

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

PRINTED: 06/30/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G037	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/23/2011
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NAME OF PROVIDER OR SUPPLIER  COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3815 ALBERMARLE STREET NW WASHINGTON, DC 20008
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(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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W 000 INITIAL COMMENTS

A recertification survey was conducted from June 21, 2011 through June 23, 2011. A sample of three clients was selected from a population of six males with various cognitive and intellectual disabilities. This survey was conducted utilizing the fundamental survey process.

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

W 124 483.420(a)(2) PROTECTION OF CLIENTS RIGHTS

The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.

This STANDARD is not met as evidenced by:  
Based on interview and record review, the facility failed to ensure the rights of each client and/or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment, for one of three clients included in the sample. (Client #2)

The finding includes:

The facility failed to provide evidence that informed consent was obtained from Client #2's

An informed consent will be obtained from Client #2's guardian prior to the administration of sedation.

*Received 7/12/11*  
Department of Health  
Health Regulation & Licensing Administration  
Intermediate Care Facilities Division  
800 North Capitol St., N.E.  
Washington, D.C. 20002

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Constance C. Keen* Program Director  
TITLE  
(X5) DATE  
7/12/11

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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(X4) ID PREFIX TAG  <b>W 124</b>	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG  <b>W 124</b>	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE  <b>7/15/11</b>
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**W 124** Continued From page 1  
brother for sedation prior to a dental appointment, as evidenced below:

During the entrance conference on June 21, 2011, at 11:19 a.m., interview with the Qualified Intellectual Disabilities Professional (QIDP) revealed that Client #2 had a brother that operated as the client's designated surrogate healthcare decision-maker due to the client's inability to give informed consent for the use of his medications.

On June 22, 2011, at 2:02 p.m., review of Client #2's medical book revealed a written physician's order dated January 27, 2011, that documented that Client #2 was to receive Ativan 2 mg by mouth one hour prior to a dental appointment on February 9, 2011. Review of the Medication Administration Record (MAR) on the same day at 2:08 p.m., revealed that on February 9, 2011, Client #1 did receive Ativan 2 mg prior to his dental appointment.

Interview with the House Manager (HM) on June 24, 2011, at approximately 11:25 a.m., confirmed that Client #1 did receive the aforementioned sedation as ordered. Further interview with the HM revealed that the consent for the use of Ativan had not been obtained prior to administering the medication.

On June 22, 2011, at 3:00 p.m., review of Client #2's psychological assessment dated September 2010, confirmed that the client lacked the capacity to grant, refuse, or withdraw consent to any ongoing medical treatment. At the time of the survey, the facility failed to provide evidence that Client #2's treatment needs, including the

The QIDP and the Primary Care Nurse will receive additional training on the procedure of obtaining consent forms before psychotropic meds and sedations are ordered.

7/15/11

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W 124 Continued From page 2  
benefits and potential side effects associated with the medication, and the right to refuse treatment, had been explained to him and/or his legally authorized representative for the use of the aforementioned sedation.

W 124

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.

W 159

This STANDARD is not met as evidenced by:  
Based on observation, interview, and record review, the facility's Qualified Intellectual Disabilities Professional (QIDP) failed to ensure that the active treatment program was integrated, coordinated, and monitored, for six of six clients residing in the facility. (Clients #1, #2, #3, #4, #5, and #6)

The findings include:

1. Cross refer to W247. The QIDP failed to ensure that staff provided clients' opportunities choice and self-management during snack time.
2. Cross refer to W262. The QIDP failed to ensure the Human Rights Committee (HRC) reviewed and approved sedation for Client #1 prior to his dental appointment.
3. Cross refer to W441. The QIDP failed to ensure staff conducted fire drills under varied conditions.
4. Cross refer to W460. The QIDP failed to

