

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

PRINTED: 10/27/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/17/2009
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NAME OF PROVIDER OR SUPPLIER MY OWN PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 4141 ANACOSTIA AVE, NE WASHINGTON, DC 20019
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W 000	INITIAL COMMENTS A recertification survey was conducted from September 15, 2009 through September 17, 2009. The survey was initiated using the fundamental survey process. A random sample of two clients was selected from a population of three male clients with various levels of mental retardation and disabilities. 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.	W 000	<p><i>Received 11/5/09</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 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations, interviews, and record reviews, the facility's governing body failed to provide general operating directions over the facility as evidenced by deficiencies cited throughout this report and the following: The physician failed to sign orders within 24 hours as required by local regulation [Title 7, Subtitle D, Chapter 13] for two of the two clients in the sample. (Client #1 and Client #2) a. Review of Client #1's medical record on September 16, 2009, at 9:30 a.m., revealed physician orders (POS) dated November 24, 2008, and February 19, 2009. The POS were for Ativan 2 mg prior to an ENT medical	W 104		See Page 2 Of 18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE 	(X6) DATE 11/5/09
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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 104	<p>Continued From page 1</p> <p>appointments. The POS were counter signed by the Primary Care Physician on December 11, 2008 and March 19, 2009 respectively. Interview with the Registered Nurse on September 16, 2009, at 10:37 a.m., indicated that POS should be counter signed by the PCP within ten days.</p> <p>Review of the facility's policy title "verbal/telephone physician orders" on September 16, 2009, at 4:00 p.m., revealed that "Scheduled drugs may never be ordered verbally or by telephone." Further interview with the RN indicated that she was not aware of the policy.</p> <p>b. Review of Client #2's medical record on September 16, 2009, at 1:15 p.m., revealed physician order (POS) dated July 14, 2009. The POS was for Ativan 3 mg prior to an ophthalmology medical appointments. The POS was counter signed by the Primary Care Physician on August 26, 2009. Interview with the Registered Nurse on September 16, 2009, at 10:37 a.m., indicated that POS should be counter signed by the PCP within ten days.</p> <p>Review of the facility's policy title "verbal/telephone physician orders on September 16, 2009, at 4:00 p.m., revealed that "Scheduled drugs may never be ordered verbally or by telephone." Further interview with the RN indicated that she was not aware of the policy.</p> <p>c. Review of Client #2's medical record on September 16, 2009, at 1:15 p.m., revealed physician order (POS) dated August 8, 2009. The POS was for Ativan 3 mg prior to an ultra sound medical appointments. The POS was counter signed by the Primary Care Physician on August 26, 2009. Interview with the Registered</p>	W 104	<p>W 104 a, b, & c</p> <p>Provider nurses will receive training on the M.O.P's policy for verbal/telephone orders. Nurses will be required to obtain physician signature within 24 hours. Further training will be provided on the provider policy on sedation orders. In future, only written orders for sedation will be received from the physician prior to administration. The provider policy on verbal/telephone orders will be revised to comply with state law. The Director of Health Services will review orders for Schedule II drugs to ensure orders are signed according to regulation standards on an ongoing basis.</p>	11.15.09 Ongoing

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W 104	Continued From page 2 Nurse on September 16, 2009, at 10:37 a.m., indicated that POS should be counter signed by the PCP within ten days.	W 104		
W 124	Review of the facility's policy title "verbal/telephone physician orders on September 16, 2009, at 4:00 p.m., revealed that "Scheduled drugs may never be ordered verbally or by telephone." Further interview with the RN indicated that she was not aware of the policy. Although the facility had a policy in place for ten days. The policy conflicts with state law. 483.420(a)(2) PROTECTION OF CLIENTS RIGHTS 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. 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 two of the two clients included in the sample. (Clients #1 and #2) The findings include: 1. The facility failed to provide evidence that informed consent was obtained from Client #1 and/or family members for sedation given during medical appointments as evidenced below: a. Review of Client #1's physician orders dated	W 124	See response on Page 4 of 18	

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W 124	<p>Continued From page 3</p> <p>November 24, 2008 and February 19, 2009, on September 16, 2009 at 9:01 a.m., revealed sedations for medical appointments on November 25, 2008 and February 19, 2009. The client received Ativan 2 mg prior to Ear Nose Throat (ENT) appointments.</p> <p>During the entrance conference on September 15, 2009, beginning at 6:10 p.m., the Qualified Mental Retardation Professional (QMRP) and Residential Manager indicated that the client had family members to assist Client #1 in making health care decisions.</p> <p>Review of Client #1's Psychological Assessment dated December 15, 2009, on September 16, 2009, at approximately 2:30 p.m., revealed that the client was not competent to make decisions regarding his health, safety, financial or residential placement. Further review of Client #1's record failed to provide evidence that written informed consent had been obtained for the use of the sedative medication.</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 client and/or family member representative.</p> <p>2. The facility failed to provide evidence that informed consent was obtained from Client #2 and/or notify family members for sedation given during medical appointments as evidenced below:</p> <p>a. Review of Client #2's physician orders dated July 14, 2009, on September 16, 2009 at 1:21 p.m., revealed a sedation for an ophthalmology appointment on July 16, 2009. The client</p>	W 124	<p>W124</p> <p>M.O.P has revised its policy to ensure that all guardians are notified in writing of procedures requiring sedation. Additionally, M.O.P has developed a consent form that provides the guardian with information about the procedure, medication used for sedation as well as any possible side effects. In the future, M.O.P will ensure that consents are received prior to medical appointments and that the consents are maintained in the individual's medical record. The Human Rights Committee Chair will oversee the above process to ensure individuals family members are informed of risk actions will occur in the event of non-compliance with the above.</p>	11.30.09 Ongoing	

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W 124	Continued From page 4 received Ativan 3 mg. b. Review of Client #2's physician orders dated August 8, 2009, on September 16, 2009 at 1:21 p.m., revealed a sedation for medical appointment on August 8, 2009. The client received Ativan 3 mg prior to an ultra sound appointment. During the entrance conference on September 15, 2009, beginning at 6:10 p.m., the Qualified Mental Retardation Professional (QMRP) and Residential Manager indicated that the client had family members to assist Client #2 in making health care decisions. Review of Client #2's Psychological Assessment dated February 22, 2009, on September 17, 2009, at approximately 9:00 a.m., revealed that the client was not competent to make decisions regarding his health, safety, financial or residential placement. Further review of Client #2's record failed to provide evidence that written informed consent had been obtained for the use of the sedative medication. At the time of the survey, the facility failed to provide evidence that the potential risks involved in using sedation, or his right to refuse treatment had been explained to the client and/or family member representative.	W 124		
W 140	483.420(b)(1)(i) CLIENT FINANCES 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.	W 140	See response on Page 6 of 18	

