DEPARTMENT OF HEALTH AND HI \N SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/27/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G055		06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEHAVIOR RESEARCH ASSOCIATES	4288 1/2 SOUTHERN AVE, SE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS	W 000		
	A recertification survey was conducted from June 14, 2011 through June 16, 2011. A sample of three clients was selected from a population of three men and two women with various cognitive and intellectual disabilities. This survey was initiated utilizing the fundamental survey process.		Recewel 7/8/11 Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002	
	The findings of the survey were based on observations and interviews with staff and clients in the home and at three day programs, as well as a review of client and administrative records, including incident reports.			
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS	W 124		
	The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.			
	This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to establish a system that would ensure clients' guardians were informed of their medical condition, developmental and behavioral status, and the risks and benefits of clients' psychotropic medications, for one of the three clients in the sample. [Client #2]			
	The finding includes:			
	On June 14, 2011, at 7:29 p.m., a nurse administered 300 mg Tegretol to Client #2,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Linda Graham, QIDP/PB 07/08/11

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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W 124	Continued From page 1 indicating that although she received Depakote and Keppra for seizure disorder, the client was also prescribed Tegretol primarily for behavior management. On June 15, 2011, the Activities Coordinator at her day program stated that Client #2's behavioral history included physical aggression, throwing tantrums, making false allegations and "flopping to the floor." The Activities Coordinator further stated that the client had shown great improvement during the preceding 12-month period, having displayed no incidents of physical aggression or flopping on the floor. On June 16, 2011, beginning at 12:13 p.m., review of Client #2's behavior support plan (BSP) dated April 29, 2011, confirmed that she received Tegretol "for aggression" and that her target behaviors included "tantrums, physical aggression, false accusations and fibbing." Her Individual Support Plan (ISP) dated May 3, 2011, indicated that Client #2 lacked the capacity to make informed decisions; therefore, she had a guardian assigned by a court of law to represent her medical and treatment needs. Further review of the ISP revealed no evidence that the client's medical guardian had participated in the annual review process or otherwise been informed of the client's medical and behavioral status. On June 16, 2011, at 12:23 p.m., review of consent forms in Client #2's chart revealed no evidence that the guardian was aware that she received 300 mg Tegretol twice daily to manage behaviors. The client's record reflected that the guardian had given informed consent for the use of Tegretol 200 mg two years ago, on May 15, 2008. There was no evidence, however, that the	W 124	W124 The QIDP will ensure that the signed consent for the use of psychotropic medication for maladaptive behaviors is in the records for review. The QIDP has contacted the limited medical guardian to receive a copy of the signed consent forms. In the future the QIDP will ensure that all signed consents are received annually or as changes occur in the medication for maladaptive behavior and filed appropriately in the individual's record for review 07/08/2011	

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W 124	Continued From page 2 guardian had been informed or consented to the increase of Tegretol from 100 mg twice daily to 200 mg twice daily. When interviewed on June 16, 2011, at 1:55 p.m., the qualified intellectual disabilities professional (QIDP) confirmed that the guardian had not attended the May 3, 2011 ISP meeting. She stated that a consent form for the increased dosage of Tegretol had been sent to the guardian prior to the May 3, 2011 ISP meeting, and that the guardian had signed it. The QIDP acknowledged, however, that the signed form was not available for review. On June 15, 2011, at 3:35 p.m., the surveyor attempted to interview the client's guardian, to no avail. The guardian did not return the message left requesting a routine interview before the survey ended later that evening. This is a repeat deficiency. _____ Previously, the Federal Deficiency Report dated May 13, 2010, included the following: "...on May 11, 2010, at 7:10 p.m., Client #1 was observed receiving Tegretol XR 300 mg. Interview with the Licensed Practical Nurse (LPN) after the medication administration indicated that the client received the aforementioned medication for her maladaptive behaviors... ...Record verification on May 13, 2010, at 10:00 a.m., revealed that Client #1's guardian had given informed consent for the use of Tegretol 200 mg on May 15, 2008. There was no consent signed, however, for the additional 100 mg of the	W 124		

