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

PRINTED: 03/10/2008
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
	09G035		02/14/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CMS	3112 13TH STREET NW WASHINGTON, DC 20010

(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 recertification survey was conducted from February 11, 2008 through February 14, 2008. The survey was initiated using the fundamental survey process. A random sampling of four clients was selected from a residential population of survey clients with various disabilities. The findings of the survey were based on observations, interviews with clients and staff in the home and at one day program, as well as a review of client and administrative records, including incident reports.		RECEIVED DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 2008 MAR 19 A 11:19	
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 observation, interview and record review, the facility's Governing Body failed to provide general operating direction over the facility. The findings include: 1. The facility failed to implement timely measures to minimize Client #4's frequent tardiness and absence from school. On February 11, 2008 at 7:45 AM a nurse was observed administering medications to the clients. Interview with the nurse indicated that she was a little late. Several vans were observed to come to the facility to pick up the clients and transport them to their respective day programs, however Client #4 remained at the facility. Interview with staff indicated Client #4's school	W 104	The Nursing staff have made arrangements for client #4 to recieve his AM medication at his school.	3/3/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Constance A. Reese
TITLE: Program Director
(X6) DATE: 3-19-08

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.

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

PRINTED: 03/10/2008
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
	09G035		02/14/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CMS	3112 13TH STREET NW WASHINGTON, DC 20010

(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 104	Continued From page 1	W 104		

bus comes early to transport him and that he did not ride on the bus because he had not taken his medications. At approximately 9:15 AM, the client were observed to leaving the house with an agency transportation staff.

Interview with with the QMRP on February 11, 2008 at 3:40 PM revealed Client #4 returned to the group home from school at approximately 1:00 PM because it was only open for a half day. The client's 1:1 staff and teacher's assistant at school on February 12, 2008 revealed the client arrived at 11:26 AM on February 11, 2007. The staff reported that since the client moved to current group home on August 1, 2007, he had been often tardy or absent. Staff indicated that the client sometimes missed his outings in the community due to his late arrival.

The attendance records revealed that the client usually arrived between 11:00 AM to 11:30 AM on the days that he was tardy. Further review of the attendance records revealed the client had arrived late 23 times and had 11 unexcused absences since school started on August 30, 2007.

Interview with the nurse at the day program indicated the school had offered to administer Client#4's AM Medication to ensure that he arrived at school on time. Further interview with both the staff at the client's school staff and the Qualified Mental Retardation Professional (QMRP) revealed that this arrangement had been discussed however was not implemented because the group home decided to arrange for the client to receive his AM medications by the time the bus arrived to transport him to school. There was no evidence that the arrangements

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

PRINTED: 03/10/2008
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
	09G035		02/14/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CMS	3112 13TH STREET NW WASHINGTON, DC 20010

(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 104	Continued From page 2	W 104		
	had been implemented to improve the client's school attendance.			
	2. The facility failed to have an effective program for trash collection and removal from the premises. On the February 11, 2008 at 4:25 PM staff informed Client #3 that it was time for him to take out the trash. The staff and the client were observed going to the trash storage area in the back yard carrying a large garbage bag. Upon arrival, two large covered trash cans were observed beside the fence. Two additional large bags of trash were on top of the covered cans. Staff indicated that the cans were already full of garbage. The bag of garbage which was taken out side by the client was then placed on top of the others. Six trash can lids were observed on the ground at the other side of the back yard. Interview with the Qualified Mental Retardation Professional on February 12, 200 at 1:20 PM revealed that the city garbage collection occurs every Tuesday. There was no evidence the facility had developed and implemented an effective plan to ensure that garbage was stored in a sanitary manner between the scheduled days of collection.		The facility will purchase additional trash cans to store garbage between scheduled days of collection.	3/28/08
	3. The facility failed to have an effective program for rodent control on the exterior of the facility. On the February 11, 2008 at 4:30 PM, while in the back yard with staff and Client #3 who were taking out the trash, the surveyor observed a large black box on the ground. The box was located approximately five feet from a large tree. A large hole was observed in the ground at the		The facility will provide a service agreement for rodent control.	3/28/08

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

PRINTED: 03/10/2008
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
	09G035		02/14/2008

NAME OF PROVIDER OR SUPPLIER: CMS

STREET ADDRESS, CITY, STATE, ZIP CODE: 3112 13TH STREET NW, WASHINGTON, DC 20010

(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 104	Continued From page 3	W 104		
	trunk of the tree. Raised areas of broken pavement and holes underneath were observed near the steps leading to the porch. Staff indicated the black box had been placed in the yard at some time in the past by the exterminator. Interview with staff indicated rats were often observed in the back yard. On February 14, 2008 the QMRP stated that the exterminator had come to the facility and showed two invoices for 2007. Further review of extermination invoices revealed none were available to show evidence that the facility/premises had been treated recently for mice, rats or other rodents. The extermination contract and recent invoices were requested from the administrative office on February 14, 2007 however was not provided. The QMRP informed the surveyor that the contract would be later faxed to Department of Health.			
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 interview and record review, the facility failed to establish and/or implement policies that ensured the health and safety of one (Client #4) of the four clients in the sample. The findings include: The facility failed to implement policies on reporting of unusual incidents.	W 149	In the future the facility will provide evidence of implementation of it's written policies that address the health and safety of client(4). Staff will be required to attend additional training on Incident Management Policies and Reporting Injuries to Nursing staff.	3/28/08

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

PRINTED: 03/10/2008
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
	09G035		02/14/2008

NAME OF PROVIDER OR SUPPLIER: CMS

STREET ADDRESS, CITY, STATE, ZIP CODE: 3112 13TH STREET NW, WASHINGTON, DC 20010

(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 149	Continued From page 4	W 149	In the future the facility will implement policies on reporting of unusual incidents in a timely manner. The QMRP will monitor documentation of staff when reporting injuries of clients.	3/28/08

a. Staff failed to timely report a Client #4's fall which resulted in an injury.

The review of an unusual incident report (UIR) dated 8/08/08 revealed that at 4:20 PM, the Qualified Mental Retardation Professional (QMRP) noted that while Client #4 was asleep, she observed him to have an abrasion on his right arm above his elbow. A body check revealed the client also had an abrasion on his right leg. Further review of the UIR revealed the client's injuries were treated by the Licensed Practical Nurse (medication nurse) at 5:30 PM.

The review of the investigative report completed by the QMRP on August 13, 2007 revealed that the staff reported that he was assisting the client down the basement steps when he accidentally lost control of the gait belt and the client fell down the basement steps.

A statement dated August 10, 2007 completed by the 8:00 AM to 4:00 PM staff caring for the client at the time of his fall was included in the investigative report. The report indicated that after the client ascended down the second step, the staff lost control of the client and he fell down the remaining stairs. This statement failed to include a time of the fall, or whether the client was checked for injury, or if the fall was reported to any other staff in the facility at the time of the fall or prior to leaving duty.

b. The review of a statement dated August 11, 2007 which was completed by a second 8:00 AM to 4:00 PM staff who was also on duty on 8/8/07 revealed that she was not aware that the client had fallen or had abrasions.

