

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

PRINTED: 09/03/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G139	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/19/2009
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NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5610 FIRST STREET NW WASHINGTON, DC 20011
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W 000	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted from August 17, 2009 through August 19, 2009. The survey was initiated using the fundamental survey process. A random sample of two clients was selected from a population of four male clients with various levels of mental retardation and disabilities.</p> <p>The findings of the survey was based on observations at the group home and one day program, interviews with clients and staff, and the review of clinical and administrative records including incident reports.</p>	W 000	<p><i>Recent audit</i></p> <p>GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002</p>	
W 140	<p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure a system had been implemented to maintain a complete accounting of clients personal funds, for two of the two clients included in the sample. (Clients #1 and #2)</p> <p>The findings include:</p> <p>1. Interview with the Qualified Mental Retardation Professional (QMRP) and House Manager and review of the facility's financial records on August 18, 2009, at 2:28 p.m., revealed that the facility assisted Client #1 with maintaining his finances. Continued interview and record review revealed that the client received Supplemental Security Income (SSI) in the amount of \$100.00 per</p>	W 140	<p>1. CMS, Inc. will reimburse Client #1 for the funds that cannot be accounted for. In the future, the QMRP and House Manager will ensure receipts are available in the records for all funds spent for all individuals.</p>	10/15/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jennifer Daniels</i>	TITLE <i>QMRP</i>	(X6) DATE <i>9/14/09</i>
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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 140	Continued From page 1 month. The bank statements were reviewed from September 2008 through June 2009. The record revealed a withdrawal of \$1,150.00 on October 7, 2008. Review of the receipts for the aforementioned withdrawal totaled \$986.88. Interview with the House Manager and QMRP on August 18, 2009, at approximately 3:30 p.m., confirmed the total amount of receipts of \$986.88. 2. Review of Client #2's financial records on August 18, 2009, at 2:00 p.m., revealed bank statements from September 2008 through March 2009. There was no bank statement from March 2009 through June 2009. Interview with the House Manager on August 18, 2009, at approximately 2:30 p.m., indicated that Client #1's bank statements were sent to his previous address (another home within the agency), then to the main office and then forwarded to the client's facility. By the end of the survey, the bank statement were not made available for review. It should be noted that the QMRP indicated that the clients received his monthly SSI of \$100.00.	W 140	2. In the future, the House Manager will ensure that all bank statements are placed in the finance books in a timely manner.	9/9/09
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, staff interview, and record review, the Qualified Mental Retardation Professional (QMRP) failed to coordinate, integrate and monitor services, for two the two clients included in the sample. (Clients #1 and #2)	W 159		

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W 159	<p>Continued From page 2</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The facility's QMRP failed to ensure that each employee had been provided with adequate training that enables the employee to perform his or her duties effectively. [See W189] 2. The facility's QMRP failed to ensure continuous active treatment was implemented in accordance with the interdisciplinary team (IDT) recommendations. [See W249] 3. The facility's QMRP failed to ensure that data was collected in the form and required frequency. [See W252] 	W 159	<ol style="list-style-type: none"> 1. Cross reference W189 2. Cross reference W249 3. Cross reference W252 	<p>9/11/09</p> <p>9/25/09</p> <p>9/25/09</p> <p>9/25/09</p>
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W 189	<p>483.430(e)(1) STAFF TRAINING PROGRAM</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observation, 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, for two of the two clients included in the sample. (Clients #1 and #2)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Observations during dinner on August 17, 2009, at 5:17 p.m., direct care staff was observed feeding Client #2. <p>During day program observation on August 18,</p>	W 189		
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W 189 Continued From page 3

2009, at 12:05 p.m., Client #2 was observed during lunch. The day program staff was observed setting the table and putting Client #2's spoon in his right hand. The client consumed his lunch independently, with no spillage.

During dinner on August 18, 2009, at 5:15 p.m., direct care staff was observed feeding Client #2 his dinner. Half way through the client's dinner, another direct care staff repositioned the client's spoon and the client consumed the rest of his meal, independently.

Interview with the Qualified Mental Retardation Professional (QMRP) and House Manager on August 19, 2009, at approximately 10:00 a.m. revealed that Client #2 can eat with minimal assistance.

Review of Client #2's clinical record on August 18, 2008, revealed an Occupational Therapy (OT) assessment dated November 28, 2007. The OT assessment indicated that the client should be told what is being served and required hand over hand assistance on occasions. Further review of the client's record revealed a Physical Therapy (PT) assessment. The assessment confirmed that the client required minimal assistance.

Review of the Client #2's Individual Support Plan (ISP) dated September 19, 2008, on August 19, 2009, at 10:00 a.m. revealed the client can feed himself with little to no assistance from staff. Assistance is needed with the placing the client's eating utensils in his hand and the staff should place them at the beginning of meals.

Review of training records on August 19, 2009, at approximately 11:00 a.m. revealed no evidence of

W 189

1. The direct care staff will receive further training on the feeding protocol for Client #2. In the future, the QMRP and Residential Manager will monitor staff with the feeding protocols of all individuals who require them.

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W 189 Continued From page 4
feeding techniques for Client #2.

2. The facility failed to ensure staff was effectively trained on Client #1's ambulation protocol.

On August 18, 2009, at 10:42 a.m., Client #1 was observed to ambulate slowly and with a slightly unsteady gait. During this time, he was observed wearing a gait belt. On August 19, 2009, at 11:15 a.m., the client was observed not wearing his gait belt as he walked alone with a slightly unsteady gait, from the living room through the dining room, to the kitchen. During this time, Client #1's one on one staff was in the kitchen preparing the client's lunch.

Interview with staff on August 18, 2009, at 10:15 a.m., had revealed that the client should wear a gait belt during ambulation to prevent falls.

Th review of Client #1's individual support plan (ISP) dated February 23, 2009 revealed he has a history an unsteady gait and falls. The review of a physician's order dated June 26, 2009 revealed a gait belt was prescribed to prevent the client from falling. Further record review on August 19, 2009 at 12:50 p.m., revealed a staff training signature form indicating that training had been provided on Client #1's walking protocol. According to the walking protocol, dated July 21, 2009, staff interventions to ensure the client's safety during ambulation included the following:

(a) During ambulation, staff should stand to the right side of the client...

(b) Provide assistance by placing arm around the client's waist, holding onto the gait belt.

W 189

2. The staff will receive further training on walking protocols and fall prevention for all individuals in the home. In the future, the QMRP will provide the staff with an assessment at the end of the training to ensure that the training was effective.