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W 124	Continued From page 3 prescribed Tegretol."	W 124		
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 interview and record review, the facility failed to ensure the rights of each client to receive assistance with managing the monies that he or she earned at their day program, for one of the three clients in the sample. (Client #3) The finding includes: On June 15, 2011, at 1:05 p.m., a support specialist at Client #3's day program stated that the client earned a stipend for days that he attended. On June 16, 2011, beginning at 1:15 p.m., review of the client's financial records in the home revealed that on June 15, 2010 (a year earlier), the qualified intellectual disabilities professional (QIDP) sent a memorandum to the client's day program informing them that numerous stipend checks had never been cashed. In the memorandum, the QIDP indicated that the original checks totaled $695.00 and she asked that the day program re-issue the funds, for deposit into Client #3's account. Attached to the memorandum was a listing of 12 stipend checks spanning the period December 2008 - March 2010.	W 125	The QIDP will ensure that a check from Capital Hill Supportive Employment for the stipends for client #3. A copy of the letter has been given again to Capital Hill Supportive Employment and a copy placed back in the individual's record. A meeting has been scheduled with the finance office to review this issue and verify why this check was not yet cut. In the future the QIDP will ensure that all stipends are deposited on a monthly basis as received. This systematic process is currently being implemented and all stipends are currently being deposited into the individuals community account. The QIDP will also ensure that the finance records are reviewed monthly and any discrepancies are identified and rectified on a monthly basis.....07/18/2011	

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W 125	Continued From page 4	W 125		
	On June 16, 2011, at 3:00 p.m., interview with the QIDP revealed that Client #3's day program never sent him a replacement check to cover the $695.00 that he had initially earned, but never deposited. The QIDP then acknowledged that the facility had not provided any further advocacy or taken any further steps to assist Client #3 in securing his funds.			
	On June 16, 2011, at approximately 4:50 p.m., review of Client #3's Individual Support Plan (ISP) dated October 5, 2010, revealed that the client was "not competent to make informed decisions about his...financial affairs...lacks the cognitive skills or experience to thoroughly understand the concepts involved in such planning...The interdisciplinary team inclusive of <client's name> assumes responsibility..." The client's Individual Financial Plan, also dated October 5, 2010, indicated that the QIDP was responsible for overseeing the management of the client's funds.			
	At the time of the survey, the facility failed to establish a system to ensure that clients received adequate assistance and support to exercise their right to receive funds, as indicated.			
W 218	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN	W 218		
	The comprehensive functional assessment must include sensorimotor development.			
	This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that clients received a comprehensive functional assessment that included their current sensory-motor			

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W 218	Continued From page 5 development and/or mobility orientation needs, for one of the three clients in the sample. [Client #2]) The finding includes: On June 14, 2011, at 6:20 p.m., Client #2 was observed descending a staircase that led from the main level of the facility to the front door. Her one-to-one staff was in front of the client, walking backwards as they descended the steps together. The client used both hands to hold the railings on both sides of the steps while the staff held her at the waist. At 6:37 p.m., the same staff was observed with Client #2 ascending the same flight of steps, from the front foyer up to the main living area. The staff walked immediately behind the client, holding the client's waist, while the client held both railings, slowly climbing the stairs. Client #2's records were reviewed on June 15, 2011, beginning at 4:09 p.m. There was no fall prevention or ambulation protocol in her records. At 4:28 p.m., review of her physical therapy (PT) evaluation, dated May 2, 2011, revealed the following: "... Staff reported that <client's name> is still unsteady during mobility...Her trunk motions are decreased throughout... There is a right greater than left leg length...Staff provide minimum assistance when using the walker for safety...She is unsteady...She uses the ramp at the rear of the home more often as her strength and mobility have deteriorated." Further review of the PT evaluation revealed no evidence that Client #2's ability to negotiate stairs had been assessed. The qualified intellectual disabilities professional	W 218	The QIDP will ensure that the physical therapist evaluates the facets of all the individuals mobility needs when evaluated. The QIDP has obtained an ambulation protocol and stair climbing protocol to meet the needs of client #2. The evaluation was done on 06/16/2011 and was sent 06/18/2011. The QIDP will ensure that every individual is thoroughly evaluated and all needs addressed. In the future the QIDP will ensure that the physical therapist thoroughly evaluates the mobility needs of each and every individual when an assessment is completed by the physical therapist or as needed 06/18/2011	