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

PRINTED: 03/10/2008
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
	09G035		02/14/2008

NAME OF PROVIDER OR SUPPLIER: CMS

STREET ADDRESS, CITY, STATE, ZIP CODE: 3112 13TH STREET NW, WASHINGTON, DC 20010

(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 149	Continued From page 5	W 149		
	c. The review of a statements dated 8/8/07 included in the investigative report which was written by the two staff on the 4:00 PM to 12:00 AM shift revealed they were not aware of the abrasions sustained by the client on 8/8/07 until they was informed by the QMRP. d. Although the client was referred to the nurse for assessment and treatment of his abrasions, the nurse indicated that he failed to report the client's injury to the PCP because he was not informed that the client had fallen down the the stairs. Further record review revealed that although the abrasions were monitored daily, there was no documented evidence that the Primary Care Physician was informed of the client's fall down the stairs and abrasions until August 15, 2007. There was no evidence the facility had implemented and effective system for the timely reporting of unusual incidents and injuries.			
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to report injuries of unknown origin to the State agency for one (Client #1).of four clients in the sample.	W 153	Cross reference to W149	3/28/08

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

PRINTED: 03/10/2008
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
	09G035		02/14/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C M S	3112 13TH STREET NW WASHINGTON, DC 20010

(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 153	Continued From page 6	W 153		
	The finding includes: The review of an unsual incident report on February 12, 1008 at 1:10 PM revealed that on August 2, 2007 at 4:25 PM, direct care staff heard Client #1 was making loud noises. Upon observation, staff saw blood falling from his eye brow. Interview with the Qualified Mental Retardation Professional (QMRP) on February 12, 2008 at 1:19 PM revealed Client #1 and Client #4 were in the basement with two direct care staff for recreational activities. Her interview with the two staff however failed to conclude how Client #1's injury occurred. The review of the agency's investigative report revealed the client wears eye goggles and may have been pushed against an object causing an abrasion by the frame of the goggles. The review of the UIR indicated that Department of Health (DOH) was informed of the client's injury on August 2, 2007 at 4:25 PM. There was no documented evidence that the UIR was received by DOH. There was no evidence this injury of unknown origin was reported to the state agency.			
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 verification, the facility failed to ensure each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP) for two	W 159		

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

PRINTED: 03/10/2008
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
	09G035		02/14/2008

NAME OF PROVIDER OR SUPPLIER: CMS

STREET ADDRESS, CITY, STATE, ZIP CODE: 3112 13TH STREET NW, WASHINGTON, DC 20010

(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 159	Continued From page 7 clients (Clients #4 and #5)residing in the facility. The findings include: 1 The QMRP failed to ensure coordination of Client #4's prescribed food texture . [See W474] 2. The QMRP failed to ensure coordination between the Interdisciplinary team (IDT) for the timely implementation of adaptive eating equipment recommended for Client #4 . [See W436,1] 3. The QMRP failed to collaborate with the IDT to ensure weight concerns for Client's #5 was addressed timely. [See W460]	W 159	1. The QMRP will meet with client #4 (IDT), and school to discuss his prescribed food texture. 2. QMRP will meet with client #4 (IDT), to discuss the implementation of adaptive eating equipment recommended. 3. QMRP addressed weight concerns with the (IDT) regarding client #5 weight, and Ensure two times a day was added to his diet. 4. QMRP addressed weight concerns with the (IDT) during client #5 last quarterly and additional tests will be ordered by his primary physician.	3/19/08 3/19/08 2/21/08 2/21/08
W 189	483.430(e)(1) STAFF TRAINING PROGRAM 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, interview and record, the facility failed to ensure continuing training was provided to each employee to enable them to perform duties effectively and competently for one (Client #4) of four clients in the sample. The findings include: The review of an investigative report dated 8/13/07 revealed that Client #4 was observed by the QMRP to have a bruise on his right leg and arm on 8/8/07. A statement dated 8/10/2007 which was written by the 8:00 AM to 4:00 PM staff who was caring for the client when he allegedly	W 189		

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

PRINTED: 03/10/2008
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
	09G035		02/14/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CMS	3112 13TH STREET NW WASHINGTON, DC 20010

(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 189	Continued From page 8	W 189	The facility will train staff on how to assist client #5 in walking with the gait belt and putting on his braces.	3/19/08
	fell was attached to the investigative report. According to the statement, on 8/8/07 the client fell down the steps after ascending the first two steps. The staff indicated that he lost control of the client and the client fell down the steps leading to the basement. According to the investigative report the client was observed by the QMRP to have an abrasion on his right arm and also on his right leg. The statement failed to indicate that the nurse was informed that the client sustained the injury during a fall down the steps. The review of the investigative report revealed that the evening medication nurse treated the client's abrasions at 5:30 PM on August 8, 2007. The report also indicated that the nurse did not notify the Primary Care Physician (PCP) of the client's injuries because he did not know the client had fallen down the basement steps. There was no evidence staff had been effectively trained on policies and procedures for incident management. Also there was no evidence that staff hd been trained on the appropriate use of Client #4's adaptive equipment (gait belt and leg braces) to ensure safety while ambulating.			
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, interview and record review, the facility failed to ensure data relative to the accomplishment of the program objective was	W 252	In the future the QMRP will revise clients #1, #2, #3, #6, and #7 objectives in the IPP with measurable criterias and nursing services will provide training in documentation to the medication nurses.	3/28/08

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

PRINTED: 03/10/2008
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
	09G035		02/14/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C M S	3112 13TH STREET NW WASHINGTON, DC 20010

(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 252	Continued From page 9	W 252		
	documented in measurable terms for five (Clients #1, #2, #3, #6 and #7) of the seven clients residing in the facility. The findings include: During medication administration on February 11, 2008 between the hours of 6:19 PM and 6:45 PM, Clients #1, #2, #3, #6, and #7 were observed to assist the nurse in the administration of their medications. Interview with the QMRP on February 12, 2008 at approximately 12: 15 PM revealed the aforementioned five clients had self medication assessments and were being provided training to participate in self medication programs to the extent of their capability. Further interview with the QMRP revealed that the nurse maintained the documentation on the clients' self medication programs. Verification of the Medication Administration Record (MAR) after the self medication programs were implemented revealed the data collection forms for February 2007 lacked any data for the month prior to February 11, 2008. The review of the MAR policy on 2/12/08 at 12:10 PM revealed if a client is on self medication training program, the nurse should document two times a week. There was no evidence the implementation of the self medication objectives were documented in measurable term by the nurse during February 2008.			
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and	W 262		

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

PRINTED: 03/10/2008
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
	09G035		02/14/2008

NAME OF PROVIDER OR SUPPLIER: CMS

STREET ADDRESS, CITY, STATE, ZIP CODE: 3112 13TH STREET NW, WASHINGTON, DC 20010

(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 262	Continued From page 10	W 262	In the future the QMRP will ensure that the Human Rights Committee review and approve increase in dosage of medications for client #4 before he is administered the medication.	3/28/08

monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.

This STANDARD is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure the committee designed to review, approve and monitor individual programs for management of inappropriate behavior and other programs that involve risks to client protection and rights were reviewed timely for one (Client #4) of four clients in the sample.

