

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

PRINTED: 06/19/2009  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>09G062</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>05/28/2009</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>COMMUNITY MULTI SERVICES, INC</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6300 9TH STREET NW<br/>WASHINGTON, DC 20011</b> |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| W 000 | <p><b>INITIAL COMMENTS</b></p> <p>A recertification survey was conducted from May 26, 2009 through May 28, 2009. The survey was initiated using the fundamental survey process. A random sample of three clients was selected from a population of six female 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 two day programs, interviews with clients and staff, and the review of clinical and administrative records including incident reports.</p>  | W 000 | <p><i>Received 6/26/09</i></p> <p>GOVERNMENT OF THE DISTRICT OF COLUMBIA<br/>DEPARTMENT OF HEALTH<br/>HEALTH REGULATION ADMINISTRATION<br/>825 NORTH CAPITOL ST., N.E., 2ND FLOOR<br/>WASHINGTON, D.C. 20002</p> |         |
| W 114 | <p><b>483.410(c)(4) CLIENT RECORDS</b></p> <p>Any individual who makes an entry in a client's record must make it legibly, date it, and sign it.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all persons making entries into the clients' records were dated, for two of the three clients in the sample. (Clients #2 and #3)</p> <p>The findings include:</p> <p>1. Review of Client #2's medical record on May 27, 2009 at approximately 2:30 PM revealed a nursing quarterly assessment which was not dated. The observation was brought to the attention of the Registered Nurse on May 28, 2009 at approximately 10:00 AM; who acknowledged that the nursing quarterly assessment was not dated.</p> <p>2. Review of Client #3's medical record on May 27, 2009 at approximately 4:00 PM revealed a nursing quarterly assessment which was not</p> | W 114 | <p>All nursing assessments will be dated and signed before being put in the medical records. The QMRP and Primary Care Nurse will review annually for signatures.</p>  | 6/23/09 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Christine L. Reese* TITLE *Program Director* (X5) DATE *6/26/09*

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 114  | Continued From page 1 dated. The observation was brought to the attention of the Registered Nurse on May 28, 2009 at approximately 11:00 AM; who acknowledged that the nursing quarterly assessment was not dated.   | W 114   |  |                      |   |
| W 124  | <p><b>483.420(a)(2) PROTECTION OF CLIENTS RIGHTS</b></p> <p>The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to establish a system that would ensure clients were informed of their risks and benefits of their medication, for one of the three clients included in the sample. (Client #2)</p> <p>The finding includes:</p> <p>The facility failed to obtain consents prior to the use of sedation for medical appointments and/or to notify the clients guardian the risks and benefits of treatments for one of the three clients included in the sample. (Client #2)</p> <p>Review of Client #2's physician orders dated May 2009, on May 27, 2009, at approximately 9:00 AM revealed the following sedations:</p> <p>- On January 5, 2009, Client #2 received Ativan 3 mg prior to an ophthalmology appointment;</p> | W 124   | <p>The QMRP will ensure that consent is obtained for all medical treatments, for all individuals from their guardians or family members. The QMRP will also ensure that all signed consent forms are included in the medical records of each individual.</p> | 6/23/09              |   |

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| W 159  | Continued From page 3<br>Professional (QMRP) failed to coordinate services, for three of the three clients included in the sample. (Clients #1, #2 and #3)<br><br>The findings include:<br><br>1. The QMRP failed to ensure that assessments were conducted, for one of three clients included in the sample. [See W212]<br><br>2. The QMRP failed to ensure that an objective was developed to address self medication training program needs identified by the interdisciplinary team (IDT), for one of the three clients in the sample. [See W227]<br><br>3. The QMRP failed to ensure each client's individual program plan (IPP) included training in activities of daily living skills in both formal and informal setting, for one of the three clients included in the sample. [See W242]<br><br>4. The QMRP failed to ensure that each client was provided opportunities to make a choice during snack time. [See W247]<br><br>5. The QMRP failed to ensure that as soon as the interdisciplinary team 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 one of the three clients included in the sample. [See W249] | W 159   | 1. Cross reference W214 and W212<br><br>2. Cross reference W227<br><br>3. Cross reference W227 and W242<br><br>4. Cross reference W247<br><br>5. Cross reference W249 | 6/23/09<br><br>6/23/09<br><br>6/23/09<br><br>6/23/09<br><br>6/23/09 & 7/8/09 |   |
| W 192  | 483.430(e)(2) STAFF TRAINING PROGRAM<br><br>For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.   | W 192   |   |  |   |

