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	09G056	A. BUILDING _____ B. WING _____	C 11/18/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMP CARE I I	1321 EMERSON STREET NW WASHINGTON, DC 20011

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W 000	INITIAL COMMENTS A monitoring survey was conducted on November 18, 2008. The Plan of Correction submitted by the facility on July 24, 2008 served as the focus for this monitoring survey. The facility was providing services and supports for five men with various disabilities. Two of the original four sampled clients were reviewed, with a third new client added. The findings of this survey were based on observations, interviews with staff and clients in the home, as well as a review of client and administrative records, including incident reports.	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations, staff interviews and record review, the facility's governing body provided general operating direction, except in the following areas: The findings include: 1. Cross-refer to W252.2, W322.3.a. and W322.3.c. The governing body failed to establish an internal quality assurance system to ensure that the Qualified Mental Retardation Professional (QMRP) monitored and coordinated the implementation of clients' behavior support plans. Clients #1 and #2 had desensitization plans developed to increase their tolerance of medical appointments. There was no evidence, however, that all staff, including the LPN responsible for	W 104	Received 12/16/08 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Adm. Assistant	12/16/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	Continued From page 1 scheduling medical appointments, had received training on correct implementation of said programs. It should be noted that there was documented evidence in both of the clients' records that the facility attempted to use drugs to sedate them for recent medical appointments, without first having documented the implementation of their desensitization plans. 2. Cross-refer to W322.2. The governing body failed to establish an internal quality assurance system to ensure that Client #2 received needed health care services. Interview with the QMRP and LPN, and review of the client's records, revealed that he repeatedly refused medical evaluations and treatment. The client's interdisciplinary team had outlined a process by which the facility should elicit his cooperation, beginning with less-intrusive behavior intervention strategies, to the use of more restrictive strategies, such as drugs for sedation (with appropriate physician's orders and written consent from the client's sister), those procedures had not been implemented, and the client's medical needs were not being met timely. 3. Cross-refer to W455. The governing body failed to ensure that the corrective strategies outlined in the facility's July 24, 2008 Plan of Correction were implemented to reach and maintain compliance with infection prevention and control standards.	W 104	**W 104.1** **Staff have been re-trained on implementation of client #1's and client #2's desensitization plans.** **The administration (governing body) has put in place a monthly tracking form consistent with implementation of the desensitization plans for clients #1 and #2. Please see attached.** **Tracking of the implementation of the desensitization plans will be done monthly by the administration to ensure compliance.** **W 104.2** **Cross reference W104.1** **W 104.3** **Cross reference W455**	12.31.08
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a	W 159		

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W 159	Continued From page 2 qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on interview and record review, the Qualified Mental Retardation Professional (QMRP) failed to coordinate and monitor programs and services, for two of the three clients in the sample. (Clients #2 and #3) The findings include: 1. Cross-refer to W252.1. The QMRP failed to ensure that staff consistently documented Client #1's targeted maladaptive behaviors, in accordance with his behavior support plan. 2. Cross-refer to W252.2. The QMRP failed to monitor and coordinate the implementation of Client #1's behavior support plan/ desensitization plan that was developed to decrease his agitation during medical appointments. 3. Cross-refer to W322.2. The QMRP failed to facilitate a coordinated, interdisciplinary team approach to meet Client #2's health care needs. In addition, the QMRP failed to monitor and coordinate the implementation of Client #2's behavior support plan/ desensitization plan that was developed to decrease his agitation during medical appointments. 4. The QMRP failed to enlist the services of the Nutritionist consultant after Client #3 was diagnosed with kidney disease to ensure that his dietary needs were met, as follows: On November 18, 2008, beginning at 1:53 PM, review of Client #3's physician's orders (POs) and	W 159	**W 159.1** **Cross reference W252.1** **W 159.2** **Cross reference W252.2** **W 159.3** **Cross reference W322.2**	

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W 159	Continued From page 3 other medical records revealed that his primary care physician (PCP) discontinued his prescribed Lithium Carbonate (300 mg every morning and 600 mg every evening), effective September 3, 2008. At approximately 2:35 PM, interview with the QMRP revealed that the Lithium Carbonate was discontinued after a nephrologist made the recommendation. At 2:47 PM, review of consultation forms revealed that Client #3 was first evaluated on May 7, 2008 due to elevated serum creatinine levels. He returned to the nephrologist on September 3, 2008, at which time he was diagnosed with renal disease. The nephrologist recommended discontinuing the lithium as a precaution. According to the September 3, 2008 telephone order, the LPN communicated the recommendation with the psychiatrist and primary care physician. At approximately 3:00 PM, review of Client #3's lab reports confirmed that his serum creatinine levels were elevated as follows: - 1/23/08 1.8 high (reference: 0.7 - 1.4 mg/dl) - 2/11/08 1.6 high - 6/12/08 1.7 high In addition, the nephrologist's September 3, 2008 report identified elevated creatinine tests on May 7, 2008 and September 3, 2008. At 4:30 PM, review of Client #3's nutrition records revealed an annual evaluation dated January 3, 2008. On March 30, 2008, the nutritionist had documented a 1st Quarter Nutrition Update. The update reflected his ongoing therapeutic diet, including a finely chopped texture and low cholesterol foods to address elevated serum cholesterol levels. The report also reflected an elevated creatinine level of 1.8.	W 159	**W 159.4** **The nutritionist has evaluated client #3 in relation to the renal disease. Please see herewith.** **The administration will conduct quarterly reviews of habilitation records to ensure that all needed assessments are completed in a timely manner.**	12.16.08