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W 189	<p>Continued From page 5</p> <p>Further review of training records on August 19, 2009 at 12:50 p.m., revealed staff had also received training on fall prevention on February 27, 2009. At the time of the survey, however, there was no evidence each staff demonstrated that training on Client #1's ambulation protocol had been effective to ensure that it was implemented at all times.</p> <p>3. [Cross refer to W474] The facility failed to ensure that staff were effectively trained to implement Client #1's therapeutic diet.</p> <p>On August 18, 2009, at 10:29 a.m., Client #1 was served a large peeled banana for a snack as he sat in the armchair in the living room. The client finished eating the banana by taking three bites from it, each time stuffing the piece of banana into his mouth.</p> <p>On August 19, 2009, at 8:50 a.m., Client #1 was observed sitting at the dining table eating a four ounce cup of applesauce. At 9:07 a.m., he was observed eating uncooked apple wedges. He used his fork to put the apple wedges into his mouth, then began to chew them. The client finished eating the apple at 9:27 a.m., then stood in the doorway of the kitchen. At that time, staff gave him a large peeled banana, which he again finished in three large bites, failing to chew it thoroughly.</p> <p>On August 19, 2009 at 10:55 a.m., Client #1's annual nutritional assessment dated January 16, 2009 revealed the texture of his diet should be Mechanically Soft. The diet plan included "soft ripened fruit, such peaches, pears an bananas which can be mashed to an appropriate consistency." Record review on August 19, 2009</p>	W 189	<p>3. The staff will receive additional training on proper food textures and diets for all individuals in the home. In the future, the QMRP will provide an assessment following the training to ensure that it was effective.</p>	9/25/09

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W 189	Continued From page 6 at 12:40 p.m. revealed the nutritionist provided training to staff on diet textures on April 8, 2009. At the time of the survey, however, there was no evidence the staff training provided had been effective to ensure Client #1 received each food in the prescribed texture and in accordance with his assessed needs.	W 189		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that as soon as the interdisciplinary team (IDT) formulated a client's individual program plan (IPP), each client received continuous active treatment services, in sufficient number and frequency to support the achievement of the objectives identified in the IPP, for two of the two clients included in the sample. (Clients #1 and #2) The finding includes: 1. During evening observations on August 17, 2009, at 6:28 PM, direct care staff was observed turning on the radio. Review of Client #2's Individual Program Plan (IPP) dated September 19, 2008, on August 18,	W 249	1. The direct care staff will be trained on the IPP goals for all individuals. In the future, the QMRP will ensure that the staff receive ongoing training on all	

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W 249	<p>Continued From page 7</p> <p>2009 at 2:01p.m. revealed a program objective which stated, "[the client] will improve his fine motor skills by locating the adaptive play button on his CD player 80% of trials three times a week for 12 consecutive months." At the time of observations, there was no evidence that staff encouraged the client to turn on his radio.</p> <p>2. The facility failed to ensure that Client #1's Behavior Support Plan (BSP) was implemented as written.</p> <p>On August 19, 2009, at 11:15 a.m., Client #1 was observed not wearing his gait belt as he walked alone, with a slightly unsteady gait, from the living room through the dining room, to the kitchen . During this time, Client #1's one on one staff was in the kitchen preparing the client's lunch.</p> <p>Interview with the same staff, also assigned to Client #1 on August 18, 2009 at 8:25 a.m., revealed the client required 1:1 supervision to address his non-compliance and to manage his challenging behaviors.</p> <p>Client #1's BSP dated November 18, 2008, was reviewed on August 19, 2009 at 9: 50 a.m. The BSP revealed that the client needed 1:1 staffing during waking hours because the client was primarily a danger to himself without it. Record review on August 19, 2009 at 12:40 p.m. revealed a policy which stated that during 1:1 hours, the staff supervising the client should be within arm's length of the client at all times.</p> <p>At the time of the survey, there was no evidence that staff had consistently implemented Client #1's BSP, by maintaining arm's length distance from the client at all times as specified in the</p>	W 249	<p>IPP goals.</p> <p>2. Cross reference W189.2</p>	<p>9/25/09</p> <p>9/25/09</p>

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W 249	<p>Continued From page 8 plan.</p> <p>3. The facility failed to ensure Client #1 received the recommended activities as recommended to increase his physical endurance.</p> <p>Observation on August 18, 2009 between the hours of 8:20 am and 10 30 a.m. revealed Client #1 seated in the armchair in the living room with his eyes closed and appearing to be asleep. He continued to appear to be sleeping, until his peers returned home from their day programs, except for intermittently going to the second level of the home, and during lunch and snack (a.m. and p.m.) time. During this time, the client's 1:1 staff was observed to intermittently attempt to engage the client in an activity, which the client refused.</p> <p>Interview with the Client #1's 1:1 staff on August 18, 2009 at 8:30 a.m., indicated that the client is usually not active on two consecutive days. On the same day at 4:45 p.m., the evening staff indicated that the client was supposed to participate in a training program recommended by the physical therapist. Further interview with the 1:1 staff, and also the residential manager and the QMRP on August 19, 2009 at 12:10 p.m., revealed Client #1 had a training objective to improve his physical endurance which had not been implemented.</p> <p>Record review on August 19, 2009 at 10:49 a.m. revealed Client #1's IPP included an objective to improve his endurance. According to strategies and activities, given physical assistance by his 1:1 direct care staff, the client will be able to participate in aerobic activities to music for 10 minutes (to include marching, stepping side to side and jumping). The review of program data</p>	W 249	<p>3. The QMRP will review all data collection sheets for all goals. All forms will be present and available in the training books in order to have evidence that all goals were implemented.</p>	9/9/09	

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W 249	Continued From page 9 revealed, as confirmed by the aforementioned staff, that there was no evidence Client #1 had received needed training to increase his physical endurance, as recommended by the IDT.	W 249		
W 252	<p>483.440(e)(1) PROGRAM DOCUMENTATION</p> <p>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that data was collected in the form and required frequency, for two of the two clients in the sample. (Clients #1 and #2)</p> <p>The finding includes:</p> <p>1. On August 17, 2009, at 6:28 p.m., Client #2 was observed jumping up and down in his chair. The direct care staff was observed standing to his left side. Interview with the direct care staff on August 17, 2009, at approximately 6:35 p.m., indicated that the client had a Behavior Support Plan (BSP) to address his maladaptive behaviors of jumping up and down.</p> <p>Record verification of Client #2's BSP dated November 18, 2008, on August 18, 2009, at 2:00 p.m., revealed the plan that identified maladaptive behavior of jumping up and down. According to the data collection instructions, staff were to record behaviors on the Antecedent Behavior Consequence (ABC) chart. Further review of the data chart on August 18, 2009, at 3:00 p.m.,</p>	W 252	<p>The direct care staff were trained on BSP's on 8/17/09 by a behavior specialist. The staff will receive a follow-up training by the QMRP to ensure that the staff have a sufficient understanding of the BSP's for all individuals, and that all documentation involved will address maladaptive behaviors, including ABC data charts and adaptive equipment data sheets.</p>	9/25/09