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W 140	<p>Continued From page 5</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 two clients in the sample. (Client's #1 and #2)</p> <p>The finding includes:</p> <p>Review of Client #1's financial record was conducted on September 17, 2009, beginning at 9:17 a.m. The bank statements were reviewed from October 2008 through August 11, 2009. According to the bank statements \$46.50 was withdrawn from the clients account on 1/5/09, 3/9/09, 4/3/09, 6/4/09, and 7/3/09. Further review of the bank statements revealed a service fee withdrawal in the amount of \$12.50 on 12/10/08, 2/11/09, 3/11/09, 5/12/09, and 6/10/09.</p> <p>Interview with the Residence Manager on September 17, 2009, at approximately 10:30 a.m., indicated that the office maintains the client's account and she would speak with the accountant. Several minutes later, the Residence Manager informed the surveyor that the bank made an error and would reimburse Client #1's account for all withdrawals.</p> <p>At the time of the survey, the facility failed to ensure a complete accounting of Client #1's personal funds by providing evidence that justified the aforementioned withdrawal.</p> <p>2. A review of Client #2's financial record was conducted on September 17, 2009, beginning at 9:17 a.m. The bank statements were reviewed from October 13, 2008 through August 11, 2009. The record revealed a withdrawal of \$500.00 from</p>	W 140	<p>W140 Client #1's withdrawals are currently under investigation by the financial institution once investigation is completed the provider anticipates reimbursement.</p> <p>Client #2 account will be reimbursed \$115.65 as the money was returned to the agency and not re-deposited into Client #2's account.</p> <p>Residence Manager/QMRP will adhere to agency established individual account management procedures by submitting banking documentation and receipts within seven days of transactions and meeting with Accounting monthly to review financial activity/reconcile each account. Accounting will inform Director of Programs of discrepancies Director of Programs in conjunction with Accounting will follow through to ensure that receipts are obtained and that on an ongoing basis, individual financial accounts are audited and reconciled monthly.</p>	11.30.09 Ongoing	11.09.09

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W 140	Continued From page 6 the client's account on December 19, 2008. Review of the receipts for the aforementioned withdrawal totaled \$384.35. At the time of survey, the facility failed to ensure a complete accounting of Client #2's personal funds.	W 140		
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 facility's Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination, monitoring, and implementation of a client's habilitation and planning, for two of two of the clients in the sample. (Clients #1 and #2) The findings include: 1. The facility's staff failed to demonstrate competency in the implementation of each clients Individual Program Plan (IPP). [See W194] 2. The facility's QMRP failed to ensure that the IPP included objectives to meet the client's needs as recommended from the comprehensive functional assessments. [See W227] 3. The facility's QMRP failed to ensure that each client was provided opportunities to make a choice during snack time. [See W247] 4. The facility's QMRP failed to ensure that each client's IPP objectives were documented consistently and accurately. [See W252]	W 159	W159 1. Reference response to W194 2. Reference response to W227 3. Reference response to W247 4. Reference response to W252	11.30.09 Ongoing

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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, staff interview and record review, the facility failed to ensure that each employee had been provided with adequate training that enables the employee to perform his or her duties effectively, efficiently and competently, for one of one staff in the facility. (LPN #1)</p> <p>The finding includes:</p> <p>[Cross Refer to W455]. The facility failed to provide effective, efficient, and competent training for the prevention and control of infection and communicable diseases for one of one staff in the facility. (LPN #1)</p>	W 189	<p>W189</p> <p>The facility nurse will conduct training on infection control to LPN' s by 11.15.09 In addition, facility nurse will observe LPN medication pass every quarterly and PRN and retrain as deemed necessary.</p>	11.15.09 Ongoing	
W 194	<p>483.430(e)(4) STAFF TRAINING PROGRAM</p> <p>Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and the record review, the facility staff failed to demonstrate competency in the implementation of each clients individual program plan, for one of two clients included in the sample. (Client #1)</p> <p>The finding includes:</p>	W 194	<p>W194</p> <p>The QMRP has written a note to remind staff to ensure client #2 is asked to wear shoes when walking. The QMRP will provide and or coordinate discipline specific training from the applicable consultant on: Individual program plans (IPP) Recommendations routinely. In addition, additional hands on training as needed will be provided/coordinated in an effort to ensure documentation on IPP objectives/recommendations is consistent and accurate.</p>	11.15.09 Ongoing	

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W 194	Continued From page 8 On September 15, 2009 at 4:35 p.m., Client #1 arrived home from the day program in a wheelchair. The direct care staff was observed propelling the client to his bedroom. At 4:58 p.m., the client was observed walking to the kitchen with no shoes on using a roller walker. Interview with the direct care staff indicated that once the client came home from day program he utilized his roller walker around the house. At 5:48 p.m., the client was observed walking from kitchen to living room. Again, the client did not have his shoes on. The client's left foot was observed in a horizontal position while the right foot was in it's normal position. At 6:50 p.m., Client #1 was observed walking to the kitchen using the roller walker with shoes on his feet. Review of Client #1's record on September 16, 2009, at approximately 3:00 PM revealed a Physical Therapy (PT) assessment dated December 15, 2008. The consultant recommended that the client should wear shoes during ambulation. Interview with the direct care staff revealed the client usually refused to walk in his shoes. At the time of the survey, the facility failed to ensure that Client #1 wore his shoes during ambulation as recommended by the PT.	W 194			
W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN 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.	W 227	See response on page 10 of 18		