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W 159	Continued From page 4 At approximately 4:35 PM, the QMRP examined Client #3's medical chart and confirmed that the most recent nutrition report was dated March 30, 2008. He indicated the nutritionist had conducted more recent quarterly reviews. Both he and the LPN Coordinator, who was present at the time, stated that the nutritionist had been there "several times" since March. However, further review of the record failed to show evidence that the nutritionist had evaluated Client #3 within the past 7 1/2 months, including since his diagnosed renal disease in September, to determine what, if any, dietary changes might be indicated. It should be noted that at approximately 5:45 PM, the QMRP looked at the visitor's log book and stated that the nutritionist had come to the facility in July 2008 (date not specified). He could not, however, confirm the purpose of her visit.	W 159		
W 193	483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on staff interview and record verification, the facility failed to ensure that the LPN Coordinator received training on implementation of the Behavior Support Plan (BSP) for one of the three clients in the sample. (Client #2) The finding includes: Cross-refer to W332.3. On November 18, 2008, review of Client #2's medical records revealed that he refused to cooperate with lab technicians on numerous attempts to obtain a blood sample.	W 193		

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W 193	Continued From page 5 The client's record documented a long history of his refusing to cooperate with medical professionals. The psychologist developed a Behavior Support Plan (BSP), dated November 8, 2007, to address this need. The BSP outlined desensitization strategies to elicit his cooperation and recommended the use of sedation if the desensitization measures did not "decrease agitation during these procedures." At 4:53 PM, the facility's LPN Coordinator, who was designated to schedule medical appointments and who worked with the clients on a daily basis, confirmed that Client #2 refused to cooperate with medical professionals. She stated that the primary care physician (PCP) was aware of the client's history of refusals. However, when asked whether the psychologist had developed a written desensitization plan, she stated that she was unsure and she referred this surveyor to the QMRP. There was no evidence that the QMRP and/or psychologist had trained the LPN on the BSP and/or the desensitization strategies as outlined in the plan. In addition, there was no evidence that the facility had implemented the desensitization measures outlined in his BSP, including since the June 12, 2008 recertification survey.	W 193	**W 193** **The LPN has been trained on implementation of the BSPs and desensitization plans for clients #1 and #2.** **The administration will conduct monthly audits of the implementation of interventions specified in the BSPs and desensitization plans for clients #1 &2.**	12.15.08
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observation and record review, the	W 252		

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W 252	Continued From page 6	W 252		

facility failed to document behavior data in accordance with the behavior support plans (BSPs), for two of the three clients in the sample. (Clients #1 and #2)

The findings include:

1. On November 18, 2008, Client #1 was observed in the facility between 7:58 AM - 9:07 AM. At approximately 8:43 AM, the LPN asked him to take a calcium tablet. He yelled at her, refused to take it and stormed out of the kitchen. She followed him into the living room, where he eventually took the tablet with water. At approximately 8:46 AM, a direct support staff reached for the calcium tablet, which the client had spit out onto the floor. As she reached down, Client #1 yelled at her and swung his fist in her direction. A moment later, he directed his fist towards her again and objected loudly as she began escorting him from the room. At approximately 8:55 AM, he yelled at the driver's aide when she approached him. As they entered the front hallway, he slapped his head, making a loud slapping sound.

At approximately 10:45 AM, the Qualified Mental Retardation Professional (QMRP) indicated that Client #1's behavior that morning was due to there being a visitor in the facility.

At 11:37 AM, review of Client #1's record revealed a behavior support plan (BSP), dated October 14, 2007, to address several targeted behaviors, including yelling, hitting out at others and slapping himself. The BSP included instructions to document each occurrence of a targeted behavior on a behavior data sheet. Subsequent review of his behavior data sheets

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W 252	Continued From page 7 revealed that staff failed to document the targeted behaviors he displayed earlier that day. There was not data indicated for the 10 PM - 8:30 AM shift. [Note: Staff on that same shift had documented "no behavior" on the two previous mornings.] 2. On November 18, 2008, beginning at 10:48 AM, review of Client #1's medical records revealed that he frequently refused to cooperate with medical professionals. The psychologist had developed a Behavior Support Plan (BSP), dated October 31, 2007, to address this need. The BSP outlined desensitization strategies to elicit his cooperation and recommended the use of sedation if the desensitization measures did not "decrease agitation during these procedures." Further review of the record revealed that Client #1: - was uncooperative on a December 21, 2007 vision appointment; - refused to cooperate with an attempt February 26, 2008 to perform a PPD test; - refused to cooperate with the dentist and with attempts to secure blood for lab work on June 30, 2008; and, - refused to cooperate with the audiologist on July 31, 2008 and August 29, 2008. At 11:37 AM, review of Client #1's behavior data sheets revealed only one documented attempt to implement the desensitization plan (audiologist on January 15, 2008) since the plan was written in October 2007. 3. Cross-refer to W322.2. Client #2 had a similar BSP to address his non-compliance with medical specialists. His behavior data reflected only one documented attempt to implement the proactive	W 252	**W 252.1** **The overnight shift staff have been trained on client #1's behavior support plan and data collection. Emphasis of the training was consistency in behavior data collection.** **W 252.2** **Cross reference W104.1**	12.15.08