The finding includes:

On February 11, 2008 at 6:10 PM PM, the Licensed Practical Nurse (LPN) was observed to administer Client #4 Seroquel 100 mg mixed with applesauce. Interview with the nurse indicated the medication was prescribed for behavior. Record review revealed Seroquel 50 mg was prescribed on September 27, 2007 and had been increased to 100 mg QD in the evening.

Interview with the QMRP on February 12, 2008 revealed Client #4's Seroquel 50 mg was increased to 100 mg on October 19, 2007 due to his sleeplessness and maladaptive behaviors. Further interview with the QMRP however indicated that the increased dosage of this medication was not reviewed and approved by the HRC until November 29, 2007. The review of the HRC minutes dated November 29, 2007 confirmed that the Seroquel 100 mg was not reviewed and approved by the HRC prior to increasing the dosage of the medication.

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

PRINTED: 03/10/2008
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
	09G035		02/14/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CMS	3112 13TH STREET NW WASHINGTON, DC 20010

(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 322	483.460(a)(3) PHYSICIAN SERVICES	W 322		
	The facility must provide or obtain preventive and general medical care.			
	This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to provide preventive and general medical care for two (Clients #2, and #3) of the four clients in the sample.			
	The findings include:			
	1. Interview with direct care staff indicated that Client #3's fluid intake was being monitored due to his past history of excessive water consumption. The client had a consultation with the endocrinologist on May 24, 2007 and an MRI was conducted to rule out Diabetes Insipidus. During the Annual Medical Assessment dated October 5, 2007 the client's diagnoses included polydipsia which was determined to be likely related to his medication. The Primary Care Physician (PCP) recommended that the client have a hemoglobin A1C every six months. Further record review revealed the Hemoglobin A1C had been conducted on April 10, 2007 and on May 23, 2007. Interview with the QMRP and record review on February 13, 2008 failed to provide evidence that the hemoglobin A1C had been repeated since May 2007.		1. Client #3 will have a repeated hemoglobin A1C.	3/20/08
	2. The facility failed to ensure the preventive measures recommended by the podiatrist to address Client #3's toe maceration were implemented. [See W331,1]		2. Client #3 will be re-evaluated by his primary podiatrist.	3/29/08
	3. The facility failed to ensure follow-up on the			

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

PRINTED: 03/10/2008
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
	09G035		02/14/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CMS	3112 13TH STREET NW WASHINGTON, DC 20010

(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 322	Continued From page 12	W 322	3. Client #2 is now recieving a high fiber diet.	2/28/08
	gastroenterologist dietary recommendation for Client #2. Observation of Client #2 on February 11, 2008 at 7:52 AM revealed his front teeth were missing. During dinner he was observed to received a chopped diet. Interview with the QMRP on February 14, 2008 revealed Client # 2 had a routine screening colonoscopy on December 19, 2007. The review of the colonoscopy report revealed the client had small internal hemorrhoids. The gastroenterologist recommended that the client be provided a high fiber diet. Further record review revealed the client was prescribed Regular, Lactose Free - No dairy (Lactose Free Milk only), Chopped Diet. There was no evidence that the gastroenterologist's recommendation for the client to be provided a high fiber diet had been addressed.			
	4. The facility failed to ensure preventive measures to address Client #2's gradual weight loss. [See W460,1]		4. Cross reference W159	2/21/08
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide nursing services in accordance with the needs of of seven (Clients #1, #2, #3, #4, #5, #6, and #7) of seven clients residing in the facility. The findings include:	W 331		

PRINTED: 03/10/2008
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G035		02/14/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CMS	3112 13TH STREET NW WASHINGTON, DC 20010

(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 331	Continued From page 13	W 331		
	1. The facility's nursing services failed to ensure follow-up on the podiatrist recommendations for Client #3. Interview with the Qualified Mental Retardation Professional (QMRP) February 14, 2008 revealed Client #3 was being monitored regularly by the podiatrist for foot care. Record review revealed on November 3, 2007, the podiatrist diagnosed the client with a new finding of maceration in the web spaces of his feet. The podiatrist reported that the maceration was probably caused by moisture. Assisting the client in drying between his toes and foot powder were recommended to help prevent the problem. During a follow-up visit to the podiatrist on January 26, 2008 maceration in the third and fourth web spaces bilaterally were diagnosed. Drying between toes was again recommended. Interview with the QMRP on February 14, 2008 indicated she purchased foot powder for the client however the nurse indicated a different type of foot powder should be used and the purchased powder was not applied. Further interview with the QMRP indicated that the client did not receive foot powder as recommended by the podiatrist. There was no evidence the facility ensured that the client received treatment for the interdigital maceration as recommended in accordance with his assessed need.		1. Cross reference W322	3/29/08
	2. The facility's nursing services failed to investigate the origin of Client #4's injuries as evidences below: The review of an unusual incident report dated 8/8/07 revealed that Client #4 sustained a		2. Cross reference W149	3/28/08

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

PRINTED: 03/10/2008
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
	09G035		02/14/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CMS	3112 13TH STREET NW WASHINGTON, DC 20010

(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 331	Continued From page 14	W 331		
	abrasions on his right arm and right shin at 4:20 PM when he fell down the stairs. Although the client was referred to the nurse for assessment and was treated of his abrasions at 5:30 PM, the nurse indicated that he did not report the incident to the PCP because he was not informed that the client had fallen down the stairs. The review of the nursing progress notes indicated that the client's abrasions were treated daily and there was no explanation on how the abrasions occurred, The PCP documented on the incident during his admission assessment on August 15, 2007. There was no documented evidence that the PCP was informed of the client's fall until that date (8/15/07).			
	3. The facility's nursing services failed to ensure documentation was maintained in measurable terms on the self medication programs objectives for Clients #1, #2, #3, #6, and #7. [See W252]		3. Cross reference W252	3/28/08
	4. The facility's nursing services failed to timely acknowledge Client #4 admission to the group home. On February 11, 2008, at 7:45 AM Client #4 was observed in the group home. Interview with staff on this date at 8:50 AM revealed Client #4 was admitted to his present group home from another interagency group home on August 1, 2007, after he reached 21 years of age on July 31, 2007. Interview with the QMRP indicated that the client's admission was an emergency placement which was considered as a temporary placement. Record review revealed no assessment of the client's health care needs or progress notes at his new group home until August 8, 2007.		4. In the future the facility's nursing services will write an admission note the date of admission of the new client.	3/28/08

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

PRINTED: 03/10/2008
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
	09G035		02/14/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CMS	3112 13TH STREET NW WASHINGTON, DC 20010

(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 331	Continued From page 15	W 331		
	5. The facility's nursing services failed to coordinate nutritional follow-up as recommended by the Primary Care Physician (PCP) for Client #5's low body weight. The review of Client #5's monthly nursing assessments for the survey period revealed that he received a Low Fat, Low cholesterol chopped, double portion diet, but had no significant weight gain. The review of the client's nursing care plan revealed it did not include interventions to address his low body weight. Although staff indicated the client usually ate well, it could not be ascertained through interview and record review that documentation was available to verify his intake and the number of calories consumed. On December 28, 2007, the PCP recommended that the client be assessed by a nutritionist for his low body weight. There was no evidence the PCP's recommendation that the client be assessed by a nutritionist had been implemented. [See W460		5. Client #5 recieved an updated nutritional assessment.	2/26/08
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure comprehensive treatment services for the maintenance of dental health for one of the four clients in the sample. (Client #1) The findings include:	W 356	Client #1 recieved follow-up dental treatment for tooth #12 to be extracted, and scaling for removalof heavy calculus. Client #1 was not cooperative, and he has to be sedated at the request of the dentist.	3/5/08

