

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

PRINTED: 10/21/2008
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 09/19/2008
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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	INITIAL COMMENTS A recertification survey was conducted from September 17, 2008 through September 19, 2008. The survey was initiated using the fundamental survey process. A random sample of three clients was selected from a resident population of four men and two women with various disabilities. In addition, a focused review was conducted of a fourth client's dental care and daytime active treatment and a fifth client's dental, GYN and dermatology services were reviewed. The findings of the survey were based on observations, interviews with clients and staff in the home and at two day programs, as well as a review of client and administrative records, including incident reports.	W 000	<p><i>Received 11/3/08</i></p> <p>GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002</p>	
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the governing body exercised general policy and operational direction over the facility, except in the following areas. The findings include: 1. Cross-refer to W368 and W369. There was no evidence that the governing body had established an internal Quality Assurance system to ensure that nursing staff and Trained Medication Employees administered medications in accordance with physician's orders.	W 104		<p>1. A new Quality Assurance Coordinator will be hired to monitor the administration of medication and review physician's orders and MARs to ensure that medication is administered as ordered. Until then, the current Nursing Coordinator and the Designating Registered Nurse will monitor the medication nurses and Trained Medication Employee, accordingly, to ensure that medication is being administered in accordance with physician's orders</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Sue R West J. MN</i>	TITLE <i>Administrator</i>	(X6) DATE <i>October 31, 2008</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 104	<p>Continued From page 1</p> <p>Medication errors were identified during the survey, such as:</p> <p>a. Client #2's Atarax was not administered (or failure to document) for 5 1/2 months;</p> <p>b. For the first 17 days of September 2008, Client #3's AM and PM doses of Carbamazepine had been reversed. He received 300 mg in the AM instead of PM and 400 mg in the PM instead of the AM. There was no evidence that the facility identified the medication error prior to the survey; and,</p> <p>c. Client #4 did not receive Naftin 1% gel at the correct time indicated on his physician's orders. The gel was administered shortly before his evening shower instead of in the morning, as prescribed. In addition, Client #4 did not receive podiatry services as scheduled between December 2007 and August 2008, during which time his foot fungus condition reportedly worsened. [See W322.1]</p> <p>2. Cross-refer to W440. The Federal Deficiency Report dated August 10, 2008 included findings that for an 8-month period from January - August 2007, the facility had not conducted fire drills at least quarterly on each shift. The facility submitted a Plan of Correction (POC), dated September 4, 2007, that included the following: "... The Fire/Safety Manager will ensure that each Shift Supervisor conducts a fire drill on his/her shift on a quarterly basis... Quality Assurance Director will monitor this practice with oversight by the QMRP." The September 19, 2008 recertification survey findings, however, revealed that fire drills still had not been conducted at least quarterly on each shift. There was no evidence</p>	W 104	<p>a. The Nursing Coordinator reviewed the MARs with the medication nurse and the Trained Medication Employee. They were informed of the importance of documenting the prescribed medication promptly following administration and not delaying documentation until the next medication pass or next day. In the future, the Nursing Coordinator will review the MARs for each individual weekly to ensure that documentation is complete. Follow up will be conducted by the Quality Assurance Coordinator.</p> <p>b. The medication nurse and Trained Medication Employee were trained on how to read the physician's orders and correctly administer medications having more than one medication administration time with different dosages for each time. The Nursing Coordinator and/or the Designated Registered Nurse will observe medication passes at least bimonthly to ensure that medication is being administered according to the physician's orders. Follow up will be conducted by the Quality Assurance Coordinator</p>	<p>10-1-08</p> <p>10-01-08</p>
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W 104	<p>Continued From page 1</p> <p>Medication errors were identified during the survey, such as:</p> <p>a. Client #2's Atarax was not administered (or failure to document) for 5 1/2 months;</p> <p>b. For the first 17 days of September 2008, Client #3's AM and PM doses of Carbamazepine had been reversed. He received 300 mg in the AM instead of PM and 400 mg in the PM instead of the AM. There was no evidence that the facility identified the medication error prior to the survey; and,</p> <p>c. Client #4 did not receive Naftin 1% gel at the correct time indicated on his physician's orders. The gel was administered shortly before his evening shower instead of in the morning, as prescribed. In addition, Client #4 did not receive podiatry services as scheduled between December 2007 and August 2008, during which time his foot fungus condition reportedly worsened. [See W322.1]</p> <p>2. Cross-refer to W440. The Federal Deficiency Report dated August 10, 2008 included findings that for an 8-month period from January - August 2007, the facility had not conducted fire drills at least quarterly on each shift. The facility submitted a Plan of Correction (POC), dated September 4, 2007, that included the following: "... The Fire/Safety Manager will ensure that each Shift Supervisor conducts a fire drill on his/her shift on a quarterly basis... Quality Assurance Director will monitor this practice with oversight by the QMRP." The September 19, 2008 recertification survey findings, however, revealed that fire drills still had not been conducted at least quarterly on each shift. There was no evidence</p>	W 104	<p>c. See 1401, #1, Page 18 - 19</p> <p>2. A new person was appointed to monitor conducted fire drills, ensure that the proper documentation is completed and filed accordingly. Fire drills were conducted as needed for this quarterly reporting period. In the future, fire drills will be conducted at least quarterly on each of the three shifts, Sunday - Saturday. Monitoring will be conducted by the newly appointed Fire Safety Coordinator with follow up completed by the Quality Assurance Coordinator.</p>	<p>10-1-08</p> <p>10-1-08</p>
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W 104 Continued From page 2
that the governing body ensured that the internal quality assurance system proposed in the September 2007 POC was effective.

W 125 483.420(a)(3) PROTECTION OF CLIENTS RIGHTS

The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.

This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to allow and encourage individual clients to exercise their rights as clients of the facility, including self-determination and due process, for one of the three clients in the sample. (Client #1)

The findings include:

1. On September 17, 2008, at approximately 6:37 AM, Client #1 lit a cigarette and went outside alone to smoke it. At approximately 6:41 AM, a staff person saw Client #1 smoking outside, opened the door and spoke to him using a harsh tone of voice, saying: "<client's first name> put it out! There's no smoking... Put it out!" He came back inside without the cigarette. Later that day, at approximately 12:43 PM, Client #1's day program case manager and nurse indicated that cigarettes were very important to him. The client reportedly became angry if/when he was unable to smoke ("yeah big time... very agitated"). They further indicated that he smoked 2 cigarettes there at the day program and had an established

W 104

W 125

1. Correction to the Statement of Deficiencies, it was stated by the QMRP that Client #1 receives a cigarette at 10:00 AM upon arriving to the Day Treatment Program. However, he would like to have a cigarette immediately after breakfast. In order to adhere to his Behavior Support Plan of 4 cigarettes a day, 10:00 AM – 8:00 PM distribution was adequate. Also, it was recommended by the former Nursing Coordinator that Client #1 not smoke too early in the morning because it elevates his blood pressure. All staff were made aware of these concerns, however, when Client #1 asks for a cigarette some staff have felt compelled to give him one to avoid a verbal and/or physical outburst by Client #1. All staff as well as Client #1 will be made aware of the newly developed smoking plan and the importance of encouraging Client #1 to follow it. The schedule will be reviewed at the November 6, 2008 Human Rights Committee meeting.

11-6-08

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W 125	<p>Continued From page 3 smoking schedule at home.</p> <p>Later that afternoon, interview with the Qualified Mental Retardation Professional (QMRP), at approximately 4:55 PM, revealed that Client #1 had agreed to a smoking schedule that included 1 cigarette first thing in the morning. There was no evidence that the staff person working the overnight/morning shift was aware that he was allowed to smoke a cigarette or otherwise encouraged him to exercise his personal right to smoke.</p> <p>2. During the September 17, 2008 afternoon interview with the QMRP, she indicated that Client #1 had agreed to smoke 4 cigarettes per day. Since that time, however, facility staff had tried to further reduce his smoking, to 2 per day. The client reportedly expected to have 4 cigarettes per day. The QMRP confirmed what day program staff had stated previously, that his behaviors increased when staff curtailed his smoking.</p> <p>Client #1's records were reviewed on September 18, 2008, beginning at 10:25 AM. He had signed a Residents' Rights form on June 5, 2006 and June 4, 2007, which included among other things "Right to live in the least restrictive setting and most normalized conditions." At 10:40 AM, review of his diagnoses revealed hypertension and chronic renal insufficiency, among others. At approximately 1:23 PM, review of his Individual Support Plan (ISP), dated December 12, 2007, revealed: "<client's name> appreciates that he is given choices and the opportunity to participate in activities of interest to him..." Then, speaking in the first person: "I would like to continue to have choices as well as opportunities to participate in activities of interest to me." "<client's name> has</p>	W 125	<p>2. As stated, Client #1 had agreed to smoke 4 cigarettes a day, however, it was stated at one time he previously smoked 2 a day and it is the long term goal to get him back down to two again. In an effort to decrease Client #1's change in behaviors, a meeting will be held at the Day Treatment Program to review Client #1's Behavior Support Plan developed by the psychologist in regards to smoking as well as the home's smoking schedule. The Behavior Support Plan in regards to smoking and the smoking schedule will be reviewed at the November 6, 2008 Human Rights Committee meeting for approval.</p> <p>In April 2008, Client #1 was enrolled in a smoking cessation class at Providence Hospital that proved to be successful for a short period of time and assisted in educating Client #1 on the dangers of smoking. The QMRP will seek reenrollment of the class and ensure that proper documentation is kept describing the agenda and Client #1's progress and attitude towards participating in the program.</p>	<p>11-30-08</p> <p>11/30/08</p>
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W 125	<p>Continued From page 4</p> <p>a history of smoking which is a risk factor associated with hypertension and renal insufficiency... I want staff to continue to monitor the number of cigarettes that I smoke to ensure that I stay within the established limit per day. I want to continue to be educated on the dangers of smoking and encouraged to decrease my smoking."</p> <p>At approximately 3:15 PM, a document "Standard Procedures Regarding Cigarettes," dated December 12, 2007, was reviewed. Client #1 had signed it that same day. The document included: "...He does not want to stop smoking... Medically he should stop smoking... workable compromise was needed... schedule... own money... total 4 per day..." The document did not, however, specify what schedule he had agreed to. In addition, the facility's Human Rights Committee (HRC) had reviewed and approved the smoking agreement.</p> <p>Further review of Client #1's record, however, failed to show evidence of an actual smoking schedule. Furthermore, interviews with staff in the home and at day program reflected conflicting statements, revealing no evidence that they were aware of a smoking schedule. The QMRP, and the Residential Manager who was present during the September 17, 2008 interview, both acknowledged that there had been no written schedule established to clearly delineate when and where he would smoke.</p> <p>3. Client #1 also was unaware of his smoke schedule. While the QMRP had indicated that he could smoke one at 4:00 PM, the client stated at approximately 2:40 PM, that he would get a cigarette at 8:00 PM. Note: It was at Client #1's</p>	W 125	<p>3. Client #1 has^{was} made aware of his smoking schedule which is why he state that he could have one at 8:00 PM. It was not noted if Client #1 had a cigarette at prior to 2:40 PM. If he requested to have it early, he would then state that his next cigarette time is 8:00 PM. The written smoking schedule will be reviewed with him as well as have his input. The Residential Manager will ensure that the smoking scheduled is implemented correctly by the staff as well as Client #1. Follow up will be conducted by the QMRP.</p>	11-1-08

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W 125	Continued From page 5 request that he accompanied this surveyor to the QMRP's office to discuss his cigarettes. 4. The facility failed to effectively coordinate and communicate with Client #1's day program, as follows: a. On September 17, 2008, his day program case manager and nurse both stated that he smoked 2 cigarettes there daily; the first at 10:00 AM and a second after lunch. During the interview with the QMRP later that day, however, she indicated that Client #1 was only supposed to smoke 1 cigarette (total) while at day program. She said he was to break a cigarette in half, smoke part of it at 10:00 AM and then finish the second half after lunch. b. During the day program observations on September 17, 2008, the day program nurse was observed looking through a desk for cigarettes to give to Client #1. She was unable to locate any. Several clients, including #1, were lined up, waiting to go outside after lunch for a smoke. The nurse and the day program case manager indicated that he would not have a cigarette that afternoon, as he had none. They suspected that others had smoked some of Client #1's supply, and acknowledged that his supply was not secured under lock and key. They stated that his not having cigarettes often precipitated behavioral outbursts, yet he was also instructed to not ask others for a cigarette. At approximately 1:10 PM, Client #1 was observed sitting outside with the others, watching as they smoked. When approached, he asked this surveyor for a cigarette. He stated that he had been out of cigarettes there "for a couple of days." There was no evidence that the facility ensured that his	W 125	4a. See 1500, #6, Page 30 Additionally, it was noted by the QMRP that in the past that was what Client #1 was encouraged to do in an effort to decrease the four to two and then have the plan amended. This effort was successful for a while, however, formally the plan was not introduced to the Human Rights Committee as a formal program because it was only an informal effort to encourage Client #1 to smoke less. The smoke half now and half later was encouraged of him at home and only suggested that he do it at the Day Treatment. For a while client #1 was amenable to the suggestion. 4b. The home provides a pack of cigarettes to the Day Treatment Program. It is anticipated that if he smokes two cigarettes a that a pack of twenty would last him for at least two weeks. However, in an effort to avoid Client #1's cigarettes being provided to others, possible training will be implemented to teach Client #1 to maintain his cigarettes on his person for his consumption while adhering to his cigarette schedule. The Residential manger will monitor this process with follow up conducted by the QMRP.	11-6-08	11-30-08

