

MAR 25 2010

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

PRINTED: 02/12/2010
 FORM APPROVED

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0080	(X2) MULTIPLE CONSTRUCTION WASHINGTON, D.C. 20002 A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/30/2010
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NAME OF PROVIDER OR SUPPLIER CENTER FOR SOCIAL CHANGE, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3073 VISTA STREET, NE WASHINGTON, DC 20018
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1 000	<p>INITIAL COMMENTS</p> <p>I. On September 25, 2009, the State Agency received an e-mail from the Department of Disabilities Services (DDS) representative referencing concerns with an individual residing at this facility. According to the notification, a home visit was conducted by the Evans Court Monitor on September 24, 2009. The findings of the visit was as a result of an incident report filed on September 14, 2009 on Resident #1's behalf.</p> <p>The notification described the incident in which Resident #1 had suffered weight loss from 77 pounds to 58 pounds (19 lbs). Reportedly, Resident #1 was observed during her meal to have excessive drooling and rumination. According to the complaint, the Evans Monitor reported that the resident was provided her meal three hours late. Additional concerns included the following:</p> <ol style="list-style-type: none"> 1. Resident #1's GI consultation had not been completed as recommended. This allegation was substantiated. 2. Resident #1's physician's orders did not accurately reflect her current diagnosis, diet, adaptive supports and nutritional procedures and instructions during meals. This allegation was substantiated. 4. Resident #1's adaptive equipment (i.e. Sippy cup) was not available for her use during the meal. This allegation was substantiated. 5. Resident #1's wheelchair was not being 	1 000	<ol style="list-style-type: none"> 1. Resident's #1 GI consultation and f/up's has been on going. Please see attached medical appointment forms and other studies done for the individual pertaining to her weight loss and regurgitation. Specifically individual has seen Dr Frazier (who is also GI specialist) on May 14 2009 and Dr Liff (Georgetown hospital) for second opinion on 10/15/09. In the future CSC nurse will ensure that all appointments are followed up as required and documents are filed appropriately and are easily accessible to the surveyor's and monitors. Please see attached. 2. The current months physician orders does reflect all individuals current diagnosis, diet, adaptive supports, & nutritional procedures & instructions during meals. (see attached) In the future the RN will ensure that all physician orders are checked for accuracy & appropriateness. 4. Resident #1's sippy cup was replaced in October 2009. In the future the residence manager & QMRP will ensure that all adaptive equipment is present in the home & in good working order. When adaptive equipment needs to be repaired or replaced, the facility will ensure that there is back up equipment. 	
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Health Regulation Administration

TITLE

(X6) DATE

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

STATE FORM

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QMS611

If continuation sheet 1 of 27

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1 000	Continued From page 1 maintained and cleaned regularly. This allegation was unsubstantiated. 6. Resident #1's meal was served 3 hours later than originally scheduled. This allegation was unsubstantiated. 7. Resident #1's nutrition/dietitian assessments were not updated to provided correct diet orders, diet texture and dietary supplements prescribed. This allegation was substantiated. Due to the nature of the complaint, an onsite investigation [#10-0134] was initiated on September 29, 2009. The findings of the investigation were based on observations in the group home, interviews with the day program staff, group home management and direct care staff, and the review of Administrative and Habilitation records, to include the agency's incident management system. II. Based on the September 29, 2009 substantiated complaint findings, on January 30, 2010, a monitoring visit was completed to evaluate the health and safety of the residents. A random sampling of three residents was selected from a resident population of five females with various disabilities. The findings were based on observation, interviews with facility staff and review of facility records; including unusual incident reports, investigations and administrative records.	1 000	7. Resident #1 nutritional assessment was updated on 2/15/10 however the case manager had the only copy. In the future the QMRP will ensure that all assessments are updated in a timely manner and present in the individual file. Additionally a copy of all assessments will be maintained in the main office at all times.	
1 041	3502.2(a) MEAL SERVICE / DINING AREAS	1 041		

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1041	<p>Continued From page 2</p> <p>Modified diets shall be as follows:</p> <p>(a) Prescribed in the resident ' s Individual Habilitation Plan and the record of the prescription for the modified diet shall be kept in the resident ' s record;</p> <p>This Statute is not met as evidenced by: Based on observation, interview, and record review, the GHMRP failed to ensure that the physician order included interventions recommended by the IDT to increase weight and to manage drooling for one of the five residents residing in the facility. (Resident #1)</p> <p>The finding includes:</p> <p>Mealtime observation and interview with the direct care staff on September 29, 2009, at approximately 6:25 a.m., revealed that Resident #1 was prescribed a regular double portion diet. According to the staff, they were instructed to give Resident #1 the first portion of double portion of diet, her fluids , and a can of boost supplement. Secondly, the staff indicated that the nutritionist instructed them to provide the resident with 2 tablespoons of peanut butter after the first portion of her diet.</p> <p>At approximately 7:15 p.m., interview with the Qualified Mental Retardation Professional (QMRP) confirmed that the client was prescribed a double portion pureed texture diet.</p> <p>Review of Resident #1's medical records at approximately 6:47 p.m., revealed the Physician's Order (PO) to be Regular Double Portions, Puree. However, further review of the order</p>	1041	<p>The Program coordinator has ensured that all prescribed diet modifications is currently in the residents record and in the future will be maintained in the record at all times & up to date.</p>	2/22/10 & ongoing