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

PRINTED: 03/10/2008
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
	09G035		02/14/2008

NAME OF PROVIDER OR SUPPLIER: CMS

STREET ADDRESS, CITY, STATE, ZIP CODE: 3112 13TH STREET NW, WASHINGTON, DC 20010

(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 356	Continued From page 16	W 356		
	Interview with the QMRP on February 13, 2008 at 3:57 PM and revealed that Client #1 had been to the dentist several times, however was still waiting to be recalled by the dentist for treatment. The subsequent record review provided the following details regarding Client #1's dental recommendations and treatment. a. Client #1 had a dental recall examination on February 28, 2007. The dentist assessed heavy calculus deposits and missing teeth in the upper left quadrant. The client was recommended to have scaling and to be provided a partial denture. It was noted that the dentist would submit preauthorization to the funding agency for approval and would reschedule the client for treatment after the approval was received. b. Client #1 went to the dentist on July 16, 2007. The review of the consultation report revealed the client was diagnosed with gingivitis and a carious lesion of tooth #12. Gross scaling of all teeth, prophylaxis and polishing were recommended. It was also recommended that an appointment be scheduled for extraction of tooth #12 after the office reopened in September 2007. c. Client #1 went to the dentist again on January 29, 2008 for a dental recall examination. He was diagnosed with moderate calculus deposits and was recommended to return for scaling after the preauthorization was returned There was no evidence the client received the recommended gross scaling for removal of heavy calculus, dental treatment to relieve gingivitis or the extraction of tooth #12.		Client #1 will return to the dentist for dental follow-up.	3/26/08
W 418	483.470(b)(4)(ii) CLIENT BEDROOMS	W 418		

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

PRINTED: 03/10/2008
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
	09G035		02/14/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CMS	3112 13TH STREET NW WASHINGTON, DC 20010

(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 418	Continued From page 17	W 418	The facility will purchase Client #7 a new mattress.	3/28/08
	The facility must provide each client with a clean, comfortable mattress. This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure that one of the seven clients residing in the facility were provided with a comfortable mattress. (Client #7) The findings include: Observation of the environment was conducted with the Qualified Mental Retardation Professional on February 14, 2008 at approximately 1:35 PM. Client #7's bed mattress was observed to have palpable springs. There was no evidence that the client was provided with a comfortable mattress.			
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure devices and aids identified by the interdisciplinary team as needed by the client were maintained in good repair for one (Client #4) of four clients in the sample.	W 436	1. Cross reference W159 #2	3/19/08

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

PRINTED: 03/10/2008
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
	09G035		02/14/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CMS	3112 13TH STREET NW WASHINGTON, DC 20010

(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 436	Continued From page 18	W 436		
	The findings include:			
	1. During dinner on February 11, 2008 at approximately 5:15 PM Client #4 was observed to eat a finely ground mixed meal which was brown and very moist. The meal was served on a High Lo plate to which a plate guard was attached at the lower edge. The client was provided hand over hand assistance to eat his meal and was encouraged to drink his beverage from a cup with a straw. Interview with the Qualified Mental Retardation Professional (QMRP) revealed the Occupational Therapist (OT) conducted an assessment of the client's feeding skill on November 13, 2007 and recommended special equipment to enhance his independence in eating. A review of the OT assessment on February 12, 2008 revealed a recommendation for a Universal Cuff, plate guard, scoop dish, and special drinking cup. Interview with the QMRP and observation confirmed that the equipment had been received at the facility. Further interview with the QMRP however indicated that the Universal Cuff and the cup with spout were not being used by the client because the Speech Pathologist had not evaluated the recommended equipment as requested. At the time of the survey, there was no evidence that the use of the universal cuff and special cup recommended by the OT had been assessed by the Speech Pathologist for implementation.			
	2. Client #4 was observed to require close monitoring during ambulation due to his unsteady gait. Interview with the QMRP and record review revealed the client had a prescribed safety order to wear leg braces during waking hours.		2. Client #4 was reassess for two new pair of braces.	2/18/08

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

PRINTED: 03/10/2008
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
	09G035		02/14/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CMS	3112 13TH STREET NW WASHINGTON, DC 20010

(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 436	Continued From page 19	W 436		
	The review of Client #4's Annual Medical Assessment on February 12, 2008 at 3:50 PM revealed an order that he be assisted during ambulation and that he wear leg braces. The review of the client's Individual Habilitation Plan (IHP) dated June 13, 2007 revealed leg braces and a gait belt were recommended to ensure the client's safety during ambulation. Interview with the QMRP on February 12, 2008 indicated Client #4 was prescribed bilateral leg braces, however at the time of the survey the braces were broken. Further interview with the QMRP revealed that maintaining the braces in good condition had been a difficult. For example, the braces were at the vendor's being repaired when the client was admitted to the facility on August 1, 2007. The client received the repaired braces approximately three weeks after his admission to the facility. Afterwards, special shoes were purchased to fit over the client's leg braces. Record review revealed a September 17, 2007 Physical Therapy (PT) Assessment which stated the client had broken two pairs of leg braces. New braces were recommended. The PT further noted that the braces did not click properly. The QMRP indicated that the braces were sent back to the vendor for adjustment and were received by the group home approximately two weeks later. The QMRP reported that the client wore them with his special shoes until approximately the last week in January 2008, when the braces broke again. The QMRP revealed that the client had an appointment to be reassessed and fitted for new braces on February 18, 2008. At the time of the survey, however the braces were not available to			

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

PRINTED: 03/10/2008
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
	09G035		02/14/2008

NAME OF PROVIDER OR SUPPLIER: CMS

STREET ADDRESS, CITY, STATE, ZIP CODE: 3112 13TH STREET NW, WASHINGTON, DC 20010

(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 436	Continued From page 20	W 436		
	assist the client during ambulation.			
W 460	483.480(a)(1) FOOD AND NUTRITION SERVICES	W 460	Cross reference W159 $3	2/21/08
	Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.		Cross reference W331	2/26/08
	This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure therapeutic diets addressed the nutritional needs one (Client#5) of the seven clients residing in the facility.			
	The finding includes:			
	Facility failed to ensure that Client #5's intake of his prescribed diet met his assessed need for weight gain.			
	a. On February 11, 2008 at 8: 25 AM, revealed that Client #5 appeared to be underweight for his height. At 5:30 PM during the dinner meal, the client was observed to consume 100% of the chopped diet provided to him. At the end of the meal, he was offered 8 ounces of Ensure (nutritional supplement) of which he also consumed 100%.			
	Interview with the QMRP revealed the client had major surgery for removal of an esophageal mass approximately fourteen months prior to the this survey. Further interview with the QMRP revealed that although the client's appetite was good, he had not regained any of his weight since his readmission to the group home. The QMRP acknowledged that the client's weight loss was			

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

PRINTED: 03/10/2008
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
	09G035		02/14/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CMS	3112 13TH STREET NW WASHINGTON, DC 20010

