dinner meal. The client was observed to wipe the saliva attached from her mouth with her hands onto her shirt. The direct care staff was not observed to redirect the behavior. Interview with the direct care staff revealed that she had received training on Client #3's Behavior Support Plan (BSP). Review of Client #3's Behavior Support Plan (BSP) dated May 28, 2008 on July 24, 2008 at approximately 1:16 PM revealed that staff was to record target behaviors on the Antecedent Behavior Consequence (ABC) charts. On July 25, 2008 at approximately 2:30 PM, the review of the ABC data collection sheets did not reflect Client #3 spitting observed on July 22, 2008. There was no evidence that the data had been collected in accordance with the BSP for Client #3, which was necessary for a functional assessment of the client's progress. It should be noted that all staff had received training on Client #3's BSP on June 17, 2008.	W 252	Staff were retrained on individual # 3' BSP (data collection on ABC data sheet) Refer to attachment #4.2 In the future the Qmrp will ensure that the staff collect data on the ABC data sheet consistently and accurately.	8-12-08
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure necessary adaptive equipment was furnished and maintained for one of the three clients included in the sample. (Client #1)	W 436		

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W 436	Continued From page 9 The finding includes: The facility failed to ensure that Client #1 was provided with the recommended adaptive feeding equipment as evidenced below:	W 436		
	On July 22, 2008 at 5:03 PM, Client #1 was observed to receive apple juice in a regular cup from the direct care staff. The staff was observed to hold Client #1's cloth bib just below her chin to catch the apple juice as it spilled from her mouth. During the dinner meal at approximately 6:15 PM, direct care staff was observed again to hold Client #1's bib up to her chin to avoid spillage as she consumed her beverage. Interview with the the direct care staff on the same day at approximately 6:20 PM revealed that Client #1 needed a top for her sippy cup. The direct care staff further revealed that she had been asking the management staff for the sippy cups for at least three weeks. The direct care staff indicated that Client #1 had three sippy cups when she transitioned to this facility in January 2008.		Refer to W 104 P.1	7-24-08
	Interview with the Assistant Director/Incident Management Coordinator/Qualified Mental Retardation Professional (QMRP) on July 24, 2008 at approximately 2:30 PM revealed that he was unaware that Client #1 was without her sippy cups. Further interview with the QMRP revealed that he had purchased at least three sippy cups for Client #1.		Refer to W 104 P.1	7-24-08
	Review of Client #1's record on July 24, 2008 at approximately 10:39 am revealed an Occupational Therapist Assessment (OT) dated June 20, 2007. According to the OT assessment, during mealtime, Client #1 should drink from a two handle sippy cup. There was no evidence		Refer to W 104 P.1	7-24-08

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W 436	Continued From page 10 that Client #1 was provided the two handle sippy cup as recommended by the OT.	W 436		
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 three clients included in the sample. (Clients #3) The finding includes: On July 22, 2008 at approximately 5:20 PM, Client #3 was observed to spit while sitting at the dining table waiting for her dinner meal. The client was further observed to wipe the saliva attached from her mouth with her hands onto her shirt. The direct care staffs did not encourage or redirect the behavior or encourage Client #3 to go back to the bathroom and wash her hands. Interview with the direct care staff on the same day at approximately 5:55 PM revealed that she had received training on infection control. Review of the staff in service training book on July 25, 2008 at approximately 2:15 PM revealed that all staff had received infection control training on July 22, 2008. There was no evidence that the training to prevent infectious diseases was effective.	W 455	all staff were trained on the infection control on 7-25-08, but apparently, the traing was not effective. Staff were retrained Refer to attacment #5 In the future the facility management will ensure that the staff receive effective training to prevent infectious diseases.	8-12-08
W 460	483.480(a)(1) FOOD AND NUTRITION SERVICES	W 460		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G111		07/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R C M OF WASHINGTON	1326 45TH PLACE, NE WASHINGTON, DC 20019

(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 460	Continued From page 11 Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure clients that were prescribed special diets received their modified diets in accordance with their needs for one of the three clients in the sample. (Client #3) The finding includes: Observations of the dinner meal on July 22, 2008 at approximately 5:51 PM revealed Client #1 was served onion baked chicken, mashed potatoes, carrots, and bread finely chopped. On July 23, 2008 at 12:16 PM, Client #3 was observed to eat chicken tacos, succotash and bread pureed during her lunch meal. Interview with the program instructor confirmed that Client #3's lunch meal was served pureed when asked. Further interview with the program instructor revealed that Client #3 is on a 1500 calorie diet finely chopped meats and vegetables. Interview with the QMRP on July 24, 2008 at approximately 3:30 PM revealed that Client #3 is on a 1500 calorie finely chopped meats and vegetable "No salt added" diet.	W 460	Refer to W 120 P.2	7-24-08
	Review of the current Physician's Orders (PO's) dated June 30, 2008 and Nutritional Assessment dated October 22, 2008 was reviewed on July 23, 2008 at approximately 4:10 PM. The PO's revealed a diet order for a "1500 calorie finely chopped meats and vegetables, No Salt Added diet." Further review of the Client #3's record revealed a nutritional assessment dated October		Refer to W 120 P.2	7-24-08