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W 227	<p>Continued From page 9</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that the Individual Program Plan (IPP) included objectives to meet the client's needs as recommended from the comprehensive functional assessments, for one of the two clients in the sample. (Client #1)</p> <p>The finding includes:</p> <p>Observations on September 15, 2009, at 4:35 p.m., Client #1 was observed being propelled in a wheelchair. At 4:58 p.m., Client #1 was observed utilizing his roller walker with staff assistance and then seated at the dining room table.</p> <p>Review of the Client #1's Physical Therapy (PT) assessment dated November 2, 2008, on September 16, 2009, at approximately 2:45 p.m., revealed a program recommendation for the client to participate in general exercises in a seated position. The program should include movements of his arms and legs. Review of the IPP dated December 19, 2008, on September 17, 2009, at 9:30 a.m., revealed no evidence of training programs to address the aforementioned recommendations included in the comprehensive functional assessment.</p> <p>The QMRP verified that no training programs had been developed for the client to complete exercises while in a seated position as recommended in the November 2, 2008 PT assessment.</p>	W 227	<p>W227</p> <p>The comprehensive functional assessments for each individual will be reviewed to ensure training programs to address assessment recommendations are included in their ISP.</p> <p>The Physical Therapist will develop a training program to accompany the exercise program that client #1 can participate in from a seated position. The Physical Therapist will train staff on implementation. QMRP will monitor the program implementation to ensure all training programs are followed to meet the client's needs.</p>	11.30.09 Ongoing	
W 247	<p>483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan must include opportunities for client choice and self-management.</p>	W 247	See response on page 11 of 18		

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W 247	Continued From page 10 This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure that each client was provided opportunities to make a choice during snack time, for three of the three clients residing in the facility. (Clients #1, #2, and #3) The finding includes: Observation on September 15, 2009, at 5:00 p.m., revealed the direct care staff giving Clients #1, #2, and #3 a cup of pudding and a cup of water. At no time during snack time were the clients offered a choice of snacks.	W 247	W247 The QMRP will train staff on individual choice including but not limited to choices made during snack time. QMRP/Residence Manager monitor staff for effective implementation	11.03.09 Ongoing
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that each client's Individual Program Plan (IPP) objectives were documented consistently and accurately, for one of two clients included in the sample. (Client #1) The finding includes: During the medication pass observation on September 15, 2009 at approximately 5:25 p.m., Client #1 was observed to punch out the medications on the correct date from the	W 252	W252 Facility RN will train LPN's and TME's on proper implementation of medication goals by 11.15.09. RN will observe and review medication goal sheet weekly for accuracy and consistent documentation and implementation. Retraining will be provided as deemed necessary. The Director of Health Services will monitor self medication program quarterly to check compliance.	11.15.09

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W 252	Continued From page 11 medication card and take the medications with three (3) verbal prompts and physical assistance. Review of Client #1's (IPP) dated September 2009 on September 15, 2009 at approximately 8:45 a.m., revealed a goal that with staff assistance [Client #1] will punch the medication out of the bubble pack during a.m. and p.m. medication delivery. Further review revealed the following objectives "ask [Client #1] if he is ready for his medication; assist [Client #1] with identifying his medication and assist [Client #1] with punching out his medication for the day". Further review revealed Client #1's level of participation was to be documented on the data collection sheet once a day as follows: (1) manual guidance; (2) Physical Prompts; (3) Visual Cues (4) Verbal Prompts and (0) no response. Review of the September 2009, data on September 15, 2009 at approximately 6:00 p.m., revealed the nursing staff did not document Client #1's level of participation on September 7-9 and September 13-14, 2009 and August 6, 12, 26, and 31, 2009. In an interview with LPN #1, on August 15, 2009, at approximately 6:05 p.m., it was acknowledged the nursing staff did not document Client #1's level of participation on the aforementioned dates. There was no evidence the data had been collected in accordance with the IPP for Client #1, which was necessary for a functional assessment of the client's progress.	W 252			
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a	W 263	W263 See response to W124	11.03.09	

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W 263	Continued From page 12 minor) or legal guardian. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure sedative medications were being administered with the written consent of a client's parent, legally appointed guardian and/or advocate for two of two sampled clients. [Client #1 and Client #2] The finding includes: [Cross-refer to W124] The facility failed to ensure written informed consent was obtained from Clients #1 and #2's family members prior to administering sedations.	W 263			
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure general and preventive care, for one of two clients included in the sample. (Client #1) The findings include: Review of Client #1's medical record on September 16, 2009, at 9:30 a.m., revealed a pharmacy review dated July 27, 2009. The pharmacist recommended to the Primary Care Physician (PCP) to decrease the client's Prilosec to once a day. Further review of the medical record revealed that the Primary Care Physician	W 322	W322 The Director of Health Services met with the PCP on 9.17.09 to discuss importance of expedient management Of pharmacy recommendations and other time sensitive documents. The physician was made aware of the recommendations for Client # 1 on or about 7/31/09 and again on 8.28.09. Pharmacy recommendations were implemented on 11/03/09. RN will immediately forward all pharmacy recommendation to the PCP upon receipt and document the transfer of information in the nursing progress notes. The RN will provide weekly oversight to ensure follow-up on the PCP's response to the recommendations	11.03.09 Ongoing	

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W 331	Continued From page 14 routine laboratory testing as determined necessary by the primary care physician (PCP), for one of the two clients included in the sample. (Client #1) Review of Client #1's medical record on September 16, 2009, at 9:30 a.m., revealed a physician's order dated September 2009, for a T4 laboratory studies to be performed every six months. Review of Client #1's medical records on September 16, 2009, at approximately 10:00 a.m., revealed no evidence of the laboratory studies for the aforementioned order In an interview with the Registered Nurse (RN) on September 16, 2009 at approximately 10:15 a.m., it was acknowledged the T4 laboratory studies were not obtained as ordered by the PCP. There was no evidence the routine laboratory testing was scheduled or obtained as recommended by the physician.	W 331	W331 continued from page 14 of 18 In the future, M.O.P RN, QMRP, Residence Manager and administration will make every effort to have medical appointments done in a timely manner to ensure all individuals receive optimal health services. All efforts to obtain medical appointments completed will be documented in the nursing progress/monthly notes. Administrative staff have provided additional training to RN's and QMRP's to ensure a careful review of medical consults to ensure appropriate and timely follow-up. Monthly chart reviews will continue with QMRP, RN and Residence Manager in an effort to meet the individual needs.	11.15.09
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on interview and record review, the facility	W 356	W 356 See response to 331	

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W 356	Continued From page 15 failed to ensure timely comprehensive treatment services for the maintenance of dental health, for one of the three clients in the sample. (Client #1) The finding includes: On September 15, 2009, at 5:00 p.m., Client #1 was observed with no teeth. Review of Client #1's medical record on September 16, 2009, at 9:30 a.m., revealed a dental consultation dated January 9, 2008. The dentist noted that the client was edentulous. His tissues were within normal limits but very little supporting ridges. The consult further noted the client should return in one year. Interview with the Residential Manger on September 16, 2009, at approximately 12:30 p.m., indicated that the client had an appointment scheduled for September 14, 2009, but could not be seen because the client's insurance expired as of July 31, 2009. At the time of the survey, the facility failed to ensure Client #1 received timely dental services follow-up.	W 356			
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to maintain in good repair, clients adaptive feeding equipment, for one of the two clients included in the sample.	W 436	W436 The newly purchased adaptive feeding equipment has been put into use and staff have been trained on their use and maintenance. The QMRP and RN will monitor and document condition of all adaptive equipment at least weekly to ensure they are in good working order using the adaptive equipment checklist. Repairs and /or new purchases will be made as needed.	11.3.09	