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W 252	<p>Continued From page 10</p> <p>revealed that Client #2 had no behaviors documented on August 17, 2009. There was no evidence that data had been collected in accordance with the Client #2's BSP.</p> <p>2. Interview with staff on August 18, 2009 at 9:17 a.m., revealed Client #1 had a behavior support plan (BSP) which addressed targeted behaviors which included skin picking, sticking his fingers up his nose, licking his fingers and urinating in his clothing.</p> <p>The review of Client #1's "personal BSP" dated November 18, 2009 on August 19, 2009 at 10:49 a.m., confirmed that the aforementioned targeted behaviors had been identified by the psychologist. According to the BSP, the objective was to reduce the client's challenging behaviors, which included skin picking, sticking his fingers up his nose, licking his fingers and urinating in his clothing to zero per month.</p> <p>The review of the ABC documentation form for monitoring the client's targeted behaviors revealed that it required the information below to be documented each time the client exhibited a targeted behavior:</p> <p>(a) Date and time (b) Antecedent (c) Behavior (d) Consequences</p> <p>On August 19, 2009 at 11:30 a.m., the review of the ABC data collected from June 16, 2009 through August 23, 2009 revealed that the time at which the behaviors occurred had not been consistently documented. There was no evidence the facility had ensure the collection of</p>	W 252			

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W 252	<p>Continued From page 11</p> <p>Client #1's behavioral data in measurable terms.</p> <p>3. On August 18, 2009, at 8:40 a.m., a pink colored area was observed on the back (right side) of Client #1's neck, which appeared to be healing. A dry red area of skin was observed at the center of the pink area.</p> <p>Interview with the staff on August 18, 2009 at 4:10 p.m. concerning how the injury to Client #1's neck occurred, revealed "He did it to himself. Skin picking is one of his behaviors." Interview with the QMRP and the residential manager on August 19, 2009 at 9:17 a.m. revealed the client had a BSP to address his skin picking. Subsequent interviews with the QMRP, the residential manager, and the R.N. revealed that the date on which the client initially injured his neck by skin picking could not be determined. There was no evidence that the facility had ensured that the client's skin picking behavior had been documented in measurable terms.</p> <p>4. On August 17, 2009, at 4:47 p.m., Client #1 was observed wearing eye glasses. Af approximately 5:05 p.m., the client was observed to remove his glasses and to give them to a staff.</p> <p>Interview with the client's 1:1 staff on August 19, 2009, at 10:23 a.m. revealed the Client #1 was supposed to wear eyeglasses, but refused to wear them.</p> <p>Record review on August 19, 2009, at 11:41 a.m., revealed Client #1 had a health objective which stated he "will be free from eye infections." Strategies and activities to achieve the objective revealed that the client "will wear polycarbonate lenses to protect his left eye." Staff were identified</p>	W 252		
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W 252	Continued From page 12 as responsible for monitoring whether the client wore his glasses. The review of program data for July 2009, reflected that the client refused to wear his eye glasses. Further record review, however, revealed there was no program data available for June and August 2009 to reflect the client's progress in the objective. At the time of the survey, there was no evidence that data to monitor client's progress on tolerance of his eyeglasses had been consistently documented.	W 252		
W 322	<p>483.460(a)(3) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain preventive and general medical care.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure general and preventative care services, for two of two clients in the sample. (Clients #1 and #2)</p> <p>The findings include:</p> <p>1. Observation of the medication pass on August 17, 2009, at approximately 6:15 p.m., revealed the Registered Nurse (RN) administered Haldol 5 mg by mouth and Seroquel 200 mg by mouth by to Client #1.</p> <p>Interview with RN on August 17, 2009, at approximately 6:16 p.m., revealed Client #1 was prescribed Haldol 5 mg and Seroquel 200 mg for behavior management.</p> <p>Review of Client #1's physician's orders (POS) dated July 13, 2009, on August 17, 2009, at approximately 6:30 p.m., revealed Client #1 was</p>	W 322	<p>1. The POS dated July 23, 2009 was placed in Client #1's records. In the future, the RN will make sure that all physicians order sheets have clearly written dates. Also, the RN will continue to ensure that all psychotropic medications are reviewed monthly by the primary care physician.</p>	9/9/09

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W 322	Continued From page 13 prescribed Haldol 5 mg and Seroquel 200 mg every evening and Prozac 60 mg every day. Further review of the POS revealed there were no updated orders in August, 2009, for Haldol 5 mg every evening by mouth and Prozac 60 mg every day by mouth. There was no documented evidence the Primary Care Physician (PCP) ordered the aforementioned psychotropic medications every thirty (30) days. 2. The facility failed to have provide evidence that recommendations made by the pharmacist were addressed by the PCP for Client #2. Review of Client #2's medical record on August 18, 2009, at 10:50 a.m., revealed on August 10, 2009, the pharmacist recommended that the client's prolactin blood levels be evaluated. The pharmacist recommended the clients prolactin levels be done every six months on February 10, 2009, and May 7, 2009, pharmacy reviews. Review of the available lab values on August 18, 2009, at approximately 11:00 a.m., failed to evidence that prolactin levels was obtained. Interview with the facility's Registered Nurse (RN) on August 19, 2009, at approximately 11:30 a.m., revealed that recommendations made by the pharmacy consultant had not been addressed. There was no evidence in the record that the PCP acknowledged the recommendation.	W 322	2. Client #2 will have Prolactin levels checked. The QMRP will make sure that the primary care nurse follow up on all recommendations given by the pharmacist.	9/15/09	
W 331	483.460(c) NURSING SERVICES 3. Cross Refer to W331. The facility's nursing staff failed to ensure health care systems were in place to monitor and identify services to maintain Client #1's skin integrity.	W 331	3. Cross reference W331	9/16/09	