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W 252	Continued From page 8 strategies that were outlined in his desensitization/ behavior plan. It should be noted that there was documented evidence in both Client #1's and #2's records that the facility proceeded with attempts to use drugs to sedate them for recent medical appointments, without first having documented the implementation of their desensitization plans.	W 252	**W 252.3** **Sedation was used after client#1 and #2 had refused to comply with three medical appointments. The missed medical appointments are outlined by the surveyor in Tag W252.2.** **The facility attempted three medical appointments before using sedation but failed to document the proactive strategies outlined in the desensitization plan.** **Staff have been trained on documenting proactive strategies outlined in the desensitization plans for clients #1 and #2.**	12.15.08
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on interview and review of medical records, the facility failed to ensure preventive and general medical care and failed to ensure timely appointments and follow-up, for two of the three clients in the sample. (Clients #2 and #3) The findings include: 1. Cross-refer to W159.4. The facility failed to secure an updated nutritional evaluation to ensure Client #3's dietary needs were being met, following a diagnosis of renal disease. 2. The facility failed to ensure that the required information for Client #3 was made available to specialists as recommended. On November 18, 2008, at approximately 4:50 PM, review of Client #3's medical records revealed a consultation form, dated August 27, 2008, on which the urologist had written "Per note: see lab work attached but no lab work	W 322		

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W 322	Continued From page 9 seen." [Note: The client had been seen by a nephrologist in May 2008.] This is a repeat deficiency. ********** Previously, in the June 12, 2008 Federal Deficiency Report, the facility was cited for failure to forward the findings/results of "liver function tests, Hepatitis screening and CAT scan of abdomen - renal cyst" to a gastro-intestinal specialist on May 27, 2008. The G-I specialist had written that the evaluation could not proceed without the information. Similarly, on February 19, 2008, the G-I specialist had indicated that the client could not be assessed due to "old laboratory studies." On July 24, 2008, the facility submitted a Plan of Correction indicating that as of July 1, 2008, the facility had "put in place a flow sheet which will be used to track laboratory results and recommendations by other clinicians..." 3. The facility's medical team failed to implement Client #2's behavior support plan (BSP), and therefore failed to meet the client's medical needs. On November 18, 2008, at 9:01 AM, the Qualified Mental Retardation Professional (QMRP) stated that Client #2's mother and sister previously had been reluctant to authorize invasive medical interventions. After the client's mother died in 2007, however, the sister had been amenable to signing consents for various procedures. Beginning at 4:40 PM, review of Client #2's	W 322	**W 322.1** **The nutritionist has updated client #3's nutritional assessments. Please see attached.** **W 322.2** **Client #3's lab work was attached to his urologist consult when the client left the facility for the appointment.** **The facility was shocked to learn that the urologist had mentioned 'no lab work attached.' On the medical consult form are emergency contact numbers for the QMRP and RN. It is expected that in an emergency situation such as the above, the consulting office would call to request the needed item.** **The urologist's office did not contact the QMRP, neither the RN about the missing labs.**	12.15.08

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W 322	Continued From page 10 medical records revealed that he refused to cooperate with lab technicians on numerous attempts to obtain a blood sample. The client's record documented a long history of his refusing to cooperate with medical professionals. The psychologist developed a Behavior Support Plan (BSP), dated November 8, 2007, to address this need. The BSP cited the client's refusal to cooperate with a variety of medical professionals, including but not limited to labs on January 18, 2007, January 30, 2007 and June 14, 2007, and the podiatrist on November 12, 2007. It outlined desensitization strategies to elicit his cooperation and recommended the use of sedation if the desensitization measures did not "decrease agitation during these procedures." At 5:00 PM, the QMRP stated that sedation would only be used if there were 3 documented attempts to implement the desensitization plan and the client remained uncooperative. Continued review of Client #2's medical records revealed the following: a. Client #1's record documented one attempt to implement the BSP/ desensitization plan (November 12, 2007, in-home podiatry care). Since that time, however, there were no documented attempts to implement the written strategies as outlined in the plan. b. Client #2 was diagnosed with hypothyroidism, for which he was prescribed Synthroid. On July 7, 2008, the client was evaluated by his endocrinologist, who added four new medications as well as Calcium and Vitamin D to his daily regimen. The endocrinologist ordered a complete metabolic panel, and wrote "Please go for your lab work now." Consultation sheets documented	W 322	**W 322.3a** **Cross reference W104.1**	

