

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

PRINTED: 07/12/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G193	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/25/2009
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NAME OF PROVIDER OR SUPPLIER WESTVIEW 02	STREET ADDRESS, CITY, STATE, ZIP CODE 74 W ST, NW WASHINGTON, DC 20015
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W 000	INITIAL COMMENTS	W 000		
W 159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP) for two of three clients in the sample. (Clients #2, and #3)</p> <p>The findings include:</p> <ol style="list-style-type: none"> The QMRP failed to coordinate services to ensure individual program objectives recommended by the interdisciplinary team were consistently implemented for Client #3. [See W249] The QMRP failed to coordinate services to ensure staff implemented lunch menus as written for Client #3. [W189,2] 	W 159	<p><i>Review 7/29/09</i></p> <p>GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002</p> <ol style="list-style-type: none"> See W249 See W189.2 	<p><i>07/31/09</i></p> <p><i>07/31/09</i></p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Shirley West* TITLE *MD* (X6) DATE *July 29, 2009*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided 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 159	Continued From page 1	W 159		
W 189	<p>3. The QMRP failed to coordinate services to ensure that staff received training on human sexuality to address the needs of the Client #2. [See W189,3]</p> <p>4. The QMRP failed to implement interventions to ensure that staff documented program data in measurable terms for Client #3. [See W252]</p> <p>483.430(e)(1) STAFF TRAINING PROGRAM</p> <p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure each employee was provided initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently for three of three clients in the sample. (Clients #1, #2 and #3)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The facility failed to ensure staff were adequately trained to implement Client #1's individual program plan objectives as recommended by the interdisciplinary team (IDT). [See W249] 2. The facility failed to ensure that staff were trained to implement the lunch menus as written. <p>[Cross refer to W249] On June 23, 2009 at 6:30 PM, staff was observed packing food leftover</p>	W 189	<ol style="list-style-type: none"> 1. See W249 2. It has been noted that Client #3 enjoys taking a hot lunch with him to school versus what is on the provided menu that should be followed by staff. The 	<p>07/31/09</p> <p>08/14/09</p>

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W 189	<p>Continued From page 2</p> <p>from dinner (beef stew, carrots, and potato) in Client #3's lunch plate for the next day. On June 25, 2009 at 8:30 AM, staff was observed preparing a lunch for Client #3 which consisted of canned ravioli, a slice of buttered whole wheat bread, and a diet soda.</p> <p>On June 25, 2009 at 8:45 AM, discussion with the staff preparing Client #3 lunch indicated the client enjoyed the leftovers and like hot food for lunch. "If they don't make the plate in the evening, we make it in the morning." Interview with the QMRP on June 25, 2009 at 4:30 PM indicated that the written menus planned by the nutritionist included breakfast, lunch and dinner. According to the QMRP, the lunch menu should be followed by the staff at all times.</p> <p>On June 25, 2009 at 4:40 PM, the review of the planned lunch menus for June 23, 24, and 25, 2009 revealed that the food provided for Client #3's lunch on June 24, and June 25, 2009 failed to coincide with the written menus. At the time of the survey, there was no evidence that the staff had been trained to implement the lunch menus as written by the nutritionist.</p> <p>3. The facility failed to ensure that staff received training on human sexuality.</p> <p>On June 23, 2009 at 10:17 AM, Client #2 was observed to complain that the birth control pills she was prescribed made her head ache. Staff was observed to tell the client that she should tell the nurse about the pain again.</p> <p>On June 23, 2009 at 10:20 AM, the surveyor asked Client #2 why she continued to take the birth control pills if they made her feel badly. The</p>	W 189	<p>2. nutritionist will be consulted on how to best accommodate Client #3's lunch preference when going to the day program at which time staff will be trained on the implementation of the Nutritionist's recommendation and/or menu plan. In the future, the QMRO will ensure that all staff are trained on how to implement the lunch menu as written by the Nutritionist as well any goals and objectives associated with the menu.</p> <p>3. The staff will be trained by the Nursing Coordinator on Human Sexuality at the next staff meeting & in-service training session. In the future, the QMRP will ensure that staff receive annual or as needed training.</p>	07/31/09	

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W 189	<p>Continued From page 3</p> <p>client commented, "I don't want to talk about that" Interview with the QMRP on June 23, 2009 at 2:35 PM revealed that the client's complaint of pain had been medically addressed. According to the QMRP, the client's behavior support plan (BSP) dated January 10, 2009 contained interventions to address provocative sexual behavior, which included inappropriate (flirting and disrobing). The BSP also addressed targeted behaviors of accusing, threats/intimidation, begging, giving - wanting back, and other types of attempted manipulative behaviors. Continued interview with the QMRP, however, revealed the staff had not been provided training on human sexuality.</p> <p>On June 23, 2009 at 2:45 PM, training records confirmed the staff were trained on the client's BSP on March 9, 2009. At the time of the survey, however, there was no evidence that staff had received training during the past year on human sexuality to increase their understanding of the client's physical and psychological needs.</p> <p>[Cross refer to W252] The facility failed to ensure staff were trained to document the ABC data as required by the behavior support plan of Client #3.</p> <p>Interview with the house manager on June 23, 2009 at 4:35 PM, indicated that staff had been trained on how to document on the clients' IPP training objectives.</p> <p>On June 25, 2009 at 10:23 AM, the review of Client #3 BSP dated January 10, 2009 revealed ABC data (antecedents, consequences, and outcome of behavioral intervention) and the</p>	W 189	<p>4. Staff were previously trained on 05/27/09 on how to implement the ABC data form. However, they will be retrained at the next staff meeting & in-service training session to ensure that all staff are knowledgeable of the form and how to complete it when needed. In the future, the QMRP will ensure that all staff are effectively trained annually on ABC data collection and retrained as problems with documentation arise.</p>	08/14/09
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W 189	<p>Continued From page 4</p> <p>behavior frequency should both be documented when behavior occurs. Record review on June 25, 2009 at 10:35 AM revealed that the ABC data had not been consistently documented and failed to coincided with the dates on the monthly behavior frequency charts for May and June 2009.</p> <p>The review of training records on June 23, 2009 at 2:45 PM revealed that staff were trained on active treatment and and data collection on April 10, 2009 . At the time of the survey, however, there was no evidence that staff had received sufficient training to ensure that all data was collected in measurable terms.</p>	W 189		
W 217	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN</p> <p>The comprehensive functional assessment must include nutritional status.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a comprehensive assessment of the caloric requirement for one of three clients in the sample. (Client #1)</p> <p>The finding includes:</p> <p>[Cross refer to W331] On June 23, 2009 at 8:30 AM, Client #1 was observed to appear slim and muscular as he boarded the van for his day program. On June 23, 2009 at 8:30 PM, Client #1 was observed to consume 100 percent of his meal (Beef Soup, carrots, baked potato, lite fruit cocktail, and water). On June 23, 2009 at 12:15 PM the client was observed to consume 100 % of his lunch. The client was also observed to</p>	W 217	<p>1. The Nutritionist will be consulted and requested to provide written documentation addressing client #1's noted weight loss as well as recommendations for a change in current diet order, if needed. The Nursing Coordinator will also be consulted along with the Primary Care Physician to inquire if Client #1's weight loss is a health concern, if so it will be documented in his Health Care Management Plan. In the future, the QMRP and Nursing Coordinator will ensure that weight loss for Client #1 as well as all clients is addressed.</p>	08/14/09