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W 218	Continued From page 6 (QIDP), the facilities coordinator (FC) and her assistant were interviewed in the facility on June 15, 2011, beginning at 4:48 p.m. They initially indicated Client #2 had an ambulation protocol. After examining her record, however, they acknowledged that there was no protocol. When asked if Client #2's ability to negotiate stairs had been assessed, they examined the PT evaluation and confirmed that this facet of her mobility needs had not been addressed. It should be noted that the FC stated that she had instructed staff to hold Client #2 by the waist only while ascending stairs. At 4:57 p.m., the FC acknowledged that she had witnessed the one-to-one staff holding the client's waist while descending the stairs on the previous evening.	W 218		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's specially-constituted committee (Human Rights Committee) failed to ensure that restrictive programs were used only with written consent, for one of the three clients in the sample. [Client #2] The findlng includes: Cross-refer to W124. The facility's human rights committee failed to ensure that written consent	W 263	The QIDP will ensure that the human rights committee ensures that written consent is obtain from client #2 limited medical guardian. The QIDP will review the records and ensure that consent is obtained annually for each individual. In the future the QIDP will ensure that written consent is obtain annually or as needed due to a medication dosage change.....07/08/2011	

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W 263	Continued From page 7	W 263		
	had been obtained from Client #2's court-appointed medical guardian prior to the implementation of her Behavior Support Plan, which incorporated the use of Tegretol.			
W 436	483.470(g)(2) SPACE AND EQUIPMENT	W 436		
	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 furnish clients' recommended adaptive equipment, for one of the three clients in the sample. (Client #1)			
	The finding includes:			
	Interview with the qualified intellectual disabilities professional (QIDP) during the entrance conference on June 14, 2011, beginning at 5:35 p.m., revealed that Client #1 was recently admitted to the facility in March 2011. During his admission, the client required walking assistance using a walker.			
	Record review revealed a physical therapy assessment dated March 23, 2011, on June 16, 2011 at 2:40 p.m., revealed recommendations to purchase a tub transfer bench, rolling walker with front wheels, and an air mattress. Further review of the records revealed signed 719A forms dated April 8, 2011. The transfer bench and rolling			

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W 436	Continued From page 8 walker were obtained; however there was no evidence that the client had received the air mattress. Interview with the QIDP on June 22, 2011, at 3:04 p.m., indicated that the licensed practical nurse (LPN) coordinator had ordered the air mattress; however the mattress had not yet arrived. This was confirmed through observation of Client #1's existing bed on the next day, at approximately 4:15 p.m. Review of the facility's Adaptive Equipment policy on June 16, 2011, at 11:15 a.m., revealed that the QIDP had the responsibility of coordinating all adaptive equipment with follow up, as needed by the assigned registered nurse (RN). The QIDP and the RN should track the status of the equipment. If the adaptive equipment was not obtained within 60 days (of identified need), the QIDP should notify the client's Service Coordinator (SC) for follow up assistance and guidance. After the 60-day period, the QIDP should provide the SC with weekly progress. More than 60 days had passed since the need for an air mattress was identified (March 23, 2011). Review of the QIDP and RN notes on June 16, 2011, beginning at approximately 12:30 p.m., revealed no evidence of Client #1's air mattress (adaptive equipment) tracking status.	W 436	The QIDP will ensure that all recommended adaptive equipment is received in a timely manner as outlined in the adaptive equipment policy. The administrative nurse has received the air mattress and it has been placed on the individuals bed on 06/21/2011. In the future the QIDP will ensure that the adaptive equipment policy is followed when adaptive equipment is not received and the service coordinator is informed to give follow-up assistance to the RN and QIDP with receiving the adaptive equipment. The QIDP and RN will both ensure that weekly notes are written concerning the adaptive equipment and forwarded to the service coordinator.....06/21/2011	
W 447	483.470(i)(2)(iii) EVACUATION DRILLS The facility must file a report and evaluation on each evacuation drill. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to establish and implement a policy to	W 447		