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W 331	<p>Continued From page 14</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the facility's nursing services failed to establish systems to provide health care monitoring and identify services in accordance with clients' needs, for four of four clients in the facility. (Clients #1, #2, #3 and #4)</p> <p>The findings include:</p> <p>1. The facility's nursing staff failed to ensure health care systems were in place to monitor and identify services to maintain Client #1's skin integrity as evidenced by:</p> <p>During medication administration observation on August 17, 2009, at approximately 6:17 p.m., Client #1 was observed to have open areas in the skin behind the right ear and on the right side of the forehead.</p> <p>In an interview with the Registered Nurse #1 (RN #1) on August 17, 2009, at approximately 6:27 p.m., it was acknowledged Client #1 had open skin areas behind the right ear and on the right side of the forehead due to self-injurious behavior (SIB). Further interview revealed Client #1's aforementioned open skin areas had not been assessed or medically treated.</p> <p>Review of Client #1's psychological assessment dated January 23, 2009, on August 17, 2009, at 6:45 p.m., confirmed Client #1 had targeted behaviors that included SIB (skin picking).</p>	W 331	<p>1. A standard procedure will be put in place for TME's and nurses to follow when Client #1 engages in skin picking behavior. The TME's and nurses will be trained on the procedure. In the future, the QMRP and DON will make sure that there are procedures in place that ensure the health and safety of all individuals.</p>	9/16/09
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W 331	<p>Continued From page 15</p> <p>Review of Client #1's August 2009, physician's order sheet (POS) and August 2009, Medication Administration Records (MAR's) on August 17, 2009 at 6:33 p.m., did not reveal any treatment orders for the aforementioned open skin areas.</p> <p>There was no documented evidence the facility establish systems to monitor and identify services to maintain the client's skin integrity.</p> <p>2. The facility's nursing services failed to follow-up on a medication error made by the trained medication employee (TME).</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on August 18, 2009, at 2:10 p.m., revealed the morning medications were administered by a TME. Interview with the TME on August 18, 2009, at 2:30 p.m., revealed that on April 23, 2009, at 8:00 a.m., she accidentally gave Client #1 medications scheduled be given to him on April 24, 2009, at 8:00 a.m. The TME stated that she documented the error on the the back of the medication administration record (MAR), then immediately telephoned the Director of Nursing (DON) to inform her of the error. According to the House Manager, who was also a TME, the policy was to notify the DON for further instructions, if a medication occurred.</p> <p>On August 18, 2009, at 2:30 p.m., documentation on the back of the MAR revealed the aforementioned medication error included the following medications: Prozac 60 mg, Haloperidol 1 mg, Docusate Sodium 100 mg and Fluoxetine 5 mg. Subsequent review of the nursing records on August 18, 2009, at 2:47 p.m., revealed no documentation of follow-up on the medication error by the DON.</p>	W 331	<p>2. In the future, the primary nurse will place a nurses's note in the records of the individual to address any medication errors.</p>	9/9/09

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W 331	<p>Continued From page 16</p> <p>At the time of the survey, there was no evidence that nursing follow-up had been implemented after the client medication error occurred.</p> <p>3. The facility failed to have provide evidence that recommendations made by the pharmacist were addressed by the nurse for Client #2.</p> <p>Review of Client #2's medical record on August 18, 2009, at 10:50 a.m., revealed the following pharmacy reviews held on August 10, 2009, May 7, 2009, and February 10, 2009. On all three of the aforementioned dates, the pharmacist recommended that the client's prolactin blood levels be done every six months. Review of the available lab values on August 18, 2009, failed to evidence that prolactin levels were obtained. Interview with the facility's Registered Nurse (RN) on August 19, 2009, at approximately 11:30 a.m., revealed that recommendations made by the pharmacy consultant had not been addressed. There was no evidence in the record that the nursing staff acknowledged the pharmacy recommendation.</p>	W 331	<p>3. Cross reference W322</p> <p>4. Cross reference W381</p> <p>5. Cross reference W455</p>	<p>9/15/09</p> <p>9/15/09</p> <p>9/15/09</p>
W 381	<p>483.460(l)(1) DRUG STORAGE AND RECORDKEEPING</p> <p>The facility must store drugs under proper conditions of security.</p>	W 381		

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W 381	Continued From page 17 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to store drugs under proper conditions of security, for four of four clients in the facility. (Clients # 1, #2, #3 and # 4) The finding includes: On August 17, 2009, at approximately 6:29 p.m., the Registered Nurse #1 (RN#1) was observed to leave the medication cabinet unlocked in the dining room when she went down to the basement of the facility. In an interview with RN #1 on August 17, 2009, at approximately 6:35 p.m., it was acknowledged that the medication cabinet was left unlocked when she went down to the basement of the facility.	W 381		
W 455	There was no evidence that all drugs were stored under proper conditions of security. 483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide an active program for the prevention, control of infection and communicable diseases, for one of five clients in the facility. (Client #2) The finding includes: During medication administration observation on August 17, 2009, at approximately 6:02 p.m., the	W 455	The medication nurse will be trained on the proper procedures for medication storage. In the future, the DON will make sure that all medication nurses receive ongoing training on medication storage. The medication nurse will be trained on infection control. The DON will continue to provide ongoing training on infection control to all medication nurses.	9/15/09 9/15/09

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W 455	Continued From page 18 Registered Nurse #1 (RN #1) was observed to use hand sanitizer to cleanse her hands prior to administrating medications. However RN #1 touched the medication cabinet drawer, touched the Medication Administration Records (MAR's) and than touched the rim of the medication cup as she administered Client #2's medication. In an interview with RN #1 on August 17, 2009, at approximately 6:30 p.m., it was acknowledged after cleaning her hands with hand sanitizer she opened the medication cabinet drawer, touched the MAR's and than touched the rim of the medication cup when administering Client #2's medication. There is no evidence that the facility's nursing staff provided an active program for the prevention and control of infection.	W 455			
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, interview, and record review, the facility failed to ensure food was served in the texture recommended, for one of the two clients in the sample. (Client #1) The finding includes: On August 19, 2009, at 10:29 a.m., Client #1 was served a large peeled banana for a snack as he sat in the armchair in the living room. The client finished eating the banana by taking three bites from it, each time stuffing the bite of banana into his mouth.	W 474	Cross reference W189	9/25/09	

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W 474	<p>Continued From page 19</p> <p>On August 19, 2009, at 8:50 a.m., Client #1 was observed sitting at the dining table eating a four ounce cup of applesauce. At 9:07 a.m., he was observed eating uncooked apple wedges. He used his fork to put the apple wedge into his mouth, then began to chew it. At 9:13 a.m., staff gave the client bite size pieces of uncooked apple. After the client finished eating the apple at 9:27 a.m., he then client stood in the doorway of the kitchen. At that time, a large peeled banana was served to the client, which he stuffed into his mouth, finishing it in three bites.</p> <p>Interview with Client #1's 1:1 direct care staff on August 18, 2009, revealed that the two things that the client seemed to enjoy most was sleeping and eating. Interview with Client #1's 1:1 direct care staff and the supervisory Registered Nurse on August 19, 2009, at 10:40 a.m., revealed the client had only three to four remaining teeth.</p> <p>Record on August 19, 2009, at 10:55 a.m., revealed the client was prescribed a lowfat, low cholesterol, mechanically soft (chopped) diet. In the annual nutritional assessment dated January 16, 2009, a concern was identified that the client gulps his food down and needs encouragement to slow his eating pace and to chew his food. According to the client "Mechanically Soft Diet" plan, soft, ripened fruits such as peaches, pears and bananas can be mashed to an appropriate consistency. Further review of the Mechanically Soft Diet Plan revealed the diet is to be used for individuals who have limited chewing ability, but tolerate a large variety and textures of food, and individuals with dental problems.</p> <p>At the time of the survey, there was no evidence the facility had addressed the client's faulty</p>	W 474		
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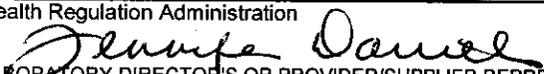
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W 474	Continued From page 20 dentition and missing teeth when providing his snacks.	W 474		

