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

PRINTED: 05/20/2008
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
	09G062		05/08/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CMS	6300 9TH STREET NW WASHINGTON, DC 20011

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W 000	INITIAL COMMENTS	W 000		
	This re-certification survey was conducted from May 7, 2008 through May 8, 2008. The survey was initiated using the fundamental survey process, however, it was necessary to extend the survey process under the conditions of ActiveTreatment and Client Behavior and Facility Practices. Six female clients, with varying degrees of disability, reside in this facility. Three of the six clients were randomly selected for the sample. The findings of the survey were based on observations at the group home and two day programs, interviews with direct care staff in the residence and the group home, and the review of the administrative records including the facility's incident management system.			
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on interviews with direct care staff, and the review of records, the facility's governing body failed to provide general operating directions over the facility as evidenced by the following: The finding includes: 1. The governing body failed to ensure that the agency's infection control policy and procedures were implemented. [See W454] 2. The governing body failed to ensure that the Qualified Mental Retardation Professional	W 104	1.Cross reference W189 2. The QMRP recieved training from Program Director. In the future	5/9/08

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DEPARTMENT OF HEALTH
HEALTH REGULATION
ADMINISTRATION
2008 MAY 30 P 4: 22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Constance A. Reese TITLE: Program Director (X6) DATE: 5/30/08

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

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W 104	Continued From page 1 (QMRP) had been adequately trained to coordinate services according to each client's needs. [See W159]	W 104	the QMRP will meet w/Program Director for monthly training.	5/19/08
	3. The governing body failed to ensure that the facility's incident management system was effective. [See W154]		3. Cross reference W154	5/12/08
W 114	483.410(c)(4) CLIENT RECORDS Any individual who makes an entry in a client's record must make it legibly, date it, and sign it. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the annual self-medication assessments were signed by the nurse for two of three clients included in the sample. (Clients #1 and #3) The findings include: 1. Review of Client #1's medical records conducted on May 8, 2008 at approximately 12:27 PM revealed a self-medication assessment dated March 25, 2008 revealed that this assessment had not been and dated by the nurse. Interview with the facility's Registered Nurse (RN) on the same day at 2:30 PM revealed her acknowledgement that she was the responsible person for signing and dating the self-medication assessment. 2. Review of Client #3's medical records conducted on May 8, 2008 at approximately 11:20 PM revealed a self-medication assessment dated March 25, 2008 revealed that this assessment had not been and dated by the nurse. Interview with the facility's Registered Nurse (RN) on the	W 114	Cross reference W331	5/30/08

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W 114	Continued From page 2 same day at 2:33 PM revealed her acknowledgement that she was the responsible person for signing and dating the self-medication assessment.	W 114		
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 staff interview and record review, the facility failed to ensure that all injuries of unknown origin and serious unusual incidents were reported immediately to the governmental agencies as required by DC regulation (22 DCMR Chapter 35 Section 3519.10) The findings include: The review of the facility's unusual incident reports and interview with the Qualified Mental Retardation Professional (QMRP) on May 8, 2008 at 1:30 PM, revealed the facility failed to report the following incident(s) to the governmental agency: An unusual incident report, dated February 12, 2008 Client #2 was observed with a laceration of unknown origin on her right leg.	W 153	The incident report for Client #2 was submitted to HRA on 02/14/08; however in the future, all incidents that occur will be reported to the governmental agencies within 24-hours or the next business day.	5/14/08
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged	W 154		

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W 154	Continued From page 3 violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure all unusual incidences of injuries of unknown origin were thoroughly investigated. The findings include: The facility failed to ensure that Client #2's injury of unknown origin (laceration to the right leg) was investigated. [See W153]	W 154	The investigation for Client #2's injury was completed by residential manager.	5/12/08
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 interviews with the Qualified Mental Retardation Professional (QMRP) and record review, the QMRP failed to ensure integration, coordination and monitoring of client's active treatment regimen. The findings include: 1. The facility's QMRP failed to ensure that Client #1's needs were met as evidenced below: Interview with the QMRP on May 7, 2008 at approximately 3:45 PM revealed that Client #1 had a new behavior of refusing instructions and non-compliance to directives which had become a barrier to her active treatment and medical services. In the past three months, according to	W 159	1. The QMRP met with the IDT team to discuss Client #1's new behavior of refusing to attend the Day Program. In the future, the QMRP will schedule a case conference whenever a new behavior is exhibited by any of the individuals.	5/15/08