(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 21	W 460		
	addressed by the interdisciplinary team (IDT) and it was determined that his caloric intake should be increased to promote a weight gain. The QMRP also indicated that the client received double portions. Direct care staff indicated that although the client was nonverbal, he was able to signal if he wanted more food. Staff reported that the client had a good appetite and received extra portions when he desired them. Interview with staff indicated the client also received 8 oz Ensure in the morning and after dinner. Both the QMRP and direct care staff indicated that the client usually ate well, however no food intake records were maintained for the client. The dietary list posted on the bulletin board in the kitchen states the client is to receive a Chopped, Low Fat, Low Cholesterol Diet. The physician's orders revealed that the client was prescribed a double portion Low Fat, Low Cholesterol Diet when readmitted from the hospital and had been prescribed to continue double portions of his diet since that time. For example, the review of the June 22, 2007 Annual Medical Assessment revealed a recommendation for a Low Fat, Low Cholesterol Heart Healthy, Double Portion Diet. It was recommended that the double portions be continued to increase the client's weight (from the 100 pounds) to within his ideal body weight (IBW). On September 10, 2007 the PCP provided a telephone order for the client to receive Ensure 1 can QD in the evening. Further record review revealed the PCP's current diet orders (dated) January 29, 2008 were for a Regular Chopped, Double Portion Low Fat , Low Cholesterol diet; Ensure 1 can QD in the evening. Interim orders were noted for November 30, 2007			

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

PRINTED: 03/10/2008
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
	09G035		02/14/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CMS	3112 13TH STREET NW WASHINGTON, DC 20010

(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 22 and December 19, 2007 to provide 8 oz Ensure BID. b. The review of the Quarterly nutritional assessment dated March 15, 2007 revealed the client had lost four pounds. The nutritionist also recommended the client's weight increase to his IBW (119 - 125 pounds) prior to his hospitalization. The nutritionist further recommended a Low Fat, Low Cholesterol, extra portions diet and that supplemental feedings be offered if the intake of diet was poor. The Annual Nutritional Assessment dated August 20, 2007 revealed the client was 5 feet, 1/2 inch tall and weighed 98 pounds (IBW: 124 to 130 pounds). According to this assessment, the weighed 107 pounds when he was discharged from the hospital on 1/10/07. A Low Fat, Low Cholesterol, Chopped Diet, extra portions if desired were recommended. Monitoring of intake and recordation of weights was recommended. The review of Client #5's Quarterly nutritional assessment dated November 15, 2007 revealed the client weighed 98 pounds and that his IBW was decreased by 5 pounds and from his Annual Assessment to 119 to 125 pounds. At that time is was recommended that the client's weight be monitored and recorded monthly. It was also recommended that the Low Cholesterol Diet with extra portions be continued and that a supplemental feeding be offered if dinner intake was poor. c. Record review revealed the following weights: 3/07 - 102 pounds; 4/07 - 100 pounds; 5/07 - 98 pounds; 6/07 - 100 pounds; 7/07 - 98 pounds; 8/07 - 97.6 pounds; 9/07 - 99 pounds; 10/07 - 98	W 460		

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

PRINTED: 03/10/2008
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
	09G035		02/14/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CMS	3112 13TH STREET NW WASHINGTON, DC 20010

(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 23	W 460		
	pounds; 11/07 -98 pounds; 12/07-98 pounds; 1/08 -99 pounds			
	Although monthly weight had been recorded by the facility, there was no documented evidence that the client's intake had been closely monitored to determine its adequacy to promote the recommended weight gain. Additionally, record review on February 14, 2008 9:37 AM revealed a progress note by the PCP dated December 28, 2007 which recommended that Client #5 be followed up by the nutritionist due to his low body weight. At the time of the survey, there was no evidence that the recommended follow-up for low body weight had occurred.			
W 474	483.480(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, staff interviews and record review, the facility failed to ensure each food was provided in the prescribed texture for one (Client #4) of the four clients in the sample. The findings include: During dinner on February 11, 2008 at approximately 5:15 PM Client #4 was observed to eat a finely ground mixed brown meal which was very moist. Interview with staff indicated that the food was a ground beef and macaroni with tomato casserole, green beans, and bread. Staff indicated the food is ground up because the client must be monitored for eating rapidly and to minimize the risk of choking.	W 474	Cross reference W159, #1	3/19/08

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

PRINTED: 03/10/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/14/2008

NAME OF PROVIDER OR SUPPLIER: CMS

STREET ADDRESS, CITY, STATE, ZIP CODE: 3112 13TH STREET NW, WASHINGTON, DC 20010

(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 474	Continued From page 24	W 474		
	The review of the list of diets on the bulletin board indicated the client is to receive a Regular, Chopped High Calorie Diet. The Assisted Feeding Protocol dated November 11, 2007 developed for Client #4 by the Speech and Language Pathologist consultant reflected that the client should receive a Mechanical Soft, Double Portion Diet. Physician's orders throughout the survey period prescribed a Regular, High Calorie Diet. The review of the Annual Nutritional Assessment dated 6/13/07, which was transferred with the client to his new group home indicated that the client received a High Calorie, chopped Diet. The review of the Nutritional Assessment Update dated November 2007 (day unspecified) indicated the client was to receive a Regular, high Calorie, Mechanical Soft, Double Portion Diet. Monthly nursing assessments conducted by the primary Registered Nurse since the client's admission to the facility stated the dietary order was Regular, high calorie (no texture modification is included). Interview with the classroom instructor and the school nurse indicated that the client's aforementioned Eating Protocol developed by the Speech and Language Consultant for the group home was brought to the Individualized Education Plan (IEP) conference by the QMRP on November 16, 2007 due to his difficulty eating at home. During the IEP, the school Occupational Therapist recommended that the Universal Cuff, scoop dish and several adaptive utensil be tried with the client. The IEP indicated that the client had no problems eating hard (regular) food at school. The QMRP gave the school SLP permission to confer with the Speech and			

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

PRINTED: 03/10/2008
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
	09G035		02/14/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CMS	3112 13TH STREET NW WASHINGTON, DC 20010

(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 474	Continued From page 25	W 474		
	Language Consultant for the group home concerning the client's dietary texture. The school SLP indicated that a conversation had occurred concerning the diet texture, however the school and the group home had not come to a consensus on the appropriate texture for the client. Interview with staff at the client's school on February 12, 2008 revealed that he continued to received regular textured food with monitoring of tolerance by his 1:1 staff during meals. According to the client's Individual Habilitation Plan (IHP) dated June 13, 2007 which was conducted prior to his discharge from his previous group home on July 31, 2007, the client was prescribed a regular chopped diet. Further review of the IHP revealed that his his strengths included being able to feed himself finger foods and being able to drink from a cup with a lid. The IHP identified a need to develop feeding skills. At the time of the survey, there was no evidence the interdisciplinary team (IDT) had collaborated to ensure that Client #4's food was served in a texture that most effectively addressed his developmental level.			