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I 041	Continued From page 3 revealed it failed to show that the Boost supplement and the peanut butter being given to the client by the staff were included in the order. The monitoring visit conducted on 1/30/2010 revealed an updated physician order dated 1/1/2010 that prescribed boost 1 bottle 4x a day and a feeding protocol, however, the order failed to reflect the use of peanut butter.	I 041		
I 054	3502.12 MEAL SERVICE / DINING AREAS Residents shall be provided training to develop eating skills and to use special eating equipment and utensils if such training is indicated in the Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure residents were provided training to develop eating skills for two of three residents in the sample. (Residents #1 and #3) The findings include: 1. On January 30, 2010, at approximately 9:10 a.m., Resident #1, who was blind, was served breakfast, consisting of pureed toasted bread and sausage (blended together) and hot cream of wheat cereal. At no time during breakfast did the staff identify the items being served. A direct care staff member, who stood to the right of the resident, was observed assisting the resident with the meal by providing hand over hand assistance. The resident sat with her head lowered to the plate. Although the staff had provided hand over hand for control of the feeding pace, the resident ate rapidly, constantly	I 054	On 2/24/10 the speech & language pathologist will conduct an in-service re-training staff on appropriate feeding protocols. Additionally, the program coordinator trained staff and residents on 2/20/10 on dining etiquette. Furthermore the QMRP will make placemats with the appropriate feeding protocols on the back as a discrete reminder to staff on portion, sizing, texture, and caloric intake Furthermore the QMRP in conjunction with the social worker will continually support residents on appropriate dining etiquette.	2/24/10 & ongoing

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1054	<p>Continued From page 4</p> <p>shoveling food into her mouth. At no time during breakfast did the staff prompt the resident to slow down the eating pace. The resident completed her meal at 9:20 a.m., 10 minutes after it was served.</p> <p>Review of the mealtime protocol revealed it required the resident to be seated upright in a chair at 90 degrees. The mealtime protocol also required the staff to prompt the resident to chew her food and to swallow. At the time of the survey, there was no evidence that the resident was encouraged to eat her meal in the manner recommended in the mealtime protocol.</p> <p>2. On January 30, 2010 at approximately 9:00 a.m., Resident #3 was observed eating her breakfast consisting of French toast, hot cream cereal, and sausage. The resident ate rapidly, cramming large pieces of the French toast into her mouth. She swallowed large mouthfuls of food with minimal chewing of the food. The resident also rapidly ate large pieces of sausages with minimal to no chewing observed.</p> <p>The resident remained in the dining room after finishing her meal, and at approximately 10:15 a.m., was given two link sausages. She also shoved the links into her mouth and ate them with minimal chewing. The staff did not encourage her to eat more slowly.</p> <p>Interview with the staff at 10:30 a.m. revealed Resident #3 generally did not eat her meals in a rapid pace, however, may have shoved the sausage in her mouth quickly because surveyors were present.</p> <p>Review of records on January 30, 2010, at approximately 11:00 a.m., revealed that Resident</p>	1054		

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I 054	Continued From page 5 #3 was prescribed a regular, high fiber, no added salt bite size diet. There was no evidence that the staff was providing training to the resident to enhance her eating skills.	I 054		
I 055	3502.13 MEAL SERVICE / DINING AREAS Each GHMRP shall train the staff in the use of proper feeding techniques and monitor their appropriate use to assist residents who require special feeding procedures or utensils. This Statute is not met as evidenced by: Based on observation and record review, the GHMRP failed to ensure staff were effectively trained to implement the mealtime protocols for 2 of 3 residents in the sample. (Resident #1 and #3) The finding includes: 1. On January 30, 2010 at approximately 9:10, Resident #1, was served breakfast consisting of pureed toasted bread and sausage (blended together) and hot cream of wheat cereal. At no time during breakfast did the staff identify the items being served. A direct care staff member, who stood to the right of the resident, was observed assisting the resident with the meal by providing hand over hand assistance. The resident sat with her head lowered to the plate; and although the staff had provided hand over hand to control the feeding pace, the resident ate rapidly, constantly shoveling food into her mouth. At no time during breakfast did the staff prompt the resident to slow down the pace. The resident completed her meal at 9:20 a.m., 10 minutes after it was served.	I 055	The Nutritionist in-serviced staff on 2/20/10 on appropriate meal preparation standards as well as the social worker will train staff on Active Treatment protocol and appropriateness when dining. (See Attached Protocol) Furthermore the Speech & Language Pathologist will train staff on appropriate feeding protocols for each resident in the program by 2/25/10. QMRP, program manager & speech & language pathologist will conduct monthly monitoring of all staff on all shifts to ensure that the appropriateness protocols are being adhered to documentation on monthly monitoring will be maintained in the QA office. 2. The speech & language pathologist will conduct training of all staff including the QMRP on each residents mealtime protocols by 2/25/10. Furthermore monthly monitoring will be conducted by the Speech & Language professional on a monthly basis results of the monitoring will be maintained in the OA office.	2/25/10 & ongoing