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| W 192  | Continued From page 4<br><br>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure employees demonstrated competency in following the menu as posted, for six of the six client's included in the sample. (Clients #1, #2, #3, #4, #5, and #6)<br><br>The finding includes:<br><br>On May 26, 2009, at 5:10 PM, Clients #1, #2, #3, #4, #5, and #6 were served chicken, sweet potatoes, salad, milk and water. Inquiry was made to the direct care staff, after the dinner about dessert and to review the menu. The posted menu called for baked ziti with italian sausage, broccoli, wheat bread, margarine, milk and apples/apple crisp. Interview with the Qualified Mental Retardation Professional (QMRP) on May 26, 2009 at approximately 7:20 PM indicated that the staff failed to prepare the posted menu items for the clients dinner. "I will have to speak to the staff that prepared the dinner." An inspection was made at 7:40 PM and revealed that the items posted on the menu were available in the facility. | W 192   | All staff were trained by the nutritionist on food portions, food consistency, substitution, and following the menus. The QMRP will ensure that staff continue to receive ongoing training on nutrition/ meal protocol quarterly. | 6/12/09              |   |
| W 214  | 483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN<br><br>The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs.<br><br>This STANDARD is not met as evidenced by: Based on interview and record review, the facility  | W 214   | A case conference was held with Client #1's IDT on 5/13/09. The behavior specialist for Client #1 revised her BSP to include behavior interventions that address food stealing.   | 6/23/09              |   |

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| W 214  | Continued From page 5<br>failed to ensure that the comprehensive functional assessment identified behavioral need interventions, for one of the three clients included in the sample. (Client #5)<br><br>The finding includes:<br><br>The facility failed to assess Client #1's behavior (food stealing) to determine it's cause and develop strategies for implementation to address the behaviors.<br><br>Interview with the day program staff on May 27, 2009 at approximately 1:15 PM indicated that Client #1 steals other clients and staff food from the refrigerator. Further interview with the day program staff revealed that the client does not have a Behavior Support Plan (BSP) to address the food stealing behavior.<br><br>Interview with the residential Qualified Mental Retardation Professional (QMRP) on May 27, 2009 at approximately 3:00 PM revealed that a case conference was held with the day program staff. During the case conference, proactive strategies were put in place to eliminate the behavior of food stealing. The proactive strategies included: put the trash can in sight of the staff, and do not allow Client #1 to enter the kitchen without supervision.<br><br>Although a case conference (no documentation to support) was held, there was no evidence that the client's food stealing had been assessed or addressed by the Interdisciplinary team to determine if a training objective was warranted. | W 214   | The QMRP will ensure that all records are available in all individuals medical and active treatment books. The QMRP/ Residential Manager will review documentation monthly. | 6/23/09              |   |
| W 227  | 483.440(c)(4) INDIVIDUAL PROGRAM PLAN  | W 227   |   |                      |   |

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| W 227 | <p>Continued From page 6</p> <p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that an objective was developed to address self medication training program needs identified by the interdisciplinary team (IDT), for three of the three clients included in the sample. (Clients #1, #2, and #3)</p> <p>The findings include:</p> <p>1. During medication administration observation on May 27, 2009, at 8:05 AM, Client #1 was observed pouring a cup of water, and using hand sanitizer, with verbal prompts from the medication nurse. She was further observed punching the medications from a bubble pack into a medication cup with physical assistance. Interview with the medication nurse, after the medication administration indicated that the client participated in the self medication administration but there was no program in place.</p> <p>Review of Client #1's self medication assessment dated April 27, 2009, on May 27, 2009, at 2:00 PM indicated that the client was capable of self-administering medication with assistance and close supervision. The assessment did not indicate that the client was recommended for a self medication program.</p> <p>Review of the Individual Program Plan (IPP)</p> | W 227 | <p>1. The self-medication assessments will be revised to include recommendations and a self-medication program will be put in place. The RN and QMRP will ensure that all individuals have programs with goals in place to improve their daily skills by reviewing monthly goals.</p> | 6/23/09 |
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| W 227  | <p>Continued From page 7 dated December 3, 2008, revealed no program goal or objective for the Client #1 to receive training in self medication.</p> <p>2. During the medication administration on May 27, 2009, at 8:43 AM, the RN was observed attempting to assist Client #2 with pouring a cup of water. The client refused and the nurse was observed pouring and preparing Client #2's medication. The RN put the medication into a cup of applesauce and handed the cup to the client. The client ate the applesauce mixture, independently. Interview with the RN, after the medication administration indicated that Client #2 does not have a program goal to participate in the self administration process.</p> <p>Review of the self medication assessment dated December 5, 2008, on May 27, 2009 at approximately 11:00 AM, indicated that the client is on Level II and requires staff assistance. Although, the assessment identified numerous skills that the client lacked, the nurse had made no recommendations for a training program. Further review of Client #2's IPP dated January 9, 2009, on May 27, 2009 at 11:15 AM revealed no program goal or objective for the client to receive training in self medication.</p> <p>3. During the medication administration observation on May 27, 2009, at 8:23 AM, Client #3 was observed pouring, punching medications from a bubble pack with hand over hand assistance from the RN. The RN put the medication in a cup of applesauce and handed the cup to the client. Client #3 was observed consuming the medication mixture, requiring verbal prompts.</p> | W 227   | <p>2. Cross reference W227.1</p> <p>3. Cross reference W227.1</p>   | <p>6/23/09</p> <p>6/23/09</p>                       |