Health Regulation Administration

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I 000	INITIAL COMMENTS A licensure survey was conducted from August 17, 2009, through August 19, 2009. A random sample of two residents was selected from a population of four male residents with various levels of mental retardation and disabilities. The findings of the survey was based on observations at the group home, one day program and the review of clinical and administrative records including incident reports.	I 000		
I 055	3502.13 MEAL SERVICE / DINING AREAS Each GHMRP shall train the staff in the use of proper feeding techniques and monitor their appropriate use to assist residents who require special feeding procedures or utensils. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the GHMRP failed to train staff in the use of proper feeding procedures for one of the two residents in the sample. (Residents #1 and #2) The findings include: 1. Observations during dinner on August 17, 2009, at 5:17 p.m., direct care staff was observed feeding Resident #2. During day program observation on August 18, 2009, at 12:05 p.m., Resident #2 was observed during lunch. The day program staff was observed setting the table and putting Resident #2's spoon in his right hand. The resident consumed his lunch independently, with no spillage.	I 055	1. Cross reference W189	9/11/09

Health Regulation Administration

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

TITLE


(X6) DATE
 9/14/09

Health Regulation Administration

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I 055	<p>Continued From page 1</p> <p>During dinner on August 18, 2009, at 5:15 p.m., direct care staff was observed feeding Resident #2 his dinner. Half way through the resident's dinner, another direct care staff repositioned the resident's spoon and the resident consumed the rest of his meal, independently.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) and House Manager on August 19, 2009, at approximately 10:00 a.m. revealed that Resident #2 can eat with minimal assistance.</p> <p>Review of Resident #2's clinical record on August 18, 2008, revealed an Occupational Therapy (OT) assessment dated November 28, 2007. The OT assessment indicated that the resident should be told what is being served and required hand over hand assistance on occasions. Further review of the resident's record revealed a Physical Therapy (PT) assessment. The assessment confirmed that the resident required minimal assistance.</p> <p>Review of the Resident #2's Individual Support Plan (ISP) dated September 19, 2008, on August 19, 2009, at 10:00 a.m. revealed the resident can self feed with little to no assistance from staff. Assistance is needed with the placing the resident's eating utensils in his hand and the staff should place them at the beginning of meals.</p> <p>Review of training records on August 19, 2009, at approximately 11:00 a.m. revealed no evidence of feeding techniques for Resident #2.</p> <p>2. The facility failed to ensure that staff were effectively trained to implement Resident #1's therapeutic diet.</p>	I 055	<p>2. Cross reference W189</p>	<p>9/25/09</p>
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NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5610 FIRST STREET NW WASHINGTON, DC 20011
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I 055	<p>Continued From page 2</p> <p>On August 19, 2009, at 10:29 a.m., Resident #1 was served a large peeled banana for a snack as he sat in the armchair in the living room. The client finished eating the banana by taking three bites from it, each time stuffing the bite of banana into his mouth.</p> <p>On August 19, 2009, at 8:50 a.m., Resident #1 was observed sitting at the dining table eating a four ounce cup of applesauce. At 9:07 a.m., he was observed eating uncooked apple wedges. He used his fork to put the apple wedge into his mouth, then began to chew it. At 9:13 a.m., staff gave the resident bite size pieces of uncooked apple. After the resident finished eating the apple at 9:27 a.m., he then resident stood in the doorway of the kitchen. At that time, a large peeled banana was served to the resident, which he stuffed into his mouth, finishing it in three bites.</p> <p>Interview with Resident #1's 1:1 direct care staff on August 18, 2009, revealed that the two things that the resident seemed to enjoy most was sleeping and eating. Interview with Resident #1's 1:1 direct care staff and the supervisory Registered Nurse on August 19, 2009, at 10:40 a.m. revealed the resident had only three to four remaining teeth.</p> <p>Record on August 19, 2009, at 10:55 a.m. revealed the resident was prescribed a low fat, low cholesterol, mechanically soft (chopped) diet. Further record review on August 19, 2009, at 12:40 p.m. revealed the nutritionist provided training to staff on diet textures on April 8, 2009. At the time of the survey, there was no evidence the training provided had been effective to ensure Resident #1 received each of his food in accordance with the texture prescribe and in</p>	I 055		
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I 055	Continued From page 3 accordance with his assess needs.	I 055		
I 082	<p>3503.10 BEDROOMS AND BATHROOMS</p> <p>Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting.</p> <p>This Statute is not met as evidenced by: Based on observation and staff interview, the Group Home for the Mentally Retarded (GHMRP) failed to ensure all bathrooms were equipped with a paper towels and soap for hand washing to accommodate the needs of residents, for four of the four residents residing in the facility. (Residents #1, #2, #3, and #4)</p> <p>The finding includes:</p> <p>An environmental inspection was conducted on August 18, 2009, at approximately 12:30 p.m., revealed there were no paper towels or soap for hand washing in the second floor bathroom.</p> <p>The Qualified Mental Retardation Professional (QMRP) confirmed the findings.</p>	I 082	<p>The direct care staff will be trained on infection control. In the future, the QMRP will ensure that the staff receive ongoing training on infection control and universal precautions.</p>	9/25/09
I 090	<p>3504.1 HOUSEKEEPING</p> <p>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.</p>	I 090		