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1055	Continued From page 6 Review of the mealtime protocol revealed it required the resident to be seated upright in a chair at 90 degrees. The mealtime protocol also required the staff to prompt the resident to chew her food and swallow. At the time of the survey staff failed to demonstrate competency in implementing mealtime protocols. 2. On January 30, 2010, at approximately 9:00 a.m., Resident #3 was observed eating her breakfast consisting of French toast, hot cream cereal, and sausage. The resident ate rapidly, cramming large pieces of the French toast into her mouth. She swallowed large mouthfuls of food with minimal chewing observed. The resident also rapidly ate large pieces of sausages with minimal to no chewing observed. The resident remained in the dining room after finishing her meal, and at approximately 10:15 a.m., was given two link sausages. She also shoved the links into her mouth and ate them with minimal chewing. The staff did not encourage her to eat more slowly. Interview with the staff at 10:30 a.m. revealed Resident #3 generally does not eat her meals in a rapid pace, however, may have shoved the sausage in her mouth quickly because surveyors were present. At the time of the survey staff failed to demonstrate competency in implementing mealtime protocols.	1055		
1090	3504.1 HOUSEKEEPING	1090		

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I 090	<p>Continued From page 7</p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure the interior of the facility was maintained in a safe, clean, orderly, attractive and sanitary manner, for five of five residents in the facility. (Residents #1, #2, #3, #4, and #5)</p> <p>The findings include:</p> <p>Observation and interview with the facility's consultant Qualified Mental Retardation Professional (QMRP) on January 30, 2010, at approximately 10:50 a.m. revealed the following:</p> <ol style="list-style-type: none"> 1. The bathroom located upstairs next to the management office failed to have any paper towels available. Additionally, the sliding glass door of the bathtub/shower had two metal objects that appeared to be stabilizers for a horizontal handle, protruding from the door. Furthermore, the metal frame for the sliding door (right side) appeared to be loose. Discussion with the consultant QMRP revealed that the residents would refrain from using the bathroom upstairs while the aforementioned conditions existed. 2. Observation of Resident #4's bedroom revealed the room was dark. Discussion with the consultant QMRP and further observation revealed that the ceiling light in the resident's room was not operable. It should be noted that interview with another monitoring consultant 	I 090	<p>The upstairs bathroom next to the management office was repaired on 2/01/10 including:</p> <ul style="list-style-type: none"> • The sliding glass door on the bathtub/shower • Tightening of the metal frame for the sliding door <p>Furthermore it is the agency policy that no resident is excluded from any portion of their home. The program coordinator has retrained staff on 2/20/10 including QMRP on individual rights. Training will continue on ongoing basis.</p> <p>2. A permanent lamp is placed in the individuals room.. The fixture in the ceiling is not being used anymore. In the future the residence manager will conduct weekly, maintenance checks to make sure all household fixtures, appliances etc are in good working order . In the event that the maintenance is needed a repair order will be submitted to the main office & repairs will be conducted within 24-48 hours in non emergency situations.</p>	2/18/10 & ongoing

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1 090	Continued From page 8 revealed the ceiling light had not been working properly since September 2009. After being informed that the resident did not have a operable light source in her bedroom, the consultant QMRP placed a standing lamp, that he retrieved from the management office, in the resident's bedroom to provide lighting. The QMRP was asked how was the resident monitored at bedtime since there was no light source. The QMRP could not answer the question, but agreed the failure to have a light source was a safety issue. 3. Observation of the carpet on the floor in the hallway of the second level of the facility revealed the edges of the carpet were rolled upward, posing a potential trip hazard. Interview with the consultant QMRP verified the carpet was in need of repair.	1 090	3. The carpet was replaced. In the future the residence manager will conduct weekly, maintenance checks to make sure all household fixtures, appliances etc are in good working order. In the event that the maintenance is needed a repair order will be submitted to the main office & repairs will be conducted within 24-48 hours in non emergency situations.	2/20/10 & ongoing
1 108	3504.15 HOUSEKEEPING Each GHMRP shall assure that each resident has at least seven (7) changes of clothing appropriate to his or her daily activities. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure that one of five residents were dressed appropriately. (Resident #1) The findings include: On January 30, 2010 from 7:00 a.m. to 10:15 a.m. Resident #1 was observed wearing pants that were appropriately 3 sizes too large for her. Interview with the Consultant Qualified Mental Retardation Professional (QMRP) revealed the resident had other pants that would fit her better. The Consultant instructed a staff member to	1 108		

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I 108	Continued From page 9 change the resident's pants. On January 30, 2010, from 7:45 a.m. to 9:50 a.m., Resident #1 was observed at the dining room table wearing a shirt that was too large; the sleeves were falling off her shoulders. At approximately 11:00 a.m., the consultant QMRP presented a bag of new clothes that were stored in a closet and indicated that the staff had purchased new clothing of for all the residents. At the time of the survey, however, there was no evidence that the Resident #1 had been provided the opportunity to wear properly fitted clothing.	I 108	The Residence manager has inventoried all of the residents clothing to ensure appropriateness. Additionally weekly monitoring of individual clothing will be conducted by staff as well as residence manager weekly to ensure good repair. (See attach clothing inventory form)	2/22/10 & ongoing	
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to provide continuous ongoing in-service training programs to ensure the privacy of one of five residents living in the facility. (Resident #2) The finding includes: On January 30, 2010 at approximately 9:00 AM, Resident #2 was observed in her housemates's bedroom pulling her down her own pants and attempting to take off her adult disposable diaper. This observation was brought to the attention of a direct care staff who then escorted the resident into the hallway with her pants still down. While in the hallway, another direct care staff pulled the resident's pants down further and used her hands to feel the diaper. After the staff determined that the diaper was not soiled, she escorted the	I 222	On 2/24/10 the social worker will re-train all staff on resident privacy and rights. Additionally, the Program Coordinator has conducted DDS rights and dignity training on 2/20/10. The QMRP and residence manager will monitor each shift to ensure that the privacy and rights of each individual living in the home.	2/24/10 & ongoing	