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W 322	Continued From page 11 that on July 17, 2008, July 24, 2008 and August 6, 2008, the client refused to cooperate with attempts to obtain a blood sample. There was no evidence, however, that the facility had implemented the desensitization measures outlined in his BSP, including since the June 12, 2008 recertification survey. It should be noted that on July 7, 2008, the endocrinologist wanted Client #2 scheduled for a follow-up appointment in 6 months. As of November 18, 2008, the recommended lab work had not been achieved, and there were no future lab visits scheduled to date. c. At 4:53 PM, the facility's LPN Coordinator, who was designated to schedule medical appointments and who worked with the clients on a daily basis, confirmed that Client #2 refused to cooperate with medical professionals. She stated that the primary care physician (PCP) was aware of the client's history of refusals. However, when asked whether the psychologist had developed a written desensitization plan, she stated that she was unsure and she referred this surveyor to the QMRP. There was no evidence that the QMRP and/or psychologist had trained the LPN on the BSP and/or the desensitization strategies as outlined in the plan. d. At 5:02 PM, the QMRP stated that in a letter dated June 24, 2006, the mother and sister had refused to authorize invasive procedures. Review of the letter, however, revealed that it was specific to a request (denied) to perform a colonoscopy. Further review of correspondences and consent forms that were filed in the client's record, revealed the following: - a consent form signed by the sister on	W 322	**W 322.b** **Client # 2 was taken to complete lab work on 12/15/08 but did not comply. Please see attached.** **The facility will attempt to do labs one more time before sedation is considered.** **W 322.c** **Cross reference 104.1** **W 322.d** **The facility will implement the desensitization plan and request consent for sedation after three episodes of noncompliance.**	12.30.08 01.10.09

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W 322	Continued From page 12 December 16, 2007 for podiatry care; - a consent form signed by the sister on December 16, 2007 for lab work; - a consent form signed by the sister on May 13, 2006 for the use of sedation prior to routine medical evaluations, including lab work; and, - a consent form signed by the sister on August 14, 2008 authorizing the use of Ativan 2 mg prior to an August 18, 2008 podiatry appointment. There were no other consent forms available for review. When queried about the May 13, 2006 consent form, the QMRP stated that Client transferred from another facility operated by the same agency to this facility in September 2006. e. At 5:22 PM, the QMRP stated that he thought Client #2 was sedated for his August 8, 2008 lab appointment. However, after reviewing the client's August 2008 Medication Administration Record (MAR) and physician's orders (POs), he acknowledged that there was no documented evidence he was sedated. In addition, at 5:25 PM, the QMRP confirmed that there had been no further attempts to perform serum lab work since August 6, 2008. f. At approximately 5:01 PM, Client #2's record revealed a consultation form dated April 7, 2008 on which the podiatrist wrote "combative," refused care, and he "needs to be sedated." On August 14, 2008, the PCP issued a telephone order for Ativan 2 mg prior to an August 18, 2008 podiatry appointment and on the same day (August 14, 2008) his sister authorized the sedation. On August 18, 2008, however, the LPN documented that the podiatrist cancelled the appointment; therefore, the Ativan was not administered. The	W 322	**W 322.e** **Cross reference W322.b**	

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W 322	Continued From page 13 client returned to the podiatrist on November 10, 2008, without sedation and refused treatment. The podiatrist again wrote "Patient needs to be sedated." Review of his POs revealed no evidence that the PCP ordered sedation for the November 10, 2008 appointment. At approximately 5:20 PM, the QMRP stated that the sister's August consent form had expired. He then acknowledged that the facility had not sought an updated consent form for the November appointment, adding "I would not give him the Ativan, just assume... Now that I have the document that says he needs sedation, I can proceed with that..." g. There was no evidence that the facility's RN had identified Client #2's ongoing, unmet needs (implementing the BSP/ desensitization plan for medical procedures, seeking appropriate physician's orders and written consent from the sister when indicated, etc.) since she began working for the facility in September 2008. In summary, the facility's QMRP and medical team failed to coordinate and implement the strategies that were outlined in Client #2's plan, to meet the client's health care needs timely and effectively. This is a repeat deficiency. ********** Previously, the June 12, 2008 Federal Deficiency Report, included the following: a. According to Client #2's medical laboratory studies reviewed June 4, 2008 at 10:00 AM, it was noted by the primary care physician to repeat	W 322	**W 322.f** **In the future, the facility shall ensure that consents are valid thirty (30) days prior to the administration of sedation.** **W 322.g** **Cross reference 104.1**	12-30-08

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W 322	Continued From page 14 an elevated ALT (73) study dated December 20, 2007. Interview with the LPN revealed that this was overlooked and would be scheduled for June 5, 2008. b. According to Client #2's nursing quarterly report dated April 1, 2008, the client had a nodule in his scalp. An x-ray was conducted as recommended on January 28, 2008; however, a CAT scan of the skull was also recommended, but not performed. The RN during interview on June 4, 2008 at 1:22 PM stated that "they were awaiting for consent." Also, the LPN indicated that clarity of with or without contrast had to be made prior to the CAT scan. There was no evidence that the attempts had been made to obtain the recommended testing. On July 24, 2008, the facility submitted a Plan of Correction that included the following: "The nurses have been in-serviced on timely follow-up of medical appointments... The facility's RN will, on a weekly basis or as needed, review all medical records to ensure that medical appointments are done on a timely manner. On 6/20/08, Client #2 was taken to do his ALT but was uncooperative. He is to follow-up under sedation... Client #2's CAT scan... was attempted on 6/17/08 but client refused... He is to follow-up under sedation." Target completion dates indicated were 7/28/08 and 7/29/08, respectively.	W 322	**W 322.g (a, b)** **These issues were resolved during the first survey and copies of the completed appointments were attached to the July 24, 2008 plan of correction sent to DOH.** **However, please find attached a copy of the completed CT scan and a copy of the needle biopsy requested by client #2's primary care physician after the CT scan was completed.**	07-28-09
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by:	W 455		