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W 217	<p>Continued From page 5</p> <p>consume 100% of his dinner on June 24, 2009 (6:40 PM).</p> <p>Interview with staff after the meal observations on June 23, and Jun 24, 2009 at the group home and the day program observations, revealed that Client #1 usually eats 100% of his food. On June 25, 2009 at 3:37 PM, the Qualified Mental Retardation Professional (QMRP) indicated that staff and the nurse weigh the clients, however the nurse is responsible for ensuring that the weights are accurately documented in the client's record.</p> <p>Record review on June 25, 2009 at 3:50 PM revealed that Client #1 had a June 1, 2009 continuing physician's order for a 1400 - 1500 Calorie - No Added Salt, Bite-Size Diet. The medical record revealed a chart on which the following weights were documented:</p> <p>January 2009 - 152 pounds February 2009 148 pounds March 2009 - 143 pounds April 2009 - 140 pounds May 2009 - 140 pounds June 2009 - 139 pounds</p> <p>On June 24, 2009 at 2:53 PM, the review of the Individual Support Plan (ISP) Nutritional Assessment dated January 15, 2009 revealed Client #1 was 5 feet, 5 inches tall and that his healthy weight range was 114 to 149 pounds. Further review of the nutritional assessments, however revealed they failed to establish a daily calorie requirement to maintain the client in optimum health. The first Quarterly Nutritional Assessment conducted on April 6, 2009 revealed that the client weighed 152 pounds (January 2009) and 148 pounds in February 2009. The</p>	W 217		
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W 217	Continued From page 6 nutritionist indicated that the client remained within his healthy body weight range and that his weight would be monitored quarterly. At the time of the survey, however, there was no evidence that the the client's additional weight loss of eight (8) pounds from February 2009 to April 2009 (140 pounds) had been addressed. Additionally, at the time of the survey, there was no evidence weight loss had been identified as a health goal, or that a comprehensive assessment of the client's caloric requirement had been conducted.	W 217			
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure continuous active treatment was implemented in accordance with the interdisciplinary team (IDT) recommendations for one of three clients in the sample. (Client #3) The finding includes: The facility failed to ensure that Client #3's individual program objectives were implemented for cleaning his lunch box and packing his lunch as evidenced below:	W 249	1. The staff will be retrained on how to implement Client #3's Individual Program Plan as recommended by the IDT. In the future, each Shift Supervisor will ensure that the training objectives are implemented on each shift as recommended. The Residential Manager will provide follow up to ensure that implementation of training objectives are documented. The QMRP will ensure that training is provided annually and as needed when concerns are observed.	07/31/09	

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W 249	<p>Continued From page 7</p> <p>Interview with Client #3's day program staff on June 23, 2009 at 1:30 PM, revealed that he brings his lunch to the day program from his group home daily.</p> <p>On June 23, 2009 at 6:30 PM, a staff at the group home was observed putting food leftover from dinner into a small plate and putting a lid on it. During this time the client was not in the kitchen.</p> <p>On June 25, 2009 at approximately 8:20 AM, staff was observed washing out a lunchbox. The staff was then observed to put ravioli and bread in a plate and pack it into the lunch box. During this time, the client was sitting at the dining table eating his breakfast and talking to an imaginary person on the telephone.</p> <p>Interview with staff indicated she was preparing the lunch for Client #3 to take for his lunch at the day program because it had not been prepared by the client and staff during the previous evening.</p> <p>Record review on June 25, 2009 at 10:50 AM, revealed that during the February 23, 2009 Individual Support Plan, the IDT recommended training objectives for Client #3 to teach him how to pack his lunchbox for his day program and to clean his lunch box when he returned to the group home from his day program. At the time of the survey, there was no evidence that Client #3 was provided the opportunity to participate in his aforementioned training as recommended by the IDT.</p>	W 249			
W 252	<p>483.440(e)(1) PROGRAM DOCUMENTATION</p> <p>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable</p>	W 252			

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W 252	<p>Continued From page 8 terms.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure accurate documentation of progress on the Individual Program Plan (IPP) objectives, for one of the three clients included in the sample. (Client #3)</p> <p>The finding includes:</p> <p>On 6/25/09 at 8:05 AM, Client #3 was observed standing at the front door, stating repeatedly, "I'm Mad". The client's breakfast was observed still on the table. At 8:15 AM, he had a conversation on a play telephone with an imaginary person, then sat at the table to finish eating his breakfast.</p> <p>Interview with staff On 6/25/09 at 8:10 AM, staff revealed that the client was upset for no reason and that he often did that. "It's one of his behaviors."</p> <p>On June 25, 2009 at 10:23 AM, the documentation forms provided to monitor the frequency of the targeted behaviors, behavioral intervention were reviewed. The subsequent review of the data revealed that the facility failed to maintain the required documentation on the client's behaviors as evidenced below:</p> <p>a. June 24, 2009 - Client #3 exhibited 2 incidents of verbal abuse and an incident of ordering staff or peers to do something. There was no documentation on the ABC data form for these behaviors.</p>	W 252			

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W 252	Continued From page 9 b. June 15, 2009 - Client #3 began to curse the nurse when he was told to come take his medications. There was no data on the behavioral frequency chart. Only ABC data was documented on June 15, 2009. c. May 1,2,3,4,6,8,13, 2009 - Client exhibited behaviors were documented on the behavioral frequency chart. ABC data was collected only on May 3, and May 20, 2009. At the time of the survey, there was no evidence that the facility had consistently maintained data on both the behavioral frequency chart and ABC data form to ensure the client's progress in the objectives could be accurately monitored.	W 252	1. Staff were trained on 3/27 on how to document on the ABC data form. However, they will be retrained at the next staff meeting & in-service training session on how and when to complete the form. The Shift Supervisor on each shift will ensure that the form is completed at the time a behavior occurs. The Residential Manager will monitor this progress and the QMRP will ensure that training is received annually and as needed when a problem with documentation is observed.	6/8/09
W 331	483.480(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure nursing services were provided in accordance with the needs of two of the six clients residing in the facility. (Clients #1 and 4) The findings include: 1. [Cross refer to W369.] The facility's nursing services failed to ensure and adequate supply of stool softener was available for Client #4 . Interview with the Registered Nurse (RN) on June 23, 2009 at 5:25 PM, revealed no Docusate Sodium was available for Client #4. Further interview with the nurse revealed the Trained Medication Aide (TME) who usually administers	W 331	1. Stool softener was obtained for Client #4. In the future, the Nursing Coordinator will ensure that an adequate amount of stool softener is obtained from the pharmacy to at least last a month.	07/1/09

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W 331	<p>Continued From page 10</p> <p>the medications in the mornings and evenings had not informed her that the client's supply of Docusate Sodium was low. According to the nurse, the protocol was that the RN be notified if there was not a sufficient amount of any medication so that she may reorder it.</p> <p>Record review on June 23, 2009 at 5:35 PM revealed the client was to receive the stool softener every evening to prevent constipation. There was no evidence nursing services were coordinated to ensure the supply of Client's stool softener was adequate for his daily dosage.</p> <p>2. The facility's nursing services failed to develop a system to ensure that the frequency and consistency of Client #4 stools were closely monitored.</p> <p>On June 23, 2009 at 5:15 PM, the review of an unusual incident report dated June 7, 2009 revealed Client #4 was taken to the emergency room due to a complaint of stomach pain and vomiting. The nurse was informed and advised the staff to take the individual to the ER. He was evaluated and diagnosed with a bowel obstruction. The client was discharged back to the group home on June 11, 2009. Discharge recommendations included implementation of a bowel movement monitoring chart and to encourage more fresh fruits and vegetables in his daily diet.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) and the RN on June 25, 2009 at 6:30 PM revealed it was difficult for staff to monitor the client's stools because he was independent for toileting and was very private. According to the nurse, staff documents the</p>	W 331	<p>2. The QMRP and Nursing Coordinator will continue to work with staff on effectively monitoring the bowel habits of Client #4 as well as maintain his privacy. Staff will be trained on possible monitoring methods at the next staff meeting & in-service training session.</p>	07/31/09	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G193	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/25/2009
NAME OF PROVIDER OR SUPPLIER WESTVIEW 02			STREET ADDRESS, CITY, STATE, ZIP CODE 74 W ST, NW WASHINGTON, DC 20015		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 331	<p>Continued From page 11</p> <p>observed stools as closely as possible and attempt to intercept the client before he flushes the commode.</p> <p>Interview with the QMRP revealed the day program maintained a weekly bowel chart for Client #4, which is sent to the group home weekly. Review of the bowel charts received from the day program for the weeks of June 15, June 22, and June 23, 2009 revealed one stool documented on June 22, 2009. On that date, two small hard balls were documented. Day program staff commented on the form "Only had one BM for the week." Further interview with the group home nurse indicated the client may be having additional stools at the group home and the day program, however due to his desire for privacy, some of the stools may not be observed.</p> <p>The review of the Nursing Quarterly review dated May 15, 2009 on June 23, 2009 at 5:10 PM revealed "[Client] is secretive and has a tendency to go to the bathroom on his own. Prefers privacy. Monitoring his bowel movements continue to be a problem for staff."</p> <p>Record review confirmed the client's diagnoses include constipation. The review of documentation at the group home revealed a form on which staff should document the client's stools on each shift. Stool records for the period June 1, 2009 through June 6, 2009 were reviewed and revealed one stool was documented (on June 4, 2009) during this time. According to the documentation forms, after the client was readmitted to the group home, stools were also observed on June 11, 2009, June 15, 2009, June 20, 2009. At the time of the survey, there was no evidence an effective system had</p>	W 331			