1. Cross reference W247 7/22/11

2. Cross reference W262 7/16/11

3. Cross reference W441 7/22/11

4. Cross reference W460 7/22/11

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<p>W 159 Continued From page 3 ensure that Clients #1 and #2 received well balanced, nutritious meals in accordance with their dietary orders.</p> <p>W 247 483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan must include opportunities for client choice and self-management.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure clients were provided with opportunities for choice and self-management during snack time, for six of six clients residing in the facility. (Clients #1, #2, #3, #4, #5, and #6)</p> <p>The finding includes:</p> <p>On June 21, 2011, beginning at 4:23 p.m., observations during snack time revealed the direct care staff placed small plates onto the dining table. A few minutes later, the direct care staff placed three (3) Ritz crackers and approximately 5 dried prunes onto the clients' plates. At 4:30 p.m., Client #5 expressed that he did not want the crackers and prunes. At 4:35 p.m., Client #2 ate the crackers and threw the prunes into the trash can. Clients #1, #2, #3, #4, #5 and #6 were not observed to participate in the serving of their snacks.</p> <p>Interview with the direct care staff on June 21, 2011, at 4:38 p.m., revealed there were several other snacks available (i.e. apples, bananas, fruit cups, etc.). Further interview revealed that he should have presented all available snacks to the individual during snack time. Interview with the</p>	<p>W 159</p> <p>W 247</p>	<p>All clients will be provided the opportunity to choose a variety of snacks during snack time. Staff will be trained on encouraging clients' choice selections and self management. QIDP and Residential Manager will make observation daily to ensure compliance.</p>	<p>7/22/11</p>
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W 247 Continued From page 4  
House Manager (HM) on June 23, 2011, at approximately 10:20 a.m., revealed that Clients #1, #2, #4, and #5 were very capable of assisting direct care staff in choosing and serving their snacks with minimal assistance.

W 247

At the time of the survey, the facility's staff failed to consistently allow clients to exercise their independence and allow options of choice.  
W 262 483.440(f)(3)(i) PROGRAM MONITORING & CHANGE

W 262

The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.

QIDP and Residential Manager will obtain consent from the Human Rights Committee prior to the administration of sedation.

7/15/11

This STANDARD is not met as evidenced by:  
Based on interview and record review, the facility failed to ensure that restrictive measures had been reviewed and/or approved by the Human Rights Committee (HRC), for one of three clients included in the sample. (Client #2)

Cross reference W124

7/15/11

The finding includes:  
  
One June 22, 2011, at 2:02 p.m., review of Client #2's medical records revealed a written Physician's Order (PO) dated January 27, 2011. According to the PO, on February, 9, 2011, Client #1 was to receive Ativan 2 mg by mouth one hour prior to his dental appointment. At 2:08 p.m., on the same day, review of the facility's Medication Administration Records (MAR) confirmed that on February 9, 201, Client #1 received Ativan 2 mg prior to his dental appointment.

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**W 262** Continued From page 5

Interview with the House Manager (HM) on June 23, 2011, at approximately 10:40 a.m., revealed that he was unsure if the Human Rights Committee (HRC) had approved the use of sedation for Client #2's dental appointment. Review of the HRC minutes on June 23, 2011, at approximately 11:00 a.m., failed to provide evidence that use of sedation was reviewed and approved by the HRC prior to its use. Additional interview with the HM on the same day at approximately 11:20 a.m., confirmed that the HRC had not approved for the used of the Ativan prior to its use.

**W 262.**

**W 331 483.460(c) NURSING SERVICES**

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

This STANDARD is not met as evidenced by:  
Based on observation, interview, and record review, the facility failed to ensure nursing services were provided in accordance with each clients needs. for one of three clients included in the sample. (Client #1)

**W 331** Cross reference W445 #a **7/22/11**

The finding includes:

Cross Refer to W455. The facility's nursing staff failed to ensure proper infection control procedures were used prior to administering Client #1's prescribed eye drops.

**W 441 483.470(I)(1) EVACUATION DRILLS**

The facility must hold evacuation drills under varied conditions.

**W 441** All fire drills will be held under varied conditions. Staff will be trained to conduct fire drills using every egress location within the facility. **7/22/11**

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W 441 Continued From page 6

This STANDARD is not met as evidenced by:  
Based on the interview and review of the fire drill records, the facility failed to conduct fire drills under varied conditions, for six of six clients residing in the facility. (Clients #1, #2, #3, #4, #5, and #6)

The finding includes:

Interview with the Qualified Intellectual Disabilities Professional (QIDP) on June 21, 2011, at 2:17 p.m., revealed that the facility had at least four methods of egress (front door, back door, back door on the 3rd floor, and the basement door). Review of the facility's fire drill records on June 21, 2011, beginning at 2:20 p.m., revealed that most of the fire drills were conducted utilizing the front door and back door exits. Further review of the fire drill records revealed that the back door on the 3rd floor was the only exit used during the overnight shift from July 2010 to present. No other exits were used during this shift. This was acknowledged through additional interview with the QIDP on the same day at approximately 2:50 p.m. There was no evidence on file at the time of survey to substantiate that all exits were used.