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W 455	Continued From page 15 Based on observation, the medication administration nurse failed to use active prevention, control, and investigation of infection and communicable diseases. The finding includes: On November 18, 2008, the morning medication pass was observed between 8:30 AM - 8:50 AM. The LPN washed her hands upon arrival. She then unlocked the medication cabinet, carried 2 boxes (one large plastic bin and a smaller metal box) of medications into the kitchen. The LPN removed from the bin a plastic bag that held Client #4's prescribed medications. She punched medications and/or multi-vitamin/mineral supplements from blister packs into a medication cup and handed the cup to Client #4. After he swallowed the pills, followed with a cup of water, the LPN used a pen to document the administration in the client's Medication Administration Record returned the blister packs to the plastic bag and placed the package back in the bin. She called for the next client to come to the kitchen and repeated the same process with the other four clients. At no time was she observed using hand sanitizer or washing her hands in between the individual client administrations. At approximately 5:35 PM, the LPN confirmed that she had washed her hands once, prior to removing the medications from the locked medication cabinet at the beginning of the. This is a repeat deficiency. **********	W 455	**W 455** **The RN will hold quarterly meetings with the LPNs to discuss infection control measures.** **The focus of the next meeting will be to discuss citations in the November 2008 PoC and how to eliminate repeated deficiencies.**	12.30.08

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W 455	Continued From page 16 Previously, the June 12, 2008 Federal Deficiency Report, included the following: During the medication administration conducted on June 4, 2008, at 5:30 PM, the nurse failed to wash her hands between individual clients administrations. The nurse washed her hands at the beginning of the administration and after thirteen administrations of medications to two clients. On July 24, 2008, the facility submitted a Plan of Correction that included the following: "The nurse in focus has been in-service <sic> on infection control... hand washing before and after individual medication pass so as to prevent cross contamination. The RN will on a quarterly basis observe the LPNs during medication pass so as to ensure compliance." The target completion date indicated was 7/30/08.	W 455		

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I 000	INITIAL COMMENTS A monitoring survey was conducted on November 18, 2008. The Plan of Correction submitted by the facility on July 24, 2008 served as the focus for this monitoring survey. The facility was providing services and supports for five men with various disabilities. Two of the original four sampled residents were reviewed, with a third new resident added. The findings of this survey were based on observations, interviews with staff and residents in the home, as well as a review of resident and administrative records, including incident reports.	I 000		
I 002	3500.2 GENERAL PROVISIONS Each GHMRP licensee and residence director shall demonstrate that he or she understands that the provisions of D.C. Law 2-137, D.C. Code, Title 6, Chapter 19 govern the care and rights of mentally retarded persons in addition to this chapter. This Statute is not met as evidenced by: Based on observations, staff interviews and record review, the GHMRP licensee and director failed to ensure the provision of supports and services 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). The findings include: 1. Cross-refer to Federal Deficiency Report - Citations W252.2 and W322.3. The governing body failed to establish an internal quality assurance system to ensure that the Qualified	I 002		

Signature TITLE Adm. Asst. (X6) DATE 12/10/08

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

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I 002	Continued From page 1 Mental Retardation Professional (QMRP) monitored and coordinated the implementation of residents' behavior support plans. Residents #1 and #2 had desensitization plans developed to increase their tolerance of medical appointments. There was no evidence, however, that all staff, including the LPN Coordinator responsible for scheduling medical appointments, had received training on correct implementation of said programs. It should be noted that there was documented evidence in both residents' records that the facility attempted to use drugs to sedate them for recent medical appointments, without first documenting implementation of their desensitization plans. 2. Cross-refer to I041.3. The governing body failed to establish an internal quality assurance system to ensure that Resident #2 received needed health care services. Interview with the QMRP and LPN, and review of the resident's records, revealed that he repeatedly refused medical evaluations and treatment. The resident's interdisciplinary team had outlined a process by which the facility should elicit his cooperation, beginning with less-intrusive behavior intervention strategies, to the use of more restrictive strategies, such as drugs for sedation (with appropriate physician's orders and written consent from the resident's sister), those procedures had not been implemented, and the resident's medical needs were not being met. 3. Cross-refer to Federal Deficiency Report - Citation W455. The governing body failed to ensure that the corrective strategies outlined in the facility's July 24, 2008 Plan of Correction were implemented to reach and maintain compliance	I 002	**I 002.1** **Cross reference W 104.1** **I 002.2** **Cross reference W 104.1** **I 002.3** **Cross reference W 455**	