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W 331	<p>Continued From page 12</p> <p>been devised to verify the frequency of the client's stools.</p> <p>3. [Cross refer to W217] The facility's nursing services failed to address Client #1's weight loss.</p> <p>The review of the March 30, 2009 monthly nursing review on June 24, 2009 at 2:50 PM revealed Client #1 had lost 5 pounds since February, 2009. Further record review revealed the client's weight loss as evidenced below:</p> <p>1/09 - 152 pounds 2/09 - 148 pounds 3/09 - 143 pounds 4/09 - 140 pounds 5/09 - 140 pounds 6/09 - 139 pounds</p> <p>Interview with the nurse and the QMRP on June 25, 2009 revealed that the nurse was responsible for monitoring the client's monthly weights.</p> <p>According to the nursing care plan dated March 30, 2009, the nurse would continue to assess, assist and provide support to the client. The care plan was signed by the RN and the QMRP. Individuals responsible for oversight of the client's nutrition included the physician, nurse, the QMRP and the dietitian. At the time of the survey, there was no evidence the nurse had coordinated services with the designated professionals identified in the client's health care plan, to ensure that the client's weight loss was addressed timely.</p>	W 331	<p>3. The Nursing Coordinator and the Primary Care Physician in conjunction with the Nutritionist will be consulted regarding Client #1's weight loss. Written documentation will be requested to state if the current weight loss is a health concern and if so it will be documented as such on the Health Management Care Plan. In the future, the Nursing Coordinator will ensure that all noted health concerns are addressed and documented on the Health Management Care Plan in a timely manner.</p>	08/14/09	
W 362	<p>483.460(j)(1) DRUG REGIMEN REVIEW</p> <p>A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly.</p>	W 362			

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W 362	Continued From page 13 This STANDARD is not met as evidenced by: Based on interview and the record review, the facility failed to ensure that quarterly drug reviews were conducted timely for three of three clients in the sample. (Clients #1, #2, and #3). The findings include: Interview with the Qualified Mental Retardation Professional (QMRP) on June 25, 2009 at approximately 5:30 PM, revealed that the pharmacist should conduct a quarterly drug medication review for each client. The review of the clients' medical record on June 25, 2009 at 5:45 PM revealed that the drug regimen reviews had been conducted at intervals greater than 120 days as evidenced below: a. Client #3: July 9, 2008, November 25, 2008, March 28 2009. b. Client #2: July 9, 2008, November 25, 2008, March 28 2009. c. Client #2: July 9, 2008, November 25, 2008, March 28 2009. At the time of the survey, there was no evidence that drug reviews had been conducted at least quarterly by the pharmacy.	W 362	1. In the future, the Nursing Coordinator and the QMRP will ensure that the Pharmacist conducts quarterly drug reviews as required.	07/1/09
W 369	483.480(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.	W 369		

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W 389	Continued From page 14 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to establish a system to ensure that all medications were administered without error for one of the six clients residing in the facility. (Client #4) The finding includes: During the evening medication administration on June 23, 2009 at 5:25 PM, Client #4 was observed to receive Lipitor 20 mg, 1 tab by the Registered Nurse (RN). The nurse was observed to look for Docusate Sodium in the medication closet for the client, however determined that it was not available. Interview with the RN on June 23, 2009 at 5:25 PM, revealed that the client was prescribed Docusate Sodium to be administered every evening as a stool softener. The nurse acknowledged that this medication was not administered because there was none available. Record review on June 23, 2009 at 5:30 PM, revealed that Client #4 was prescribed to receive Docusate Sodium 50 mg/5 ml, 2 teaspoonful (100 mg=10 ml) every evening as a stool softener to prevent constipation. At the time of the survey, there was no evidence that Client #4 received his stool softener as prescribed.	W 389	1. See W331 #1	6/21/09	
W 426	483.470(d)(3) CLIENT BATHROOMS The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water,	W 426			

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W 426	<p>Continued From page 15</p> <p>ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure water temperatures did not exceed 110 degrees Fahrenheit at areas of the facility used by six of six clients (Clients #1, #2, #3, #4, #5, and #6)</p> <p>The findings include:</p> <p>On June 24, 2009 at approximately 6:00 PM, during hand washing, the surveyor noted the hot water temperature to be very warm to touch.</p> <p>Measurement of the hot water temperatures on June 24, 2009 between 6:11 PM to 6:15 PM revealed that they exceeded 110 Fahrenheit as evidenced below.</p> <p>a. Kitchen 110 degrees Fahrenheit b. Powder room: 110 degrees Fahrenheit c. Second floor bathroom #1 - 124 degrees Fahrenheit d. Second floor bathroom #2 - 122 degrees Fahrenheit</p> <p>The Qualified Mental Retardation Professional (QMRP) was requested to notify the administrator of the hot water temperatures.</p> <p>At 6:35 PM the water temperatures were checked again and were the following:</p> <p>a. Kitchen: 108 degrees Fahrenheit a. Powder Room - 116 degrees Fahrenheit b. Second floor bathroom #1: 119 degrees</p>	W 426	<p>1. Staff have been instructed to keep a daily log of the hot water temperature when it is checked prior to the morning and night time showers. Staff will be retrained on how to check and document the water temperature as instructed to immediately notify the Environmental Manager at anytime it exceeds 110 degrees Fahrenheit.</p>	07/31/09

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W 426	Continued From page 16 Fahrenheit c. Second floor bathroom #1: 118 degrees Fahrenheit d. Basement: 118 degrees Fahrenheit Interview with the QMRP revealed that at approximately 6:25 PM, the maintenance supervisor reduced the temperature setting on the hot water heater. Observation of the temperature setting on the hot water heater revealed that it was on "low". Interview with the shift leader and the QMRP revealed that the temperature setting on the hot water had been lowered, however it would take a time for the temperature to decrease. Measurement of the water temperature's on June 24, 2009 at 7:10 PM in the aforementioned areas of the facility used by the clients, revealed the water temperatures ranging from 105 Fahrenheit to 110 degrees Fahrenheit. There was no evidence however, that the facility had ensured that the hot water temperatures did not exceed 110 degrees Fahrenheit at all times.	W 426			
W 460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure timely nutritional follow-up for one of six clients residing in the facility. (Client #4) The finding includes:	W 460			

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W 480	<p>Continued From page 17</p> <p>[Cross refer to W474] Client #4 was observed to have missing teeth. On June 23 and 24, 2009 at dinner, the client received a regular diet with chopped meat.</p> <p>Interview with the staff on June 24, 2009 at 6:40 PM, revealed that Client #4 usually eats all of his food and also received a nutritional supplement, Ensure Plus three times a day to promote weight gain. Interview with the Qualified Mental Retardation Professional (QMRP) on June 25, 2009 at 6:30 PM revealed the client's nutritional status had not been reassessed after his readmission to the group home on June 11, 2009. Interview with the nurse on June 25, 2009 at 6:30 PM, revealed that although the client was prescribed a stool softener, constipation continued to intermittently be a concern.</p> <p>Record review on June 25 2009 at 6:35 PM confirmed that the appropriateness of the client's diet had not been reassessed by the nutritionist since the client's readmission to his group home from the hospital. Additionally, there was no evidence a follow-up had been conducted on the nutritionist's January 15, 2009 recommendation to consider ground food for the client to improve his tolerance of his diet.</p>	W 400	<p>1. The Nutritionist will be consulted to review the discharge summary from Client #4's June 2009 hospitalization and requested to make any recommendations regarding his nutritional status due to the hospitalization. The Speech Pathologist will also be consulted to follow up on the Nutritionist's recommendation for a change in diet texture to ground food. In the future, the QMRP along with the Nursing coordinator will ensure that all individuals are assessed by the appropriate discipline following hospitalization as well as conduct follow up is on all recommendations.</p>	08/19/09
W 474	<p>483.480(b)(2)(iii) MEAL SERVICES</p> <p>Food must be served in a form consistent with the developmental level of the client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure food was served in the texture recommended for one of the</p>	W 474		