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STREET ADDRESS, CITY, STATE, ZIP CODE: 1326 45TH PLACE, NE WASHINGTON, DC 20019

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W 460	Continued From page 12 17, 2007. According to the assessment, the nutritionist recommended that Client #3 receive a 1500 calorie finely chopped meats and vegetable diet. At the time of the survey, the facility failed to ensure Client #3 received her specially prescribed diet as ordered at the day program.	W 460	Refer to W 120 P.2	7-24-08
W 474	483.460(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure each clients diet was served in a form consisted with their developmental level for one of three clients in the sample. (Client ##3) The finding includes: Observations of the dinner meal on July 22, 2008 at approximately 5:51 PM revealed Client #1 was served onion baked chicken, mashed potatoes, carrots, and bread finely chopped. On July 23, 2008 at 12:16 PM, Client #3 was observed to eat chicken tacos, succotash and bread pureed during her lunch meal. Interview with the program instructor confirmed that Client #3's lunch meal was served pureed when asked. Further interview with the program instructor revealed that Client #3 is on a 1500 calorie diet finely chopped meats and vegetables. Interview with the QMRP on July 24, 2008 at approximately 3:30 PM revealed that Client #3 is on a 1500 calorie finely chopped meats and vegetable "No salt added" diet. Review of the current Physician's Orders (PO's)	W 474	Refer to W 120 P.2 Refer to W 460 P 12 Refer to W 474 P. 14	7-24-08 7-24-08 7-24-08

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W 474	Continued From page 13 dated June 30, 2008 and Nutritional Assessment dated October 22, 2008 was reviewed on July 23, 2008 at approximately 4:10 PM. The PO's revealed a diet order for a " 1500 calorie finely chopped meats and vegetables, No Salt Added diet." Further review of the Client #3's record revealed a nutritional assessment dated October 17, 2007. According to the assessment, the nutritionist recommended Client #3 receive a 1500 calorie finely chopped meats and vegetable diet. At the time of the survey, the facility failed to ensure Client #3 received her prescribed diet as order at the day program.	W 474	Refer to W 120 P. 2 Refer to W 460 P. 12	7-24-08 7-24-08

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	HFD03-0142		07/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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I 000	INITIAL COMMENTS A licensure survey was conducted from July 22, 2008 through July 25, 2008. The survey was initiated utilizing the fundamental survey process. A random sample of three clients was selected from a population of six females with varying degrees of mental retardation. The findings of the survey were based on observations at the group home and three day programs. Also the findings were based on interviews with direct care staff and management in both the group home and the day programs, as well as a review of habilitation and administrative records, to include the review of the facility's unusual incident management system.	I 000		
I 022	3501.5 ENVIRONMENTAL REQ / USE OF SPACE Each window shall be supplied with curtains, shades or blinds, which are kept clean, and in good repair. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure blinds and/or curtains at each window. The finding includes: On July 25, 2008 at approximately 2:11 PM the blinds in the bathroom #1 was observed to be torn.	I 022	The blind torn inthe bathroom #1 was replaced	8-04-08
I 042	3502.2(b) MEAL SERVICE / DINING AREAS Modified diets shall be as follows: (b) Planned, prepared, and served by individuals	I 042		

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Program Director — (X6) DATE: 8-14-08

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	HFD03-0142		07/25/2008

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I 042	Continued From page 1 who have received instruction from a dietitian; and... This Statute Is not met as evidenced by: Based on observation, staff interview and record review, the GHMRP failed to ensure residents that were prescribed special diets received their modified diets in accordance with their needs for one of the three residents in the sample. (Resident #3) The findings include: 1. Observations of the dinner meal on July 22, 2008 at approximately 5:51 PM revealed Resident #1 was served onion baked chicken, mashed potatoes, carrots, and bread finely chopped. On July 23, 2008 at 12:16 PM, Resident #3 was observed to eat chicken tacos, succotash and bread pureed during her lunch meal. Interview with the program instructor confirmed that Resident #3's lunch meal was served pureed when asked by the surveyor. Further interview with the program instructor revealed that Resident #3 was on a 1500 calorie diet finely chopped meats and vegetables. Interview with the QMRP on July 24, 2008 at approximately 3:30 PM revealed that Resident #3 was on a 1500 calorie finely chopped meats and vegetable "No salt added" diet. Review of the current Physician's Orders (PO's) dated June 30, 2008 and Nutritional Assessment dated October 22, 2008 were reviewed on July 23, 2008 at approximately 4:10 PM. The PO's revealed a diet order for a "1500 calorie finely chopped meats and vegetables, No Salt Added diet." 2. Also refer to federal deficiency citation W120.	I 042	The Qmrp reported to the day program, and inserviced the day Program Director on client # 3's diet Refer to attachment #1 In the future the home management will ensure that the client #3's diet is implemented as prescribed at the day program. The Qmrp reported to the day program, and inserviced the day Program Director on client # 3's diet Refer to attachment #1 In the future the home management will ensure that the client #3's diet is implemented as prescribed at the day program.	7-24-08 7-24-08