PRINTED: 03/10/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/14/2008
NAME OF PROVIDER OR SUPPLIER: CMS	STREET ADDRESS, CITY, STATE, ZIP CODE: 3112 13TH STREET NW WASHINGTON, DC 20010		

(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) COMPLETE DATE
I 000	INITIAL COMMENTS	I 000		
	A relicensure survey was conducted from February 11, 2008 through February 14, 2008. The survey was initiated using the fundamental survey process. A random sampling of four clients was selected from a residential population of seven males with various disabilities. The findings of the survey were based on observations, interviews with staff in the home and three day programs, as well as a review of client and administrative records, including incident reports.			
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, interview and record review, the GHMRP failed to ensure the interior and exterior of each GHMRP were maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. The findings include: Basement:	I 090		
	1. Screeching sound heard which was noted to be coming from the dryer during operation.		1. Dryer was replaced.	3/6/08
	2. An accumulation of dust was observed behind the radiator in the laundry room.		2. Dust will be removed from behind the radiator in the laundry room.	3/28/08

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Constance A. Reese

TITLE: Program Director

(X6) DATE: 3/19/08

STATE FORM 6899 JIUL11

PRINTED: 03/10/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/14/2008
NAME OF PROVIDER OR SUPPLIER CMS	STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010		

(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) COMPLETE DATE
L090	Continued From page 1	L090		
	3. Carpet installed in the hallway of the basement was not secured at the doorway between the laundry room and the hallway. The strip to secure the carpet to the floor was partially detached. These created potential trip hazards.		3. Carpet in hallway of basement will be repaired.	4/4/08
	4. The shower located in the basement bathroom was observed to have several unsecured ceramic tiles on the wall, near the floor.		4. Ceramic tiles in the basement bathroom will be repaired.	4/4/08
	5. The protective covering for ceiling fan in the basement bathroom was observed to hang approximately one inch below the ceiling.		5. Ceiling fan in basement bath-room will be repaired.	4/4/08
	First Floor: 1. The vinyl floor covering which was stapled to the stairs leading to the basement was not tightly secured to the floor at the top stem, which created a potential trip hazard.		1. The vinyl floor covering stapled to basement steps will be repaired.	4/4/08
	2. A hole was observed in back of the cabinet underneath the sink, directly beside the dishwasher. The hole was approximately 1/2 inch by 2 inches in size.		2. The hole in back of cabinet under kitchen sink will be repaired.	4/4/08
	3. A large wet area was observed on the bottom of the cabinet located underneath the sink.		3. The leak will be repaired under the kitchen sink.	4/4/08
	4. A section approximately 3" by 1" in size was observed to be missing from the corner of one of the floor tiles near the kitchen sink.		4. The floor tile will be replaced near the kitchen sink.	4/4/08
	5. The light bulb was not operable underneath the right side of the range hood above the range in the kitchen.		5. A light bulb will be replaced underneath the right side of the range hood.	4/4/08
	6. The cover of the meat storage pan in the refrigerator was missing. The handle of the left produce storage pan broken and covered with tape		6. New storage pans will be purchased.	4/4/08

PRINTED: 03/10/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/14/2008
NAME OF PROVIDER OR SUPPLIER CMS	STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010		

(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) COMPLETE DATE
I 090	Continued From page 2	I 090		
	7. The radiator covers in the hallway had nail heads that protruded from the edge of the furring strips which secured the screen in place. Two torn areas were observed in the metal screen in the same radiator cover.		7. The covers on the radiator will be replaced.	4/4/08
	8. No toilet tissue holder observed in the bathroom and no paper towel holder was available in the first floor bathroom.		8. Toilet tissue holders will be put in bathrooms and a paper towel holder in the first floor bathroom.	4/4/08
	9. The vinyl covering on the seat of a chair had multiple torn areas. The chair was observed at the small table located in the dining room throughout the survey.		9. The seat of the chair will be repaired.	3/28/08
	10. Three large brown stained areas were observed on the ceiling in the dining room. The areas measured approximately 4 feet by 8 inches, 2 feet by 1 foot, and 2 feet by 6 inches.		10. The ceiling tiles will be replaced.	4/4/08
	11. The door of the bathroom located on the first floor was observed to have space (approximately 1/4 inch) between the door and the frame, permitting the interior to be visible, and therefore did not allow for privacy.		11. The first floor bathroom's door will be repaired.	4/4/08
	Second and third floors 1. Several cracked and loose tiles were observed on the floor in the second floor hallway.		1. The tiles will be replaced.	4/4/08
	2. The lamps were observed to be inoperable in all four bedrooms in the facility. Further inspection of the lamps in the clients' bedrooms revealed they lacked working light bulbs. Interview with the QMRP revealed that the light bulbs are usually replaced by the maintenance staff and that only a few are left in the home.		2. Light bulbs will be placed in the lamps.	3/28/08
	3. Client #7's headboard was observed to be		3. The metal spindle will be replaced on the headboard of Client #7.	4/4/08

PRINTED: 03/10/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 02/14/2008
NAME OF PROVIDER OR SUPPLIER CMS	STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010		

(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) COMPLETE DATE
I 090	Continued From page 3	I 090		
	made of metal. The metal spindle was missing from the right side of the headboard.			
	4. The shelves were broken from Client #1's and #3's shoe storage units.		4. The shelves will be removed from Client #1 and #3 shoe storage unit.	4/4/08
	5. The radiator cover in Client #5's bedroom was observed to have one of the furring strips missing which secured the metal screen in place..		5. The radiator cover in number #5 room will be replaced.	4/4/08
	6. No toilet paper holder in the bathroom.		6. Toilet paper holder will be replaced in the bathroom.	3/28/08
	7. A circular hole approximately 2 inches in circumference was observed in the wall in the second floor hallway.		7. The circular hole will be repaired.	4/4/08
	Exterior 1. Several torn areas were observed in the carpet installed on the steps leading to the front porch, which created a potential hazard.		1. Front steps carpet will be repaired.	3/28/08
	2. A torn area was observed in the carpet where back porch is attached to the first step, which created a potential hazard.		2. Torn carpets on the back porch will be repaired.	4/4/08
	3. The GHMRP failed to have an effective program for trash collection and removal from the premises.		3. The group home will purchase additional cans.	3/28/08
	On the February 11, 2008 at 4:25 PM staff informed Client #3 that it was time for him to take out the trash. The staff and the client were observed going to the trash storage area in the back yard carrying a large garbage bag. Upon arrival, two large covered trash cans were observed beside the fence. Two additional large bags of trash were on top of the covered cans. Staff indicated that the cans were already full of garbage. The bag of garbage which was taken out side by the client was then placed on top of			

PRINTED: 03/10/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/14/2008
NAME OF PROVIDER OR SUPPLIER C M S	STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010		

(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) COMPLETE DATE
I 090	Continued From page 4	I 090		
	the others. Six trash can lids were observed on the ground at the other side of the back yard. Interview with the Qualified Mental Retardation Professional on February 12, 200 at 1:20 PM revealed that the city garbage collection occurs every Tuesday. There was no evidence the facility had developed and implemented an effective plan to ensure that garbage was stored in a sanitary manner between the scheduled days of collection.			
I 093	3504.4 HOUSEKEEPING Each GHMRP that is cited by the Department of Consumer and Regulatory Affairs for violation of § 3504.3 shall contract with a licensed exterminator within seventy-two hours (72 hrs.) of receipt of written notice to provide for elimination of any infestation. This Statute is not met as evidenced by: The GHMRP that is cited by the Department of Consumer and Regulatory Affairs for violation of § 3504.3 shall contract with a licensed exterminator within seventy-two hours (72 hrs.) of receipt of written notice to provide for elimination of any infestation. The finding includes: On the February 11, 2008 at 4:30 PM, while in the back yard with staff and Resident #3 who were taking out the trash, the surveyor observed a large black box on the ground. The box was located approximately five feet from a large tree.	I 093	Cross reference W104	3/28/08