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W 474	<p>Continued From page 18 six clients residing in the facility. (Client #4)</p> <p>The finding includes:</p> <p>Dinner observations on June 23, 2009 at 6:30 PM, and on June 24, 2009 at 6:40 PM revealed Client #4 ate all of food. His jaws were observed protruding, and appeared to be lightly chewing his food. Further observation revealed the food was of a regular consistency, however, the staff had chopped the client's meat.</p> <p>Staff interview on both days at dinner time concerning the client's protruding jaws during the meal observations revealed "That's the way he chews."</p> <p>On June 23, 2009 at 5: 15 PM, the review of an unusual incident report dated June 7, 2009 revealed that Client #4 was admitted to the hospital through the Emergency Room (ER) for stomach pain. He was diagnosed with constipation/bowel obstruction. During the hospitalization, the client's nutrition and hydration was maintained via nasogastric tube (NGT). The client's diet was upgraded to a mechanically soft diet during his hospitalization, and he was subsequently discharged to his group home on this diet. The review of the discharge summary revealed a recommendation that more fresh fruits and vegetables in the client's daily diet (to improve bowel elimination).</p> <p>On June 23, 2009 at 5:30 PM, the Individual Support Plan (ISP) nutritional assessment dated January 15, 2009 revealed "He has many missing teeth and doesn't appear to chew food very well. Regular Double Portions at each meal with high fiber. May benefit from having foods ground</p>	W 474	<p>1. The Speech Pathologist will be consulted to follow up on the recommendation made by the Nutritionist regarding Client #4 benefiting from a ground diet. The Speech Pathologist will be informed of his dental status to ensure that an adequate diet texture is recommended.</p>	08/14/09

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W 474	<p>Continued From page 19</p> <p>before he eats it." There was no evidence that the nutritionist had followed up on her recommendation to modify the texture of the client's food to maximize his tolerance of high fiber foods.</p> <p>On June 24, 2009 at 11:40 AM, the review of the physician's orders dated June 1, 2009 revealed the client was prescribed a "Regular, Double Portions with each meal. Apples and other high fiber snacks. Further record revealed the client's diagnosis of Advanced Periodontal Disease and a need for repair of carious tooth lesions .</p> <p>At the time of the survey, there was no evidence the facility had addressed the client's faulty dentition and missing teeth when prescribing the texture of his diet.</p>	W 474			

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1 000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted on June 23, 2009 through June 25, 2009. A random sampling of three resident's from the residential population of six resident's with varying degrees of disability was selected for the survey. The results of the survey were based on observations in the home and at two day programs, staff interviews, as well as a review of the resident and administrative records, including a review of the unusual incident reports.</p>	1 000		
1 047	<p>3502.5 MEAL SERVICE / DINING AREAS</p> <p>Each GHMRP shall be responsible for ensuring that meals, which are served away from the GHMRP, are suited to the dietary needs of residents as indicated in the Individual Habilitation Plan.</p> <p>This Statute is not met as evidenced by: Based on observation, interviews, and record review, the GHMRP failed to verify that the lunches prepared to be taken to the day program were suited to the dietary needs of one of three residents in the sample. (Resident #3)</p> <p>The finding includes:</p> <p>The GHMRP failed to ensure that staff implement the lunch menus as written.</p> <p>On June 25, 2009 at 8:30 AM, staff was observed preparing a lunch for Resident #3 which consisted of canned ravioli, a slice of buttered whole wheat bread, and a diet soda.</p> <p>On June 25, 2009 at 8:45 AM, discussion with the staff preparing Resident #3's lunch indicated the</p>	1 047	<p>1. It has been noted that Client #3 enjoys taking a hot lunch with him to school versus what is on the provided menu that should be followed by staff. The nutritionist will be consulted on how to best accommodate Client #3's lunch preference when going to the day program at which time staff will be trained on the implementation of the Nutritionist's recommendation and/or menu plan. In the future, the QMRO will ensure that all staff are trained on how to implement the lunch menu as written by the Nutritionist as well any goals and objectives associated with the menu.</p>	08/14/09

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Don West J.M.D.* TITLE: *July 29, 2009*

STATE FORM (X6) DATE

Health Regulation Administration

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1047	Continued From page 1 resident enjoyed the leftovers and like hot food for lunch. "if they don't make the plate in the evening, we make it in the morning." Interview with the QMRP on June 25, 2009 at 4:30 PM indicated that the written menus planned by the nutritionist included breakfast, lunch and dinner. According to the QMRP, the lunch menu should be followed by the staff at all times. On June 25, 2009 at 4:40 PM, the review of the planned lunch menus for June 23, 24, and 25, 2009 revealed that the food provided for Resident #3's lunch on June 24, and June 25, 2009 failed to coincide with the written menus. At the time of the survey, there was no evidence that the staff had been trained to implement the lunch menus as written by the nutritionist.	1047		
1056	3502.14 MEAL SERVICE / DINING AREAS Each GHMRP shall train staff in the storage, preparation and serving of food, the cleaning and care of equipment, and food preparation in order to maintain sanitary conditions at all times. This Statute is not met as evidenced by: Based on observations, interview and review of staff training records, the GHMRP failed to ensure sanitary food handling and storage practices. The findings include: 1. On June 25, 2009 at 12:22 PM, a package of frozen chicken was observed in a shallow container of water which was on the counter in the kitchen. At 1:15 PM and again at 2:30 PM, the chicken was observed to remain in this location. At 2:55 PM, the chicken was observed	1056	1. The staff were trained on July 3, 2009 on how to properly thaw frozen food items.	07/3/09

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1056	Continued From page 2 to have been placed on the bottom shelf of the refrigerator. Interview with the Qualified Mental Retardation Professional on June 25, 2009 at approximately 4:30 PM, revealed that some staff on every shift had completed certified food handler training. The review of training records on June 23, 2009 at approximately 2:45 PM verified three of the staff, S1, S9, and S12 were certified food handlers. There was no evidence, however, that that general training had been provided to the other staff to ensure safe food handling practices. There was no evidence the GHMRP had implemented effective food handling procedures to prevent the potential growth of food borne organisms. 2. The GHMRP failed to ensure effective training in food handling to ensure ensure the proper cleaning and maintenance of food service equipment. a. The filter underneath the range hood was observed to have a heavy accumulation of grease. The ceramic tiles installed on the wall behind the range had greasy residue. b. The surface of the broiler of the range had a white substance which appeared to be chemical residue from oven cleaner. c. All lower cabinets contained operational soil and were in need of cleaning.	1056	2. The staff will be trained on how to properly clean and maintain food service equipment. a. The filter underneath the range hood will be replaced. The ceramic tile installed on the wall behind the range was cleaned of the greasy residue. b. The surface of the broiler of the range was cleaned of the white substance that appeared to be a chemical residue from oven cleaner. c. All of the lower cabinets were cleaned. In the future each Shift Supervisor will ensure the cleanliness and maintenance of all food service equipment. Monitoring will be conducted by the Residential Manager.	07/3/09 08/3/09 07/1/09 07/1/09 07/1/09
1058	3502.16 MEAL SERVICE / DINING AREAS A review and consultation by a dietitian or nutritionist shall be conducted at least quarterly to ensure that each resident who has been prescribed a modified diet receives adequate	1058		