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W 159	Continued From page 4 the QMRP, this behavior had increased. Reportedly, interview and record review revealed the only intervention to address this behavior was an increase of the client's psychotropic medication (Topamax 300 mg BID to Topamax 400 mg BID); however, Client #1's refusals continued to increase after the medication increase. The medical records, behavior support documentation, and Human Rights Committee minutes did not evidence that the QMRP had informed the Interdisciplinary Team of the emergence of Client's #1's new behavior. 2. The facility's QMRP failed to ensure that Client #1 was provided consistent day program active treatment services as evidenced below: On May 8, 2008 at approximately 10:10 AM interview with the day program case manager revealed that Client #1 had not been in attendance at the day program from the period May 5th through May 7th. Further interview revealed that the day program had not been notified as to reason the client had not been attending the day program. Reportedly, the client regularly attends the day program a total of twenty days per month. Review of the Client #1's day program Individual Program Plan documentation confirmed that Client #1 had missed a large percentage of her day program active treatment for the past three months as evidenced below: April 11 days missed over 50% attendance	W 159	2. The QMRP will instruct the 1:1 staff of Client #1 to document when she refuses to go to the day program. The QMRP will monitor to ensure that any future behavior changes are documented.	5/16/08

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W 159	Continued From page 5 March 7 days missed over 25% attendance February 7 days missed over 25% attendance On May 8, 2008 at 2:30 PM, interview with the Qualified Mental Retardation Professional (QMRP) revealed that Client #1 was refusing to get off the van on several occasion when arriving at the day program and Client #1 was refusing to leave the group home to go to the day program. According to the QMRP this was a new behavior which had increased in the last three months. Further interview with QMRP revealed that the client had some changes in her medication regimen. Reportedly the QMRP revealed that the client was refusing to eat and to got to medical appointment as well. The QMRP further indicated that the IDT team had not been made aware that Client #1's refusal of instructions and non-compliance behavior was becoming a barrier to her receiving consistent active treatment interventions. It should be further noted that the QMRP was unable to provide consistent behavior data on the client refusals and/or an alternative activity schedule for Client #1 when she refuses to go to her day program. There was no evidence that the QMRP had informed the interdisciplinary team (IDT) of the client's new behavior of refusals to attend the day program. 3. The QMRP failed to ensure that each employee had been provided with adequate	W 159	3. Cross reference W189	5/9/08

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W 159	Continued From page 6 training that enables the employee to perform his or her duties effectively, efficiently and competently. [See to W189]	W 159		
	4. The QMRP failed to ensure that an alternative schedule of activities was established for Client #1. [See W250]		4. A day program schedule was implemented for Client #1 when she refuses to go to the day program.	5/16/08
	5. The QMRP failed to ensure that Client #1's new behaviors was assessed. [See W212]		5. A functional analysis was conducted by behavioral specialist to address Client #1's new behavior of refusing to attend the day program.	5/20/08
	6. The QMRP failed to ensure that incidents of unknown origin were investigated according to the agency's policies. [See W154]			
W 189	483.430(e)(1) STAFF TRAINING PROGRAM	W 189		
	The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.			
	This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that each employee had been provided with adequate training that enables the employee to perform his or her duties effectively, efficiently and competently.			
	The findings include:			
	1. The facility staff failed to ensure that infection control practices were implemented in accordance with the agency policy and procedures. (See W454)		1. The staff recieved infection control training by RN.	5/9/08
	2. The facility failed to ensure that the direct care staff implemented Client #1's BSP as evidenced			

