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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G056	A. BUILDING ____ B. WING ____	06/12/2008

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 This recertification survey was conducted from June 4 through June 6, 2008 and initiated as a fundamental survey. As a result of information gathered from interviews and from records, the survey process was extended in the Condition of Health Care Services. There was a census of six male residents, whose ages range from fifty (50) to seventy eights (78) years. These residents were diagnosed with varying levels of mental retardation. Client #4, who was admitted to the facility on April 9, 2008, was hospitalized shortly thereafter (May 19, 2008), and subsequently died on June 11, 2008. During the survey, an investigation of Client #4's death was conducted to determine compliance with federal and local standards of care prior to his demise. The findings concluded from this survey and investigation were based on observations in the residential and day program settings, interviews with staff, and the review of 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 failed to provide general operating directions over the facility as evidenced by the following and the deficiencies cited throughout this report for one of four clients in the facility.:	W 104		

RECEIVED DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION
2008 JUL 24 P 2:47

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dr. Rodwell Bucklist[illegible] | TITLE: Administrator | (X6) DATE: 7/23/08

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 The findings include: Interview with the facility's Register Nurse (RN) on June 12, 2008 at 10:00 AM revealed that she was not been made aware of Client #4's discharge/intake meeting. She indicated that she did not review the client's records prior to his admission on April 9, 2008. The RN stated that first became aware of client #4's medical diagnoses (hypertension, prostrate cancer, severe anemia, leg edema, mental retardation, alzheimer, right leg ulcer, insomnia and hyperactive bladder) after his admission on April 10, 2008. She described the admission information received from the client's former placement and family as minimal and in bits and pieces. The Qualified Mental Retardation Professional was interviewed on June 12, 2008 at 10:30 AM, and stated that she could not recall informing the RN the client's admission meeting. The QMRP further confirmed that the facility's LPN was also not present during the admission intake meeting. According to Client#4's medical records reviewed on June 12, 2008 at 9:40 AM, the facility's RN performed a baseline nursing assessment on the day after his admission (April 10, 2008). The assessment revealed an ulcer, swelling, and poor circulation on the client's right leg. The RN indicated that these findings, along with her concerns about the admission, was reported to the facility's main office. The facility's governing body failed to ensure that the pertinent professional team contracted to administer professional medical services were involved with Client #4's admission to ensure the	W 104	**W 104** **Given the demise of client #4 shortly after his admission to CCII, this is a significant learning lesson for the Qualified Mental Retardation Professional (QMRP) and the administration of Comprehensive Care II (CCII). In the future, the QMRP and the administration will ensure that the facility's Registered Nurse (RN) and the primary care physician are strongly involved in an intake meeting. They will have the final say on whether CCII will be able to meet the medical needs of a new client.** **07/10/08**	

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W 104	Continued From page 2 facility could provide for the client's medical needs. It should be noted that there was no evidence that the primary care physician had been informed of the discharge and/or consideration of intake for client #4. It also should be noted that the client was referred to a wound care specialist on April 28, 2008. The specialist reported that "the records that came with him from the [placement] are cursory at best".	W 104		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observations, interviews with clients, staff, and the Qualified Mental Retardation Professional (QMRP), the QMRP failed to ensure that client's active treatment programs to include interventions were established, integrated, coordinated, and monitored. The findings include: 1. The QMRP failed to ensure that the Individual Program Plan (IPP) had been revised for one of three Clients (#1) who had successfully completed their objectives.[Cross Reference W255] 2. The Qualified Mental Retardation Professional (QMRP) failed to ensure that objective criterions	W 159	**W 159:1** **Cross Reference W 255** **W 159:2** **Cross Reference W 257** **W 159:3** **Cross Reference W 436** **08/01/08**	

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W 159	Continued From page 3 for client [#1] had been considered for revision to increase the success for one of three clients in the sample. [Cross Reference W257] 3. The QMRP failed to ensure that client #3 was tought to use his devices and to make informed choices about the use of his eyeglasses and hearing aide. [Cross Reference W436]	W 159		
W 255	483.440(f)(1)(i) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on interviews and the review of records, the facility failed to ensure that the Individual Program Plan (IPP) had been revised for three of the Client (#1) who had successfully completed their objectives. The findings include: The QMRP failed to ensure that revisions to IPPs were made in response to the clients achievement of the criterion levels. Client #1 had a program that read "given VP, the client will be prompted to use the restroom every 2 hrs while at home". The data reviewed revealed that from January 2008 to April 2008, the client performed at 100% verbal prompting as related by the criterion although, the data	W 255	**W 255** **The Interdisciplinary Team (IDT) will meet on 07/30/08 to discuss the Individual Program Plan (IPP) goals of the clients at this facility. Shortly after the meeting, IPP goals will be revised as recommended.** **In the future, IPP goals will be reviewed and revised at least quarterly.**	**08/01/08**