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W 125	<p>Continued From page 6</p> <p>cigarettes were stored in a secure manner at day program.</p> <p>5. Client #1's "Standard Procedures Regarding Cigarettes," dated December 12, 2007, indicated that the client would smoke 4 cigarettes per day. This was not, however, reflected in his Health Management Care Plan (HMCP), dated December 31, 2007. The HMCP said he would only smoke 2 cigarettes per day. There was no evidence that the nurse and QMRP had effectively communicated to ensure consistent application of the client's agreed-upon "schedule."</p> <p>6. Cross-refer to W262. During the September 17, 2008 afternoon interview with the QMRP, she indicated that facility staff had reduced Client #1's smoking to 2 cigarettes per day. That was consistent with what the nurse wrote in the HMCP. However, the agreement that the client signed December 12, 2007 was for 4 cigarettes per day. There was no evidence that Client #1 consented to smoking fewer than 4 per day. The Human Rights Committee (HRC) had approved the initial December 12, 2007 procedures/ agreement, for 4 cigarettes. There was no evidence that the HRC had approved limiting him to just 2 per day. In addition, there was no evidence that the HRC sought to determine whether Client #1's December 2007 agreement was being implemented as written, to ensure that his rights were protected.</p> <p>It should be noted that attempts to reach Client #1's brother by telephone during the survey were unsuccessful. His brother had attended the December 12, 2007 ISP meeting. Interviews with facility staff and review of the client's record revealed that the brother remained involved in the</p>	W 125	<p>5. As stated, Client #1 agreed to smoke 4 cigarettes a day on December 12, 2007, at his annual ISP meeting. The HMCP dated December 31, 2007 was completed by the former Nursing Coordinator. The QMRP will review the plan with the new Nursing Coordinator and ensure that the HMCP is amended.</p> <p>6. Informally, Client #1 was encouraged to smoke less than 4 cigarettes a day. However, this was not a formal plan but at that time, Client #1 was not as obsessed with smoking as he now and it was not as difficult to encourage him to smoke less or redirect him when he wanted to smoke. The suggestion for the plan to be amended was not discussed at the Human Rights meeting. It was the plan that if Client #1 was successful in smoking fewer than 4 cigarettes a day that it would be suggested that the plan be formally amended. However, although he was encouraged to smoke less he was never denied during that period of smoking the approved 4 cigarettes. In the future, the QMRP will address the Human Rights Committee in regards to make informal changes to any plans as a trial effort.</p>	11-10-08 <i>Ongoing</i>
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W 125	Continued From page 7 client's life. Without speaking with the brother, however, it remained unclear what was his understanding of his brother's smoking schedule.	W 125	Client #1's brother was at the December 12, 2007 ISP meeting and made aware of the current Behavior Support Plan in regards to smoking.	11-15-08
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on interview, and record review, the Qualified Mental Retardation Professional (QMRP) failed to adequately monitor, integrate, and coordinate the health, safety and active treatment needs, for six of the six clients residing in the facility. (Clients #1, #2, #3, #4, #5 and #6) The findings include: 1. Cross-refer to W125 and W262. The QMRP failed to ensure that: a. direct support staff only restricted Client #1's freedom to smoke cigarettes to the extent authorized by his interdisciplinary team and in accordance with his approved program ("Standard Procedures Regarding Cigarettes"); b. Client #1's personal property (i.e., cigarettes) were secured at his day program; c. failed to establish a written smoking schedule to assist Client #1 and support staff in the home and at day program with adherence to the plan that the client agreed to in December 2007; and, d. failed to have the facility's Human Rights	W 159	However, in an effort to ensure that he understands it as well as approves of it, the QMRP will send a copy of the plan to him for his review along with a consent form for Behavior Support Plans for his signature, should he approve of it. 1a. The QMRP will ensure that all staff is aware of, understands, and implements Client #1's Standard Procedures Regarding Cigarettes as it is written. 1b. A tracking method will be developed to assure that Client #1's cigarettes are secured at the Day Treatment Plan. Additionally, a plan will be developed to assess if Client #1 can maintain his cigarettes on his person and adhere to the smoking plan. The Residential Manger will monitor the process with follow up conducted by the QMRP	11-15-08 10-21-08

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W 125	Continued From page 7 client's life. Without speaking with the brother, however, it remained unclear what was his understanding of his brother's smoking schedule.	W 125		
W 159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by: Based on interview, and record review, the Qualified Mental Retardation Professional (QMRP) failed to adequately monitor, integrate, and coordinate the health, safety and active treatment needs, for six of the six clients residing in the facility. (Clients #1, #2, #3, #4, #5 and #6)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Cross-refer to W125 and W262. The QMRP failed to ensure that: <ol style="list-style-type: none"> a. direct support staff only restricted Client #1's freedom to smoke cigarettes to the extent authorized by his interdisciplinary team and in accordance with his approved program ("Standard Procedures Regarding Cigarettes"); b. Client #1's personal property (i.e., cigarettes) were secured at his day program; c. failed to establish a written smoking schedule to assist Client #1 and support staff in the home and at day program with adherence to the plan that the client agreed to in December 2007; and, d. failed to have the facility's Human Rights 	W 159	<p>1c. A written smoking schedule was developed for Client #1. The schedule will be reviewed at the November 6, 2008 Human rights Committee meeting for approval. Upon approval the staff and the Day Treatment Program will be instructed on how to implement the schedule.</p> <p>1d. The Standard Procedures Regarding Cigarettes for Client #1 will be reviewed at the November 6, 2008 as well as the newly developed smoking schedule. The plan and the schedule will be reviewed at the quarterly follow up meetings.</p> <p>3. The QMRP spoke with the Speech Pathologist at Client #2's Day Treatment Program regarding her communication device and was informed that it should be repaired and returned to Client #2 on or before November 7, 2008. Upon its return the QMRP will ensure that Client # 2 receives continues active treatment using her Mini Merc Communication device.</p>	<p>11-1-08</p> <p>11-6-08</p> <p>10-28-08</p>

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W 159	Continued From page 8 Committee actively monitor the implementation of Client #1's smoking program ("Standard Procedures Regarding Cigarettes") which the committee authorized in December 2007. 2. Cross-refer to W242. The QMRP failed to ensure that Client #4's individual program plans (IPP) included training to help acquire skills in the area of dental hygiene. 3. Cross-refer to W249. The QMRP failed to ensure that Client #2 received continuous active treatment using the Mini Merc Communication Device as recommended by the interdisciplinary team (IDT). 4. Cross-refer to W436. The QMRP failed to coordinate services to ensure that Client #2's Mini Merc Communication Device was maintained in good repair and failed to ensure that Client #1 was encourage to wear his eyeglasses. 5. Cross-refer to W440. The QMRP failed to provide oversight to staff to ensure that fire drills were conducted at least quarterly on each shift, as indicated in the Plan of Correction, dated September 4, 2007.	W 159	4. The QMRP follow up accordingly with the day treatment program on the two occasions that it was in need of repair by submitting the necessary 719As as well as following up with Essential Rehabilitation. In the future the QMRP will ensure that proper documentation is kept to indicate steps taking to ensure that communication device remains in good repair. A program will be put into place to ensure that Client #1 will wear his eyeglasses to ensure that he wears them daily, if he so chooses. The Residential Manager will monitor the program with follow up by the QMRP.	Ongoing	
W 242	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.	W 242	5. A new person has been appointed to oversee that fire drills are conducted as required and in a timely manner by all shifts. Follow up will be conducted by the Quality Assurance Coordinator.	10-1-08	

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W 242	<p>Continued From page 9</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that clients' individual program plans (IPP) included training to acquire skill in the area of dental hygiene for one (Client #4) of six clients residing in the facility.</p> <p>The finding includes:</p> <p>Cross refer to W356. On September 17, 2008 at 8:05 AM, Client #5's front teeth were observed to be missing. Interview with the Qualified Mental Retardation Professional (QMRP) revealed the client had a history of refusing to get off the van when taken to receive medical and dental services.</p> <p>Subsequent review of Client #4's Individual Support Plan (ISP) dated 12/17/07 revealed he had a generalized scaling, adult prophylaxis and polishing of his teeth on 7/5/07. The dentist recommended that his teeth be brushed two to three times daily and that he have a follow-up visit in 6 months. Review of dental consultation forms revealed that he refused to exit the van when taken for dental assessments appointments in April 2008 and July 2008.</p> <p>Interview with the QMRP on September 19, 2008 at approximately 3:30 PM revealed the client required staff assistance to brush his teeth and that they were brushed after breakfast and dinner. The QMRP indicated that in the past, unsuccessful attempts had been made to train the client to brush his teeth. She acknowledged however that the client was presently not receiving training to enable him to increase his independence in tooth brushing and oral hygiene.</p>	W 242	<p>Since Client #4 does not attend a day treatment program a formal tooth brushing program will be implemented by his one to one counselor following lunch. This will allow for adequate training time as well as adhere to the dentist recommendation of having his teeth brushed 2 – 3 times a day. The night shift and evening shift will continue to brush his teeth as recommended without formal documentation. This program will be ongoing and monitored by the QMRP.</p> <p>The Nursing Coordinator has scheduled Client #4 to see the dentist on November 10, 2008 for follow up of abscess and routine dental care. Appointments for routine dental care will scheduled as recommended as well as ongoing measures taken to ensure that Client #4 is compliant.</p>	<p>11-1-08</p> <p>11-10-08</p>
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W 242	Continued From page 10	W 242		
W 249	Also, at the time of the survey, the record failed to show evidence of the facility's efforts to enhance the client personal skill in maintaining his dental hygiene. 483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that one (Client #2) of the three clients in the sample received continuous active treatment as recommended by the interdisciplinary team (IDT). The finding includes: The facility failed to consistently implement Client #2's individual program plan (IPP) which was recommended to enhance her communication skills as follows: Cross-refer to W436. On September 17, 2008, at approximately 8:20 AM, Client #2 was observed seated on the couch in the lounge with her eyes closed. At 8:30 AM, a staff repeatedly told her it was time to leave for the day program and asked her to get up. After several requests, the client answered in a barely audible voice, then got up from the couch and left the room with the staff.	W 249	In the past, Client #2 had a formal program requiring staff to encourage her to speak louder. However, it has been observed that Client #2 rarely speaks above a whisper until agitated at which time she screams and yells. She was diagnosed by the Speech Pathologist at her day treatment program as having Apraxia that describes a person with difficulty initiating speech sounds, groping for sounds, or in severe cases, the inability to produce sound at all. Therefore, the program was discontinued, but staff was instructed to continue to encourage her to verbalize and speak louder during social interaction. Upon repair of the Mini Merc communication device, Client #2's program will continue. The QMRP will ensure that the program is implemented as recommend as well as that the device receives routine monitoring to ensure that is operable at all times.	<i>ongoing</i> <i>11-15-08</i>

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W 249	<p>Continued From page 11</p> <p>Staff indicated that the client was receiving training to encourage her to speak louder.</p> <p>Review of Client #2's Individual Support Plan (ISP) dated 10/22/07 reflected that an electronic communication system (Mini Merc) had been obtained for the client in accordance with the 2006 IDT recommendation. The Individual Program Plan (IPP) for 2007 - 2008 included a goal "to increase the client's functional communication skills". The current objective to be implemented at the group home stated that "Given verbal prompts, Ms. . . will use her communication device to increase her consistency of scanning selections with 80% accuracy per session" as measured by active treatment documentation. Interview with group home staff indicated that the client could use her Mini Merc daily if she desired. The IPP however required that the objective be implemented on Wednesdays only at the group home. Staff confirmed that the procedure was for the client to take the Mini Merc to the day program in the morning and bring it back to the group home each evening so that it could be available to her in both settings.</p> <p>Interview with the day program instructor on September 17, 2008 at 12:35 PM revealed the client was supposed to receive training using a communication device at the group home and also at her day program. The client had a day program communication objective "Ms..will increase her communication skills via AAC (include electronic device, signs and residual voice) with verbal prompts each day she is present with a month by October 31, 2008". The day program staff disclosed that the objective was currently not being implemented as scheduled</p>	W 249		
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W 262	<p>Continued From page 13</p> <p>recommended that he stop smoking due to his diagnoses of hypertension and chronic renal insufficiency. The client refused to quit altogether; however, he had agreed to smoke 4 cigarettes per day. Since that time, however, facility staff had further reduced his smoking to 2 per day.</p> <p>Client #1's records were reviewed on September 18, 2008, beginning at 10:25 AM. He had signed a Residents' Rights form on June 5, 2006 and June 4, 2007, which included among other things "Right to live in the least restrictive setting and most normalized conditions." At approximately 1:23 PM, review of his Individual Support Plan (ISP), dated December 12, 2007, revealed: "<client's name> appreciates that he is given choices and the opportunity to participate in activities of interest to him..." Then, speaking in the first person: "I would like to continue to have choices as well as opportunities to participate in activities of interest to me." "<client's name> has a history of smoking which is a risk factor associated with hypertension and renal insufficiency... I want staff to continue to monitor the number of cigarettes that I smoke to ensure that I stay within the established limit per day. I want to continue to be educated on the dangers of smoking and encouraged to decrease my smoking."</p> <p>At approximately 3:15 PM, a document "Standard Procedures Regarding Cigarettes," dated December 12, 2007, was reviewed. Client #1 had signed it that same day. The document included: "...He does not want to stop smoking... Medically he should stop smoking... workable compromise was needed... schedule... own money... total 4 per day..." the document did not specify what</p>	W 262		
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W 262	<p>Continued From page 14</p> <p>schedule he had agreed to. The facility's Human Rights Committee (HRC) reviewed and approved the smoking agreement on December 12, 2007.</p> <p>During the September 17, 2008 afternoon interview with the QMRP, she indicated that facility staff had reduced Client #1's smoking to 2 cigarettes per day. That was consistent with what the nurse wrote in the HMCP. However, the agreement that the client had signed December 12, 2007 was for 4 cigarettes per day. There was no evidence that Client #1 consented to being denied cigarettes in order to reduce the number below 4 per day.</p> <p>On September 19, 2008, at approximately 8:40 AM, review of the minutes recorded for HRC meetings held after the December 2007 approval date revealed the following:</p> <p>3/27/08 - "continue to adhere to BSP regarding smoking (4 per day) but should also be encouraged to decrease smoking each day to aid in the improvement of his health Should not be totally denied."</p> <p>6/6/08 - no mention of cigarettes</p> <p>9/5/08 - no mention of cigarettes</p> <p>The word "encourage" used by the HRC at the March 27, 2008 meeting was consistent with the language ("monitoring... encourage") in the client's "Standard Procedures Regarding Cigarettes." There was no evidence, however, that the HRC had approved limiting the client to just 2 cigarettes per day. In addition, there was no evidence that the HRC monitored his smoking plan to determine whether the agreement to</p>	W 262			

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W 262	Continued From page 15 smoke just 4 cigarettes was implemented with full respect of his due process rights. It should be noted that there was no written schedule established that clearly outlined when Client #1 could smoke either a half cigarette or a whole cigarette. Survey interviews revealed staff and Client #1 provided contradictory statements regarding when he could smoke. It should be further noted that Client #1's record reflected numerous behavioral outbursts that were documented when staff did not allow him to smoke.	W 262		
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 observation, interview and record review, the facility failed to provide preventive and general medical care, for two of six clients residing in the facility. (Clients #3 and #4) The findings include: 1. The facility failed to ensure recommended medical follow-up for Client #4 to address his podiatry needs. Observation of Client #4 on September 17, 2008 at 5:37 PM revealed the Registered Nurse (RN) applied Naftin 1% Gel to his left hand and right foot. It should be noted that according to direct support staff, Client #4 routinely took a shower every evening before bedtime. On September 18,	W 322	1. See 1401, #1, Page 19	11-15-08