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W 436	Continued From page 16 (Client #1) The finding includes: During meal observations on September 15, 2009, at 7:10 p.m., and September 16, 2009, at 7:25 a.m., Client #1 was observed eating utilizing a built up handle (sponge like) spoon. The handle was observed to be worn and torn. On September 16, 2009, observations at the day program at approximately 12:20 p.m., revealed Client #1 eating lunch using a built up handle (hard plastic) spoon. Interview with the House Manager on September 17, 2009, at approximately 9:30 a.m., confirmed that the client had been using the worn and torn built up handle spoon. Further interview with the Program Director on September 17, 2009, at approximately 2:00 p.m., indicated that new adaptive eating utensils had been purchased for Client #1. Record verification of Client #1's Individual Support Plan (ISP) dated December 19, 2008, and the Physical Therapy Assessment dated November 2, 2008, on September 16, 2009, at 2:21 p.m., revealed that the client required a built up handle spoon to encourage his independence during meals. At the time of the survey, the facility failed to provide Client #1 with the newly purchased built-up handle spoon.	W 436			
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases.	W 455	W455 Cross reference W189		

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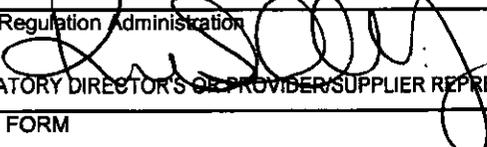
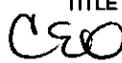
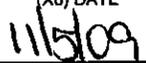
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W 455	<p>Continued From page 17</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide an active program for the prevention, control of infection and communicable diseases, for one of two clients in the sample. (Client #1,)</p> <p>The finding includes:</p> <p>During medication administration observation on September 15, 2009, at approximately 5:25 p.m., Licensed Practical Nurse #1 (LPN #1) was observed to wash her hands with soap and water in the kitchen sink prior to administrating medications. However LPN#1 touched the dining counter, touched the Medication Administration Records (MAR's) and then touched the rim of the medication cup as she provided Client #1 with physically assistance in punching medications from the bubble pack.</p> <p>In an interview with LPN #1 on September 15, 2009, at approximately 5:45 p.m., it was acknowledged after washing her hands with soap and water she touched the dining counter, touched the MAR's and than touched the rim of the medication cup as she provided Client #1 with physical assistance in punching medications from the bubble pack.</p> <p>There is no evidence that the facility's nursing staff provided an active program for the prevention and control of infection.</p>	W 455			

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I 000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from September 15, 2009 through September 17, 2009. The survey was initiated using the fundamental survey process. A random sample of two residents was selected from a population of three male residents 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 residents and staff, and the review of clinical and administrative records including incident reports.</p>	I 000		
I 022	<p>3501.5 ENVIRONMENTAL REQ / USE OF SPACE</p> <p>Each window shall be supplied with curtains, shades or blinds, which are kept clean, and in good repair.</p> <p>This Statute is not met as evidenced by: On September 17, 2009 beginning at 3:22 p.m., a walk-through of the interior and exterior of the GHMRP revealed the following:</p> <ol style="list-style-type: none"> 1. A former resident's Hoyer lift and walker were being stored in Resident #3's bedroom. 2. The wood at the lower right corner of Resident #3's bedroom dresser was damaged. 3. There was an accumulation of dust on the window blinds throughout the facility. 4. The paint was damaged (scrapes and scratches) on walls throughout the facility, most notably in Resident #3's bedroom, the hallway leading to Resident #3's bedroom, the door 	I 022	<p>I022</p> <ol style="list-style-type: none"> 1. The Hoyer lift and walker were removed from Individual #3 bedroom on 11.03.09. Storage space has been developed in the basement area for storage of all extra equipment. The QMRP/Manager will monitor residence weekly using the Environmental Compliance Form to ensure that all unnecessary items are placed in the appropriate storage areas. 2. The dresser of Individual #3 will be repaired or replaced by 11.15.09. The QMRP will monitor residence weekly using the Environmental Compliance Form to ensure that all furnishings are in good working order and request replacement/ repair as necessary. The QMRP/Manager will monitor residence weekly using the Environmental Compliance Form to ensure that all unnecessary items are placed in the appropriate storage areas. 3. All window blinds will be cleaned and staff will be trained on proper cleanliness of the residence and implement the Residential Housekeeping Checklist Form for staff accountability.. The QMRP/Manager will monitor residence weekly using the Environmental Checklist to ensure proper upkeep. 4 The damaged walls throughout the facility, including Individual #3 bedroom, the hallway leading to individual #3 bedroom, the door separating the hallway from the front foyer and in the common bathroom (nearest the front door) will be repaired and re-painted as needed The QMRP/Manager will monitor residence weekly using the Environmental Checklist to ensure proper upkeep and request repairs as necessary. <p>I022 continued on page 2 of 20</p>	<p>11.03.09 Ongoing</p> <p>11.15.09 Ongoing</p> <p>11.30.09 Ongoing</p> <p>12.15.09 Ongoing</p>