W 441

W 454 483.470(f)(1) INFECTION CONTROL

The facility must provide a sanitary environment to avoid sources and transmission of infections.

This STANDARD is not met as evidenced by:  
Based on observations and interview, the facility failed to ensure sanitary conditions at all times, for six of six clients residing in the facility. (Clients #1, #2, #3, #4, #5, and #6)

W 454 Staff will be trained on Infection Control by the primary nurse. QIDP and Residential Manager will ensure the Infection Control procedures are practiced at all times by frequently monitoring for cleanliness and sanitation throughout the facility.

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(X4) ID PREFIX TAG  <b>W 454</b>	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG  <b>W 454</b>	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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**W 454** Continued From page 7

The finding includes:

On June 21, 2011, at 4:53 p.m., Client #1 was observed to spit on top of the bowl of broccoli which was wrapped tightly in Reynolds wrap. A few seconds later, the staff removed the wrap from the broccoli and replaced with new wrapping. Approximately one minute later, Client #1 spat on the stove top seven more times. He was verbally prompted to stop spitting by the direct care staff who was preparing the dinner meal. The staff was never observed to clean off the spit that remained on the stove top. At 5:14 p.m., the surveyor informed the House Manager (HM) that spit was remained on the stove top as the staff continued to prepare the clients' dinner meal during this time. Interview with the direct care staff after the dinner meal on June 21, 2011, at 5:37 p.m., acknowledged that he did not wipe off the stove top.

**W 454**

At the time of the survey, there was no evidence that the facility maintained a sanitary environment to avoid sources and transmission of infection.

**W 455** 483.470(l)(1) INFECTION CONTROL

**W 455**

There must be an active program for the prevention, control, and investigation of infection and communicable diseases.

This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide an active program for the prevention and control of infection and communicable diseases for one of three clients included in the sample. (Client #1)

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W 455 Continued From page 8

The findings include:

a. On June 21, 2011, at 4:15 p.m., the Trained Medication Employee (TME) was observed to wash her hands with soap and water prior to administering medications. Approximately one minute later, the TME unlocked the medication cabinet and retrieved Client #1's eye drops. The TME was then observed to administer one eye drop to both eyes of Client #1 with her bare hands. She was not observed to wash and/or sanitize her hands before administering the eye drops.

Interview with the TME on June 23, 2011, at approximately 9:26 a.m., acknowledged that she did not wash and/or sanitize her hands, or place gloves on prior to administering Client #1's eye drops.

The facility's nursing staff failed to ensure proper infection control procedures were used prior to administering Client #1's prescribed eye drops.

b. On June 21, 2011, at 5:07 p.m., Client #1 was observed digging in the trash can. Seconds later, the client took his left fingers and rubbed them on the floor right beside the trash can. Direct care staff verbally prompted Client #1 to stop. The client stopped and went to the dining to sit down for dinner. At no time did staff redirect Client #1 to wash his hands prior to eating his dinner.

Interview with the direct care staff on June 21, 2011, at approximately 5:12 p.m., acknowledged that he did not redirect Client #1 to wash his hands. Interview with the House Manager (HM)

W 455

a. The Trained Medication Employee (TME) will receive additional training on hand washing and universal precautions when applying eyedrops. Primary care nurse will monitor for compliance.

7/22/11

b. Cross reference W454

7/22/11

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W 455 Continued From page 9  
on June 23, 2011, at approximately 10:10 a.m., revealed that all staff including clients had received training on hand washing. When asked, Client #1 did not have a hand washing program.

The facility's staff failed to provide proper infection control procedures prior the Client #1's dinner meal.

W 460 483.480(a)(1) FOOD AND NUTRITION SERVICES

Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.

This STANDARD is not met as evidenced by:  
Based on observation, interview and record review, the facility failed to ensure the provision of a well balanced, nourishing diet, for one of three clients included the sample. (Client #1)

The finding includes:

The facility staff failed to ensure that Client #2 received the appropriate amount of food during dinner time, as evidenced below:

On June 21, 2011, at approximately 5:11 p.m., observations of the dinner meal revealed Client #1 was served meaty macaroni baked (3 oz), broccoll, one slice of wheat bread with margarine, and skim milk and water for his beverage. At 5:17 p.m., staff was observed to place a second serving of meaty macaroni baked (3 oz) onto the client's plate. At 5:23 p.m., Client #1 served himself a second serving of broccoll (1 cup). At 5:30 p.m., Client #1 was given a third serving of

W 455:

W 460

Staff will be trained on Client #1's nutritional plan. QIDP and Residential Manager will monitor the implementation of the nutritional plan for portion control.

7/22/11

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W 460	Continued From page 10 meaty macaroni baked.  Interview with the direct care staff on June 21, 2011, at approximately 6:45 p.m., revealed that Client #1 did receive three servings of meaty macaroni baked during dinner time. Further interview revealed that Client #1 was prescribed a regular diet with a single serving during dinner time. On June 22, 2011, at 1:21 p.m., review of the current Nutritional Quarterly (NQ) dated May 1, 2011, confirmed that Client #1 was prescribed a regular diet with single servings. Further review of the NQ revealed the client's desirable body weight (DBW) is 142 lbs - 154 lbs. Since April 2011, Client #1 has gained approximately five pounds and is currently over his DBW.	W 460			

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Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0095</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/23/2011</b>
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NAME OF PROVIDER OR SUPPLIER  <b>COMMUNITY MULTI SERVICES, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3815 ALBERMARLE STREET NW WASHINGTON, DC 20008</b>
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**1 000 INITIAL COMMENTS**

A licensure survey was conducted from June 21, 2011 through June 23, 2011. A sample of three residents was selected from a population of six males with various cognitive and intellectual disabilities. This survey was conducted utilizing the fundamental survey process.

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

1 000

**1 022 3501.5 ENVIRONMENTAL REQ / USE OF SPACE**

Each window shall be supplied with curtains, shades or blinds, which are kept clean, and in good repair.

This Statute is not met as evidenced by:  
Based on observation and interview, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure the all windows located inside the facility had blinds and/or curtains, for one of six residents residing in the facility. (Resident #4)

The finding includes:

On June 23, 2011, beginning at 11:45 a.m., an environmental walk-thru of the interior of the GHPID revealed the window located in Resident #4's bedroom was observed without blinds, shades, and/or curtains. The neighbor's backyard was clearly visible when standing in the client's bedroom. Interview with the House Manager (HM) who conducted the environmental walk-thru with the surveyor, acknowledged that

1 022

The blinds in Resident #4's bedroom will be placed over the window.

7/15/11

Health Regulation & Licensing Administration  
*Constantine A. Reese* - Program Director  
 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE  
 7/12/11

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I 022 Continued From page 1  
Resident #4's bedroom window was without a cover, to ensure the resident's privacy.

I 042 3502.2(b) MEAL SERVICE / DINING AREAS  
Modified diets shall be as follows:  
  
(b) Planned, prepared, and served by individuals who have received instruction from a dietitian; and...  
  
This Statute is not met as evidenced by:  
Based on observation, interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure that modified diets were served as prescribed, for one of the three residents (Resident #1) included in the sample.  
  
The finding includes:  
  
The GHPID staff failed to ensure that Resident #2 received the appropriate amount of food during dinner time, as evidenced below:  
  
On June 21, 2011, at approximately 5:11 p.m., observations of the dinner meal revealed Resident #1 was served meaty macaroni baked (3 oz), broccoli, one slice of wheat bread with margarine, and skim milk and water for his beverage. At 5:17 p.m., staff was observed to place a second serving of meaty macaroni baked (3 oz) onto the resident's plate. At 5:23 p.m., Resident #1 served himself a second serving of broccoli (1 cup). At 5:30 p.m., Resident #1 was given a third serving of meaty macaroni baked.  
  