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NAME OF PROVIDER OR SUPPLIER WESTVIEW 02	STREET ADDRESS, CITY, STATE, ZIP CODE 74 W ST, NW WASHINGTON, DC 20015
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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1058	<p>Continued From page 3</p> <p>nutrition according to his or her Individual Habilitation Plan.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that a dietitian or nutritionist conducted at least a quarterly review and consultation for one of the six residents in the GHMRP. (Resident #4)</p> <p>The findings include:</p> <p>The facility failed to ensure that Client #4 received a nutritional assessment at least quarterly and failed to ensure the client was provided food of the recommended texture as evidenced below:</p> <p>Dinner observations on June 23, 2009 at 6:30 PM, and on June 24, 2009 (6:40 PM) revealed the Client #4 ate all of food. His jaws were observed protruding, and appeared to lightly chew his food. Further observation revealed the food was in a regular consistency, however, the staff had chopped the client's meat.</p> <p>Staff interview on both days at dinner time concerning the client's protruding jaws during the meal observations indicated "That's the way he chews."</p> <p>On June 23, 2009 at 5: 15 PM, the review of an unusual incident report dated June 7, 2009 revealed that Client #4 was admitted to the hospital through the Emergency Room for stomach pain. He was diagnosed with constipation/bowel obstruction. During the hospitalization, the client 's nutrition and</p>	1058	<p>1. The Nutritionist will be consulted to review the discharge summary from Client #4's June 2009 hospitalization and requested to make any recommendations regarding his nutritional status due to the hospitalization. The Speech Pathologist will also be consulted to follow up on the Nutritionist's recommendation for a change in diet texture to ground food. In the future, the QMRP along with the Nursing coordinator will ensure that all individuals are assessed by the appropriate discipline following hospitalization as well as conduct follow up is on all recommendations. The QMRP will also ensure that the Nutritionist as well as other disciplines conduct quarterly reviews as required.</p>	08/14/09
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Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0202	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/25/2009
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NAME OF PROVIDER OR SUPPLIER WESTVIEW 02	STREET ADDRESS, CITY, STATE, ZIP CODE 74 W ST, NW WASHINGTON, DC 20015
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1 058	<p>Continued From page 4</p> <p>hydration was maintained via nasogastric tube (ngt). The client's diet was upgraded to a mechanically soft diet during his hospitalization, and he was subsequently discharged to his group home on this diet. The review of the discharge summary revealed a recommendation that more fresh fruits and vegetables in the client's daily diet.</p> <p>Further review on June 25 2009 at 6:35 PM, confirmed that the appropriateness of the client's diet had not been reassessed by the nutritionist since the client's readmission to his group home from the hospital. Additionally, there was no evidence follow-up had been conducted on the nutritionist's January 15, 2009 recommendation to consider ground food for the client to improve his tolerance of his diet.</p>	1 058		
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1 073	<p>3503.3(b) BEDROOMS AND BATHROOMS</p> <p>Each bedroom shall be equipped with at least the following items for each resident:</p> <p>(b) Clean comfortable pillow;</p> <p>This Statute is not met as evidenced by: Based on observation, the GHMRP failed to ensure each bedroom was equipped with clean and comfortable bed pillows for three of the six residents in the facility. (Resident #3, #4 and #5)</p> <p>The finding includes:</p> <p>Observation of the environment on June 25, 2009 at approximately 2:30 PM, revealed that the bed pillows of Resident #3 and #5 were flat and appeared to be uncomfortable. Resident #4's bed pillow was observed to be lumpy.</p>	1 073	<p>1. New pillows will be purchased for Clients #3, 4, & 6. In the future, the Residential Manager will ensure that all clients have clean comfortable pillows. The pillows will be checked monthly and changes as needed.</p>	08/3/09
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0202	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/25/2009
NAME OF PROVIDER OR SUPPLIER WESTVIEW 02		STREET ADDRESS, CITY, STATE, ZIP CODE 74 W ST, NW WASHINGTON, DC 20015		
(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 082	Continued From page 5	I 082		
I 082	3503.10 BEDROOMS AND BATHROOMS Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting. This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure all bathrooms were equipped with paper towels and cup dispensers to accommodate the needs of all residents residing in the facility. [Residents #1, #2, #3, #4, #5 and #6] The finding includes: Observation of the GHMRP environment was conducted on June 25, 2009 with the Qualified Mental Retardation Professional (QMRP), beginning at 2:00 PM. The observations revealed there were no paper towel and cup dispensers available in the bathrooms. The QMRP acknowledged the aforementioned bathroom fixtures were not available. At the time of the survey, there was no evidence these bathroom fixtures were provided as required.	I 082	1. Paper towels, paper cups, and soap is now available in all bathrooms throughout the home and will continue to be available as required. Each Shift Supervisor will ensure that these items remain available and are replenished when needed. The Residential Manager will monitor this process.	7/16/09
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.	I 090		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD83-0202	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/25/2009
NAME OF PROVIDER OR SUPPLIER WESTVIEW 02		STREET ADDRESS, CITY, STATE, ZIP CODE 74 W ST, NW WASHINGTON, DC 20015		
(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 090	<p>Continued From page 6</p> <p>This Statute is not met as evidenced by: Based on observation and interview the GHMRP failed to maintain the interior of the GHMRP in a safe, clean, orderly, and attractive manner.</p> <p>The findings include:</p> <p>I. The GHMRP failed to maintain the interior environment safe, clean, orderly, and attractive as evidenced below:</p> <p>A. Observation of the water temperature in the GHMRP on June 24, 2009 at approximately 6:00 PM revealed that it felt very warm to touch.</p> <p>Measurement of the hot water temperatures on June 24, 2009 between 6:11 PM to 6:15 PM revealed that they exceeded 110 Fahrenheit as evidenced below:</p> <p>a. Kitchen 110 degrees Fahrenheit b. Powder room: 110 degrees Fahrenheit c. Second floor bathroom #1 - 124 degrees Fahrenheit d. Second floor bathroom #2 - 122 degrees Fahrenheit</p> <p>The QMRP was requested to notify the administer of the hot water temperature.</p> <p>At 6:35 PM the water temperatures were checked again and were the following:</p> <p>a. Kitchen: 108 degrees Fahrenheit b. Powder Room - 116 degrees Fahrenheit c. Second floor bathroom #1: 119 degrees Fahrenheit d. Second floor bathroom #1: 118 degrees Fahrenheit</p>	I 090	<p>1. Staff have been instructed to keep a daily log of the hot water temperature when it is checked prior to the morning and night time showers. Staff will be retrained on how to check and document the water temperature as instructed to immediately notify the Environmental Manager at anytime it exceeds 110 degrees Fahrenheit.</p>	07/1/09

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NAME OF PROVIDER OR SUPPLIER WESTVIEW 02		STREET ADDRESS, CITY, STATE, ZIP CODE 74 W ST, NW WASHINGTON, DC 20015		
(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
1090	<p>Continued From page 7</p> <p>e. Basement: 118 degrees Fahrenheit</p> <p>Interview with the QMRP revealed that at approximately 6:25 PM, the maintenance supervisor reduced the temperature setting on the hot water heater. Observation of the temperature setting on the hot water heater revealed that it was on "low". Interview with the shift leader and the Qualified Mental Retardation Professional (QMRP) revealed that the temperature setting on the hot water had been lowered, however it would take a time for the temperature to decrease.</p> <p>Measurement of the water temperatures on June 24, 2009 at 7:10 PM in the aforementioned areas of the GHMRP used by the residents, revealed the water temperatures ranging from 105 Fahrenheit to 110 degrees Fahrenheit. There was no evidence however, that the GHMRP had ensured that the hot water temperatures did not exceed 110 degrees Fahrenheit at all times.</p> <p>B. Observation of the GHMRP environment was conducted on June 25, 2009 with the QMRP, beginning at 2:00 PM. The observations revealed the following concerns:</p> <ol style="list-style-type: none"> 1. Several splintered edges were observed on the front of the wine storage unit located beside the dining table. 2. The knob, needed to open the left door of the buffet in the dining room, was missing. 3. A flexi glass dining table cover was stored leaning against the wall behind the buffet. The table cover extended several inches above the top of the buffet and had a slightly sharp edge, which present a potential safety hazard. 	1090	<ol style="list-style-type: none"> B1. The splintered edges on wine store unit in the dinning room have been repaired. B2. The knobs on the left door of the buffet table in the dinning room will be replaced. B3. The flexi glass that was stored in the dinning room was removed. 	<p>07/1/09</p> <p>08/3/09</p> <p>07/1/09</p>