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1 090	Continued From page 4 This Statute is not met as evidenced by: Based on observation and interview, the Group Home for the Mentally Retarded (GHMRP) failed to ensure the interior of the GHMRP was maintained in a safe, clean, orderly, attractive, and sanitary manner for four of four residents included residing in the facility. (Residents #1, #2, #3, and #4) The findings include: An environmental inspection was conducted on August 18, 2009, at approximately 9:45 a.m. which revealed the following: 1. There was chipping paint on the kitchen wall near the entrance way; 2. There was water stains and chipping paint in the dining room above the window frame; 3. There was chipping paint in the first floor hallway; 4. The front porch had chipping and peeling paint on the floor; 5. There was chipping and peeling paint and rust on the metal banister on the front porch; and 6. The porch had cob webs in the corners of the ceiling. The Qualified Mental Retardation Professional (QMRP) confirmed the findings.	1 090	All environmental concerns will be addressed and repaired. In the future, the QMRP will make sure that all environmental issues are addressed during weekly inspections. 1. The kitchen wall will be painted near the entrance way. 9/30/09 2. Window frames in dining room will be repaired and painted. 9/30/09 3. First floor hallway will be painted. 9/30/09 4. The front porch floor will be scaled and painted. 9/30/09 5. Metal banister on front porch will be scaled and painted. 9/30/09 6. Cob webs will be removed from the corners of the porch. 9/30/09	
1 189	3508.7 ADMINISTRATIVE SUPPORT Each GHMRP shall maintain records of residents' funds received and disbursed. This Statute is not met as evidenced by: Based on interview and record review, the Group Home for the Mentally Retarded (GHMRP) failed to maintain each resident's funds disbursed, for	1 189		

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I 189	<p>Continued From page 5</p> <p>two of the two residents included in the sample. (Residents #1 and #2)</p> <p>The findings include:</p> <p>1. Interview with the Qualified Mental Retardation Professional (QMRP) and House Manager and review of the facility's financial records on August 18, 2009, at 2:28 p.m., revealed that the facility assisted Resident #1 with maintaining his finances. Continued interview and record review revealed that the client received Supplemental Security Income (SSI) in the amount of \$100.00 per month. The bank statements were reviewed from September 2008, through June 2009. The record revealed a withdrawal of \$1,150.00 on October 7, 2008. Review of the receipts for the aforementioned withdrawal totaled \$986.88.</p> <p>Interview with the House Manager and QMRP on August 18, 2009, at approximately 3:30 p.m., confirmed the total amount of receipts totaled \$986.88.</p> <p>2. Review of Resident #2's financial records on August 18, 2009, at 2:00 p.m., revealed bank statements from September 2008, through March 2009. There was no bank statement from March 2009 through June 2009. Interview with the House Manager on August 18, 2009, at approximately 2:30 p.m., indicated that Resident #1's bank statements were sent to his previous address (another home within the agency), then to the main office and then forward to the resident's facility. By the end of the survey, the bank statement were not made available for review. It should be noted that the QMRP indicated that the resident received his monthly SSI of \$100.00.</p>	I 189	<p>1. Cross reference W140</p> <p>2. Cross reference W140</p>	<p>10/15/09</p> <p>9/9/09</p>

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I 206	Continued From page 6	I 206		
I 206	<p>3509.6 PERSONNEL POLICIES</p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on interviews and record review, the facility failed to achieve compliance with state regulations pertaining to health (22DCMR 35, section 3509.6) for two of nine staff.(Staff #1 and #2)</p> <p>The finding includes:</p> <p>The State regulatory agency conducted a review of personnel records on August 18, 2009, at approximately 9:35 a.m., at which time, there was no evidence of current health certificates on file for two direct care staff.</p> <p>Interview with the Qualified Mental Retardation Professional confirmed the missing health certificates were not available.</p>	I 206	<p>The files will be updated and in the future, all personnel folders will contain necessary documents. CMS Human Resource Dept. will review files quarterly.</p>	9/9/09
I 226	<p>3510.5(c) STAFF TRAINING</p> <p>Each training program shall include, but not be limited to, the following:</p> <p>(c) Infection control for staff and residents;</p> <p>This Statute is not met as evidenced by:</p>	I 226		

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I 226	<p>Continued From page 7</p> <p>Based on observation and interview, the Group Home for the Mentally Retarded (GHMRP) failed to ensure effective training on infection control, for one of one nursing staff in the facility. (RN #1)</p> <p>The finding includes:</p> <p>1. During medication administration observation on August 17, 2009, at approximately 6:02 p.m., the Registered Nurse #1 (RN #1) was observed to use hand sanitizer to cleanse her hands prior to administrating medications. However RN #1 touched the the medication cabinet drawer, touched the Medication Administration Records (MAR's) and than touched the rim of the medication cup as she administered Resident #2's medication.</p> <p>In an interview with RN #1 on August 17, 2009, at approximately 6:30 p.m., it was acknowledged after cleaning her hands with hand sanitizer she opened the medication cabinet drawer, touched the MAR's and than touched the rim of the medication cup when administering Resident #2's medication.</p> <p>There is no evidence that the facility's nursing staff had effective training on infection control.</p>	I 226	<p>Cross reference W331</p>	<p>9/15/09</p>
I 229	<p>3510.5(f) STAFF TRAINING</p> <p>Each training program shall include, but not be limited to, the following:</p> <p>(f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies;</p>	I 229		

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I 229	<p>Continued From page 8</p> <p>This Statute is not met as evidenced by: Based on observation, 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, for two of the two residents included in the sample. (Residents #1 and #2)</p> <p>The findings include:</p> <p>1. Observations during dinner on August 17, 2009, at 5:17 p.m., direct care staff was observed feeding Resident #2.</p> <p>During day program observation on August 18, 2009, at 12:05 p.m., Resident #2 was observed during lunch. The day program staff was observed setting the table and putting Resident #2's spoon in his right hand. The resident consumed his lunch independently, with no spillage.</p> <p>During dinner on August 18, 2009, at 5:15 p.m., direct care staff was observed feeding Resident #2 his dinner. Half way through the resident's dinner, another direct care staff repositioned the resident's spoon and the resident consumed the rest of his meal, independently.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) and House Manager on August 19, 2009, at approximately 10:00 a.m. revealed that Resident #2 can eat with minimal assistance.</p> <p>Review of Resident #2's clinical record on August 18, 2008, revealed an Occupational Therapy (OT) assessment dated November 28, 2007. The OT assessment indicated that the resident</p>	I 229	<p>1. Cross reference W189</p>	9/11/09

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I 229	<p>Continued From page 9</p> <p>should be told what is being served and required hand over hand assistance on occasions. Further review of the resident's record revealed a Physical Therapy (PT) assessment. The assessment confirmed that the resident required minimal assistance.</p> <p>Review of the Resident #2's Individual Support Plan (ISP) dated September 19, 2008, on August 19, 2009, at 10:00 a.m. revealed the resident can feed himself with little to no assistance from staff. Assistance is needed with the placing the resident's eating utensils in his hand and the staff should place them at the beginning of meals.</p> <p>Review of training records on August 19, 2009, at approximately 11:00 a.m. revealed no evidence of feeding techniques for Resident #2.</p> <p>2. The facility failed to ensure staff was effectively trained on Resident #1's ambulation protocol.</p> <p>On August 18, 2009, at 10:42 a.m., Resident #1 was observed to ambulate slowly and with a slightly unsteady gait. During this time, he was observed wearing a gait belt. On August 19, 2009, at 11:15 a.m., the resident was observed not wearing his gait belt as he walked alone with a slightly unsteady gait, from the living room through the dining room, to the kitchen. During this time, Resident #1's one on one staff was in the kitchen preparing the resident's lunch.</p> <p>Interview with staff on August 18, 2009, at 10:15 a.m., had revealed that the resident should wear a gait belt during ambulation to prevent falls.</p> <p>Th review of Resident #1's individual support plan (ISP) dated February 23, 2009 revealed he has a</p>	I 229	<p>2. Cross reference W189</p>	9/25/09