Health Regulation Administration  LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE 	(X6) DATE 
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I 022	Continued From page 1 separating the hallway from the front froyer and in the common bathroom (nearest the front door.) 5. There was an accumulation of leaves and debris in the stairwell outside the door to the garage.	I 022	1022 continued from page 1 of 20 5. The leaves and debris, which have accumulated in the stairwell outside the door to the garage, will be removed by 11.15.09. The QMRP/Manager will monitor residence weekly using the housekeeping checklist.. Staff have been reminded to sweep exterior stairwell weekly.	11.15.09 Ongoing
I 043	3502.2(c) MEAL SERVICE / DINING AREAS Modified diets shall be as follows: (c) Reviewed at least quarterly by a dietitian. 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 modified diets were reviewed at least quarterly by a dietitian, for one of the two residents in the sample. (Resident #2) The finding includes: On September 15, 2009, at 7:10 p.m., Client #2 was observed having a Boost liquid nutrional supplement. On September 16, 2009, at approximately 9:55 a.m., it was stated that Resident #2 received an 8 oz serving of Boost liquid nutritional supplement twice daily. Beginning at 1:09 p.m., review of his nutrition records and physician's orders (POs) confirmed that his diet orders included Boost supplement twice daily. In addition, his diet orders included "regular, no salt added, offer seconds; soft, bite sized texture as tolerated." Shortly thereafter, at 1:31 p.m., review of Resident #2's nutrition records revealed that the consulting nutritionist had assessed his dietary needs on September 30, 2008, February 10,	I 043	1043 The RN has notified the nutritionist of outstanding quarterly evaluations as of 11.05.09. Additionally the Director of Health Services has met with the consultant nutritionist to reiterate the importance of timely quarterly nutritional reviews. The RN and QMRP will create a calendar of due dates for nutritional evaluations. The RN will provide the Nutritionist with a reminder notice one week prior to the due date of each evaluation. The RN will notify the Director of Health Services if nutritional assessments are not completed within seven days of the due date for further follow-up.	11.05.09 Ongoing

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I 043	Continued From page 2 2009 and on August 5, 2009. There was no documented evidence that a nutritionist/dietitian had reviewed Resident #2's diet at least quarterly.	I 043		
I 058	3502.16 MEAL SERVICE / DINING AREAS A review and consultation by a dietitian or nutritionist shall be conducted at least quarterly to ensure that each resident who has been prescribed a modified diet receives adequate nutrition according to his or her Individual Habilitation Plan. 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 modified diets were reviewed at least quarterly by a dietitian or nutritionist to ensure the adequacy of his diet, for one of the two residents in the sample. (Resident #2) The findings include: Cross-refer to 3502.2(c). On September 16, 2009, interview with the residence manager and review of Resident #2's nutrition records and physician's orders (POs) revealed that his diet orders were: regular, no salt added, offer seconds; soft, bite sized texture as tolerated.; Boost liquid Supplement 8 oz. 2 times daily for nutritional supplement." The consulting nutritionist had documented reviews on September 30, 2008, February 10, 2009 and on August 5, 2009. There was no evidence that the nutritionist ensured the adequacy of his nutritional intake, as follows:	I 058	1058 See response on page 4 of 20	

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I 058	<p>Continued From page 3</p> <p>1. On September 17, 2009, beginning at 10:21 a.m., review of Resident #2's Monthly Nursing Assessments revealed that he had been below his weight and had stayed below his Ideal Body Weight Range (115 - 127 pounds) for much of the past year. The September 30, 2008, Nutritional Assessment documented a drop, from 116 pounds in July 2008, to 105 pounds in September 2008. It was then that the nutritionist recommended adding the liquid nutritional supplement. However, Resident #2's weight stayed between 111.0 - 111.4 pounds through the first 7 months of 2009. In August 2009, his weight dropped to 110.5 pounds.</p> <p>2. On September 17, 2009, beginning at 1:18 p.m., review of Resident #2's Medication Administration Records (MARs) revealed that he had missed numerous servings of Boost supplement in recent months. His June 2009, MARs showed that he did not receive the supplement on June 7, 8, 21, 22, 29 and 30, 2009. The facility's Registered Nurse (RN) was interviewed immediately. She acknowledged that there had been gaps, attributing it to a "supplier delay."</p> <p>Continued review of Resident #2's MARs revealed that this had been an ongoing deficient practice for many months, with "none available" or "out of Boost" documented on:</p> <p>March 19, 26, 27, 28 and 30, 2009; April 15, 2009; July 1 - 6, 26 and 27, 2009; and, September 15, 2009.</p> <p>To date, there was no evidence that the nutritionist had identified this concern.</p>	I 058	<p>I058 1, 2 & 3: Supply of Boost is closely monitored by the RN, QMRP and Residence Manager. A weekly inspection of of supply is made by the RN to ensure adequate supply is always available in the home. Staff have been provided training on how to replenish supply if needed. The nutritionist has been informed that Client #2 needs an updated nutritional evaluation to address his weight loss by 11.15.09. Additionally the RN will review the medication administration record to monitor consistent servings of nutritional supplement. The Director of Health Services will continue to obtain adequate surplus supply and have available to ensure there are are no gaps in supply.</p>	11.15.09 Ongoing

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I 082	Continued From page 4	I 082		
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, the Group Home for the Mentally Retarded Persons (GHMRP) failed to equip all bathrooms used by residents with paper cups and dispensers, for two of the two bathrooms in the facility.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. On September 17, 2009, at approximately 3:26 p.m., there was no paper cup dispenser observed in the "common restroom" located near the front foyer and family room, and there were no paper cups available for resident use. 2. Similarly, at approximately 3:48 p.m., there was no paper cup dispenser observed in the restroom located at the far end of the hallway, and there were no paper cups available for the residents. 	I 082	<p>I082</p> <p>1 & 2. Paper cup dispensers will be purchased and installed in the "common restroom" and the restroom located down the hall. Cups will be made available for resident use.</p> <p>The QMRP/Manager will monitor residence weekly and provide supplies of disposable paper cups on an ongoing basis.</p>	11.10.09 Ongoing
I 109	<p>3504.16 HOUSEKEEPING</p> <p>Each GHMRP shall label inconspicuously each item of clothing as belonging to a particular resident as indicated in his or her Individual Habilitation Plan (IHP).</p> <p>This Statute is not met as evidenced by: Based on observation and interview, the Group</p>	I 109	<p>I109</p> <p>Staff will receive training on how to label clothing and personal items in an inconspicuous manner. Clothing and personal items that are easily recognized by the individual owners will not be labeled. QMRP/Manager will observe quarterly to ensure compliance.</p>	11.15.09