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W 322	<p>Continued From page 16</p> <p>2008, at approximately 8:50 AM, review of Client #4's POs (dated August 1, 2008) revealed that the gel was to be applied between his toes and to his plantar foot at 6:00 AM every morning. The MAR sheet for September 2008 did not reflect a 6:00 AM administration. Instead, there was a handwritten "prn" for the designated time.</p> <p>Further record review on September 18, 2008, at 9:45 AM, revealed that Client #4 was assessed by the podiatrist on December 18, 2007. The podiatrist diagnosed bilateral interdigital tinea (foot fungus). Naftin 1% Gen between toes daily for two months was prescribed. Podiatry follow-up in three months was recommended. Interview with the Director of Nursing (DON) and additional record review on September 19, 2008, at 5:15 PM, confirmed that the client had no podiatry follow-up until eight months later, August 13, 2008, .</p> <p>On August 13, 2008, the podiatrist diagnosed the client with interdigital and plantar tinea pedis. Naftin 1% get between and on bottom of feet daily was prescribed. There was no evidence, however that Client #4 received timely podiatry follow-up and treatment services to alleviate his foot fungus.</p> <p>2. Cross-refer to W356. The facility failed to ensure that Client #4 was assessed to determine the origin of his recurrent tooth abscesses. Unusual incident reports revealed that Client #4 was treated at an emergency room on July 15, 2008 and August 2, 2008 for tooth abscesses. Review of the discharge summaries revealed a recommendation for follow-up assessment at the dental clinic in five days. At the time of the survey, there was no evidence that the</p>	W 322	<p>2. See 1401, #2, Page 20</p>	11-15-08

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W 322	<p>Continued From page 17 recommended assessment had been conducted.</p> <p>3. On July 7, 2008, Client #3 was taken to the emergency room for evaluation due to feeling hot and refusal to eat. The review of the discharge summary revealed the client had a chief complaint of cough and fever. He was diagnosed with bronchitis and was treated with an intravenous antibiotic. A chest X-ray performed during the hospitalization showed a foreign body in the client's neck. Due to the discovery of the foreign body, a CT scan of the neck was performed. The scan revealed two linear foreign bodies in the retropharyngeal and prevertebral soft tissues of the neck. The consulting ENT specialist determined there was no evidence of airway distress or dysphagia and that the client's foreign bodies could be followed on an outpatient basis. A discharge summary revealed the client was readmitted to the group home on July 15, 2008, however continued on oral antibiotics.</p> <p>On July 18, 2008 the primary care physician (PCP) noted that the client had been treated in the hospital for pneumonia and a foreign found in his neck. The PCP recommended ENT f/u to assess the status of the foreign body and that the client continue on the antibiotics. During the ENT visit on July 22, 2008, the specialist documented that he was unable to evaluate the metal in the client's neck because he was uncooperative. He therefore recommended to "(1) obtain the CD with actual images of the CT scan of the neck from the hospitalization; (2) Sedate the patient adequately for thorough examination on next visit, including flexible nasal endoscopy and possible ear cleaning, (3) Return visit in two weeks." The facility, however, did not ensure timely follow-up with the ENT.</p>	W 322	<p>See 1401, #3, Page 20 Additionally, the Nursing Coordinator will seek, in writing, confirmation weather or not Client #3 needs to be followed by ENT or not. If so, how often and if not, what safety measures should be taken. Also, it will be asked if previous recommendations to have a endoscopy and ear cleaning still need to be carried out since he has been asymptomatic since July.</p> <p>Additionally, the Nursing coordinator will suggest to the Primary Care Physician that a repeat CT Scan be formed with the possibility of determine the origin of the foreign bodies as well as assess if there are any additional concerns.</p>	<p>11-15-08</p> <p>11-15-08</p>
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W 322	Continued From page 18 The next ENT appointment was September 4, 2008 (six weeks later). The clinic reviewed the CT scan of the client's neck and noted that it showed metallic foreign bodies in the left nasopharynx and right supraglottic region. In accordance with the CT scan results, he again recommended naso-endoscopy and laryngoscopy. He further noted, however, that due to the client's inability to cooperate, the procedures could not be performed. The recommended procedures were deferred pending the occurrence of symptoms of distress, such as fevers, decreased neck range of motion limitation or sore throat. Interview with the Director of Nursing (DON) indicated the client would continue to be monitored and that he would be taken to the ER if the aforementioned symptoms occur. Although the facility had taken the approach of monitoring the client symptomatically, there was no evidence the origin of the metallic foreign bodies in the client neck had been determined. (Note: Record review revealed the client had physician's order for 1:1 staff 7 days per week, due to his maladaptive behaviors which included swallowing non-food items.)	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 interviews, and record verification, the facility's nursing services failed to establish systems to provide health care monitoring and identify services in accordance with clients' needs for three of six clients residing in the facility.	W 331		

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PRINTED: 10/21/2008
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 09/19/2008	
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 331	<p>Continued From page 19 (Clients #2, #3, and #4)</p> <p>The findings include:</p> <p>1. The facility's nursing staff failed to ensure that Client #4 received timely and appropriate oral hygiene and dental care supports and services.</p> <p>a. Cross-refer to W356. Review of unusual incidents on September 17, 2008 revealed Client #4 had two dental emergencies for which he required services from a hospital emergency room. On July 15, 2008, he was diagnosed with poor dental hygiene, tooth abscess and gingivitis. He returned to the ER on August 2, 2008 at which time he was diagnosed with a periapical abscess.</p> <p>b. On September 18, 2008, at 10:30 AM, review of Client #4's Health Management Care Plan (HMCP), dated June 30, 2008, revealed that it failed to identify dental hygiene as a concern. There was no evidence that timely and ongoing interventions /strategies had been implemented to manage the client's dental health.</p> <p>2. The facility's nursing staff failed to ensure that Client #4 received effective daily foot care and timely podiatry services, as follows:</p> <p>a. Cross-refer to W369.2. Nursing staff failed to ensure that Client #4's Medication Administration Record (MAR) accurately reflected his physician's orders (POs). Specifically, his POs included an order for Naftin 1% gel apply between toes every morning at 6 AM. A nurse, however, was observed applying the gel to his feet on the evening of September 17, 2008 (a short while before he took a shower). Review of his September MAR showed that someone had</p>	W 331	<p>1a. See 1401, #1, Page 22</p> <p>1b. The QMRP will alert the Nursing Coordinator of the oversight of not identifying Client #4's dental concerns on the Health Care Management Plan.</p> <p>2a. See 1401, 2a, Page 22</p>	<p>11-15-08</p> <p>11-15-08</p> <p>11-15-08</p>

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W 331	<p>Continued From page 20</p> <p>written "prn" as the designated time for applying the gel. On September 19, 2008, at approximately 4:50 PM, interview with the RN revealed no evidence that nursing staff had identified the discrepancy between his POs and MARs prior to the survey.</p> <p>b. Facility nurses failed to schedule podiatry visits at the prescribed intervals. On December 17, 2007, the podiatrist diagnosed bilateral interdigital tinea pedis and prescribed Naftin 1% gel to be applied between the client's toes. The podiatrist recommended a follow-up appointment in three months. The next documented podiatry care, however, was provided eight months later, on August 13, 2008. The podiatrist found that in addition to interdigital tinea pedis, the fungal condition had spread to the soles of his feet. Naftin 1% gel was prescribed again. Interview with the Director of Nursing (DON) and additional record review on September 19, 2008 at 5:15 PM confirmed that the resident had no podiatry follow-up until eight months later, August 13, 2008.</p> <p>c. Facility nurses failed to update Client #4's HMCP to address his tinea pedis. On September 18, 2008, at approximately 9:45 AM, review of Client #4's HMCP, dated September 18, 2008, revealed that it failed to identify tinea pedis (foot fungus) as a concern.</p> <p>The was no evidence timely interventions /strategies had been implemented to address Client #4's recurrent foot fungus.</p> <p>3. Cross-refer to W368.1. Nursing staff failed to identify that Client #2's MARs failed to reflect administration of Atarax once daily, as prescribed, for the 5 1/2 months preceding the survey</p>	W 331	<p>b. See 1401, 2b, Page 23</p> <p>c. See 1401, 2c, Page 23</p> <p>See 1401, 2b, Page 23</p> <p>3. See 1401, #3, Page 23</p>	<p>11-15-08</p> <p>11-15-08</p> <p>Ongoing</p> <p>10-1-08</p>
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W 331	Continued From page 21 (beginning April 1, 2008). On September 19, 2008, review of the blister pack of Atarax revealed that the Atarax had been removed from the blister pack for each day thus far in the month. Nurses had not determined whether this was a documentation error of if the client did not receive the Atarax as prescribed.	W 331		
W 356	<p>4. Cross-refer to W369.1. For the first 17 days of September 2008, Client #3's AM and PM doses of Carbamezapine had been reversed. He received 300 mg in the AM instead of PM and 400 mg in the PM instead of the AM. There was no evidence that nursing staff had identified the medication error prior to the survey.</p> <p>483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT</p> <p>The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure care necessary for maintenance of dental health, for one of the six clients residing in the facility. (Client #4)</p> <p>The finding includes:</p> <p>On September 17, 2008 at 8:05 AM, Client #4's front teeth were observed to be missing. Interview with the Qualified Mental Retardation Professional (QMRP) during the entrance conference later that morning revealed that the client had been recently treated at the hospital for</p>	W 356	4. See W104a	10-1-08

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W 356	<p>Continued From page 22</p> <p>dental emergencies. Record review confirmed the following information regarding the client's dental health care:</p> <p>a. On July 5, 2007, the dentist performed a general scaling, prophylaxis and polishing. Tooth brushing 2 to 3 times a day and follow-up in 6 months were recommended. Further record review revealed the client refused to get off the van when he was taken to the dentist in April 2008 for follow-up.</p> <p>b. An unusual incident report dated July 15, 2008 documented swelling of Client #4's client's lower gum area. He was taken to the emergency room (ER) for evaluation and diagnosed with a tooth abscess and gingivitis. Augmentin 500 mg by mouth was prescribed three times daily to treat the infection. Additionally, dental care, including mouth care after meals and a follow-up dental appointment were recommended. A nursing progress note dated July 18, 2008 indicated the client's jaw was less edematous; however, the client refused to get off the van when he was taken on the follow-up appointment. The nurse further documented that another dental appointment would be scheduled for the client. Interview with the Director of Nursing (DON) on 9/19/08 confirmed that the client did not receive follow-up as recommended after the ER visit because he refused to get off the van.</p> <p>Interview with the QMRP on September 19, 2008 revealed that the client required assistance from staff to maintain his dental hygiene. The QMRP further acknowledged that routinely, the client's teeth had been brushed after breakfast and dinner only and that his mouth/teeth had not been cleaned after each meal as recommended by the</p>	W 356	<p>1a. See W1401, #1, Page 22</p> <p>1b. See W242</p>	<p>11-15-08</p> <p>11-1-08</p>

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W 356	Continued From page 23 ER physician. c. A nursing progress note dated August 2, 2008 documented swelling of the client's left jaw was reported by staff on that afternoon. Review of the ER discharge summary for August 2, 2008 revealed the client was diagnosed with poor dental hygiene and a periapical abscess. Pen VK, 500 mg four times daily (for infection) and Motrin 600 mg (for pain) were prescribed by mouth. Additionally, follow-up with failure at the dental clinic in five days was recommended. Interview with the DON on September 17, 2008 at 4:50 PM revealed she attempted to schedule the appointment with the dental clinic; however, clinic staff told her to schedule the follow-up appointment with the primary care physician. Review of the monthly nursing summary dated August 31, 2008 revealed the client went to the PCP on 8/18/08 but refused to exit the van; follow-up next month. At the time of the survey, there was no evidence Client #4 had been assessed to determine the primary cause of his recurrent dental abscesses. There was no evidence the facility had implemented measures to ensure the maintenance of the client's dental health.	W 356	1c. See 1401, #1, Page 22	11-15-08	
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that all medications were administered in accordance with physician's orders, for three of the six clients	W 368			

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W 368	<p>Continued From page 24 residing in the facility. (Client #2, #3 and #4)</p> <p>The findings include:</p> <p>1. There was no evidence that Client #2 was administered Hydroxyzine (Atarax) in accordance with her physician's orders during the 5 1/2 months prior to the survey, as follows:</p> <p>a. On September 18, 2008, at 9:13 AM, review of Client #2's August 2008 physician's orders (POs) revealed the following order: "Hydroxyzine 25 mg, 1 tab once daily by mouth for itching/allergies (Atarax)." The POs did not, however, specify the time of day for administering the medication. Review of her August 2008 Medication Administration Record (MAR) revealed that the designated administration time was 6:00 AM. Further review of the MAR, however, revealed no documentation showing that she received Atarax that month. The MAR spaces were blank and neither the morning Trained Medication Employee (TME) nor the evening LPN had made any notations or entries on the MAR to indicate why she did not receive the medication.</p> <p>b. Review of Client #2's POs and MARs for the months of May, June and July 2008 revealed no designated administration time for the Atarax. The spaces on the MARs for Atarax were blank and there was no documented evidence that she received Atarax during those 3 months. There were no entries on the MARs to indicate why she did not receive the medication.</p> <p>c. Client #2's April 2008 POs also reflected "once daily by mouth," without specifying an administration time. Although the April MAR reflected a 6:00 PM administration time, there</p>	W 368	<p>1a. See 1401, #3, Page 23 See also W104a</p> <p>1b. The QMRP will alert the Nursing Coordinator to the oversight in order to have the corrections made to the MARs by the pharmacist if it still applies. However, all medication was administered as prescribed. In the future, the Nursing Coordinator will thoroughly review the MARs for such errors.</p> <p>1c. The QMRP will alert the Nursing Coordinator and have the corrections made to the MARs by the pharmacist if the concern still applies. However, it was noted that all medications were give as prescribed. In the future, the Nursing Coordinator will thoroughly review all MARs for such errors.</p>	<p>10-1-08</p> <p>11-15-08</p> <p>11-15-08</p>

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W 368	<p>Continued From page 25</p> <p>was no documented evidence that she received Atarax at any time, AM or PM, throughout April 2008. There were no entries on the MAR to indicate why she did not receive the medication.</p> <p>d. Client #2's MARs indicated that the most recent documented administration of Atarax was on March 31, 2008.</p> <p>e. The evening medication nurse was in the facility later that day. At 5:13 PM, the LPN unlocked the nurse's closet and retrieved the MAR book. Client #2's MAR sheet for September 2008 did not designate an administration time for the Atarax. The spaces on the MAR were blank. After reviewing the MAR, the LPN confirmed that there was no documentation entered thus far in September to show that Client #2 had been receiving Atarax.</p> <p>f. The recently-contracted Registered Nurse (RN) was in the facility on the following day. On September 19, 2008, at 5:10 PM, she retrieved the MAR book and found that since the MARs were examined on the previous evening with the LPN, someone had marked "AM" on the MAR as the designated administration time. Further review revealed initials indicating the Atarax had been administered on the mornings of September 18 and 19, 2008. The spaces remained blank on the previous days that month, with no entries indicating why she did not receive the medication prior to September 18, 2008. [Note: At the time that the MARs were first reviewed with the evening medication nurse on September 18, 2008, there had been no documentation to suggest that she had received the Atarax earlier that day.] The RN retrieved the Atarax blister pack and found that the medication had been</p>	W 368	<p>d. See W104a</p> <p>e. See W104a.</p> <p>f. See W104a</p>	<p>10-1-08</p> <p>10-1-08</p> <p>10-1-08</p>

