

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

PRINTED: 03/17/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/05/2010
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NAME OF PROVIDER OR SUPPLIER WESTVIEW 01	STREET ADDRESS, CITY, STATE, ZIP CODE 3200 12TH STREET, NE WASHINGTON, DC 20017
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{W 000}	<p>INITIAL COMMENTS</p> <p>A revisit was conducted on March 4, 2010 and March 5, 2010, to verify the facility's compliance with condition-level deficiencies cited during the January 22, 2010 recertification survey. Three out of three clients remained in the sampled residential population from the previous survey. A fourth client was added to the sample. The findings of the survey were based on observations in the home, interviews with clients, direct care staff, administrative and nursing staff in the home, as well as a review of the clinical, administrative, and habilitation records, including unusual incident reports.</p> <p>The revisit resulted in a determination that, even though the facility had made some progress in addressing the deficient practices cited in the January 22, 2010 report, the facility remained not in compliance with the Conditions of Participation in Governing Body, Client Protections and Active Treatment Services.</p> <p>Previously, a recertification survey was conducted from January 19, 2010, through January 22, 2010. The fundamental survey process was initiated however due to concerns in Client Protections and Active Treatment, the survey was extended those areas. The extension led to the determination that the facility was not in compliance with the Conditions of Participation in Client Protections and Active Treatment.</p> <p>The findings of the survey were based on observations, interviews with clients, interviews with staff in the home and at two day program, as</p>	{W 000}	<p><i>Received</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>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>And R West JMD</i>	TITLE <i>Administrator</i>	(X6) DATE <i>April 8, 2010</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{W 000} Continued From page 1 well as a review of client and administrative records, including incident reports.

{W 100} 440.150(c) ICF SERVICES OTHER THAN IN INSTITUTIONS

"Intermediate care facility services" may include services in an institution for the mentally retarded (hereafter referred to as intermediate care facilities for persons with mental retardation) or persons with related conditions if:

- (1) The primary purpose of the institution is to provide health or rehabilitative services for mentally retarded individuals or persons with related conditions;
- (2) The institution meets the standards in Subpart E of Part 442 of this Chapter; and
- (3) The mentally retarded recipient for whom payment is requested is receiving active treatment as specified in §483.440.

This STANDARD is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to meet the Conditions of Participation in Client Protections, for four of the six clients residing in the facility, and failed to meet the Condition of Participation in Active Treatment, for three of the four clients in the sample.

The findings include:

Since the January 22, 2010 recertification survey, the facility failed to ensure that Clients #1 and #3 were protected from mistreatment and abuse, and failed to ensure the rights of Clients #4, #5 and #6 [See W122, W124, W130, W140, W149, W153, W154 and W156]. The facility also failed

{W 000}

{W 100}

Program goals have been revised and direct care staff have been trained on program goals and documentation. Person 1 alternative day program schedule has also been revised to increase his active treatment. Current assessments are obtained and recommendation are currently implemented. Westview will continue to maintain active treatment by QMRP monitoring of the program documentation and monthly staff trainings.

3-2-10

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{W 100}	Continued From page 2 to ensure that Clients #1, #3 and #6 received continuous, aggressive active treatment programming and services. [See W195, W196, W212, W249, W250 and W252]	{W 100}	
{W 102}	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.	{W 102}	Westview has increased their support to our incident management coordinator by hiring an consultant to help catch up any delinquent reports. The Incident Manager is trained and all reports will be submitted per Department of Health and DDS policy mandates. All investigation will be reviewed by QMRP and Administrator before final submission to governing agencies. All individuals accounts have been reviewed and all unaccounted for funds have been replaced. Westview policy for individuals fund management will be implemented and all staff having contact will clients funds have been trained on this policy.
{W 114}	483.410(c)(4) CLIENT RECORDS Any individual who makes an entry in a client's record must make it legibly, date it, and sign it. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the primary care physician (PCP) consistently noted the date on which he made entries into clients' records. The finding includes: On March 5, 2010, at approximately 12:25 p.m., review of Client #2's medical chart revealed that the PCP had initialed but not signed the February 2010 physician's orders (POs). A few minutes later, the qualified mental retardation professional examined the POs and concurred that the PCP had not dated the entry. Similar findings were	{W 114}	<p>1) See: Attachment I - Physical injury of Unknown Origin.</p> <p>2) Attachment II - a. Guidelines for deposits and withdrawal of Individual Personal Funds b. Unsubstantiated Client withdrawal c. Audit of Individuals # 4 #5 #6</p> <p>All physician orders are signed. Physician orders will be signed prior to the next month. Additionally all assessments will signed prior to submission to QMRP.</p>

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{W 114}	Continued From page 3 observed in other clients' records. [Note: The client's March 2010 POs were unavailable for review. They were locked in the medication closet and there was no one in the facility with a key to open it.]	{W 114}		
{W 122}	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on interview and record review, the facility failed to ensure an effective system to protect Client #8's right for privacy during medication administration [Refer to W130]; the facility failed to ensure a system had been implemented to maintain a complete accounting of clients' personal funds [Refer to W140]; the facility failed to develop and implement policies that ensure each client's health and safety [Refer to W149]; the facility failed to ensure the immediate notification of the State Agency of allegations of abuse [Refer to W153]; failed to thoroughly investigate allegations of abuse [Refer to W154]; and the facility's Human Rights Committee failed to ensure that restrictive programs were used only with the written consent from clients' legal	{W 122}	All individuals are receiving treatment in a manner that assure privacy and dignity. TME has been released from his position with our agency and all medications are passed by licensed nurses. Consent have been obtained for all person on psychotropic medication and for any modification s to their behavior support plans. <i>Attachment III Consent forms</i>	

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{W 122}	Continued From page 4 guardians [Refer to W124 and W263].	{W 122}		
{W 124}	<p>The effects of these systemic practices resulted in the failure of the facility to protect its clients from potential harm and to ensure their general safety and well being.</p> <p>483.420(a)(2) PROTECTION OF CLIENTS RIGHTS</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: The facility failed to ensure that Client #1's legal guardian received information regarding the client's condition, attendant risks of treatment and the right to refuse treatment, prior to the implementation of his Behavior Support Plan (BSP).</p> <p>The finding includes:</p> <p>Observation of the evening medication administration on March 4, 2010, at 6:00 p.m., revealed Client #1 was observed receiving Risperidone 3mg. Interview with the trained medication employee (TME) during the medication administration, revealed the aforementioned medications were used to address the client's behaviors.</p> <p>Interview with the qualified mental retardation professional (QMRP) on March 4, 2010, at 12:20</p>	{W 124}		

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{W 124}	<p>Continued From page 5</p> <p>p.m., revealed that Client #1's guardian had not been to the facility or otherwise received a review of the client's condition and treatment needs since the January 22, 2010 recertification survey. The QMRP indicated that he had made attempts to reach the guardian by telephone. On March 5, 2010, at 9:40 a.m., the QMRP reported that Client #1's guardian would be meeting with him "today" to sign a consent form for the client's BSP and psychotropic medication.</p> <p>However, at the time that the survey ended at 3:15 p.m., the facility failed to provide evidence that informed consent was obtained from Client #1's legal guardian.</p> <hr/> <p>Previously, the January 22, 2010 deficiency report included the following:</p> <p>Based on observation, staff interview, and record review, the facility failed to establish a system that would ensure clients, family members or guardians were informed of their risks and benefits of clients restrictive measures, for two of the three clients included in the sample. (Clients #1 and #3)</p> <p>The findings include:</p> <p>1. The facility failed to ensure that informed consent was obtained from Client #3's guardian prior to the administration of his psychotropic medications.</p> <p>During the entrance conference on January 19, 2010, at 8:30 a.m., the Qualified Mental</p>	{W 124}	<p>1. Consent forms are signed guardians are aware of medications possible side effects. Review of any medication changes will be presented to IDT team and HRC Committee</p>		

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{W 124}	<p>Continued From page 6</p> <p>Retardation Professional (QMRP) indicated that Client #3 received psychotropic medications to address his maladaptive behaviors. Further interview revealed the client did not have the capacity to give informed consent for the use of medications and habilitation services.</p> <p>Observation of the evening medication administration on January 19, 2010, at 5:40 p.m., revealed Client #3 was observed receiving Haldol 10 mg, Depakote 500 mg and Risperidone 4 mg. Interview with the trained medication employee (TME) during the medication administration, revealed the aforementioned medications were used to address the client's behaviors.</p> <p>The QMRP's statement was verified on January 20, 2010, at 2:30 p.m., through review of Client #3's psychological assessment. According to the assessment, Client #3 "does not evidence the capacity to make decisions on his own behalf in treatment, habilitation, residential placement and financial matters". Further interview with the QMRP during the survey, revealed that the client had a court appointed guardian who is involved in his habilitation planning and decision making process.</p> <p>Record verification on January 20, 2010, at 2:45 p.m., revealed that Client #3's guardian had given informed consent for the use of Haldol 3 mg QAM and 4 mg QPM, Risperdal 4 mg, twice a day, Cogentin 1 mg QAM and Depakote 500 mg, twice a day dated May 11, 2009. There was no consent signed, however, for the client's current Haldol 10 mg, twice a day.</p> <p>At the time of the survey, the facility failed to provide evidence that informed consent was</p>	{W 124}		
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{W 124}	<p>Continued From page 7</p> <p>obtained from the client and/or legally authorized representative prior to the administration of the psychotropic medication.</p> <p>2. The facility failed to ensure that informed consent was obtained from Client #1's guardian prior to the to the implementation of his Behavior Support Plan (BSP).</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on January 19, 2009, at 8:30 a.m., during the entrance conference revealed that Client #1 had a Behavior Support Plan (BSP) to address his maladaptive behaviors. Further interview revealed the client did not have the capacity to give informed consent for the use of medications and habilitation services.</p> <p>The QMRP's statement was verified on January 20, 2010 at 10:30 a.m., through review of Client #1's psychological assessment. According to the assessment, Client #1 "does not show competency or intellectual capacity to make independent decisions regarding his habilitation plans, medical or psychological issues, residential placement or financial matters". Further interview with the QMRP during the survey, revealed that the client had a court appointed guardian who is involved in his habilitation planning and decision making process.</p> <p>Review of the incident book on January 19, 2010, at 8:55 a.m., revealed Client #1 was restrained by two direct care support on October 25, 2009.</p> <p>At the time of the survey, the facility failed to provide evidence that informed consent was obtained from the client and/or legally authorized</p>	{W 124}			

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{W 124}	Continued From page 8	{W 124}		
{W 130}	<p>representative prior to implementing Client # 1's BSP.</p> <p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure an effective system to protect the clients' right for privacy during medication administration, for one of the six clients residing in the facility. (Client #6)</p> <p>The finding includes:</p> <p>On March 4, 2010, at approximately 6:18 p.m., the trained medication employee (TME) informed this surveyor that Client #6 was "always last since I have to take it <medication> down to it." [Note: The medication closet (nursing office) was located on the 2nd floor.] He explained that it was difficult for the client to walk up stairs. At 8:35 p.m., the TME stated "I usually walk it down to him <client> ... in the day room." After preparing the medications, the TME carried them downstairs, stating that since Client #6 was not going to come upstairs, he was bringing them to him. Once in "the day room," the TME administered Client #6's medications while several staff and Clients #1, #2, #3 and #4 sat nearby, watching.</p> <p>This is a repeat deficiency.</p>	{W 130}	<p>All individuals are receiving treatment in a manner that assure privacy and dignity. TME has been released from his position with our agency and all medications are passed by licensed nurses.</p>	

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(W 130) Continued From page 9

Previously, the January 22, 2010 deficiency report included the following:

On January 19, 2010, at 6:00 p.m., the trained medication employee (TME) was observed to prepare Client #6's medications, upstairs in the nurse's office. The TME went downstairs, interrupted Client #6's dinner and spoon fed him his medication. Clients #1, #2, #3, #4, and #5 were present at the dining room table eating dinner. At the time, direct care staff were assisting clients with eating their dinner. Interview with the house manager on January 19, 2010, at 6:20 p.m., confirmed the observation.

(W 130)

(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.

This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to account for all clients' funds that were being managed by the facility on their behalf, for three of the six clients residing in the facility. (Clients #4, #5 and #6)

The findings include:

On March 4, 2010, at 12:26 p.m., interview with the qualified mental retardation professional (QMRP) revealed that the facility had audited the accounts of Clients #1, #2 and #3 and determined that \$2,531.70 (total) could not be accounted for those 3 individuals. He then presented three photocopied deposit slips, and a company check

(W 140)

Accounts for Individuals 4, 5, 6 are audited and all funds not accounted for by receipt is replaced in their accounts.

See attachment II Page 3

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{W 140}	Continued From page 10 for said amount, dated March 3, 2010. When asked about the other 3 clients whose accounts were being managed by the facility, the QMRP stated that Clients #4, #5 and #6's accounts had not yet been audited. Later that day, at approximately 6:05 p.m., the incident management coordinator (IMC) presented three bank receipts as evidence that the clients' funds had been redeposited into their accounts. Dates on the receipts indicated that the deposit had been made on March 4, 2010, which was confirmed by the IMC. The IMC also confirmed that the accounts managed by the facility on behalf of Clients #4, #5 and #6 had not yet received similar audits and, therefore, the status of those three clients' personal funds remained unknown.	{W 140}	<i>Audit of # 4, #5, #6 Completed - See attachments II Page 3</i>		
{W 149}	Previously, the January 22, 2010 survey revealed that the facility failed to ensure a system had been implemented to maintain a complete accounting of residents' personal funds, for three of the three residents in the sample. (Resident #1, #2 and #3) There were no receipts available for review for numerous withdrawals made from the clients' personal funds that were being managed by the facility. 483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.	{W 149}			

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{W 149} Continued From page 11
This STANDARD is not met as evidenced by:
Based on interview and record review, the facility failed to ensure that staff consistently implemented policies developed to protect client safety, for four of the six clients residing in the facility. (Clients #1, #4, #5 and #6)

The findings include:

1. [Cross Refer to See W140]. The facility failed to ensure a system had been implemented to maintain a complete accounting of clients' personal funds.

2. [Cross Refer to W153]. The facility failed to ensure client to client mistreatment and injuries unknown origin were reported immediately to the administrator in accordance with the agency's developed policy.

3. [Cross Refer to W154]. The facility failed to thoroughly investigate all incidents of client to client mistreatment and injuries unknown origin in accordance with the agency's developed policy.

{W 149}

1. Westview will train all staff who handle individuals fund on money management policy. All receipts will be rectified within a 7 day period.
2. All injuries of unknown origin are treated as a serious reportable. Serious reportable incident are reported and investigated within governing agencies guidelines.
3. Westview has hired a consultant to help bring all incidents current. The QMRP and Administrator will be more involved with this process by receiving report of all incidents and assuring that the IMC has reported the incident and investigated the incident according to governing agencies guidelines.

{W 153} 483.420(d)(2) STAFF TREATMENT OF CLIENTS

The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.

{W 153}

See Attachment I and II Page 3

This STANDARD is not met as evidenced by:
There were no documented reports or allegations of abuse, neglect, or injuries of unknown origin since a team of State Agency investigators were

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{W 153} Continued From page 12

in the facility on February 22, 2010. They investigated two allegations of abuse that occurred within the first week of February 2010 (after the January 22, 2010 recertification survey). Investigators determined that the facility failed to report to the State Agency timely a February 1, 2010 allegation of physical abuse of Client #1 by a staff. The allegation was reported to the State Agency on February 4, 2010, 3 days later. (See Federal Deficiency Report, dated February 26, 2010)

Previously, the January 22, 2010 deficiency report included the following:

Based on interview and record review, the facility failed to ensure client to client mistreatment and injuries unknown origin were reported immediately to the administrator or to other officials in accordance with district law (22 DCMR, Chapter 35, Section 3519.10), for two of the six clients residing in the facility. (Clients #1 and #2)

The findings include:

1. Review of the facility's incident reports and corresponding investigative reports on January 19, 2010, beginning at 8:58 a.m., revealed the following:

On August 27, 2009, at 2:00 p.m., the Incident Management Coordinator (IMC) received a phone call from Department of Disabilities Services (DDS) investigator on August 27, 2009, at 2:00 p.m., stating that their office received an

{W 153}

1. Incident Manager has reviewed reporting policies with DDS Incident Investigator. Westview will also report all incidents to its Administrator and QMRP when they occur to assure proper notification to all governing bodies.