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I 109	Continued From page 5 Home for Mentally Retarded Persons (GHMRP) failed to ensure that clothing items that were labeled had been labeled inconspicuously, for one of the two residents in the sample. The finding includes: On September 16, 2009, at 7:32 a.m., Resident #2 was observed wearing a white, floppy canvas hat. Resident #2's initials were written across the front and back of the hat in large black letters. On September 16, 2009, Resident #1 was observed at a community recreation center between 10:25 a.m. - 11:18 a.m. He was engaged in activities with his day program staff and peers. During the entire observation period, he was observed wearing a white, floppy canvas hat. His first and last name initials were written conspicuously across the front of the hat in large letters. During the September 17, 2009, at 4:10 p.m., during the exit conference, the residence manager acknowledged that she too had seen the initials on his hat.	I 109		
I 161	3507.2 POLICIES AND PROCEDURES The manual shall be approved by the governing body of the GHMRP and shall be reviewed at least annually. This Statute is not met as evidenced by: Based on interview and record review, the Group for Mentally Retarded Persons (GHMRP) governing body failed to review its policies and procedures annually. The finding includes: On September 16, 2009, at approximately 10:00	I 161	I 161 The policy and procedure manual will be reviewed by the governing body at the on 12.15.09. In the future the policy and procedure manual will be reviewed and approved annually by the governing body and the signature sheet will be kept on file in the administrative offices and a copy placed in each Policy and Procedure Manual	12.15.09

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I 161	Continued From page 6 a.m., review of the policy and procedure manual failed to provide evidence that the agency's policy manual had not been reviewed and approved annually by the governing body as required. The last noted date for review was September 27, 2007. Interview with the Program Director on September 17, 2009, at approximately 11:00 a.m., revealed that the agency was in the process of updating the agency's policies.	I 161		
I 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 received and disbursed, for two of the two residents included in the sample. (Residents #1 and #2) The finding includes: Review of Resident #1's financial record was conducted on September 17, 2009, beginning at 9:17 a.m. The bank statements were reviewed from October 2008 through August 11, 2009. According to the bank statements \$46.50 was withdrawn from the clients account on 1/5/09, 3/9/09, 4/3/09, 6/4/09, and 7/3/09. Further review of the bank statements revealed a service fee withdrawal in the amount of \$12.50 on 12/10/08, 2/11/09, 3/11/09, 5/12/09, and 6/10/09. Interview with the Residence Manager on September 17, 2009, at approximately 10:30 a.m., indicated that the office maintains the resident's account and she would speak with the accountant. Several minutes later, the	I 189	I189 Client #1's withdrawals are currently under investigation by the financial institution, once investigation is completed the provider anticipates reimbursement. Client #2 account will be reimbursed \$115.65 as the money was returned to agency and not deposited. Residence Manager/QMRP will adhere to agency established individual account management procedures by submitting banking documentation and receipts within seven days of transactions and meeting with Accounting monthly to review financial activity/reconcile each account. Accounting will inform Director of Programs of discrepancies Director of Programs in conjunction with Accounting will follow through to ensure that receipts are obtained and that on an ongoing basis, individual financial accounts are audited and reconciled monthly.	11.30.09

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I 189	Continued From page 7 Residence Manager informed the surveyor that the bank made an error and would reimburse Resident #1's account for all withdrawals. At the time of the survey, the facility failed to ensure a complete accounting of Resident #1's personal funds by providing evidence that justified the aforementioned withdrawal. 2. A review of Resident #2's financial record was conducted on September 17, 2009, beginning at 9:17 a.m. The bank statements were reviewed from October 13, 2008 through August 11, 2009. The record revealed a withdrawal of \$500.00 from the resident's account on December 19, 2008. Review of the receipts for the aforementioned withdrawal totaled \$384.35. There was no evidence that the facility maintain a complete and full accounting of the residents personal funds entrusted to the facility.	I 189		
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure that all staff obtained annual health certificates/ inventories. The findings include: On September 16, 2009 at approximately 9:40	I 206	I206 See response on page 9 of 20	

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I 206	Continued From page 8 a.m. the residence manager agreed to make available for review the personnel records for all employees and consultants, including evidence of annual health certificates/ inventories. Review of the personnel records later that day, beginning at 1:55 p.m., revealed the following: 1. There were no health certificates/ inventories made available for review for 2 of the 7 direct support staff (S2 and S4). 2. The health certificates/ inventories on file for 3 of the remaining 5 direct support staff had expired, as follows: (S1 expired on 2/28/09, S3 expired on 12/13/08 and S5 on 12/4/08). 3. The health certificates/ inventories on file for the behavior specialist and pharmacist had expired on 6/18/09 and 6/20/09, respectively. 4. Although there were records of tuberculin screenings (PPDs) for the physical therapist and recreation therapist (both negative), there was no evidence of physicians' health inventories/ certificates on file for either consultant. 5. There was no health certificate/ inventory made available for review for the podiatrist. At approximately 4:50 p.m., the Qualified Mental Retardation Professional said she would ask their corporate office for additional documentation. No additional information was provided before the survey ended the following day. This is a repeat deficiency. ***** In a State licensure deficiency report dated September 26, 2008, the facility was cited for failure to show evidence of health certificates for one direct support staff, the registered nurse, psychiatrist, behavior specialist and the podiatrist.	I 206	I206 All staff not in compliance with required health certificates/inventories will be suspended until compliance is met. To monitor compliance on a ongoing basis, Human Resources will develop and implement a training compliance checklist to be utilized by QMRP/Residence Managers and reviewed with staff. All new employees will be required to present a valid health certificate prior to the first day of employment. In conjunction with Health Services and Human Resources a training compliance checklist will be implemented to monitor compliance. All consultants with outstanding health certificates/inventories will not be employed until compliance is made. The QMRP/Residence Manager will review with Human Resources residential staff personnel files quarterly for compliance. Human Resources will develop and implement a training compliance checklist to be utilized by QMRP/Residence Managers and reviewed with staff. All new employees will be required to present a valid health certificate prior to the first day of employment. In conjunction with Health Services and Human Resources a training compliance checklist will be implemented to monitor compliance. All consultants with outstanding health certificates/inventories will not be employed until compliance is made. The QMRP/Residence Manager will review with Human Resources residential staff personnel files quarterly for compliance.	11.30.09 Ongoing
I 226	3510.5(c) STAFF TRAINING Each training program shall include, but not be	I 226	I226 See response on page 10 of 20	

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I 226	Continued From page 9 limited to, the following: (c) Infection control for staff and residents; This Statute is not met as evidenced by: 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. (LPN #1) The finding includes: During medication administration observation on September 15, 2009, at approximately 5:25 p.m., Licensed Practical Nurse #1 (LPN #1) was observed to wash her hands with soap and water in the kitchen sink prior to administrating medications. However LPN#1 touched the dining room counter, touched the Medication Administration Records (MAR's) and than touched the rim of the medication cup as she provided Resident #1 with physically assistance in punching medications from the bubble pack. In an interview with LPN #1 on September 15, 2009, at approximately 5:45 p.m., it was acknowledged after washing her hands with soap and water she touched the dining room counter, touched the MAR's and than touched the rim of the medication cup as she provided Resident #1 with physical assistance in punching medications from the bubble pack. There is no evidence that the facility's nursing staff demonstrated effective training on the prevention and control of infection.	I 226	I226 The facility nurse will conduct training on infection control to LPN' s by 11.30.09 In addition, facility nurse will observe LPN medication pass every quarter and PRN and retrain as deemed necessary. Facility RN will train LPN's and TMEs on proper implementation of medication goals by 11.15.09. RN will review medication goal sheet weekly for accuracy and consistent documentation, retraining will be provided as deemed necessary. The Director of Health Services will monitor self medication program documentation quarterly to check compliance.	11.15.09 Ongoing