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I 054	3502.12 MEAL SERVICE / DINING AREAS Residents shall be provided training to develop eating skills and to use special eating equipment and utensils if such training is indicated in the Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to train staff in the use of proper feeding procedures or utensils. The finding includes: See Federal Deficiency Report - Citation W436.	I 054	The sippy cup is currently in the home. In the future, the facility will ensure that individual #1 adaptive equipment is available in the facility, and used as prescribed.	7-24-08
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: Based on observation, the GHMRP failed to ensure the interior and exterior of the GHMRP was maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. The findings include: Internal 1. Dust build up was observed on top of the oven fan.	I 090	The dust was on the top of the oven was cleaned.	7-25-08

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I 090	Continued From page 3	I 090		
	2. The closet door knob located in Resident #6's room was inoperable.		The door knob was replaced	8-04-08
	3. The dresser in Resident #6's room was observed to be missing a knob.		The missing knob was replaced	8-04-08
	External			
	1. Mold and mildew was observed growing on the ramp leading from the drive way to the back door.		The mold was washed	8-04-08
	2. Nails were exposed on the ramp leading from the drive way to the back door.		The exposed nails were removed	8-04-08
	3. There were several missing and loose wooden poles detached from the foundation of the ramp.		The ramp wa fixed	8-04-08
	4. There were exposed black wires connected to the ramp.		The exposed wires were removed	8-04-08
I 206	3509.6 PERSONNEL POLICIES	I 206		
	Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties.			
	This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that all staff had current health certificates on file.			

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I 206	Continued From page 4 The finding includes: Review of the personnel files conducted on July 25, 2008, revealed the GHMRP failed to provide evidence of current health certificates for four (4) consultants and one Licensed Practical Nurse (LPN) at the time of the survey. (C#4, #5, #7, #11, and LPN #2)	I 206	All of the personnel files will be updated	8-31-08
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (c) Infection control for staff and residents; This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current training in First Aid and CPR for employees. The findings include: On July 25, 2008, review of personnel records/training records revealed five staffs were without current documentation of First Aid and CPR, or both at the time of the survey. (S#3, #7, #10, #11, and #14)	I 227	The staff without CPR/First Aid will take the class on 8-17-08	
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observations, staff interviews and the review of records, the GHRMP staff failed to demonstrate competency in the implementation	I 422		

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I 422	Continued From page 5 of Resident #3's Behavior Support Plan (BSP). The finding includes: On July 22, 2008 at approximately 5:20 PM, Resident #3 was observed to spit while sitting at the dining table waiting for her dinner meal. The client was further observed to wipe the saliva attached from her mouth with her hands onto her shirt. Two direct care staffs were within two feet from Resident #3. Interview with the direct care staff on the same day at approximately 6:05 PM revealed that Resident #3 has behaviors of rectal digging, spitting, and physical aggression. Review of Resident #3's Behavior Support Plan (BSP) dated May 28, 2008 on July 24, 2008 at approximately 1:16 PM revealed the following targeted behaviors: 1) Spitting on herself, at others, or on the furniture; 2) Rectal Digging; 3) mild physical aggression (i.e. deliberately coughing on others, pushing or hitting staff/peers, tossing the personal items of others (belonging to her home) to the floor or into the street. Further review of the BSP revealed the following proactive procedures to address the spitting as detailed below:	I 422	Staff were retrained on individual # 3' BSP Refer to attachment #4.1 In the future the Qmrp will ensure that the staff implement individual #3's BSP proactive procedures.	8-12-08
	1). Should the resident spit on herself or a piece of furniture, immediately intervene. Direct her to stop and go over to her.		Staff were retrained on individual # 3' BSP Refer to attachment #4.1 In the future the Qmrp will ensure that the staff implement individual #3's BSP proactive procedures.	8-12-08
	2). Provide her with an antibacterial (hand) wipe to use on her clothing. One for other surfaces should be provided for cleansing those.		Staff were retrained on individual # 3' BSP Refer to attachment #4.1 In the future the Qmrp will ensure that the staff implement individual #3's BSP proactive procedures.	8-12 -08
	3). Either independently or with manual assistance, the resident shares the responsibility (with a staff member) for cleaning herself and the surface on which she spat.			

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I 422	Continued From page 6 There was no evidence that staff demonstrated competency in the implementation of Resident #3' s BSP.	I 422	Staff were retrained on individual # 3' BSP Refer to attachment #4.1 In the future the Qmrp will ensure that the staff implement individual #3's BSP proactive procedures.	8-12-08

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R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on the review of records, the GHMRP failed to ensure criminal background checks for the previous seven (7) years, in all jurisdictions where staff had worked or resided within the seven (7) years prior to the check. The finding includes: Review of the personnel files on July 25, 2008 revealed the GHMRP failed provide evidence of a criminal background checks for the previous seven years in all jurisdiction where three staff person had worked or resided at the time of the survey. (Staff #1, #3, #5, and #10)	R 125	All of thel personnel files will be updated by	8-31-08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Program Director TITLE (X6) DATE 8-14-08