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W 255	Continued From page 4 reflected a decrease in May 2008.	W 255		
W 257	483.440(f)(1)(iii) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. This STANDARD is not met as evidenced by: Based on interview with the direct care staff at the facility and review of client's individual program plan (IPP) and documentation of progress, the Qualified Mental Retardation Professional (QMRP) failed to ensure that objective criterions for client [#1] had been considered for revision to increase the success for the clients. The finding includes: Information taken from client #1's IPP that was reviewed on June 5, 2008 at 2:00 PM. 1. Client #1's IPP reflected an objective that read "Given verbal promtping , the client will complete steps of hand washing 60% of the trials per month. The documentation reflected that the client performed at 100% hand over hands. from January 2008 to May 2008. 2. Client #1's IPP reflected "given physical assistance the client will identify coins according to values three times a week". The documentation reviewed from January 2008 to May 2008 reflected that the client performed at 100% hand over hands. from .	W 257	**W 257: 1; 2; 3** **Cross Reference W 255.** **08/01/08**	

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W 257	Continued From page 5 3. Client #1's IPP revealed that the client had a program that read "given physical assistance, the client will state or point to named items on his LEO machine sixty. It was documented that staff attempted; however, the client refused. from January 2008 to May 2008. Although, client #1 demonstrated, according to the documentation, a lack of achievement there was no evidence that the client had been encouraged to succeed through revisions to the IPPs.	W 257		
W 316	483.450(e)(4)(ii) DRUG USAGE Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually. This STANDARD is not met as evidenced by: Based on observation, staff interview, and review of psychotropic medication documents the facility failed to attempt to decrease the psychotropic medications for one of three clients (#3) in the sample. The finding includes: During the medication administration observed on June 4, 2008 at approximately 6:00 PM, client #3 was administered Seroquel 300 mg and Depakote 500 mg. Review of the psychotropic medication review documents revealed that client #3's "targeted behaviors averaged 0-2 episodes per quarter and zero for the quarter of April 2007 to June 2007". In November 2007, there was one incident reported, in December 2007, two incidents, January 2008 there were three incidents and in March 2008 there were four	W 316		

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W 316	Continued From page 6 incidents recorded. According to the staff interviewed on June 6, 2008 at 5:00 PM client #3 "will get agitated and makes noise at night and talks about little people bothering him; however," he is easily redirected". The staff denied that client #3 demonstrated any physical or verbal aggression. Although, client #3 did not achieve his psychiatric goal to "reduce his targeted behaviors to zero occurrences in 6 months", he demonstrated minimal behavioral episodes. Based on client #3's achievement, it could not be determined that the interdisciplinary team had considered a medication reduction atleast annually or contraindicated the attempt (s).	W 316	**W 316** **Client #3 medications re titrated based on inputs from his day program and behavior frequencies at his home. Even though client #3's behavior frequencies are low at home, over the past months, the day program had reported significant increased episodes of anxiety and hallucinatory talks. This was used as a basis for not reducing his medication.** **08/01/08**	
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 medical record review, the facility failed to ensure preventive and general medical care and failed to ensure timely appointments and follow up for three of four clients reviewed in health care. The findings include: 1. The facility failed to ensure that nurses scheduled timely appointment for follow up appointments recommended for client #2. a. According to client #2's medical laboratory studies reviewed June 4, 2008 at 10:00 AM, it	W 322		

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W 322	Continued From page 7 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 client #2 nursing quaterly 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. 2. The facility failed to ensure that the required information for client # 3 was made available to specialist as recommendated: Client #3's medical record was reviewed on June 6, 2008 at 11:35 AM. The record reflected that client # 3 had a Gastrointerologist appointment scheduled May 27, 2008 for evaluation. The specialist would not evaluate client #3 and documented on the consultation form "where are LFT and Hepatitis screening and CAT scan of abdomen- renal cyst". It was further documented "Information requested was not sent completed and do not return unless information is sent with patient". It should be noted that client #3's last GI appointment was February 19, 2008 and at that time the GI consultant noted that the Liver Functioning Test (LFT) was too old. The GI	W 322	**W 322:1a** **The nurses have been in-serviced on timely follow-up of medical appointments.** **A monthly nursing notes/form has been put in place which will be used as a tracking mechanism for 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 in a timely manner. On 06/20/08, client # 2 was taken to do his ALT but was uncooperative. He is to follow-up under sedation. 07/28/08** **W 322:1b** **Client #2's CAT scan of the skull without contrast was attempted on 06/17/08, but client refused. Please find attached the consult. He is to follow-up under sedation.** **07/29/08**	