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I 230	Continued From page 10	I 230		
I 230	<p>3510.5(g) STAFF TRAINING</p> <p>Each training program shall include, but not be limited to, the following:</p> <p>(g) Habilitation planning and implementation;</p> <p>This Statute is not met as evidenced by: Based on observation, interview, and record review, the Group Home for the Mentally Retarded (GHMRP) failed to ensure nursing staff were effectively trained in providing habilitation services for one of two residents in the sample. (Resident #4)</p> <p>The finding includes:</p> <p>During the medication pass observation on September 15, 2009 at approximately 5:25 p.m., Resident #1 was observed to punch out the medications on the correct date from the medication card and take the medications with three verbal prompts and physical assistance.</p> <p>Review of Resident #1's Individual Program Plan (IPP) dated September 2009 on September 15, 2009 at approximately 8:45 a.m., revealed a goal that with staff assistance [Resident #1] will punch the medication out of the bubble pack during a.m. and p.m. medication delivery. Further review revealed the following objectives "ask [Resident #1] if he is ready for his medication; assist [Resident #1] with identifying his medication and assist [Resident #1] with punching out his medication for the day". Further review revealed Resident #1's level of participation was to be documented on the data collection sheet once a day as follows: (1) Manual guidance; (2) Physical Prompts; ;(3)Visual Cues (4) Verbal Prompts and (0) No response. Review of the September 2009</p>	I 230	<p>Facility RN will train LPN's and TME's on proper implementation of medication goals by 11.15.09. RN will observe and review medication goal sheet weekly for accuracy and consistent documentation and implementation. Retraining will be provided as deemed necessary. The Director of Health Services will monitor self medication program quarterly to check compliance.</p>	11.15.09 Ongoing

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I 230	Continued From page 11 data on September 15, 2009, at approximately 6:00 p.m., revealed the nursing staff did not document Resident #1's level of participation on September 7-9 and September 13-14, 2009 and August 6, 12, 26 and 31, 2009. In an interview with LPN #1, on August 15, 2009, at approximately 6:05 p.m., it was acknowledged the nursing staff did not document Resident #1's level of participation on the aforementioned dates. There was no evidence the data had been collected in accordance with the IPP for the resident which was necessary for a functional assessment of the resident's progress.	I 230			
I 274	3513.1(e) ADMINISTRATIVE RECORDS Each GHMRP shall maintain for each authorized agency ' s inspection, at any time, the following administrative records: (e) Signed agreements or contracts for professional services; 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 six of the eleven consultants reviewed. (Primary Care Physician, Occupational Therapist, Nutritonist, Recreation Therapist, Social Worker and Podiatrist. The finding includes: On September 16, 2009 at approximately 9:40 a.m. the residence manager agreed to make available for review the personnel records for all employees and consultants, including evidence of	I 274	I274 Contract agreements on file for the identified consultants will be updated to reflect My Own Place. The governing body will complete contractual agreements and a copy will be filed in the personnel records of the respective consultants.	11.30.09	

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I 274	Continued From page 12 written agreements or contracts with consultants. Review of the personnel records later that day, beginning at 1:55 p.m., revealed the following: There was no evidence that the agency's governing body had entered into written agreements or contracts with the following consultants: 1. primary care physician; 2. occupational therapist; 3. nutritionist; 4. recreation therapist; 5. social worker; and 6. podiatrist.	I 274		
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 interview and record verification, the facility's primary care physician failed to sign telephone orders within 24 hours as required by local regulation (Title 7, Subtitle D. Chapter 13), for two of the two residents in the sample. (Residents #1 and #2) The findings include:	I 401	I 401 See response on page 14 of 20	

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I 401	Continued From page 14 telephone." Further interview with the RN indicated that she was not aware of the policy. c. Review of Resident #2's medical record on September 16, 2009, at 1:15 p.m., revealed physician order (POS) dated August 8, 2009. The POS was for Ativan 3 mg prior to an ultra sound medical appointments. The POS was counter signed by the Primary Care Physician on August 26, 2009. Interview with the Registered Nurse on September 16, 2009, at 10:37 a.m., indicated that POS should be counter signed by the PCP within ten days. Review of the facility's policy title "verbal/telephone physician orders on September 16, 2009, at 4:00 p.m., revealed that "Scheduled drugs may never be ordered verbally or by telephone." Further interview with the RN indicated that she was not aware of the policy. Although the facility had a policy in place for ten days. The policy conflicts with state law.	I 401		
I 420	3521.1 HABILITATION AND TRAINING Each GHMRP shall provide habilitation and 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. This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for the Mentally Retarded Persons (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	I 420	I420 See response on page 16 Of 20	

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I 420	Continued From page 15 social functioning, for one of the two residents included in the sample. (Resident #1) The finding includes: Observations on September 15, 2009, at 4:35 p.m., Resident #1 was observed being propelled in a wheelchair. At 4:58 p.m., Resident #1 was observed coming to the dining room table. Review of the Resident #1's Physical Therapy assessment dated November 2, 2008, on September 16, 2009, at approximately 2:45 p.m., revealed program recommendations for the resident to participate in general exercises in a seated position. The program should include movements of his arms and legs. Review of the IPP dated December 19, 2008, on September 17, 2009, at 9:30 a.m., revealed no evidence of training programs to address the aforementioned recommendations.	I 420	I420 The comprehensive functional assessments for each individual will be reviewed to ensure training programs to address assessment recommendations are included in their ISP. The Physical Therapist will develop a training program to accompany the exercise program that client #1 can participate in from a seated position. The Physical Therapist will train staff on implementation. QMRP will monitor the program implementation to ensure all training programs are followed to meet the client's needs.	11.15.09 Ongoing
I 441	3521.7(k) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (k) Mobility (including ambulation, transportation, mapping and orientation, and use of mobility equipment); This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure the habilitation of its residents included training in the area of mobility, for one of the two residents included in hte sample. (Resident #1)	I 441	I 441 See response on page 17 of 20	