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W 189	Continued From page 7 below: On May 7, 2008 at approximately 6:03 PM, observation of the meal and interview with the QMRP revealed that Client #1 has a rumination behavior. Further observation of the meal revealed that the QMRP removed the client's cup from the table prior to Client #1 beginning her meal. At no time throughout the meal did the QMRP return the cup of fluids to the table for the client to have an opportunity to drink. At the end of the meal the one on one staff provide Client #1 with all of her fluids at the same time. The one on one staff commented " [the client] is ruminating". Further interview with the QMRP who indicated that Client #1 had rumination behavior during her lunch. Review of the Nutritional Assessment 1/3/08 recommended as part of the nutritional intervention plan, Client #1 was to "Sip liquids between bites to slow eating pace". Additionally, the nutritionist indicated that providing fluids throughout the meal would decrease the client's opportunity for the rumination behavior. 3. The facility staff failed to ensure that direct care staff encouraged Client #1 to use her adaptive equipment in accordance with her needs. [See W436]	W 189	2. The staff will recieve BSP training by behavior specialist in order to ensure proper implementation of BSP. The nutritionist will revise her recommendation for Client#1 regarding her liquid intake to match that in Client#1's BSP. In the future, QMRP will communicate quarterly w/ consultants to ~~ensure that~~ all assessments are consistent with each other. 3. The staff will recieve training on Client#1's adaptive equipment use program by behavior specialist.	6/6/08 5/28/08 6/6/08
W 212	483.440(c)(3)(i) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the presenting problems and disabilities and where possible, their causes. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that	W 212		

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W 212	Continued From page 8 assessments to determine the presenting problems were conducted for one of three clients included in the sample. (Client #1) The findings include: 1. The facility failed to assess Client #1's new behavior (refusal of instructions and non-compliance) to determine it cause and develop strategies for implementation to address the behaviors. a) Observations conducted on May 7, 2008 between 1:29 PM and 2:30 PM, Client #1 was observed not wearing her protective helmet. Client #1 refused to wear her protective helmet after several attempts were made by the House Manager and direct care staff at 2:28 PM. At 2:31 PM, Client #1 exhibited behaviors of tantruming and throwing objects onto the floor. Client #1's 1:1 staff placed the protective helmet onto her head after she calmed down. Interview with the direct care staff and the house manager on May 7th and on May 8th revealed that the client often refused to wear her protective helmet. Reportedly, after much coercing the client will reluctantly allow the staff to place the helmet on her head. Review of Client #1's Behavior Support Plan dated 11/27/07 confirmed that the client frequently refused to wear the protective helmet. The Client #1's current Physician's Orders (PO's) dated May 2008 prescribed the "protective helmet to be worn during waking hours". There was no evidence that the client's	W 212	Cross reference W159	5/15/08

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W 212	Continued From page 9 noncompliance had been assessed or addressed by the Interdisciplinary team. b) On May 8, 2008 at 2:30 PM, interview with the Qualified Mental Retardation Professional (QMRP) revealed that Client #1 refuses to get off the van when at the day program on several occasions and refusing to leave the group home to go to the day program. According to the QMRP this was a new behavior which had increased significantly in the past three months. Further interview with QMRP revealed that the client medication regimen had been changed and it was not clear if this may have been one of the contributing factors to her refusal to attend the day program. According to the QMRP, the IDT has not met to address the client non-complaint/refusal behavior which have significantly increased in April. The records revealed that the client had missed 11 out of twenty days from her day program. The QMRP further indicated that the IDT team had not been made aware that Client #1's new behavior of refusal and non-compliance and that the behavior was a barrier to her receiving consistent active treatment interventions and scheduled medical consultations. c) Interview with the House Manager and QMRP on May 8, 2008 at approximately 3:45 PM reveal that Client #1 refusedto wear her eye glasses. Further interview with the QMRP indicated that the client's eye glasses were misplaced.Interview with the direct care staff confirmed that Client #1 consistently refused to wear her eye glasses. There was no evidence that the Interdisciplinary team addressed the client's refusal to wear her	W 212		

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W 212	Continued From page 10 eye glasses. Interview with the QMRP on May 7, 2008 at approximately 3:45 PM revealed that Client #1 had a new behavior of refusing instructions and non-compliance to directives which had become a barrier to her active treatment and medical services. In the past three months, according to the QMRP, this behavior had increased significantly. Reportedly, interview and record review revealed the only intervention to address this behavior was an increase of the client's psychotropic medication (Topamax 300 mg BID to Topamax 400 mg BID); however, Client #1's refusals continued to increase after the medication increase.	W 212		
W 250	483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to develop an active treatment schedule that outlines current active treatment program when clients are home from the day program for one of the three clients included the sample. (Client #1) The finding includes: On May 8, 2008 at 2:30 PM, interview with the Qualified Mental Retardation Professional (QMRP) revealed that Client #1 refuses to get off the van when at the day program on several	W 250	Cross reference W159	5/16/08