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{W 153}	<p>Continued From page 13</p> <p>anonymous fax alleging abuse against Client #1. The statement alleged that the client was "acting out", grabbed a staff and in return the staff used force to release himself.</p> <p>An interview was conducted with the IMC on January 19, 2010, at approximately 10:45 a.m., that revealed that she did not complete an incident report. According to the notification section of the investigative report revealed that the administrator was notified on August 28, 2009, at 2:45 p.m., (24 hours after the phone call). Further interview revealed that all allegations of abuse should be reported to the administrator, immediately.</p> <p>2. Review of the Client #2's nursing notes on January 20, 2010, beginning at 9:51 a.m., revealed the following client to client mistreatment and injuries of unknown origin:</p> <p>a. On December 18, 2009, at 6:50 p.m., the registered nurse (RN) noted that Client #2 sustained a bite to her right lower arm by Client #4.</p> <p>b. On September 14, 2009, the RN noted a round bruise on Client #2's right forearm.</p> <p>c. On June 27, 2009, the RN noted a fading bruise on Client #2's left forearm.</p> <p>d. On April 28, 2009, the RN noted that she received a page from the facility at 6:45 a.m. The RN was apprised of a bruise on Client #2's arms. Upon arrival to assess the client, the RN observed a large ecchymosed area on her left forearm. The RN further noted that she had assessed the client's vital signs, placed ear drops</p>	{W 153}	<p>2. Incident of unknown origin will be reported to governing agencies and treated as serious reportable incidents in reporting and investigated like all serious reported incidents.</p> <p>a. Incident is reported as is investigated as a serious reportable injury.</p> <p>b. Incident is reported as is investigated as a serious reportable injury</p> <p>c. Incident is reported as is investigated as a serious reportable injury</p> <p>d. Incident is reported as is investigated as a serious reportable injury</p> <p><i>see Attachment I Page 3</i></p>	
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(W 153)	Continued From page 14 in her ears and provided nail care on either April 25, or April 26, 2009, and did not note any bruises or made aware of any incidents that had taken place. An interview was conducted with the RN on January 21, 2010, beginning at 1:15 p.m., via telephone. The RN was aware of the bite incident; however, the other aforementioned bruises were noted during visits to the facility. Inquiry was made of the RN, about the facility's incident reporting procedures. The RN stated, "If a client receives an injury of unknown origin, the direct care staff should report the injury of unknown origin to the QMRP or House Manager and complete an incident report. An interview was conducted with the IMC on January 19, 2010, at approximately 10:45 a.m., that revealed she was not aware of the injuries of unknown origin for Client #2.	(W 153)		
(W 154)	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: There were no documented reports or allegations of abuse, neglect, or injuries of unknown origin since a team of State Agency investigators were in the facility on February 22, 2010. They investigated two allegations of abuse that occurred within the first week of February 2010	(W 154)		

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{W 154}	<p>Continued From page 15 (after the January 22, 2010 recertification survey). Results of their investigations revealed a failure to thoroughly investigate a February 1, 2010 report of physical abuse of Client #1 by a staff. (See Federal Deficiency Report, dated February 26, 2010)</p> <hr/> <p>Previously, the January 22, 2010 deficiency report included the following:</p> <p>Based on interview and record review, the facility failed to thoroughly investigate all incidents, for two of the six clients residing in the facility. (Clients #2 and #6)</p> <p>The findings include:</p> <p>1. Review of the facility's unusual incident reports (UIR) and investigative reports on January 19, 2010, beginning at 8:56 a.m., revealed the following client to client mistreatment and injuries of unknown origin:</p> <p>Review of the Client #2's nursing notes on January 20, 2010, beginning at 9:51 a.m., revealed the following client to client mistreatment and injuries of unknown origin revealed the following:</p> <p>a. On December 18, 2009, at 6:50 p.m., the registered nurse noted that Client #2 sustained a bite to the right lower arm from Client #4.</p> <p>b. On September 14, 2009, the RN noted a round bruise on the Client #2's right forearm.</p>	{W 154}	<p>All noted incident have reports generated. These incidents are noted as serious reportable these incidents have been investigated per governing body policies. In the future all incidents of unknown origin will be reported and investigated within allotted policy time frame.</p> <p><i>Attachment III Policy for Incident Management Reporting Protocol</i></p>	
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{W 154}	<p>Continued From page 16</p> <p>c. On June 27, 2009, the RN noted a fading bruise on Client #2's left forearm.</p> <p>d. On April 28, 2009, the RN noted that she received a page from the facility at 6:45 a.m. The RN was apprised of a bruise on Client #2's arms. Upon arrive to assess the client, the RN observed a large ecchymosed area on her left forearm. The RN further noted that she had assessed the client's vital signs, placed ear drops in her ears and provided nail care on either April 25, 2009, or April 26, 2009, and did not observe any bruises or made aware of any incidents that took place.</p> <p>Review of the facility's incident reports on January 4, 2010, at 5:00 p.m., revealed no evidence of the aforementioned incident reports.</p> <p>An interview was conducted with the IMC on January 19, 2010, at approximately 10:45 a.m., that revealed that she was not aware of the injuries of unknown origin for Client #2. However she noted that according to the facility's policy, the first person that discovers an injury of unknown origin should complete an incident report and informed the QMRP and/or the House Manager. She further indicated that investigations were not conducted because she was not informed of the injuries of unknown origin.</p> <p>2. Review of the facility's incident reports and investigative reports on January 21, 2010, at 8:56 p.m., revealed Client #6's investigation report dated March 24, 2009. The investigation report stated, "S/P fall, ... substantiated and resolved." However, the investigative report failed to document how the fall was substantiated and or a conclusion. Review of the recommendations</p>	{W 154}	<p>2. This incident has been reinvestigated and staff received training per Physical Therapist recommendations.</p> <p><i>See Attached V A</i></p>	
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{W 154}	Continued From page 17 revealed the 1:1 direct support staff needs more training on how to assist his client up and down the stairs.	{W 154}		
{W 195}	483.440 ACTIVE TREATMENT SERVICES The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: Based observations, interviews, and record reviews, the facility failed to provide continuous and aggressive active treatment services and interventions in accordance with recommendations of the interdisciplinary team (IDT), [Refer to W196, W249]; the facility failed to ensure that clients who received psychotropic medications had a psychiatric assessment [Refer to W212]; the facility failed to implement clients' training programs in accordance with their IPP [Refer to W249]; the facility failed to develop an alternative and a regular active treatment schedule that outlined the current active treatment programs [See W250]; and, the facility failed to ensure that data was collected in the form and required frequency [See W252]. The findings of these systemic practices results in the facility's failure to adequately govern the facility in a manner that would ensure its clients' were provided active treatment to address their	{W 195}	See Response to W196, W212, W249, W250, W252	

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{W 195}	Continued From page 18 identified needs.	{W 195}		
{W 196}	<p>483.440(a)(1) ACTIVE TREATMENT</p> <p>Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward:</p> <p>(i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and</p> <p>(ii) The prevention or deceleration of regression or loss of current optimal functional status.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interviews, and record review, the facility failed to ensure that clients received continuous active treatment program in accordance with recommendations made by the interdisciplinary team (IDT) for three of the three clients included in the sample. (Clients #1, #3 and #6)</p> <p>The findings include:</p> <p>1. The facility failed to ensure that Client #1 received continuous active treatment during the daytime, as evidenced below:</p> <p>On March 4, 2010, at 11:12 a.m., the facility's van pulled up to the group home. The driver stepped out; however, Client #1 and his 1:1 direct support staff remained inside the van. At 11:19 a.m., the driver got back in and the van drove away with the client and his staff. At 2:50 p.m., Client #1 was observed entering the facility. Interview with</p>	{W 196}	<p>1. Alternative Day Program has been created for person #1. Staff have received training on active treatment and program documentation.</p>	

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{W 196}	<p>Continued From page 19</p> <p>the 1:1 staff, at approximately 3:00 p.m., revealed Client #1 had refused to go into his day program as well as a medical appointment. The 1:1 staff further indicated that no other active treatment had taken place. Earlier that day, at approximately 2:00 p.m., review of the client's program book revealed no documented evidence of an alternative activity schedule for Client #1. Even though the facility's Plan of Correction, signed March 2, 2010, stated that a schedule had been developed (completed February 5, 2010), interview with the qualified mental retardation professional (QMRP) on March 5, 2010, at 2:27 p.m., revealed that the client was without an alternative activity schedule. The QMRP was unable to state what, if any, structured active treatment Client #1 had received that day.</p> <p>2. The facility failed to ensure that Client #1 received continuous active treatment during the evening, as evidenced below.</p> <p>On March 4, 2010, Client #1 and his 1:1 direct support staff were observed in the facility, beginning at 2:50 p.m. At 2:55 p.m., his 1:1 support staff gave Client #1 a magazine. The client flipped through the magazine for approximately 10 minutes. At 3:17 p.m., the client was observed watching television in the living room. Moments later, however, he stood up and for approximately 45 minutes, he walked back and forth from the living room to the dining room, repeatedly. During that period, he was observing other clients and staff. His 1:1 support staff did not engage him in an active treatment program or otherwise encourage the client to participate in a structured activity. At 4:04 p.m., the 1:1 support staff asked Client #1 to take his dishes to the kitchen; however, he refused.</p>	{W 196}	<p>2. Staff have received training on active treatment. QMRP will coach and monitor program.</p> <p><i>Attachment X</i></p>	
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{W 196}	<p>Continued From page 20</p> <p>For the period of 4:06 p.m. - 4:34 p.m., Client #1 was observed walking back and forth from the living room to the dining room, or going upstairs (briefly), and looking out of windows. During this 28-minute period, his 1:1 support staff did not engage him in an active treatment program or otherwise encourage the client to participate in a structured activity.</p> <p>Client #1 took a walk in the community (3 blocks) with a staff and 3 of his peers, from 4:34 p.m. - 4:59 p.m. At 5:00 p.m., he resumed his pacing and observing others and was not engaged in a meaningful activity until dinner was served, at 5:43 p.m. He finished his dinner at 5:57 p.m., and took his dishes to the kitchen after his 1:1 direct support staff asked him to do so. For the next 38-minute period (5:58 p.m. - 6:30 p.m.), however, he went into the living room where he sat and watched the other clients watching television with staff. Except for the community walk and the mealtime supports (i.e. instruction to take dishes to kitchen), Client #1 was not involved in meaningful activities for the period 2:55 p.m. - 6:30 p.m.</p> <p>It should be noted that earlier that day, at approximately 2:00 p.m., review of the client's program book revealed no documented evidence of an alternative activity schedule for days when he refused to go into his day program. Even though the facility's Plan of Correction, signed March 2, 2010, stated that a schedule had been developed (completed February 5, 2010), interview with the QMRP on March 5, 2010, at 2:27 p.m., confirmed that the client remained without an evening activity schedule.</p>	{W 196}		
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{W 196}	<p>Continued From page 21</p> <p>3. Cross-refer to W249.2. The facility failed to ensure that staff in the home were implementing Client #6's IPP objectives.</p> <hr/> <p>Previously, the January 22, 2010 deficiency report included the following:</p> <p>Based on observation, staff interviews, and record review, the facility failed to ensure that clients received continuous active treatment program in accordance with recommendations made 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>On January 19, 2010, Client #1's home activities beginning at 7:30 a.m., were observed and revealed the following:</p> <p>a) Upon the surveyors' arrival at 7:30 a.m., a direct care support staff was observed talking on his cell phone, outside. Once the surveyor entered the facility, Client #1 was observed eating breakfast with his peers. Further observations revealed staff walking in and out the dining room as the clients ate breakfast. Interview with the direct support staff at approximately 7:50 a.m., revealed Client #1 required a 1:1 direct care support staff (24 hours). There was no evidence that a 1:1 direct care support staff was present during breakfast.</p> <p>b) On January 19, 2010, at 8:30 am., Client #1 was observed entering the facility's van to go to</p>	{W 196}		
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{W 196}	<p>Continued From page 22</p> <p>his day program. At 10:00 a.m., Client #1 returned home. Interview with his 1:1 direct support staff revealed the client refused to get off the van because he did not want to go to his day program. From 10:00 a.m., until 10:30 a.m., Client #1 was observed looking out the dining room window. At 11:45 a.m., the client was observed leaving the facility with staff and returned at 12:35 p.m. Interview with his 1:1 direct support staff revealed the client went to lunch at McDonalds. At 12:45 p.m., the 1:1 direct support staff handed the client a magazine and he flipped through the pages briefly then began to watch television. At 1:02 p.m., the 1:1 direct support staff handed him the same magazine. The client flipped through the pages briefly then began to look around the living room. Shortly after he began to look out the window.</p> <p>Interview with the 1:1 direct support staff on January 21, 2010, at 1:20 p.m., revealed "I give him his freedom and space during the day because he is programmed in the evenings." Further interview revealed "If you get into his space too much he will go into his behaviors." Minutes later, the 1:1 direct support staff revealed Client #1 was going to ride on the van to pick the other clients up from their day programs.</p> <p>Review of the client's habilitation record on January 21, 2010, revealed no documented evidence of training programs for January 2010. Further record review revealed the last QMRP monthly notes were dated September 3, 2009.</p> <p>c. Observation on January 19, 2010, at approximately 3:00 p.m., revealed Client #1 looking out the window. At 3:50 p.m., the client was observed leaving the group home. Interview</p>	{W 196}		
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{W 198} Continued From page 23

with the direct support staff indicated the client was going to ride on the van to take another client to a medical appointment. At 4:40 p.m., Client #1 arrived home and began to look out the dining room window. The 1:1 direct support staff was in the living room. At 5:00 p.m., the client and his 1:1 direct support staff went into the living room to watch television. At 5:05 p.m., Client #1 began to look out the dining room window again. The direct support staff named three things that was out the window. At 5:15 p.m., the 1:1 direct support staff handed Client #1 a magazine and he flipped through the magazine briefly. Interview with the 1:1 direct support staff at 5:53 p.m., revealed, "we usually take him for a ride in the evenings."

Record review on January 21, 2010, beginning at 9:10 a.m., revealed an activity schedule included in Client #1's Individual Support Plan (ISP), dated December 12, 2008. Interview with the 1:1 direct support staff on January 21, 2010, at 11:40 a.m., revealed he has not seen Client #1's activity schedule since his last ISP in December 2008.

At 6:00 p.m., the direct support staff was observed setting the table for dinner. At 6:05 p.m., Client #1 was observed eating his dinner while wearing his winter coat. After he completed his dinner, staff was observed taking the client's dishes to the kitchen.

Review of Client #1's occupational therapy assessment dated December 12, 2008, on January 21, 2010, at 10:00 p.m., revealed Client #1 was able to place "his cup and utensil onto his plate and take his plate to the kitchen when finished eating.

{W 198}

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(W 196)

Continued From page 24

Observations on January 19, 2010, at 6:25 p.m., revealed Client #1 watching television in Client #5's bedroom. Interview with the direct support staff revealed Client #1 broke his television last week, therefore he "lets him enjoy himself." The support staff was observed downstairs while Client #1 was upstairs looking out Client #2's bedroom window. At 6:44 p.m., Client #1 was observed walking into the dining room wearing a dirty suit jacket (a white substance was all over his jacket). Interview with the 1:1 direct support staff revealed Client #1 "likes to wear that jacket." Further interview revealed he will display his behavior if he is redirected.

Review of Client #1's occupational therapy assessment dated December 12, 2009, on January 21, 2010, at 10:00 p.m., revealed Client #1 was able to "place dirty clothing into the hamper and load the washing machine and the dryer with verbal prompting."

Review of Client #3's IPP revealed that the recommended training programs were not consistently implemented as evidenced below:

- The client will independently Say hi to his 1:1 counselor by name, when he arrives to work on 4 out of 4 trials a week.
- The client will independently set his place at the dinner table on 3 out of 3 trials a week.
- The Client will independently remove his dishes from the table after dinner on 3 out of 3 trials a week.
- Given visual demonstration and verbal prompting. The client will participate in structured

(W 10e)

Person # 1 has a replacement television in his room. Staff also has received training on individual rights, and privacy.

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{W 196}	<p>Continued From page 25 exercise on 3 out of 3 trials a week.</p> <ul style="list-style-type: none"> - Given a model, the client will identify the function of 5 community helpers with 80% accuracy per session for six consecutive months. - The client will independently participate in a table top activity for 30 minutes on 4 out of 4 trials a week. <p>Interview with the Qualified Mental Retardation Professional (QMRP) on January 21, 2010, at 11:00 a.m., revealed that the program had not been implemented since his Individual Support Plan (ISP) meeting. Further interview revealed that Client #1's ISP meeting was held on December 11, 2009.</p>	{W 196}		
{W 212}	<p>483.440(c)(3)(i) INDIVIDUAL PROGRAM PLAN</p> <p>The comprehensive functional assessment must identify the presenting problems and disabilities and where possible, their causes.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that clients received comprehensive functional assessments, for three of the three clients in the sample. (Clients #1, #2 and #3)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. On March 5, 2010, at approximately 2:40 p.m., interview with the qualified mental retardation professional (QMRP), followed by a review of Client #1's records, revealed no changes made since the January 22, 2010 survey findings that follow: 	{W 212}	<p>1. Current psychological report are obtained and placed in person # 1. Pre ISP meeting have been added to schedule to assure all documents are given during ISP</p>	

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{W 212}	<p>Continued From page 26</p> <p>The facility failed to ensure that Client #1 received a psychological assessment.</p> <p>Observation of the evening medication administration on January 19, 2010, at 6:00 p.m., revealed Client #1 received Tegretol 500 mg, and Risperdal 3 mg. Interview with the trained medication employee (TME) on January 19, 2010, during the medication administration indicated that the medication was prescribed for behavior management. Review of the client's physicians orders (POS) dated January 2010, on January 20, 2010 at 10:30 a.m., revealed that the aforementioned medications were prescribed for the client's psychotic disorder.</p> <p>Review of Client #1's psychological assessment dated December 6, 2008 on January 21, 2010, at 10:15 a.m., stated, "complete an annual psychological assessment update within one year." Interview with the qualified mental retardation professional (QMRP) on January 21, 2010, at approximately 3:00 p.m., indicated that Client #1's psychological assessment had not been completed. There was no evidence of a current psychological assessment.</p> <p>2. On March 5, 2010, at approximately 2:40 p.m., interview with the qualified mental retardation professional (QMRP), followed by a review of Client #2's and Client #3's records, revealed no changes made since the January 22, 2010 survey findings that follow:</p> <p>The facility failed to ensure clients who received psychotropic medication had a psychiatric assessment, for two of the three clients in the sample. (Clients #2 and #3)</p>	{W 212}	<p>2. All person who receive psychotropic medication are seeing their psychiatrist monthly. An assessment is obtained for person 2 and 3.</p> <p><i>See Attachment III P-4</i></p>	