PRINTED: 03/10/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/14/2008
NAME OF PROVIDER OR SUPPLIER CMS	STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010		

(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) COMPLETE DATE
I 093	Continued From page 5	I 093		
	A large hole was observed in the ground at the trunk of the tree. Raised areas of broken pavement and holes underneath were observed near the steps leading to the porch. Staff indicated the black box had been placed in the yard at some time in the past by the exterminator. Interview with staff indicated rats were often observed in the back yard. On February 14, 2008 the QMRP stated that the exterminator had come to the facility and showed two invoices for 2007. The review of extermination invoices revealed none were available to show evidence that the facility/premises had been treated recently for mice, rats or other rodents. The extermination contract and recent invoices were requested from the administrative office on February 14, 2008, however was not provided. The QMRP informed the surveyor that the contract would be later faxed to Department of Health. At the time of the survey, there was no documented evidence that the GHMRP had a contract with a licensed exterminator.			
I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP's governing body failed to provide general operating direction over the facility. The findings include:	I 180	Cross reference W104	3/3/08

PRINTED: 03/10/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/14/2008
NAME OF PROVIDER OR SUPPLIER CMS	STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010		

(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) COMPLETE DATE
I 180	Continued From page 6	I 180		
	1. The GHMRP failed to implement timely measures to minimize Resident #4's frequent tardiness and absence from school. On February 11, 2008 at 7:45 AM a nurse was observed administering medications to the residents. Interview with the nurse indicated that she was a little late. Several vans were observed to come to the facility to pick up the residents and transport them to their respective day programs, however Resident #4 remained at the GHMRP. Interview with staff indicated Resident #4's school bus comes early to transport him and that he did not ride on the bus because he had not taken his medications. At approximately 9:15 AM, the resident were observed to leaving the house with an agency transportation staff. Interview with with the QMRP on February 11, 2008 at 3:40 PM revealed Resident #4 returned to the group home from school at approximately 1:00 PM because it was only open for a half day. The resident's 1:1 staff and teacher's assistant at school on February 12, 2008 revealed the resident arrived at 11:26 AM on February 11, 2007. The staff reported that since the resident moved to his current group home on August 1, 2007, he had been often tardy or absent. Staff indicated that the resident sometimes missed his outings in the community due to his late arrival. The attendance records revealed that the resident usually arrived between 11:00 AM to 11:30 AM on the days that he was tardy. Further review of the attendance records revealed the resident had arrived late 23 times and had 11 unexcused absences since school started on August 30, 2007. Interview with the nurse at the day program			

PRINTED: 03/10/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/14/2008
NAME OF PROVIDER OR SUPPLIER CMS	STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010		

(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) COMPLETE DATE
I 180	Continued From page 7	I 180		
	indicated the school had offered to administer Resident#4's AM Medication to ensure that he arrived at school on time. Further interview with both the staff at the resident's school staff and the Qualified Mental Retardation Professional (QMRP) revealed that this arrangement had been discussed however was not implemented because the group home decided to arrange for the resident to receive his AM medications by the time the bus arrived to transport him to school. There was no evidence that the GHMRP arrangements had been implemented to improve the resident's school attendance. 2. The facility failed to orient staff timely to ensure Resident #4's health and safety needs prior to transferring him to his present group home. Interview with staff on February 11, 2008 at 8:50 AM revealed Resident #4 was admitted to his present group home from another interagency group home on August 1, 2007, after he reached 21 years of age on July 31, 2007. Interview with the QMRP indicated that the resident's admission was an emergency placement which was considered as a temporary placement. The QMRP indicated that the resident came to the group home for dinner and an overnight visit prior to his transfer. Interview with the QMRP revealed that the resident was transferred to his present group home on in emergency status due to his projected bed becoming unavailable. Further interview with the QMRP also revealed the draft of the resident's Individual Habilitation Plan (IHP), conducted on June 13, 2007 was provided to his new group home at the time of his transfer. A review of the resident's records was conducted		Cross reference W331 #4	3/28/08

PRINTED: 03/10/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/14/2008
NAME OF PROVIDER OR SUPPLIER C M S	STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010		

(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) COMPLETE DATE
I 180	Continued From page 8	I 180		
	on February 12, 2008. This review revealed a QMRP progress note dated August 1, 2007 acknowledging the resident's admission to his present group home. Review of the IHP revealed the resident should wear leg braces and wear a gait belt to ensure his safety during ambulation. Further record review however revealed no progress note by any other professional regarding the resident's health and safety needs until 8/8/07. It should be noted that Resident #4 sustained a fall down the basement steps on August 8, 2007. Comprehensive training/orientation to the resident was not provided to staff until August 17, 2007, two weeks after his admission to the facility. There was no evidence the facility was provided a comprehensive transition plan for Resident #4 prior to his admission to his new group.			
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure a continuous, ongoing in-service training program to diirect care staff in accordance with Individual Support Plan recommendations. The findings include: 1. The facility failed to ensure that staff was provided training in sign language skills as recommended by the Individual Support Plans of Residents #1 and #3. Observation of Residents #1 and #3 on February 11, 2008 at 8:10 AM while they were preparing to	I 222	1. The facility will provide sign language training for residents #1 and #3.	3/19/08

PRINTED: 03/10/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/14/2008
NAME OF PROVIDER OR SUPPLIER CMS	STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010		

(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) COMPLETE DATE
I 222	Continued From page 9	I 222		
	leave for their day programs revealed they did not clearly respond when staff was spoke to them. Interview with staff indicated both residents were able to comprehend when verbally prompted to participated in their activities of daily living, however were also able to understand sign language. Interview with the QMRP on February 13, 2008 at 1:13 PM indicated staff had been trained in sign language in the past however had no training had been provided in sign language during the last twelve months. a. Interview with staff at 5:40 PM on February 11, 2008 indicated that Resident #1 has a program objective to learn the sign language for eat, drink, walk and bathroom. Record review revealed the Individual Support Plans for Resident #1 dated December 14, 2007 indicated that training in sign language should be conducted annually to staff working with the resident. b. The review of the Resident #3's ISP dated December 13, 2007 also documented that sign language training should be provided at least annually to staff working with him. Further review of the ISP revealed the resident is non-verbal, has good language comprehension skills, knows many signs and is able to communicate basic needs using sign language and gestures. The review of staff training records failed to provide evidence that sign language training had been provided to staff in accordance with the ISP recommendations for Residents #1 and #3. 2. The GHMRP failed to ensure training on the use of manual restraints (MANDT) was current. Interview with the QMRP on February 13, 2008 at approximately 2:15 PM revealed that Resident #1 had a Behavior Support Plan (BSP which		In the future the GHMRP will provide training on the use of manual restraints(MANDT).	4/4/08