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W 250	Continued From page 11 occasions and refusing to leave the group home to go to the day program. According to the QMRP this was a new behavior which had increased significantly in the past three months. Further interview with QMRP revealed that the client medication regimen had been changed and it was not clear if this may have been one of the contributing factors to her refusal to attend the day program. Reportedly the QMRP revealed that the client was refusing to eat on occasion and to got to medical appointment as well. Later on May 8, 2008 at approximately 3:15 PM, according to the house manager and QMRP the days in which the client refuses to go to the day program and remains at the group home, she is encourage to participate in a variety of activities. However, Client #1 refuses all other activities except for her favorite blocks. The QMRP was asked to provide documentation of the program attempts and the list of the activities, however, was unable to provided any supportive documentation of her efforts. The QMRP further indicated that there is no formal alternative schedule of activities in place when Client #1 refuse to go to the day program. According to the QMRP, the IDT has not met to address the client non-complaint/refusal behavior which have significantly increased in April and she has missed 11 out of twenty days from her day program.	W 250		
W 325	482.460(a)(3)(iii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician.	W 325		

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W 325	Continued From page 12 This STANDARD is not met as evidenced by: Based on interview and record verification, the facility failed to provide routine laboratory testing as determined necessary by the physician for one of the three clients in the sample. (Client #3) The finding includes: The facility failed to ensure that Client #3 obtained laboratory studies as prescribed by the physician's orders as evidence below: Review of Client #3's physician orders dated May 2008 reviewed on May 8, 2008 at approximately 11:20 AM revealed an order for laboratory studies to include Digoxin levels every three months. Record verification indicated that the client received labs on April 22, 2008 and November 2, 2007. The next time Client #3 received labs was in 2006 according to the records. Interview with the facility's Registered Nurse (RN) revealed that she would have to check with the the Director of Nursing for the other labs. At the end of the survey, there was no other labs given to the surveyors.	W 325	The primary nurse will check the physician order sheet monthly to ensure ordered lab test are completed. The Director of Nursing will make the schedule for periodic lab tests.	5/30/08
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 interview and record review the facility failed to ensure nursing services in accordance with the needs of three of three clients included in the sample. (Client #1, #2 and #3) The findings include	W 331		

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	09G062		05/08/2008

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W 331	Continued From page 13	W 331		
	1. The facility's nursing service failed to ensure that direct care staff implemented the infection control practices in accordance with the agency's policy. [See W454]		1.Cross reference W189	5/9/08
	2. On May 8, 2008 at approximately 2:15 PM, interview with the Registered Nurse (RN) and review of the Health Management Care Plan (HMCP) dated January 8, 2008 revealed that Client #1 was visual impaired and was encourage to use protective glasses. According to the Registered Nurse (RN) who developed the HMCP, she was unsure to the purpose for the use of Client #1's eye glasses. Review of the Physician's Orders May 2008 failed to include the client's use of the protective glasses.		2.The primary nurse will review the physician order sheet to include the use of any adaptive equipment.	5/30/08
	3. The facility's nursing staff failed to ensure that annual self-medication assessments were signed by the nurse. [See W114]		3.The self-medication assessment will be reviewed and signed by the primary nurse.	5/30/08
W 436	483.470(g)(2) SPACE AND EQUIPMENT	W 436		
	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 teach clients to use and make informed choices about the use of their adaptive equipment for one of three clients included in the sample. (Client #1)			