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| W 247  | Continued From page 9<br>cup of water. Observation and interview with the Qualified Mental Retardation Professional (QMRP) on May 27, 2009, indicated that the clients enjoyed the snack they received. During the environmental inspection on May 28, 2009, there was a variety of snacks in the pantry and the refrigerator. At no time during snack time were the clients given the opportunity to select a snack from the variety of food choices.   | W 247   |   |   |
| W 249  | 483.440(d)(1) PROGRAM IMPLEMENTATION<br><br>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.<br><br>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 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 one of the three clients included in the sample. (Client #3)<br><br>The findings include:<br><br>1. During evening observations on May 26, 2009 at 5:30 PM, Client #3 was observed placing her dinner dishes in the kitchen sink. The direct care staff was observed rinsing the dishes and placing | W 249   | 1. All staff will be trained on the IPP goals of all individuals in the home.                                   |   |

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| W 249  | Continued From page 10<br>them in the dishwasher. Interview with the direct care staff indicated that the client may help sometimes with dinner clean up.  | W 249   | The staff will receive ongoing training on all goals and objectives for each individual.  | 7/8/09               |   |
|  | <p>Review of Client #3's IPP dated August 25, 2008, on May 28, 2009, at 11:15 AM revealed a program that required Client #3 to rinse her dishes after eating dinner independently in 100% of the trials daily for 12 consecutive months. At the time of observations, there was no evidence that staff implemented Client #3's program objective (rinse her dishes) as required.</p> <p>2. Observation during the dinner meal on May 26, 2009 at 5:10 PM, Client #3 was observed with a small amount of food on her plate. Interview with the direct care staff and Qualified Mental Retardation Professional (QMRP), after dinner revealed that Client #3 was on a 1500 calorie restrictive diet.</p> <p>Review of Client #3's IPP dated August 25, 2008, on May 28, 2009, at 11:15 AM revealed a program that stated, "[the client] will participate in large muscle toning activities when given minimum physical assistance in 60% of the trials.</p> <p>Review of the data collection record on May 28, 2009, at 12:30 reflected no program data sheets. In an interview with the QMRP on May 28, 2009, she acknowledged that the program was not be implemented.</p> <p>3. Day program observations were conducted on May 27, 2009 at approximately 1:30 PM for Client #3. The Individual Program Plan (IPP) Coordinator and day program staff revealed that Client #3 used a assistive communication device (LEO) to communicate her needs. Further</p> |   | <p>2. Client #3 refuses to participate in a formal exercise program. The QMRP will ensure that documentation is included in Client #3's IPP book that references Client #3's weekly community walking activity. The QMRP will ensure that all record books include all relevant and necessary documentation for all individuals by reviewing records monthly.</p> <p>3. All staff will be trained on the use of Client #3's communication device. The QMRP will ensure that all staff receive ongoing training on Client #3's</p> | 6/23/09              |   |

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| W 249  | Continued From page 11<br>interview indicated that the communication device was transported to and from the day program. There was no observation noted of Client #3 using a communication device during the survey observation or process.  | W 249   | communication program by scheduling additional training.  | 7/8/09  |
| W 263  | Interview with the QMRP on May 27, 2009 at 3:30 PM confirmed that the Client #3 had such a device. It was further revealed that the client had a program goal to improve her communication skills. Review of Client #3's IPP dated August 25, 2008, revealed an objective stated, "[the client] will improve her communication skills by using her LEO communication device to activate a sound when she presses a picture 80% of trials, etc...."<br><br>There was no evidence that staff implemented Client #3's communication program as recommended by the IDT.<br><b>483.440(f)(3)(ii) PROGRAM MONITORING &amp; CHANGE</b><br><br>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.<br><br>This STANDARD is not met as evidenced by: Based on interview and record review, the facility's specially-constituted committee failed to ensure that restrictive programs were used only after written consents had been obtained, for one of the three clients included in the sample. (Client #2)<br><br>The finding includes:<br><br>Review of Client #2's physician orders dated May | W 263   | Cross reference W124  | 6/23/09   |