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W 368	<p>Continued From page 26 removed from each bubble up through September 19, 2008.</p> <p>It should be noted that the RN said Atarax was usually administered in the evening because it could have a sedative effect.</p> <p>2. Cross-refer to W369.1. Client #3's September 2008 MAR documented that for the first 17 days of the month, the administration of his AM and PM doses Carbamazepine had been reversed. Instead of receiving 400 mg in the morning and 300 mg in the evening as ordered, the MAR (coupled with observation the evening of September 17, 2008) revealed that he had received the morning dose in the evening and vice versa. There was no evidence that the facility identified the error (wrong administration time written on the blister packs) prior to the survey.</p> <p>3. Cross-refer to W369.2. Client #4 was not administered Naftin 1% gel in the morning in accordance with his POs.</p>	W 368	<p>2. See W1401, #4, Page 24</p> <p>3. See 1401, #1, Page 19</p>	<p>10-1-08</p> <p>10-1-08</p>
W 369	<p>483.460(k)(2) DRUG ADMINISTRATION</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 medications were administered as prescribed, for three of the six clients residing in the facility. (Clients #2, #3 and #4)</p> <p>The findings include:</p>	W 369		

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W 369	<p>Continued From page 27</p> <p>The evening medication administration pass was observed on September 17, 2008, beginning at 5:13 PM. The following errors were observed:</p> <p>1. Client #3 did not receive the correct dose of Carbamazepine in accordance with physician's orders, as follows:</p> <p>The medication nurse began preparing Client #3's medications at 5:14 PM. Among the medications administered was Carbamazepine, two 200 mg tablets (400 mg dose). However, on September 18, 2008, at 10:05 AM, review of his September 2008 physician's orders (POs) revealed that the prescribed evening dose was not 400 mg; it was 1 1/2 tabs (300 mg). The POs did, however, reflect 400 mg Carbamazepine every morning.</p> <p>The evening medication nurse was in the facility the following evening. On September 18, 2008, at 5:13 PM, the LPN unlocked the nurse's closet and retrieved the basket containing Client #3's evening medications. "PM" was written by hand, in black magic marker, on the blister pack containing 2 tabs (400 mg) Carbamazepine in each bubble. The typed pharmacy label correctly indicated 400 mg in AM. In a basket holding Client #3's morning medications, the LPN found another Carbamazepine blister pack, with 1 1/2 tabs (300 mg). "AM" had been written on it with magic marker; however, the typed pharmacy label correctly indicated 300 mg in the PM. When asked about the handwritten markings, the LPN said she couldn't say, she had only started working in the facility in June 2008. The LPN acknowledged that the error had not been identified in the 17 days prior to the survey.</p>	W 369	<p>1. See W104, #1, page 24</p>	<p>10-1-08</p>
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W 369	<p>Continued From page 28</p> <p>When interviewed the next day, the recently-contracted Registered Nurse (RN) also could not say with certainty whether the blister packs arrived from the pharmacy with the "AM" and "PM" written on them, or if they had been marked incorrectly after they were delivered by the pharmacy to the facility. At 5:05 PM, the RN retrieved the Carbamazepine blister packs from the medication closet and found that the handwritten "AM" and "PM" had been changed with black magic marker and now reflected the correct time of day for administering the medication.</p> <p>2. Client #4 did not receive Naftin 1% gel at the correct time indicated on his physician's orders, as follows:</p> <p>At 5:37 PM, the medication nurse applied Naftin 1% gel to Client #4's left and right foot. On September 18, 2008, at approximately 8:50 AM, review of Client #4's POs (dated August 1, 2008) revealed that the gel was to be applied at 6:00 AM every morning.</p> <p>The evening medication nurse was in the facility the following evening. On September 18, 2008, at 5:13 PM, the LPN unlocked the nurse's closet and retrieved the Medication Administration Record (MAR) book. The MAR sheet for September 2008 did not reflect a 6:00 AM administration. Instead, there was a handwritten "prn" for the designated time.</p> <p>It should be noted that according to direct support staff, Client #4 routinely took a shower every evening before bedtime.</p> <p>It should be further noted that Client #4 did not</p>	W 369	2. See 1401, #1, Page 19	10-1-08
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W 369	Continued From page 29 receive podiatry services as scheduled between December 2007 and August 2008, during which time the foot fungus reportedly worsened. [See W322]	W 369		
	3. On September 18, 2008, review of Client #2's MARs revealed no documented evidence that she had received Atarax "daily" in accordance with her physician's orders, since March 31, 2008. [See W368]		3. See W368	10-1-08
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the communication device/aids identified by Client #2's interdisciplinary team (IDT) as needed was maintained in good repair and available for use, and failed to ensure that Client #1 was trained and encouraged to use his eye glasses. The findings include: 1. Cross-refer to W249. The facility failed to ensure that Client #2's Mini Merc Communication Device was maintained in good repair, as follows: On September 17, 2008 after breakfast Client #2 was observed seated on the couch after breakfast with her eyes closed. At approximately	W 436	1. See W249	10-1-08

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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W 436	<p>Continued From page 30</p> <p>8:20 AM, a staff repeatedly told her it was time to leave for the day program and asked her to get up. After being requested to leave several times, the client spoke in a barely audible voice, then got up from the couch and left the room with the staff.</p> <p>Cross-refer to W249. Client #2 was observed at her day program on September 17, 2008, beginning at 12:35 PM. The classroom instructor stated that the client was scheduled to receive training using a Mini Merc Communication Device (MMCD) daily to enhance her language skills. The instructor mentioned that the training objective could not be implemented daily because the client's MMCD was broken. She also acknowledged that the program implementation frequency was dependent on whether another client allowed Client #2 to use his MMCD. Record review revealed the objective was being implemented using the MMCD 2 to 3 times a week.</p> <p>Subsequent discussion with the classroom instructor and with the Speech/Language Pathologist (SLP) on September 17, 2008 at 1:10 PM revealed information regarding the availability of the client's personal MMCD as follows:</p> <ul style="list-style-type: none"> a) 3/11/08 Keyboard picked up for repairs by vendor today. b) 5/27/08 MMCD picked up by vendor for repairs. c) 6/19/08 MMCD returned from vendor after repairs. d) 7/23/08 Day program discovered MMCD to be inoperable (would not turn on, screen detached 	W 436		
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W 436	<p>Continued From page 31</p> <p>from the frame, screw found at the bottom of the bag. MMCD does not charge to activate.</p> <p>e) 7/31/08 MMCD picked up by vendor for repairs. At the time of the survey, the MMCD had not been returned by the vendor that performed the repairs.</p> <p>Further interview with the day program instructor on September 17, 2008 revealed the client independently brings the device to the classroom. On September 19, 2008, the QMRP confirmed that the communication device was sent on the van with the client each morning and returned to the group home each evening. Discussion with day program and group home staff, as well as the review of training records confirmed that group home staff attended a training session on the MMCD on February 26, 2008, There was no evidence, however, that the training was effective to ensure care of the device to minimize the risk of damage and to maintain it in good repair for the client's use.</p> <p>2. Client #1 was not encouraged and taught to wear his prescription eye glasses, as follows:</p> <p>On September 17, 2008, the QMRP was asked about assistive/ adaptive equipment during the Entrance Conference. Client #1 was not identified as having any special devices. He was observed in the facility between 6:36 AM - 8:33 AM and was not wearing eye glasses. He did not wear eye glasses during day program observations later that day, between 12:21 PM - 1:14 PM. He was without eye glasses during the evening observations, from 2:25 PM - 6:30 PM. Similarly, he was not wearing eye glasses the</p>	W 436	<p>The QMRP will schedule a training sessions for all staff that works with Client #2 to ensure that everyone understands how to operate the device as well as care for it.</p> <p>2. A formal program was implemented fro Client #1 in the past, when he first received the eyeglasses. However, he did not achieve the program at the independent level and always had to receive verbal reminders to wear the eyeglasses. A formal program will be implemented for at least 90 days in order to get Client #1 in the practice of wearing his eyeglasses daily. If he continues to require verbal prompting, the staff will implement the programming informally and encourage him to wear his eyeglasses daily if he chooses to.</p>	<p>11-30-08</p> <p>11-1-08</p>

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W 436	<p>Continued From page 32 following morning (September 18, 2008) before he left for day program.</p> <p>On September 18, 2008, at 10:45 AM, review of his individual support plan (ISP) revealed that he was prescribed eye glasses, for myopia. Review of his QMRP summaries failed to show evidence that his use of eye glasses was being monitored. The nurse monthlies reflected his prescription eye glasses; however, they failed to indicate their status.</p> <p>On September 19, 2008, at approximately 5:00 PM, the RN stated that she had never seen him wear eye glasses. At 5:05 PM, Client #1 was interviewed with staff in the living room. He said he used to have eye glasses but they were misplaced "last year." He was unclear as to when he misplaced them. The direct support staff confirmed that he hadn't seen him wearing glasses for "a long time;" he guessed that it had been 2 or 3 years. At 6:10 PM, Client #1 arrived at the nurse/QMRP office for his evening medications and was wearing glasses. He said he had found them "in my drawer." He replied "yeah" when asked if the glasses helped him see better.</p>	W 436		
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 conduct simulated fire drills at least quarterly on each shift.</p> <p>The findings include:</p>	W 440		

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W 440	<p>Continued From page 33</p> <p>On September 17, 2008, at approximately 10:55 AM, interview with the Qualified Mental Retardation Professional and review of the weekly staffing schedule indicated that there were primarily three designated shifts (7:00 AM - 3:00 PM; 3:00 PM - 11:30 PM; and 11:00 PM - 7:30 AM). Later that day, beginning at 3:18 PM, review of the facility's fire drill records revealed the following:</p> <ol style="list-style-type: none"> 1. The most recent documented evacuation drill during the morning shift was held on April 6, 2008 (5 months earlier); 2. The most recent documented evacuation drill during the evening shift was held on May 15, 2008 (4 months earlier); 3. The most recent documented evacuation drill during the overnight shift was held on March 11, 2008 (6 months earlier). <p>At approximately 4:10 PM, the Fire/Safety Manager indicated there were no additional fire drill records available for review.</p> <p>This is a repeat deficiency.</p> <p>*****</p> <p>Previously, the August 10, 2007 Federal Deficiency Report included the following: "Review of the fire drill records on August 6, 2007, at approximately 1:50 AM, revealed that the facility failed to document a fire drill for each shift from January 2007 through August 2007. At the time of the survey, there was no evidence that</p>	W 440	See 1135, #1, 2, and 3	11-1-08
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W 440	<p>Continued From page 34 evacuation drills were being held on each shift per quarter as required."</p> <p>On September 4, 2007, the facility submitted a Plan of Correction that included the following: "Staff were reformed of the fire drill schedule... posted on the bulletin board... The Fire/Safety Manager will ensure that each Shift Supervisor conducts a fire drill on his/her shift on a quarterly basis... Quality Assurance Director will monitor this practice with oversight by the QMRP."</p>	W 440		

Health Regulation Administration

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1 000 INITIAL COMMENTS

A licensure survey was conducted from September 17, 2008 through September 19, 2008. A random sample of three residents was selected from a resident population of four men and two women with various disabilities. In addition, a focused review was conducted of a fourth resident's dental care and daytime active treatment and a fifth resident's dental, GYN and dermatology services.

The findings of the survey were based on observations, interviews with residents and staff in the home and at two day programs, as well as a review of resident and administrative records, including incident reports.

1 000

Received 11/3/08

**GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION
825 NORTH CAPITOL ST., N.E., 2ND FLOOR
WASHINGTON, D.C. 20002**

1 090 3504.1 HOUSEKEEPING

The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.

This Statute is not met as evidenced by:
Based on observation and interview, the GHMRP failed to maintain the interior and exterior of the facility in a safe and attractive manner.

The findings include:

During observation of the environment on September 19, 2008 beginning at 5:30 PM the following concerns were identified:

1. Bulk trash items were observed by the fence at the back of the yard.

1 090

1. All items observed by the fence and requiring pick up by bulk trash was removed. In the future, the Environmental manager will ensure that no trash or bulk items are stored anywhere in the backyard for an extended period of time. Bulk trash will be called immediately.