PRINTED: 03/10/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/14/2008
NAME OF PROVIDER OR SUPPLIER CMS	STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010		

(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) COMPLETE DATE
I 222	Continued From page 10	I 222		
	included the use of manual restraints. According to the approved BSP dated 11/26/07, if the resident "does not respond to redirection or the use of safety zone and touch control, and there is imminent danger that he will harm another person or himself, then staff may consider using manual restraint....." The review of training records on February 13, 2008 revealed that MANDT certificates expired on December 4, 2007. There was no evidence all staff were trained on all approved interventions in Resident #1's BSP. 3. The facility failed to ensure that staff was provided effective training on policies and procedures governing incident management and the use of Resident #4's adaptive equipment (gait belt and leg braces) to ensure his safety while ambulating. See Federal Deficiency Report - Citation W189		Cross reference W189	3/19/08
I 357	3518.4(c) DISCHARGE / TRANSFER POLICIES PROCEDURES Each GHMRP shall plan for voluntary or involuntary transfer or discharge of a resident on a non-emergency basis and shall provide the following: (c) Identification of the resident ' s needs and the corresponding services and programming required in the new setting; and... This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to identify Resident #4's needs and the corresponding services and programming required in his new setting. The findings include:	I 357	Cross reference W331 #4	3/28/08

PRINTED: 03/10/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/14/2008
NAME OF PROVIDER OR SUPPLIER C M S	STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010		

(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) COMPLETE DATE
I 357	Continued From page 11	I 357		
	The GHMRP failed failed to ensure a post discharge plan of care was provided timely to assist Resident #4 to adjust to his new living environment. Interview with direct care staff on February 11, 2008 at 9:00 AM revealed that Resident #4 was transferred to the group home on August 1, 2007 as an emergency placement. Further interview with the QMRP indicated that the resident had been transitioned to go to another group home, however was unable to relocate there because the anticipated vacancy did not occur. The QMRP indicated that Resident #4 came for dinner, spent a night and then moved into his present group home as an emergency placement. The move to his current facility was intended to be temporary however had already extended to seven months Interview with the QMRP indicated that a date had not been determined for the resident to move from his current facility. The QMRP indicated that the social worker did an assessment on the resident prior to his discharge from the previous group home. No previous transition plan from the other facility was available and that no transition plan had been done for the resident prior to the transfer to his current home. Record review the resident was 21 years of age on July 21, 2007 and had reached the maximum allowed age in his previous group home. A summary completed by the social worker dated July 10, 2007 was noted which recommended the resident be transferred to an ICFMR. The psychological assessment dated June 12, 2007 recommended that the resident's residential placement be continued in a facility with 24 hour supervision.			

PRINTED: 03/10/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/14/2008
NAME OF PROVIDER OR SUPPLIER C M S	STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010		

(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) COMPLETE DATE
I 357	Continued From page 12	I 357		
	Further record review revealed that after the resident's admission to the his present group home on August 1, 2007, the QMRP wrote a progress note acknowledging his admission to the GHMRP. No nursing progress notes were observed in the record until August 8, 2007, when the nurse began to document on the resident's abrasions reported to have been sustained during a fall. An assessment was conducted by the Primary Care Physician (PCP) on August 15, 2007 by the primary care physician. The review of training records revealed staff at the current facility were not provided a comprehensive orientation to the resident's active treatment and health care needs until August 17, 2007. There was no evidence the resident was provided a comprehensive post discharge plan of care from his previous group home prior to his transfer to a new group home.			
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview and record verification, the GHMRP failed to ensure professional services were provided timely for seven (Residents #1, #2, #3, #4, #5, #6 and #7) of the seven residents in the GHMRP. The findings include: 1. The GHMRP failed to provide preventive and	I 401		

PRINTED: 03/10/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/14/2008
NAME OF PROVIDER OR SUPPLIER CMS	STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010		

(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) COMPLETE DATE
I 401	Continued From page 13	I 401		
	general medical care for Residents #2 and #3. [See Federal Deficiency Report - W322]		1. Cross reference W322 #3	2/28/08
	2. The GHMRP failed to provide nursing services in accordance with the needs of seven (Residents #1, #2, #3, #4, #5, #6, and #7) of seven Residents residing in the GHMRP. [See Federal Deficiency Report - W331]		2. Cross references #, W322, #2, W159, #3, W252, #4, W331	3/28/08
	3. The GHMRP failed to ensure dental treatment services in accordance with the needs of Resident #1. [See Federal Deficiency Report - W356]		3. Cross reference W356	3/26/08
	4. The GHMRP failed to ensure therapeutic diets addressed the nutritional needs of one (Resident #5) of the seven residents residing in the GHMRP. See Federal Deficiency Report - W460]		4. Cross reference W159 #3, and W331	2/21/08
	5. The GHMRP failed to the dietary texture needs were addressed for one (Resident #4) of seven residents in the GHMRP [See Federal Deficiency Report - W474]		5. Cross reference W159 #1	3/19/08
	]			
I 422	3521.3 HABILITATION AND TRAINING	I 422	Cross reference W252	3/28/08
	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 observation, interview and record review, the GHMRP failed to ensure that training provided to Residents #1, #2, #3, #6 and #7 to increase their independence in self medication			

PRINTED: 03/10/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/14/2008
NAME OF PROVIDER OR SUPPLIER CMS	STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010		

(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) COMPLETE DATE
I 422	Continued From page 14	I 422		
	was documented. The finding includes: During medication administration on February 11, 2008 between the hours of 6:19 PM and 6:45 PM, Residents #1, #2, #3, #6, and #7 were observed to assist the nurse in the administration of their medications. Interview with the QMRP on February 12, 2008 at approximately 12: 15 PM revealed the aforementioned five residents had self medication assessments and were being provided training to participate in self medication programs to the extent of their capability. Further interview with the QMRP revealed that the nurse maintained the documentation on the residents' self medication programs. Verification of the Medication Administration Record (MAR) after the self medication programs were implemented revealed the data collection forms for February 2007 lacked any data for the month prior to February 11, 2008. The review of the MAR policy on 2/12/08 at 12:10 PM revealed if a resident is on self medication training program, the nurse should document two times a week. There was no evidence the implementation of the self medication objectives were documented in measurable term by the nurse during February 2008.			
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	I 500		

PRINTED: 03/10/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/14/2008
NAME OF PROVIDER OR SUPPLIER CMS	STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010		

(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) COMPLETE DATE
I 500	Continued From page 15	I 500		
	laws. This Statute is not met as evidenced by: Based on on observation, interview and record review, the GHMRP failed to ensure that the rights of each resident were protected in accordance with D.C. Law 2-137, this chapter and other applicable laws. The findings include: See Federal Deficiency Report - Citation W104, W262, W322, W331, W356, W418, W460, and W474		Cross reference W104 Cross reference W262 Cross reference W322, #1, #2, and #3 Cross references W322, W149, W252 and W331 Cross reference W356 Cross reference W418 Cross references W159 #3 Cross reference Cross reference W159 #1	3/3/08 3/28/08 3/20/08 3/28/08 3/28/08 3/26/08 3/5/08 3/28/08 2/21/08 2/26/08 3/19/08