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

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OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>09G062   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                    |   | (X3) DATE SURVEY COMPLETED<br><br>05/28/2009 |
| NAME OF PROVIDER OR SUPPLIER<br><br>COMMUNITY MULTI SERVICES, INC |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6300 9TH STREET NW<br>WASHINGTON, DC 20011 |   |  |
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| W 263   | <p>Continued From page 12</p> <p>2009, on May 27, 2009, at approximately 9:00 AM revealed the following sedations:</p> <ul style="list-style-type: none"> <li>- On January 5, 2009, Client #2 received Ativan 3 mg prior to an ophthalmology appointment;</li> <li>- On January 9, 2009, Client #2 received Ativan 3 mg one hour prior to an ultrasound study; and</li> <li>- On February 6, 2009, Client #2 received Ativan 2 mg one hour prior to an ophthalmology appointment.</li> </ul> <p>During the entrance conference on May 26, 2009, at 5:00 PM, the QMRP indicated that Client #2 had family members who had signed consents for the client's scheduled psychotropic medications. Further interview with the QMRP revealed the client did not have the capacity to give informed consent for the use of her medications and habilitation services.</p> <p>Further review of Client #2's Psychological Assessment dated January 3, 2009, on May 27, 2009, at 11:00 AM revealed that Client #2 "is not able to make independent decisions concerning her habilitation. She lacks the cognitive skills necessary to understand the implications of such decisions and therefore cannot give her informed consent. She lacks the judgment and insight required to make decisions independently." The QMRP further revealed the client did have a legal guardian to assist him in decision making.</p> <p>Review of the client's medical record and additional interview with the QMRP on May 27, 2009, at approximately 2:00 PM failed to evidence that written informed consent had been obtained from the legal guardian. [See W124]</p> | W 263   |   |  |

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

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FORM APPROVED  
OMB NO. 0938-0391

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| W 322  | <p><b>483.460(a)(3) PHYSICIAN SERVICES</b></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 interview and record review, the facility failed to ensure general and preventative care services, for one of three clients included in the sample. (Client #3)</p> <p>The finding includes:</p> <p>The facility failed to have evidence that a recommendation made by the pharmacist was addressed by the Primary Care Physician (PCP) for Client#3.</p> <p>Review of Client #3's medical record on May 27, 2009 at approximately 3:00 PM revealed pharmacy reviews dated May 4, 2009, and February 3, 2009. On the pharmacy reviews, the pharmacist recommended to the primary care physician that the client should be considered for Calcium with Vitamin D due to her diagnosis of Anticonvulsant usage. Interview with the facility's Registered Nurse (RN) on May 28, 2009 at 10:30 AM revealed that primary care physician indicated that the client was already receiving Vitamin A tablet, once per day. However, there was no evidence in the record that the PCP acknowledged the recommendation made from the pharmacist.</p> | W 322   | <p><b>Client #3 started a prescription for Calcium with Vitamin D on 6/10/09. The primary care physician will review all recommendations given by the pharmacist as they are given. The primary care physician will date and sign recommendations.</b></p> | 6/23/09              |   |
| W 325  | <p><b>482.460(a)(3)(iii) PHYSICIAN SERVICES</b></p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory</p>  | W 325   |  |                      |   |

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

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| W 325  | <p>Continued From page 14</p> <p>examinations as determined necessary by the physician.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide routine laboratory testing as determined necessary by the physician, for three of the three clients included in the sample. (Clients #1, #2 and #3)</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. On May 27, 2009, at 8:43 AM, Client #2 was administered Tegretol 400 mg by mouth. Interview with the Registered Nurse (RN) revealed that the medication was prescribed for the client's maladaptive behaviors. Review of Client #2's Physician's Orders (POS) dated May 2009 at approximately 10:00 AM revealed an order for the client to receive Tegretol levels every six months. Review of the laboratory tests on May 27, 2009 at 10:15 AM revealed Client #2 received tegretol laboratory studies October 2008 and July 2008. Further record review and interview with the facility's RN on the same day at 1:55 PM acknowledged that Client # 2's Tegretol levels were not obtained as recommended by the physician.</li> <li>2. Review of Client #2's POS on May 27, 2009 at approximately 10:00 AM revealed an order for a chest X-Ray every two years. Further record review revealed a chest X-ray was completed on January 8, 2007. Interview with the RN indicated that there was not a current chest X-ray.</li> <li>3. The facility failed to obtain laboratory studies as ordered by the Primary Care Physician (PCP).</li> </ol> | W 325   |   |   |

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

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| W 325  | Continued From page 15<br><br>a. Review of Client #1's current physician order dated may 2009, on May 27, 2009 at approximately 10:00 AM revealed an order for the client to have laboratory studies for TSH and TSH4, annually. Further review of the record revealed no evidence of the laboratory studies for TSH or TSH4 were completed.<br><br>Interview with the Registered Nurse (RN) on May 27, 2009 at approximately 11:00 AM revealed that the TSH4 laboratory studies were not completed.<br><br>Record review revealed no evidence of the aforementioned laboratory studies.<br><br>b. Review of Client #3's current physician order dated May 2009 on May 27, 2009 at 3:00 PM revealed an order for the client to have laboratory studies to include: urinalysis, lipid profile, Hepatitis profile, TSH and T4, annually. Further review of the record revealed the aforementioned laboratory studies were not completed or available for record review.<br><br>Interview with the RN on May 28, 2009, at approximately 11:00 AM confirmed the missing laboratory studies. | W 325   | a. Client #1 had her TSH and T4 tested on 10/31/08. Both levels were within normal limits. (TSH:0.663; 0.450-4.500 and T4: 1.03; 0.61-1.76).<br><br>b. Client #3 had her annual lab work to include Lipid Profile (WNL), Hepatitis Profile (immune), TSH(0.726), and T4(1.18). The urinalysis will be completed 6/29/09. The RN will ensure that all labwork is completed as prescribed by the primary care physician and will document in nursing monthly progress notes. | 6/23/09              |   |
| W 369  | 483.460(k)(2) DRUG ADMINISTRATION<br><br>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.<br><br>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to administer medication without error, for one of the six clients residing in the facility.   | W 369   |  | 6/23/09<br>6/29/09   |   |