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NAME OF PROVIDER OR SUPPLIER WESTVIEW 02		STREET ADDRESS, CITY, STATE, ZIP CODE 74 W ST, NW WASHINGTON, DC 20015		
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1000	Continued From page 8 4. The door strip attached to the bottom of the front entrance door did not fit securely to the floor. Light was observed underneath the bottom of the door. 5. The edge of the carpet, attached to the top step at the front entrance, was rolled upward, and presented a potential trip hazard. 6. Heavy stains, appearing to have been caused by a liquid substance were observed on the wall, by the window and beside the electrical outlet in the bedroom of Resident #2. 7. A large yellow stain was observed on the ceiling of the dining room. Two stained ceiling tiles were observed in the kitchen 8. The mirror on the wall in the bedroom of Residents #1 and #3 was observed to be mobile when pressure was applied. At 5:10 PM the mirror was observed to have been removed from the wall, pending a secure attachment. 9. One of the storage drawers in Resident #1's bed was missing. The other storage drawer in Resident #1's bed was not secured on tract. 10. The bottom drawers in Resident #1's chest of drawers could not be opened completely because of insufficient space between the foot of the bed and the chest of drawers. 11. A nail was exposed at the corner of the lower drawer of the chest belonging to Resident #1. 12. The end of the down spout, located near the front entrance door to the basement was bent, creating a potential for water accumulation on the	1000	B4. A door sweep for the front entrance door will be provided. B5. The carpet attached to the top step at the front entrance door will be repaired and/or replaced as needed. B6. The wall in Client #2's bedroom has been cleaned and will be painted to delete the stains. B7. The ceiling tiles in the kitchen will be replaced. B8. The mirror on the wall in client #1 & 3's bedroom will be secured. B9. The storage drawers in the Client #1's bed will be replaced and the other drawer will be repaired. However a new bedding unit will be purchased. B10. A smaller bed and dresser for client # 1 will purchased in order to accommodate the space and allow him to open his drawers completely.	08/31/09 08/31/09 07/11/09 08/31/09 08/03/09 08/31/09 08/14/09 08/31/09

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HF093-6282	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/28/2009
NAME OF PROVIDER OR SUPPLIER WESTVIEW 02		STREET ADDRESS, CITY, STATE, ZIP CODE 74 W ST, NW WASHINGTON, DC 20015		
(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
1000	Continued From page 8 4. The door strip attached to the bottom of the front entrance door did not fit securely to the floor. Light was observed underneath the bottom of the door. 5. The edge of the carpet, attached to the top step at the front entrance, was rolled upward, and presented a potential trip hazard. 6. Heavy stains, appearing to have been caused by a liquid substance were observed on the wall, by the window and beside the electrical outlet in the bedroom of Resident #2. 7. A large yellow stain was observed on the ceiling of the dining room. Two stained ceiling tiles were observed in the kitchen 8. The mirror on the wall in the bedroom of Residents #1 and #3 was observed to be mobile when pressure was applied. At 5:10 PM the mirror was observed to have been removed from the wall, pending a secure attachment. 9. One of the storage drawers in Resident #1's bed was missing. The other storage drawer in Resident #1's bed was not secured on track. 10. The bottom drawers in Resident #1's chest of drawers could not be opened completely because of insufficient space between the foot of the bed and the chest of drawers. 11. A nail was exposed at the corner of the lower drawer of the chest belonging to Resident #1. 12. The end of the down spout, located near the front entrance door to the basement was bent, creating a potential for water accumulation on the	1000	B11. The nail that was exposed at the corner of Client #1's drawer was removed. B12. A new drain spout will be purchased to replace the one located near the front entrance door to the basement.	07/1/09 08/3/09

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0292	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/25/2009
NAME OF PROVIDER OR SUPPLIER WESTVIEW 02		STREET ADDRESS, CITY, STATE, ZIP CODE 74 W ST, NW WASHINGTON, DC 20015		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
1 090	Continued From page 9 roof. 13. A heavy accumulation of soap scum was observed on the back of the shower curtain in the front bathroom. Caulking was partially missing from around the tub where it was sealed to the wall. 14. Heavily scaling paint was observed on the window sill underneath the air conditioner in the area of egress from the second floor. C. On June 25, 2009 at 3:55 PM, the cover of the electrical outlet near the refrigerator in the medication area/office was observed to be not attached to the wall. Electrical wires were exposed behind the outlet cover.	1 090	B13. A new shower curtain was purchased for the front bathroom as well as the other bathrooms in the home. In the future, each Shift Supervisor will monitor the cleanliness of the shower curtains and advise staff to wash when needed as well as advise the Residential Manager that new ones need to be purchased due to wear and tare.	07/10/09
1 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been performed and that the employee's health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that annual health certificates/ inventories was obtained for seven (7) of twelve (12) staff and and two (2) of six (6) consultants working in the facility. The findings include: Interview with the Qualified Mental Retardation	1 206	B14. The area on the window ceil underneath the air conditioner on the second floor will be repainted. C. The cover of the electrical outlet in the medication office was repaired.	08/31/09 07/16/09

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1208	Continued From page 10 Professional (QMRP) during the entrance conference on June 23, 2009 at 10:30 AM, revealed that several direct care staff had been recently hired to work at the group home. At this time, the QMRP was requested to obtain the the health certificates of all for staff working in the facility. Review of the provided records on June 23, 2009 at 2:30 PM revealed a health certificate had not been provided for each of the employees. The review of additional health certificates provided on June 25, 2009 at 4:30 PM revealed there was no health certificate available for S2, S3, S4, S6, S8, S11, and S12. S5 had a Tuberculin screening, however lack a health certificate. Review of the provided records on June 23, 2009 at 2:30 PM revealed a health certificate had not been provided for each of the employees. The review of additional health certificates provided on June 25, 2009 at 4:30 PM revealed there was no health certificate available for C4 and C5.	1208	A health certificate for S2 will be obtained. A health certificate for S3, newly hired, will be obtained. A health certificate for S4 will be obtained. A health certificate for S6 will be obtained. S8 is no longer an employee of Westview, Inc. A health certificate for S11, newly hired, will be obtained. S12 is no longer an employee at W Street.	08/31/09 08/31/09 08/31/09 08/31/09 07/17/09 08/31/09 07/17/09
1222	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, interview and record review, the GHMRP failed to ensure ongoing in-service programs were scheduled for all personnel in accordance with the needs of one of the three residents in the sample. (Resident #3) The findings include: 1. The GHMRP failed to ensure staff were	1222	A health certificate will be obtained for S5. A health certificate fro C4 will be obtained. A health certificate for C5 will be obtained.	08/31/09 08/31/09 08/31/09

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NAME OF PROVIDER OR SUPPLIER WESTVIEW 02		STREET ADDRESS, CITY, STATE, ZIP CODE 74 W ST, NW WASHINGTON, DC 20015		
(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
1222	<p>Continued From page 11</p> <p>adequately trained to implement Resident #3's individual program plan objectives as recommended by the interdisciplinary team (IDT). [See 3521.3]</p> <p>2. The GHMRP failed to ensure that staff were trained to implement the lunch menus as written.</p> <p>[Cross refer to 3521.3] On June 23, 2009 at 6:30 PM, staff was observed packing food leftover from dinner (beef stew, carrots, and potato) in Resident #3's lunch plate for the next day. On June 25, 2009 at 8:30 AM, staff was observed preparing a lunch for Resident #3 which consisted of canned ravioli, a slice of buttered whole wheat bread, and a diet soda.</p> <p>On June 25, 2009 at 8:45 AM, discussion with the staff preparing Resident #3 lunch indicated the resident enjoyed the leftovers and like hot food for lunch. "If they don't make the plate in the evening, we make it in the morning." Interview with the QMRP on June 25, 2009 at 4:30 PM indicated that the written menus planned by the nutritionist included breakfast, lunch and dinner. According to the QMRP, the lunch menu should be followed by the staff at all times.</p> <p>On June 25, 2009 at 4:40 PM, the review of the planned lunch menus for June 23, 24, and 25, 2009 revealed that the food provided for Resident #3's lunch on June 24, and June 25, 2009 failed to coincide with the written menus. At the time of the survey, there was no evidence that the staff had been trained to implement the lunch menus as written by the nutritionist.</p> <p>3. [Cross refer to See 3521.3] The GHMRP failed to ensure staff were trained to document the ABC data as required by the behavior support</p>	1222	<p>3. Staff were trained on 3/27 on how to document on the ABC data form. However, they will be retrained at the next staff meeting & in-service training session on how and when to complete the form. The Shift Supervisor on each shift will ensure that the form is completed at the time a behavior occurs. The Residential Manager will monitor this progress and the QMRP will ensure that training is received annually and as needed when a problem with documentation is observed.</p>	08/14/09

