STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G153	A. BUILDING _____ B. WING _____	10/01/2009

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COMP CARE I I	1329 LONGFELLOW STREET NW WASHINGTON, DC 20011

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W 000	INITIAL COMMENTS A recertification survey was conducted from September 28, 2009 through October 1, 2009. This survey was initiated utilizing the fundamental process; however, due to concerns in the areas of active treatment, the process was extended to review the facility's level of compliance in the Conditions of Participation (CoP) for Active Treatment. A random sampling of two clients was selected from a population of four men with various levels of mental retardation and disabilities. The findings of the survey were based on observations at two day programs, interviews one guardian/mother, interviews with staff in the home and at one day program, as well as a review of client and administrative records, including incident/investigation reports.	W 000	Received 10/21/09 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
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, interviews, and record review, the facility failed to ensure that outside services met the needs of each client, for one of two clients in the sample. (Client #1) The finding includes: The facility failed to ensure that the day program implemented Client #1's behavior support plan as prescribed. Observation at Client #1's day program on	W 120		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
DC Redacted Board	Administrator	10/26/09

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 September 29, 2009 at 12:34 p.m., revealed the direct care aid prompting Client #1 to put pieces of a puzzle together. At 12:37 p.m., Client #1 placed his hand in his mouth. At 12:47 p.m., Client #1 began to bite his wrist. The staff stated, "That is one of his behaviors". However, the staff did not intervene. At 12:54 p.m., Client #1 began to bite his wrist again. The staff repeated the client's name until he stopped. At 12:59 p.m., as Client #1 began to bite his wrist again, the direct care aid tapped his elbow several times and asked him to stop. One minute later, Client #1 began to bite his wrist. The staff took his wrist out his mouth and said stop. Interview with the day program staff at 12:58 p.m., indicated that he is required to ask the client to stop or repeat his name when he is biting his wrist. Review of the day program behavior support plan (BSP) dated August 2008 (outdated) at approximately 1:00 p.m., revealed the following procedures for addressing Client #'1 target behavior of hand biting: a. Staff should give him a specific verbal prompt to stop by saying his name and stating "please put you ' re hands down." b. Wait 10 -15 seconds and repeat the verbal prompt if necessary, combining it with a light physical prompt if there is no risk of staff being injured. c. Staff should provide verbal praise and reinforcement when he complies and then immediately direct him to an alternative activity.	W 120	**W 120** **The Qualified Mental Retardation (QMRP) and the House Manager (HM) will meet with the day program's Interdisciplinary Team (IDT) to discuss implementation of interventions specified in client #1's Behavior Support Plan (BSP). The residential facility will request the day program to train staff on implementation of client's Behavior Support Plan (BSP).** **The QMRP and the HM will on a monthly basis visit the day program to monitor counselors implementation of client #1's BSP. During the monitoring, discrepancies in implementing the BSP will be brought to the attention of the day program's Case Manager.**	11/30/09

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W 120	Continued From page 2 At the time of the survey, there was no evidence that the day program counselor implemented Client #1's BSP.	W 120		
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 observation, interview and record review, the facility failed to implement its established policy on abuse, neglect and mistreatment, to ensure the health and safety for one of three clients in the facility. (Client #3) The finding includes: On September 30, 2009, at approximately 2:30 p.m., interview with Staff #3 revealed that Client #1 came home on September 29, 2009, and stated that his class mate pushed and slammed him against the wall at his day program. Further interview revealed that staff informed the license practical nurse (LPN) on the same day. Interview with the LPN at 4:34 p.m., revealed that he assessed Client #3 for head injuries and there were no signs of injury or pain. Additional interview with Staff #3 and the LPN revealed that they did not complete an incident report. Interview with the qualified mental retardation professional (QMRP) and the house manager at approximately 4:50 p.m., revealed that they were not made aware of the allegation. Further interview indicated that the staff is required to	W 149	**W 149** **Administrative action was taken against the two staff who failed to report such allegation of abuse.** **Staff have been trained on the facility's incident management policy and procedure.** **Staff shall be trained quarterly on incident management and reporting.**	11/30/09