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I 002	Continued From page 2 with infection prevention and control standards.	I 002		
I 058	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 nutrition according to his or her Individual Habilitation Plan. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that residents were evaluated by a nutritionist at least quarterly, for two of the three residents in the sample. (Residents #2 and #3) The findings include: On November 18, 2008, beginning at 1:53 PM, review of Resident #3's medical records revealed that his primary care physician (PCP) discontinued his prescribed Lithium Carbonate (300 mg every morning and 600 mg every evening), effective September 3, 2008, after the resident was diagnosed with renal disease. Further review of the chart failed to show evidence that the nutritionist had been informed of the change in the resident's condition. At 4:30 PM, review of Resident #3's nutrition records revealed an annual evaluation dated January 3, 2008. On March 30, 2008, the nutritionist documented a 1st quarter nutrition update. The update reflected his ongoing therapeutic diet, including a finely chopped texture and low cholesterol foods to address elevated serum cholesterol levels. The report	I 058		

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I 058	Continued From page 3 also reflected an elevated creatinine level of 1.8. At approximately 4:35 PM, the QMRP examined Resident #3's medical chart and confirmed that the most recent nutrition review was dated March 30, 2008. He indicated the nutritionist had conducted more recent quarterly reviews. Both he and the LPN Coordinator, who was present at the time, stated that the nutritionist had been there "several times" since March. However, further review of the record failed to show evidence that the nutritionist had evaluated Resident #3 within the past 7 1/2 months, including since his diagnosed renal disease in September, to determine what, if any, dietary changes might be indicated. 2. Resident #2 was obese and was prescribed a specialized diet. At 4:40 PM, review of Resident #2's record revealed that the nutritionist had prepared an annual evaluation on January 3, 2008 and a 1st quarter update on March 30, 2008. There was no evidence, however, that the nutritionist had reviewed his prescribed diet within the past 7 1/2 months. At approximately 5:45 PM, the QMRP looked at the visitor's log book and stated that the nutritionist had come to the facility in July 2008 (date not specified). He could not, however, confirm the purpose of her visit.	I 058	**I 058 (1 & 2). Cross reference W159.4**	
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.	I 082		

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I 082	Continued From page 4 This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to equip bathrooms with the necessary items for each resident's use. The findings include: 1. On November 18, 2008, at 9:10 AM, there was no hand soap and no paper towels in the restroom in the basement. At approximately 12:25 PM, paper towels and hand soap were observed in that bathroom. During the Exit conference, at approximately 5:58 PM, the Qualified Mental Retardation Professional acknowledged the absence of towels and soap earlier in the day. He said he had observed the deficiency that morning and asked a maintenance person to bring supplies. This was achieved by 11:00 AM, thereby abating the deficiency. 2. On November 18, 2008, at 9:13 AM, there was no hand soap and no paper towels in the restroom on the main floor (adjacent to the kitchen). At approximately 12:25 PM, paper towels and hand soap were observed in that bathroom. A maintenance person had brought some supplies before 11:00 AM, thereby abating the deficiency. 3. On November 18, 2008, at 9:13 AM, there were no paper cups in the cup holder located in the restroom on the main floor (adjacent to the kitchen). During the Exit conference, at approximately 5:58 PM, the Qualified Mental Retardation Professional acknowledged the absence of paper cups. He explained that the supply closet was locked and the only individual with a key (the House Manager) was out on leave that day.	I 082	**I 082 (1, 2 & 3)** **These issues were abated during the survey.** **The facility is cognizance of the fact that all bathrooms shall be equipped with soap (hand sanitizer) for hand washing, a paper towel, toilet tissue, cup dispenser, mirror and adequate lighting.** **The home will continue to adhere to the above-mentioned items at all times.** **A spare key to the storage room will be kept on site at all times.**	11.18.08

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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 staff interview and record verification, the facility failed to ensure that the LPN Coordinator received training on implementation of the Behavior Support Plan (BSP) for one of the three residents in the sample. (Resident #2) The finding includes: Cross-refer to I401.3. On November 18, 2008, review of Resident #2's medical records revealed that he refused to cooperate with lab technicians on numerous attempts to obtain a blood sample. The resident's record documented a long history of his refusing to cooperate with medical professionals. The psychologist developed a Behavior Support Plan (BSP), dated November 8, 2007, to address this need. The BSP outlined desensitization strategies to elicit his cooperation and recommended the use of sedation if the desensitization measures did not "decrease agitation during these procedures." At 4:53 PM, the facility's LPN Coordinator, who was designated to schedule medical appointments and who worked with the residents on a daily basis, confirmed that Resident #2 refused to cooperate with medical professionals. She stated that the primary care physician (PCP) was aware of the resident's history of refusals.	I 229	**I 229** **Cross reference W104.1**	