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NAME OF PROVIDER OR SUPPLIER WESTVIEW 02			STREET ADDRESS, CITY, STATE, ZIP CODE 74 W ST, NW WASHINGTON, DC 20015		
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I 222	Continued From page 12 plan of Resident #3. Interview with the house manager on June 23, 2009 at 4:35 PM, indicated that staff had been trained on how to document on the residents' IPP training objectives. On June 25, 2009 at 10:23 AM, the review of Resident #3 BSP dated January 10, 2009 revealed ABC data (antecedents, consequences, and outcome of behavioral intervention) and the behavior frequency should both be documented when behavior occurs. Record review on June 25, 2009 at 10:35 AM revealed that the ABC data had not been consisted documented and failed to coincided with the dates on the monthly behavior frequency charts for May and June 2009. The review of training records on June 23, 2009 at 2:45 PM revealed that staff were trained on active treatment and and data collection on April 10, 2009 . At the time of the survey, however, there was no evidence that staff had received sufficient training to ensure that all data was collected in measurable terms.	I 222			
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 staff interview and record review, the	I 227			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0202	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/26/2009
NAME OF PROVIDER OR SUPPLIER WESTVIEW 02		STREET ADDRESS, CITY, STATE, ZIP CODE 74 W ST, NW WASHINGTON, DC 20015		
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I 227	<p>Continued From page 13</p> <p>GHMRP failed to ensure for twelve of twelve staff (12/12) employed by the GHMRP had current had current training to implement emergency measures to address the needs of the six of six residents. (Residents #1, #2 #3, #4, #5, and #6)</p> <p>The findings include:</p> <p>During the entrance conference on June 23, 2009 at 10:30 AM 2009 at 9:30 AM, the Qualified Mental Retardation Professional (QMRP) was requested to obtain the training records for staff working in the GHMRP.</p> <p>The review of training records on June 23, 2009 at 2:50 PM revealed no evidence of current certification in Cardiopulmonary Resuscitation (CPR) for three of the twelve (12) staff, S3, S7, and S11.</p> <p>The review of training records on June 23, 2009 at 2:50 PM also revealed no evidence that any of the twelve staff working in the facility had current First aid Certification. Interview with the Qualified Mental Retardation Professional on June 23, 2009 at 3:05 PM revealed no evidence that any of the twelve staff working had a current First Aid Certification.</p> <p>Interview with the QMRP on June 23, 2009 at 3:05 PM revealed that S3 and S11 were new employees and had not obtained there First Aid Certification yet. Further interview with the QMRP revealed that the First Aid Certifications of the other ten (10) employees (S1, S2, S4, S5, S6, S7, S8, S9, S10 and S12) had expired.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) during the entrance</p>	I 227	<p>CPR training will be scheduled for S3, newly hired.</p> <p>CPR training will be scheduled for S7.</p> <p>CPR training will be scheduled for S11.</p> <p>In the future, the QMRP will ensure that all staff are trained as needed in CPR.</p> <p>The QMRP will ensure that all staff are trained in First Aid, to include the 10 listed on the deficiency report, as they certifications expire.</p>	<p>08/31/09</p> <p>08/31/09</p> <p>08/31/09</p>

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0202	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/25/2009
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NAME OF PROVIDER OR SUPPLIER WESTVIEW 02	STREET ADDRESS, CITY, STATE, ZIP CODE 74 W ST, NW WASHINGTON, DC 20015
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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I 227	Continued From page 14 conference on June 23, 2009 at 10:30 AM, revealed that several direct care staff had been recently hired to work at the group home. At this time, the QMRP was requested to obtain the health certificates of all for staff working in the facility.	I 227		
I 229	<p>3510.5(f) STAFF TRAINING</p> <p>Each training program shall include, but not be limited to, the following:</p> <p>(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;</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that staff received training on human sexuality and nutrition to address the needs of three of three residents in the sample. (Residents #1, #2 #3, and #5)</p> <p>The finding includes:</p> <p>1. On June 23, 2009 at 10:17 AM, Resident #2 was observed to complain that the birth control pills she was prescribed made her head ache. Staff was observed to tell the resident that she should tell the nurse about the pain again.</p> <p>On June 23, 2009 at 10:20 AM, the surveyor asked Resident #2 why she continued to take the why she continued to take the birth control pills if they make her feel badly. The resident commented, "I don't want to talk about that!" Interview with the QMRP on June 23, 2009 at 2:35 PM revealed that the resident's complaint of</p>	I 229	<p>1. The Nursing Coordinator will conduct training on Human Sexuality. The QMRP will ensure that training is conducted annually or as needed when concerns arise.</p>	07/31/09

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NAME OF PROVIDER OR SUPPLIER WESTVIEW 02		STREET ADDRESS, CITY, STATE, ZIP CODE 74 W ST, NW WASHINGTON, DC 20016		
(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 229	<p>Continued From page 15</p> <p>pain had been medically addressed. According to the QMRP, the resident's behavior support plan (BSP) dated January 10, 2009 contained interventions to address provocative sexual behavior, which included inappropriate (flirting and disrobing). The BSP also addressed targeted behaviors of accusing, threats/intimidation, begging, giving - wanting back, and other types of attempted manipulative behaviors. Continued interview with the QMRP, however, revealed the staff had not been provided training on human sexuality.</p> <p>On June 23, 2009 at 2:45 PM, training records confirmed the staff were trained on the resident's BSP on March 9, 2009. At the time of the survey, however, there was no evidence that staff had received training during the past year on human sexuality to increase their understanding of the resident's physical and psychological needs.</p> <p>2. The facility failed to ensure that staff received training on implementation of the residents therapeutic diets.</p> <p>Observation of the dinner meal on June 23, 2009 at 6:30 PM revealed that except for Resident #4 and #5, all portions sizes appeared to be the same.</p> <p>Interview with staff on June 23, 2009 at 6:40 PM revealed that five of the six residents in the GHMRP were on calorie restricted diets. The review of the menu after dinner revealed, Resident #5 was prescribed a 1200 calorie, low fat, weight reduction diet. The menu revealed that Resident #4 was prescribed a Regular, No Added Salt, high fiber diet (May have seconds and May have apples anytime). Staff indicated that these menus were for the regular diets.</p>	I 229	<p>2. The Nutritionist will conduct training on the implementation of the clients' therapeutic diets. The QMRP will ensure that training is conducted annually or as diet status change.</p>	08/14/09

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0202	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/28/2009
NAME OF PROVIDER OR SUPPLIER WESTVIEW 02			STREET ADDRESS, CITY, STATE, ZIP CODE 74 W ST, NW WASHINGTON, DC 20015		
(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 229	Continued From page 16 Interview with the QMRP on June 25, 2009 at 3:35 PM indicated that the nutritionist was due to provide in-service training to staff The review of the physician's orders for June 1, 2009 on June 24, 2009 at 10:35 AM revealed that Residents #1, #2, #3, and #5 were all prescribed a 1400 - 1500 calorie diet. The review of training records on June 24, 2009 at approximately 10:50 AM revealed no documentation to verify that staff had received training on nutrition and modified diets. At the time of the survey, there was no evidence the facility ensure that staff received training in nutrition for the accurate implementation of the client's diets.	I 229			
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 record review, the GHMRP failed to ensure professional services were provided in accordance with the assessed needs of two of the six residents in the GHMRP. (Residents #1 and #4) The findings include: 1. The facility's nursing services failed to timely address Client #1's weight loss. The review of the March 30, 2009 monthly nursing review on June 24, 2009 at 2:50 PM	I 401	The Nursing Coordinator and the Primary Care Physician in conjunction with the Nutritionist will be consulted regarding Client #1's weight loss. Written documentation will be requested to state if the current weight loss is a health concern and if so it will be documented as such on the Health Management Care Plan. In the future, the Nursing Coordinator will ensure that all noted health concerns are addressed and documented on the Health Management Care Plan in a timely manner.	08/24/09	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0202	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/25/2009
NAME OF PROVIDER OR SUPPLIER WESTVIEW 02		STREET ADDRESS, CITY, STATE, ZIP CODE 74 W ST, NW WASHINGTON, DC 20015		
(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
1401	<p>Continued From page 17</p> <p>revealed Client #1 had lost 5 pounds since February, 2009. Further record review revealed the client's weight loss as evidenced below:</p> <p>1/09 - 152 pounds 2/09 - 148 pounds 3/09 - 143 pounds 4/09 - 140 pounds 5/09 - 140 pounds 6/09 - 139 pounds</p> <p>interview with the nurse and the QMRP on June 25, 2009 revealed that the nurse was responsible for monitoring the client's monthly weights.</p> <p>According to the nursing care plan dated March 30, 2009, the nurse nurse would continue to assess, assist and provide support to the client. The care plan was signed by the RN and the QMRP. Individuals responsible for oversight of the client's nutrition included the physician, nurse, the QMRP and the dietitian. At the time of the survey, the was no evidence the nurse had coordinated services with the designated professionals identified in the client's health care plan to ensure that the client's substantial weight loss was addressed timely.</p> <p>2. The facility failed to ensure a comprehensive nutritional assessment of the caloric requirement for Resident #1.</p> <p>On June 23, 2009 at 8:30 AM, Resident #1 was observed to appear slim and muscular as he boarded the van for his day program. On June 23, 2009 at 6:30 PM, Resident #1 was observed to consume 100 percent of his meal (Beef Soup, carrots, baked potato, lite fruit cocktail, and water). On June 23, 2009 at 12:15 PM the resident was observed to consume 100 % of his</p>	1401	<p>2. The Nutritionist will be consulted and requested to provide written documentation addressing client #1's noted weight loss as well as recommendations for a change in current diet order, if needed. The Nursing Coordinator will also be consulted along with the Primary Care Physician to inquire if Client #1's weight loss is a health concern, if so it will be documented in his Health Care Management Plan. In the future, the QMRP and Nursing Coordinator will ensure that weight loss for Client #1 as well as all clients is addressed.</p>	08/14/09