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

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| W 369   | Continued From page 16<br>(Client #5)<br><br>The finding includes:<br><br>Review of the Client #5's medical administration record (MAR) on May 27, 2009 at approximately 10:00 AM revealed that the Client #5 received Debrox ear drops on February 1, 2009, through February 5, 2009, April 1, 2009, through April 5, 2009, and May 1, 2009 through May 5, 2009. Further review of the client's physician orders at 11:00 AM revealed an order for the client to receive Debrox ear wax removal every other month (February, April, June, August, September and November). Interview with the Registered Nurse (RN) on May 28, 2009, at approximately 10:00 AM confirmed that a medication error occurred. The RN further indicated that an unusual incident should have been written. However, further review of the facility's policy revealed no evidence of an incident report on the medication error. | W 369  | An incident report was completed on the incident.<br><br>All medication nurses and Trained Medication Employees that administer medication in the group home will receive additional training on MAR. | 5/27/09<br><br>6/26/09 |  |
| W 371   | 483.460(k)(4) DRUG ADMINISTRATION<br><br>The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise.<br><br>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to implement an effective system to ensure each client participate in a self-medication program, for three of the three clients included in the sample. (Clients #1, #2 and #3)   | W 371  |   |                        |  |

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

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| W 371  | <p>Continued From page 17</p> <p>The findings include:</p> <p>1. On May 27, 2009, at 8:05 AM, Client #1 was observed participating in the medication administration process with verbal to physical assistance from the medication nurse. Interview with the Registered Nurse (RN), after the medication administration indicated that the client participated in the self medication administration but there was no program in place.</p> <p>Review of Client #1's self medication assessment dated April 27, 2009, on May 27, 2009, at 2:00 PM indicated that the client was capable of self-administering medication with assistance and close supervision. The assessment did not indicate that the client was recommended for a self medication program.</p> <p>Review of the Individual Program Plan (IPP) dated December 3, 2008, revealed no program goal or objective for the Client #1 to receive training in self medication.</p> <p>2. During the medication administration on May 27, 2009, at 8:43 AM, the RN was observed attempting to assist Client #2 with pouring a cup of water. The client refused and the nurse was observed pouring and preparing Client #2's medication. The RN put the medication into a cup of applesauce and handed the cup to the client. The client ate the applesauce mixture, independently. Interview with the RN, after the medication administration indicated that Client #2 does not have a program goal to participate in the self administration process.</p> <p>Review of the self medication assessment dated</p> | W 371   | Cross reference W227  | 6/23/09              |   |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| W 371  | Continued From page 18<br>December 5, 2008, on May 27, 2009 at approximately 11:00 AM, indicated that the client is on Level II and requires staff assistance. Although, the assessment identified numerous skills that the client lacked, the nurse had made no recommendations for a training program. Further review of Client #2's IPP dated January 9, 2009, on May 27, 2009 at 11:15 AM revealed no program goal or objective for the client to receive training in self medication.<br><br>3. On May 27, 2009, at 8:23 AM, the Client #3 poured a cup of water and punched her from the bubble pack with hand over hand assistance from the RN. The RN put the medication in a cup of applesauce and handed the cup to the client. Client #3 was observed consuming the medication mixture, requiring verbal prompts.<br><br>Review of Client #3's self medication assessment dated April 27, 2009 on May 28, 2009, at 10:00 AM indicated that the client, "will have an opportunity to participate in the process of medication administration." However, the assessment did not indicated that the client was recommended for a self medication program.<br><br>Review of Client #3's IPP dated August 25, 2009, on May 28, 2009, at 10:15 AM revealed no program goal or objective for Client #3 to receive training in self medication. | W 371   |   |   |
| W 436  | 483.470(g)(2) SPACE AND EQUIPMENT<br><br>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.   | W 436   |   |   |

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

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| W 436  | Continued From page 19<br><br>This STANDARD is not met as evidenced by:<br>Based on staff interview and record review, the facility failed to furnish and maintain in good repair hearing aids, for one of the three clients included in the sample. (Client #1)<br><br>The finding includes:<br><br>Review of Client #1's medical record on May 27, 2009, at approximately 11:00 AM revealed a diagnosis to include bilaterally hearing loss. Further review of an audiology consult dated October 10, 2008 on the same date at 11:10 AM revealed recommendation of continued use of the amplification (hearing aids). Interview with the Qualified Mental Retardation Professional on May 27, 2009, at 3:00 PM indicated that the client's hearing aid was broken and had been for approximately six months.<br><br>At the time of the survey, there was no evidence that Client #1 hearing aids had been maintained and in good repair. | W 436   | Client #1's hearing aids will be replaced. Since February 23, 2009 Client #1 had an appointment for a fitting on 6/1/09, but she was in the hospital at that time. The next available time for a fitting at the Audiology Clinic at Washington Hospital Center is July 15, 2009 at 11:00am. | 7/15/09              |   |