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W 447	Continued From page 9 ensure that each fire evacuation drill report form was monitored and evaluated. The finding includes: The facility's fire drill report forms were reviewed on June 15, 2011, beginning at 6:13 p.m. Two different report forms documented that a drill had been conducted at 6:30 p.m. on January 13, 2011. Further review of the forms, however, revealed differing information was recorded on each form regarding the number of staff that participated in the drill, the length of time it took to complete the drill, the weather conditions and other information. Both forms had been signed by the facility's house manager (HM). At 6:37 p.m., the qualified intellectual disabilities professional (QIDP) and the facilities coordinator (FC) stated that the HM was responsible for ensuring that fire drills were conducted and that the report forms were filed in the appropriate binder. They further indicated that once the drill reports were placed in the log book, no additional review or evaluation was conducted by management. Only the HM reviewed the drill reports. Upon examining the two drill report forms in question, they confirmed that there was differing information and they summoned the HM. At 6:42 p.m., interview with the HM confirmed that she had conducted the two drills on January 13, 2011. She stated there had been a systems malfunction when she first ran a drill. The fire department had come to the facility, re-set the alarm system, and she subsequently ran a second drill to verify that everything was operating properly. Upon examining the two drill report	W 447		

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W 447	Continued From page 10 forms in question, the HM acknowledged that she had not documented any problems encountered. At 6:52 p.m., the QIDP stated that there had been similar problems encountered "3 or 4 times during the past year or year and a half." Review of the facility's fire drill report forms, however, had not revealed any problems during the past year. At 7:05 p.m., review of the facility's policies and procedures for conducting fire drills revealed that the policies did not specify how the report forms should be completed nor did they address evaluation of the drill after completion of the form. Moments later, the QIDP and the FC both acknowledged that the facility had not established a system to evaluation each fire drill and its corresponding report form.	W 447	The QIDP will ensure that the fire drills are reviewed monthly and evaluated by the QIDP upon their completion. The QIDP will revise the policy for fire drills to include how the report forms should be completed and revise it to address the evaluation of the fire drill after completion of the form. The staff will be trained on that when a malfunction occurs that information should be placed on the fire drill form. In the future the QIDP will ensure that all fire drills are reviewed and any concerns are addressed in a timely manner 07/08/2011	

Health Regulation & Licensing Administration

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I 000	INITIAL COMMENTS A licensure survey was conducted from May 10, 2011 through May 11, 2011. A sample of three residents was selected from a population of three men and two women with various cognitive and intellectual disabilities. The findings of the survey were based on observations and interviews with staff and residents in the home and at three day programs, as well as a review of resident and administrative records, including incident reports.	I 000		
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans; This Statute is not met as evidenced by: Based on record review and interview, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to have on file current training in cardiopulmonary resuscitation (CPR), for four of the seventeen staff (Staff #1, #2, #3 and #5), three of the eight nurses (Nurse #1, #2, and #4), and current training in first aid, for five of the eleven direct support staff (Staff #1, #2, #3, #4 and #5) The findings include: 1. Review of the personnel and training records on June 15, 2011, beginning at 3:20 p.m., revealed the GHPID failed to provide	I 227	1. The QIDP and Facility Coordinator has scheduled a CPR training on 06/29/2011 and another class is scheduled for 07/13/2011. In the future the QIDP will ensure that there is 100% compliance for CPR and First Aide for all individuals who work for the company. A chart has been developed to establish when each CPR and First Aide card expires and will be reviewed at least monthly by the QIDP/Facility Coordinator 07/08/2011	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Linda Graham TITLE QIDP/PB (X6) DATE 07/08/11

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Health Regulation & Licensing Administration

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	HFD03-0084		06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEHAVIOR RESEARCH ASSOCIATES	4288 1/2 SOUTHERN AVE, SE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 227	Continued From page 1 documentation of staff certification in CPR for Staff #1, #2, #3 and #5 and current training in first aid for Staff #1, #2, #3, #4 and #5. 2. Further review revealed no evidence of current CPR certifications for Nurses #1, #2 and #4. When interviewed on June 16, 2011, at 1:00 p.m., the qualified intellectual disabilities professional acknowledged that the aforementioned staff records were without evidence of documented training.	I 227	2. The QIDP will ensure that all nursing staffs have been trained in CPR and First Aide. In the future the QIDP/Facility Coordinator will track all CPR and First Aide expiration dates on a monthly basis.....07/08/2011.	
I 271	3513.1(b) ADMINISTRATIVE RECORDS Each GHMRP shall maintain for each authorized agency's inspection, at any time, the following administrative records: (b) Personnel records for all staff including job descriptions either at the GHMRP or in a central office and made available upon request; This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure that all the required administrative records were available for inspection, for one of the twelve consultants providing services in the facility. (occupational therapist) The finding includes: On June 14, 2011, beginning at 5:35 p.m., during the entrance conference the qualified intellectual disabilities professional (QIDP) and Program Assistant agreed to make available for review the personnel records of all employees, including licensed professional health consultants. On	I 271	The QIDP will ensure that there is evidence of an occupational therapist on file. A new occupational therapist has been placed on contract for the company. In the future the QIDP will ensure that all consultants have the appropriate credentials on file and they are reviewed on a monthly basis.....07/08/2011	