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W 322	Continued From page 8 consultant requested that the laboratory studies be repeated and to follow up every three months. 3. There was no evidence that the primary care physician monitored the client's laboratory studies and consultants' recommendation as reflected below. a. Client #3's laboratory study dated March 26, 2008 reflected AST 62 H and ALT 59 H (therapeutic range13-51). The Primary Care Physician ordered the client to be evaluated by the GI specialist. Records reviewed that the client had gone to the GI for an evaluation in February 2008, but due to "old laboratory studies" the GI could not assess the client. There was no evidence that the PCP was made aware of the GI visit. c. According to a nursing monthly progress note, the CT scan of abdomen requested by the GI was completed April 21, 2008. The radiology report reflected "simple, small, cyst in both kidneys." The GI physician referred to these cyst as "renal cyst." It could not be determined that the primary care physician had addressed the radiology report. d. According to laboratory studies dated February 15, 2008, client #4's AST was 77 H and ALT 72 H. Although both were elevated, the elevation was not addressed by the PCP.	W 322	**W 322:2** **Cross Reference I 401: 2** **07/11/08** **W 322:3a** **Comprehensive Care II has put in place a flow sheet which will be used to track laboratory results and recommendations by other clinicians. Each client's flow sheet will be addressed by his primary care physician (pcp) on a monthly basis or as needed so as to ensure that laboratory values and other medical appointments are reviewed on a timely basis.** **07/01/08** **W 322, 3b** **Cross Reference W322:3a** **W 322:3c** **Cross Reference W322:3a** **W 322, 3d** **Cross Reference W322:3d** **07/01/08**	
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by:	W 331		

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W 331	Continued From page 9 Based on interview and record review, the facility failed to provide each client with nursing services in accordance with their needs. The findings include: The nursing staff failed to monitor as recommended client #3's nutritional intake as evidenced by the following:. During the medication administration conducted on June 4, 2008, the nurse was observed giving client #3 Ensure. Review of the client's nutritional quarterly dated March 31, 2008 reflected that the client was within his desired body weight range; however, the record indicated that Ensure was ordered daily "until weight stability is supported by food intake." Review of the food intake chart revealed that in May 2008, ten breakfast and seven dinner meals were not documented; and in June 2008, two breakfast and three dinner meals were not documented. It also should be noted that there was no documentation of client #3's meal intake at his/her day program although the staff interviewed on June 5, 2008 stated that the client eats 100% of his lunch meal.	W 331	**W 331** **The nursing staff have been in-serviced on monitoring of nutritional intake and reporting the outcome to the nutritionist. The House Manager (HM) will on a daily basis (5 days a week) monitor documentation of nutritional intake so as to ensure compliance.** **The day program has been supplied with a tracking form for nutritional intake.** **07/20/08**	
W 336	483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on medical record review and confirmation by the Qualified Mental Retardation Professional, a review of one of four clients health status had	W 336		

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W 336	Continued From page 10 not been reviewed quarterly. The finding includes: Client #3's medical records that were reviewed on June 6, 2008 at 9:45 AM revealed that the client had his annual assessment dated October 2007. There was no quaterly nursing review on file. This was confirmed with the Qualified Mental Retardation Professional during this record review at 10:00 AM.	W 336	**W 336** **The RN has updated all quarterlies. The QMRP will, on a monthly audit the medical books to ensure that assessments are updated.** **07/30/08**	
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on review of medical records, it was identified that the facility failed to ensure that client (#3) had comprehensive dental treatment follow up as recommended for maintenance of dental health. The finding includes: According to client #3's dental records, reviewed on June 6, 2008 at 9:45 AM, his last dental visit was November 13, 2007. Records reflected that the dentist recommended extractions be performed of mobile teeth # 5, 20, 23, 24, 25, 29. A nursing note dated December 3, 2007 indicated that the dentist reported that preauthorization for dental services were not back. At the time of this survey, client #3 had not had the recommended	W 356	**W 356** **The approval of preauthorization for dental treatment is purely out of the domain of the ICF/MR provider. MAA is responsible for approving the authorization. Several Efforts were made by the provider in following up with the said dental appointment. However, client #3 visited his dentist on 06/18/08 and mobile teeth #s 23, 24,& 25 were extracted. Please find consult herewith.** **07/30/08**	