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I 229	Continued From page 6 However, when asked whether the psychologist had developed a written desensitization plan, she stated that she was unsure and she referred this surveyor to the QMRP. There was no evidence that the QMRP and/or psychologist had trained the LPN on the BSP and/or the desensitization strategies as outlined in the plan. In addition, there was no evidence that the facility had implemented the desensitization measures outlined in his BSP, including since the June 12, 2008 recertification survey.	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 interview and review of medical records, the facility failed to ensure preventive and general medical care and failed to ensure timely appointments and follow-up, for two of the three residents in the sample. (Residents #2 and #3) The findings include: 1. Cross-refer to I058. The GHMRP failed to secure an updated nutritional assessment after Resident #3 was diagnosed with kidney disease to ensure that his dietary needs were met. 2. The facility failed to ensure that the required information for Resident #3 was made available to specialists as recommended.	I 401		

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I 401	Continued From page 7 On November 18, 2008, at approximately 4:50 PM, review of Resident #3's medical records revealed a consultation form, dated August 27, 2008, on which the urologist had written "Per note: see lab work attached but no lab work seen." [Note: The client had been seen by a nephrologist in May 2008.] This is a repeat deficiency. ********** Previously, in the June 12, 2008 Federal Deficiency Report, the facility was cited for failure to forward the findings/results of "liver function tests, Hepatitis screening and CAT scan of abdomen - renal cyst" to a gastro-intestinal specialist on May 27, 2008. The G-I specialist had written that the evaluation could not proceed without the information. Similarly, on February 19, 2008, the G-I specialist had indicated that the client could not be assessed due to "old laboratory studies." On July 24, 2008, the facility submitted a Plan of Correction indicating that as of July 1, 2008, the facility had "put in place a flow sheet which will be used to track laboratory results and recommendations by other clinicians..." 3. The facility's medical team failed to implement Resident #2's behavior support plan (BSP), and therefore failed to meet the resident's medical needs. On November 18, 2008, at 9:01 AM, the Qualified Mental Retardation Professional (QMRP) stated that Resident #2's mother and sister previously had been reluctant to authorize invasive medical	I 401	**I 401.1, 2.** **Cross reference W 322.2**	

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I 401	Continued From page 8 interventions. After the resident's mother died in 2007, however, the sister had been amenable to signing consents for various procedures. Beginning at 4:40 PM, review of Resident #2's medical records revealed that he refused to cooperate with lab technicians on numerous attempts to obtain a blood sample. The resident's record documented a long history of his refusing to cooperate with medical professionals. The psychologist developed a Behavior Support Plan (BSP), dated November 8, 2007, to address this need. The BSP cited the resident's refusal to cooperate with a variety of medical professionals, including but not limited to labs on January 18, 2007, January 30, 2007 and June 14, 2007, and the podiatrist on November 12, 2007. It outlined desensitization strategies to elicit his cooperation and recommended the use of sedation if the desensitization measures did not "decrease agitation during these procedures." At 5:00 PM, the QMRP stated that sedation would only be used if there were 3 documented attempts to implement the desensitization plan and the resident remained uncooperative. Continued review of Resident #2's medical records revealed the following: a. Resident #1's record documented one attempt to implement the BSP/ desensitization plan (November 12, 2007, in-home podiatry care). Since that time, however, there were no documented attempts to implement the written strategies as outlined in the plan. b. Resident #2 was diagnosed with hypothyroidism, for which he was prescribed Synthroid. On July 7, 2008, the resident was evaluated by his endocrinologist, who added four	I 401	**I 401.a** **Cross reference W104.1**	

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I 401	Continued From page 9 new medications as well as Calcium and Vitamin D to his daily regimen. The endocrinologist ordered a complete metabolic panel, and wrote "Please go for your lab work now." Consultation sheets documented that on July 17, 2008, July 24, 2008 and August 6, 2008, the resident refused to cooperate with attempts to obtain a blood sample. There was no evidence, however, that the facility had implemented the desensitization measures outlined in his BSP, including since the June 12, 2008 recertification survey. It should be noted that on July 7, 2007, the endocrinologist wanted Resident #2 scheduled for a follow-up appointment in 6 months. As of November 18, 2008, the recommended lab work had not been achieved, and there were no future lab visits scheduled to date. c. At 4:53 PM, the facility's LPN, who was designated to schedule medical appointments, confirmed that Resident #2 refused to cooperate with medical professionals. She stated that the primary care physician (PCP) was aware of the resident's history of refusals. However, when asked whether the psychologist had developed a written desensitization plan, she stated that she was unsure and she referred this surveyor to the QMRP. There was no evidence that the QMRP and/or psychologist had trained the LPN on the BSP and/or the desensitization strategies as outlined in the plan. d. At 5:02 PM, the QMRP stated that in a letter dated June 24, 2006, the mother and sister had refused to authorize invasive procedures. Review of the letter, however, revealed that it was specific to a request (denied) to perform a colonoscopy. Further review of correspondences	I 401	**I 401.3b** **Client # 2 was taken to complete lab work on 12/15/08 but did not comply. Please see attached.** **The facility will attempt to do labs one more time before sedation is considered.** **I 401. 3c** **Cross reference W104.1**	12·30·08