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{W 212}	<p>Continued From page 27</p> <p>a. Observation of the evening medication administration on January 19, 2010, at 5:45 p.m., revealed Client #2 received Risperdal and Tegretol. Interview with the trained medication employee (TME) on January 19, 2010, during the medication administration indicated that the medication was prescribed for behavior management. Review of the client's physicians orders dated January 2010, on January 20, 2010, at 10:30 a.m., revealed that the aforementioned medications were incorporated in a Personal Behavior Support Plan (PBSP) dated November 4, 2009.</p> <p>Review of Client #2's medical evaluation dated October 29, 2009, on January 19, 2010, at approximately 10:00 AM, revealed that the psychotropic medications were prescribed to address behaviors associated with a diagnosis of bipolar disorder.</p> <p>Further review of the client's medical record revealed no documented evidence of a psychiatric assessment.</p> <p>b. Observation of the evening medication administration on January 19, 2010, at 5:40 p.m., revealed Client #3 received Haldol, Depakote and Risperdal. Interview with the trained medication employee (TME) on January 19, 2010, during the medication administration indicated that the medication was prescribed for behavior management. Review of the client's physicians orders dated January 2010, on January 20, 2010 at 1:34 p.m., revealed that the aforementioned medications were incorporated in a Personal Behavior Support Plan (PBSP) dated December 10, 2008.</p>	{W 212}	<p>a. Psychiatric Assessment for person #2 has been obtained</p> <p><i>Attachmet IVb</i></p> <p>b. Psychiatric Assessment for person #3 has been obtained</p>	

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{W 212}	<p>Continued From page 28</p> <p>Review of Client #3's medical evaluation dated December 2008, on January 20, 2010 at approximately 2:00 p.m., revealed that the psychotropic medications were prescribed to address behaviors associated with a diagnosis of chronic schizophrenia paranoid.</p> <p>Further review of the client's medical record revealed no documented evidence of a psychiatric assessment.</p> <p>3. On March 5, 2010, at approximately 2:40 p.m., interview with the qualified mental retardation professional (QMRP), followed by a review of Client #1's and Client #2's records, revealed no changes made since the January 22, 2010 survey findings that follow.</p> <p>The facility failed to assess Clients #1 and #2 to determine their need to participate in a self medication program.</p> <p>a. Observation of the medication administration on January 19, 2010, at 6:02 p.m., the trained medication employee (TME) was observed preparing and spoon feeding the client his medications, pouring Client #1's cup of water. Observations throughout the survey from January 19, 2010, through January 22, 2010, revealed that the client was independent in feeding himself.</p> <p>Interview with the TME during the medication observation indicated that the client did not participate in a self medication training program. Review of the medical record revealed no self medication assessment. Further Interview with the QMRP on January 21, 2010, at approximately 10:00 a.m., confirmed that there was no</p>	{W 212}	<p>3. Person #1 and #2 medication assessments is completed and will be done annually prior to ISP</p> <p>a. medication assessment completed</p>	
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{W 212}	Continued From page 29 self-medication assessment. b. Observation of the medication administration on January 19, 2010, at 5:45 p.m., the TME was observed preparing Client #2's medications. The TME punched the pills into a medication cup, put the pills in a cup of applesauce, spoon fed it to the client and poured the client a cup of water. Observations throughout the survey from January 19, 2010, through January 22, 2010, revealed that Client #2 pouring water into a cup and feeding herself independently. Interview with the TME during the medication observation indicated that the client did not participate in a self medication training program. Review of the medical record revealed no self medication assessment. Further interview with the QMRP on January 21, 2010, at approximately 10:00 a.m., confirmed that there was no self-medication assessment.	{W 212}	b. medication assessment completed		
{W 249}	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to implement clients' Individual Program Plan (IPP), for two of the four clients in the sample. (Clients #3 and #6)	{W 249}			

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{W 249}

Continued From page 30

The findings include:

1. There was no evidence that Client #3's self-medication training program was being implemented, as follows:

The evening medication pass was observed on March 4, 2010. Beginning at approximately 6:12 p.m., Client #3 retrieved, prepared, self-administered and placed back into storage his own medications, while the trained medication employee (TME) observed. The administration process was identical to that observed during the January 22, 2010 recertification survey. There was no evidence that the TME implemented Client #3's program to "identify the label," when "given a description of a medicine and/or warning label."

When interviewed the following day, at 10:43 a.m., the qualified mental retardation professional (QMRP) stated that he did not think Client #3's self-medication training program was being implemented yet. He did not offer further information. At 12:30 p.m., the client's March 2010 program data collection sheet and MAR were unavailable for review and verification. They were locked in the medication closet and there was no one in the facility with a key to open it.

This is a repeat deficiency.

2. The facility failed to ensure that Client #6's training programs were implemented, as follows:

a. Client #6's 1:1 direct support staff was interviewed on March 4, 2010, beginning at 4:35 p.m. He stated that the only training programs he

{W 249}

Self Medication program is currently implemented. Upon record review the program was implemented daily. The Administrator will have a back up key to the medication closet. MAR will be kept outside of medication closet.

see attachment VI

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{W 249}	<p>Continued From page 31</p> <p>worked on with the client were (1) drying himself off with a towel after showering, (2) using a tooth brush properly, and (3) using an exercise bicycle. At 4:46 p.m., review of Client #6's program data book revealed no evidence of a towel-drying, tooth brushing or exercise bicycle goal/objective. Instead, one of the objectives was "Given verbal prompts, <client's name> will pull up his pants on 80% of the trials..." The data sheets for January and February 2010 were both blank and devoid of performance data.</p> <p>b. There was no evidence that Client #6's two physical therapy programs were being implemented, as follows:</p> <p>1) Client #6's IPP, dated December 11, 2009, included a goal to improve ambulation endurance. The client "should ambulate for 10 minutes with staff assistance, 3 days per week, for 6 consecutive months." Review of the client's program book, however, failed to show evidence that data collection sheets had been established for that objective. Instead, the program book contained data sheets for a previous program (dated June 5, 2009) for him to "ambulate for 100 ft. with rolling walker, 3 days per week, with staff assistance for 6 consecutive months." The data sheets were left blank.</p> <p>c. Similarly, Client #6's IPP, dated December 11, 2009, included another physical therapy goal for the client to "stand unsupported for 8 consecutive minutes, 3 times per week, for 6 months." The data sheets for January and February 2010 had also been left blank and were devoid of performance data.</p> <p>d. Client #6's IPP, dated December 11, 2009,</p>	{W 249}	<p>All Staff have been re-trained on programs and documentation for person # 6 and all individuals. Documentation of these programs are monitored by QMRP</p>	
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(W 249)	<p>Continued From page 32</p> <p>included other training and/or service objectives, such as "independently put together a multi-piece puzzle" and "Given verbal prompting, <client's name> will throw the ball to a staff or peer on 5/10 trials per session..." Data sheets for both of these programs had been left blank and were devoid of performance data.</p> <p>On March 4, 2010, at 10:20 a.m., the QMRP stated that the client's PT goals had changed, to reflect that he was refusing to use the rolling walker. He examined the data sheets in the client's program book and acknowledged that he didn't see evidence that staff had been implementing Client #6's December 2009 IPP. He then acknowledged that the staff assigned to provide Client #6 with 1:1 support had not received training on his program goals and objectives.</p> <p>3. On March 4, 2010, at 4:00 p.m., Client #6's 1:1 direct support staff was observed holding a cup of water (with a splash of juice for flavor) up to the client's mouth. The client had his mouth open and the staff began pouring sips of flavored water into his mouth. The client's hands were both placed on his lap while he drank. Moments earlier, Client #6 had been observed holding feeding himself. This surveyor, therefore, asked whether the client could hold his own cup. The staff replied "yes, when he wants to." Upon this inquiry, the 1:1 staff guided the client's hand to the flavored water and the client picked up the glass and began to drink independently. There was no evidence that the 1:1 staff encouraged the maintenance of Client #6 self-feeding skills.</p>	(W 249)			

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{W 249}	Continued From page 33 Previously, the January 22, 2010 deficiency report included the following: 1. The trained medication employee (TME) arrived in the facility at 5:30 p.m., and explained to Client #3 that he needed to take his medications to control his maladaptive behaviors. Observation of the medication administration on January 19, 2010, at 5:40 p.m., Client #3 was observed locating a key, unlocking his medication box, punching his medications from the bubble packs, pouring a cup of water and consuming his medications, independently. After the client consumed his medications, he locked the medication box and put the box back into the cabinet. The TME was observed signing the medication administration record (MAR). Interview with the TME indicated that the client is independent in taking his medications; however, he does not indicate the medication usage or sign the MARs. Review of the client's IPP dated December 13, 2009, revealed a program objective which stated, "given a description of a medicine and/or warning label, [the client] will identify the label for 10/12 trials offered for six consecutive months as measured by program documentation." Interview with the Qualified Mental Retardation Professional (QMRP) on January 21, 2010, at 10:00 a.m., revealed that the program had not been implemented since his Individual Support Plan (ISP) meeting was held on December 13, 2009.	{W 249}	Medication personnel are trained on person self medication goal implementation of individuals program will be monitored by Nurse and QMRP		
{W 250}	483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.	{W 250}			

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{W 250}	<p>Continued From page 34</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop an alternative and a regular active treatment schedule that outlined the current active treatment programs, for three of the four clients in the sample. (Clients #1, #2 and #6)</p> <p>The findings include:</p> <p>1. The facility failed to ensure an alternative daytime activity schedule was developed for Client #1, as evidenced below.</p> <p>On March 4, 2010, at 11:12 a.m., the facility's van pulled up to the group home. The driver stepped out; however, Client #1 and his 1:1 direct support staff remained inside the van. At 11:19 a.m., the driver got back in and the van drove away with the client and his staff. At 2:50 p.m., Client #1 was observed entering the facility. Interview with the 1:1 staff, at approximately 3:00 p.m., revealed Client #1 had refused to go into his day program as well as a medical appointment. The 1:1 staff further indicated that no other active treatment had taken place. Earlier that day, at approximately 2:00 p.m., review of the client's program book revealed no documented evidence of an alternative activity schedule for Client #1. Even though the facility's Plan of Correction, signed March 2, 2010, stated that a schedule had been developed (completed February 5, 2010), interview with the qualified mental retardation professional (QMRP) on March 5, 2010, at 2:27 p.m., confirmed that the client remained without an alternative activity schedule.</p>	{W 250}	<p>Program goals are developed for person # 1. Staff are re-trained on active treatment, engaging persons in activities that they enjoy. Monitoring person #1 activities and ongoing coaching by QMRP and Home Manager will increase.</p>	
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{W 250} Continued From page 35

It should be noted that interview with the facility's driver on March 5, 2010, at approximately 11:00 a.m., revealed that Client #1 had refused to go into his day program again that morning.

2. The facility failed to develop an active treatment schedule that outlined Client #1's evening active treatment programs, as evidenced below:

Observation on March 4, 2010, at 2:55 p.m., revealed Client #1 flipping through pages of a magazine. At 3:17 p.m., the client was observed watching television in the living room. At 4:04 p.m., the 1:1 support staff asked Client #1 to take his dishes to the kitchen; however, he refused. At 4:06 p.m., the client was observed looking out Client #2's bedroom window. At 4:16 p.m., he went downstairs and began to look out the dining room window. At 5:09 p.m., he went into the living room and began to call Client #6's name as he watched television. After dinner, at 5:57 p.m., he took his dishes to the kitchen after his 1:1 direct support staff made the request. At 6:04 p.m., he was observed looking out the window again. At 6:30 p.m., he went into the living room where the other clients were watching television and began to look around. Except for the mealtime supports (i.e. instruction to take dishes to kitchen), Client #1 was not involved in meaningful activities for the period 2:55 p.m. - 6:30 p.m.

Earlier that day, at approximately 2:00 p.m., review of the client's program book revealed no documented evidence of an alternative activity schedule for Client #1. Even though the facility's Plan of Correction, signed March 2, 2010, stated that a schedule had been developed (completed

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{W 250}	<p>Continued From page 36</p> <p>February 5, 2010), interview with the QMRP on March 5, 2010, at 2:27 p.m., confirmed that the client remained without an evening activity schedule.</p> <p>3. On March 5, 2010, at 2:27 p.m., the QMRP stated that Client #2 and Client #6 also remained without activity schedules.</p> <hr/> <p>Previously, the January 22, 2010 survey revealed that the facility had failed to develop activity schedules for Clients #1, #2 and #3. In addition, Client #1 was without an alternative daytime schedule, even though he frequently refused to enter his day program.</p>	{W 250}		
{W 252}	<p>483.440(e)(1) PROGRAM DOCUMENTATION</p> <p>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that data was collected in the form and required frequency, for two of the six clients residing in the facility. (Clients #1 and #6)</p> <p>The findings include:</p> <p>1. Client #6 and his assigned 1:1 direct support staff person were observed in the facility on March 4, 2010, beginning at 2:52 p.m. The 1:1</p>	{W 252}	<p>All staff received training on individual programs and documentation an increase of monitoring and coaching of these programs by QMRP and House Manager has occurred and will continue. Staff trainings also have increased to twice per month to increased knowledge of the individual best practices to serve our individuals.</p>	

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{W 252}	<p>Continued From page 37</p> <p>support staff was interviewed, beginning 4:35 p.m. He stated that the only training programs he worked on with the client were (1) drying himself off with a towel after showering, (2) using a tooth brush properly, and (3) using an exercise bicycle.</p> <p>Beginning at 4:36 p.m., review of the data collection forms in Client #6's program book revealed no correlation with the programs that the 1:1 had just described. Instead, there were data sheets for documenting the client's:</p> <ul style="list-style-type: none"> - participation in table top activities; - ambulating on stairs; - putting together a multi-piece puzzle; - participating in community outings; - ball toss with staff and peers, and, - pulling up his pants. <p>All of the aforementioned program data sheets were blank.</p> <p>2. Similarly, review of Client #6's program book on March 4, 2010, beginning at 4:46 p.m., revealed that staff had not been documenting Client #6's behavioral status on the appropriate data collection sheet. The February 2010 data sheet for the 3 p.m. - 11 p.m. shift evidenced data for the dates February 1 - 21, 2010; the remaining 7 days, however, had been left blank. Similarly, the January 2010 behavior data sheet (evening shift) provided data for January 1 - 19, 2010 only; the remainder of the month was without data. There was no march 2010 behavior data sheet observed in the program book. Client #6's 1:1 staff indicated that they were without a data sheet for the month of March.</p> <p>The qualified mental retardation professional (QMRP) was asked about Client #6's programs and data collection on the following day, at 10:20</p>	{W 252}		
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{W 252}	<p>Continued From page 38</p> <p>a.m. He examined the data collection sheets and acknowledged that staff had not been collecting performance data on the programs. Upon further discussion, the QMRP acknowledged that the 1:1 staff assigned to provide Client #6 with support had not yet received training on the December 2009 IPP goals/objectives.</p> <hr/> <p>Previously, the January 22, 2010 deficiency report included the following:</p> <p>Interview with Client #1's guardian on January 21, 2010, at approximately 4:30 p.m., revealed, sometime in June or July 2009, while Client #1 was outside his home, he became aggressive and began to hit others around him. Further interview indicated the client took a while to calm down.</p> <p>Review of Client #1's Behavior Support Plan (BSP) dated December 10, 2008, on January 21, 2010 at 10:30 a.m., revealed "hitting others" and "aggression" were two of the client's targeted behaviors. Further review of the BSP revealed that all incidents of targeted behaviors should be recorded at the end of each shift. At approximately 2:00 p.m., review of the data collection sheets from June 2009 and July 2009, revealed no evidence of targeted behaviors (aggression and/or hitting of others).</p> <p>Interview with the incident management coordinator and qualified mental retardation professional (QMRP) on January 22, 2010, at approximately 11:30 a.m., revealed they were not aware of the incident.</p>	{W 252}		
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{W 263}	483.440(f)(3)(ii) PROGRAM MONITORING &	{W 263}		
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(W 263)

Continued From page 39
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 minor) or legal guardian.

This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the Human Rights Committee failed to ensure that restrictive measures were being implemented only with the written consent of clients' court appointed guardians, for one of the four clients in the sample. (Client #1)

The finding includes:

Cross-refer to W124.1 Observation of the evening medication administration on March 4, 2010, at 1:00 p.m., revealed Client #1 was observed receiving Risperidone 3mg. Interview with the trained medication employee (TME) during the medication administration, revealed the aforementioned medications were used to address the client's behaviors.

Interview with the qualified mental retardation professional (QMRP) on March 4, 2010, at 12:20 p.m., revealed that he had tried making arrangements to meet with Client #1's guardian. Further interview on March 5, 2010, at 9:40 a.m., revealed that Client #1's guardian would be meeting with him that day to sign his consent form for his BSP and psychotropic medication.

At the time of the survey exit at 3:15 p.m., the facility failed to provide evidence that informed consent was obtained from Client #1's legal

(W 263)

Consents are obtained for all individuals, guardians and HRC committee will be made aware of any changes to medication or BSP's.