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I 441	Continued From page 16 The finding includes: On September 15, 2009 at 4:35 p.m., Resident #1 arrived home from day program in a wheelchair. The direct care staff was observed propelling the resident to his bedroom. At 4:58 p.m., the resident was observed walking to the kitchen with no shoes on using a roller walker. At 5:48 p.m., the resident was observed walking from kitchen to living room. Again the resident did not have on shoes. The resident's left foot was observed in a horizontal position while the right foot was in it's normal position. Interview with the direct care staff indicated that once the resident came home from day program he utilized his roller walker around the house. At 6:18 p.m., the Qualified Mental Retardation Professional (QMRP), Residence Manager, Registered Nurse and Program Director entered the facility. At 6:50 p.m., Resident #1 was observed walking to the kitchen using her roller walker with shoes on his feet. Review of Resident #1's record on September 16, 2009, at approximately 3:00 PM revealed a Physical Therapy (PT) assessment dated December 15, 2008. According to the assessment, the consultant recommended that the resident should wear shoes during ambulation. Further interview with the direct care staff indicated that the resident usually refused to walk in his shoes. At the time of the survey, the facility failed to ensure staff kept shoes on Resident #1 during ambulation as recommended by the PT.	I 441	I 441 The QMRP has written a note to remind staff to ensure client #2 is asked to wear shoes when walking. The QMRP will provide and or coordinate discipline specific training from the applicable consultant on: Individual program plans (IPP) Recommendations routinely. In addition, additional hands on training as needed will be provided/coordinated in an effort to ensure documentation on IPP objectives/recommendations is consistent and accurate.	11.30.09 Ongoing
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure	I 500	I 500 See response on page 18 of 20	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0228	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/17/2009
NAME OF PROVIDER OR SUPPLIER MY OWN PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 4141 ANACOSTIA AVE, NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 500	Continued From page 17 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. This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for the Mentally Retarded (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 District and Federal Laws, for two of the three residents included in the sample. (Resident #1, Resident #2) The finding includes: 1. The facility failed to obtain consents prior to the use of sedation for a medical appointments and/or to notify the clients family members of the risks and benefits of treatments for two of the two residents in the sample. (Resident #1 and Resident #2) a. Review of Resident #1's physician orders dated November 24, 2008 and February 19, 2009, on September 16, 2009 at 9:01 a.m., revealed sedations for medical appointments on November 25, 2008 and February 19, 2009. The resident received Ativan 2 mg prior to Ear Nose Throat (ENT) appointments. During the entrance conference on September 15, 2009, beginning at 6:10 p.m., the Qualified Mental Retardation Professional (QMRP) and Residential Manager indicated that the resident had family members to assist Resident #1 in making health care decisions.	I 500	I 500 M.O.P has revised its policy to ensure that all guardians are notified in writing of procedures requiring sedation. Additionally, M.O.P has developed a consent form that provides the guardian with information about the procedure, medication used for sedation as well as any possible side effects. In the future, M.O.P will ensure that consents are received prior to medical appointments and that the consents are maintained in the individual's medical record. The Human Rights Committee Chair will oversee the above process to ensure individuals family members are informed of risk actions will occur in the event of non-compliance with the above.	11.15.09

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I 500	Continued From page 18 Review of Resident #1's Psychological Assessment dated December 15, 2009, on September 16, 2009, at approximately 2:30 p.m., revealed that the resident was not competent to make decisions regarding his health, safety, financial or residential placement. Further review of Resident #1's record failed to provide evidence that written informed consent had been obtained for the use of the sedative medication. 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 client and/or family member representative. [See also Federal Deficiency W263] b. Review of Resident #2's physician orders dated July 14, 2009, on September 16, 2009 at 1:21 p.m., revealed a sedation for medical appointments on July 16, 2009. The resident received Ativan 3 mg prior to an ophthalmology appointment. c. Review of Resident #2's physician orders dated August 8, 2009, on September 16, 2009 at 1:21 p.m., revealed a sedation for medical appointments on August 8, 2009. The resident received Ativan 3 mg prior to an ultra sound appointment. During the entrance conference on September 15, 2009, beginning at 6:10 p.m., the Qualified Mental Retardation Professional (QMRP) and Residential Manager indicated that the resident had family members to assist Resident #2 in making health care decisions. Review of Resident #2's Psychological	I 500		

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I 500	Continued From page 19 Assessment dated February 22, 2009, on September 17, 2009, at approximately 9:00 a.m., revealed that the resident was not competent to make decisions regarding his health, safety, financial or residential placement. 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. At the time of the survey, the GHMRP 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 family member representative.	I 500			

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R 000	INITIAL COMMENTS A licensure survey was conducted from September 15, 2009 through September 17, 2009. A random sample of two residents was selected from a population of three male residents with various levels of mental retardation and disabilities. 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.	R 000		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on the review of personnel records, the GHMRP failed to ensure criminal background checks for all jurisdictions in which the employees had worked or resided within the seven years prior to the check, for two out of seven direct support staff. (S2 and S6) The findings include: On September 16, 2009, at 9:40 a.m., the residence manager agreed to provide documentation needed to show evidence of criminal background checks for all employees. Later that day beginning at 1:55 p.m., review of the materials presented revealed the following: 1. Statewide background checks for Washington, DC and Maryland had been	R 125	R125 Background checks will be completed on S2 and S6 by 11/15/09 to include on jurisdictions where they have lived and worked Criminal background checks for all employees will now include jurisdictions where the prospective employee has lived and worked. The Human Resources Coordinator will include this requirement in the pre-employment screening process for prospective new employees. Staff will not be deployed to the programs until the provider has received a satisfactory criminal background check.	11.15.09 Ongoing

Health Regulation Administration

TITLE

(X6) DATE

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

Health Regulation Administration

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R 125	Continued From page 1 documented for S2. However, her personnel records indicated that she had worked in Fairfax, VA from April 2004 until October 2004. There was no evidence, however, that a background check had been obtained in that jurisdiction. 2. A District of Columbia background check had been documented for S6. However, her personnel records indicated that she had worked in Maryland from October 2000 until September 2006. There was no evidence, however, that a background check had been obtained in the Maryland. At approximately 4:50 p.m., the qualified mental retardation professional said she would ask their corporate office for additional documentation. No additional information was provided before the survey ended the following day.	R 125		