9/20/08

Health Regulation Administration

David West J MD ADMINISTRATOR TITLE **October 31, 2008** (X6) DATE

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

Health Regulation Administration

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1090	<p>Continued From page 1</p> <p>2. The picnic table in the yard which was used daily for the residents daily for recreational activities was observed to have warped boards on the top and on the seats.</p> <p>3. Numerous cigarette butts were on the ground near the tree in the yard. The residents sat in the yard in this area during the survey. Staff indicated that they enjoyed sitting in the yard.</p> <p>4. No lighting was observed at the fire exit from the second floor. The light fixture which was secured to the the exterior wall beside the exit door was without a light bulb.</p> <p>5. The water level in the commode was observed to remain near the toilet seat when the toilet was flushed in two of the three bathrooms located in the group home. These bathrooms were located off the hallway on the second floor and on the first floor.</p> <p>6. Louvers were broken on the blinds in the bathroom located on the second floor, off the hallway.</p> <p>7. Multiple cracked tiles were noted on the floor of the second floor. Interview with staff indicated that some of the broken tiles had recently been replaced.</p> <p>8. The caulking was no longer present at the end of the tub in the bathroom used by the female clients.</p> <p>9. The bathroom used by the female clients lacked a grab bar to ensure their safety when using the shower/bath tub. According to incident reports, Resident #5 had fallen in the facility.</p>	1090	<p>2. The picnic table in the back yard with the warped boards will be removed and a new picnic table will be purchased. In the future, the Environmental Manger will ensure that all lawn furniture is maintained. Oversight will be conducted by the Quality Assurance Coordinator.</p> <p>3. All cigarette butts observed on the ground near the tree in the backyard as well as other areas in the yard were removed. In the future, the Maintenance Worker will check the yard daily for cigarette butts and other debris and cleaned accordingly. Oversight will be conducted by the Environmental Manager with follow up by the Quality Assurance Coordinator.</p> <p>4. A light bulb was placed in the fire exit on the second floor and in the light fixture on the exterior wall beside the exit door. In the future, the Maintenance Worker will check all light fixtures on a weekly basis for missing or inoperable bulbs and replace as needed. Oversight will be conducted by the Environmental Manager with follow up by the Quality Assurance Coordinator.</p>	<p>11-30-08</p> <p>9-20-08</p> <p>9-20-08</p>
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1 090	<p>Continued From page 1</p> <p>2. The picnic table in the yard which was used daily for the residents daily for recreational activities was observed to have warped boards on the top and on the seats.</p> <p>3. Numerous cigarette butts were on the ground near the tree in the yard. The residents sat in the yard in this area during the survey. Staff indicated that they enjoyed sitting in the yard.</p> <p>4. No lighting was observed at the fire exit from the second floor. The light fixture which was secured to the the exterior wall beside the exit door was without a light bulb.</p> <p>5. The water level in the commode was observed to remain near the toilet seat when the toilet was flushed in two of the three bathrooms located in the group home. These bathrooms were located off the hallway on the second floor and on the first floor.</p> <p>6. Louvers were broken on the blinds in the bathroom located on the second floor, off the hallway.</p> <p>7. Multiple cracked tiles were noted on the floor of the second floor. Interview with staff indicated that some of the broken tiles had recently been replaced.</p> <p>8. The caulking was no longer present at the end of the tub in the bathroom used by the female clients.</p> <p>9. The bathroom used by the female clients lacked a grab bar to ensure their safety when using the shower/bath tub. According to incident reports, Resident #5 had fallen in the facility.</p>	1 090	<p>5. The commodes on the first floor and off the hallway on the second floor were replaced and/or repaired. In the future, the Environmental Manager, upon report of any malfunctions with the commodes will immediately have commode repaired and/or replaced.</p> <p>6. The blinds off the hallway were replaced. In the future, broken blinds will be removed and/or replaced accordingly upon observance of being broken. The Maintenance Worker will check blinds weekly for needed replacement or repair. Oversight will be conducted by the Environmental Manger with follow up conducted by the Quality Assurance Coordinator. It is the plan of the provider to replace all blinds with another form of window covering in order to prevent further continued replacement of blinds.</p> <p>7. The cracked tiles observed on the second floor will be replaced. The Maintenance Worker will check for broken tiles on a monthly basis and any observed or reported broken tiles will be replaced immediately. Oversight will be conducted by the Environmental Manger.</p>	<p>10-1-08</p> <p>10-1-08</p> <p>11/1/09</p>
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1 090	<p>Continued From page 1</p> <p>2. The picnic table in the yard which was used daily for the residents daily for recreational activities was observed to have warped boards on the top and on the seats.</p> <p>3. Numerous cigarette butts were on the ground near the tree in the yard. The residents sat in the yard in this area during the survey. Staff indicated that they enjoyed sitting in the yard.</p> <p>4. No lighting was observed at the fire exit from the second floor. The light fixture which was secured to the the exterior wall beside the exit door was without a light bulb.</p> <p>5. The water level in the commode was observed to remain near the toilet seat when the toilet was flushed in two of the three bathrooms located in the group home. These bathrooms were located off the hallway on the second floor and on the first floor.</p> <p>6. Louvers were broken on the blinds in the bathroom located on the second floor, off the hallway.</p> <p>7. Multiple cracked tiles were noted on the floor of the second floor. Interview with staff indicated that some of the broken tiles had recently been replaced.</p> <p>8. The caulking was no longer present at the end of the tub in the bathroom used by the female clients.</p> <p>9. The bathroom used by the female clients lacked a grab bar to ensure their safety when using the shower/bath tub. According to incident reports. Resident #5 had fallen in the facility.</p>	1 090	<p>8. The tub in the bathroom used by the female individuals was caulked as needed. In the future, the Maintenance Worker will check the tub monthly for loss of caulking and repair immediately. Oversight will be conducted by the Environmental Manger and follow up conducted by the Quality Assurance Coordinator.</p> <p>9. Grab bars will be placed in the shower/bath tub used by the female individuals to ensure their safety.</p>	<p>10-1-08</p> <p>11-15-08</p>
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I 090	<p>Continued From page 2</p> <p>10. The metal clip on the baseboard heating was not secured at the top which caused it to project outward.</p> <p>11. Several of Client #3's dresser drawers were difficult to open. In addition, one drawer was missing a handle.</p> <p>12. The filter in the hood above the kitchen range had become detached from its frame.</p> <p>13. Dead bugs were observed in the kitchen ceiling light fixture.</p>	I 090	<p>10. The metal clip on the baseboard heating will be repaired and/or replaced accordingly.</p> <p>11. The dresser drawers in Client #3's bedroom were first, lessened of clothing and secondly, shaved underneath for smoother opening. The drawer handle was also replaced; The staff was instructed not to overload the drawers which makes it difficult for them to open. Also, the Maintenance Worker will check all drawers on a monthly basis to identify if any of them need shaving. Oversight will be conducted by the Environmental Manager and follow up by the Quality Assurance Coordinator.</p>	<p>12-1-08</p> <p>10-1-08</p>
I 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 GHMRP failed to conduct simulated fire drills at least quarterly on each shift.</p> <p>The findings include:</p> <p>On September 17, 2008, at approximately 10:55 AM, interview with the Qualified Mental Retardation Professional and review of the weekly staffing schedule indicated that there were primarily three designated shifts (7:00 AM - 3:00 PM; 3:00 PM - 11:30 PM; and 11:00 PM - 7:30 AM). Later that day, beginning at 3:18 PM, review of the facility's fire drill records revealed the following:</p> <p>1. The most recent documented evacuation drill during the morning shift was held on April 6, 2008</p>	I 135	<p>12. The filter in the hood above the kitchen range was reattached to its frame.</p> <p>13. The ceiling light fixture in the kitchen was cleaned of the bugs. In the future, the Maintenance Worker will check the light fixture and clean it accordingly. Oversight will be conducted by the Environmental Manger and follow up by the Quality Assurance Coordinator.</p>	<p>9-20-08</p> <p>9-20-08</p>

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I 090 Continued From page 2

10. The metal clip on the baseboard heating was not secured at the top which caused it to project outward.

11. Several of Client #3's dresser drawers were difficult to open. In addition, one drawer was missing a handle.

12. The filter in the hood above the kitchen range had become detached from its frame.

13. Dead bugs were observed in the kitchen ceiling light fixture.

I 090

I 135 3505.5 FIRE SAFETY

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.

This Statute is not met as evidenced by:
Based on interview and record review, the GHMRP failed to conduct simulated fire drills at least quarterly on each shift.

The findings include:

On September 17, 2008, at approximately 10:55 AM, interview with the Qualified Mental Retardation Professional and review of the weekly staffing schedule indicated that there were primarily three designated shifts (7:00 AM - 3:00 PM; 3:00 PM - 11:30 PM; and 11:00 PM - 7:30 AM). Later that day, beginning at 3:18 PM, review of the facility's fire drill records revealed the following:

1. The most recent documented evacuation drill during the morning shift was held on April 6, 2008

I 135

1. A new person has been appointed to monitor conducted fire drills, and ensure that proper documentation is completed and filed accordingly. Fire drills have been conducted as needed for this quarterly reporting period. In the future, fire drills will be conducted at least quarterly on all three shifts, to include the weekend. Oversight will be conducted by the Quality Assurance Coordinator.

10-1-08

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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
I 135	Continued From page 3 (5 months earlier); 2. The most recent documented evacuation drill during the evening shift was held on May 15, 2008 (4 months earlier); 3. The most recent documented evacuation drill during the overnight shift was held on March 11, 2008 (6 months earlier). At approximately 4:10 PM, the Fire/Safety Manager indicated there were no additional fire drill records available for review. This is a repeat deficiency and will be referred to the Office of the Fire Marshall. ***** Previously, the August 10, 2007 Federal Deficiency Report included the following: Review of the fire drill records on August 6, 2007, at approximately 1:50 AM, revealed that the facility failed to document a fire drill for each shift from January 2007 through August 2007. At the time of the survey, there was no evidence that evacuation drills were being held on each shift per quarter as required. On September 4, 2007, the facility submitted a Plan of Correction that included the following: "Staff were reformed of the fire drill schedule... posted on the bulletin board... The Fire/Safety Manager will ensure that each Shift Supervisor conducts a fire drill on his/her shift on a quarterly basis... Quality Assurance Director will monitor this practice with oversight by the QMRP."	I 135	2. A fire drill was conducted on the evening shift and made current for this quarterly reporting period. 3. A fire drill was conducted on the overnight shift and made current for this quarterly reporting period.	10-1-08 10-20-08

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I 202	Continued From page 4	I 202		
I 202	3509.2 PERSONNEL POLICIES	I 202	<p>An Administrative Assistant Aide was hired to perform all personnel chart reviews. She was given the necessary forms to complete the review as well as a form letter to inform the staff and/or consultants of needed documentation.</p> <p>1. The records are currently being reviewed and necessary documentation is being gathered. In the future, with the hiring of a Administrative Assistant Aid, the personnel charts will always be kept current and ready of review upon annual survey.</p> <p>a. A signed job description was obtained for S12, S4 is no longer employed. A job signed job description needs to be obtained from S2.</p> <p>b. The personnel folder for S14 was misplaced and is being reconstructed, some information was obtained. S15 is no longer employed. S16's folder was also misplaced and reconstruction has to be completed.</p>	<p>10-1-08</p> <p>12-1-08</p> <p>10-31-08</p> <p>11-30-08</p>
	<p>Each staff person shall have a written job description, which details each of his or her major responsibilities and duties and supervisory control.</p>			
	<p>This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide evidence that each employee had a written job description which detailed his or her responsibilities and duties and supervisory control.</p>			
	<p>The findings include:</p>			
	<p>On September 17, 2008, interview with the Qualified Mental Retardation Professional (QMRP) indicated that at the time of hire, all staff received a written job description. Reportedly, staff were asked to sign the written job description (document) after a discussion with their supervisor. The document would then be filed in his or her personnel record for later review and verification by regulatory authorities. Review of personnel records on September 19, 2008, beginning at 4:35 PM, however, revealed the following:</p>			
	<p>1. There were signed job descriptions in 10 of the 16 direct support staff records. Of the remaining 6 direct support staff:</p>			
	<p>a. The personnel records for 3 staff (S2, S4 and S12) did not include a copy of a written, signed job description, in accordance with facility policies.</p>			
	<p>b. There were no personnel records made</p>			

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I 202	<p>Continued From page 5</p> <p>available for review onsite for another 3 staff (S14, S15 and S16); therefore, there was no evidence that they had received a written job description.</p> <p>2. There was no evidence that the Residential Manager had received a written job description since she was hired in June 2008.</p> <p>On September 22, 2008 (post-survey), the facility sent additional documentation via facsimile. The fax did not, however, include any additional information regarding job descriptions.</p> <p>This is a repeat deficiency. There was no evidence that the Human Resource Department, QMRP, Residential Manager and Shift Supervisors Administrative Assistant ensured compliance since their August 2007 annual licensure survey.</p> <p>*****</p> <p>Previously, a State Licensure Deficiency Report dated August 10, 2007 cited the GHMRP's failure to provide evidence that three staff had received written job descriptions at the beginning of employment.</p> <p>In a Plan of Correction, dated September 4, 2007 - Citation I203, the GHMRP wrote the following: "In the future, job descriptions will be signed immediately at the completion of training, filed accordingly, and reviewed and signed annually by the direct care staff. The complete personnel folders, to include signed job descriptions, will be available for review... This practice will be conducted by the Human Resource Department with oversight by the QMRP, Residential Manager and Shift Supervisors."</p>	I 202	<p>2. A written job description was reviewed and signed by the Residential Manager at the time of hire but was inadvertently not placed in the personnel record cabinet.</p> <p>See 1202</p>	9-18-08
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I 203	<p>3509.3 PERSONNEL POLICIES</p> <p>Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide evidence that the supervisor discussed the contents of job descriptions with each employee at the beginning of their employment and annually thereafter.</p> <p>The findings include:</p> <p>On September 17, 2008, interview with the Qualified Mental Retardation Professional (QMRP) indicated that they had staff to sign their written job description (document) after a discussion with their supervisor. Reportedly, this was done at the time of hire and after subsequent periodic reviews. Review of personnel records on September 19, 2008, beginning at 4:35 PM, revealed the following:</p> <p>1. There were signed job descriptions in 10 of the 16 direct support staff records. There was no evidence, however, that a supervisor had reviewed job descriptions with 3 of those 10 staff within the past 12 months, as follows:</p> <p>a. The most recent job description discussion for S8 had been documented on June 4, 2007.</p> <p>b. The most recent job description review for S11 had been documented on September 22, 2006.</p> <p>c. S13 had signed his job description on September 10, 2006 and June 3, 2007, but not in the 15 months immediately prior to the survey.</p>	I 203	<p>1a. A updated signed job description needs to be obtained from S8.</p> <p>1b. S11 is no longer on the schedule.</p> <p>1c. An updated signed job description needs to be obtained from S13.</p>	<p>11-10-08</p> <p>9-30-08</p> <p>11-10-08</p>
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I 203	<p>Continued From page 7</p> <p>2. Cross-refer to I202. There were 6 direct support staff for whom there was no evidence that a supervisor had reviewed their job descriptions with them.</p> <p>3. There was no evidence that a supervisor had discussed the contents of the Residential Manager's job description since she was hired in June 2008.</p> <p>On September 22, 2008 (post-survey), the facility sent additional documentation via facsimile. The fax did not, however, include any additional information regarding job description reviews.</p> <p>This is a repeat deficiency. There was no evidence that the Human Resource Department, QMRP, Residential Manager and Shift Supervisors ensured compliance since their August 2007 annual licensure survey.</p> <p>*****</p> <p>Previously, a State Licensure Deficiency Report dated August 10, 2007 included the following: "Interview with Qualified Mental Retardation Professional (QMRP) and review of the personnel records on August 6, 2007, at 2:50 PM, and August 10, 2007, at 9:53 AM, revealed the GHMRP failed to provide evidence that three staff had the contents of their job descriptions discussed with them at the beginning of employment and/or annually thereafter."</p> <p>In a Plan of Correction, dated September 4, 2007, the GHMRP wrote the following: "In the future, job descriptions will be signed immediately at the completion of training, filed accordingly, and reviewed and signed annually by the direct care staff. The complete personnel folders, to</p>	I 203	<p>2. See 1202, Page 5 & 6</p> <p>3. See 1202, #2, Page 6</p> <p>The former plan of correction will be implemented as stated and job descriptions will be signed and filed accordingly at the completion of the training. This practice will be completed by the Residential Manager with follow up by the QMRP.</p>	<p>11-10-08</p> <p>11-10-08</p> <p>Ongoing</p>
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I 203 Continued From page 8
include signed job descriptions, will be available for review... This practice will be conducted by the Human Resource Department with oversight by the QMRP, Residential Manager and Shift Supervisors."

I 203

I 204 3509.4 PERSONNEL POLICIES
Each employee shall be given a copy of his or her job description to review and sign at the beginning of employment.

This Statute is not met as evidenced by:
Based on interview and record review, the GHMRP failed to provide evidence that the each employee had received a written job description to review and sign at the beginning of employment.

The findings include:

Cross-refer to I202.

1. There was no evidence that S2, S4, S12, S14, S15 and S16 received a written job description at the time of hire to review and sign, in accordance with facility policies.

2. There was no evidence that the Residential Manager received a written job description to review and sign after she was hired in June 2008.

This is a repeat deficiency. There was no evidence that the Human Resource Department, QMRP, Residential Manager and Shift Supervisors Administrative Assistant ensured compliance since their August 2007 annual licensure survey.

I 204

1. A job description needs to be obtained for S2. S4 is no longer employed. A job description was obtained for S12, S14, and S16. S15 is no longer employed.