See Attachment III P-4

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{W 263}	<p>Continued From page 40</p> <p>guardian. In addition, there was no evidence that Human Rights Committee had determined whether the facility had obtained legal consents prior to the implementation of restrictive measures.</p> <hr/> <p>Previously, the January 22, 2010 deficiency report included the following:</p> <p>Based on observation, staff interview and record review, the facility failed to ensure restrictive measures were being implemented with the written consent of the client's court appointed legal guardian, for two of three clients included in the sample. (Client #1 and Client #3)</p> <p>The findings include:</p> <p>The facility failed to ensure that informed consent was obtained from Client #1's guardian prior to the to the implementation of his Behavior Support Plan (BSP).</p> <p>Interview with the qualified mental retardation professional (QMRP) on January 19, 2009, at 8:30 a.m., during the entrance conference revealed that Client #1 had a BSP to address his maladaptive behaviors. Further interview revealed the client did not have the capacity to give informed consent for the use of medications and habilitation services.</p> <p>The QMRP's statement was verified on January 20, 2010 at 10:30 a.m., through review of Client #1's psychological assessment. According to the assessment, Client #1 "does not show</p>	{W 263}		

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{W 263}	Continued From page 41 competency or intellectual capacity to make independent decisions regarding his habilitation plans, medical or psychological issues, residential placement or financial matters". Further interview with the QMRP during the survey, revealed that the client had a court appointed guardian who is involved in his habilitation planning and decision making process. Review of the incident book on January 19, 2010, at 8:55 a.m., revealed Client #1 was restrained by two direct care support on October 25, 2009. At the time of the survey, the facility failed to provide evidence that informed consent was obtained from the client and/or legally authorized representative prior to implementing Client #1's BSP.	{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 four clients in the sample. (Client #1) The findings include: 1. The facility's primary care physician (PCP) failed to address Client #1's recommended diet change. Review of Client #1's medical record on March 5, 2010, at approximately 2:30 p.m., revealed a nutrition quarterly review dated March 13, 2009.	{W 322}		

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{W 322}	<p>Continued From page 42</p> <p>The nutritionist recommended to discontinue the no concentrated sweets diet. Further review of the medical record revealed no evidence that the PCP had addressed the nutritionist recommendation since the January 22, 2010 recertification survey.</p> <p>2. The facility's PCP failed to ensure that Client #1 received a new extra-depth shoe as recommended by the podiatrist.</p> <p>On March 5, 2010, at 11:05 a.m., interview with the qualified mental retardation professional (QMRP) revealed that the podiatrist had not been contacted. The QMRP further stated that there had been no changes made to Client #1's shoes since the January 22, 2010 survey. Review of Client #1's medical records, at 1:50 p.m., confirmed that the client had not been seen by the podiatrist since the January 22, 2010 recertification survey.</p> <p>Previously, the January 22, 2010 deficiency report had included the following:</p> <p>1. The facility's primary care physician (PCP) failed to address Client #1's recommended diet change.</p> <p>Review of Client #1's medical record on January 20, 2010, at approximately 1:00 p.m., revealed a nutrition quarterly review dated March 13, 2009. The nutritionist recommended to discontinue the no concentrated sweets diet. Further review of the medical record revealed no evidence that the PCP had addressed the nutritionist</p>	{W 322}	<p>Person #1 has seen Podiatrist and corrective shoes are ordered.</p>	
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{W 322} Continued From page 43 recommendation.

2. The facility's PCP failed to ensure that Client #1 received a new extra-depth shoe as recommended by the podiatrist.

Record review of Client #1 medical records on January 20, 2010, at 1:30 p.m., revealed a diagnosis of club feet. The client had been seen by a podiatrist on May 12, 2009. It was recommended that the facility "call the office if it is time to order new extra-depth shoe." Interview with the qualified mental retardation professional (QMRP) revealed Client #1 wore orthopedic insoles inside his shoes. Further interview revealed the client needed new shoes and new insoles. The QMRP also stated that he was unaware of the podiatrist recommendation.

{W 322}

{W 331} 483.460(c) NURSING SERVICES

The facility must provide clients with nursing services in accordance with their needs.

This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the facility's nursing staff failed to ensure clients received annual nursing assessments for one of four clients included in the sample. (Client #1)

The finding includes:

Review of Client #1's medical record on March 5, 2010, at 2:55 p.m., revealed the same annual nursing assessment, dated December 8, 2008, that was observed during the January 22, 2010 recertification survey. At approximately 3:00

{W 331}

Nursing assessment for all individuals are current.

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(W 331)	<p>Continued From page 44</p> <p>p.m., interview with the qualified mental retardation professional revealed that he could not confirm whether the client had been reevaluated and the RN was not available for interview at that time. The QMRP examined Client #1's record and confirmed that there was no evidence of a current annual nursing assessment.</p> <hr/> <p>Previously, the January 22, 2010 deficiency report included the following:</p> <p>Based on observation, interview and record verification, the facility's nursing staff failed to ensure clients received annual nursing assessments for two of three clients included in the sample. (Client #1 and #3)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of Client #1's medical record on January 20, 2010 at 1:53 p.m., revealed an annual nursing assessment dated December 8, 2008. Interview with the qualified mental retardation professional (QMRP) at approximately 11:00 a.m., revealed the RN was not available for interview. Further interview confirmed the facility did not have a current annual nursing assessment. 2. Review of Client #3 medical record on January 20, 2010, at 1:35 p.m., revealed an annual nursing assessment dated December 8, 2008. Interview with the QMRP on January 20, 2010, at approximately 4:00 p.m., revealed the RN was not available for interview. The QMRP confirmed the expired nursing assessment. 	(W 331)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/06/2010
NAME OF PROVIDER OR SUPPLIER WESTVIEW 01			STREET ADDRESS, CITY, STATE, ZIP CODE 3200 12TH STREET, NE WASHINGTON, DC 20017		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{W 368}	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that all drugs were administered in compliance with the physician's orders, for one of the six clients residing in the facility. (Client #2)</p> <p>The findings include:</p> <p>1. The evening medication pass was observed on March 4, 2010, beginning at approximately 8:00 p.m. Client #2 was administered Atarax 25 mg at approximately 8:28 p.m. The next morning, at 11:16 a.m., review of her February 2010 physician's orders (signed on February 1, 2010) revealed an order to administer Atarax 25 mg, one tablet at bedtime, at 8:00 p.m. At 12:30 p.m., the client's March 2010 POs and MAR were unavailable for review. They were locked in the medication closet and there was no one in the facility with a key to open it.</p> <p>It should be noted that the Plan of Correction, dated March 2, 2010, indicated that the facility would contact the physician to assure the POs were "correct." However, there were no POs or telephone orders in Client #2's medical record that would suggest that the Atarax order had been changed since the RN signed the February POs on February 1, 2010.</p> <p>2. Cross-refer to W369. Client #2's physician's</p>	{W 368}	<p>The nurses no longer share their area and MAR is available to QMRP and Administrator.</p> <p>1. PO is corrected and medication is given as ordered/</p>		

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NAME OF PROVIDER OR SUPPLIER WESTVIEW 01	STREET ADDRESS, CITY, STATE, ZIP CODE 3200 12TH STREET, NE WASHINGTON, DC 20017
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{W 368}	<p>Continued From page 46</p> <p>orders reflected 3 ml. Risperidol to be administered at 6:00 p.m. every evening. During the March 4, 2010 evening medication administration, the trained medication employee (TME) was observed to prepare 11 oz. of Risperidone instead. After he poured the medication, however, the TME asked the surveyor for comment. The potential error was immediately brought to the TME's attention, and he subsequently changed the amount to 3 ml., before he administered it to Client #2.</p> <p>Previously, the January 22, 2010 deficiency report included the following:</p> <p>Observation of the medication administration on January 19, 2010, at 5:45 p.m., revealed the trained medication employee (TME) administered Client #2, Atarax 25 mg, one tablet by mouth.</p> <p>Review of Client #2's physician's orders (POS) dated January 2010, on January 20, 2010, at approximately 10:00 a.m., revealed an order to administer Atarax 25 mg, one tablet at bedtime.</p> <p>During an interview with qualified mental retardation professional (QMRP) on January 20, 2010, at approximately 10:15 a.m., revealed that the client's medications are administered twice a day (approximately 6:00 a.m., and 6:00 p.m.).</p> <p>There was no documented evidence all drugs were administered in compliance with the physician's orders.</p>	{W 368}	<p>2. TME was retrained on proper medication administration and subsequently removed from administering medication for Westview.</p> <p>TME</p>	
{W 369}	483.460(k)(2) DRUG ADMINISTRATION	{W 369}		

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{W 369}	<p>Continued From page 47</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that clients received all prescribed medications without error, for one of the six clients residing in the facility. (Client #2)</p> <p>The finding includes:</p> <p>During the March 4, 2010 evening medication administration, at 6:21 p.m., the trained medication employee (TME) was observed preparing liquid Risperidone for Client #2. The TME stated that the client should receive 3 ml of the medication. He began using a syringe to draw the liquid from its original bottle (with the pharmacy label) and placed it in a small, clear plastic medication cup. After several draws, he examined the amount in the cup, said there was too much, and then removed some of it from the medication cup, using the syringe. After further examination, the TME indicated that he had finished, then turned to this surveyor and asked for an opinion. Observation revealed that there was 11 ml of Risperidone in the medicine cup. The discrepancy (11 ml v. 3 ml) was immediately brought to the TME's attention.</p> <p>The TME pointed to the graduated markings/measurements on the syringe, which showed that the maximum measurable dose was 3 ml. He then drew 3 ml of Risperidone into the syringe from the medication cup, poured the remainder into a large plastic cup, and then</p>	{W 369}		

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{W 369}	Continued From page 48 emptied the 3 ml syringe back into the medication cup, for administration to Client #2. The TME stated that he had planned to administer only 3 ml. However, the pouring techniques observed, and comments made during the preparation process were not consistent with that.	{W 369}	All medication is now administered by licensed nurses. They are monitored <i>and by</i> RN. <i>Head</i>
{W 390}	Previously, the January 22, 2010 deficiency report included the following: Observation of the medication administration on January 19, 2010, at 5:40 p.m., revealed Client #3 was administered two tablets of Reglan 10 mg. Comparison of the medication administration observation and the physician orders dated January 2010, on January 20, 2010, at approximately 9:00 a.m., revealed that the client was ordered Reglan 10 mg. Interview with the trained medication employee indicated that the client received two tablets of Reglan equaling 20 mg. The RN was not available during the survey to clarify the client's medication regime. 483.460(m)(2)(i) DRUG LABELING The facility must remove from use outdated drugs. This STANDARD is not met as evidenced by: On March 4, 2010, the evening medication pass was observed from approximately 6:00 p.m. - 6:51 p.m. The medication closet was locked and inaccessible on the following day, therefore, compliance with this regulation could not be determined. It should be noted that the facility's Plan of Correction, dated March 2, 2010,	{W 390}	<i>See W-212</i>

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(W 390)	Continued From page 49 indicated "all expired medication was disposed and replaced with unexpired medication" effective January 22, 2010. Previously, the January 22, 21010 deficiency report included the following: Based on observation, interview and record review, the facility's nurse failed to remove from use, out dated medications, for two of six clients residing in the facility. (Clients #4 and #5) The findings include: a. On January 22, 2010, beginning at 10:50 a.m., during an environmental inspection, a tube of Mupirocin urg/Fluocinide was observed in Client #4's topical storage box. The label on the tube had an expiration date of December 7, 2009. The House Manager on duty at that time reviewed the label and confirmed that the medication had expired. b. Similarly, on January 22, 2010, beginning at 10:50 a.m., during an inspection a tube of Desoxmetasone ointment 0.25% was observed in Client #5's topical storage box. The label on the tube had an expiration date of December 7, 2009. The House Manager on duty at that time reviewed the label and confirmed that the medication had expired. At the time of the survey, there was no evidence that the facility's nursing staff ensured that expired medications were removed from the clients' supplies after the expiration date.	(W 390)	have All expired medications has been disposed. <i>copy of Nursing policy attached</i> <i>VI P-29</i>	

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(W 440)	<p>483.470(i)(1) EVACUATION DRILLS</p> <p>The facility must hold evacuation drills at least quarterly for each shift of personnel.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to hold evacuation drills at least quarterly for each shift of personnel, for one (1) of the three (3) shifts of duty reviewed.</p> <p>The findings include:</p> <p>After the January 22, 2010 survey, the facility submitted a revised schedule of fire drills for calendar year 2010. The Plan of Correction, dated March 2, 2010, indicated that drills would be conducted monthly, with a completion date of February 15, 2010.</p> <p>1. On March 5, 2010, beginning at 12:08 p.m., review of the fire drill log revealed that the most recent evacuation drill conducted on the 3:00 p.m. - 11:00 p.m. shift was documented on September 20, 2009. However, review of the 2010 schedule revealed that an evacuation drill should have been conducted "within the first 10 days" of February 2010.</p> <p>2. The most recent drill that was documented for the 11:00 p.m. - 7:00 a.m. shift was held on September 12, 2009 (almost 6 months earlier).</p> <p>Previously, the January 22, 2010 findings included the following:</p> <p>Interview with the Qualified Mental Retardation</p>	(W 440)	<p>Fire Drills have been conducted and will be conducted at least once a month</p> <p><i>attached VIII</i></p>	

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{W 440} Continued From page 51
Professional (QMRP) and review of the staffing pattern on January 21, 2010, at 3:40 p.m., revealed the following staffing pattern:

Sunday - Saturday
7:00 a.m. - 3:00 p.m.;
3:00 p.m. - 11:00 p.m.; and
11:00 p.m. - 7:00 a.m.

Review of the fire drill log revealed that the 7:00 a.m. - 3:00 p.m. shift last fire drill was held on October 11, 2009 and the 3:00 p.m. - 11:00 p.m. shift, last drill was held on September 20, 2009, and the 11:00 p.m. - 7:00 a.m., shift the last drill was held on September 10, 2009. Interview with the qualified mental retardation professional (QMRP) on January 21, 2010, at approximately 4:30 p.m., indicated that a schedule was developed and the staff failed to hold fire evacuation drills on the assigned dates.

{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.

This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure proper infection control procedures for one of the six clients residing in the facility. (Client #1)

The finding includes:

Observation on March 4, 2010, at 3:55 p.m., revealed that the 1:1 direct support staff asked Client # 1 to sit at the table for snacks. Client #1 was observed eating a half of a cheese sandwich

{W 440}

{W 455}

All staff have received training on Universal precaution by QMRP and Nutritionist. Staff will be monitored during mealtime to assure the practice of

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(W 455)	<p>Continued From page 52</p> <p>with his hands. Client #1 was not observed to be asked to or independently washed his hands prior to consuming his sandwich dinner.</p> <p>Observation on March 4, 2010, revealed the nutritionist posting memo for infection training on the living room door. Interview with the nutritionist revealed that he had an in-service training on infection control scheduled for staff on March 6, 2010.</p> <p>There was no evidence that proper infection control procedures were implemented prior to the client having snacks.</p> <hr/> <p>Previously, the January 22, 2010 deficiency report included:</p> <ol style="list-style-type: none"> Evening observation on January 19, 2010, at 5:30 p.m., revealed the direct care staff was removing chicken from the bone and placing chicken on Clients #1, #2, #3, #4, #5 and #6 plates, with the use of gloves. Further observations revealed the direct care staff opening a dirty trash can wearing the same gloves she wore to handle the chicken. <p>Review of the training records on January 22, 2010, at approximately 11:00 a.m., revealed that staff was trained on infection control on May 7, 2009.</p> <p>Interview with the house manager on January 22, 2010, at approximately 11:30 a.m., revealed that hand washing was required when handling food.</p>	(W 455)		

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{W 455}	<p>Continued From page 53</p> <p>There was no evidence that proper infection control procedures were implemented during dinner preparation.</p> <p>2. Observation on January 19, 2010, at 6:00 p.m., revealed that Client #1, #2, #3, #4, #5, and #6 at the table being served dinner (chicken, mashed potatoes, mixed vegetables and corn bread). None of the clients were observed to be asked to or independently washed their hands prior to consuming their their dinner.</p> <p>Review of the training records on January 22, 2010, at approximately 11:00 a.m., revealed that staff was trained on infection control on May 7, 2009.</p> <p>There was no evidence that proper infection control procedures were implemented prior to the clients having dinner.</p>	{W 455}			

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0093	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/05/2010
NAME OF PROVIDER OR SUPPLIER WESTVIEW 01		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 12TH STREET, NE WASHINGTON, DC 20017	
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{1 000}	<p>INITIAL COMMENTS</p> <p>A revisit was conducted on March 4, 2010 and March 5, 2010, to verify the facility's compliance with deficiencies cited during the January 22, 2010 licensure survey. Three out of three residents remained in the sampled residential population from the previous survey. A fourth resident was added to the sample. The findings of the survey were based on observations in the home, interviews with residents, direct care staff, administrative and nursing staff in the home, as well as a review of the clinical, administrative, and habilitation records, including unusual incident reports.</p> <p>The revisit resulted in a determination that, even though the facility had made some progress in addressing the deficient practices cited in the January 22, 2010 report, there were continued, unabated deficiencies, as evidenced in the report that follows.</p>	{1 000}	
{1 135}	<p>3505.5 FIRE SAFETY</p> <p>Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the facility failed to hold evacuation drills at least quarterly for each shift of personnel, for one (1) of the three (3) shifts of duty reviewed.</p> <p>The findings include:</p> <p>After the January 22, 2010 survey, the facility submitted a revised schedule of fire drills for calendar year 2010. The Plan of Correction,</p>	{1 135}	<p>A fire drill has been conducted on each shift during the month of March and April to bring us into compliance with the quarterly fire drill requirements. A fire drill schedule has been developed and a shift supervisor has been assigned to be responsible for instructing staff each month to perform their fire drills each month. Each shift will perform fires drills at least four times per year. A fire drill review sheet has been developed and placed in the front of the fire book. The Environmental Manager and the QMRP will monitor and sign off on the fire drill review sheet each month to ensure proper oversight is being provided. (See attached forms)</p>