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W 436	Continued From page 14 The findings include: The facility failed to ensure that Client #1 was provided instruction/training in the use of their adaptive equipment in accordance with the client's needs. For example: 1. Observations conducted on May 7, 2008 between 1:29 PM and 2:30 PM, Client #1 was observed not wearing her protective helmet. Client #1 refused to wear her protective helmet after several attempts to encourage her to do so was made by the House Manager and direct care staff. At 2:31 PM, Client #1 exhibited behaviors of tantruming and throwing objects onto the floor. Client #1's 1:1 staff placed the protective helmet onto her head after she calmed down. Interview with the direct care staff and the house manager on May 7th and May 8th revealed that the client often refuses to wear her protective helmet. According to staff, the client requires much coercing before the client would allow the staff to put on her helmet. Review of Client #1's current Physician's Orders (PO's) dated May 2008 revealed under safety orders, "protective helmet to be worn during waking hours". There was no evidence that the client was taught the use and take care of her helmet. 2. Interview with the House Manager and QMRP on May 8, 2008 at approximately 3:45 PM revealed that Client #1 refused to wear her eye glasses. Further interview with the QMRP revealed that she had not seen her eye glasses for a while.	W 436	Cross reference W189	5/9/08

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W 436	Continued From page 15 Interview with the direct care staff confirm that on a regular basis Client #1 refused to wear her eye glasses. Interview with the house manager revealed that she was unaware of the location of Client #1's eye glasses. Interview with the QMRP at approximately 4:00 PM revealed that she had discovered Client #1's eye glasses broken in her back pack. It is unclear of the length of time Client #1's glasses were in her back pack broken. Review of the Health Management Care Plan (HMCP) dated January 8, 2008 revealed that Client #1 was visual impaired and the HMCP risk procedures included "encourage use of protective glasses".	W 436		
W 454	483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a sanitary environment to avoid sources and transmission of infection. The finding includes: Observation on May 7, 2008 at approximately 5:31 PM revealed that Client #6 was setting the table with each client silverware. At each attempt to place the silverware on the table, the client was observed to place her hand over her mouth and then pick up a utensil and place it on the table. Observation on the May 8, 2008 at approximately 5:45 PM, Client #6 was observed to wipe her mouth and nose while placing utensils on the table. At no time was the direct care staff observed to encourage the client to was her	W 454	Cross reference W189	5/9/08

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W 454	Continued From page 16 hands.	W 454		

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I 000	INITIAL COMMENTS This licensure survey was conducted from May 7, 2008 through May 8, 2008. The survey was initiated using the fundamental survey process, however, it was necessary to extend the survey process under the conditions of ActiveTreatment and Client Behavior and Facility Practices. Six female clients, with varying degrees of disability, reside in this facility. Three of the six clients were randomly selected for the sample. The findings of the survey were based on observations at the group home and two day programs, interviews with direct care staff in the residence and the group home, and the review of the administrative records including the facility's incident management system.	I 000		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation, the GHMRP failed to ensure the interior and exterior of the GHMRP was maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. The finding includes: Observations of the GHMRP 's environment on 5/8/08 beginning at 2:30 PM revealed the exhaust fan over the kitchen stove was not working.	I 090	The exhaust fan over the kitchen stove will be repaired.	6/30/08

Health Regulation Administration

Constance A. Reese Program Director 5/30/08

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

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I 161	3507.2 POLICIES AND PROCEDURES The manual shall be approved by the governing body of the GHMRP and shall be reviewed at least annually. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP governing body failed to review its policies and procedures annually. The finding includes: Review of the policy and procedures manual on May 8, 2007 failed to provide evidence that the agency's policy manual had not been reviewed and approved annually by the governing body as required. The last noted date for review was in 2006.	I 161	The policy and procedures manual will be reviewed and updated. In the future, the policy and procedures manual will be reviewed annually.	6/15/08
I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current job descriptions for all employees annually. The finding includes: Review of the personnel files conducted on 5/8/08 revealed that GHMRP failed to provide evidence of current signed job descriptions for one direct care staff, the House Manager, and the Qualified Mental Retardation Professional. (TT)	I 203	The direct care staff(TT) has a current and signed job description contract in personnel folder. The QMRP has a current and signed job description contract in personnel folder. The House Manager has a current and signed job description contract in personnel folder.	5/18/08 5/14/08 5/19/08

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I 206	Continued From page 2	I 206		
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that each employee, prior to employment and annually thereafter, provided evidence of a physician's certification that documented a health inventory had been performed and that the employee's health status would allow him or her to perform their required duties. The findings include: Interview with the QMRP and review of the GHMRP's personnel files on 5/8/08 revealed the GHMRP failed to provide evidence that current health certificates were on file one direct care staff. (RG)	I 206	The direct care staff (RG) has a current health certificate in her personnel folder. In the future, dates will be legible on all documentation.	5/8/08
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 observations, interview and record verification, the GHMRP failed to ensure continuous, ongoing in-service training programs were conducted for all personnel.	I 222	Cross reference W189	5/9/08 6/6/08

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I 222	Continued From page 3 The finding includes: See Federal Deficiency Report Citation W189	I 222		
I 291	3514.2 RESIDENT RECORDS Each record shall be kept current, dated, and signed by each individual who makes an entry. This Statute is not met as evidenced by: Based on interview, and record review the GHMRP failed to ensure each clients records were kept current. The finding includes: (See Federal Deficiency Citation W114)	I 291	Cross reference W331	5/30/08
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident 's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on observations, staff interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to report to its administrator and to governmental officials the	I 379	Cross reference W153 & W154	5/14/08 5/12/08

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I 379	Continued From page 4 mistreatment and notification made to guardians. The findings include: See Federal Deficiency Report Citation - Citation W153, and W154	I 379		
I 395	3520.2(e) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (e) Nursing; This Statute is not met as evidenced by: Based on interview and record review the GHMRP failed to ensure nursing services in accordance with the needs of three of three clients included in the sample. (Resident #1, #2 and #3) The findings include 1. The facility's nursing service failed to ensure that direct care staff implemented the infection control practices in accordance with the agency's policy. [See W454] 2. On May 8, 2008 at approximately 2:15 PM, interview with the Registered Nurse (RN) and	I 395	1.Cross reference W189 2. Cross reference W331	5/9/08 5/30/08

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I 395	Continued From page 5 review of the Health Management Care Plan (HMCP) dated January 8, 2008 revealed that Resident #1 was visual impaired and was encourage to use protective glasses. According to the Registered Nurse (RN) who developed the HMCP, she was unsure to the purpose for the use of Resident #1's eye glasses. Review of the Physician's Orders May 2008 failed to include the client's use of the protective glasses. [See W331 and W436]	I 395		
	3. The facility's nursing staff failed to ensure that annual self-medication assessments were signed by the nurse. [See W114]		3. Cross reference W331	5/30/08
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 review, the GHMRP failed to ensure that assessments to determine the presenting problems were conducted for one of three residnets included in the sample. (Resident #1) The finding includes: The facility failed to assess Resident #1's new behavior (refusal of instructions and non-compliance) to determine it cause and develop strategies for implementation to address the behaviors. [See W212]	I 401	Cross reference W159	5/15/08

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I 423	3521.4 HABILITATION AND TRAINING Each GHMRP shall monitor and review each resident ' s Individual Habilitation Plan on an ongoing basis to ensure participation of the resident and appropriate GHMRP staff in revision of such Plans whenever necessary. The schedule for the reviews shall be documented within each IHP. This Statute is not met as evidenced by: Based on interview, and record review, the Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination of services for one of three residents included in the sample. (Resident #1) The findings include: 1. The facility's QMRP failed to ensure that Resident #1's needs were met as evidenced below: Interview with the QMRP on May 7, 2008 at approximately 3:45 PM revealed that Resident #1 had a new behavior of refusing instructions and non-compliance to directives which had become a barrier to her active treatment and medical services. In the past three months, according to the QMRP, this behavior had increased. Reportedly, interview and record review revealed the only intervention to address this behavior was an increase of the client's psychotropic medication (Topamax 300 mg BID to Topamax 400 mg BID); however, Resident #1's refusals continued to increase after the medication increase.	I 423	1. Cross reference W159	5/15/08