Health Regulation Administration

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                         |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>HFD03-0083</b>                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br><b>05/28/2009</b> |
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| 1 000  | <b>INITIAL COMMENTS</b><br><br>A recertification survey was conducted from May 26, 2009 through May 28, 2009. The survey was initiated using the fundamental survey process. A random sample of three residents was selected from a population of six female residents with various levels of mental retardation and disabilities.<br><br>The findings of the survey was based on observations at the group home and two day programs, interviews with residents and staff, and the review of clinical and administrative records including incident reports.   | 1 000   |   |   |
| 1 090  | <b>3504.1 HOUSEKEEPING</b><br><br>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.<br><br>This Statute is not met as evidenced by: Based on observation and interview the GHMRP failed to maintain the interior of the GHMRP in a safe, clean, orderly, and attractive manner .<br><br>The finding includes:<br><br>The GHMRP failed to maintain the exterior environment safe as evidenced below:<br><br>During the environmental inspection on May 28, 2009, at approximately 120 PM, a can of anti-freeze was sitting on a table in the back yard. | 1 090   | <b>The container of anti-freeze was removed immediately. The GHMRP will ensure that all chemicals are locked away and out of reach of the individuals. The QMRP/ House Manager will complete a weekly inspection of the facility.</b> | <b>6/23/09</b>                                      |
| 1 291  | <b>3514.2 RESIDENT RECORDS</b>  | 1 291   |   |   |

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Constantine P. Reese* Program Director

(X6) DATE  
**6/26/09**

Health Regulation Administration

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| I 291  | Continued From page 1<br><br>Each record shall be kept current, dated, and signed by each individual who makes an entry.<br><br>This Statute is not met as evidenced by:<br>Based on record review, the GHMRP failed to ensure each residents nursing quarterly assessments were dated, for two of the three residents in the facility. (Residents #2 and #3)<br><br>The findings include:<br><br>1. Review of Resident #2's medical record on May 27, 2009 at approximately 2:30 PM revealed a nursing quarterly assessment which was not dated. The observation was brought to the attention of the Registered Nurse on May 28, 2009 at approximately 10:00 AM; who acknowledged that the nursing quarterly assessment was not dated.<br><br>2. Review of Resident #3's medical record on May 27, 2009 at approximately 4:00 PM revealed a nursing quarterly assessment which was not dated. The observation was brought to the attention of the Registered Nurse on May 28, 2009 at approximately 11:00 AM; who acknowledged that the nursing quarterly assessment was not dated. | I 291   | <b>Cross reference W114</b>   | <b>6/23/09</b>                                      |
| I 401  | <b>3520.3 PROFESSION SERVICES: GENERAL PROVISIONS</b><br><br>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.<br><br>This Statute is not met as evidenced by:  | I 401   | <b>Cross reference W214</b>   | <b>6/23/09</b>                                      |

Health Regulation Administration

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>HFD03-0083</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>05/28/2009</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>COMMUNITY MULTI SERVICES, INC</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6300 9TH STREET NW<br/>WASHINGTON, DC 20011</b> |
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| 1401 | <p>Continued From page 2</p> <p>Based on observation, interview and record review, the GHMRP failed to ensure evaluations were conducted for one of the three residents included in the sample. (Resident #1)</p> <p>The finding includes:</p> <p>The facility failed to assess Resident #1's behavior (food stealing) to determine it's cause and develop strategies for implementation to address the behaviors.</p> <p>Interview with the day program staff on May 27, 2009 at approximately 1:15 PM indicated that Resident #1 steals other clients and staff food from the refrigerator. Further interview with the day program staff revealed that the resident does not have a Behavior Support Plan (BSP) to address the food stealing behavior.</p> <p>Interview with the residential Qualified Mental Retardation Professional (QMRP) on May 27, 2009 at approximately 3:00 PM revealed that a case conference was held with the day program staff. During the case conference, proactive strategies were put in place to eliminate the behavior of food stealing. The proactive strategies included: put the trash can in sight of the staff, and do not allow Resident #1 to enter the kitchen without supervision.</p> <p>Although a case conference (no documentation to support) was held, there was no evidence that the resident's food stealing had been assessed or addressed by the Interdisciplinary team.</p> | 1401 |  |  |
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| 1420 | <p>3521.1 HABILITATION AND TRAINING</p> <p>Each GHMRP shall provide habilitation and</p> | 1420 | Cross reference W227 | 6/23/09 |
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Health Regulation Administration