2. See 1202, #2

11-10-08
10-31-08
11-10-08

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I 204	<p>Continued From page 9</p> <p>Previously, a State Licensure Deficiency Report dated August 10, 2007 cited the GHMRP's failure to provide evidence that three staff had received written job descriptions at the beginning of employment.</p> <p>In a Plan of Correction, dated September 4, 2007 - Citation I203, the GHMRP wrote the following: "In the future, job descriptions will be signed immediately at the completion of training, filed accordingly, and reviewed and signed annually by the direct care staff. The complete personnel folders, to include signed job descriptions, will be available for review... This practice will be conducted by the Human Resource Department with oversight by the QMRP, Residential Manager and Shift Supervisors."</p>	I 204		
I 206	<p>3509.6 PERSONNEL POLICIES</p> <p>Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that all staff obtained annual health certificates/ inventories.</p> <p>The findings include:</p> <p>Review of the personnel records on September 19, 2008, beginning at 4:35 PM, revealed the</p>	I 206		

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I 206	<p>Continued From page 10</p> <p>following:</p> <ol style="list-style-type: none"> There were no health certificates/ inventories made available for review for 6 of the 16 direct support staff (S3, S4, S6, S7, S8 and S12). The health certificates/ inventories on file for 5 of the remaining 10 direct support staff had expired, as follows: (S1 expired on 7/24/07; S2 8/13/08; S9 6/1/08; S11 9/22/07; and S13 6/3/08). There were no personnel records made available for review onsite for 3 staff (S14, S15 and S16); therefore, there was no evidence that they had obtained a health inventory. There was no health certificate/ inventory made available for review for the Residential Manager. The health certificate/ inventory on file for the consulting primary care physician had expired on August 15, 2008. There were no health certificates/ inventories made available for review for the consulting social worker, occupational therapist and podiatrist. <p>On September 22, 2008 (post-survey), the facility sent additional documentation via facsimile. The fax did not, however, include evidence of health certificates/ inventories for the above-referenced employees.</p> <p>This is a repeat deficiency. There was no evidence that the Human Resource Department, Qualified Mental Retardation Professional</p>	I 206	<ol style="list-style-type: none"> *S3 health certificate was obtained *S4 is no longer employed *A health certificate needs to be obtained for S6 *A health certificate needs to be obtained for S7 *S8 health certificate was obtained *S12 health certificate was obtained *A health certificate needs to be obtained for S1 *A health certificate needs to be obtained from S2 *A health certificate needs to be obtained from S9 *S11 is no longer on the schedule *A health certificate needs to be obtained for S13 *S14 – See 1202, 1b *S15 is no longer employed *S16 – See 1202, 1b A health certificate was obtained for the Residential Manager An updated health certificate needs to be obtained for the primary care physician. A health certificate needs to be obtained for the social worker, occupational therapist, and podiatrist. 	<p>10-31-08 - 11-10-08 12-31-08 10-31-08 10-31-08 12-31-08 12-31-08 12-31-08 - 12-31-08 11-30-08 11-30-08 9-20-08 11-30-08</p>
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I 206	<p>Continued From page 11</p> <p>(QMRP) and/or Assistant Administrator ensured compliance since their August 2007 annual licensure survey.</p> <p>*****</p> <p>Previously, a State Licensure Deficiency Report, dated August 10, 2007, included the following: "Interview with Qualified Mental Retardation Professional (QMRP) and review of the personnel records on August 6, 2007, at 2:50 PM, and August 10, 2007, at 9:53 AM, revealed the facility failed to provide evidence that seventeen (17) staff, two (2) nurses and seven (7) professional consultants had current health certificates on file."</p> <p>In a Plan of Correction, dated September 4, 2007, the GHMRP wrote the following: "In the future, the Human Resource Department will provide all persons requesting an application for employment with a copy of the... form that must be filled out by their physician and submitted with their completed application packet... Current employees will be given a copy of the form along with a 60 day notification letter... Should the employee not submit the completed form as requested... said employee will be placed on administrative leave until the information... personnel records will be reviewed on a quarterly basis by the Human Resource Department. This process will be monitored by the QMRP along with the Assistant Administrator."</p>	I 206		
I 227	<p>3510.5(d) STAFF TRAINING</p> <p>Each training program shall include, but not be limited to, the following:</p> <p>(d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the</p>	I 227		

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I 227	<p>Continued From page 12</p> <p>Heimlich maneuver, disaster plans and fire evacuation plans;</p> <p>This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to effectively train staff to implement emergency measures for six of the six residents of the facility. (Residents #1, #2, #3, #4, #5 and #6)</p> <p>The findings include:</p> <p>During the September 17, 2008 Entrance Conference, at approximately 10:50 AM, the Qualified Mental Retardation Professional (QMRP) stated that all staff were expected to maintain current Cardiopulmonary Resuscitation (CPR) certification and First Aid training. Newly-hired staff reportedly were asked to secure said training and certification within 30 days. She further stated that staff were "definitely" expected to have CPR and First Aid training "by the end of their 90-day probationary period."</p> <p>On September 19, 2008, beginning at approximately 4:35 PM, review of staff and consultant records revealed the following:</p> <ol style="list-style-type: none"> 1. There was no documented evidence of CPR certification and First Aid training for 5 of the 14 direct support staff (S6, S11, S12, S15 and S16) who had been employed for longer than 90 days. 2. There was no documented evidence of CPR certification and First Aid training available for the Residential Manager (employment application dated June 1, 2008). 3. There was no documented evidence of CPR 	I 227	<ol style="list-style-type: none"> 1. CPR training will be scheduled for the staff listed in the Statement of Deficiencies Report. However, S4, and S15 are no longer employed with Westview, Inc. In the future, the QMRP will ensure that all staff are trained in CPR and First Aid upon completion of the orientation and within 30 days of being hired. Oversight will be conducted by the Quality Assurance Coordinator. 2. The Residential Manager will also be scheduled for CPR and First Aid training. 3. Verification that the Trained Medication Employee was trained in CPR and First Aid will be obtained. Should it be noted that he/she is not trained, he/she will be scheduled to take the training with the other employees in need of the trainings. 	<p>11-30-08</p> <p>11-30-08</p> <p>11-30-08</p>
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I 227	Continued From page 13 certification for the Trained Medication Employee who routinely administered medications during the morning medication pass. On September 22, 2008 (post-survey), the facility sent additional documentation via facsimile. The fax did not, however, include evidence of CPR certification and First Aid training for the above-referenced employees.	I 227		
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure direct care staff had current training on the use of manual restraint on Client #4 to prevent him from harming self or others. The finding is: On September 18, at 4:40 PM, loud verbal outbursts were noted to be coming from the first floor. Observation a few minutes later revealed Client #4 lying on the dining room floor kicking, attempting to get up, and intermittently yelling loudly. During this time he was being physically restrained by two male staff. Interview with the staff revealed the client was being restrained because he exhibited physical aggression and attempted to exit the facility. Hr remained on the	I 229	Upon finding a trainer, all staff will be trained accordingly in using manual restraints and dealing with persons with difficult behaviors. Retraining will be conducted annually, as recommended by the instructor, as needed, and when new staff are hired. The QMRP will ensure that this practice is carried out with follow up conducted by the Quality Assurance Coordinator.	12-31-08

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I 229	<p>Continued From page 14</p> <p>floor for approximately 5 more minutes, and was then assisted to stand. Staff indicated that the client would not allow them to change his soiled protective undergarment. He was observed to continue to attempt to exit the facility</p> <p>The review of Client #4's Personal Behavior Support Plan (PBSP) revealed "As a last resort it may be necessary for staff to use manual restraint to prevent or stop him from harming self or others. This should be done by staff identified and authorized by (the GHMRP) as having been trained in using these techniques to manage physical aggression, preferably by more than one staff person. This often does involve force does involve holding him, moving him to another room, physically stopping a fight..."</p> <p>The review of training record on 9/19/08 revealed direct care staff had received training on the client's behavior support plans on..... Further review of training records however revealed no evidence of current training to staff on the use of manual restraint. The QMRP acknowledged that direct staff lacked current certification in the use of manual restraints to manage the clients' physically aggressive behaviors had expired.</p>	I 229		
I 271	<p>3513.1(b) ADMINISTRATIVE RECORDS</p> <p>Each GHMRP shall maintain for each authorized agency's inspection, at any time, the following administrative records:</p> <p>(b) Personnel records for all staff including job descriptions either at the GHMRP or in a central office and made available upon request;</p> <p>This Statute is not met as evidenced by: Based on record review, the GHMRP failed to</p>	I 271		

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1271	<p>Continued From page 15</p> <p>provide evidence of personnel records for all staff.</p> <p>The findings include:</p> <p>On September 17, 2008, at 11:17 AM, the Qualified Mental Retardation Professional (QMRP) was given a list of documents and information needed for completion of the survey. She agreed to present personnel records for all employees.</p> <p>1. On September 19, 2008, beginning at 4:35 PM, review of the files made available revealed no evidence of a personnel record being maintained for 3 direct support staff (S14, S15 and S16). The survey ended later that evening.</p> <p>2. On September 22, 2008, the facility sent additional documentation via facsimile. The faxed information reflected current CPR and First Aid for S14. However, no additional information that had been requested during the survey for this employee was made available for review.</p> <p>3. The September 22, 2008 facsimile received from the facility (post-survey) reflected S15's resume. However, no additional information that had been requested during the survey for this employee was made available for review.</p> <p>4. The September 22, 2008 facsimile received from the facility (post-survey) reflected no personnel-related information that had been requested during the survey for S16.</p> <p>This is a repeat deficiency. There was no evidence that the QMRP and Assistant Administrator established, maintained and made available for review complete personnel records</p>	1271	<p>1. The personnel folder for S14 was misplaced, but has since been located. S15 is no longer employed with Westview, Inc. The personnel folder for S16 was also misplaced and will be reconstructed to meet compliance. The newly hired Administrative Aide was appointed to maintain all personnel folders to ensure compliance. Oversight will be conducted by the Quality Assurance Coordinator.</p> <p>2. As noted above, S14's personnel folder was misplaced but has since been located. It will be reconstructed for compliance.</p> <p>3. S15 is no longer employed with Westview, Inc.</p> <p>4. As noted above, S16's personnel folder was misplaced and is being reconstructed for compliance.</p>	<p>10-31-08</p> <p>11-30-08</p> <p>11-30-08</p>

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1271	<p>Continued From page 16 for all employees.</p> <p>*****</p> <p>Previously, a State Licensure Deficiency Report dated August 10, 2007 included the following: "Interview with Qualified Mental Retardation Professional (QMRP) and review of the personnel records on August 6, 2007, at 2:50 PM, and August 10, 2007, at 9:53 AM, revealed the GHMRP failed to provide evidence of personnel files for the two direct care staff, and two professional consultants."</p> <p>In a Plan of Correction, dated September 4, 2007, the GHMRP wrote the following: "In the future, the Human Resources Department will ensure that all employees have a personnel folder in the facility... is complete, and available for review... The QMRP and the Assistant Administrator will monitor this process."</p>	1271	<p>Due to the overwhelming worked load of both the QMRP and Administrative Assistant and Administrative Aide was appointed to maintain all personnel records. She will be given the necessary forms to complete record reviews for compliance. The audit will be conducted quarterly with oversight by the Quality Assurance Coordinator.</p>	10-1-08
1274	<p>3513.1(e) ADMINISTRATIVE RECORDS</p> <p>Each GHMRP shall maintain for each authorized agency ' s inspection, at any time, the following administrative records:</p> <p>(e) Signed agreements or contracts for professional services;</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide evidence of a signed agreement or contract with each consultant providing professional services.</p> <p>The findings include:</p> <p>Interview with the Qualified Mental Retardation</p>	1274		

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1 274	<p>Continued From page 17</p> <p>Professional and review of personnel records on September 19, 2008 revealed no evidence that the GHMRP had entered into written agreements or contracts with the consulting:</p> <ol style="list-style-type: none"> 1. podiatrist, and 2. psychiatrist. <p>On September 22, 2008 (post-survey), the facility sent additional documentation via facsimile. The fax did not, however, include evidence of written agreements or contracts with the above-referenced health professionals.</p>	1 274	<ol style="list-style-type: none"> 1. The QMRP was unaware that the Podiatrist needed the required personnel documents. The surveyor on sight explained to the QMRP that sine he provides services in the home, he should be considered as any other consultant. The required documentation will be requested and maintained as required. 2. A signed contract will be obtained from the Psychiatrist as required. 	<p>11-30-08</p> <p>11-30-08</p>
1 401	<p>3520.3 PROFESSION SERVICES: GENERAL PROVISIONS</p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to provide preventive and general health services in accordance with the needs of three of the six residents residing in the facility. (Residents #2, #3 and #4)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The facility failed to ensure recommended medical follow-up for Resident #4 to address his podiatry needs. <p>Observation of Resident #4 on September 17, 2008 at 5:37 PM revealed the Registered Nurse</p>	1 401		

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I 401	<p>Continued From page 18</p> <p>(RN) applied Naftin 1% Gel to his left hand and right foot. It should be noted that according to direct support staff, Resident #4 routinely took a shower every evening before bedtime. On September 18, 2008, at approximately 8:50 AM, review of Resident #4's POs (dated August 1, 2008) revealed that the gel was to be applied between his toes and to his plantar foot at 6:00 AM every morning. The MAR sheet for September 2008 did not reflect a 6:00 AM administration. Instead, there was a handwritten "pm" for the designated time.</p> <p>Further record review on September 18, 2008 at 9:45 AM revealed that Resident #4 was assessed by the podiatrist on December 18, 2007. The podiatrist diagnosed bilateral interdigital tinea (foot fungus). Naptin 1% Gen between toes daily for two months was prescribed. Podiatry follow-up in three months was recommended. Interview with the Director of Nursing (DON) and additional record review on September 19, 2008 at 5:15 PM confirmed that the resident had no podiatry follow - up until eight months later, August 13, 2008, .</p> <p>On August 13, 2008, the podiatrist diagnosed the resident with interdigital and plantar tinea pedis. Naftin 1% get between and on bottom of feet daily was prescribed. There was no evidence, however that Resident #4 received timely podiatry follow-up and treatment services to alleviate his foot fungus.</p> <p>2. Cross refer to W356 on the Federal Deficiency Report. The facility failed to ensure Resident #4 was assessed to determine the origin of his recurrent tooth abscesses. Unusual incident reports revealed that Resident #4 was treated at th emergency room on July 15, 2008 and August</p>	I 401	<p>1. Correction to the Statement of Deficiencies, the podiatrist order reads Naftin 1% gel between the toes and the bottom of the feet every day for 90 days. The nurse assures that on the day in questioned, the medication was applied appropriately. As for the Physician's Orders, the Pharmacist inadvertently transcribed the orders incorrectly to read PRN instead of daily (QD). This has since been corrected by the Nursing Coordinator to read Naftin Gel 1% gel between the toes and the bottom of the feet every day (QD) for 90 days and will be applied at night in order to be effective; however, QD can either be day or night. Due to abrupt change over in Nursing Personnel, the initial follow up was not initially implemented. However, in the future, all follow up will be conducted by the Nursing Coordinator as recommended and ordered by consulting physicians and the Primary Care Physician. Oversight will be conducted by the Quality Assurance Coordinator to ensure compliance.</p>	10-1-08
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PRINTED: 10/21/2008
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1401	<p>Continued From page 19</p> <p>2, 2008 for tooth abscesses. The review of the discharge summaries revealed recommendation for follow-up assessment at the dental clinic in five days. At the time of the survey, there was no evidence that he recommended assessment had not been conducted.</p> <p>3. On July 7, 2008, Resident #3 was taken to the emergency room for evaluation due to feeling hot and refusal to eat. The review of the discharge summary revealed the resident had a chief complaint of cough and fever. He was diagnosed with bronchitis and was treated with an intravenous antibiotic. A chest X-ray performed during the hospitalization showed a foreign body in the resident's neck. Due to the discovery of the foreign body, a CT scan of the neck was by which two linear foreign bodies were observed in the retropharyngeal and prevertebral soft tissues. The consulting ENT specialist determined there was no evidence of airway distress or dysphagia and that the resident's foreign bodies could be followed on an outpatient basis. A discharge summary revealed the resident was readmitted to the group home on July 15, 200, however continued on oral antibiotics.</p> <p>On July 18, 2008 a consultation report written by the primary care physician (PCP) noted that the resident had been treated in the hospital for pneumonia and a foreign found in his neck. The PCP recommended ENT f/u to assess the status of the foreign body and that the resident continue on the antibiotics. During a the ENT visit on July 22, 2008, the specialist documented that he was unable to evaluate the metal in the resident's neck because he was uncooperative. He therefore recommended to (1) obtain the CD with actual images of the CT scan of the neck from the hospitalization; (2) Sedate the patient</p>	1401	<p>2. Client #4 was scheduled for dental follow up as recommended during visits to the emergency room. He was scheduled on July 17th to see the selected dentist and when taken to the office, he refused to get out of the van in order to go into the dental office. During this time, his regular dentist was on vacation. The Nursing Coordinator consulted DC General Hospital to schedule an appointment. Upon describing current problem it was recommended and noted that he could be maintained until the return of hi usual dentist. During this time, Client #4 was on antibiotic and the Nursing Coordinator continued to seek an alternative dentist to render the recommended follow up and care. In the future, the Nursing coordinator will continue to implement all recommend follow up services in a timely manner. Oversight will be conducted by the Quality Assurance Coordinator.</p>	10-1-08