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I 271	Continued From page 2 June 15, 2011, beginning at 3:20 p.m., review of the personnel records revealed the GHPID failed to provide evidence of personnel records for the occupational therapist. On June 16, 2011, at approximately 1:00 p.m., the QIDP acknowledged that there was no personnel file available for review.	I 271		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure comprehensive evaluation of each resident's mobility/ physical therapy needs, for one of the three residents in the sample. (Resident #2) The finding includes: On June 14, 2011, at 6:20 p.m., Resident #2 was observed descending a staircase that led from the main level of the facility to the front door. Her one-to-one staff was in front of the resident, walking backwards as they descended the steps together. The resident used both hands to hold the railings on both sides of the steps while the staff held her at the waist. At 6:37 p.m., the same staff was observed with Resident #2 ascending the same flight of steps, from the front foyer up to the main living area. The staff walked	I 401	The QIDP will ensure that the physical therapist evaluates the facets of all individuals mobility needs when evaluated. The QIDP has obtained an ambulation protocol and stair climbing protocol to meet the needs of client #2. The evaluation was done on 06/16/2011 and was sent on 06/18/2011. The QIDP will ensure that every individual is thoroughly evaluated and all needs addressed. In the future the QIDP will ensure that the physical therapist thoroughly evaluates the mobility needs of each and every individual when an assessment is completed by the physical therapist or as needed 06/18/2011	

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I 401	Continued From page 3	I 401		

immediately behind the resident, holding the resident's waist, while the resident held both railings, slowly climbing the stairs.

Resident #2's records were reviewed on June 15, 2011, beginning at 4:09 p.m. There was no fall prevention or ambulation protocol in her records. At 4:28 p.m., review of her physical therapy (PT) evaluation, dated May 2, 2011, revealed the following: "... Staff reported that <resident's name> is still unsteady during mobility...Her trunk motions are decreased throughout... There is a right greater than left leg length...Staff provide minimum assistance when using the walker for safety...She is unsteady...She uses the ramp at the rear of the home more often as her strength and mobility have deteriorated." Further review of the PT evaluation revealed no evidence that Resident #2's ability to negotiate stairs had been assessed.

The qualified intellectual disabilities professional (QIDP), the facilities coordinator (FC) and her assistant were interviewed in the facility on June 15, 2011, beginning at 4:48 p.m. They initially indicated Resident #2 had an ambulation protocol. After examining her record, however, they acknowledged that there was no protocol. When asked if Resident #2's ability to negotiate stairs had been assessed, they examined the PT evaluation and confirmed that this facet of her mobility needs had not been addressed.

It should be noted that the FC stated that she had instructed staff to hold Resident #2 by the waist only while ascending stairs. At 4:57 p.m., the FC acknowledged that she had witnessed the one-to-one staff holding the resident's waist while descending the stairs on the previous evening.