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W 356	Continued From page 11 extractions of his mobile teeth.	W 356		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, client and staff interviews, and record review, the facility failed to furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of recommended equipment. The findings include: An interview was conducted with client #3's day program direct care support specialist on June 6, 2008 at 11:15 AM. The specialist emphasized that client #3 had a hearing aid and eyeglasses that were significant to his functioning in the program a) It was revealed that client #3 "had not had his hearing aid but once in the last 3 months". During the observations at the facility, conducted on June 4, 2008 from 4:00 PM to 8:00 PM, and again on June 6, 2008, at approximately, 1:00 PM, this surveyor did not observe client #3 wearing a hearing aide. The Qualified Mental Retardation Professional (QMRP) interview on June 6, 2008, and revealed that client #3 worn his hearing aide on the previous day, June 5, 2008.	W 436	**W 436a** **Client #3 received his hearing aid on 05/21/08. Please see evidence attached. A training program to manage his hearing aid was put in place in June 2008. Since 06/15/08, client # 3 has been consistently wearing his hearing aid to his day program** **06/15/08**	

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W 436	Continued From page 12 Client #3's medical record reflected that on March 26, 2008 and May 21, 2008 the client was fitted with hearing aid replacements. A training program to support the client use of the hearing aid was developed June 2008, several months after the client received his aid. There was no evidence that a training program had been implemented. b) According to the day program staff, client #3 eyeglasses was loosely fitting and fell from his eyes and broke. Since that time he was not observed wearing eyeglasses. On June 4, 2008 at approximately 4:10 PM, the Qualified Mental Retardation Professional (QMRP) asked client #3 where was his eyeglasses. Twenty to 30 minutes later, the client with the assistance of staff located his glasses. Client #3 wore his eyeglasses for approximately one hour. There was no evidence that a training program had been implemented to teach him to care and wear his glasses.	W 436	**W 436b** **A string has been attached to client #3's eyeglasses so as to prevent it from falling from his eyes. A program goal has been in put in place geared towards teaching client #3 in caring for his glasses and optimizing usage.** **07/01/08**	
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: Based on observation, the medication administration nurse failed to use active prevention, control, and investigation of infection and communicable diseases. The finding includes: During the medication administration conducted on June 4, 2008, at 5:30 PM, the nurse failed to	W 455		

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	09G056	A. BUILDING ______ B. WING ______	06/12/2008

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W 455	Continued From page 13 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.	W 455	**W 455** **The nurse in focus has been in-service on infection control. The emphasis of the training was 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.** **07/30/08**	

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I 000	INITIAL COMMENTS This licensure survey was conducted from June 4 through June 6, 2008 and initiated as a fundamental survey. There as a census of six male residents, whose ages range from fifty (50) to seventy eights (78) years. These residents were diagnosed with varying levels of mental retardation. Client #4, who was admitted to the facility on April 9, 2008, was hospitalized shortly thereafter (May 19, 2008), and subsequently died on June 11, 2008. During the survey, an investigation of Client #4's death was conducted to determine compliance with federal and local standards of care prior to his demise. The findings concluded from this survey and investigation were based on observations in the residential and day program settings, interviews with staff, and the review of records, including incident reports	I 000		
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 medical record review, the facility's professional services failed to ensure preventive and general medical care for three of four clients reviewed in health care. The findings include:	I 401	RECEIVED DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 2008 JUL 24 P 2:48	

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: T. Rodnell Buckles | TITLE: Administrator | (X6) DATE: 7/23/08

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I 401	Continued From page 1 1. The facility failed to ensure that nurses scheduled timely appointment for follow up appointments recommended for client #2. 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 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 nursing quaterly 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. 2. The facility failed to ensure that the required information for client # 3 was made available to specialist as recommendated: Client #3's medical record was reviewed on June 6, 2008 at 11:35 AM. The record reflected that client # 3 had a Gastrointerologist appointment scheduled May 27, 2008 for evaluation. The specialist would not evaluate client #3 and documented on the consultation form "where are LFT and Hepatitis screening and CAT scan of abdomen- renal cyst". It was further documented "Information requested was not sent completed and do not return unless information is sent with	I 401	**I 401:1a** **Cross Reference W322:1a** **07/30/08** **I 401:1b** **Cross Reference W322:1b** **07/30/08** **I 401: 2** **The facility's RN has in-serviced the Licensed Practical Nurses (LPNs) on the significance of sending complete requested information on appointments. The RN will, on a monthly basis review all upcoming appointments and assist the LPN in gathering requested information.** **The CAT scan of the abdomen to rule out renal cyst for client #3 was done on 04/21/08. The Liver Function Test (LFT) was done on 07/11/08 and has been reviewed by his primary care physician. Please find evidence herewith.** **07/11/08**	