Interview with the direct care staff on June 21, 2011, at approximately 6:45 p.m., revealed that Resident #1 did receive three servings of meaty

I 022

I 042

Cross reference W460	7/22/11
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I 042	Continued From page 2  macaroni baked during dinner time. Further interview revealed that Resident #1 was prescribed a regular diet with a single serving during dinner time. On June 22, 2011, at 1:21 p.m., review of the current Nutritional Quarterly (NQ) dated May 1, 2011, confirmed that Resident #1 was prescribed a regular diet with single servings. Further review of the NQ revealed the resident's desirable body weight (DBW) is 142 lbs - 154 lbs. Since April 2011, Resident #1 has gained approximately five pounds and is currently over his DBW.	I 042		
I 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 Group Home for Persons with Intellectual Disabilities (GHPID) maintained the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner, for six of six residents residing in the home. (Residents #1, #2, #3, #4, #5, and #6)  The findings include:  Observation and interview conducted with the facility House Manager (HM) on June 23, 2011, beginning at 11:45 p.m., revealed the following:  interior  1. The kitchen window screen was observed to	I 090		
			1. The kitchen window screen will be replaced.	7/15/11

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I 090	<p>Continued From page 3</p> <p>be detached from its foundation.</p> <p>2. The vent cover located underneath the stove was observed with heavy build up of grease and grime. The vent cover was also observed to be rusted.</p> <p>The bathroom window located on the first level was observed to be inoperable. The bathroom window would not open.</p> <p>3. The blinds located in the bathroom near the basement were observe to be torn.</p> <p>The HM acknowledged the above-cited deficiencies at the conclusion of the environmental walk-through.</p>	I 090	<p>2. The vent cover will be replaced. The vent cover will be cleaned regularly and monitored for cleanliness by the Residential Manager.</p> <p>3. The blinds located in the basement will be replaced.</p>	<p>7/15/11</p> <p>7/15/11</p>
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I 180	<p>3508.1 ADMINISTRATIVE SUPPORT</p> <p>Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure adequate administrative support to effectively meet the needs of six of six residents residing in the GHPID. (Residents #1, #2, #3, #4, #5, and #6)</p> <p>The findings include:</p> <p>1. Cross refer to W247. The QIDP failed to ensure that staff provided Residents' opportunities choice and self-management during snack time.</p>	I 180	<p>1. Cross reference W245</p>	<p>7/22/11</p>
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I 180 Continued From page 4

2. Cross refer to W262. The QIDP failed to ensure the Human Rights Committee (HRC) reviewed and approved sedation for Resident #1 prior to his dental appointment.

3. Cross refer to W441. The QIDP failed to ensure staff conducted fire drills under varied conditions.

4. Cross refer to W460. The QIDP failed to ensure that Residents #1 and #2 received well balanced, nutritious meals in accordance with their dietary orders.

I 180

3. Cross reference W262	7/15/11
4. Cross reference W441	7/22/11
5. Cross reference W460	7/22/11

I 500 3523.1 RESIDENTS RIGHTS

Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws.

This Statute is not met as evidenced by:  
Based on observations, interviews and record review, the Group Home for Persons with Intellectually Disabilities (GHPID) failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and other District and federal laws that govern the care and rights of persons with intellectually disabilities, for one of the three residents included in the sample. (Resident #2)

The finding includes:

The GHPID failed to provide evidence that

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I 500	Continued From page 5  informed consent was obtained from Resident #2's brother for sedation prior to a dental appointment, as evidenced below:  During the entrance conference on June 21, 2011, at 11:19 a.m., interview with the Qualified Intellectual Disabilities Professional (QIPD) revealed that Resident #2 had a brother that operated as the resident's designated surrogate healthcare decision-maker due to the resident's inability to give informed consent for the use of his medications.  On June 22, 2011, at 2:02 p.m., review of Resident #2's medical book revealed a written physician's order dated January 27, 2011, that documented that Resident #2 was to receive Ativan 2 mg by mouth one hour prior to a dental appointment on February 9, 2011. Review of the Medication Administration Record (MAR) on the same day at 2:08 p.m., revealed that on February 9, 2011, Resident #2 did receive Ativan 2 mg prior to his dental appointment.  interview with the House Manager (HM) on June 24, 2011, at approximately 11:25 a.m., confirmed that Resident #1 did receive the aforementioned sedation as ordered. Further interview with the HM revealed that the consent for the use of Ativan had not been obtained prior to administering the medication.  On June 22, 2011, at 3:00 p.m., review of Resident #2's psychological assessment dated September 2010, confirmed that the resident lacked the capacity to grant, refuse, or withdraw consent to any ongoing medical treatment. At the time of the survey, the GHPID failed to provide evidence that Resident #2's treatment needs, including the benefits and potential side effects	I 500	Cross reference W124	7/15/11

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I 500	Continued From page 6  associated with the medication, and the right to refuse treatment, had been explained to him and/or his legally authorized representative for the use of the aforementioned sedation.	I 500		
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