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I 500	Continued From page 4	I 500		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observations, interviews and record review, the Group Home for Persons with Intellectual 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 federal regulations 42 CFR 483 Sub-Part 1 (for Intermediate Care Facilities for Persons with Intellectual Disabilities), for three of the three residents in the sample. (Residents #1, #2 and #3) The findings include: 1. [483.470(g)(2)] The GHPID failed to furnish residents' recommended adaptive equipment, for one of the three residents in the sample. (Resident #1) Interview with the qualified intellectual disabilities professional (QIDP) during the entrance conference on June 14, 2011, beginning at 5:35 p.m., revealed that Resident #1 was recently admitted to the facility in March 2011. During his admission, the resident required walking assistance using a walker. Record review revealed a physical therapy assessment dated March 23, 2011, on June 16, 2011 at 2:40 p.m., revealed recommendations to	I 500	1. The QIDP will ensure that all recommended adaptive equipment is received in a timely manner as outlined in the adaptive equipment policy. The administrative nurse has received the air mattress and it has been placed on the individuals bed on 06/21/2011. In the future the QIDP will ensure that the adaptive equipment policy is followed when adaptive equipment is not received and the service coordinator is informed to give follow-up assistance to the RN and QIDP with receiving the adaptive equipment. The QIDP and RN will both ensure that weekly notes are written concerning the adaptive equipment and forwarded to the service coordinator.....06/21/2011	

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I 500	Continued From page 5 purchase a tub transfer bench, rolling walker with front wheels, and an air mattress. Further review of the records revealed signed 719A forms dated April 8, 2011. The transfer bench and rolling walker were obtained; however there was no evidence that the resident had received the air mattress. Interview with the QIDP on June 22, 2011, at 3:04 p.m., indicated that the licensed practical nurse (LPN) coordinator had ordered the air mattress; however the mattress had not yet arrived. This was confirmed through observation of Resident #1's existing bed on the next day, at approximately 4:15 p.m. Review of the facility's Adaptive Equipment policy on June 16, 2011, at 11:15 a.m., revealed that the QIDP had the responsibility of coordinating all adaptive equipment with follow up, as needed by the assigned registered nurse (RN). The QIDP and the RN should track the status of the equipment. If the adaptive equipment was not obtained within 60 days (of identified need), the QIDP should notify the resident's Service Coordinator (SC) for follow up assistance and guidance. After the 60-day period, the QIDP should provide the SC with weekly progress. More than 60 days had passed since the need for an air mattress was identified (March 23, 2011). Review of the QIDP and RN notes on June 16, 2011, beginning at approximately 12:30 p.m., revealed no evidence of Resident #1's air mattress (adaptive equipment) tracking status. 2. [483.420(a)(2)] The GHPID failed to inform each resident or legal guardian of the resident's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.	I 500		

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I 500	Continued From page 6 On June 14, 2011, at 7:29 p.m., a nurse administered 300 mg Tegretol to Resident #2, indicating that although she received Oepakote and Keppra for seizure disorder, the resident was also prescribed Tegretol primarily for behavior management. On June 15, 2011, the Activities Coordinator at her day program stated that Resident #2's behavioral history included physical aggression, throwing tantrums, making false allegations and "flopping to the floor." The Activities Coordinator further stated that the resident had shown great improvement during the preceding 12-month period, having displayed no incidents of physical aggression or flopping on the floor. On June 16, 2011, beginning at 12:13 p.m., review of Resident #2's behavior support plan (BSP) dated April 29, 2011, confirmed that she received Tegretol "for aggression" and that her target behaviors included "tantrums, physical aggression, false accusations and fibbing." Her Individual Support Plan (ISP) dated May 3, 2011, indicated that Resident #2 lacked the capacity to make informed decisions; therefore, she had a guardian assigned by a court of law to represent her medical and treatment needs. Further review of the ISP revealed no evidence that the resident's medical guardian had participated in the annual review process or otherwise been informed of the resident's medical and behavioral status. On June 16, 2011, at 12:23 p.m., review of consent forms in Resident #2's chart revealed no evidence that the guardian was aware that she received 300 mg Tegretol twice daily to manage behaviors. The resident's record reflected that the guardian had given informed consent for the use of Tegretol 200 mg two years ago, on May	I 500	2. The QIDP will ensure that the signed consent for the use of psychotropic medication for maladaptive behaviors is in the records for review. The QIDP has contacted the limited medical guardian to receive a copy of the signed consent forms. In the future the QIDP will ensure that all signed consents are received annually or as changes occur in the medication for maladaptive behavior and filed appropriately in the individual's record for review 07/08/2011	