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W 149	Continued From page 3 report and write an incident report for all allegations abuse, neglect, and mistreatment. Review of the incident management policy dated September 2000, on September 30, 2009 at approximately 5:30 p.m., revealed "Any alleged, suspected or actual incident of mistreatment, abuse or neglect by a person not employed or otherwise associated with the facility, shall be reported immediately to the QMRP/Director by the facility staff member or other representative witnessing or hearing of the alleged incident". There was no evidence the facility implemented its established policy on mistreatment, neglect and abuse to ensure all clients were safe from harm.	W 149		
W 153	483.420(d)(2) STAFF TREATMENT OF 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 record review the facility failed to ensure that all allegations of mistreatment, neglect or abuse, are reported immediately to the administrator and the Department of Health (DOH), Health Regulation Administration, for one of three clients residing in the facility. (Clients #3) The finding includes:	W 153		

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W 153	Continued From page 4 1. On September 30, 2009, at approximately 2:30 p.m., interview with Staff #3 revealed that Client #1 came home on September 29, 2009, and stated that his class mate pushed and slammed him against the wall at his day program. Further interview revealed that staff informed the license practical nurse (LPN) on the same day. Interview with the LPN at 4:34 p.m., revealed that he assessed Client #3 for head injury and there were no signs of injury or pain. Additional interview with Staff #3 and the LPN revealed that they did not complete an incident report. Interview with the qualified mental retardation professional (QMRP) and the house manager on September 30, 2009 at approximately 4:50 p.m., revealed that they were not made aware of the allegation. Further interview indicated that the staff is required to report and write an incident report for all allegations. On September 30, 2009, at approximately 6:00 p.m., there was no evidence that the administrator had been inform of the alleged allegation.	W 153	W 153 Cross reference W 149.	
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to thoroughly investigate all incidents for one of two clients included in the sample. (Client #2) The finding includes:	W 154		

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W 154	Continued From page 5 On September 29, 2009, at approximately 2:16 p.m., review of an unusual incident report (UIR) revealed that on the evening of July 15, 2009, the licensed practical nurse (LPN) came to administer evening medications. Staff #1 went upstairs to get Client #2 for his evening medications and observed Client #2 attacking the Administrative Staff (AS). Further review of the UIR revealed Client #2 destroyed property by throwing a chair and kicking and breaking the dining table. The client was transported to CPEP via the law enforcement (police) as result of his maladaptive behaviors. On September 30, 2009, at approximately 10:30 a.m., interview with the qualified mental retardation professional (QMRP) revealed AS was upstairs in the administrative office located beside Client #2's bedroom. The QMRP stated that Client #2 left his bedroom, went into the office and started attacking AS. The QMRP further stated Client #2's assigned 1:1 staff was downstairs in the kitchen preparing dinner. On October 1, 2009, at approximately 10:05 a.m., the QMRP provided the surveyor with internal investigation report dated July 15, 2009 (three days later). The report revealed that Client #2 exhibited significant behaviors towards AS by hitting him. Client #2's behavior escalated to property destruction (destroyed the dining table and a chair). Law enforcement (police) was called and transported Client #2 to CPEP. Further review of the investigation failed to evidence an interview with Staff #1 who witnessed AS being attacked by Client #2. The	W 154	**W 154** **The deficient practice of failing to include written interviews and statements from witnesses during an investigation has been corrected through modification of the provider's investigation form to include sections of written interviews and statements.** **Justification of this claim is evident in the provider's investigation report of the incident of September 30, 2009. An investigation report including written interviews and statements was submitted to DOH within five (5) working days from the date of the incident. Please refer to W149 for details of incident.** **The administrative office will review all investigations to ensure that written interviews and statements are included in the reports. The administrator will sign all reviewed investigations.**	11/30/09