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I 229	<p>Continued From page 10</p> <p>history an unsteady gait and falls. The review of a physician's order dated June 26, 2009 revealed a gait belt was prescribed to prevent the resident from falling. Further record review on August 19, 2009 at 12:50 p.m., revealed a staff training signature form indicating that training had been provided on Resident #1's walking protocol. According to the walking protocol, dated July 21, 2009, staff interventions to ensure the resident's safety during ambulation included the following:</p> <p>(a) During ambulation, staff should stand to the right side of the resident...</p> <p>(b) Provide assistance by placing arm around the resident's waist, holding onto the gait belt.</p> <p>Further review of training records on August 19, 2009 at 12:50 p.m., revealed staff had also received training on fall prevention on February 27, 2009. At the time of the survey, however, there was no evidence each staff demonstrated that training on Resident #1's ambulation protocol had been effective to ensure that it was implemented at all times.</p> <p>3. [Cross refer to Federal Deficiency Report - W474] The facility failed to ensure that staff were effectively trained to implement Resident #1's therapeutic diet.</p> <p>On August 18, 2009, at 10:29 a.m., Resident #1 was served a large peeled banana for a snack as he sat in the armchair in the living room. The resident finished eating the banana by taking three bites from it, each time stuffing the piece of banana into his mouth.</p> <p>On August 19, 2009, at 8:50 a.m., Resident #1 was observed sitting at the dining table eating a four ounce cup of applesauce. At 9:07 a.m., he</p>	I 229	<p>3. Cross reference W474</p>	<p>9/25/09</p>
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I 229	<p>Continued From page 11</p> <p>was observed eating uncooked apple wedges. He used his fork to put the apple wedges into his mouth, then began to chew them. The resident finished eating the apple at 9:27 a.m., then stood in the doorway of the kitchen. At that time, staff gave him a large peeled banana, which he again finished in three large bites, failing to chew it thoroughly.</p> <p>On August 19, 2009 at 10:55 a.m., Resident #1's annual nutritional assessment dated January 16, 2009 revealed the texture of his diet should be Mechanically Soft. The diet plan included "soft ripened fruit, such peaches, pears an bananas which can be mashed to an appropriate consistency." Record review on August 19, 2009 at 12:40 p.m. revealed the nutritionist provided training to staff on diet textures on April 8, 2009. At the time of the survey, however, there was no evidence the staff training provided had been effective to ensure Resident #1 received each food in the prescribed texture and in accordance with his assessed needs.</p>	I 229		
I 274	<p>3513.1(e) ADMINISTRATIVE RECORDS</p> <p>Each GHMRP shall maintain for each authorized agency ' s inspection, at any time, the following administrative records:</p> <p>(e) Signed agreements or contracts for professional services;</p> <p>This Statute is not met as evidenced by: Based on record review, the Group Home for the Mentally Retarded (GHMRP) failed to provide evidence of contracts for four of the eleven consultants reviewed. (Occupational Therapist, Social Worker, Speech Pathologist and Psychiatrist)</p>	I 274		

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I 274	Continued From page 12 The finding includes: The State regulatory agency conducted a review of personnel records on August 18, 2009 at approximately 8:45 am, at which time there was no evidence of a signed professional contract or record for the Occupational Therapist, Social Worker, Speech Pathologist and Psychiatrist). The Qualified Mental Retardation Professional (QMRP) confirmed the findings.	I 274	The files were updated. In the future, the QMRP will ensure that all files for all consultants are current.	9/9/09
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 Group Home for the Mentally Retarded (GHMRP) failed to ensure that five of seven nurses had annual 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. The finding includes:	I 395		

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I 395	Continued From page 13 The State regulatory agency conducted a review of personnel records on August 18, 2009 at approximately 10:45 a.m., at which time the GHMRP failed to ensure that five of seven nurses had annual 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. The Qualified Mental Retardation Professional (QMRP) confirmed the findings.	I 395	The files were updated. In the future, the QMRP will ensure that all files for all of the nurses are up to date.	9/9/09
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, staff interview and record verification, the Group Home for the Mentally Retarded (GHMRP) failed to provide professional services that included 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, for one of two residents in the facility. (Resident #1) The findings include: 1. Observation of the medication pass on August 17, 2009, at approximately 6:15 p.m., revealed the Registered Nurse (RN) administered Haldol 5	I 401	1. Cross reference W322	9/9/09

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I 401	<p>Continued From page 14</p> <p>mg and Seroquel 200 mg to Resident #1.</p> <p>Interview with RN on August 17, 2009, at approximately 6:16 p.m., revealed Resident #1 was prescribed Haldol 5 mg and Seroquel 200 mg for behavior management. Review of Resident #1's physician's orders (POS) dated July 13, 2009, on August 17, 2009, at approximately 6:30 p.m., revealed Resident #1 was prescribed Haldol 5mg and Seroquel 200 mg every evening and Prozac 60 mg every day. Further review of the POS revealed there were no updated orders in August, 2009, for Haldol 5 mg every evening and Prozac 60 mg every day.</p> <p>There was no documented evidence the Primary Care Physician (PCP) ordered the aforementioned psychotropic medications every thirty (30)days.</p> <p>2. The facility's nursing staff failed to ensure health care systems were in place to monitor and identify services to maintain Resident #1's skin integrity as evidenced by:</p> <p>During medication administration observation on August 17, 2009, at approximately 6:17 p.m., Resident #1 was observed to have open areas in the skin behind the right ear and on the right side of the forehead. In an interview with the Registered Nurse #1 (RN #1) on August 17, 2009, at approximately 6:27 p.m., it was acknowledged Resident #1 had open skin areas behind the right ear and on the right side of the forehead due to self-injurious behavior (SIB). Further interview revealed Resident #1's aforementioned open skin areas had not been assessed or medically treated. Review of Resident #1's psychological assessment dated January 23, 2009, on August 17, 2009, at 6:45</p>	I 401	<p>2. Cross reference W331</p>	<p>9/16/09</p>