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1401	<p>Continued From page 19</p> <p>2, 2008 for tooth abscesses. The review of the discharge summaries revealed recommendation for follow-up assessment at the dental clinic in five days. At the time of the survey, there was no evidence that he recommended assessment had not been conducted.</p> <p>3. On July 7, 2008, Resident #3 was taken to the emergency room for evaluation due to feeling hot and refusal to eat. The review of the discharge summary revealed the resident had a chief complaint of cough and fever. He was diagnosed with bronchitis and was treated with an intravenous antibiotic. A chest X-ray performed during the hospitalization showed a foreign body in the resident's neck. Due to the discovery of the foreign body, a CT scan of the neck was by which two linear foreign bodies were observed in the retropharyngeal and prevertebral soft tissues. The consulting ENT specialist determined there was no evidence of airway distress or dysphagia and that the resident's foreign bodies could be followed on an outpatient basis. A discharge summary revealed the resident was readmitted to the group home on July 15, 200, however continued on oral antibiotics.</p> <p>On July 18, 2008 a consultation report written by the primary care physician (PCP) noted that the resident had been treated in the hospital for pneumonia and a foreign found in his neck. The PCP recommended ENT f/u to assess the status of the foreign body and that the resident continue on the antibiotics. During a the ENT visit on July 22, 2008, the specialist documented that he was unable to evaluate the metal in the resident's neck because he was uncooperative. He therefore recommended to (1) obtain the CD with actual images of the CT scan of the neck from the hospitalization; (2) Sedate the patient</p>	1401	<p>3. As stated in the Statement of Deficiencies, it was noted that client #3 had two foreign bodies located in the soft tissues of his neck. Client #3 was followed up with ENT as recommended. According to the report he did not need to return unless risk factors were observed, such as difficulty swallowing or shortness of breath, at which time he would be taken to the emergency room. Thereafter, he would be followed up by ENT. The Nursing Coordinator will in-service staff on what signs and symptoms to look for that would indicate Client #3 being at risk in regards to the foreign bodies in his neck. Nursing assessments will also be conducted during the medication pass.</p> <p>In addition, the Nursing Coordinator will recommend to the Primary Care Physician that the CT Scan be repeated in order to obtain a more definitive diagnosis or etiology of the foreign bodies.</p>	<p>11-15-08</p> <p>11-15-08</p>
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I 401	<p>Continued From page 20</p> <p>adequately for thorough examination on next visit, including flexible nasal endoscopy and possible ear cleaning, (3) Return visit in two weeks.</p> <p>During the next appointment on September 4, 2008 six weeks later, the ENT reviewed the CT scan of the resident's neck and noted that it showed metallic foreign bodies in the left nasopharynx and right supraglottic region. In accordance with the CT scan results, he again recommended naso-endoscopy and laryngoscopy. He further noted however that due to the resident inability to cooperate, the procedures could not be performed. The recommended procedures were deferred pending the occurrence of symptoms of distress, such as fevers, decreased neck range of motion limitation or sore throat. Interview with the Director of Nursing (DON) indicated the resident would continue to be monitored and that he would be taken to the ER if the aforementioned symptoms occur. Although the facility had taken the approach of monitoring the resident asymptotically, there was no evidence the origin of the metallic foreign bodies in the resident neck had been determined.</p> <p>(Note: Record review revealed the resident a physician ' s order for 1:1 staff s/day 7 days per week due to his maladaptive behaviors which included swallowing non-food items.)</p> <p>Based on interviews, and record verification, the facility's nursing services failed to establish systems to provide health care monitoring and identify services in accordance with residents' needs for three of six residents residing in the facility. (Resident #4)</p> <p>The findings include:</p>	I 401		

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I 401	Continued From page 21 1. The facility's nursing staff failed to ensure that Resident #4 received timely and appropriate oral hygiene and dental care supports and services to prevent a. Cross-refer to W356. Review of unusual incidents on September 17, 2008 revealed the resident had two dental emergencies for which he required services from a hospital emergency room. On July 15, 2008, he was diagnosed with poor dental hygiene, tooth abscess and gingivitis. He returned to the ER on August 2, 2008 at which time he was diagnosed with a periapical abscess. b. On September 19, 2008, at approximately xxxx PM, review of Resident #4's Health Management Care Plan (HMCP), dated xxxx, 2008, revealed that it failed to identify dental hygiene as a concern. There was no evidence that timely and ongoing interventions /strategies had been implemented to manage the resident's dental health. 2. The facility's nursing staff failed to ensure that Resident #4 received effective daily foot care and timely podiatry services, as follows: a. Cross-refer to W369.2. Nursing staff failed to ensure that Resident #4's Medication Administration Record (MAR) accurately reflected his physician's orders (POs). Specifically, his POs included an order for Naftin 1% gel apply between toes every morning at 6AM. A nurse, however, was observed applying the gel to his feet on the evening of September 17, 2008 (a short while before he took a shower). Review of his September MAR showed that someone had written "prn" as the designated time for applying the gel. On September 19, 2008, at	I 401	1. Numerous dental appointments, since 2007, were scheduled; however, due to Client #3's repeated non-compliance with getting off the van, appointments were not kept. However, every effort has been made of late, due to repeated abscess to obtain a successful and complete dental exam. In the future, the Nursing Coordinator will ensure that Client #4 receives timely and appropriate oral care. His next dental appointment is scheduled for October 30, 2008. 2. See 1401 #1 a. The Nursing Coordinator corrected the discrepancy on the MAR to accurately read, per the podiatrist's order, "apply Naftin 1% gel between the toes and to the bottom of the feet every day for 90 days. Every day could refer to the morning or evening; however, it is recommended that it be given after the evening shower in order to be more effective.	10-30-08 10-30-08 10-1-08
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I 401	Continued From page 22 approximately 4:50 PM, interview with the RN revealed no evidence that nursing staff had identified the discrepancy between his POs and MARs prior to the survey. b. Facility nurses failed to schedule podiatry visits at the prescribed intervals. On December 17, 2007, the podiatrist diagnosed bilateral interdigital tinea pedis and prescribed Naftin 1% gel to be applied between the resident's toes. The podiatrist recommended a follow-up appointment in three months. The next documented podiatry care, however, was provided eight months later, on August 13, 2008. The podiatrist found that in addition to interdigital tinea pedis, the fungal condition had spread to the soles of his feet. Naftin 1% gel was prescribed again. When interviewed on September 19, 2008, the QMRP and the DON had no explanation as to why the resident had not received treatment by the podiatrist timely. c. Facility nurses failed to update Resident #4's HMCP to address his tinea pedis. On September 18, 2008, at approximately xxxx AM, review of Resident #4's HMCP, dated xxxx, 2008, revealed that it failed to identify tinea pedis (foot fungus) as a concern. The was no evidence timely interventions /strategies had been implemented to address Resident #4's recurrent foot fungus. 3. Cross-refer to W368.1. Nursing staff failed to identify that Resident #2's MARs failed to reflect administration of Atarax once daily, as prescribed, for the 5 1/2 months preceding the survey (beginning April 1, 2008). On September 19, 2008, review of the blister pack of Atarax revealed that	I 401	3. The Nursing Coordinator addressed the issue regarding the Atarax and the prescribed time (s) that is to be given with the nursing staff. Due to the abrupt change in nursing personnel discrepancies may have occurred during the entrance of the new nursing staff. In the future, the Nursing Coordinator will ensure that all discrepancies are clarified before implementation.	10-1-08

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1401	Continued From page 23	1401		
	<p>4. Cross-refer to W369.1. For the first 17 days of September 2008, Resident #3's AM and PM doses of Carbamezapine had been reversed. He received 300 mg in the AM instead of PM and 400 mg in the PM instead of the AM. There was no evidence that nursing staff had identified the medication error prior to the survey.</p>		<p>4. See 1401 #3 According to the Nursing Coordinator, Client #3's Carbamezapine blister packs were labeled correctly and the colored baskets storing the medications were identified accordingly. The green basket has been identified for the morning medication and the purple basket for the evening medication. Each nursing personnel was instructed on the changes and how to administer the medication according to the physician's orders. In the future, the Nursing Coordinator will ensure that all medication blister packs and storage bins are labeled correctly.</p>	10-1-08
1422	3521.3 HABILITATION AND TRAINING	1422		
	<p>Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident 's Individual Habilitation Plan.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure consistent implementation of the individual habilitation plan for one (Resident #2) of three residents in the sample.</p> <p>The finding includes:</p> <p>The GHMRP failed to consistently implement Resident #2's communication objective recommended to enhance her communication skills as follows:</p> <p>On September 17, 2008 at approximately 8:20 AM, Resident #2 was observed seated on the couch in the lounge with her eyes closed. At 8:30 AM, a staff repeatedly told her it was time to leave for the day program and asked her to get up. After several requests, the resident answered in a barely audible voice, then got up from the couch and left the room with the staff. Staff indicated that the resident was receiving training to encourage her to speak louder.</p>			

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I 422	<p>Continued From page 24</p> <p>Review of Resident #2's Individual Support Plan (ISP) dated 10/22/07 reflected that an electronic communication system (Mini Merc) had been obtained for the Resident in accordance with the 2006 IDT recommendation. The Individual Program Plan (IPP) for 2007 - 2008 included a goal "to increase the resident's functional communication skills". The current objective to be implemented at the group home stated that "Given verbal prompts, Ms. ... will use her communication device to increase her consistency of scanning selections with 80% accuracy per session" as measured by active treatment documentation. Interview with group home staff indicated that the resident could use her Mini Merc daily if she desired. The IPP however required that the objective be implemented on Wednesdays only at the group home. Staff confirmed that the procedure was for the resident to take the Mini Merc to the day program in the morning and bring it back to the group home each evening so that it could be available to her in both settings.</p> <p>Interview with the day program instructor on September 17, 2008 at 12:35 PM revealed the resident is supposed to receive training using a a communication device at the group home and also at her day program. The resident had a day program communication objective "Ms...will increase her communication skills via AAC (include electronic device, signs and residual voice) with verbal prompts each day she is present with a month by October 31, 2008". The day program staff disclosed that the objective was currently not being implemented as scheduled because electronic device (Mini Merc) was broken.</p> <p>Subsequent interview with the day program</p>	I 422	<p>As indicated on the Statement of Deficiencies, Client #2's communication device was in repair at the time of the survey. However, the device has not inoperable since March 2008, but inoperable on two occasions, March 2008 and July 2008. Conversations were held with Essential Rehabilitation and the area of concern was if Medicaid would repair the device. The QMRP spoke with the Speech Pathologist, at Art and Drama, on 10/28/08 in regards to the device and was informed that Essential Rehabilitation repaired the device and would return it to the school within a week.</p> <p>However, in the future, if and/or when the communication device is broken the QMRP will ensure that Client #2 receives alternative communication skills training.</p> <p>Additionally, Client #2 had a formal objective, in the past to speak louder. However, this objective was never achieved because Client #2's voice only elevates when she is agitated or displaying verbally aggressive behaviors. She was diagnosed by the Speech Pathologist as having Apraxia that is having difficulty initiating speech sounds and in severe cases, an inability to produce sound at all. Therefore, the staff was instructed to <u>informally encourage Client #2 to</u></p>	<p>11-15-08</p> <p>ongoing</p> <p>ongoing</p>
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speaking louder daily during social interaction.