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W 154	Continued From page 6 investigation failed to include written interviews and statements from the witnesses including the licensed practical nurse. This was confirmed through interview with the facility's QMRP on October 1, 2009, at approximately 10:35 a.m.	W 154		
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure required investigations were reviewed by the administrator within five working days, for one of two clients included in the sample. (Client #2) The finding includes: Cross refer to W154. Interview with the qualified mental retardation professional (QMRP) and review of the facility's incidents reports and corresponding investigative reports on October 1, 2009, at approximately 10:35 a.m., revealed an incident dated July 15, 2009. The incident revealed that Client #2 was transported to CPEP via law enforcement (police) for attacking staff and severely destroying property. Review of the corresponding investigative report revealed that the QMRP completed the investigation. There was no writtenn evidence that the results of the investigation was reviewed and signed by the administrator.	W 156	W 156 Cross reference W 154.	
W 159	483.430(a) QUALIFIED MENTAL	W 159		

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W 159	Continued From page 7 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, interview and record review, the facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by the qualified mental retardation professional (QMRP), for three of three clients residing in the facility. (Clients #1, #2, and #3) The findings include: 1. Cross refer to W120. The QMRP failed to ensure that the day program implemented Client #1's behavior support plan as prescribed. 2. Cross refer W193. The QMRP failed to ensure staff demonstrated competency in the implementation of the behavior support plans. 3. Cross refer to W247. The facility's QMRP failed to ensure that Client #3 client was provided opportunities to make a choice during snack time. 4. Cross refer to W249. The facility's QMRP failed to ensure continuous active treatment was implemented in accordance with the interdisciplinary team (IDT) recommendations. 5. Cross refer to W252. The QMRP failed to ensure facility documented behaviors on the data collection sheets in accordance with the behavior support plans.	W 159	W 159 1. Cross reference W 120 2. Cross reference W 193 3. Cross reference W 247 4. Cross reference W 249 5. Cross reference W 252 6. Cross reference W 440	

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W 159	Continued From page 8 6. Cross refer to W440. The QMRP failed to ensure that fire evaluation drills were conducted quarterly on all shifts.	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 observations, staff interviews and record review, the facility staff failed to demonstrate competency in the implementation of behavior support plans (BSPs), for two of two clients included in the sample. (Clients #1 and #2) The findings include: 1. Cross-refer W249. On September 28, 2009, Client #1 was observed biting his wrist on several occasions. Record review on September 29, 2009, at 10:40 a.m., confirmed Client #1's BSP, dated June 1, 2009, included hand biting and screaming as a target behavior. Further record review revealed the following procedures for hand biting and screaming: a. Hand Biting - "At any time that Client #1 begins to engage in self-injurious behaviors, verbally prompt him to stop and redirect him to an activity involving manipulation of an object using his hands." "Staff should place the object in his hands and initiate the manipulating action for a while, till he begins to do it himself." b. Screaming - If Client #1 begins to scream,	W 193		