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I 401	Continued From page 2 patient". It should be noted that client #3's last GI appointment was February 19, 2008 and at that time the GI consultant noted that the Liver Functioning Test (LFT) was too old. The GI consultant requested that the laboratory studies be repeated and to follow up every three months. 3. There was no evidence that the primary care physician monitored the client's laboratory studies and consultants' recommendation as reflected below. a. Client #3's laboratory study dated March 26, 2008 reflected AST 62 H and ALT 59 H (therapeutic range13-51). The Primary Care Physician ordered the client to be evaluated by the GI specialist. Records reviewed that the client had gone to the GI for an evaluation in February 2008, but due to "old laboratory studies" the GI could not assess the client. There was no evidence that the PCP was made aware of the GI visit. c. According to a nursing monthly progress note, the CT scan of abdomen requested by the GI was completed April 21, 2008. The radiology report reflected "simple, small, cyst in both kidneys." The GI physician referred to these cyst as "renal cyst." It could not be determined that the primary care physician had addressed the radiology report. d. According to laboratory studies dated February 15, 2008, client #4's AST was 77 H and ALT 72 H. Although both were elevated, the elevation was not addressed by the PCP. 4. According to client #3's dental records,	I 401	**I 401:3a, b, c, d** **Cross Reference W322:3a.** **07/30/08**	

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I 401	Continued From page 3 reviewed on June 6, 2008 at 9:45 AM, his last dental visit was November 13, 2007. Records reflected that the dentist recommended extractions be performed of mobile teeth # 5, 20, 23, 24, 25, 29. A nursing note dated December 3, 2007 indicated that the dentist reported that preauthorization for dental services were not back. At the time of this survey, client #3 had not had the recommended extractions of his mobile teeth. 5. During the medication administration conducted on June 4, 2008, the nurse was observed giving client #3 Ensure. Review of the client's nutritional quarterly dated March 31, 2008 reflected that the client was within his desired body weight range; however, the record indicated that Ensure was ordered daily "until weight stability is supported by food intake." Review of the food intake chart revealed that in May 2008, ten breakfast and seven dinner meals were not documented; and in June 2008, two breakfast and three dinner meals were not documented. It also should be noted that there was no documentation of client #3's meal intake at his/her day program although the staff interviewed on June 5, 2008 stated that the client eats 100% of his lunch meal.	I 401	**I 401:4** **Cross Reference W356.** **07/30/08** **I 401:5** **Cross Reference W331.** **07/30/08**	
I 407	3520.9 PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall obtain from each professional service provider a written report at least quarterly for services provided during the preceding quarter. This Statute is not met as evidenced by: Based on record review the GHMRP failed to obtain from each professional service provider a	I 407		

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I 407	Continued From page 4 written report at least quarterly for services provided during the preceding quarter. The findings include: The Registered Nurse (RN) and the primary care physician failed to conduct a quarterly assessments for client # three (3). The client's ISP was dated October 2007 however, there were no reviews for January and April 2008. The absence of these reviews were acknowledged by the QMRP during the review conducted on June 6, 2008 at 11:00 AM	I 407	**I 407** **Cross Reference W 336.** **07/30/08**	
I 426	3521.5(c) HABILITATION AND TRAINING Each GHMRP shall make modifications to the resident ' s program at least every six (6) months or when the client: (c) Is failing to progress toward identified objectives after reasonable efforts have been made; This Statute is not met as evidenced by: Based on interview with the direct care staff at the facility and review of client's individual program plan (IPP) and documentation of progress, the GHMRP shall make modifications to the resident ' s program at least every six (6) months or when the client: (c) Is failing to progress toward identified objectives after reasonable efforts have been made; The finding includes: Information taken from client #1's IPP that was reviewed on June 5, 2008 at 2:00 PM.	I 426		

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I 426	Continued From page 5 1. Client #1's IPP reflected an objective that read "Given verbal promtping , the client will complete steps of hand washing 60% of the trials per month. The documentation reflected that the client performed at 100% hand over hands. from January 2008 to May 2008. 2. Client #1's IPP reflected "given physical assistance the client will identify coins according to values three times a week". The documentation reviewed from January 2008 to May 2008 reflected that the client performed at 100% hand over hands. from . 3. Client #1's IPP revealed that the client had a program that read "given physical assistance, the client will state or point to named items on his LEO machine sixty. It was documented that staff attempted; however, the client refused. from January 2008 to May 2008. Although, client #1 demonstrated, according to the documentation, a lack of achievement there was no evidence that the client had been encouraged to succeed through revisions to the IPPs.	I 426	**I 426:1, 2, 3.** **Cross Reference W 255.** **07/30/08**	