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I 422	Continued From page 25 instructor later that day revealed that the Mini Merc had been with the vendor for repairs since July 23, 2008. Record review revealed that the communication device had been with the vendor for repairs during three extended periods since March 11, 2008. At the time of the survey, There was no evidence the GHMRP ensured continuous active treatment for the resident in her communication objective at home and at her day program. See also Federal Deficiency Report - W436.	I 422	1. All staff were trained on Client #1's Behavior Support Plan that addresses his smoking. A smoking schedule has been established and explained to staff the importance of following the plan. It was also explained to them that although Client #1 cannot be denied smoking, we can only encourage him to smoke less as ordered by is doctor. A smoking schedule was developed and includes Client #1's involvement. The QMRP and the Residential Manger will monitor the program to ensure compliance.	10-1-08
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: A. Based on observation, interview and record review, the facility failed to allow and encourage individual residents to exercise their rights as residents of the facility, including self-determination and due process, for one of the three residents in the sample. (Resident #1) The findings include: 1. On September 17, 2008, at approximately 6:37 AM, Resident #1 lit a cigarette and went outside alone to smoke it. At approximately 6:41 AM, a staff person saw Resident #1 smoking outside, opened the door and spoke to him using a harsh tone of voice, saying: "<resident's first name> put it out! There's no smoking... Put it out!" He came back inside without the cigarette.	I 500		

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I 500	Continued From page 26 Later that day, at approximately 12:43 PM, Resident #1's day program case manager and nurse indicated that cigarettes were very important to him. The resident reportedly became angry if/when he was unable to smoke ("yeah big time... very agitated"). They further indicated that he smoked 2 cigarettes there at the day program and had an established smoking schedule at home. Later that afternoon, interview with the Qualified Mental Retardation Professional (QMRP), at approximately 4:55 PM, revealed that Resident #1 had agreed to a smoking schedule that included 1 cigarette first thing in the morning. There was no evidence that the staff person working the overnight/morning shift was aware that he was allowed to smoke a cigarette or otherwise encouraged him to exercise his personal right to smoke. 2. During the September 17, 2008 afternoon interview with the QMRP, she indicated that Resident #1 had agreed to smoke 4 cigarettes per day. Since that time, however, facility staff had tried to further reduce his smoking, to 2 per day. The resident reportedly expected to have 4 cigarettes per day. The QMRP confirmed what day program staff had stated previously, that his behaviors increased when staff curtailed his smoking. Resident #1's records were reviewed on September 18, 2008, beginning at 10:25 AM. He had signed a Residents' Rights form on June 5, 2006 and June 4, 2007, which included among other things "Right to live in the least restrictive setting and most normalized conditions." At 10:40 AM, review of his diagnoses revealed hypertension and chronic renal insufficiency,	I 500	2. A meeting will be scheduled with the Day Treatment Program to discuss Client #1's behaviors as well as review the Behavior Support Plan developed by the Psychologist and the home's smoking schedule.	11-15-08

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I 500	<p>Continued From page 27</p> <p>among others. At approximately 1:23 PM, review of his Individual Support Plan (ISP), dated December 12, 2007, revealed: "<resident's name> appreciates that he is given choices and the opportunity to participate in activities of interest to him..." Then, speaking in the first person: "I would like to continue to have choices as well as opportunities to participate in activities of interest to me." "<resident's name> has a history of smoking which is a risk factor associated with hypertension and renal insufficiency... I want staff to continue to monitor the number of cigarettes that I smoke to ensure that I stay within the established limit per day. I want to continue to be educated on the dangers of smoking and encouraged to decrease my smoking."</p> <p>At approximately 3:15 PM, a document "Standard Procedures Regarding Cigarettes," dated December 12, 2007, was reviewed. Resident #1 had signed it that same day. The document included: "...He does not want to stop smoking... Medically he should stop smoking... workable compromise was needed... schedule... own money... total 4 per day..." The document did not, however, specify what schedule he had agreed to. In addition, the facility's Human Rights Committee (HRC) had reviewed and approved the smoking agreement.</p> <p>Further review of Resident #1's record, however, failed to show evidence of an actual smoking schedule. Furthermore, interviews with staff in the home and at day program reflected conflicting statements, revealing no evidence that they were aware of a smoking schedule. The QMRP, and the Residential Manager who was present during the September 17, 2008 interview, both acknowledged that there had been no written</p>	I 500		

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I 500	Continued From page 28 schedule established to clearly delineate when and where he would smoke. 3. Resident #1 also was unaware of his smoke schedule. While the QMRP had indicated that he could smoke one at 4:00 PM, the resident stated at approximately 2:40 PM, that he would get a cigarette at 8:00 PM. Note: It was at Resident #1's request that he accompanied this surveyor to the QMRP's office to discuss his cigarettes. 4. The facility failed effectively coordinate and communicate Resident #1's day program, as follows: a. On September 17, 2008, his day program case manager and nurse both stated that he smoked 2 cigarettes there daily; the first at 10:00 AM and a second after lunch. During the interview with the QMRP later that day, however, she indicated that Resident #1 was only supposed to smoke 1 cigarette (total) while at day program. She said he was to break a cigarette in half, smoke part of it at 10:00 AM and then finish the second half after lunch. b. During the day program observations on September 17, 2008, the day program nurse was observed looking through a desk for cigarettes to give to Resident #1. She was unable to locate any. Several residents, including #1, were lined up, waiting to go outside after lunch for a smoke. The nurse and the day program case manager indicated that he would not have a cigarette that afternoon, as he had none. They suspected that others had smoked some of Resident #1's supply, and acknowledged that his supply was not secured under lock and key. They stated that his not having cigarettes often precipitated behavioral outbursts, yet he was also instructed	I 500	3. Client #1 and the QMRP have verbally discussed his smoking times and Client # 1 can indicate that he smokes at 10AM, 2PM, 4PM and 8PM. The schedule was presented to him in writing. 4a. Corrections to the Statement of Deficiencies, the QMRP stated that in the past he was down to one cigarette a day a the Day Treatment Program and at that time agreed to smoke half in the morning and the second half after lunch. Currently the times are 10 AM and on or around 2:00 PM, which is after lunch. However, the QMRP will schedule a meeting to jointly review Client #1's Behavior Support Plan that addresses smoking, and an effective schedule for the home and the day treatment program in an effort to decrease the behaviors centered around smoking.	10-1-08 11-1-08

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1500	<p>Continued From page 29</p> <p>to not ask others for a cigarette. At approximately 1:10 PM, Resident #1 was observed sitting outside with the others, watching as they smoked. When approached, he asked this surveyor for a cigarette. He stated that he had been out of cigarettes there "for a couple of days." There was no evidence that the facility ensured that his cigarettes were stored in a secure manner at day program.</p> <p>5. Resident #1's "Standard Procedures Regarding Cigarettes," dated December 12, 2007, indicated that the resident would smoke 4 cigarettes per day. This was not, however, reflected in his Health Management Care Plan (HMCP), dated December 31, 2007. The HMCP said he would only smoke 2 cigarettes per day. There was no evidence that the nurse and QMRP had effectively communicated to ensure consistent application of the resident's agreed-upon "schedule."</p> <p>6. Cross-refer to Federal Deficiency Report - Citation W262. During the September 17, 2008 afternoon interview with the QMRP, she indicated that facility staff had reduced Resident #1's smoking to 2 cigarettes per day. That was consistent with what the nurse wrote in the HMCP. However, the agreement that the resident signed December 12, 2007 was for 4 cigarettes per day. There was no evidence that Resident #1 consented to smoking fewer than 4 per day. The Human Rights Committee (HRC) had approved the initial December 12, 2007 procedures/ agreement, for 4 cigarettes. There was no evidence that the HRC had approved limiting him to just 2 per day. In addition, there was no evidence that the HRC sought to determine whether Resident #1's December 2007 agreement was being implemented as written, to</p>	1500	<p>4b. In the past, the day treatment program was provided with a pack of cigarettes with the understanding that 20 cigarettes at 2 a day would last him approximately 2 weeks. In an effort to assist Client #1 with maintaining his smoking schedule, he will be provided with his cigarettes on a daily basis to carry on his person to the day treatment program so that he will have them to smoke at the appropriate smoking times, as well as not allow his cigarettes to be given to others.</p> <p>5. The Health Management Care Plan will be updated by the new Nursing Coordinator to indicate Client #1's current smoking plan.</p>	<p>ongoing</p> <p>11-15-08</p>

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I 500	Continued From page 29 to not ask others for a cigarette. At approximately 1:10 PM, Resident #1 was observed sitting outside with the others, watching as they smoked. When approached, he asked this surveyor for a cigarette. He stated that he had been out of cigarettes there "for a couple of days." There was no evidence that the facility ensured that his cigarettes were stored in a secure manner at day program. 5. Resident #1's "Standard Procedures Regarding Cigarettes," dated December 12, 2007, indicated that the resident would smoke 4 cigarettes per day. This was not, however, reflected in his Health Management Care Plan (HMCP), dated December 31, 2007. The HMCP said he would only smoke 2 cigarettes per day. There was no evidence that the nurse and QMRP had effectively communicated to ensure consistent application of the resident's agreed-upon "schedule." 6. Cross-refer to Federal Deficiency Report - Citation W262. During the September 17, 2008 afternoon interview with the QMRP, she indicated that facility staff had reduced Resident #1's smoking to 2 cigarettes per day. That was consistent with what the nurse wrote in the HMCP. However, the agreement that the resident signed December 12, 2007 was for 4 cigarettes per day. There was no evidence that Resident #1 consented to smoking fewer than 4 per day. The Human Rights Committee (HRC) had approved the initial December 12, 2007 procedures/ agreement, for 4 cigarettes. There was no evidence that the HRC had approved limiting him to just 2 per day. In addition, there was no evidence that the HRC sought to determine whether Resident #1's December 2007 agreement was being implemented as written, to	I 500	6. Correction to the Statement of Deficiencies, the QMRP indicate that he smokes 2 at the Day Treatment Program and 2 at home in the evenings. This would bring a total of 4 cigarettes per day on holidays, weekends, and when he stays home due to medical appointments. The Human Rights Committee agreed to the plan that is currently being implemented. The team was not approached regarding him smoking 2 a day. The HRC will convene on November 6, 2008 and the current smoking schedule and the Behavior Support Plan will be reviewed.	11-6-08

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I 500	Continued From page 30 ensure that his rights were protected. It should be noted that attempts to reach Resident #1's brother by telephone during the survey were unsuccessful. His brother had attended the December 12, 2007 ISP meeting. Interviews with facility staff and review of the resident's record revealed that the brother remained involved in the resident's life. Without speaking with the brother, however, it remained unclear what was his understanding of his brother's smoking schedule. B. Cross-refer to Federal Deficiency Report - Citation W249. The facility failed to consistently implement Resident #2's individual program plan (IPP) to enhance her communication skills. C. Cross-refer to Federal Deficiency Report - Citation W322. The facility failed to provide preventive and general medical care for Residents #3 and #4. D. Cross-refer to Federal Deficiency Report - Citations W368 and W369. The facility failed to ensure that all medications were administered in accordance with Resident #2's, #3's and #4's physician's orders. E. Cross-refer to Federal Deficiency Report - Citation W436. The facility failed to ensure the communication device/aids prescribed by Resident #2's interdisciplinary team (IDT) was maintained in good repair and available for use, and failed to ensure that Resident #1 was trained and encouraged to use his eye glasses.	I 500	B. See W249 C. See W322 D. See W368 and W369 E. See W436	11-15-08 10-1-08 10-1-08 ongoing

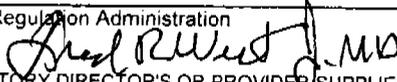
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R 122	<p>4701.2 BACKGROUND CHECK REQUIREMENT</p> <p>Except as provided in section 4701.6, each facility shall obtain a criminal background check, and shall either obtain or conduct a check of the District of Columbia Nurse Aide Abuse Registry, before employing or using the contract services of an unlicensed person.</p> <p>This Statute is not met as evidenced by: Based on interview and review of personnel records, the GHMRP failed to ensure criminal background checks had been obtained before employing or using the contract services of an unlicensed person.</p> <p>The findings include:</p> <p>On September 17, 2008, the Qualified Mental Retardation Professional (QMRP) agreed to provide documentation needed to show evidence of criminal background checks for all staff employed in the facility. On September 19, 2008, beginning at 4:35 PM, review of the materials presented revealed the following:</p> <ol style="list-style-type: none"> 1. Review of 2 direct support staff persons' personnel records (S4 and S5) revealed no documented evidence that a background check had been obtained prior to employment. Their employment applications had been signed on 7/7/08 and 1/21/05, respectively. 2. There was no personnel information made available for 3 direct support staff (S14, S15 and S16); therefore, there was no evidence that a background check had been obtained prior to employment. <p>On September 22, 2008 (post-survey), the facility sent additional documentation via facsimile. The</p>	R 122	<p><i>Received 11/3/08</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> <p><i>i. S4 no longer employed S5 Folder was misplaced and being recompiled some information obtain and attach 11-15-08 S4 Folder was misplaced and being recompiled some info obtained. S15 no longer employed S16 recompiled 11-30-08</i></p>	<p><i>11-15-08</i></p> <p><i>11-15-08</i></p> <p><i>11-30-08</i></p>
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Health Regulation Administration

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

Administrator TITLE

October 31, 2008 (X6) DATE

Health Regulation Administration

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R 122	Continued From page 1 fax did not, however, include evidence of criminal background checks for the above-referenced employees. It should be noted that there were two additional staff (S2 and S7) for which there was no evidence of comprehensive criminal background checks, to include all jurisdictions in which he/she lived or worked (see R125).	R 122		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on the review of personnel records, the GHMRP failed to ensure criminal background checks for all jurisdictions in which the employees had worked or resided within the seven (7) years prior to the check. The findings include: On September 17, 2008, the Qualified Mental Retardation Professional (QMRP) agreed to provide documentation needed to show evidence of criminal background checks for all staff employed in the facility. On September 19, 2008, beginning at 4:35 PM, review of the personnel materials presented revealed the following: 1. There was no evidence of comprehensive criminal backgrounds checks for two direct support staff (S2 and S7), as follows:	R 125		

S2 background check will be obtain S7 background check will be obtain 11-15-08

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R 125	<p>Continued From page 2</p> <p>a. A District of Columbia background check had been documented for S2 on July 14, 2008. However, her personnel records indicated that she had lived in Maryland and there was no evidence that a background check had been obtained in that jurisdiction.</p> <p>b. Similarly, a District of Columbia background check had been documented for S7 on April 7, 2004. Her personnel records indicated that she had lived and worked in Maryland. There was no evidence that a background check had been obtained in that jurisdiction, even though her name had been included on the Staff Identifier list that accompanied the August 10, 2007 State Deficiency Report.</p> <p>2. In addition, there was no personnel information made available for another 3 direct support staff (S14, S15 and S16); therefore, there was no evidence that a background check had been obtained in every jurisdiction in which they had lived and worked during the 7 years prior to his or her hiring.</p> <p>This is a repeat deficiency. There was no evidence that the Human Resource Department, Qualified Mental Retardation Professional (QMRP) and/or Assistant Administrator ensured compliance since their August 2007 annual licensure survey.</p> <p>*****</p> <p>Previously, a State Licensure Deficiency Report, dated August 10, 2007, included the following: "Interview with Qualified Mental Retardation Professional (QMRP) and review of the personnel records on August 6, 2007, at 2:50 PM, and</p>	R 125	<p>S2 a maryland background check will be obtain</p> <p>b. S7 a maryland background check will be obtain</p> <p>S14 has been compiled and attach. S15 no longer employed S16 was mis placed will be compiled</p>	<p>11-15-08</p> <p>11-15-08</p>
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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 09/19/2008
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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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R 125	<p>Continued From page 3</p> <p>August 10, 2007, at 9:53 AM, revealed the facility failed to provide evidence that seventeen (17) staff, two (2) nurses and seven (7) professional consultants had current health certificates on file."</p> <p>In a Plan of Correction, dated September 4, 2007, the GHMRP wrote the following: "In the future, the Human Resource Department will provide all persons requesting an application for employment with a copy of the... form that must be filled out by their physician and submitted with their completed application packet... Current employees will be given a copy of the form along with a 60 day notification letter... Should the employee not submit the completed form as requested... said employee will be placed on administrative leave until the information... personnel records will be reviewed on a quarterly basis by the Human Resource Department. This process will be monitored by the QMRP along with the Assistant Administrator."</p>	R 125	<p>A new admin aide has been hired to obtain all personnel documentation, appropriate forms to complete rec. Revised and request req. information has been giving to the admin aide on going mon. will cert.</p>	10-1-08
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