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W 193	Continued From page 9 "attempt first to determine what may be causing him to do so. Ask him to show you what he wants. Address these needs first." There was no evidence that staff implemented these intervention strategies as recommended by the psychologist. 2. Cross-refer to W249.2. The facility failed to ensure that Client #2's 1:1 staff demonstrated competency in implementing Client #2's BSP by remaining in physical arms length as evidence below: Upon entering the facility on September 28, 2009, at 4:35 p.m., to start the annual recertification process, Client #2 was observed to immediately walked over from the dining area to the front door to greet the surveyors by saying "get out, I don't want you her. You need to leave now." Further observations at approximately 4:36 p.m., Staff #1 who was not indentified as Client #2's 1:1 staff at that time, immediately intervened by redirecting Client #2 to another area of the home. Client #2's identified 1:1 staff remained in the dining area during this time. Interview with the QMRP on September 29, 2009, at approximately 3:00 p.m., revealed Client #2's received 1:1 staffing from 8:00 a.m. to 12:00 a.m., to address his maladaptive behaviors of physical aggression (mainly toward women), absconding, self-injurious behaviors, and making false allegations. Review of Client #2's behavior support plan (BSP) dated June 2, 2009, on September 29, 2009 approximately 3:40 p.m., confirmed the QMRP's	W 193	**W 193, 1a, b & 2** **Staff will be in-serviced on implementation of interventions specified in client #1's and client #2's BSPs. During the in-service, emphasis will be placed on staff being at physical arms length of client #2 at all times during waking hours.** **The House Manager (HM) and QMRP will on a weekly basis monitor staff implementation of interventions specified in client #1's and client #2's BSP.**	11/30/09

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W 193	Continued From page 10 interview of the aforementioned maladaptive behaviors. Further review of Client #2's BSP revealed that one of the 1:1 staff duties and responsibilities was "being physically present arm's length" from Client #2 during waking hours (from time he is awake till he goes to sleep), while at the day program, while on community outings and while in the community to ensure prevention of physical aggression against others, injury against himself and absconding. At the time of the survey, there was no evidence that on September 28, 2009, the facility staff demonstrated competency in the implementation of the client's BSP.	W 193		
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that each client was provided opportunities for choice, encouraged and taught to make choices for one of three clients residing in the facility. (Client #3) The finding includes: On September 29, 2009, at 3:13 p.m., Staff #3 was observed to retrieve a bag of white cheddar popcorn from the kitchen to bring to Client #3 who was sitting at the dining table talking with the surveyors. Staff opened the bag of popcorn and gave it to Client #3. Interview with Staff #3 on September 30, 2009, at approximately 2:30 p.m., confirmed that she did not provide and/or offer	W 247		

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W 247	Continued From page 11 Client #3 a choice of snack during snack time. Staff #3 stated that Client #3 was not in a talkative mood; therefore, she gave him popcorn because she knew he like it. Review of Client #3's Individual Support Plan on September 30, 2009, at approximately 4:30 p.m., stated "provide me [Client #3] with freedom of choice and participation in all activities pertaining to me" At the time of the survey, the facility failed to ensure Client #3 was afforded opportunities for choice and/or self-management during snack time.	W 247	**W 247** **Staff will be trained on provision of choices, promotion of self-management, and rights.** **The House Manager will on a weekly basis observe staff to ensure compliance with provision of choices, promotion of self-management, and implementation of clients' rights.**	
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, interviews and record review, facility staff failed to ensure continuous implementation of clients' behavior support plans, for two of two clients included in the sample. (Clients #1 and #2) The findings include: 1. On September 28, 2009, at 6:37 p.m., Client #1 was observed sitting in the living room on the	W 249		11/30/09

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W 249	Continued From page 12 floor. Further observation revealed Client #1 making a loud noise and biting his hands. At 6:43 p.m., Staff #1 assisted Client #1 into the dining room to eat. After Client #1 sat down, he began to yell then proceeded to walk back into the living room. Staff #1 took Client #1's ice tea into the living room and offered it to him. At 6:49 p.m., Staff #1 assisted the client into the dining room. Once Staff #1 placed Client#1's bib around his neck, he began to yell and bite his wrist. At 6:54 p.m., Staff #1 took Client #1 for a walk outside. At 6:58 p.m., Client #1 returned from his walk and began to yell and bite his hand. At 7:02 p.m., Client #1 was observed biting his wrist and Staff #1 asked him to stop. Interview with the Qualified Mental Retardation Professional (QMRP) on September 28, 2009, at approximately 4:50 p.m., revealed that Client #1 had a Behavior Support Plan (BSP) to address his maladaptive behaviors. Record verification of Client #1's BSP dated June 1, 2009, on September 29, 2009 at 10:40 a.m., revealed the client had maladaptive behaviors of hand biting, screaming and pica. Further review of the BSP revealed staff were to record Antecedent Behavior Consequence (ABC) on the data collection sheets daily. Review of the data collection sheets on September 29, 2009, at approximately 3:00 PM, revealed that Client #1 bit his hand from 4:00 p.m. to 4:07 p.m. and from 7:30 p.m. to 7:30 p.m. Further review of the data collections sheets revealed that the Client #1 screamed from 4:00 p.m. to 4:01 p.m. and from 8 p.m. to 8:10 p.m. There was no evidence that staff implemented	W 249	**W 249.1** **Staff will be trained on implementation of intervention strategies in client#1's BSP and accurate data collection.** **The House Manager and QMRP will once monthly per shift conduct monitoring of staff implementation of client#1's BSP and behavior data collection to ensure compliance.**	11/30/09

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W 249	Continued From page 13 these intervention strategies as recommended by the psychologist. 2. Observations On September 28, 2009, beginning at 4:35 p.m. to 6:48 p.m., revealed staff failed to implement Client #1's BSP as follows: - At 4:35 p.m., Upon entering the facility to start the annual recertification process, Client #2 was observed to immediately walked over from the dining area to the front door to greet the surveyors by saying "get out, I don't want you here. You need to leave now." - At approximately 4:36 p.m., Staff #1 who was not indentified as Client #2's 1:1 staff at that time, immediately intervened by redirecting Client #2 to another area of the home. Client #2's identified 1:1 staff remained in the dining area during this time. - At 5:07 p.m., the qualified mental retardation professional (QMRP) was observed to transport Client #2 on a community walk. Staff #2 (assigned to Client #2) was observed to transport Client #1 on a community walk during this time. - At 5:52 p.m., Client #2 returned back from his community walk. He was observed to go upstairs to wash his hands without a 1:1 staff accompanying him. - At 5:56 p.m., Client #2 was observed upstairs in his bedroom while an assigned different 1:1 staff (Staff #1) was observed in the kitchen preparing dinner. - At 6:04 p.m., Client #2 was upstairs in his bedroom while his Staff #1 was observed in the	W 249		

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W 249	Continued From page 14 living room looking out the window. - At 6:06 p.m., Staff #1 was observed to go upstairs to Client #2's bedroom to ask him if he wanted to assist with dinner preparation. The client stated, maybe next time. Staff #1 returned back to the kitchen/dining area. - At 6:08 p.m., the QMRP was observed in Client #2's bedroom encouraging him to come down to the dining area to eat dinner. Client #2 stated that he would eat after the surveyors leave. Shortly afterwards, Client #2 was observed to come to the dining to eat his dinner. - At 6:20 p.m., Client #2 finished his dinner and placed his dishes in the dishwasher after rinsing them off. - At 6:21 p.m., Client #2 returned back to his bedroom alone. - At 6:23 p.m., the QMRP stated to Staff #1 to go upstairs to sit with Client #2. Staff #1 was observed to place a seat outside of Client #2's bedroom door. Interview with Staff #1 on September 28, 2009, at 5:16 p.m., revealed Client #2's second shift 1:1 called off and that Staff #2 was his assigned 1:1 staff for today. Further interview with Staff #1 revealed that Staff #2 had worked with Client #2 several times, but was not an assigned staff for this facility. Interview with the QMRP on the same day at approximately 5:53 p.m., revealed Staff #1 was the assigned 1:1 staff for Client #2 for the evening of September 28, 2009. The QMRP further	W 249		

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W 249	Continued From page 15 stated that Staff #1 was identified as the assigned 1:1 staff when Client #2's original 1:1 staff was absent. Additional interview with the QMRP on September 29, 2009, at approximately 3:00 p.m., revealed Client #2's received 1:1 staffing from 8:00 a.m. to 12:00 a.m., to address his maladaptive behaviors of physical aggression (mainly toward women), absconding, self-injurious behaviors, and making false allegations. Review of Client #2's behavior support plan (BSP) dated June 2, 2009, on September 29 approximately 3:40 p.m., confirmed the QMRP's interview of the aforementioned maladaptive behaviors. Further review of Client #2's BSP revealed the 1:1 staff duties and responsibilities were as follows: a. Being "physically present arm's length" from Client #2 during waking hours (from time he is awake till he goes to sleep), while at the day program, while on community outings and while in the community to ensure prevention of physical aggression against others, injury against himself and absconding. b. Always ensuring that Client #2 remains at least three arms lengths of distance from visitors. c. Providing timely and discreet cues to the visitor/s not to stand with back turn to Client #2. At the time of the survey, there was no evidence that Client #2's 1:1 staff implemented his BSP as recommended. Note: It should be noted that the BSP also	W 249	**W 249.2** **The residential provider will make provisions to ensure that client #2 is assigned a male staff at all times as specified in client #2's BSP.** **The facility will train staff on implementation of intervention strategies specified in client #2's BSP. The training will emphasize the significance of 1:1 staff to be at arms length of client #2 at all times. Also, staff will be advised to ensure that client #2 is three arms distance away from visitors.** **The QMRP and the HM will on a monthly basis monitor staff implementation of client#2's BSP.**	11/30/09

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W 249	Continued From page 16 recommended that Client #2 be assigned a male 1:1 staff person who is of equal (or greater) physical stature as Client #2 (i.e. at least matching his height and weight). During an interview on September 29, 2009, at approximately 3:30 p.m., interview with Staff #3 (female) revealed that she sometimes serves as Client #2's 1:1 staff during the second shift weekly. It should be further noted that one of the surveyors was a female in which Client #2 showed verbal aggression toward while entering the facility.	W 249		
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, interview, and record review, the facility failed to ensure that data was collected in the form and frequency required for one of the two clients in the sample. (Client #1) The finding includes: On September 28, 2009, at 6:37 p.m., Client #1 was observed sitting in the living room on the floor. Further observation revealed Client #1 making a loud noise and biting his hands. At 6:43 p.m., Staff #1 assisted Client #1 into the dining room to eat. After Client #1 sat down, he began to yell then proceeded to walk back into the living room. Staff #1 took Client #1's ice tea into the living room and offered it to him. At 6:49 p.m., Staff #1 assisted the client into the dining room.	W 252		

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W 252	Continued From page 17 Once Staff #1 placed Client#1's bib around his neck, he began to yell and bite his wrist. At 6:54 p.m., Staff #1 took Client #1 for a walk outside. At 6:58 p.m., Client #1 returned from his walk and began to yell and bite his hand. At 7:02 p.m., Client #1 was observed biting his wrist and Staff #1 asked him to stop. Interview with the Qualified Mental Retardation Professional (QMRP) on September 28, 2009, at approximately 4:50 p.m., revealed that Client #1 had a Behavior Support Plan (BSP) to address his maladaptive behaviors. Record verification of Client #1's BSP dated June 1, 2009, on September 29, 2009 at 10:40 a.m., revealed the client had maladaptive behaviors of hand biting, screaming and pica. Further review of the BSP revealed staff were to record Antecedent Behavior Consequence (ABC) on the data collection sheets daily. Review of the data collection sheets on September 29, 2009, at approximately 3:00 PM, revealed that Client #1 bit his hand from 4:00 p.m. to 4:07 p.m. and from 7:30 p.m. to 7:30 p.m. Further review of the data collections sheets revealed that the Client #1 screamed from 4:00 p.m. to 4:01 p.m. and from 8 p.m. to 8:10 p.m. Interview with Staff #1 on September 30, 2009, at approximately 3:30 p.m., confirmed that all the behaviors were not document. There was no evidence that data had been collected in accordance with the Client #1's BSP.	W 252	**W 252** **Staff will be trained on accurate collection of behavior data.** **The HM will on a weekly basis review behavior data sheets to ensure consistent documentation of behavior episodes.**	**11/30/09**
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	W 325		