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| I 420 | <p>Continued From page 3</p> <p>training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning.</p> <p>This Statute is not met as evidenced by:<br/>Based on observation, interview and record review, the GHMRP failed to provide habilitation and training to its residents that would enable them to acquire and maintain life skills needed to cope with their environments and achieve optimum levels of physical, mental and social functioning for three of the three residents included in the sample. (Residents #1, #2, and #3)</p> <p>The findings include:</p> <p>1. During medication administration observation on May 27, 2009, at 8:05 AM, Resident #1 was observed pouring a cup of water, and using hand sanitizer, with verbal prompts from the medication nurse. She was further observed punching the medications from a bubble pack into a medication cup with physical assistance. Interview with the medication nurse, after the medication administration indicated that the resident participated in the self medication administration but there was no program in place.</p> <p>Review of Resident #1's self medication assessment dated April 27, 2009, on May 27, 2009, at 2:00 PM indicated that the resident was capable of self-administering medication with assistance and close supervision. The assessment did not indicated that the resident was recommended for a self medication program.</p> | I 420 |  |  |
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Health Regulation Administration

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>HFD03-0083</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>05/28/2009</b> |
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| 1420 | <p>Continued From page 4</p> <p>Review of the Individual Program Plan (IPP) dated December 3, 2008, revealed no program goal or objective for the Resident #1 to receive training in self medication.</p> <p>2. During the medication administration on May 27, 2009, at 8:43 AM, the RN was observed attempting to assist Resident #2 with pouring a cup of water. The resident refused and the nurse was observed pouring and preparing Resident #2's medication. The RN put the medication into a cup of applesauce and handed the cup to the resident. The resident ate the applesauce mixture, independently. Interview with the RN, after the medication administration indicated that Resident #2 does not have a program goal to participate in the self administration process.</p> <p>Review of the self medication assessment dated December 5, 2008, on May 27, 2009 at approximately 11:00 AM, indicated that the resident is on Level II and requires staff assistance. Although, the assessment identified numerous skills that the client lacked, the nurse had made no recommendations for a training program. Further review of Resident #2's IPP dated January 9, 2009, on May 27, 2009 at 11:15 AM revealed no program goal or objective for the resident to receive training in self medication.</p> <p>3. During the medication administration observation on May 27, 2009, at 8:23 AM, Resident #3 was observed pouring, punching medications from a bubble pack with hand over hand assistance from the RN. The RN put the medication in a cup of applesauce and handed the cup to the resident. Resident #3 was observed consuming the medication mixture, requiring verbal prompts.</p> | 1420 |  |  |
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## Health Regulation Administration

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| I 420  | Continued From page 5<br><br>Review of Resident #3's self medication assessment dated April 27, 2009 on May 28, 2009, at 10:00 AM indicated that the client, "will have an opportunity to participate in the process of medication administration." However, the assessment did not indicated that the resident was recommended for a self medication program.<br><br>Review of Resident #3's IPP dated August 25, 2008, on May 28, 2009, at 10:15 AM revealed no program goal or objective for Resident #3 to receive training in self medication.   | I 420   |   |   |
| I 422  | <b>3521.3 HABILITATION AND TRAINING</b><br><br>Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident 's Individual Habilitation Plan.<br><br>This Statute is not met as evidenced by:<br>Based on observation, staff interview and record review, the GHMRP failed to ensure habilitation, training and assistance was provided to residents in accordance with their Individual Habilitation Plan (IHP), for one of the three residents included in the sample. (Resident #3)<br><br>The finding includes:<br><br>1. During evening observations on May 26, 2009 at 5:30 PM, Resident #3 was observed placing her dinner dishes in the kitchen sink. The direct care staff was observed rinsing the dishes and placing them in the dishwasher. Interview with the direct care staff indicated that the resident may help sometimes with dinner clean up.<br><br>Review of Resident #3's IPP dated August 25, 2008, on May 28, 2009, at 11:15 AM revealed a | I 422   | <b>Cross reference W249</b>   | <b>7/8/09</b>                                       |



## Health Regulation Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                         |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>HFD03-0083</b>                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br><b>05/28/2009</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>COMMUNITY MULTI SERVICES, INC</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6300 9TH STREET NW<br/>WASHINGTON, DC 20011</b> |   |   |
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| I 422  | Continued From page 7<br><br>PM confirmed that the Resident #3 had such a device. It was further revealed that the resident had a program goal to improve her communication skills. Review of Resident #3's IPP dated August 25, 2008, revealed an objective stated, "[the resident] will improve her communication skills by using her LEO communication device to activate a sound when she presses a picture 80% of trials, etc...."<br><br>There was no evidence that staff implemented Resident #3's communication program as recommended by the IDT.  | I 422   |   |   |
| I 436  | 3521.7(f) HABILITATION AND TRAINING<br><br>The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas:<br><br>(f) Health care (including skills related to nutrition, use and self-administration of medication, first aid, care and use of prosthetic and orthotic devices, preventive health care, and safety);<br><br>This Statute is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that its residents were afforded the opportunity to learn how to take part in their self medication program as required by this section and as evidenced below, for three of the three residents included in the sample. (Residents #1, #2 and #3)<br><br>The findings include:<br><br>1. On May 27, 2009, at 8:05 AM, Resident #1 was observed participating in the medication administration process with verbal to physical assistance from the medication nurse. Interview | I 436   | Cross reference W227  | 6/23/09   |