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0202	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/25/2009
NAME OF PROVIDER OR SUPPLIER WESTVIEW 02		STREET ADDRESS, CITY, STATE, ZIP CODE 74 W ST, NW WASHINGTON, DC 20015		
(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	<p>Continued From page 18</p> <p>lunch. The resident was also observed to consume 100% of his dinner on June 24, 2009 (6:40 PM).</p> <p>Interview with staff after the meal observations on June 23, and Jun 24, 2009 at the group home and the day program observations, revealed that Resident #1 usually eats 100% of his food. On June 25, 2009 at 3:37 PM, the Qualified Mental Retardation Professional (QMRP) indicated that staff and the nurse weigh the residents, however the nurse is responsible for ensuring that the weights are accurately documented in the resident's record.</p> <p>Record review on June 25, 2009 at 3:50 PM revealed that Resident #1 had a June 1, 2009 continuing physician's order for a 1400 - 1500 Calorie - No Added Salt, Bite-Size Diet. The medical record revealed a chart on which the were documented. (See 0401.1 in above citation.)</p> <p>On June 24, 2009 at 2:53 PM, the review of the Individual Support Plan (ISP) Nutritional Assessment dated January 15, 2009 revealed Resident #1 was 5 feet, 5 inches tall and that his healthy weight range was 114 to 149 pounds. Further review of the nutritional assessments, however revealed they failed to establish a daily calorie requirement to maintain the resident in optimum health. For example, the first Quarterly Nutritional Assessment conducted on April 6, 2009 revealed that the resident weighed 152 pounds (January 2009) and 148 pounds in February 2009. The nutritionist indicated that the resident remained within his healthy body weight range and that his weight would be monitored quarterly. At the time of the survey, however, there was no evidence that the the resident's additional weight loss of eight (8) pounds from</p>	I 401		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD93-0292	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/25/2009
NAME OF PROVIDER OR SUPPLIER WESTVIEW 02		STREET ADDRESS, CITY, STATE, ZIP CODE 74 W ST, NW WASHINGTON, DC 20015		
(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 422	<p>Continued From page 25</p> <p>dinner into a small plate and putting a lid on it. During this time the resident was not in the kitchen.</p> <p>On June 25, 2009 at approximately 8:20 AM, staff was observed washing out a lunchbox. The staff was then observed to put ravioli and bread in a plate and pack it into the lunch box. During this time, the resident was sitting at the dining table eating his breakfast and talking to an imaginary person on the telephone.</p> <p>Interview with staff indicated she was preparing the lunch for Resident #3 to take for his lunch at the day program because it had not been prepared by the resident and staff during the previous evening.</p> <p>Record review on June 25, 2009 at 10:50 AM, revealed that during the February 23, 2009 Individual Support Plan, the IDT recommended training objectives for Resident #3 to teach him how to pack his lunchbox for his day program and to clean his lunch box when he returned to the group home from his day program. At the time of the survey, there was no evidence that Resident #3 was provided the opportunity to participate in</p> <p>2. The GHMRP failed to ensure accurate documentation of progress on the Individual Program Plan (IPP) objectives for Resident #3.</p> <p>On June 25, 2009 at 8:05 AM, Resident #3 was observed standing at the front door, stating repeatedly, "I'm Mad". The resident's breakfast was observed to be still on the table. At 8:15 AM, and had a conversation on a play telephone with an imaginary person, then sat at the table to finish eating his breakfast.</p>	I 422	<p>The staff will be retrained on Client #3's goal and objectives and their implementation to allow Client #3 the opportunity to participate.</p>	07/31/09

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NAME OF PROVIDER OR SUPPLIER WESTVIEW 02		STREET ADDRESS, CITY, STATE, ZIP CODE 74 W ST, NW WASHINGTON, DC 20015		
(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 422	<p>Continued From page 26</p> <p>Interview with staff On 6/25/09 at 8:10 AM, Resident #3 revealed that the resident was upset for no reason, that he often did that. "It's one of his behaviors."</p> <p>On June 25, 2009 at 10:23 AM, the documentation forms provided to monitor the frequency of the targeted behaviors, behavioral intervention) were reviewed. The subsequent review of the data on revealed that the GHMRP failed to maintain the required documentation on the resident's behaviors as evidenced below.</p> <p>a. June 24, 2009 - Resident #3 exhibited 2 incidents of verbal abuse and an incident of ordering staff or peers to do something. There was no documentation on the ABC data form for these behaviors.</p> <p>b. June 15, 2009 - Resident #3 began to curse the nurse when he was told to come take his medications. There was no data on the behavioral frequency chart. Only ABC data was documented on June 15, 2009.</p> <p>c. May 1,2,3,4,6,8,13, 2009 - Resident exhibited behaviors were documented on the behavioral frequency chart. ABC data was collected only on May 3, and May 20, 2009.</p> <p>At the time of the survey, there was no evidence that the GHMRP had consistently maintained data on both the behavioral frequency chart and ABC data form to ensure the resident's progress in the objectives could be accurately monitored.</p>	I 422	<p>2. Staff were previously trained on <i>BRM</i> on how to implement the ABC data form. However, they will be retrained at the next staff meeting & in-service training session to ensure that all staff are knowledgeable of the form and how to complete it when needed. In the future, the QMRP will ensure that all staff are effectively trained annually on ABC data collection and retrained as problems with documentation arise.</p> <p>Each Shift Supervisor will ensure that all documentation is completed before the end of the shift. Monitoring of this process will be conducted by the Residential Manager.</p>	08/14/09

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NAME OF PROVIDER OR SUPPLIER WESTVIEW 02		STREET ADDRESS, CITY, STATE, ZIP CODE 74 W ST, NW WASHINGTON, DC 20015		
(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 422	Continued From page 27	I 422		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(01) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HP000-0002	(02) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(03) DATE SURVEY COMPLETED 06/25/2009
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NAME OF PROVIDER OR SUPPLIER WESTVIEW 02	STREET ADDRESS, CITY, STATE, ZIP CODE 74 W ST, NW WASHINGTON, DC 20016
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(04) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(05) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted on June 23, 2009 through June 25, 2009. A random sampling of three resident's from the residential population of six resident's with varying degrees of disability was selected for the survey. The results of the survey were based on observations in the home and at two day programs, staff interviews, as well as a review of the resident and administrative records, including a review of the unusual incident reports.</p>	R 000	<p><i>Received 7/29/09</i></p> <p>GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002</p>	
R 125	<p>4701.5 BACKGROUND CHECK REQUIREMENT</p> <p>The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years. In all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the GMHRP failed to ensure criminal background checks disclosed the criminal history of any prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker had worked or resided within the seven (7) years prior to the check for three (3) of twelve (12) employees.</p> <p>The findings include:</p> <p>On June 23, 2009 at 10:30 AM, an entrance conference was conducted with the Qualified Mental Retardation Professional (QMRP) to request documents needed during the survey process. During this time, evidence of criminal</p>	R 125	<p>Criminal background checks were obtained for S2, S6, and S3. In the future, the Human Resource Coordinator will ensure that criminal background checks are conducted and obtained upon hire.</p>	7/1/09

Health Regulation Administration *Shirley West J. MD* Administrator TITLE *July 29, 2009* (06) DATE

LICENSURE REGULATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE