STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCT...	(X3) DATE SURVEY COMPLETED
	09G056	A. BUILDING _____ B. WING _____	07/30/2010

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W 000	INITIAL COMMENTS An recertification survey was conducted from July 28, 2010, through July 30, 2010, utilizing the fundamental survey process. A random sample of three clients was selected from a population of five males with various levels of mental retardation and disabilities. The findings of the survey were based on observations at the group home and three day programs, interviews with clients and staff, and the review of clinical and administrative records including incident reports.	W 000	Received 8/16/10 DOH-HCLA-1CFD	
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that outside services met the needs of each client, for one of three clients in the sample. (Client #2) The finding includes: The facility failed to ensure that the day program implemented Client #2's behavior support plan as prescribed. Observation at Client #2's day program on July 28, 2010, at 11:31 a.m., revealed the client leaning over the surveyor. At the same time, the qualified mental retardation professional (QMRP) told the client he was too close and to give the surveyor her personal space. (Note: the QMRP came to the day program to give him his eye	W 120		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Johnnie Jenkins	Adm. Asst.	8/16/10

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 120	Continued From page 1 glasses). At 12:30 p.m., Client #2 stood close to the surveyor and held her hand while she spoke with his day program staff. At no time did the day program staff request the client to give the surveyor her personal space. Interview with the day program staff at 12:35 p.m., indicated that he is required to ask the client to stand within arms length and to give individuals their personal space. Review of the day program behavior support plan (BSP) dated October 20, 2009, at approximately 12:40 p.m., revealed the following procedures for addressing Client #1's target behavior of inappropriate social behavior: a. Staff should "ask him to utilize his string as a way to remind him of the appropriate distance." b. He should receive praise for initiating conversation in an appropriate manner. c. If he continues his target behavior, staff should disengage, physically and conversationally, from him until he uses the appropriate behavior. At the time of the survey, there was no evidence that the day program staff implemented Client #1's BSP.	W 120	**W 120** **A case conference will be held with client #2's day program to discuss consistency in implementing interventions specified in the Behavior Support Plan (BSP).** **Twice monthly, for the next three months, the Qualified Mental Retardation Professional (QMRP) will visit client#2 at his day program to observe implementation of the interventions specified in the BSP.**	08/31/10
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.	W 124		

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W 124	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, facility failed to establish a system that would ensure clients, family members and/or legal guardians were informed of the risks and benefits of restrictive programs and supports, for two of the three clients included in the sample. (Clients #1 and #3) The findings include: 1. The facility failed to provide evidence that informed consent was obtained from Client #1's family member for psychotropic medications as evidenced below: During the entrance conference on July 28, 2010, beginning at 10:00 a.m., the qualified mental retardation professional (QMRP) indicated that Client #1 had family members who assisted the client in making health care decisions. a. Observations during the medication administration, on July 29, 2010, at 7:11 a.m., revealed that Client #1 received Tegretol 300 mg and Zyprexa 5 mg. Interview with the Licensed Practical Nurse (LPN) after the medication administration indicated that the client received the aforementioned medication for his maladaptive behaviors. Review of the client's current physician orders dated July 2010, on July 29, 2010, at approximately 9:30 a.m., confirmed the aforementioned medications. In addition, the client was ordered Remeron 30 mg, by mouth, at	W 124	**W 124, 1a** **The facility will adhere to obtaining consent for psychotropic medications in a timely manner.** **Consent shall be obtained from a family member and/or guardian before newly prescribed psychotropic medications or sedative hypnotic drugs are administered.**	08/25/10

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W 124	Continued From page 3 bedtime. According to the POS, the Remeron 15 mg was written on August 20, 2009, and increased to 30 mg on January 26, 2010. Review of Client #1's Psychological Assessment dated January 15, 2010, on July 29, 2010, at approximately 3:00 p.m., revealed that the client was not competent to make decisions regarding his health, safety, financial or residential placement. Further review of the client's record failed to provide evidence that informed consent had been obtained for the use of the Remeron. Further review of the client's record revealed a signed consent dated June 23, 2010. On the consent form was Tegretol 300 mg, three times a day, Tegretol 600 mg, every evening (weekends), Zyprexa 5 mg, in the morning Zyprexa 20 mg, in the evening and Remeron 30 mg, at bedtime. Interview with the QMRP on July 30, 2010, at approximately 12:20 p.m., indicated that the consent for the Remeron was not obtained timely. However, once the QMRP realized he obtained consent from Client #1's family member. b. Review of Client #1's POS dated August 20, 2010, on July 29, 2010, at approximately 9:30 a.m., revealed an order for Zoloft 50 mg, at bedtime. Further review of the medication administration record (MAR) on July 29, 2010, confirmed that the client received the prescribed Zoloft from July 27, 2009, through August 25, 2009. Review of Client #1's record on July 29, 2010, at approximately 9:30 a.m., revealed a psychological assessment dated January 15, 2010. According to the assessment, Client #1 "is not able to make independent decisions concerning his residential	W 124		

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W 124	Continued From page 4 or day placements. He lacked the cognitive skills necessary to understand the implications of such decisions and therefore cannot give her informed consent. He lacked the judgment and insight required to make decisions independently." Further review of the record revealed no evidence of a signed consent for the prescribed Zoloft. The facility failed to provide evidence that the potential risks involved in using this medication, or his right to refuse treatment had been explained to the client and/or guardian, prior to the implementation of the psychotropic medication. 2. The facility failed to provide evidence that informed consent was obtained from Client #3's family members for sedation given during medical appointments as evidenced below: During the entrance conference on July 28, 2010, beginning at 10:00 a.m., qualified mental retardation professional (QMRP) indicated that Client #3 had an active family member to assist the client in making health care decisions. Review of Client #3's physician orders (POS) on July 30, 2010, beginning at 11:00 a.m., revealed the following orders: - On July 19, 2010, Ativan 4 mg, prior to dental examination; and - On July 23, 2010, Ativan 2 mg, prior to laboratory studies. Review of Client #3's medication administration record (MAR), confirmed that the client was administered the aforementioned sedations.	W 124	**W 124, 1b** **Consent shall be obtained from a family member and/or guardian in a timely manner before newly prescribed psychotropic medications or sedative hypnotic drugs are administered.** **Client #1 shall be informed of the risks involved in taking his prescribed medications, and his right to refuse treatment. Such rights shall be reviewed with client#1 annually or as needed.**	08/31/10

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W 124	Continued From page 5 Further record review revealed signed consents dated May 27, 2010. The signed consents were for Ativan 2 mg, prior to an ophthalmology, and podiatry examinations, and Ativan 4 mg, prior to dental appointment. Laboratory studies consult was not included on the signed consent form. Furthermore, the client was sedated for Ativan 4 mg and the signed consent was signed for Ativan 2 mg. Interview with the QMRP on July 30, 2010, at approximately 1:30 p.m., revealed that he was not aware of the laboratory studies consult and the use of Ativan 4 mg, for the schedule dental appointment. Review of Client #3's Psychological Assessment dated October 20, 2009, on July 30, 2010, beginning at 12:30 p.m.,revealed that the client was not competent to make decisions regarding his health, safety, financial or residential placement. Further review of the client's record failed to provide evidence that informed consent had been obtained for the use of the sedation. At the time of the survey, the facility failed to provide evidence that the potential risks involved in using this medication, or his right to refuse treatment had been explained to the client and/or family members.	W 124	**W 124, 2.** **There was a breakdown in communication between the facility's nurse and the QMRP in specifying the use of sedation. And as such, the consent for sedation was not sought. A communication book will be put in place which will foster communication between the nursing department and the QMRP on issues such as sedation, psychotropic medication, and other restrictions.** **Consent for sedation will be tracked and sought in a timely manner in the future.**	**08/31/10**
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure policies that prohibit mistreatment	W 149		

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W 149	Continued From page 6 or abuse were consistently implemented for one of three clients included in the sample. (Client #3). The findings include: The facility failed to ensure its incident management policy was implemented as outlined. Review of Client #3's nursing note dated April 5, 2010, on July 30, 2010, at approximately 1:00 p.m., revealed that a client at the day program hit Client #3 across the left side of his face. Further review revealed that the facility's License Practical Nurse administered Tylenol for pain. Interview with the Qualified Mental Retardation Professional (QMRP) on July 30, 2010, at approximately 2:30 p.m., revealed he was unaware of the incident. Further interview revealed there was no incident report completed. According to the review of the facility's incident management policy on July 28, 2010, at approximately 9:30 a.m, it revealed that all incidents are classified into either a serious reportable or reportable incident. The policy further revealed that abuse was classified as a serious reportable incident that should have been both verbally reported immediately to the facility's immediate supervisor and to the Department of Health. Additionally, the incident should have been documented on an incident report form and forwarded to the Department of Health. It should be further noted that the policy also indicated that an incident report should be completed for all reportable incidents. At the time of the survey, the facility failed to ensure that its incident management policy was implemented as outlined.	W 149	**W 149** **Direct Care Staff (DCS) and nurses will be re-trained on the facility's incident management policy.** **Such training will be held quarterly so as to enhance staff understanding and competency in incident management policy and procedure.**	**08/31/10**
W 153	483.420(d)(2) STAFF TREATMENT OF	W 153		

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W 153	Continued From page 7 CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and review of the client's records, the facility failed to ensure that all incidents of abuse were consistently reported immediately to the administrator and to the State agency, for one of the thee clients included in the sample. (Client #3) The finding includes: Review of Client #3's nursing note dated April 5, 2010, on July 30, 2010, at approximately 1:00 p.m., revealed that a client at the day program hit Client #3 across the left side of his face. Further review revealed that the facility's License Practical Nurse administered Tylenol for pain. Interview with the Qualified Mental Retardation Professional (QMRP) on July 30, 2010, at approximately 2:30 p.m., revealed he was unaware of the incident. Further interview revealed there was no incident report completed. At the time of the survey, there was no evidence that the facility reported the incident of abuse to the administrator or to the Department of Health.	W 153	W 153 Cross reference W 149.	
W 192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed	W 192		

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W 192	Continued From page 8 toward clients' health needs. This STANDARD is not met as evidenced by: Based on observations, staff interview and record review, the facility failed to ensure that staff followed client's meal time protocol and physician orders, for one of the three clients included in the sample. (Client #2) The finding includes: On July 28, 2010, direct care staff was observed preparing Client #1's snack. The client had a choice of apples (cut into quarters), plums, fresh peaches (whole) and graham crackers (broken in half). The client choose the peach. At 5:53 p.m., Client #1 was observed eating dinner. The meal consisted of penne pasta, shredded cabbage, pasta sauce, canned fruit pears and beverage. Interview with the direct care staff, who prepared the client's meal on July 28, 2010, at 6:05 p.m., revealed that the client was on a low sodium, finely chopped meats and vegetable diet. Review of the current physician orders dated July 2010, revealed a diet order of low cholesterol, low sodium, finely chopped meats and vegetables diet. On July 29, 2010, at 11:30 a.m., interview with the license practical nurse revealed that if a client is ordered a finely chopped meal, they should not receive shredded vegetables. Review of the facility's in-service training records on July 30, 2010, at 9:50 a.m., revealed that all staff had received nutritional training on May 11, 2010. There was no evidence that training had	W 192	**W 192** **All staff will be re-trained on diet type, texture, and portion control.** **The House Manager and the facility's Licensed Practical Nurse (LPN) will on a daily basis (5 days a week) observe staff in demonstrating competency in adhering to diet type, texture, and portion control. Such observations shall be done for three months.** **A staff found not to be in compliance with diet orders will be provided with one-on-one in-service and supervision.**	**08/31/10**

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W 192	Continued From page 9 been effective.	W 192		
W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that the Individual Program Plan (IPP) included objectives to meet the client's needs as recommended from the comprehensive functional assessments, for one of the three clients in the sample. (Client #1) The finding includes: Observations on July 28, 2010, at 6:15 p.m., revealed direct care staff assisting Client #3 with his shower. Interview with direct care staff, on the same date, at 6:50 p.m., indicated that he has to assist the client with a shower, to include lathering his wash cloth and rinsing him. Review of the Client #1's Psychology assessment and Occupational Therapy assessment dated October 20, 2009 and October 1, 2009, respectively on July 30, 2010, at approximately 10:45 a.m., revealed a program recommendation for the client to participate in a showering routine. The program should provide simple step by step directive for him to soap himself and use the shower head to wash off the soap. Review of the IPP dated October 23, 2009, on July 30, 2010, at 11:00 a.m., revealed no evidence of training programs to address the aforementioned	W 227	**W 227** **An Individual Program Plan (IPP) will be put in place which will be geared towards enhancing client #1's ability in participating in shower routine. Such program shall be monitored quarterly for progress.**	**08/25/10**

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W 227	Continued From page 10 recommendations included in the comprehensive functional assessment. The QMRP verified on July 30, 2010, at approximately 12:45 p.m., that no training programs had been developed for the client to participate in a showering program as recommended in the aforementioned assessments.	W 227		
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, staff interview and record review, the facility's qualified mental retardation professional (QMRP) failed to ensure client's received continuous active treatment, for two of the three clients included in the sample. (Clients #1and #3) The findings include: 1. During medication administration observation on July 29, 2010, at 7:11 a.m., revealed Licensed Practical Nurse #1 (LPN #1) placed a cup of medications into Client #1's hands in order for the client to consume the medication with two (2) physical prompts. Further observation revealed Client #1 picked up a cup of water and consumed	W 249	**W 249, 1.** **All of the clients in the facility have self medication programs. The facility's LPN and Direct Care Staff will be re-trained on implementing the self-medication programs.** **The facility's RN will, on a monthly basis observe the full implementation of the self medication programs.**	**08/25/10**

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W 249	Continued From page 11 the contents with one (1) verbal prompt. During a face-to-face interview with LPN #1 on July 29, 2010, at approximately 7:45 a.m., revealed Client #1 had a self-medication program however, the program was implemented in the evening. Review of Client #1's self-medication program dated July, 2010, on July 29, 2010, at approximately 9:00 a.m., indicated that given verbal assistance Client #1 will punch his medications from a bingo card (blister pack/bubble pack to a cup 60% of recorded trials per month. Further review revealed the self-medication program was as follows: a. Wash his hands; b. Identify medications to be punched; b. Put cup under meds to be punched and c. Punch meds There was no evidence that the client was given the opportunity to fully participate in the self-medication program. 2. During medication administration observation on July 29, 2010, at 7:16 a.m., revealed LPN #1 went into the kitchen and then poured water into a cup on the counter and placed the cup of water into Client #3's hand. Further observation revealed LPN #1 held the medication and water cups to Client #3's mouth in order for the client to consume the medication and water with three (3) physical prompts. During a face-to-face interview with LPN #1 on July 29, 2010, at approximately 7:46 a.m., revealed Client #3 had a self-medication program	W 249	**W 249, 2** **Cross reference W249,1.**	

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W 249	Continued From page 12 however, the program was implemented in the evening. Review of Client #3's self-medication program dated July, 2010, on July 29, 2010, at approximately 9:10 a.m., indicated that given verbal prompts, Client #3 will get his cup and fill it with water when it is time for his medications. Further review revealed the self- medication program was as follows: a. Wash hands; b. Get a cup; b. Fill cup with water and c. Go to medication dispensation area There was no evidence that the client was given the opportunity to fully participate in the self-medication program.	W 249		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the facility failed to ensure that restrictive measures had been reviewed and/or approved by the Human Rights Committee (HRC), for two of two clients in the sample. (Client #1) The finding includes:	W 262		

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W 262	Continued From page 13 Minutes taken at meetings of the facility's HRC for the period July 2009 through June 2010, were reviewed on July 29, 2010, beginning at 2:10 p.m. According to the documents, sedations are part of the review process. Review of Client #3's medical chart on July 30, 2010, beginning 12:15 p.m., revealed the following orders: - On July 6, 2010, Ativan 4 mg, prior to podiatry examination; - On July 19, 2010, Ativan 4 mg, prior to dental examination; and - On July 23, 2010, Ativan 2 mg, prior to laboratory studies. Interview with the qualified mental retardation professional (QMRP)on July 30, 2010, at approximately 1:30 p.m., revealed that Client #3 received the sedation to address his non-compliance prior to the medical appointments. Record review revealed HRC meeting notes dated May 31, 2010. The HRC minutes approved for Client #3 to receive Ativan 2 mg for medical appointments (dental and podiatry). Further review revealed no evidence that the facility's HRC reviewed and/or approved Ativan 2 mg prior to a laboratory study. Further interview with the QMRP, at 1:55 p.m., indicated that he thought Client #3 was going to receive Ativan 2 mg for the above mentioned medical appointments. There was no evidence, however, that the HRC reviewed and/or approved the use of Ativan 4 mg	W 262	**W 262** **In accordance with W124 (2): when communication for the need of sedation in exact dose and purpose is conveyed to the QMRP through the established communication book, the Human Rights Committee will convene to discuss the pros and cons of such sedation and provide approval or disapproval.**	**08/31/10**

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W 262	Continued From page 14 for the dental and podiatry appointments and the use of Ativan 2 mg for a labortory study.	W 262		
W 325	482.460(a)(3)(iii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician. This STANDARD is not met as evidenced by: Based on interview, and record review, the facility failed to provide routine laboratory testing as determined necessary by the physician, for one of three clients included in the sample. (Client #3) The finding includes: The facility failed to obtain laboratory studies as ordered by the Primary Care Physician (PCP). Review of Client #3's physician's order (PO) from July 1, 2009, to July 1 2010, on July 30, 2010, at 12:30 p.m., revealed an order for the client to have laboratory studies for CBC and urinalysis every year. Subsequent review of his medical records revealed the last CBC study was May 27, 2009. There were no laboratory results available in the client's record for a urinalysis study. Interview with the license practical nurse (LPN) on July 30, 2010, at approximately 1:00 p.m., confirmed that the laboratory studies were not completed as ordered.	W 325	**W 325** **Quarterly Audits will be conducted on all habilitation records to ensure that all recommendations and medical appointments are followed up as recommended and in a timely manner.**	**08/31/10**
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	W 336		

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W 336	Continued From page 15 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 interview and record review, the facility's registered nurse (RN) failed to ensure physical examinations were conducted quarterly or on a more frequent basis, for three of the three clients included in the sample. (Client #, #2 and #3) The findings include: 1. Interview with the facility's Licensed Practical Nurse (LPN) Coordinator on July 29, 2010, at approximately 9:30 a.m., revealed that the Registered Nurse (RN) should complete quarterly nursing exams. Review of Client #1's medical record on July 29, 2010, at 10:00 a.m., revealed a nursing assessment dated January 8, 2010. Further record review revealed no quarterly nursing reviews. The LPN Coordinator confirmed the missing nursing quarterly reviews for Client #1. 2. Review of Client #2's medical record on July 29, 2010, at 9:36 a.m., revealed an annual nursing assessment dated April 12, 2009. Further review of the client's record revealed there was no nursing quarterly assessment in the record after October 20, 2009. Interview with the License Practical Nurse (LPN) on July 30, 2010, at 10:28 a.m., revealed that nursing quarterlies are required to be completed every quarter (3 months).	W 336	**W 336, 1.** **Quarterly Audits will be conducted by the Quality Assurance (QA) staff to ensure that all assessments are completed and filed as required.** **336, 2** **See W336, 1.**	**08/31/10**

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W 336	Continued From page 16 3. Review of Client #3's medical record on July 30, 2010, at 12:10 p.m., revealed an annual nursing assessment dated October 1, 2009. Further review of the client's record revealed there was no nursing quarterly assessment prior to April 2010. Interview with the License Practical Nurse (LPN) on July 30, 2010, at approximately 10:30 a.m., revealed that nursing quarterlies are required to be completed every quarter (3 months).	W 336		
W 362	483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that drug regimen reviews were conducted at least quarterly to obtain relevant input from the pharmacist, for three of three clients in the sample. (Clients #1, #2, and #3) The findings include: Interview with the licensed practical nurse (LPN) coordinator on July 28, 2010, at approximately 4:00 p.m., revealed the pharmacist is required to the facility every three months to conduct reviews of the clients' medications. Record review on July 29, 2010 at 11:00 a.m. revealed pharmacy reviews dated January 9, 2010 and May 2, 2010, for Clients #1, #2 and #3. There was no evidence, however, that drug regimen reviews were conducted least quarterly, as required.	W 362	**W 362** **The pharmacist has been informed of the requirement to conduct reviews quarterly.** **Quarterly Audits will be conducted by the Quality Assurance staff to ensure that pharmacy reviews are conducted every three months (quarterly) instead of every four (4) months.**	**08/31/10**

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W 362	Continued From page 17 Interview with the facility's LPN Coordinator on July 29, 2010, at approximately 2:00 p.m., confirmed that the pharmacy reviews were completed every four months.	W 362		
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, interview and record review, the facility failed to ensure the timely provision of assistive devices (dentures) recommended by the interdisciplinary team for one of three clients in the sample. (Client #2) The finding include: On July 28, 2010, at 11:15 p.m., Client #2 was observed with no teeth. Review of Client #1's medical record on July 28, 2010, at 5:10 p.m., revealed a nursing progress note dated June 29, 2010. The progress note stated that the client broke his upper dentures. The next nursing progress note dated July 28, 2010, revealed the License Practical Nurse (LPN) scheduled an dental appointment for August 13, 2010. Interview with the (LPN) on July 29, 2010, at approximately 2:30 p.m., indicated Medicaid would not cover Client #2's dentures until 2012. Further interview revealed that the LPN made an appointment after the qualified mental retardation	W 436	**W436** **A portion of the Quality Assurance audit will be, auditing of timely completion of medical appointments and/or implementation of recommendations.** **The facility's RN will on a monthly basis review all medical records to ensure that appointments are completed in a timely manner.**	**08/31/10**

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W 436	Continued From page 18 professional suggested that she call the hospital's dental school. At the time of the survey, the facility failed to ensure Client #1 received timely dental services.	W 436		

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I 000	INITIAL COMMENTS An licensure survey was conducted from July 28, 2010, through July 30, 2010. A random sample of three residents was selected from a population of five males with various levels of mental retardation and disabilities. The findings of the survey were based on observations at the group home, three day programs, interviews with residents and staff, and the review of clinical and administrative records including incident reports.	I 000		
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. This Statute is not met as evidenced by: Based on observation and interview, the Group Home for Persons with Mental Retardation (GHMRP) failed to maintain the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner for five of five residents residing in the facility. The findings include: Observation and interview with the facility's Program Manager (PM) on July 29, 2010, beginning at approximately 10:45 a.m., revealed the following: Interior: 1. The entrance hallway ceiling had cracks and	I 090		

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I 090	Continued From page 1 water stains. 2. The first floor den ceiling had water damage. 3. The first floor bathroom ceiling had water damage. The Program Manager (PM) acknowledged the above deficiencies on July 29, 2010, at approximately 11:30 a.m.	I 090	**I 090** **1. The entrance hallway will be repaired** **2. The first floor bathroom ceiling will be repaired.** **Monthly environmental audits (internal and external audits) will be conducted by the maintenance division to ensure that all maintenance issues are resolved in a timely manner.**	**08/31/10**
I 191	3508.8(b) ADMINISTRATIVE SUPPORT Each GHMRP licensee shall carry or ensure that the premise carries the following insurance in at least the following amounts: (b) Liability coverage (premises, personal injury, and products liability in the amount of three hundred thousand dollars ($ 300,000)) per occurrence; and Professional liability. This Statute is not met as evidenced by: Based on record review and interview, the Group Home for Persons with Mental Retardation (GHMRP) failed to have on file for review, professional liability insurance, for four of eleven consultants. (Registered Nurse #2, two Med. Nurses #4 and #5, and the Pharmacist #9) The finding includes: Review of the personnel records on July 29, 2010, at approximately 1:30 p.m., revealed the GHMRP failed to have evidence of professional liability insurance for the Registered Nurse, two Medication Nurses and the Pharmacist. These deficiencies were acknowledged by the House Manager on July 29, 2010, at	I 191	**I 191** **Medication Nurses #4 and #5 are employees of Comprehensive Care II, Inc. Thus, they do not need liability Insurance.** **Registered Nurse #2 and Pharmacist #9 have been requested to submit their liability insurance.** **The Assistant Administrator will, on a monthly basis check all folders of staff and consultant to ensure that required documents are updated as needed.**	**08/31/10**

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I 191	Continued From page 2 approximately 1:45 p.m.	I 191		
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 observations, staff interview and record verification, the Group Home for Persons with Mental Retardation (GHMRP) failed ensure staff received effective training in the area of nutrition, for one of the three residents included in the sample. (Resident #1) The finding includes: On July 28, 2010, direct care staff was observed preparing Resident #1's snack. The client had a choice of apples (cut into quarters), plums, fresh peaches (whole) and graham crackers (broken in half). The resident choose the peach. At 5:53 p.m., Resident #1 was observed eating dinner. The meal consisted of penne pasta, shredded cabbage, pasta sauce, canned fruit pears and beverage. Interview with the direct care staff, who prepared Resident #1's meal on July 28, 2010, at 6:05 p.m., revealed that the resident was on a low sodium finely chopped meats and vegetable diet. Review of the current physician orders dated July 2010, revealed a diet order of low cholesterol, low sodium, finely chopped meats and vegetables	I 229	**I 229** **All staff will be re-trained on diet type, texture, and portion control.** **The House Manager, and the facility's Licensed Practical Nurse (LPN) will on a daily basis (5 days a week) observe staff in demonstrating competency in adhering to diet type, texture, and portion control. Such observations shall be done for three months. A staff found not to be in compliance with diet orders will be provided with one-on-one in-service and supervision.**	08/31/10

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I 229	Continued From page 3 diet. On July 29, 2010, at 11:30 a.m., interview with the license practical nurse revealed that if a resident is ordered a finely chopped meal, they should not receive shredded vegetables. Review of the facility's in-service training records on July 30, 2010, at 9:50 a.m., revealed that all staff had received nutritional training on May 11, 2010. There was no evidence that training had been effective.	I 229		
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Persons with Mental Retardation (GHMRP) failed to ensure that all incidents that present a risk to resident's health and well-being were reported immediately to the Department of Health, Health Regulation and Licensing Administration (DOH/HRLA), for one of three residents included in the sample. (Resident #3) The finding includes:	I 379		

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I 379	Continued From page 4 Review of Resident #3's nursing note dated April 5, 2010, on July 30, 2010, at approximately 1:00 p.m., revealed that a resident at the day program hit Resident #3 across the left side of his face. Further review revealed that the facility's License Practical Nurse administered Tylenol for pain. Interview with the Qualified Mental Retardation Professional (QMRP) on July 30, 2010, at approximately 2:30 p.m., revealed he was unaware of the incident. Further interview revealed there was no incident report completed. At the time of the survey, there was no evidence that the facility reported the incident of abuse to the administrator or to the Department of Health.	I 379	**I 379** **Direct Care Staff (DCS) and nurses will be re-trained on the facility's incident management policy.** **Such training shall be held quarterly so as to enhance staff's understanding and competency in incident management policy and procedure.**	**08/31/10**
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 record review, the group home for mentally retarded persons (GHMRP) failed to ensure professional services were provided in accordance with the needs, for one of three residents included in the sample. (Resident #3) The finding includes: The facility failed to obtain laboratory studies as ordered by the Primary Care Physician (PCP). Review of Resident #3's physician's order (PO)	I 401		

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I 401	Continued From page 5 from July 1, 2009, to July 1, 2010, on July 30, 2010, at 12:30 p.m., revealed an order for the resident to have laboratory studies for CBC and urinalysis every year. Subsequent review of his medical records revealed the last CBC study was May 27, 2009. There were no laboratory results available in the resident's record for a urinalysis study. Interview with the license practical nurse (LPN) on July 30, 2010, at approximately 1:00 p.m., confirmed that the laboratory studies were not completed as ordered.	I 401	**I 401** **Quarterly Audits will be conducted by the QA person on all habilitation records to ensure that all recommendations and medical appointments are followed up as recommended.**	**08/31/10**
I 405	3520.7 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall be provided by programs operated by the GHMRP or personnel employed by the GHMRP or by arrangements between the GHMRP and other service providers, including both public and private agencies and individual practitioners. This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure professional services had been provided in accordance with each resident's needs, for one of the three residents residing in the facility. (Resident #2) The findings include: The facility failed to ensure that the day program implemented Resident #2's behavior support plan as prescribed. Observation at Resident #2's day program on July 28, 2010, at 11:31 a.m., revealed the	I 405		

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I 405	Continued From page 6 resident leaning over the surveyor. At the same time, the qualified mental retardation professional (QMRP) told the resident he was too close and to give the surveyor her personal space. (Note: the QMRP came to the day program to give him his eye glasses). At 12:30 p.m., Resident #2 stood close to the surveyor and held her hand while she spoke with his day program staff. At no time did the day program staff request the resident to give the surveyor her personal space. Interview with the day program staff at 12:35 p.m., indicated that he is required to ask the Resident #1 to stand within arms length and to give individuals their personal space. Review of the day program behavior support plan (BSP) dated October 20, 2009, at approximately 12:40 p.m., revealed the following procedures for addressing Resident #1's target behavior of inappropriate social behavior: a. Staff should, "ask him to utilize his string as a way to remind him of the appropriate distance." b. Staff should receive praise for initiating conversation in an appropriate manner. c. If he continues his target behavior, staff should disengage, physically and conversationally, from him until he uses the appropriate behavior. At the time of the survey, there was no evidence that the day program staff implemented Resident #1's BSP.	I 405	**I 405** **A case conference will be held with client #2's day program to discuss consistency in implementation of interventions specified in the Behavior Support Plan (BSP).** **Twice monthly, for the next three months, the Qualified Mental Retardation Professional (QMRP) will visit client #2 at his day program to observe implementation of client #2's BSP.**	08/31/10
I 420	3521.1 HABILITATION AND TRAINING Each GHMRP shall provide habilitation and training to its residents to enable them to acquire	I 420		

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I 420	Continued From page 7 and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning. This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to provide habilitation and training to its residents that would enable them to acquire and maintain life skills needed to cope with their environments and achieve optimum levels of physical, mental and social functioning, for one of the three residents included in the sample. (Resident #3) The finding includes: Observations on July 28, 2010, at 6:15 p.m., revealed direct care staff assisting Resident #3 with his shower. Interview with direct care staff, on the same date, at 6:50 p.m., indicated that he has to assist the resident with a shower, to include lathering his wash cloth and rinsing him. Review of the Resident #1's Psychology assessment and Occupational Therapy assessment dated October 20, 2009 and October 1, 2009, respectively on July 30, 2010, at approximately 10:45 a.m., revealed a program recommendation for the resident to participate in a showering routine. The program should provide simple step by step directive for him to soap himself and use the shower head to wash off the soap. Review of the Individual Program Plan (IPP) dated October 23, 2009, on July 30, 2010, revealed no evidence of training programs to address the aforementioned recommendations included in the comprehensive functional assessment.	I 420		

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I 420	Continued From page 8 The QMRP verified on July 30, 2010, at approximately 12:45 p.m., that no training programs had been developed for the resident to participate in a showering program as recommended in the aforementioned assessments.	I 420	**I 420** **An Individual Program Plan (IPP) will be put in place which will be geared towards enhancing client #1's ability in participating in shower routine. Such program shall be monitored quarterly for progress.**	**08/25/10**
I 472	3522.3 MEDICATIONS The physician who identifies the self-administration of medications as a goal for a resident shall develop and monitor the plan for implementation. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the group home for mentally retarded person's (GHMRP) failed to ensure resident's received continuous active treatment, for two of the three residents included in the sample. (Residents #1 and #3) The findings include: 1. During medication administration observation on July 29, 2010, at 7:11 a.m., revealed Licensed Practical Nurse #1 (LPN #1) placed a cup of medications into Resident #1's hands in order for the resident to consume the medication with two (2) physical prompts. Further observation revealed Resident #1 picked up a cup of water and consumed the contents with one (1) verbal prompt. During a face-to-face interview with LPN #1 on July 29, 2010, at approximately 7:45 a.m., revealed Resident #1 had a self-medication program however, the program was implemented in the evening.	I 472		

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I 472	Continued From page 9 Review of Resident #1's self-medication program dated July, 2010, on July 29, 2010, at approximately 9:00 a.m., indicated that given verbal assistance Resident #1's will punch his medications from a bingo card (blister pack/bubble pack to a cup 60% of recorded trials per month. Further review revealed the self-medication program was as follows: a. Wash his hands; b. Identify medications to be punched; b. Put cup under meds to be punched and c. Punch meds There was no evidence that the resident was given the opportunity to fully participate in the self- medication program. 2. During medication administration observation on July 29, 2010, at 7:16 a.m., revealed LPN #1 went into the kitchen and then poured water into a cup on the counter and placed the cup of water into Resident #3's hand. Further observation revealed LPN #1 held the medication and water cups to Resident #3's mouth in order for the resident to consume the medication and water with three (3) physical prompts. During a face-to-face interview with LPN #1 on July 29, 2010, at approximately 7:46 a.m., revealed Resident #3 had a self-medication program however, the program was implemented in the evening. Review of Resident #3's self-medication program dated July, 2010, on July 29, 2010, at approximately 9:10 a.m., indicated that given verbal prompts, Resident #3 will get his cup and fill it with water when it is time for his medications.	I 472		

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I 472	Continued From page 10 Further review revealed the self- medication program was as follows: a. Wash hands; b. Get a cup; b. Fill cup with water and c. Go to medication dispensation area There was no evidence that the resident was given the opportunity to fully participate in the self- medication program.	I 472	**I 472** **All of the clients in the facility have self medication programs. The facility's LPN and Direct Care Staff will be re-trained on implementing the self-medication programs.** **The facility's RN will, on a monthly basis observe the full implementation of the self medication programs.**	
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observations, interviews and record review, the Group Home for the Mentally Retarded Persons (GHMRP) failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and other District and federal laws that govern the care and rights of persons with mental retardation, for two of the three residents included in the sample. (Residents #1 and #3) The findings include: 1. The facility failed to provide evidence that informed consent was obtained from Resident #1's family member for psychotropic medications as evidenced below:	I 500		**08/31/10**

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I 500	Continued From page 11 During the entrance conference on July 28, 2010, beginning at 10:00 a.m., the qualified mental retardation professional (QMRP) indicated that Resident #1 had family members who assisted the resident in making health care decisions. a. Observations during the medication administration, on July 29, 2010, at 7:11 a.m., revealed that Resident #1 received Tegretol 300 mg and Zyprexa 5 mg. Interview with the Licensed Practical Nurse (LPN) after the medication administration indicated that the resident received the aforementioned medication for his maladaptive behaviors. Review of the resident's current physician orders dated July 2010, on July 29, 2010, at approximately 9:30 a.m., confirmed the aforementioned medications. In addition, the resident was ordered Remeron 30 mg, by mouth, at bedtime. According to the POS, the Remeron 15 mg was written on August 20, 2009, and increased to 30 mg on January 26, 2010. Review of Resident #1's Psychological Assessment dated January 15, 2010, on July 29, 2010, at approximately 3:00 p.m., revealed that the resident was not competent to make decisions regarding his health, safety, financial or residential placement. Further review of the resident's record failed to provide evidence that informed consent had been obtained for the use of the Remeron. Further review of the resident's record revealed a signed consent dated June 23, 2010. On the consent form was Tegretol 300 mg, three times a day, Tegretol 600 mg, every evening (weekends), Zyprexa 5 mg, in the morning Zyprexa 20 mg, in the evening and Remeron 30 mg, at bedtime.	I 500	**I 500, 1.** **Consent shall be obtained from a family member and/or guardian in a timely manner before newly prescribed psychotropic medications or sedative hypnotic drugs are administered.** **Client #1 shall be informed of the risks involved in taking his prescribed medications, and his right to refuse treatment. Such rights shall be reviewed with client#1 annually or as needed.**	08/31/10

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I 500	Continued From page 12 Interview with the QMRP on July 20, 2010, at approximately 12:20 p.m., indicated that the consent for the Remeron was not obtained timely. However, once the QMRP realized this, he obtained consent from Resident #1's family member. b. Review of Resident #1's POS dated August 20, 2010, on July 29, 2010, at approximately 9:30 a.m., revealed an order for Zoloft 50 mg, at bedtime. Further review of the medication administration record (MAR) on July 29, 2010, confirmed that the resident received the prescribed Zoloft from July 27, 2009, through August 25, 2009. Review of Resident #1's record on July 29, 2010, at approximately 9:30 a.m., revealed a psychological assessment dated January 15, 2010. According to the assessment, Resident #1 "is not able to make independent decisions concerning his residential or day placements. He lacked the cognitive skills necessary to understand the implications of such decisions and therefore cannot give her informed consent. He lacked the judgment and insight required to make decisions independently." Further review of the record revealed no evidence of a signed consent for the prescribed Zoloft. The facility failed to provide evidence that the potential risks involved in using this medication, or his right to refuse treatment had been explained to the client and/or guardian, prior to the implementation of the psychotropic medication. 2. The facility failed to provide evidence that informed consent was obtained from Resident	I 500		

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I 500	Continued From page 13 #3's family members for sedation given during medical appointments as evidenced below: During the entrance conference on July 28, 2010, beginning at 10:00 a.m., qualified mental retardation professional (QMRP) indicated that Resident #3 had an active family member to assist the resident in making health care decisions. Review of Resident #3's physician orders (POS) on July 30, 2010, beginning at 11:00 a.m., revealed the following orders: - On July 19, 2010, Ativan 4 mg, prior to dental examination; and - On July 23, 2010, Ativan 2 mg, prior to laboratory studies. Review of Resident #3's medication administration record (MAR), confirmed that the client was administered the aforementioned sedations. Further record review revealed signed consents dated May 27, 2010. The signed consents were for Ativan 2 mg, prior to an ophthalmology, and podiatry examinations, and Ativan 4 mg, prior to dental appointment. Laboratory studies consult was not included on the signed consent form. Furthermore, the resident was sedated for Ativan 4 mg and the signed consent was signed for Ativan 2 mg. Interview with the QMRP on July 30, 2010, at approximately 1:30 p.m., revealed that he was not aware of the laboratory studies consult and the use of Ativan 4 mg, for the schedule dental appointment. Review of Resident #3's Psychological Assessment dated October 20, 2009, on July 30,	I 500		

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I 500	Continued From page 14 2010, beginning at 12:30 p.m.,revealed that the resident was not competent to make decisions regarding his health, safety, financial or residential placement. Further review of the resident's record failed to provide evidence that informed consent had been obtained for the use of the sedation. At the time of the survey, the facility failed to provide evidence that the potential risks involved in using this medication, or his right to refuse treatment had been explained to the resident and/or family members.	I 500	**I 500, 2.** **There was a breakdown in communication between the facility's nurse and the QMRP in specifying the use of sedation. And as such, the consent for sedation was not sought. A communication book will be put in place which will foster communication between the nursing department and the QMRP on issues such as sedation, psychotropic medications, and other restrictions.** **Consent for sedation will be tracked and sought timely in the future.**	**08/31/10**