Health Regulation Administration

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| I 436  | <p>Continued From page 8</p> <p>with the Registered Nurse (RN), after the medication administration indicated that the resident participated in the self medication administration but there was no program in place.</p> <p>Review of Resident #1's self medication assessment dated April 27, 2009, on May 27, 2009, at 2:00 PM indicated that the resident was capable of self-administering medication with assistance and close supervision. The assessment did not indicate that the resident was recommended for a self medication program.</p> <p>Review of the Individual Program Plan (IPP) dated December 3, 2008, revealed no program goal or objective for the Resident #1 to receive training in self medication.</p> <p>2. During the medication administration on May 27, 2009, at 8:43 AM, the RN was observed attempting to assist Resident #2 with pouring a cup of water. The resident refused and the nurse was observed pouring and preparing Resident #2's medication. The RN put the medication into a cup of applesauce and handed the cup to the resident. The resident ate the applesauce mixture, independently. Interview with the RN, after the medication administration indicated that Resident #2 does not have a program goal to participate in the self administration process.</p> <p>Review of the self medication assessment dated December 5, 2008, on May 27, 2009 at approximately 11:00 AM, indicated that the client is on Level II and requires staff assistance. Although, the assessment identified numerous skills that the client lacked, the nurse had made no recommendations for a training program. Further review of Resident #2's IPP dated</p> | I 436   |   |   |

## Health Regulation Administration

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| I 436  | Continued From page 9<br><br>January 9, 2009, on May 27, 2009 at 11:15 AM revealed no program goal or objective for the resident to receive training in self medication.<br><br>3. On May 27, 2009, at 8:23 AM, the Resident #3 poured a cup of water and punched her from the bubble pack with hand over hand assistance from the RN. The RN put the medication in a cup of applesauce and handed the cup to the resident. Resident #3 was observed consuming the medication mixture, requiring verbal prompts.<br><br>Review of Resident #3's self medication assessment dated April 27, 2009 on May 28, 2009, at 10:00 AM indicated that the client, "will have an opportunity to participate in the process of medication administration." However, the assessment did not indicated that the client was recommended for a self medication program.<br><br>Review of Resident #3's IPP dated August 25, 2009, on May 28, 2009, at 10:15 AM revealed no program goal or objective for Resident #3 to receive training in self medication. | I 436   |   |   |
| I 500  | 3523.1 RESIDENT'S RIGHTS<br><br>Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws.<br><br>This Statute is not met as evidenced by:<br>Based on interview and record review, the GHMRP failed to ensure the rights of residents were observed and protected in accordance with D.C. Law 2-137 (Rights of Mentally Retarded Citizens), this chapter, and other applicable   | I 500   | <b>Cross reference W124</b>   | <b>6/23/09</b>                                      |

## Health Regulation Administration

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                         |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>HFD03-0083</b>                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br><b>05/28/2009</b> |
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| I 500  | <p>Continued From page 10</p> <p>District and Federal Laws, for one of the three residents included in the sample. (Resident #2)</p> <p>The findings include:</p> <p>The facility failed to obtain consents prior to the use of sedation for a medical appointments and/or to notify the clients guardian the risks and benefits of treatments for one of the three residents included in the sample. (Resident #2)</p> <p>Review of Resident #2's physician orders dated May 2009, on May 27, 2009, at approximately 9:00 AM revealed the following sedations:</p> <ul style="list-style-type: none"> <li>- On January 5, 2009, Resident #2 received Ativan 3 mg prior to an ophthalmology appointment;</li> <li>- On January 9, 2009, Resident #2 received Ativan 3 mg one hour prior to an ultrasound study; and</li> <li>- On February 6, 2009, Resident #2 received Ativan 2 mg one hour prior to an ophthalmology appointment.</li> </ul> <p>During the entrance conference on May 26, 2009, at 5:00 PM, the QMRP indicated that Resident #2 had family members who had signed consents for the resident's scheduled psychotropic medications.</p> <p>On May 26, 2009, further review of Resident #2's record failed to provide evidence that written informed consent had been obtained for the use of the sedative medication. Continued review of Resident #2's records revealed a Psychological assessment dated January 3, 2009, indicated that the resident's cognitive abilities tested in the</p> | I 500   |   |   |

Health Regulation Administration

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>HFD03-0083</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>05/28/2009</b> |
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| 1500 | <p>Continued From page 11</p> <p>profound range of retardation and she lacked the capacity to process information effectively to make sound decisions.</p> <p>At the time of the survey, the facility failed to provide evidence that the potential risks involved in using this medication, or his right to refuse treatment had been explained to the resident and/or legal sanction representative.</p> | 1500 |  |  |
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