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W 325	Continued From page 18 includes routine screening laboratory examinations as determined necessary by the physician. This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility's nursing staff failed to provide routine laboratory testing as determined necessary by the primary care physician (PCP), for two of two clients included in the sample. (Clients #1 and #2) The findings include: 1. Observation of the medication administration pass on September 30, 2009, at 7:42 a.m., revealed Client #1 was administered Phenobarbital 15mg, Alprazolam XR 2mg, Dilantin 50mg, and Clonopin 1 mg by mouth. Review of the physician orders dated February 2009, revealed an order to obtain quarterly phenobarbital levels. Further review of the client's medical record revealed that the last laboratory study for the aforementioned medication was conducted on January 10, 2009. Interview with the license practical nurse (LPN) on September 30, 2009 at 1:00 p.m., confirmed that Client #1 did not receive his quarterly laboratory study for phenobarbital as recommended. 2. On September 30, 2009, at 7:06 a.m., observations of the medication administration pass revealed Client #2 was administered Haldol	W 325	**W 325.1 & 2** **The facility's Registered Nurse (RN) and the QMRP will on a quarterly basis conduct internal audits of medical records to ensure compliance with physician's orders, and other recommendations.**	11/30/09

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W 325	Continued From page 19 2 mg, Cogentin 1 mg, Risperdal 2 mg, and Depakote 500 mg by mouth. Review of Client #2's medical record on September 30, 2009, at 3:06 p.m., revealed Physician's Orders (POs) dated October 2009. The POs revealed Client #2 had diagnoses of seizure disorder, intermittent explosive disorder, and schizophrenia paranoid and was prescribed the aforementioned medications. Further review of the POs revealed an order for folic acid serum labs to be tested monthly. Review of the labs on the same day at approximately 3:30 p.m., revealed the most current folic acid serum laboratory study was conducted on September 2009. The next laboratory study conducted prior to September 2009 was in March 2009 (six months earlier) in which the labs were within normal limits. Interview with the facility's licensed practical nurse (LPN) on September 30, 2009, at approximately 3:50 p.m., acknowledged that Client #2's folic acid serum labs were not tested monthly as prescribed by the primary care physician.	W 325	**W 331.1** **The RN will in-service the Licensed Practical Nurse (LPN) on adherence to Physician's Orders (PO).** **Quarterly audits will be conducted by the RN to ensure that the LPN is complying with orders.**	11/30/09
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: Based on observation, interview and record verification, the facility's nursing services failed to establish systems to provide health care monitoring and identify services in accordance with clients' needs, for two of two clients included	W 331		

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W 331	Continued From page 20 in the sample. (Clients # 1 and #2) The findings include: 1. Observation on September 30, 2009, at 4:55 p.m., revealed dark blotches on Client #2's wrist and arms. Interview with Staff #1 indicated that the blotches were a result of client biting his arms. Review of the dermatologist recommendation dated June 26, 2009, on September 29, 2009, at 4:25 p.m., revealed that staff is required to "apply Lidex ointment to thick plaques on arms twice daily and cover area with ace bandage to prevent biting." There was no evidence that Client #1 wore an ace bandage to prevent biting as recommended. Interview with the qualified mental retardation professional (QMRP)on October 1, 2009, at approximately 11:00 a.m., confirmed that Client #1 was not wearing an ace bandage. Further interview revealed that the license practical nurse (LPN) was required to put the ace bandage on during the morning medication administration. 2. Cross Refer to W325. The facility's nursing staff failed to provide routine laboratory testing as determined necessary by the primary care physician (PCP), for Client #2.	W 331	W 331.2 Cross reference W 325.	
W 393	483.460(n)(1) LABORATORY SERVICES If a facility chooses to provide laboratory services, the laboratory must meet the requirements specified in part 493 of this chapter. This STANDARD is not met as evidenced by: Based on observation, and interview, the facility	W 393		