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I 401	<p>Continued From page 15</p> <p>p.m., confirmed Resident #1 had targeted behaviors that included SIB (skin picking). Review of Resident #1's August 2009, physician's order sheet (POS) and August 2009, Medication Administration Records (MAR's) on August 17, 2009, at 6:50 p.m., did not reveal any treatment orders for the aforementioned open skin areas.</p> <p>There was no documented evidence the facility establish systems to monitor and identify services to maintain the resident's skin integrity.</p>	I 401		
I 422	<p>3521.3 HABILITATION AND TRAINING</p> <p>Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan.</p> <p>This Statute is not met as evidenced by: A. Based on observation, interview and record review, the GHMRP failed to provide training and assistance to each resident in accordance with the resident's Individual Habilitation Plan for two of two residents in the sample. (Residents #1 and #2).</p> <p>The finding includes:</p> <p>1. During evening observations on August 17, 2009, at 6:28 PM, direct care staff was observed turning on the radio.</p> <p>Review of Resident #2's Individual Program Plan dated September 19, 2008, on August 18, 2009 at 2:01 p.m. revealed a program objective which stated, "[the resident] will improve his fine motor skills by locating the adaptive play button on his CD player 80% of trials three times a week for 12 consecutive months." At the time of observations, there was no evidence that staff</p>	I 422	<p>1. Cross reference W249</p>	<p>9/25/09</p>

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I 422	<p>Continued From page 16</p> <p>encouraged the resident to turn on his radio.</p> <p>2. The facility failed to ensure that Resident #1's Behavior Support Plan (BSP) was implemented as written.</p> <p>On August 19, 2009, at 11:15 a.m., Resident #1 was observed not wearing his gait belt as he walked alone, with a slightly unsteady gait, from the living room through the dining room, to the kitchen. During this time, Resident #1's one on one staff was in the kitchen preparing the resident's lunch.</p> <p>Interview with the same staff, also assigned to Resident #1 on August 18, 2009 at 8:25 a.m., revealed the resident required 1:1 supervision to address his non-compliance and to manage his challenging behaviors.</p> <p>Resident #1's BSP dated November 18, 2008, was reviewed on August 19, 2009 at 9: 50 AM. The BSP revealed that the resident needed 1:1 staffing during waking hours because the resident was primarily a danger to himself without it. Record review on August 19, 2009 at 12:40 p.m. revealed a policy which stated that during 1:1 hours, the staff supervising the resident should be within arm's length of the resident at all times.</p> <p>At the time of the survey, there was no evidence that staff had consistently implemented Resident #1's BSP, by maintaining arm's length distance from the resident at all times as specified in the plan.</p> <p>3. The facility failed to ensure Resident #1 receive the recommended activities identified by the IDT to increase his physical endurance.</p>	I 422	<p>2. Cross reference W189</p> <p>3. Cross reference W249</p>	<p>9/25/09</p> <p>9/9/09</p>

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I 422	<p>Continued From page 17</p> <p>Observation on August 18, 2009 between the hours of 8:20 am and 10 30 a.m. revealed Resident #1 seated in the armchair in the living room with his eyes closed and appearing to be asleep. He continued to appear to be sleeping, until his peers returned home from their day programs, except for intermittently going to the second level of the home, and during lunch and snack (a.m. and p.m.) time. During this time, the resident's 1:1 staff was observed to intermittently attempt to engage the resident in an activity, which the resident refused.</p> <p>Interview with the Resident #1's 1:1 staff on August 18, 2009 at 8:30 a.m., indicated that the resident is usually not active on two consecutive days. On the same day at 4:45 p.m., the evening staff indicated that the resident was supposed to participate in a training program recommended by the physical therapist. Further interview with the 1:1 staff, and also the residential manager and the QMRP on August 19, 2009 at 12:10 p.m., revealed Resident #1 had a training objective to improve his physical endurance which had not been implemented.</p> <p>Record review on August 19, 2009 at 10:49 a.m. revealed Resident #1's IPP included an objective to improve his endurance. According to strategies and activities, given physical assistance by his 1:1 direct care staff, the resident will be able to participate in aerobic activities to music for 10 minutes (to include marching, stepping side to side and jumping). The review of program data revealed, as confirmed by the aforementioned staff, that there was no evidence Resident #1 had received needed training to increase his physical endurance, as recommended by the IDT.</p>	I 422		

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I 422	<p>Continued From page 20</p> <p>the date on which the resident initially injured his neck by skin picking could not be determined. There was no evidence that the facility had ensured that the resident's skin picking behavior had been documented in measurable terms.</p> <p>4. On August 17, 2009, at 4:47 PM, Resident #1 was observed wearing eye glasses. Af approximately 5:05 p.m., the resident was observed to remove his glasses and to give then to a staff.</p> <p>Interview with the resident's 1:1 staff on August 19, 2009, at 10:23 a.m. revealed the Resident #1 was supposed to wear eyeglasses, but refused to wear them.</p> <p>Record review on August 19, 2009, at 11:41 a.m., revealed Resident #1 had a health objective which stated he "will be free from eye infections." Strategies and activities to achieve the objective revealed that the resident "will wear polycarbonate lenses to protect his left eye." Staff were identified as responsible for monitoring whether the resident wore his glasses. The review of program data for July 2009, reflected that the resident refused to wear his eye glasses. Further record review, however, revealed there was no program data available for June and August 2009 to reflect the resident's progress in the objective. At the time of the survey, there was no evidence that data to monitor resident's progress on tolerance of his eyeglasses had been consistently documented.</p>	I 422	4. Cross reference W252	9/25/09

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I 422	<p>Continued From page 19</p> <p>was to reduce the resident's challenging behaviors, which included skin picking, sticking his fingers up his nose, licking his fingers and urinating in his clothing to zero per month.</p> <p>The review of the ABC documentation form for monitoring the resident's targeted behaviors revealed that it required the information below to be documented each time the resident exhibited a targeted behavior:</p> <p>(a) Date and time (b) Antecedent (c) Behavior (d)Consequences</p> <p>On August 19, 2009 at 11:30 a.m., the review of the ABC data collected from June 16, 2009 through August 23, 2009 revealed that the time at which the behaviors occurred had not been consistently documented. There was no evidence the facility had ensure the collection of Resident #1's behavioral data in measurable terms.</p> <p>3. On August 18, 2009, at 8:40 a.m., a pink colored area was observed on the back (right side) of Resident #1's neck, which appeared to be healing. A dry red area of skin was observed at the center of the pink area.</p> <p>Interview with the staff on August 18, 2009 at 4:10 p.m. concerning how the injury to Resident #1's neck occurred, revealed "He did it to himself. Skin picking is one of his behaviors." Interview with the QMRP and the residential manager on August 19, 2009 at 9:17 a.m. revealed the resident had a BSP to address his skin picking. Subsequent interviews with the QMRP, the residential manager, and the R.N. revealed that</p>	I 422	3. Cross reference W252	9/25/09