Health Regulation Administration

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

Prof R West MD

TITLE
Administrator

(X6) DATE

4/8/10

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD83-8883	(K2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(K3) DATE SURVEY COMPLETED R 03/09/2010
NAME OF PROVIDER OR SUPPLIER WESTVIEW 01		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 12TH STREET, NE WASHINGTON, DC 20017		
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(I 136)	<p>Continued From page 1</p> <p>dated March 2, 2010, indicated that drills would be conducted monthly, with a completion date of February 16, 2010.</p> <p>1. On March 5, 2010, beginning at 12:08 p.m., review of the fire drill log revealed that the most recent evacuation drill conducted on the 3:00 p.m. - 11:00 p.m. shift was documented on September 20, 2009. However, review of the 2010 schedule revealed that an evacuation drill should have been conducted "within the first 10 days" of February 2010.</p> <p>2. The most recent drill that was documented for the 11:00 p.m. - 7:00 a.m. shift was held on September 12, 2009 (almost 6 months earlier).</p> <hr/> <p>Previously, the January 22, 2010 findings included the following:</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) and review of the staffing pattern on January 21, 2010, at 3:40 p.m., revealed the following staffing pattern:</p> <p>Sunday - Saturday 7:00 a.m. - 3:00 p.m.; 3:00 p.m. - 11:00 p.m.; and 11:00 p.m. - 7:00 a.m.</p> <p>Review of the fire drill log revealed that the 7:00 a.m. - 3:00 p.m. shift last fire drill was held on October 11, 2009 and the 3:00 p.m. - 11:00 p.m. shift, last drill was held on September 20, 2009, and the 11:00 p.m. - 7:00 a.m., shift the last drill was held on September 10, 2009. Interview with the qualified mental retardation professional (QMRP) on January 21, 2010, at approximately</p>	(I 136)	<p>2. A Fire Drill for the 11:00 PM - 7:00 AM shift was conducted on 03/31/10 and the next fire drill will be conducted on or prior to 06/31/10, meeting the at least quarterly requirement. (See attached Fire Drill dated 03/31/10)</p> <p>7-3 ?</p>	

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0093	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/05/2010
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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) COMPLETE DATE
{1 135}	Continued From page 2 4:30 p.m., indicated that a schedule was developed and the staff failed to hold fire evacuation drills on the assigned dates.	{1 135}		
{1 189}	3508.7 ADMINISTRATIVE SUPPORT Each GHMRP shall maintain records of residents' funds received and disbursed. This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to account for all residents' funds that were being managed by the facility on their behalf, for three of the six residents residing in the facility. (Residents #4, #5 and #6) The findings include: On March 4, 2010, at 12:26 p.m., interview with the qualified mental retardation professional (QMRP) revealed that the facility had audited the accounts of Residents #1, #2 and #3 and determined that \$2,531.70 (total) could not be accounted for those 3 individuals. He then presented three photocopied deposit slips, and a company check for said amount, dated March 3, 2010. When asked about the other 3 residents whose accounts were being managed by the facility, the QMRP stated that Residents #4, #5 and #6's accounts had not yet been audited. Later that day, at approximately 6:05 p.m., the incident management coordinator (IMC) presented three bank receipts as evidence that the residents' funds had been redeposited into their accounts. Dates on the receipts indicated that the deposit had been made on March 4, 2010, which was confirmed by the IMC. The IMC also confirmed that the accounts managed by the facility on behalf of Residents #4, #5 and #6 had	{1 189}	Tag: 1189 An audit of residents #4, 5&6 has been completed. Any monies that are owed to these individuals will be redeposited into their accounts. A new process has been put in place to ensure that there is better oversight over the funds of the individuals we serve. A reconciliation form has been formulated to assist with proper documentation. When a request is made for funds the QMRP must sign off on the request. All staff that has the responsibility for making purchases for the individuals will be trained regarding the new process for requesting funds. All receipts and left over funds must be returned within seven days of request. The QMRP or House Manager will be responsible for checking the receipts and purchases that are made. The form will be completed by the Business Office Assistant once the receipts and left over funds are returned. Should receipts and monies not be returned within the allotted time it will be reported to the Business Manager and further action will be taken until the reconciliation of prior requested funds. (See Attachments)	

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0093	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/05/2010
NAME OF PROVIDER OR SUPPLIER WESTVIEW 01		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 12TH STREET, NE WASHINGTON, DC 20017		
(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 189)	<p>Continued From page 3</p> <p>not yet received similar audits and, therefore, the status of those three residents' personal funds remained unknown.</p> <hr/> <p>Previously, the January 22, 2010 survey revealed that the facility failed to ensure a system had been implemented to maintain a complete accounting of residents' personal funds, for three of the three residents in the sample. (Resident #1, #2 and #3) as follows:</p> <p>Interview with the qualified mental retardation professional (QMRP), house manager (HM), administrative assistant and review of the facility's financial records on January 21, 2010, beginning at 12:40 p.m., revealed that the facility assisted Residents #1, #2 and #3 with maintaining their finances. Continued interview and record review revealed that the residents received Supplemental Security Income (SSI) in the amount of \$70.00 per month.</p> <p>a. Resident #1's bank statements were reviewed from January 2009 through December 2009 and revealed the following withdrawals:</p> <ul style="list-style-type: none"> - January 13, 2009, in the amount of \$60.00; - February 15, 2009, in the amount of \$20.00; - February 25, 2009, in the amount of \$160.00; - March 24, 2009, in the amount of \$70.00; - March 30, 2009, in the amount of \$40.00; - May 2009, (statement did not reflect exact 	(I 189)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/05/2010
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NAME OF PROVIDER OR SUPPLIER WESTVIEW 01	STREET ADDRESS, CITY, STATE, ZIP CODE 3200 12TH STREET, NE WASHINGTON, DC 20017
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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) COMPLETE DATE
1189	<p>Continued From page 3</p> <p>not yet received similar audits and, therefore, the status of those three residents' personal funds remained unknown.</p> <hr/> <p>Previously, the January 22, 2010 survey revealed that the facility failed to ensure a system had been implemented to maintain a complete accounting of residents' personal funds, for three of the three residents in the sample. (Resident #1, #2 and #3) as follows:</p> <p>Interview with the qualified mental retardation professional (QMRP), house manager (HM), administrative assistant and review of the facility's financial records on January 21, 2010, beginning at 12:40 p.m., revealed that the facility assisted Residents #1, #2 and #3 with maintaining their finances. Continued interview and record review revealed that the residents received Supplemental Security Income (SSI) in the amount of \$70.00 per month.</p> <p>a. Resident #1's bank statements were reviewed from January 2009 through December 2009 and revealed the following withdrawals:</p> <ul style="list-style-type: none"> - January 13, 2009, in the amount of \$50.00; - February 15, 2009, in the amount of \$20.00; - February 25, 2009, in the amount of \$160.00; - March 24, 2009, in the amount of \$70.00; - March 30, 2009, in the amount of \$40.00; - May 2009, (statement did not reflect exact 	1189	<p>000</p> <p>0-00 *</p> <p>60-00 *</p> <p>20-00 *</p> <p>160-00 *</p> <p>70-00 *</p> <p>40-00 *</p> <p>350-00 *</p> <p>24-50 *</p> <p>200-00 *</p> <p>008</p> <p>924-50 *</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0093	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/05/2010
NAME OF PROVIDER OR SUPPLIER WESTVIEW 01			STREET ADDRESS, CITY, STATE, ZIP CODE 3200 12TH STREET, NE WASHINGTON, DC 20017		
(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 189)	Continued From page 4 date); - June 2009, (statement did not reflect exact date); - August 7, 2009, in the amount of \$350.00; - December 10, 2009, in the amount of \$24.50; and - December 28, 2009, in the amount of \$200.00. There were no receipts for the aforementioned withdrawals. b. Resident #2's bank statements were reviewed from December 2008 through December 2009 and revealed the following withdrawals: - December 1, 2009, in the amount of \$340.20. There were no receipts; - February 5, 2009, in the amount of \$20.00. There were no receipts; - March 30, 2009, in the amount of \$25.00. There were no receipts; - May 6, 2009, in the amount of \$45.00. There were no receipts; - June 11, 2009, in the amount of \$210.00. There were no receipts; and - December 28, 2009 in the amount of \$200.00. There were no receipts. c. Resident #3's bank statements were reviewed from January 2008 through December 2009 and revealed the following withdrawals:	(I 189)			

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NAME OF PROVIDER OR SUPPLIER WESTVIEW 01	STREET ADDRESS, CITY, STATE, ZIP CODE 3300 12TH STREET, NE WASHINGTON, DC 20017
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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) COMPLETE DATE
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(1 189)	<p>Continued From page 4</p> <p>date);</p> <ul style="list-style-type: none"> - June 2009, (statement did not reflect exact date); - August 7, 2009, in the amount of \$350.00; - December 10, 2009, in the amount of \$24.50; and - December 28, 2009, in the amount of \$200.00. <p>There were no receipts for the aforementioned withdrawals.</p> <p>b. Resident #2's bank statements were reviewed from December 2008 through December 2009 and revealed the following withdrawals:</p> <ul style="list-style-type: none"> - December 1, 2009, in the amount of \$340.20. There were no receipts; - February 5, 2009, in the amount of \$20.00. There were no receipts; - March 30, 2009, in the amount of \$25.00. There were no receipts; - May 6, 2009, in the amount of \$45.00. There were no receipts; - June 11, 2009, in the amount of \$210.00. There were no receipts; and - December 28, 2009 in the amount of \$200.00. There were no receipts. <p>c. Resident #3's bank statements were reviewed from January 2008 through December 2009 and revealed the following withdrawals:</p>	(1 189)	<p>000</p> <p>0 - 00 *</p> <p>340 - 20 +</p> <p>20 - 00 +</p> <p>25 - 00 +</p> <p>45 - 00 +</p> <p>210 - 00 +</p> <p>200 - 00 +</p> <p>006</p> <p>840 - 20 *</p>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0093	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/05/2010
NAME OF PROVIDER OR SUPPLIER WESTVIEW 01			STREET ADDRESS, CITY, STATE, ZIP CODE 3200 12TH STREET, NE WASHINGTON, DC 20017		
(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	
(1 189)	Continued From page 5 - January 13, 2009, in the amount of \$117.00. There were no receipts; - February 25, 2009, in the amount of \$200.00. There were no receipts; - February 11, 2009, in the amount of \$260.00. There were no receipts; - March 30, 2009, in the amount of \$60.00. There were no receipts; and - April 10, 2009, in the amount of \$60.00. There were no receipts. At the time of the survey, the facility failed to ensure a complete accounting of the residents personal funds by providing evidence that justified the aforementioned withdrawals.	(1 189)			
(1 203)	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on interview and record review, the the Group Home for the Mentally Retardated Persons (GHMRP) failed to have on file for review, current job descriptions for all employees, for twelve (12) of the thirty (30) staff. The finding includes: Interview with the qualified mental retardation professional (QMRP) and review of the GHMRP's personnel files conducted on January 21, 2010, beginning at 10:00 a.m., revealed the GHMRP	(1 203)	potentials employees are requested to provide a current health certificate prior to hire. Staff is required to complete an orientation. If the health certificate has not been received upon completion of orientation they cannot start employment until received. To ensure that all job descriptions are reviewed on an annual basis a staff meeting will be conducted the beginning of each year and the job descriptions will be reviewed and signed to ensure compliance. To prevent staff from having expired		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(01) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0003	(02) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(03) DATE SURVEY COMPLETED R 03/05/2010
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NAME OF PROVIDER OR SUPPLIER WESTVIEW 01	STREET ADDRESS, CITY, STATE, ZIP CODE 3300 12TH STREET, NE WASHINGTON, DC 20017
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(04) 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)	(05) COMPLETE DATE
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(1 100) Continued From page 5

- January 13, 2009, in the amount of \$117.00. There were no receipts;
- February 25, 2009, in the amount of \$200.00. There were no receipts;
- February 11, 2009, in the amount of \$260.00. There were no receipts;
- March 30, 2009, in the amount of \$60.00. There were no receipts; and
- April 10, 2009, in the amount of \$60.00. There were no receipts.

At the time of the survey, the facility failed to ensure a complete accounting of the residents personal funds by providing evidence that justified the aforementioned withdrawals.

(1 100)

117.00 +
200.00 +
260.00 +
60.00 +
60.00 +

697.00 *

005

(1 203) 3509.3 PERSONNEL POLICIES

Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter.

This Statute is not met as evidenced by:
Based on interview and record review, the the Group Home for the Mentally Retarded Persons (GHMRP) failed to have on file for review, current job descriptions for all employees, for twelve (12) of the thirty (30) staff.

The finding includes:

Interview with the qualified mental retardation professional (QMRP) and review of the GHMRP's personnel files conducted on January 21, 2010, beginning at 10:00 a.m., revealed the GHMRP

(1 203)

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD00-0000	(2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(3) DATE SURVEY COMPLETED R 03/08/10
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NAME OF PROVIDER OR SUPPLIER WESTVIEW #1	STREET ADDRESS, CITY, STATE, ZIP CODE 3300 12TH STREET, NE WASHINGTON, DC 20017
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(4) 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)	COR I
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§ 206) Continued From page 7

The finding includes:

Interview with the qualified mental retardation professional (QMRP) and review of the personnel records on January 21, 2010, beginning at 10:00 a.m., revealed the QMRP failed to provide evidence that current health certificates were on file for twenty five of the thirty staff, six of the ten consultants and two of the two registered nurses.

§ 227) 3510.5(d) STAFF TRAINING

Each training program shall include, but not be limited to, the following:

(d) Emergency procedures including first aid, cardiopulmonary resuscitation (CPR), the Heimlich maneuver, disaster plans and fire evacuation plans;

This Statute is not met as evidenced by: Based on interview, the QMRP failed to ensure that all staff received training and/or certification in cardiopulmonary resuscitation (CPR) and First Aid.

The finding includes:

On March 4, 2010, at 11:40 a.m., the qualified mental retardation professional presented signature sheets of in-service training that was provided for staff since the January 22, 2010 licensure survey. Review of the documents, however, revealed no evidence that any of the previously-identified staff had received CPR and/or First Aid training. The QMRP stated that he thought perhaps the RN had conducted training. However, he and administrative

§ 206)

1227

A CPR training session for said employees will be scheduled by May 1, 2010.

In the future, upon determining the number of employees that will be attending the New Employee Orientation and potentially being hired, a training session for CPR will be scheduled for immediately following the orientation, with a tentative number of participants, to ensure that all newly hired employees are trained in emergency procedures, i.e., CPR before working with the individuals. Thereafter, a training session for recertification will be scheduled within a month prior to the expiration date of the certification card. Should a staff person fail to attend the scheduled training, he/she will be responsible for obtaining the training on their own within thirty after their scheduled training session and/or before their current certification expires. If this does not occur, the staff person will be removed from the schedule until a current certification is submitted.

This practice will be conducted in coordination with the QMRP, Residential Manager, and the Human Resource personnel.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0083	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/05/2010
NAME OF PROVIDER OR SUPPLIER WESTVIEW 01		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 12TH STREET, NE WASHINGTON, DC 20017		
(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 227)	Continued From page 8 personnel were unable to locate evidence of said training before the survey ended on March 5, 2010. Previously, the January 22, 2010 deficiency report included the following: Based on record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to have on file for review current training in cardiopulmonary resuscitation (CPR) for fifteen (15) of the thirty (30) staff and current training in first aid, for twenty one (21) of the thirty (30) staff. The finding includes: Review of the personnel and training records on January 21, 2010, beginning at 10:00 a.m., revealed the GHMRP failed to provide documentation of staff training in CPR, for fifteen of the thirty staff and current training in first aid, for twenty one of the thirty staff.	(I 227)	Employees were trained in CPR and First Aid on May 10, 2009. For new staff that have not received CPR and First Aid a training a has been scheduled prior to April 8, 2010. Prior to May 10, 2010 training will be scheduled to ensure CPR and First Aid cards do not expire. Training in Disaster and evacuation plans will be conducted prior to April 9, 2010. To ensure compliance in the future an annual In-service training schedule will be established and adhered. The QMRP will ensure that all training required training are conducted and scheduled in a timely manner to ensure all staff receive the necessary training. In-service sheets will be signed by employees to ensure compliance. Make up in-services will be provided for all staff to ensure compliance.	
(I 291)	3514.2 RESIDENT RECORDS Each record shall be kept current, dated, and signed by each individual who makes an entry. This Statute is not met as evidenced by: Based on record review and interview, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that the primary care physician (PCP) consistently noted the date on which he made entries into residents' records. The finding includes:	(I 291)	The Nursing Coordinator in conjunction with the QMRP will review the notes written in the Medical Records upon notice that the Primary Care Physician has completed his book review and documentation to include PO's.	