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I 500	Continued From page 7 15, 2008. There was no evidence, however, that the guardian had been informed or consented to the increase of Tegretol from 100 mg twice daily to 200 mg twice daily. When interviewed on June 16, 2011, at 1:55 p.m., the qualified intellectual disabilities professional (QIDP) confirmed that the guardian had not attended the May 3, 2011 ISP meeting. She stated that a consent form for the increased dosage of Tegretol had been sent to the guardian prior to the May 3, 2011 ISP meeting, and that the guardian had signed it. The QIDP acknowledged, however, that the signed form was not available for review. On June 15, 2011, at 3:35 p.m., the surveyor attempted to interview the resident's guardian, to no avail. The guardian did not return the message left requesting a routine interview before the survey ended later that evening. This is a repeat deficiency. --- Previously, the Federal Deficiency Report dated May 13, 2010, included the following: "...on May 11, 2010, at 7:10 p.m., Resident #1 was observed receiving Tegretol XR 300 mg. Interview with the Licensed Practical Nurse (LPN) after the medication administration indicated that the resident received the aforementioned medication for her maladaptive behaviors... ...Record verification on May 13, 2010, at 10:00 a.m., revealed that Resident #1's guardian had given informed consent for the use of Tegretol 200 mg on May 15, 2008. There was no consent signed, however, for the additional 100 mg of the prescribed Tegretol."	I 500		

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I 500	Continued From page 8	I 500		
	3. [483.440(f)(3)(ii)] The GHPID failed to ensure that its human rights committee committee insured that <restrictive> programs were conducted only with the written informed consent of the resident or legal guardian. Cross-refer to I500.2. The GHPID's human rights committee failed to ensure that written consent had been obtained from Resident #2's court-appointed medical guardian prior to the implementation of her Behavior Support Plan, which incorporated the use of Tegretol.		3. The QIDP will ensure that the human rights committee ensures that written consent is obtain from client #2 limited medical guardian. The QIDP will review the records and ensure that consent is obtained annually for each individual. In the future the QIDP will ensure that written consent is obtain annually or as needed due to a medication dosage change.....07/08/2011	
	4. [483.420(a)(3)] The GHPID failed to facilitate and encourage individual residents to exercise their rights as residents of the facility... including the right to file complaints and the right to due process. On June 15, 2011, at 1:05 p.m., a support specialist at Resident #3's day program stated that the resident earned a stipend for days that he attended. On June 16, 2011, beginning at 1:15 p.m., review of the resident's financial records in the home revealed that on June 15, 2010 (a year earlier), the qualified intellectual disabilities professional (QIDP) sent a memorandum to the resident's day program informing them that numerous stipend checks had never been cashed. In the memorandum, the QIDP indicated that the original checks totaled $695.00 and she asked that the day program re-issue the funds, for deposit into Resident #3's account. Attached to the memorandum was a listing of 12 stipend checks spanning the period December 2008 - March 2010. On June 16, 2011, at 3:00 p.m., interview with the QIDP revealed that Resident #3's day program		4. The QIDP will ensure that a check from Capital Hill Supportive Employment for the stipends for client #3. A copy of the letter has been given again to Capital Hill Supportive Employment and a copy placed back in the individual's record. A meeting has been scheduled with the finance office to review this issue and verify why this check was not yet cut. In the future the QIDP will ensure that all stipends are deposited on a monthly basis as received. This systematic process is currently being implemented and all stipends are currently being deposited into the individuals community account. The QIDP will also ensure that the finance records are reviewed monthly and any discrepancies are identified and rectified on a monthly basis.....07/18/2011	

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	never sent him a replacement check to cover the $695.00 that he had initially earned, but never deposited. The QIDP then acknowledged that the facility had not provided any further advocacy or taken any further steps to assist Resident #3 in securing his funds. On June 16, 2011, at approximately 4:50 p.m., review of Resident #3's Individual Support Plan (ISP) dated October 5, 2010, revealed that the resident was "not competent to make informed decisions about his...financial affairs...lacks the cognitive skills or experience to thoroughly understand the concepts involved in such planning...The interdisciplinary team inclusive of <resident's name> assumes responsibility..." The resident's Individual Financial Plan, also dated October 5, 2010, indicated that the QIDP was responsible for overseeing the management of the resident's funds. At the time of the survey, the facility failed to establish a system to ensure that residents received adequate assistance and support to exercise their right to receive funds, as indicated.			