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I 222	Continued From page 10 resident upstairs. Although review of the training records revealed a staff sign-in form indicating that six staff received training on privacy, the aforementioned observations determined that staff were not trained effectively to ensure the resident's privacy.	I 222		
I 228	3510.5(e) STAFF TRAINING Each training program shall include, but not be limited to, the following: (e) Resident ' s rights; This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure staff were effectively trained on resident's rights to privacy for of 1 of 5 residents living in the facility. (Resident #2) The finding includes: On January 30, 2010, at approximately 9:00 a.m., Resident #2 was observed in her housemates's bedroom pulling her down her own pants and attempting to take off her adult disposable diaper. This observation was brought to the attention of a direct care staff who then escorted the resident into the hallway with her pants still down. While in the hallway, another direct care staff pulled the resident's pants down further and used her hands to feel the diaper. After the staff determined that the diaper was not soiled, she escorted the resident upstairs. Although review of the training records revealed a staff sign-in form indicating that six staff received training on privacy, the aforementioned	I 228	On 2/24/10 the social worker will re-train all staff on resident privacy and rights. Additionally, the Program Coordinator has conducted DDS rights and dignity training on 2/20/10. The QMRP and residence manager will monitor each shift to ensure that the privacy and rights of each individual living in the home.	2/24/10 & ongoing

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I 228	Continued From page 11 observations determined that staff were not trained effectively on the resident's right to privacy during personal care.	I 228	Additionally, the QMRP has developed a program to assist staff and residents with identifying times and signals that may be helpful in promoting toileting independence.	
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, the GHMRP failed to ensure staff were effectively trained to address the behavioral needs of one of five residents in the facility. (Resident #3) The finding includes: On January 30, 2010, at approximately 9:18 a.m., the staff was observed removing 4 bottles of nutrition supplements (Boost) from Resident #1's dresser drawer. The staff stated that the nurse placed the bottles of Boost in the drawer to hide them from Resident #3. The staff explained that Resident #3 "likes to drink" Resident #1's Boost and when he drinks it, she has diarrhea. At approximately 9:30 a.m., after Resident #3 completed breakfast, the resident was observed constantly going in and out of the kitchen and Resident's #1 bedroom looking through cabinets and drawers. A direct care staff, who was holding and shaking a bottle of Boost, said to the resident "sit down and you will get your Boost." The resident immediately responded by sitting at the dining room table momentarily. The staff	I 229	The Program Coordinator has ensured that the following trainings will be completed by 2/25/10 <ul style="list-style-type: none"> • Behavior Management-Dr. Byrd (psychologist) • Sexuality & Recreation- Social worker • Nutrition-Jennifer Bunns (RDL) • Total Communications – Jennifer Hooker (Speech & Language) • Assistive Technologies- Occupational Therapy <p>Additionally staff has been properly trained on appropriate techniques to redirect or encourage positive behavioral outcomes. The QMRP and Residence manager will be available during each shift to ensure that best practices are being employed at all times.</p>	2/25/10 & ongoing

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I 229	Continued From page 12 continued to use the Boost to redirect the resident to the chair or out of the kitchen and Resident #1's bedroom. This interaction continued from 9:30 a.m. until the 10:00 a.m. The staff explained to the surveyor that she used the Boost as "a carrot" to get the resident to behave. According to Resident #3's record, Boost is not recommended and the behavior support plan does not include the use of Boost as a behavioral intervention. There was no evidence that staff had been trained to not use Boost or food as a behavioral intervention.	I 229		
I 260	3512.1 RECORDKEEPING: GENERAL PROVISIONS Each Residence Director shall maintain current and accurate records and reports as required by this section. This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for Mentally Retarded Person's (GHMRP) failed to maintain current medical records for one of the five residents residing in the facility. (Resident #1) The findings include: On January 30, 2010, at approximately 9:10 a.m., Resident #1, who was blind, was served breakfast consisting of pureed toasted bread and sausage (blended together) and hot cream of wheat cereal. At no time during breakfast did the staff identify the items being served. A direct care staff member, who stood to the right	I 260		

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I 260	Continued From page 13 of the resident, was observed assisting the resident with the meal by providing hand over hand assistance. The resident sat with her head lowered to the plate; and although the staff had provided hand over hand assistance to control of the feeding pace, the resident ate rapidly, constantly shoveling food into her mouth. At no time during breakfast did the staff prompt the resident to slow down the pace. The resident completed her meal at 9:20 a.m., 10 minutes after she began eating. Review of the mealtime protocol revealed it required the resident to be seated upright in a chair at a 90 degree angle. It should be noted that interview with the QMRP on January 30, 2010, at 10:30 a.m., revealed that an Occupational Therapy (OT) and Physical Therapy (PT) assessment had been conducted for the resident several months earlier. The assessments, however were not available for review during the monitoring visit to verify if the resident could physically eat at a 90 degree angle. Throughout the survey, the resident was observed to stand and ambulate with her back bent almost parallel to the floor. Additionally, at the time of the survey, there was no evidence that the resident's slumping posture (face near her plate) while eating her meals had been assessed to determine her specific mealtime needs.	I 260	Resident #1's OT and PT evaluations are now present and part of her file in the home. (See Attached) Furthermore Quarterly file audits completed by the program coordinator will ensure that all records are properly maintained in the home, and that staff have access to vital information in order to work with each resident appropriately and accurately. The QMRP and residence manager will adjust their daily schedule to ensure best practices in the home at all times on a shift by shift basis.	2/22/10 & ongoing
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident's health, welfare, living arrangement, well being or in any other way	I 379		