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I 423	Continued From page 7 The medical records, behavior support documentation, and Human Rights Committee minutes did not evidence that the QMRP had informed the Interdisciplinary Team of the emergence of Resident's #1's new behavior. 2. The facility's QMRP failed to ensure that Resident #1 was provided consistent day program active treatment services as evidenced below: On May 8, 2008 at approximately 10:10 AM interview with the day program case manager revealed that Resident #1 had not been in attendance at the day program from the period May 5th through May 7th. Further interview revealed that the day program had not been notified as to reason the resident had not been attending the day program. Reportedly, the resident regularly attends the day program a total of twenty days per month. Review of the Resident #1's day program Individual Program Plan documentation confirmed that Resident #1 had missed a large percentage of her day program active treatment for the past three months as evidenced below: April 11 days missed over 50% attendance March 7 days missed over 25% attendance February 7 days missed over 25% attendance On May 8, 2008 at 2:30 PM, interview with the Qualified Mental Retardation Professional	I 423	2. Cross reference W159	5/16/08

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I 423	Continued From page 8 (QMRP) revealed that Resident #1 was refusing to get off the van on several occasion when arriving at the day program and Resident #1 was refusing to leave the group home to go to the day program. According to the QMRP this was a new behavior which had increased in the last three months. Further interview with QMRP revealed that the client had some changes in her medication regimen. Reportedly the QMRP revealed that the client was refusing to eat and to got to medical appointment as well. The QMRP further indicated that the IDT team had not been made aware that Resident #1's refusal of instructions and non-compliance behavior was becoming a barrier to her receiving consistent active treatment interventions. It should be further noted that the QMRP was unable to provide consistent behavior data on the client refusals and/or an alternative activity schedule for Resident #1 when she refuses to go to her day program. There was no evidence that the QMRP had informed the interdisciplinary team (IDT) of the resident's new behavior of refusals to attend the day program.	I 423		
	3. The QMRP failed to ensure that each employee had been provided with adequate training that enables the employee to perform his or her duties effectively, efficiently and competently. [See to W189]		3. Cross reference W189	5/9/08 6/6/08
	4. The QMRP failed to ensure that an alternative schedule of activities was established for Resident #1. [See W250]		4. Cross reference W159	5/16/08
	5. The QMRP failed to ensure that Resident #1's new behaviors was assessed. [See W212]		5. Cross reference W159	5/15/08 5/20/08

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I 423	Continued From page 9	I 423		
	6. The QMRP failed to ensure that incidents of unknown origin were investigated according to the agency's policies. [See W154]		6. Cross reference W154	5/12/08
I 456	3521.10(b) HABILITATION AND TRAINING Each GHMRP shall develop an activity schedule for each resident that includes the following unless contraindicated by the resident ' s Individual Habilitation Plan: (b) No periods of unscheduled activity that extends longer than three (3) continuous hours; This Statute is not met as evidenced by: Based on interviews and record review, the GHMRP failed to develop an active treatment schedule that outlines current active treatment program when clients are home from the day program for one of the three residents included the sample. (Resident #1) The finding includes: On May 8, 2008 at 2:30 PM, interview with the Qualified Mental Retardation Professional (QMRP) revealed that Resident #1 refuses to get off the van when at the day program on several occasions and refusing to leave the group home to go to the day program. According to the QMRP this was a new behavior which had increased significantly in the past three months. Further interview with QMRP revealed that the resident medication regimen had been changed and it was not clear if this may have been one of the contributing factors to her refusal to attend the day program. Reportedly the QMRP revealed that the client was refusing to eat on occasion and to got to medical appointment as well.	I 456	Cross reference W159	5/16/08

PRINTED: 05/20/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G062	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/08/2008
NAME OF PROVIDER OR SUPPLIER C M S	STREET ADDRESS, CITY, STATE, ZIP CODE 6300 9TH STREET NW WASHINGTON, DC 20011		

(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 456	Continued From page 10 Later on May 8, 2008 at approximately 3:15 PM, according to the house manager and QMRP the days in which the client refuses to go to the day program and remains at the group home, she is encourage to participate in a variety of activities. However, Resident #1 refuses all other activities except for her favorite blocks. The QMRP was asked to provide documentation of the program attempts and the list of the activities, however, was unable to provided any supportive documentation of her efforts. The QMRP further indicated that there is no formal alternative schedule of activities in place when Resident #1 refuse to go to the day program. According to the QMRP, the IDT has not met to address the resident non-complaint/refusal behavior which have significantly increased in April and she has missed 11 out of twenty days from her day program.	I 456		