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I 401	Continued From page 10 and consent forms that were filed in the resident's record, revealed the following: - a consent form signed by the sister on December 16, 2007 for podiatry care; - a consent form signed by the sister on December 16, 2007 for lab work; - a consent form signed by the sister on May 13, 2006 for the use of sedation prior to routine medical evaluations, including lab work; and, - a consent form signed by the sister on August 14, 2008 authorizing the use of Ativan 2 mg prior to an August 18, 2008 podiatry appointment. There were no other consent forms available for review. When queried about the May 13, 2006 consent form, the QMRP stated that Resident transferred from another facility operated by the same agency to this facility in September 2006. e. At 5:22 PM, the QMRP stated that he thought Resident #2 was sedated for his August 8, 2008 lab appointment. However, after reviewing the resident's August 2008 Medication Administration Record (MAR) and physician's orders (POs), he acknowledged that there was no documented evidence he was sedated. In addition, at 5:25 PM, the QMRP confirmed that there had been no further attempts to perform serum lab work since August 6, 2008. f. At approximately 5:01 PM, Resident #2's record revealed a consultation form dated April 7, 2008 on which the podiatrist wrote "combative," refused care, and he "needs to be sedated." On August 14, 2008, the PCP issued a telephone order for Ativan 2 mg prior to an August 18, 2008 podiatry appointment and on the same day (August 14, 2008) his sister authorized the sedation. On August 18, 2008, however, the LPN	I 401	**I 401. 3e** **The last consent was signed on August 14, 2008.** **The home had to conduct three more attempts before requesting consent for sedation.** **Client # 2 was taken to complete lab work on 12/15/08 but did not comply. Please see attached.** **The facility will attempt to do labs one more time before sedation is considered.** **I 401. 3f** **In the future, the facility shall ensure that consents are valid thirty (30) days prior to the administration of sedation.**	12.30.08 12.30.08

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I 401	Continued From page 11 documented that the podiatrist cancelled the appointment; therefore, the Ativan was not administered. The resident returned to the podiatrist on November 10, 2008, without sedation and refused treatment. The podiatrist again wrote "Patient needs to be sedated." Review of his POs revealed no evidence that the PCP ordered sedation for the November 10, 2008 appointment. At approximately 5:20 PM, the QMRP stated that the sister's August consent form had expired. He then acknowledged that the facility had not sought an updated consent form for the November appointment, adding "I would not give him the Ativan, just assume... Now that I have the document that says he needs sedation, I can proceed with that..." 6. There was no evidence that the facility's RN had identified Resident #2's ongoing, unmet needs (implementing the BSP/ desensitization plan for medical procedures, seeking appropriate physician's orders and written consent from the sister when indicated, etc.) since she began working for the facility in September 2008. In summary, the facility's QMRP and medical team failed to coordinate and implement the strategies that were outlined in Resident #2's plan, to meet the resident's health care needs timely and effectively. This is a repeat deficiency. ********** Previously, the June 12, 2008 Federal Deficiency Report included the following: a. According to Resident #2's medical laboratory studies reviewed June 4, 2008 at 10:00 AM, it	I 401		

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I 401	Continued From page 12 was noted by the primary care physician to repeat an elevated ALT (73) study dated December 20, 2007. Interview with the LPN revealed that this was overlooked and would be scheduled for June 5, 2008. b. According to Resident #2's nursing quarterly report dated April 1, 2008, the resident had a nodule in his scalp. An x-ray was conducted as recommended on January 28, 2008; however, a CAT scan of the skull was also recommended, but not performed. The RN during interview on June 4, 2008 at 1:22 PM stated that "they were awaiting for consent." Also, the LPN indicated that clarity of with or without contrast had to be made prior to the CAT scan. There was no evidence that the attempts had been made to obtain the recommended testing. On July 24, 2008, the facility submitted a Plan of Correction that included the following: "The nurses have been in-serviced on timely follow-up of medical appointments... The facility's RN will, on a weekly basis or as needed, review all medical records to ensure that medical appointments are done on a timely manner. On 6/20/08, Resident #2 was taken to do his ALT but was uncooperative. He is to follow-up under sedation... Resident #2's CAT scan... was attempted on 6/17/08 but resident refused... He is to follow-up under sedation." Target completion dates indicated were 7/28/08 and 7/29/08, respectively.	I 401	**I 401. 6b** **These issues were resolved during the first survey and copies of the completed appointments were attached to the July 24, 2008 plan of correction sent to DOH.** **However, please find attached a copy of the completed CT scan and a copy of the needle biopsy requested by client #2's primary care physician after the CT scan was completed.**	07.29.08
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal	I 500		

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I 500	Continued From page 13 laws. 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) that governs the care and rights of persons with mental retardation. The findings include: The facility failed to protect residents' rights to receive prompt and adequate medical attention [Title 7, Chapter 13, § 7-1305.05(g), formerly § 6-1965(g)], as follows: 1. Cross-refer to I058. The GHMRP failed to enlist the services of the Nutritionist consultant after Resident #3 was diagnosed with kidney disease, to ensure that his dietary needs were met. 2. Cross-refer to I041.3. The facility's QMRP and medical team failed to coordinate and implement the strategies that were outlined in Resident #2's plan, to meet the resident's health care needs timely and effectively.	I 500	**I 500.1** **Cross reference W159.4** **I 500.2** **Cross reference W 104.1**	