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I 379	<p>Continued From page 14</p> <p>places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all allegations of mistreatment, neglect or abuse, are reported immediately to the administrator and the Department of Health (DOH), Health Regulation Administration, for one of six clients residing in the facility. (Resident #1 and #2)</p> <p>The findings include:</p> <p>The review of the facility's unusual incident management system and interview with the consultant Qualified Mental Retardation Professional (QMRP) on January 30, 2010 at 9:30 a.m., revealed the facility failed to notify the governmental agency of the following incidents timely:</p> <ol style="list-style-type: none"> 1. On October 13, 2009, Resident #1 was taken to her Primary Care Physician for evaluation of vigorous head shaking, restlessness and agitation. The resident was assessed and it was determined that further evaluation was warranted. The resident was transported by staff to the emergency room for further evaluation. 2. On August 16, 2009, Resident #1's forehead was observed swollen. The origin of the swelling was reported as unknown. She was taken to the emergency room for further evaluation. 	I 379	<p>During resident's #1 emergency room visits in May, June, August & October, 2009 her DDS case manager, as well next of kin and pertinent persons in her circle of support were notified of her hospital visits, and plan of treatment. DDS policy however does not classify routine emergency visits where non-emergency personnel was not dispatched as a serious reportable therefore requiring notification to HRLA/DOH. However upon the results of this current survey executive management was notified that all incidents regardless of classification are required to be reported to DOH immediately. Therefore the organization has changed its policy to reflect the appropriate notification procedures.</p>	2/22/10 & ongoing

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I 379	Continued From page 15 3. On June 6, 2009, Resident #1 was observed pale, restless and uncomfortable. She was taken to the emergency room and diagnosed with a urinary tract infection. 4.. On May 9, 2009, the day program nurse observed Resident #1's face was swollen (right side). She was transported to the emergency room and diagnosed with temporomandibular joint (TMJ) There was no evidence that the aforementioned emergency room visits had been reported to DOH/HRLA.	I 379		
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, interview and a record review, the GHMRP failed to ensure timely professional assessment, treatment, and monitoring, for two of five residents. (Resident #1 and #2) The findings include: 1. On September 25, 2009 , the state agency received an e-mail from the Department of Disability Services (DDS) which referenced an allegation by the Evans Court Monitor made on September 24, 2009. The complainant alleged that Resident #1's nutrition/dietitian assessments	I 401	1. The nutritional assessment was updated and corrected on 2/15/10. All staff were retrained on 2/20/10. Additionally the facility RN will ensure that all current P.O.F correspond with the most recent professional assessments and orders from the appropriate discipline.	2/20/10 & ongoing

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I 401	<p>Continued From page 16</p> <p>were not updated to provide correct diet orders, During the January 30, 2010, monitoring visit, the allegation was partially substantiated as evidenced below:</p> <p>At approximately 9:10 a.m., Resident #1, who was blind, was served breakfast, consisting of pureed toasted bread and sausage (blended together) and hot cream of wheat cereal. Interview with the direct support staff revealed the Resident #1 was prescribed a pureed diet. Interview with the consultant QMRP at approximately 10:40 a.m. indicated that the nutritionist had instructed staff on the resident's diet.</p> <p>The review of the physician's orders dated January 2, 2010, and the Mealtime Protocol (dated October 2009) revealed the resident was prescribed a High Fiber, pureed diet. The Nutrition Assessment Update (dated January 3, 2010) however, documented inaccurately as the resident's diet order as "Regular, Ground meat, all other foods finely chopped, high fiber...." At the time of the survey, there was no evidence the nutritionist had ensured Resident #1's diet dietary order in the nutritional update was in accordance with the current physician's orders.</p> <p>2. The GHMRP failed to ensure timely professional assessment and monitoring for Resident #1's drooling/rumination.</p> <p>On January 30, 2010, at approximately 9:10 a.m., Resident #1, who was blind, was served breakfast consisting of pureed toasted bread and sausage (blended together) and hot cream of wheat cereal. At no time during breakfast did the staff identify the items being served.</p>	I 401	<p>2. Staff have been appropriately re-trained on resident #1's appropriate feeding & mealtime protocol. Additionally all corresponding documentation has been updated and is accurately prescribing the same meal time supports to ensure accuracy of delivery. (See Speech, Nutritionist assessment & current P.O.F attached)</p>	2/20/10 & ongoing

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1401	<p>Continued From page 17</p> <p>A direct care staff member, who stood to the right of the resident, was observed assisting the resident with the meal by providing hand over hand assistance. The resident sat with her head lowered to the plate; and although the staff gave hand over hand assistance to control the pace, the resident ate rapidly, consistently shoveling food into her mouth. At no time during breakfast did the staff prompt the resident to slow down the pace.</p> <p>After the breakfast meal on January 30, 2010, at approximately 9:20 a.m., Resident #1 was fed heaping tablespoons of peanut butter. Immediately after the resident consumed the peanut butter, the resident began to ruminate and subsequently the food began to run out of her mouth and nose onto her clothing. She continue to regurgitate food for 1½ hours. During this time the resident clothes hands and mouth were covered with vomit. The resident was observed using her shirt and pant leg to wipe her hands and mouth. Although staff observed the resident's soaked clothing and dirty hands and mouth, staff did not intervene until 9:45 a.m., 25 minutes after the resident began to regurgitate. At that time, the staff used a wet rag (stained and tattered) to wipe her clothes, hands, chair and then wiped her face before rinsing the rag and continuing the clean-up process.</p> <p>At approximately 9:48 a.m. the staff was observed putting another shirt on top of the resident soak shirt. Furthermore, the second shirt was placed on backwards. The staff stated that the resident must wear the shirt backwards so that the shirt buttoned in the back to prevent the resident from ripping it off. The resident continued to regurgitate on her clothing for another hour.</p>	1401		

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I 401	<p>Continued From page 18</p> <p>Interview with staff revealed that the resident regurgitates 1½ to 2 hours after meals and the amount of food expelled was normal for the individual. The staff also stated that the wearing of two garments during mealtime was also routine. Review of the resident's physician's order suggested the use of a protected garment during meals.</p> <p>On January 29, 2010, beginning at approximately 10:15 a.m., record review was conducted to determine a possible origin of Resident #1's drooling/vomiting after meals and to determine interventions to address the health concern. Review of the resident consultant evaluations documented the following:</p> <p>(a) April 22, 2009 - (Speech and Language Clinical Swallowing Evaluation) Resident #1 was referred to a speech and language pathologist for a clinical swallowing evaluation due to her history of dysphagia and recent symptoms of regurgitation of food. The assessment revealed the resident "presents with a moderate oral phase dysphagia, a grossly functional pharyngeal state swallow, and severe esophageal stage dysphagia characterized by rumination or reflux or some backflow of the food five to ten minutes after the meal." It was recommended that the diet texture be downgraded from mechanical soft to puree texture, with thin liquids using a sipper cup with one-to-one feeding assistance. " The patient should be seated upright, 90 degrees hip flexion during the meals and should remain upright for at least 45 minutes to an hour after eating. The resident was recommended for GI consultation secondary to signs of questionable reflux versus rumination.</p>	I 401		

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I 401	<p>Continued From page 19</p> <p>(b) September 24, 2009 - (Secondary GI Consult) double portions of regular pureed texture diet with Boost Plus 4 times a day (QID), High Calorie Snacks as tolerated. "Daily weights and calorie counts". There was no documented evidence the resident had received the GI assessment to address the possible reflux until September 2009, five months after it was recommended by the SLP in April 2009.</p> <p>(c) November 4, 2009 - CT Thorax/ABD/Pelvis with contrast (abnormal weight loss - unspecified dysphagia; evaluate for malignancy).</p> <p>(d) November 13, 2009 Endoscopy (Re: weight loss)</p> <p>Interview with QMRP on January 30, 2010, revealed that various tests had been conducted to assess the origin of Resident #1's drooling/rumination and weight loss. At the time of the survey, the resident's weight was approaching the lower end of her desirable body weight (IBW 90+or -10%). There was no evidence, however, that a viable solution had been identified or recommended to reduce the frequency and the duration of the drooling/rumination.</p> <p>3. The review of the Resident #1's clinical records on January 30, 2010, revealed that the GHMRP failed to clearly identify her hydration needs to ensure interventions were implemented as evidenced below:</p> <p>(a) Physician's orders dated January 2, 2010, revealed "Boost Plus Vanilla Liquid, One bottle by mouth four times a day, Enulose 10gm/15 ml Solution, 15 ml (10 gms) by mouth every evening for constipation; Liquids: regular (thin) Give</p>	I 401	<p>3. On 2/22/10 the team will meet to discuss resident #1 drooling/rumination & weight loss. The P.O.F will be reviewed along with all professional recommendations, and the team will make the necessary changes to the P.O.F as well as the H.M.C.P to address resident's #1 health needs by the end of the meeting. Additionally, the team will discuss and develop a plan of care with preventative measures as well signs to look for as it relates to functional decline.</p>	2/22/10 & ongoing

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I 401	<p>Continued From page 20</p> <p>liquids 20 minutes after meals." When she is given water, squeeze one teaspoon of lemon juice into water...Give one teaspoon of lemon juice per 8 ounces of water." Further review of the Physician's orders determined no daily recommendation of water to address the resident's hydration needs.</p> <p>(b) The Nutrition Assessment update (January 3, 2010) revealed Resident #2's fluid need increased due to the Lactulose prescribed daily for constipation. The nutrition update also documented the resident's increased need for fluids to compensate for water loss during excessive drooling after meals. Further review of the Nutrition Assessment update determined no daily recommendation of water to address the resident's hydration needs.</p> <p>(c) The Mealtime Protocol dated October 2009 revealed "When she is given water, squeeze 1 teaspoon of lemon juice into water (for 8 ounces of water). Further review of the Mealtime Protocol determined the no daily recommendation of water to address the resident's hydration needs.</p> <p>(d) It should be noted that the Health Care Management Care Plan (HMCP) dated March 11, 2009 included interventions to address constipation "Encourage fluid intake of at least 6-8 glasses of water daily. Maintain bowel records and report to nurse if no bowel movement in 2 days." Record review, however, revealed no system had been implemented to ensure the accurate monitoring of the resident's water intake or bowel movement frequency.</p> <p>At the time of the survey, there was no evidence the health care team had collaborated to ensure that Resident #1 hydration needs were being</p>	I 401		

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I 401	<p>Continued From page 21</p> <p>adequately addressed.</p> <p>4. The GHMRP failed to ensure timely dental treatment services for Resident #2.</p> <p>Review of Resident #2's records on January 30, 2010, at 11:00 a.m. revealed the resident was seen by the dentist on February 18, 2009. According the dental consultation form, the resident received scaling and was diagnosed with carries of teeth #4 and #5. The dental consultant documented a treatment plan for the resident to include fillings and extractions. A follow-up date was scheduled for March 18, 2009. At the time of the survey, however, there was no evidence that Resident #2 received the necessary follow-up dental services.</p> <p>5. The GHMRP failed to ensure required information necessary to monitor Resident #2's target behavior incident frequency was documented on the Psychotropic Medication Review forms.</p> <p>Observations on January 30, 2010, between 7:34 a.m. and 10:23 a.m. revealed Resident #2 intermittently ascended and descended the stairs located off of the foyer, near the facility's front entrance 17 times. Interview with the facility's staff at approximately 7:35 a.m. revealed the resident enjoyed the aforementioned activity.</p> <p>Review of Resident #2's record on January 30, 2010, at 10:21 a.m. failed to provide evidence of a comprehensive psychiatric assessment. Within the record however, were psychotropic medication reviews dated October 28, 2008, November 20, 2008, April 6, 2009, and June 2009. Further review of the April 2009 and June 2009 psychotropic medication review forms</p>	I 401	<p>4. A follow-up dental appointment was made for 3/11/2010 @ 9:30am. Unfortunately the delay in treatment was due to the dental office's delay in getting authorization for the scaling. However in the future the residence will be more vigilant in documenting efforts to work with the dental office while awaiting authorization for services.</p> <p>5. The QMRP and RN did review the psychotropic record to ensure that in the future all pertinent information including # of targeted incidents is accurately completed on the form. The QMRP will ensure that the data is accurately tallied monthly and represented on the review form and the RN will assess the data prior to presenting to the psychiatrist for follow-up.</p>	<p>3/11/10 & ongoing</p> <p>2/21/10 & ongoing</p>

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I 401	<p>Continued From page 22</p> <p>revealed the forms documented head rubbing as the resident's targeted behavior, but failed to identify the number of incidents exhibited by Resident #2 for the period reviewed.</p> <p>Interview with the consultant QMRP revealed that psychotropic reviews are conducted on a quarterly basis. The consultant QMRP further indicated that it was the nurse's responsibility to complete the medication review form, including the target behavior incident frequency, exhibited for each month of the quarter reviewed. Continued review of Resident #2's psychotropic medication review forms on January 30, 2010, however, revealed there was no incident frequency data documented for the April 2009 and June 2009 psychotropic reviews (6 months).</p> <p>6. The GHMRP failed to ensure that professional service, treatments and supports had been completed to ensure that Resident #1's needs were met.</p> <p>On September 25, 2009, at approximately 7:30 p.m., interview with the QMRP and review of the Speech and Language Assessment dated January 12, 2008, revealed that it was not current. further review of the recommendation indicated that the consultant was to "Re-evaluate language and communication skills in one year." Review of the Individual Support Plan (ISP) failed to evidence an updated assessment had been conducted. It should be noted that the Oral Peripheral Mechanism section stated "The mealtime protocol may need to be changed to indicate the change in texture of Resident #1's food texture."</p>	I 401	<p>6. The Speech & Language evaluation was completed on 2/17/10 and staff were trained on updated feeding protocols on 2/20/10. In the future the program coordinator will ensure that assessments are accurate, up to date, present in the record and be effectively implemented during quarterly reviews, the results of which will be submitted to the main office and deficiencies will be immediately corrected.</p>	2/20/10 & ongoing

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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 401	Continued From page 23 At the time of the investigation, there was no evidence that the Speech and Language evaluation was completed as recommendation. 7. On September 29, 2009, at approximately 3:00 p.m., a telephone interview with the facility's Registered Nurse (RN) revealed that a swallow study was completed for Resident #1 on April 22, 2009. The swallowing study recommendations include a GI study, however there was no evidence that the GI Study had been completed.	I 401		
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure habilitation, training and assistance were provided to its residents in accordance with their Individual Habilitation Plan(s), for one of the three residents included in the sample. (Resident #2) The finding includes: Observations on January 30, 2010, between 7:34 a.m. and 10:23 a.m. revealed Resident #2 intermittently ascended and descended the stairs located off of the foyer near the facility's front entrance 17 times. Interview with the facility's staff at approximately 7:35 a.m. revealed the resident enjoyed the aforementioned activity. At 8:53 a.m., Resident #2 was observed to enter the management office located on the second	I 422	7. The GI study is scheduled to be completed on 3/17/10. In the future the facility RN as well as QMRP and residence coordinator will ensure that all recommendation receive immediate follow-up in an effort to avoid functional decline of any resident. Quarterly reviews of the facility and medical records will ensure that follow-up treatment and recommendations are done in a timely manner. 1. Resident's #1 GI consultation and f/up's has been on going. Please see attached medical appointment forms and other studies done for the individual pertaining to her weight loss and regurgitation. Specifically individual has seen Dr Frazier (who is also GI specialist) on May 14 2009 and Dr Liff (Georgetown hospital) for second opinion on 10/15/09. In the future CSC nurse will ensure that all appointments are followed up as required and documents are filed appropriately and are easily accessible to the surveyor's and monitors. Please see attached.	3/17/10 & ongoing

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1422	Continued From page 24 floor. While there, Resident #2 grabbed a surveyor's lower left sleeve and released it upon the surveyor's request. The resident was additionally, observed to stand behind the surveyor and hit herself on the head and rub it. Review of the resident's record on January 30, 2010, at approximately 11:50 a.m. revealed the client had a behavior support plan dated April 14, 2009. The plan documented the resident required support for self injurious behaviors, specifically hitting herself on the head and rubbing her head). Continued review of Resident #2's weekly activity schedule dated July 1, 2009, at approximately 11:55 a.m. revealed the resident should have been involved in the following activities: 7:00 a.m. - Morning preparation and medications 8:00 a.m. - Breakfast 9:00 a.m. - Bank/cleaners 10:00 a.m. - No activity indicated 11:00 a.m. - No activity indicated 12:00 p.m. - Lunch/medications At the time of the surveyor's arrival at 7:00 a.m., Resident #2 was already up and dressed. Additionally, Resident #2 was not escorted to the bank or cleaners. Furthermore, there was no substitute/alternative hour long activity offered in place of the scheduled outing. Finally, the facility failed to ensure the implementation of the resident's behavior support plan to address her self injurious behavior.	1422	Staff were re-trained by the program coordinator on appropriately behavior interventions to address resident #1's self injurious behavior. Additionally the psychologist will conduct training on 2/25/10 and both psychologist & program coordinator will monitor staff over the next few days as well as on an ongoing basis to ensure appropriateness and accuracy. (see attached training sign-in/observation sheet) Additionally, the program coordinator reviewed resident #1's activity schedule and revised in accordance with individual's , likes and wants and needs. Likewise a alternative schedule was developed to account for those times when scheduling changed need to be made or behavior impedes the regularly scheduled activity.	2/25/10 & ongoing
1500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and	1500		

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I 500	<p>Continued From page 25</p> <p>protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws.</p> <p>This Statute is not met as evidenced by: Based on observations, interviews and record review, the GHMRP failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and other District and federal laws that govern the care and rights of persons with mental retardation, for two of the five residents of the facility. (Residents #1, #2 and #4)</p> <p>The findings include:</p> <p>(Chapter 13, § 7-1305.02. Living conditions; teaching of skills [Formerly § 6-1962]</p> <p>Customers shall be provided with the least restrictive and most normal living conditions possible....This standard shall apply to dress, grooming, movement, use of free time, and contact and communication with the community, including access to services outside of the institution or residential facility. Customers shall be taught skills that help them learn how to effectively utilize their environment and how to make choices necessary for daily living....)</p> <p>1. HRLA received a report via e-mail on January 29, 2010 from Department on Disabilities Serves (DDS) from University Legal Services (ULS). Attached to the e-mail was a report dated January 22, 2010 of an onsite visit completed by their nurse consultant who alleged that all residents (4 of 5 Class members) were noted</p>	I 500	<p>On 2/20/10 residence coordinator completed training on individual rights and dignity (see attached training documentation)</p> <p>Additionally the Program coordinator conducted training on 2/20/10 on rights and dignity. In the future the residents in the home will receive hair care from a licensed professional who will take their choice of style into consideration.</p>	2/20/10 & ongoing

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I 500	<p>Continued From page 26</p> <p>with significant deficiencies on September 29, 2009, December 1, 2009, December 16, 2009 and January 22, 2010. The report alleged that the residents' dignity and civil rights were violated (hair was cut so short that their scalps were visible, described as "bald-like".</p> <p>During the HRLA monitoring visit in January 30, 2010, this allegation was substantiated. It was determined that the residents' right to choice in grooming (hair styling) had been violated as evidenced below:</p> <p>Upon entering the facility on January 30, 2010, at approximately 7:30 a.m., the surveyor observed five of five residents to have very short hair cuts. Closer observation of each of the residents revealed their scalp to be clearly visible. Staff interview revealed the residents' hair had been cut by a professional barber approximately two weeks prior to the survey. At the time of the monitoring survey, however, it could not be determined who had authorized the barber to give the residents the "bald-like" hair cuts. Additionally, there was no evidence, the residents were being trained to make a choice of hair style or had been provided the opportunity to select their individualized style of hair grooming.</p> <p>Note: Interview with the consultant QMRP on January 30, 2010, revealed that Resident #2's hair cut was quite different than her normal style. The QMRP revealed that the residents hair is maintained at the base of her neck. He further indicated that he was not pleased with the length of the resident's hair and the actions made by staff to allow the resident's hair to be cut so closely.</p>	I 500		