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NAME OF PROVIDER OR SUPPLIER WESTVIEW 01		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 12TH STREET, NE WASHINGTON, DC 20017		
(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
{ 291}	Continued From page 9 On March 5, 2010, at approximately 12:25 p.m., review of Resident #2's medical chart revealed that the PCP had initialed but not signed the February 2010 physician's orders (POs). A few minutes later, the qualified mental retardation professional examined the POs and concurred that the PCP had not dated the entry. Similar findings were observed in other residents' records. [Note: The resident's March 2010 POs were unavailable for review. They were locked in the medication closet and there was no one in the facility with a key to open it.] Previously, the January 22, 2010 deficiency report revealed that the facility's nurse failed to ensure that the residents' quarterly nursing assessments were signed by the person completing the assessments, for two of three residents included in the sample. (Residents #1 and #2)	{ 291}	The Physicians orders for March 2010 for each individual are signed and attached for review. The PO's will be made available for all inspections. A key will be available in the facility And designated personnel will have knowledge of key location. A new Nursing Coordinator has been Identified and will be hired. The QMRP and the Nursing Coordinator will monitor all medical entries for the individuals. The incident report for resident #1 Has been completed and is available for review. (See attached incident Report) The IMC has been retrained by DDS on Incident Management policies and procedures. The IMC is fully aware of the agencies that should receive notification of all incidents. A training was provided to the staff on March 26, 2010 by the IMC on reporting incidents. Westview has hired someone to assist the IMC to put incidents in the system and report them in a timeline as required.	
{ 379}	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by:	{ 379}		

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NAME OF PROVIDER OR SUPPLIER WESTVIEW #1	STREET ADDRESS, CITY, STATE, ZIP CODE 3200 12TH STREET, NE WASHINGTON, DC 20017
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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) COMPLETE DATE
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§ 3709	<p>Continued From page 10</p> <p>There were no documented reports or allegations of abuse, neglect, or injuries of unknown origin since a team of Department of Health investigators were in the GHMRP on February 22, 2010. They investigated two allegations of abuse that occurred within the first week of February 2010 (after the January 22, 2010 recertification survey). Investigators determined that the facility failed to report to the Department of Health timely a February 1, 2010 allegation of physical abuse of Resident #1 by a staff. The allegation was reported to the Department of Health on February 4, 2010, 3 days later. (See Licensure Deficiency Report, dated February 28, 2010)</p> <hr/> <p>Previously, the January 22, 2010 licensure deficiency report included the following:</p> <p>Based on interview and record review, the the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure resident to resident mistreatment and injuries unknown origin were reported immediately to the administrator or to other officials in accordance with district law (22 DCMR, Chapter 38, Section 3619.10), for two of the six residents residing in the facility. (Resident #1 and #2)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of the facility's incident reports and corresponding investigative reports on January 19, 2010, beginning at 8:56 a.m., revealed the following: 	§ 3709	<p>1379</p> <p>The Incident Report for Resident #1 was completed and is available for review. (See attached Incident and Investigation Reports)</p> <p>All staff will be retrained on Incident Management to include reporting and documenting of the incident. The Westview, Inc.'s IMC is fully aware of the notification policies and will adhere to them from this point forward, ensuring that the Department of Health and other required outside agencies are notified immediately by telephone following any report or allegation of abuse and in writing within 24 hours.</p> <p>The Westview, Inc.'s IMC will continue to receive ongoing training on the policies and practices required of an IMC.</p> <ol style="list-style-type: none"> 1. As stated, the Westview, Inc.'s IMC did not immediately notify the Administrator of the alleged incident regarding Resident #1. 	
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March 13 2010

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/08/2010
NAME OF PROVIDER OR SUPPLIER WESTVIEW 01		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 12TH STREET, NE WASHINGTON, DC 20017		
(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
{1 379}	Continued From page 11 On August 27, 2009, at 2:00 p.m., the Incident Management Coordinator (IMC) received a phone call from Department of Disabilities Services (DDS) investigator on August 27, 2009, at 2:00 p.m., stating that their office received an anonymous fax alleging abuse against Resident #1. The statement alleged that the resident was "acting out", grabbed a staff and in return the staff used force to release himself. An interview was conducted with the IMC on January 19, 2010, at approximately 10:45 a.m., that revealed that she did not complete an incident report. According to the notification section of the investigative report revealed that the administrator was notified on August 28, 2009, at 2:45 p.m., (24 hours after the phone call). Further interview revealed that all allegations of abuse should be reported to the administrator, immediately. 2. Review of the Resident #2's nursing notes on January 20, 2010, beginning at 9:51 a.m., revealed the following Resident to Resident mistreatment and injuries of unknown origin: a. On December 18, 2009, at 6:50 p.m., the registered nurse (RN) noted that Resident #2 sustained a bite to her right lower arm by Resident #4. b. On September 14, 2009, the RN noted a round bruise on Resident #2's right forearm. c. On June 27, 2009, the RN noted a fading bruise on Resident #2's left forearm. d. On April 28, 2009, the RN noted that she received a page from the facility at 6:45 a.m. The RN was apprised of a bruise on Resident #2's	{ 379}	The Westview, Inc.'s IMC is fully aware of the notification policies and will adhere to them from this point forward, ensuring that the Administrator is notified immediately of any allegations of abuse, neglect or other incidents regarding all residents. The Westview, Inc.'s IMC will continue to receive ongoing training on the policies and practices required of an IMC. 2. Said incidents regarding Resident #2 was properly investigated, documented, and reported to the appropriate persons to include the Administrator. (See attached Investigation Report)	

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NAME OF PROVIDER OR SUPPLIER WESTVIEW 01		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 12TH STREET, NE WASHINGTON, DC 20017		
(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 379)	Continued From page 12 arms. Upon arrival to assess the resident, the RN observed a large ecchymosed area on her left forearm. The RN further noted that she had assessed the resident's vital signs, placed ear drops in her ears and provided nail care on either April 25, or April 26, 2009, and did not note any bruises or made aware of any incidents that had taken place. An interview was conducted with the RN on January 21, 2010, beginning at 1:15 p.m., via telephone. The RN was aware of the bite incident; however, the other aforementioned bruises were noted during visits to the facility. Inquiry was made of the RN, about the facility's incident reporting procedures. The RN stated, "If a resident receives an injury of unknown origin, the direct care staff should report the injury of unknown origin to the QMRP or House Manager and complete an incident report. An interview was conducted with the IMC on January 19, 2010, at approximately 10:45 a.m., that revealed she was not aware of the injuries of unknown origin for Resident #2. At the time of the survey, the facility failed to provide evidence that the administrator had been notified of the aforementioned incidents.	(I 379)	The RN will be required to follow up with Westview's IMC regarding any reports or allegations of abuse or neglect from staff to the RN or any bruises or marks on any individual observed by the RN or other nursing personnel.	
(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.	(I 401)	A psychological assessment was Completed for resident #1 on 12/09/09(See attachment)	

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{ 401 }	<p>Continued From page 13</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that residents received comprehensive functional assessments, for three of the three residents in the sample. (Residents #1, #2 and #3)</p> <p>The findings include:</p> <p>1. On March 5, 2010, at approximately 2:40 p.m., interview with the qualified mental retardation professional (QMRP), followed by a review of Resident #1's records, revealed no changes made since the January 22, 2010 survey findings that follow:</p> <p>The facility failed to ensure that Resident #1 received a psychological assessment.</p> <p>Observation of the evening medication administration on January 19, 2010, at 6:00 p.m., revealed Resident #1 received Tegretol 500 mg, and Risperdal 3 mg. Interview with the trained medication employee (TME) on January 19, 2010, during the medication administration indicated that the medication was prescribed for behavior management. Review of the resident's physicians orders (POS) dated January 2010, on January 20, 2010 at 10:30 a.m., revealed that the aforementioned medications were prescribed for the resident's psychotic disorder.</p> <p>Review of Resident #1's psychological assessment dated December 6, 2008 on January 21, 2010, at 10:15 a.m., stated, "complete an annual psychological assessment update within one year." Interview with the qualified mental retardation professional (QMRP) on January 21, 2010, at approximately 3:00 p.m., indicated that Resident #1's psychological assessment had not</p>	{ 401 }	<p>The psychological assessment has been filed accordingly in resident #1's ISP record for review by outside agencies as well as Westview, Inc.'s personnel. In the future all required assessments will be kept current and placed in the ISP records. This will be monitored by the Quality Assurance.</p>

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(1 401)	<p>Continued From page 14</p> <p>been completed. There was no evidence of a current psychological assessment.</p> <p>2. On March 5, 2010, at approximately 2:40 p.m., interview with the qualified mental retardation professional (QMRP), followed by a review of Resident #2's and Resident #3's records, revealed no changes made since the January 22, 2010 survey findings that follow:</p> <p>The facility failed to ensure residents who received psychotropic medication had a psychiatric assessment, for two of the three residents in the sample. (Residents #2 and #3)</p> <p>a. Observation of the evening medication administration on January 19, 2010, at 5:45 p.m., revealed Resident #2 received Risperdal and Tegretol. Interview with the trained medication employee (TME) on January 19, 2010, during the medication administration indicated that the medication was prescribed for behavior management. Review of the resident's physicians orders dated January 2010, on January 20, 2010, at 10:30 a.m., revealed that the aforementioned medications were incorporated in a Personal Behavior Support Plan (PBSP) dated November 4, 2009.</p> <p>Review of Resident #2's medical evaluation dated October 29, 2009, on January 19, 2010, at approximately 10:00 AM, revealed that the psychotropic medications were prescribed to address behaviors associated with a diagnosis of bipolar disorder.</p> <p>Further review of the resident's medical record revealed no documented evidence of a psychiatric assessment.</p>	(1 401)	<p>A comprehensive psychiatric assessment will be completed prior to April 30, 2010 for resident #2 and will be submitted to HRA for review. All required and necessary assessments will be kept current and placed in the ISP book. The QMRP will ensure that this practice is maintained in conjunction with QA personnel.</p>	

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NAME OF PROVIDER OR SUPPLIER WESTVIEW #1	STREET ADDRESS, CITY, STATE, ZIP CODE 3200 12TH STREET, NE WASHINGTON, DC 20017
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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) COMPLETE DATE
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(# 401) Continued From page 15

b. Observation of the evening medication administration on January 19, 2010, at 6:40 p.m., revealed Resident #3 received Haldol, Depakote and Risperdal. Interview with the trained medication employee (TME) on January 19, 2010, during the medication administration indicated that the medication was prescribed for behavior management. Review of the resident's physicians orders dated January 2010, on January 20, 2010 at 1:34 p.m., revealed that the aforementioned medications were incorporated in a Personal Behavior Support Plan (PBSP) dated December 10, 2008.

Review of Resident #3's medical evaluation dated December 2008, on January 20, 2010 at approximately 2:00 p.m., revealed that the psychotropic medications were prescribed to address behaviors associated with a diagnosis of chronic schizophrenia paranoid.

Further review of the resident's medical record revealed no documented evidence of a psychiatric assessment.

3. On March 5, 2010, at approximately 2:40 p.m., interview with the qualified mental retardation professional (QMRP), followed by a review of Resident #1's and Resident #2's records, revealed no changes made since the January 22, 2010 survey findings that follow.

The facility failed to assess Residents #1 and #2 to determine their need to participate in a self medication program.

a. Observation of the medication administration on January 19, 2010, at 6:02 p.m., the trained medication employee (TME) was observed preparing and spoon feeding the resident his

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(1 401)	<p>Continued From page 16</p> <p>medications, pouring Resident #1's cup of water. Observations throughout the survey from January 19, 2010, through January 22, 2010, revealed that the resident was independent in feeding himself.</p> <p>Interview with the TME during the medication observation indicated that the resident did not participate in a self medication training program. Review of the medical record revealed no self medication assessment. Further interview with the QMRP on January 21, 2010, at approximately 10:00 a.m., confirmed that there was no self-medication assessment.</p> <p>b. Observation of the medication administration on January 19, 2010, at 5:45 p.m., the TME was observed preparing Resident #2's medications. The TME punched the pills into a medication cup, put the pills in a cup of applesauce, spoon fed it to the resident and poured the resident a cup of water. Observations throughout the survey from January 19, 2010, through January 22, 2010, revealed that Resident #2 pouring water into a cup and feeding herself independently.</p> <p>Interview with the TME during the medication observation indicated that the resident did not participate in a self medication training program. Review of the medical record revealed no self medication assessment. Further interview with the QMRP on January 21, 2010, at approximately 10:00 a.m., confirmed that there was no self-medication assessment.</p>	(1 401)		
(1 420)	<p>3521.1 HABILITATION AND TRAINING</p> <p>Each GHRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope</p>	(1 420)		

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{1 420}	Continued From page 17 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, staff interviews, and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that residents received continuous active treatment program in accordance with recommendations made by the interdisciplinary team (IDT), for three of the four residents included in the sample. (Residents #1, #3 and #6) The findings include: 1. The facility failed to ensure that Resident #1 received continuous active treatment during the daytime, as evidenced below: On March 4, 2010, at 11:12 a.m., the facility's van pulled up to the group home. The driver stepped out; however, Resident #1 and his 1:1 direct support staff remained inside the van. At 11:19 a.m., the driver got back in and the van drove away with the resident and his staff. At 2:50 p.m., Resident #1 was observed entering the facility. Interview with the 1:1 staff, at approximately 3:00 p.m., revealed Resident #1 had refused to go into his day program as well as a medical appointment. The 1:1 staff further indicated that no other active treatment had taken place. Earlier that day, at approximately 2:00 p.m., review of the resident's program book revealed no documented evidence of an alternative activity schedule for Resident #1. Even though the facility's Plan of Correction, signed March 2, 2010, stated that a schedule had been developed (completed February 5, 2010), interview with the qualified mental retardation professional (QMRP)	{1 420}	1. An alternative active treatment schedule has been developed for resident #1. Staff has been trained on the new schedule. The schedule has been placed in his program book for access and implantation. In future QMRP will ensure that alternative schedules are available for use when individuals do not attend their day placements.	

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{1 420}	<p>Continued From page 18</p> <p>on March 5, 2010, at 2:27 p.m., revealed that the resident was without an alternative activity schedule. The QMRP was unable to state what, if any, structured active treatment Resident #1 had received that day.</p> <p>2. The facility failed to ensure that Resident #1 received continuous active treatment during the evening, as evidenced below:</p> <p>On March 4, 2010, Resident #1 and his 1:1 direct support staff were observed in the facility, beginning at 2:50 p.m. At 2:55 p.m., his 1:1 support staff gave Resident #1 a magazine. The resident flipped through the magazine for approximately 10 minutes. At 3:17 p.m., the resident was observed watching television in the living room. Moments later, however, he stood up and for approximately 45 minutes, he walked back and forth from the living room to the dining room, repeatedly. During that period, he was observing other residents and staff. His 1:1 support staff did not engage him in an active treatment program or otherwise encourage the resident to participate in a structured activity. At 4:04 p.m., the 1:1 support staff asked Resident #1 to take his dishes to the kitchen; however, he refused.</p> <p>For the period of 4:06 p.m. - 4:34 p.m., Resident #1 was observed walking back and forth from the living room to the dining room, or going upstairs (briefly), and looking out of windows. During this 28-minute period, his 1:1 support staff did not engage him in an active treatment program or otherwise encourage the resident to participate in a structured activity.</p> <p>Resident #1 took a walk in the community (3 blocks) with a staff and 3 of his peers, from 4:34</p>	{1 420}	<p>2. Daily active treatment schedules have been developed and placed in program books. Staff has been trained on the new schedule. The schedule has been placed in his program book for access and implantation. In future QMRP will ensure that active treatment schedules are available for staff to implement.</p>	

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{1 420}	Continued From page 19 p.m. - 4:59 p.m. At 5:00 p.m., he resumed his pacing and observing others and was not engaged in a meaningful activity until dinner was served, at 5:43 p.m. He finished his dinner at 5:57 p.m., and took his dishes to the kitchen after his 1:1 direct support staff asked him to do so. For the next 38-minute period (5:58 p.m. - 6:30 p.m.), however, he went into the living room where he sat and watched the other residents watching television with staff. Except for the community walk and the mealtime supports (i.e. instruction to take dishes to kitchen), Resident #1 was not involved in meaningful activities for the period 2:55 p.m. - 6:30 p.m. It should be noted that earlier that day, at approximately 2:00 p.m., review of the resident's program book revealed no documented evidence of an alternative activity schedule for days when he refused to go into his day program. Even though the facility's Plan of Correction, signed March 2, 2010, stated that a schedule had been developed (completed February 5, 2010), interview with the QMRP on March 5, 2010, at 2:27 p.m., confirmed that the resident remained without an evening activity schedule. 3. There was no evidence that Resident #3's self-medication training program was being implemented, as follows: The evening medication pass was observed on March 4, 2010. Beginning at approximately 6:12 p.m., Resident #3 retrieved, prepared, self-administered and placed back into storage his own medications, while the trained medication employee (TME) observed. The administration process was identical to that observed during the January 22, 2010 recertification survey. There was no evidence that the TME implemented	{1 420}	The Nursing Coordinator will train all individuals who pass medications on how to document the self medication program for resident #3. All new personnel will be trained upon hire. The Nursing Coordinator will check documentation on a monthly basis to ensure implementation. The QMRP will also follow-up monthly.	

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(I 420)	<p>Continued From page 20</p> <p>Resident #3's program to "Identify the label," when "given a description of a medicine and/or warning label."</p> <p>When interviewed the following day, at 10:43 a.m., the qualified mental retardation professional (QMRP) stated that he did not think Resident #3's self-medication training program was being implemented yet. He did not offer further information. At 12:30 p.m., the resident's March 2010 program data collection sheet and MAR were unavailable for review and verification. They were locked in the medication closet and there was no one in the facility with a key to open it.</p> <p>This is a repeat deficiency.</p> <p>4. The facility failed to ensure that Resident #6's training programs were implemented, as follows:</p> <p>a. Resident #6's 1:1 direct support staff was interviewed on March 4, 2010, beginning at 4:35 p.m. He stated that the only training programs he worked on with the resident were (1) drying himself off with a towel after showering, (2) using a tooth brush properly, and (3) using an exercise bicycle. At 4:46 p.m., review of Resident #6's program data book revealed no evidence of a towel-drying, tooth brushing or exercise bicycle goal/objective. Instead, one of the objectives was "Given verbal prompts, <resident's name> will pull up his pants on 80% of the trials..." The data sheets for January and February 2010 were both blank and devoid of performance data.</p> <p>b. There was no evidence that Resident #6's two physical therapy programs were being implemented, as follows:</p>	(I 420)	<p>4. By April 15, 2010, the QMRP will review Resident #6's active treatment programs to ensure that they are accurate according to his ISP and data sheets are made available to staff for implementation of the programs and documentation.</p> <p>Upon completion of the IPP Record, the QMRP will retrain the staff, to include the one to one, to ensure that all staff are aware of all of Resident #6's active treatment programs.</p> <p>5. By April 15, 2010, the QMRP will train all staff, to include the one to one, on how to maintain Resident #6's self-feeding skills.</p>	

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(I 420)	<p>Continued From page 21</p> <p>1) Resident #6's IPP, dated December 11, 2009, included a goal to improve ambulation endurance. The resident "should ambulate for 10 minutes with staff assistance, 3 days per week, for 6 consecutive months." Review of the resident's program book, however, failed to show evidence that data collection sheets had been established for that objective. Instead, the program book contained data sheets for a previous program (dated June 6, 2009) for him to "ambulate for 100 ft. with rolling walker, 3 days per week, with staff assistance for 6 consecutive months." The data sheets were left blank.</p> <p>c. Similarly, Resident #6's IPP, dated December 11, 2009, included another physical therapy goal for the resident to "stand unsupported for 8 consecutive minutes, 3 times per week, for 6 months." The data sheets for January and February 2010 had also been left blank and were devoid of performance data.</p> <p>d. Resident #6's IPP, dated December 11, 2009, included other training and/or service objectives, such as "Independently put together a multi-piece puzzle" and "Given verbal prompting, <resident's name> will throw the ball to a staff or peer on 5/10 trials per session..." Data sheets for both of these programs had been left blank and were devoid of performance data.</p> <p>On March 4, 2010, at 10:20 a.m., the QMRP stated that the resident's PT goals had changed, to reflect that he was refusing to use the rolling walker. He examined the data sheets in the resident's program book and acknowledged that he didn't see evidence that staff had been implementing Resident #6's December 2009 IPP. He then acknowledged that the staff assigned to provide Resident #6 with 1:1 support had not</p>	(I 420)	<p>By April 15, 2010, The QMRP will update Resident #1's Individual Program Plan to include program plans recommended at this December 11, 2009 Individual Support Plan meeting. Data sheets will be placed in the record for staff access, review, and documentation. The Staff will be retrained on the implementation of the recommended programs and how to document accordingly. The QMRP will monitor for accuracy on a monthly basis.</p> <p>In the future, the QMRP will update IPP programs according to each Resident's annual ISP. The staff will be trained on revised programs and data collection sheets will be placed in each resident's data collection book for access by all staff for implementation and documentation. This practice will be monitored by the Quality Assurance personnel.</p>	
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(I 420)	<p>Continued From page 22</p> <p>received training on his program goals and objectives.</p> <p>5. On March 4, 2010, at 4:00 p.m., Resident #6's 1:1 direct support staff was observed holding a cup of water (with a splash of juice "for flavor") up to the resident's mouth. The resident had his mouth open and the staff began pouring sips of flavored water into his mouth. The resident's hands were both placed on his lap while he drank. Moments earlier, Resident #6 had been observed holding feeding himself. This surveyor, therefore, asked whether the resident could hold his own cup. The staff replied "yes, when he wants to." Upon this inquiry, the 1:1 staff guided the resident's hand to the flavored water and the resident picked up the glass and began to drink independently. There was no evidence that the 1:1 staff encouraged the maintenance of Resident #6 self-feeding skills.</p> <hr/> <p>Previously, the January 22, 2010 deficiency report included the following:</p> <p>Based on observation, staff interviews, and record review, the facility failed to ensure that residents received continuous active treatment program in accordance with recommendations made by the interdisciplinary team (IDT) for three of the three residents included in the sample. (Residents #1, #2 and #3)</p> <p>The findings include:</p> <p>On January 19, 2010, Resident #1's home activities beginning at 7:30 a.m., were observed and revealed the following:</p>	(I 420)		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HF002-0003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/05/2010
NAME OF PROVIDER OR SUPPLIER WESTVIEW 01		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 12TH STREET, NE WASHINGTON, DC 20017		
(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 420)	Continued From page 23 a) Upon the surveyors' arrival at 7:30 a.m., a direct care support staff was observed talking on his cell phone, outside. Once the surveyor entered the facility, Resident #1 was observed eating breakfast with his peers. Further observations revealed staff walking in and out the dining room as the residents ate breakfast. Interview with the direct support staff at approximately 7:50 a.m., revealed Resident #1 required a 1:1 direct care support staff (24 hours). There was no evidence that a 1:1 direct care support staff was present during breakfast. b) On January 19, 2010, at 8:30 a.m., Resident #1 was observed entering the facility's van to go to his day program. At 10:00 a.m., Resident #1 returned home. Interview with his 1:1 direct support staff revealed the resident refused to get off the van because he did not want to go to his day program. From 10:00 a.m., until 10:30 a.m., Resident #1 was observed looking out the dining room window. At 11:45 a.m., the resident was observed leaving the facility with staff and returned at 12:35 p.m. Interview with his 1:1 direct support staff revealed the resident went to lunch at McDonalds. At 12:45 p.m., the 1:1 direct support staff handed the resident a magazine and he flipped through the pages briefly then began to watch television. At 1:02 p.m., the 1:1 direct support staff handed him the same magazine. The resident flipped through the pages briefly then began to look around the living room. Shortly after he began to look out the window. Interview with the 1:1 direct support staff on January 21, 2010, at 1:20 p.m., revealed "I give him his freedom and space during the day because he is programmed in the evenings." Further interview revealed "if you get into his	(I 420)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(01) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD63-0083	(02) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(03) DATE SURVEY COMPLETED R 03/09/2010
NAME OF PROVIDER OR SUPPLIER WESTVIEW #1			STREET ADDRESS, CITY, STATE, ZIP CODE 3200 12TH STREET, NE WASHINGTON, DC 20017		
(04) 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)	(05) COMPLETE DATE	
(I 420)	Continued From page 25 At 6:00 p.m., the direct support staff was observed setting the table for dinner. At 6:05 p.m., Resident #1 was observed eating his dinner while wearing his winter coat. After he completed his dinner, staff was observed taking the resident's dishes to the kitchen. Review of Resident #1's occupational therapy assessment dated December 12, 2009, on January 21, 2010, at 10:00 p.m., revealed Resident #1 was able to place "his cup and utensil onto his plate and take his plate to the kitchen when finished eating. Observations on January 19, 2010, at 6:25 p.m., revealed Resident #1 watching television in Resident #5's bedroom. Interview with the direct support staff revealed Resident #1 broke his television last week, therefore he "lets him enjoy himself." The support staff was observed downstairs while Resident #1 was upstairs looking out Resident #2's bedroom window. At 6:44 p.m., Resident #1 was observed walking into the dining room wearing a dirty suit jacket (a white substance was all over his jacket). Interview with the 1:1 direct support staff revealed Resident #1 "likes to wear that jacket." Further interview revealed he will display his behavior if he is redirected. Review of Resident #1's occupational therapy assessment dated December 12, 2009, on January 21, 2010, at 10:00 p.m., revealed Resident #1 was able to "place dirty clothing into the hamper and load the washing machine and the dryer with verbal prompting." Review of Resident #3's IPP revealed that the recommended training programs were not	(I 420)			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0003	(C2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(C3) DATE SURVEY COMPLETED R 03/05/2010
NAME OF PROVIDER OR SUPPLIER WESTVIEW 01			STREET ADDRESS, CITY, STATE, ZIP CODE 3300 12TH STREET, NE WASHINGTON, DC 20017		
(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)	(C5) COMPLETE DATE	
(I 420)	Continued From page 26 consistently implemented as evidenced below: - The resident will independently Say hi to his 1:1 counselor by name, when he arrives to work on 4 out of 4 trials a week. - The resident will independently set his place at the dinner table on 3 out of 3 trials a week. - The Resident will independently remove his dishes from the table after dinner on 3 out of 3 trials a week. - Given visual demonstration and verbal prompting. The resident will participate in structured exercise on 3 out of 3 trials a week. - Given a model, the resident will identify the function of 5 community helpers with 80% accuracy per session for six consecutive months. - The resident will independently participate in a table top activity for 30 minutes on 4 out of 4 trials a week. Interview with the Qualified Mental Retardation Professional (QMRP) on January 21, 2010, at 11:00 a.m., revealed that the program had not been implemented since his Individual Support Plan (ISP) meeting. Further interview revealed that Resident #1's ISP meeting was held on December 11, 2009.	(I 420)			
(I 458)	3621.11 HABILITATION AND TRAINING Each resident ' s activity schedule shall be available to direct care staff and be carried out daily. This Statute is not met as evidenced by:	(I 458)			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/05/2010
NAME OF PROVIDER OR SUPPLIER WESTVIEW 01		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 12TH STREET, NE WASHINGTON, DC 20017		
(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
(J 458)	<p>Continued From page 27</p> <p>Based on observation, interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to develop an alternative and a regular active treatment schedule that outlined the current active treatment programs, for three of the four residents in the sample. (Residents #1, #2 and #3)</p> <p>The findings include:</p> <p>1. The facility failed to ensure an alternative daytime activity schedule was developed for Resident #1, as evidenced below:</p> <p>On March 4, 2010, at 11:12 a.m., the facility's van pulled up to the group home. The driver stepped out; however, Resident #1 and his 1:1 direct support staff remained inside the van. At 11:19 a.m., the driver got back in and the van drove away with the resident and his staff. At 2:50 p.m., Resident #1 was observed entering the facility. Interview with the 1:1 staff, at approximately 3:00 p.m., revealed Resident #1 had refused to go into his day program as well as a medical appointment. The 1:1 staff further indicated that no other active treatment had taken place. Earlier that day, at approximately 2:00 p.m., review of the resident's program book revealed no documented evidence of an alternative activity schedule for Resident #1. Even though the facility's Plan of Correction, signed March 2, 2010, stated that a schedule had been developed (completed February 5, 2010), interview with the qualified mental retardation professional (QMRP) on March 5, 2010, at 2:27 p.m., confirmed that the resident remained without an alternative activity schedule.</p> <p>It should be noted that interview with the facility's</p>	(J 458)	<p>1458</p> <p>1. An alternative active treatment plan will be developed for Resident #1 by April 15, 2010. The Activity Schedule and corresponding data collection sheets will be placed in his record for access, review, implementation, and documentation by his assigned One to One staff.</p> <p>The QMRP will retrain all staff on the new day active treatment programs and schedule.</p> <p>In the future, the QMRP will ensure that the individual is provided with an alternative active treatment program if he/she does not attend an outside day treatment program. This practice will be monitored by the Quality Assurance personnel.</p>	

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 09/06/2010
NAME OF PROVIDER OR SUPPLIER WESTVIEW 01			STREET ADDRESS, CITY, STATE, ZIP CODE 3200 12TH STREET, NE WASHINGTON, DC 20017		
(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	
(1 458)	Continued From page 28 driver on March 5, 2010, at approximately 11:00 a.m., revealed that Resident #1 had refused to go into his day program again that morning. 2. The facility failed to develop an active treatment schedule that outlined Resident #1's evening active treatment programs, as evidenced below: Observation on March 4, 2010, at 2:55 p.m., revealed Resident #1 flipping through pages of a magazine. At 3:17 p.m., the resident was observed watching television in the living room. At 4:04 p.m., the 1:1 support staff asked Resident #1 to take his dishes to the kitchen; however, he refused. At 4:06 p.m., the resident was observed looking out Resident #2's bedroom window. At 4:16 p.m., he went downstairs and began to look out the dining room window. At 5:09 p.m., he went into the living room and began to call Resident #6's name as he watched television. After dinner, at 5:57 p.m., he took his dishes to the kitchen after his 1:1 direct support staff made the request. At 6:04 p.m., he was observed looking out the window again. At 6:30 p.m., he went into the living room where the other residents were watching television and began to look around. Except for the mealtime supports (i.e. instruction to take dishes to kitchen), Resident #1 was not involved in meaningful activities for the period 2:55 p.m. - 6:30 p.m. Earlier that day, at approximately 2:00 p.m., review of the resident's program book revealed no documented evidence of an alternative activity schedule for Resident #1. Even though the facility's Plan of Correction, signed March 2, 2010, stated that a schedule had been developed (completed February 8, 2010), interview with the QMRP on March 5, 2010, at 2:27 p.m., confirmed	(1 458)	1-458 Continued 2. An evening active treatment schedule will be developed for Resident #1 by April 15, 2010. The Activity Schedule and corresponding data collection sheets will be placed in his record for access, review, implementation, and documentation by his assigned One to One staff. The QMRP will retrain all staff on the new evening active treatment programs. In the future, the QMRP will ensure that the individual is provided with a continuous active treatment program during the evening and weekend hours. This practice will be monitored by the Quality Assurance personnel		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(01) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NFD03-0003	(02) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(03) DATE SURVEY COMPLETED R 03/05/2010
NAME OF PROVIDER OR SUPPLIER WESTVIEW 01		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 12TH STREET, NE WASHINGTON, DC 20017	
(04) 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)
(I 458)	<p>Continued From page 29</p> <p>that the resident remained without an evening activity schedule.</p> <p>3. On March 5, 2010, at 2:27 p.m., the QMRP stated that Resident #2 and Resident #6 also remained without activity schedules.</p> <hr/> <p>Previously, the January 22, 2010 deficiency report included the following:</p> <p>1. The facility failed to ensure an alternative activity schedule was developed for Resident #1 as evidenced below:</p> <p>On January 19, 2010, at 8:30 a.m., Resident #1 was observed entering the facility's van to go to his day program. At 10:00 a.m., Resident #1 returned home. Interview with his 1:1 direct support staff revealed the resident refused to get off the van because he did not want to go to his day program. From 10:00 a.m., until 10:30 a.m., Resident #1 was observed looking out the dining room window. At 11:45 a.m., the resident was observed leaving the facility with staff and returned at 12:35 p.m. Interview with his 1:1 direct support staff revealed the resident went to lunch at McDonalds. At 12:45 p.m., the 1:1 direct support staff handed the resident a magazine and he flipped through the pages briefly then began to watch television. At 1:02 p.m., the 1:1 direct support staff handed him the same magazine. The resident flipped through the pages briefly then began to look around the living room. Shortly after he began to look out the window.</p> <p>Interview with the 1:1 direct support staff on January 21, 2010, at 1:20 p.m., revealed 7 give</p>	(I 458)	<p>3. 2. An active treatment schedule will be developed for Resident #2 and 6 by April 15, 2010. The Activity Schedule and corresponding data collection sheets will be placed in each resident's his record for access, review, implantation, and documentation by the assigned staff.</p> <p>The QMRP will retrain all staff on the active treatment schedule.</p> <p>In the future, the QMRP will ensure that the individual is provided with a continuous active treatment program and schedule the evening and weekend hours. This practice will be monitored by the Quality Assurance personnel</p>

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/08/2010
NAME OF PROVIDER OR SUPPLIER WESTVIEW #1		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 12TH STREET, NE WASHINGTON, DC 20017		
(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
{ 458 }	Continued From page 30 him his freedom and space during the day because he is programmed in the evenings." Further interview revealed "if you get into his space too much he will go into his behaviors." Minutes later, the 1:1 direct support staff revealed Resident #1 was going to ride on the van to pick the other residents up from their day programs. Review of the resident's habilitation record on January 21, 2010, revealed no documented evidence of training programs for January 2010. Further record review revealed the last Qualified Mental Retardation Professional (QMRP) monthly notes were dated September 3, 2009. 2. The facility failed to develop an active treatment scheduled that outlines the current active treatment programs, for three of the three residents included in the sample. a. Observation on January 19, 2010, at approximately 3:00 p.m., revealed Resident #1 looking out the window. At 3:50 p.m., the resident was observed leaving the group home. Interview with the direct support staff indicated the resident was going to ride on the van to take another resident to a medical appointment. Record review on January 21, 2010, beginning at 9:10 a.m., revealed an activity schedule included in Resident #1's Individual Support Plan (ISP), dated December 12, 2008. Interview with the 1:1 direct support staff on January 21, 2010, at 11:40 a.m., revealed he has not seen Resident #1's activity schedule since his last ISP in December 2008. Interview with the QMRP on January 19, 2010, at approximately 12:05 p.m., indicated that Resident #1 had an ISP meeting on December 11, 2008.	{ 458 }		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(01) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0003	(02) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(03) DATE SURVEY COMPLETED R 03/05/2010
NAME OF PROVIDER OR SUPPLIER WESTVIEW 01		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 12TH STREET, NE WASHINGTON, DC 20017		
(04) 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)	(05) COMPLETE DATE
(1 458)	<p>Continued From page 31</p> <p>The resident's individual program plan (IPP) goals and objectives were developed and approved by the interdisciplinary team. The resident's habilitation records were reviewed on the same day at approximately 12:30 p.m., to determine if the records contained an activity schedule. Although the records revealed a schedule, the residents' IPP or training programs were not included in the schedule. The QMRP was made aware on the same day that the activity schedule lacked information regarding the days and timeframe for the implementation of the resident's IPP goals and objectives.</p> <p>b. Interview with the QMRP on January 19, 2010, at approximately 12:05 p.m., indicated that Resident #2 had an ISP meeting on November 23, 2009. The resident's IPP goals and objectives were developed and approved by the interdisciplinary team. The resident's habilitation records were reviewed on the same day at approximately 12:30 p.m., to determine if the records contained an activity schedule. Although the records revealed a schedule, the residents' IPP or training programs were not included in the schedule. The QMRP was made aware on the same day that the activity schedule lacked information regarding the days and timeframe for the implementation of the resident's IPP goals and objectives.</p> <p>c. Interview with the QMRP on January 19, 2010, at approximately 12:05 p.m., indicated that Resident #3 had an ISP meeting on December 13, 2009. The resident's IPP goals and objectives were developed and approved by the interdisciplinary team. The resident's habilitation records were reviewed on the same day at approximately 12:30 p.m., to determine if the records contained an activity schedule. Although</p>	(1 458)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(01) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0003	(02) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(03) DATE SURVEY COMPLETED R 03/05/2010
NAME OF PROVIDER OR SUPPLIER WESTVIEW 01		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 12TH STREET, NE WASHINGTON, DC 20017		
(04) 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)	(05) COMPLETE DATE
(1 458)	Continued From page 32 the records revealed a schedule, the residents' IPP or training programs were not included in the schedule. The CNRP was made aware on the same day that the activity schedule lacked information regarding the days and timeframe for the implementation of the resident's IPP goals and objectives.	(1 458)		
(1 473)	3522.4 MEDICATIONS The Residence Director shall report any irregularities in the resident's drug regimens to the prescribing physician. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that all drugs were administered in compliance with the physician's orders, for one of the six residents residing in the facility. (Resident #2) The findings include: The evening medication pass was observed on March 4, 2010, beginning at approximately 6:00 p.m. Resident #2 was administered Alarax 25 mg at approximately 6:28 p.m. The next morning, at 11:16 a.m., review of her February 1, 2010 physician's orders (signed on February 1, 2010) revealed an order to administer Alarax 25 mg, one tablet at bedtime, at 8:00 p.m. At 12:30 p.m., the resident's March 2010 POs and MAR were unavailable for review. They were locked in the medication closet and there was no one in the facility with a key to open it. It should be noted that the Plan of Correction, dated March 2, 2010, indicated that the facility would contact the physician to assure the POs were "correct."	(1 473)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0003	(K2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(K3) DATE SURVEY COMPLETED R 03/03/2010
NAME OF PROVIDER OR SUPPLIER WESTVIEW 01			STREET ADDRESS, CITY, STATE, ZIP CODE 3200 12TH STREET, NE WASHINGTON, DC 20017		
(K4) 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)	(K5) COMPLETE DATE	
(I 473)	<p>Continued From page 33</p> <p>However, there were no POs or telephone orders in Resident #2's medical record that would suggest that the Atarax order had been changed since the RN signed the February POs on February 1, 2010.</p> <hr/> <p>Previously, the January 22, 2010 deficiency report included the following:</p> <ol style="list-style-type: none"> Observation of the medication administration on January 19, 2010, at 5:45 p.m., revealed the trained medication employee (TME) administered Resident #2, Atarax 25 mg, one tablet by mouth. <p>Review of Resident #2's physician's orders (POS) dated January 2010, on January 20, 2010, at approximately 10:00 a.m., revealed an order to administer Atarax 25 mg, one tablet at bedtime.</p> <p>During an interview with qualified mental retardation professional (QMRP) on January 20, 2010, at approximately 10:15 a.m., revealed that the resident's medications are administered twice a day (approximately 8:00 a.m., and 6:00 p.m.)</p> <ol style="list-style-type: none"> Observation of the medication administration on January 19, 2010, at 5:40 p.m., revealed Resident #3 was administered two tablets of Reglan 10 mg. Comparison of the medication administration observation and the physician orders dated January 2010, on January 20, 2010, at approximately 9:00 a.m., revealed that the resident was ordered Reglan 10 mg. Interview with the trained medication employee indicated that the resident received two tablets of Reglan equaling 20 mg. 	(I 473)	<p>1473</p> <ol style="list-style-type: none"> The Nursing Coordinator will discuss with the Primary Care Physician of the changes in Resident #2's drug regimen by April 15, 2010 and document said discussion. The Physician Order's will be reviewed and/or revised to correspond with the time Resident #2's medication are to be given as prescribed by the physician. 		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(01) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NFD03-0003	(02) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(03) DATE SURVEY COMPLETED R 03/05/2010
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NAME OF PROVIDER OR SUPPLIER WESTVIEW 01	STREET ADDRESS, CITY, STATE, ZIP CODE 3200 12TH STREET, NE WASHINGTON, DC 20017
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(04) 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)	(05) COMPLETE DATE
(1 484)	Continued From page 34	(1 484)		
(1 484)	<p>3522.11 MEDICATIONS</p> <p>Each GHMRP shall promptly destroy prescribed medication that is discontinued by the physician or has reached the expiration date, or has a worn, illegible, or missing label.</p> <p>This Statute is not met as evidenced by: On March 4, 2010, the evening medication pass was observed from approximately 6:00 p.m. - 6:51 p.m. The medication closet was locked and inaccessible on the following day, therefore, compliance with this regulation could not be determined. It should be noted that the facility's Plan of Correction, dated March 2, 2010, indicated "all expired medication was disposed and replaced with unexpired medication" effective January 22, 2010.</p> <hr/> <p>Previously, the January 22, 21010 deficiency report included the following:</p> <p>Based on observation and record review, the Group Home for Mentally Retarded Persons (GHMRP) nurse failed to remove from use, out dated medications, for two of six residents residing in the facility. (Residents #4 and #5)</p> <p>The findings include:</p> <p>a. On January 22, 2010, beginning at 10:50 a.m., during an environmental inspection, a tube of Mupirocin ury/Fluocinide was observed in Resident #4's topical storage box. The label on the tube had an expiration date of December 7, 2009. The House Manager on duty at that time reviewed the label and confirmed that the</p>	(1 484)	<p>1-184</p> <p>The registered Nurse will ensure that all medications are properly destroyed upon discontinuation, expiration, or the labels have been worn, destroyed, or missing. Monitoring of the medication boxes will be conducted by the Registered Nurse on a monthly basis and documentation of such activity will be placed in the MAR book for review as needed.</p> <p>a. The medication found in Resident 4's room with an expired label was removed and replaced with current medication.</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0003	(K2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(K3) DATE SURVEY COMPLETED R 03/05/2010
NAME OF PROVIDER OR SUPPLIER WESTVIEW 01		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 12TH STREET, NE WASHINGTON, DC 20017		
(L4) 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)	(M) COMPLETE DATE
(I 484)	Continued From page 35 medication had expired. b. Similarly, on January 22, 2010, beginning at 10:50 a.m., during an inspection a tube of Desoximetasone ointment 0.25% was observed in Resident #5's topical storage box. The label on the tube had an expiration date of December 7, 2009. The House Manager on duty at that time reviewed the label and confirmed that the medication had expired. At the time of the survey, there was no evidence that the facility's nursing staff ensured that expired medications were removed from the residents' supplies after the expiration date.	(I 484)	b. The medication found in Resident #5's room with an expired label was removed and replaced with current medication.	
(I 500)	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observations, interviews and record review, the GHMRP failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and other District and federal laws that govern the care and rights of persons with mental retardation, for two of the six residents of the facility. (Residents #1, #2 and #8) The findings include: 1. The facility failed to protect residents' rights by not informing the residents' medical guardians of	(I 500)		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(01) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HPD83-8883	(02) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(03) DATE SURVEY COMPLETED R 03/05/2010
NAME OF PROVIDER OR SUPPLIER WESTVIEW 01		STREET ADDRESS, CITY, STATE, ZIP CODE 3280 12TH STREET, NE WASHINGTON, DC 20017		
(04) 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)	(05) COMPLETE DATE
(1 500)	<p>Continued From page 36</p> <p>changes in their condition and the use of psychotropic medications for behavior management [Title 7, Chapter 13, § 7-1305.05(h), formerly § 6-1965(h)], as follows:</p> <p>Observation of the evening medication administration on March 4, 2010, at 6:00 p.m., revealed Resident #1 was observed receiving Risperidone 3mg. Interview with the trained medication employee (TME) during the medication administration, revealed the aforementioned medications were used to address the resident's behaviors.</p> <p>Interview with the qualified mental retardation professional (QMRP) on March 4, 2010, at 12:20 p.m., revealed that Resident #1's guardian had not been to the facility or otherwise received a review of the resident's condition and treatment needs since the January 22, 2010 recertification survey. The QMRP indicated that he had made attempts to reach the guardian by telephone. On March 5, 2010, at 9:40 a.m., the QMRP reported that Resident #1's guardian would be meeting with him "today" to sign a consent form for the resident's BSP and psychotropic medication.</p> <p>However, at the time that the survey ended at 3:15 p.m., the facility failed to provide evidence that informed consent was obtained from Resident #1's legal guardian. In addition, there was no evidence that the facility's Human Rights Committee had determined whether the facility would obtain legal consent prior to the implementation of restrictive measures.</p> <p>2. Based on observation, the facility failed to ensure Resident #1's right to privacy during medication administration, as follows:</p>	(1 500)	<p>1500</p> <p>1. The QMRP will make the guardian of Resident #1 aware of any medication changes by April 15, 2010, at which time consent forms for said medications will be signed.</p> <p>In the future, all consent forms will be signed by the appropriate persons at the Resident's annual ISP meeting or six month review. Additional consent will be obtained when any new medications are prescribed or there is a change in dosage of the already prescribed medications. The Human Rights Committee will be informed when consent is obtained.</p> <p>2. The Nursing Coordinator will retrain all medication passers, to include the TME, or observing privacy during medication pass, by April 15, 2010.</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(01) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0003	(02) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(03) DATE SURVEY COMPLETED R 03/05/2010
NAME OF PROVIDER OR SUPPLIER WESTVIEW #1			STREET ADDRESS, CITY, STATE, ZIP CODE 3200 12TH STREET, NE WASHINGTON, DC 20017		
(04) 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)		(05) COMPLETE DATE
(J 500)	<p>Continued From page 37</p> <p>During the evening medication pass on March 4, 2010, at approximately 6:18 p.m., the trained medication employee (TME) informed this surveyor that Resident #6 was "always last since I have to take it <medication> down to it." [Note: The medication closet (nursing office) was located on the 2nd floor.] He explained that it was difficult for the resident to walk up stairs. At 6:35 p.m., the TME stated "I usually walk it down to him <resident> ... in the day room." After preparing the medications, the TME carried them downstairs, stating that since Resident #6 was not going to come upstairs, he was bringing them to him. Once in "the day room," the TME administered Resident #6's medications while several staff and Residents #1, #2, #3 and #4 sat nearby, watching.</p> <p>3. Based on observation, interview and record review, the facility failed to ensure that residents received their medications without error, for one of the four residents in the sample (Resident #2), as follows:</p> <p>a. The evening medication pass was observed on March 4, 2010, beginning at approximately 6:00 p.m. Resident #2 was administered Atarax 25 mg at approximately 6:28 p.m. The next morning, at 11:16 a.m., review of her February 1, 2010 physician's orders (signed on February 1, 2010) revealed an order to administer Atarax 25 mg, one tablet at bedtime, at 8:00 p.m. At 12:30 p.m., the resident's March 2010 POs and MAR were unavailable for review. They were locked in the medication closet and there was no one in the facility with a key to open it.</p> <p>It should be noted that the Plan of Correction, dated March 2, 2010, indicated that the facility would contact the physician to assure the POs</p>	(J 500)	<p>At anytime medication has to be taken to an individual, the medication nurse will be instructed to ask the staff and other individuals to leave the room so that the medication can be administered to said individual in private if an alternative location can not be secured.</p> <p>This practice will be monitored by the Nursing Coordinator and Quality Assurance personnel.</p> <p>3. The Nursing Coordinator will discuss with the Primary Care Physician of the changes in Resident #2's drug regimen by April 15, 2010 and document said discussion. The Physician Order's will be reviewed and/or revised to correspond with the time Resident #2's medication are to be given as prescribed by the physician.</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HF000-0003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/05/2010
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NAME OF PROVIDER OR SUPPLIER WESTVIEW 01	STREET ADDRESS, CITY, STATE, ZIP CODE 3200 12TH STREET, NE WASHINGTON, DC 20017
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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) COMPLETE DATE
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(1 500) Continued From page 38

were "correct."
However, there were no POs or telephone orders in Resident #2's medical record that would suggest that the Atarax order had been changed since the RN signed the February POs on February 1, 2010.

b. Cross-refer to Federal Deficiency Report - Citation W300. Resident #2's physician's orders reflected 3 ml. Risperidol to be administered at 6:00 p.m. every evening. During the March 4, 2010 evening medication administration, the trained medication employee (TME) was observed to prepare 11 oz. of Risperidone instead. After he poured the medication, however, the TME asked the surveyor for comment. The potential error was immediately brought to the TME's attention, and he subsequently changed the amount to 3 ml., before he administered it to Resident #2.

4. Based on observation, staff interviews, and record review, the Group Home for Mentally Retarded Persons (GMRP) failed to ensure the residents' right to receive continuous active treatment program in accordance with recommendations made by the interdisciplinary team (IDT), for three of the four residents in the sample. (Residents #1, #3 and #5)

Previously, the January 22, 2010 deficiency report included the following:

1. The facility failed to ensure that informed consent was obtained from Resident #3's guardian prior to the administration of his psychotropic medications.

(1 500)

4. The QMRP will formulate a continuous active treatment program for Resident #1,3, and 6 by April 15, 2010. The staff will be trained on the programs and schedule. Corresponding data sheets will be placed in each resident's record for access by staff for implementation and documentation.

In the future the QMRP will ensure that active treatment programs and schedules are developed immediately following the ISP meeting.

1. Consent for Resident #3's psychotropic medication will be obtained from his identified decision maker by April 15, 2010 and filed in the record for review.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/05/2010
NAME OF PROVIDER OR SUPPLIER WESTVIEW 01		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 12TH STREET, NE WASHINGTON, DC 20017		
(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
(1 500)	Continued From page 39 During the entrance conference on January 19, 2010, at 8:30 a.m., the Qualified Mental Retardation Professional (QMRP) indicated that Resident #3 received psychotropic medications to address his maladaptive behaviors. Further interview revealed the resident did not have the capacity to give informed consent for the use of medications and habilitation services. Observation of the evening medication administration on January 19, 2010, at 5:40 p.m., revealed Resident #3 was observed receiving Haldol 10 mg, Depakote 500 mg and Risperidone 4 mg. Interview with the trained medication employee (TME) during the medication administration, revealed the aforementioned medications were used to address the resident's behaviors. The QMRP's statement was verified on January 20, 2010, at 2:30 p.m., through review of Resident #3's psychological assessment. According to the assessment, Resident #3 "does not evidence the capacity to make decisions on his own behalf in treatment, habilitation, residential placement and financial matters". Further interview with the QMRP during the survey, revealed that the resident had a court appointed guardian who is involved in his habilitation planning and decision making process. Record verification on January 20, 2010, at 2:45 p.m., revealed that Resident #3's guardian had given informed consent for the use of Haldol 3 mg QAM and 4 mg QPM, Risperdal 4 mg, twice a day, Cogentin 1 mg QAM and Depakote 500 mg, twice a day dated May 11, 2009. There was no consent signed, however, for the resident's	(1 500)	In the future, all consent forms will be signed by the appropriate persons at the Resident's annual ISP meeting or six month review. Additional consent will be obtained when any new medications are prescribed or there is a change in dosage of the already prescribed medications. The Human Rights Committee will be informed when consent is obtained.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0003	(K2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(K3) DATE SURVEY COMPLETED R 03/06/2010
NAME OF PROVIDER OR SUPPLIER WESTVIEW #1			STREET ADDRESS, CITY, STATE, ZIP CODE 3200 12TH STREET, NE WASHINGTON, DC 20017		
(K4) 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)	(K5) COMPLETE DATE	
(I 500)	<p>Continued From page 40</p> <p>current Haldol 10 mg, twice a day.</p> <p>At the time of the survey, the facility failed to provide evidence that informed consent was obtained from the resident and/or legally authorized representative prior to the administration of the psychotropic medication.</p> <p>2. The facility failed to ensure that informed consent was obtained from Resident #1's guardian prior to the to the implementation of his Behavior Support Plan (BSP).</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on January 19, 2009, at 8:30 a.m., during the entrance conference revealed that Resident #1 had a Behavior Support Plan (BSP) to address his maladaptive behaviors. Further interview revealed the resident did not have the capacity to give informed consent for the use of medications and habilitation services.</p> <p>The QMRP's statement was verified on January 20, 2010 at 10:30 a.m., through review of Resident #1's psychological assessment. According to the assessment, Resident #1 "does not show competency or intellectual capacity to make independent decisions regarding his habilitation plans, medical or psychological issues, residential placement or financial matters". Further interview with the QMRP during the survey, revealed that the resident had a court appointed guardian who is involved in his habilitation planning and decision making process.</p> <p>Review of the incident book on January 19, 2010, at 8:55 a.m., revealed Resident #1 was restrained by two direct care support on October</p>	(I 500)	<p>2. Consent for Resident #1's Behavior Support Plan will be obtained from his guardian by April 15, 2010 and filed in the record for review.</p> <p>In the future, all consent forms will be signed by the appropriate persons at the Resident's annual ISP meeting or six month review. Additional consent will be obtained when the Behavior Support Plan is revised. The Human Rights Committee will be informed when consent is obtained.</p> <p>This practice will be monitored by the QMRP in conjunction with the Quality Assurance personnel.</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/05/2010
NAME OF PROVIDER OR SUPPLIER WESTVIEW 01		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 12TH STREET, NE WASHINGTON, DC 20017		
(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
(J 500)	Continued From page 41 25, 2009. At the time of the survey, the facility failed to provide evidence that informed consent was obtained from the resident and/or legally authorized representative prior to implementing Resident # 1's BSP.	(J 500)		