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W 393	Continued From page 21 failed to ensure it met the requirements for performing glucose monitoring testing, for one of the two clients (Client #4) residing in the facility. The finding includes: Observation of the morning medication administration on September 30, 2009, at 7:42 a.m., revealed Client #4 had a blood glucose level checked (via fingerstick). Interview with the Licensed Practical Nurse (LPN) on the aforementioned date was conducted to ascertain if the facility had been certified to conduct the blood glucose testing as required by part 493 of the Clinical Laboratory Improvement Act (CLIA). According to the LPN, he had no knowledge if the facility had a CLIA certification. Interview with the facility's Registered Nurse, (RN) revealed they had not obtained the CLIA certification. The surveyor provided the necessary contact information to the provider to obtain the certification. At the time of the medication administration, there was no evidence that the CLIA certification had been obtained.	W 393	**W 393** **The facility has contacted the source provided by the surveyor in obtaining the certification.** **The facility has started the process of obtaining certification for performing laboratory procedure.**	11/30/09
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on interview and the review of fire drill reports, the facility failed to hold evacuation drills at least quarterly for each shift of personnel, on one of five shifts of drills reviewed. The finding includes:	W 440		

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W 440	Continued From page 22 Interview with the house manager (HM) on September 29, 2009, at 2:30 p.m., revealed the facility had five shifts of direct care personnel. The shifts were identified as weekdays 8 AM - 4 PM, 3 PM - 10 PM, 10 PM - 8 AM and 10 AM - 10 PM on the weekend. Review of the fire drill reports from November 2008 to October 2009 was conducted on September 29, 2009, at 2:32 p.m. Further review of the fire drill reports from February 2009 to September 2009 revealed that no fire drills were conducted during the 8 AM to 4 PM shifts during the week. Interview with the HM on September 30, 2009, at 10:05 p.m. acknowledged that fire drills were not in the fire drill log book for this period. At the time of the survey, the facility failed to provide evidence of fire drills conducted quarterly as required.	W 440	**W 440** **The QMRP will restructure the fire drill book into five partitions in accordance with the five shifts.** **Monthly reviews of the fire drill book will be conducted by the QMRP and HM to ensure that all shifts conduct a fire drill at least once quarterly.** **Staff will be in-serviced on conducting and recording of fire drills.**	11/30/09

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I 000	INITIAL COMMENTS A licensure survey was conducted from September 28, 2009 through October 1, 2009. This survey was initiated utilizing the fundamental process; however, due to concerns in the areas of active treatment, the process was extended to review the facility's level of compliance in the Conditions of Participation (CoP) for Active Treatment. A random sampling of two residents was selected from a population of four men with various levels of mental retardation and disabilities. The findings of the survey were based on observations at two day programs, interview with one guardian/mother, interviews with staff in the home and at one day program, as well as a review of client and administrative records, including incident/investigation reports.	I 000		
I 091	3504.2 HOUSEKEEPING Housekeeping and maintenance equipment shall be well constructed, properly maintained and appropriate to the function for which it is to be used. This Statute is not met as evidenced by: Based on observations and interview, the GHMRP failed to maintain the interior and exterior of the GHMRP in a safe, clean, orderly, attractive, and sanitary manner for four of four residents residing in the facility. (Residents #1, #2, #3, and #4) The findings include: Observation and interview with the house	I 091		

Dr Barbara Bazron — Administrator — 10/26/09

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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I 091	Continued From page 1 manager (HM) during the environmental walk through on October 1, 2009, beginning at 10:44 a.m., revealed the following: 1. The window in the kitchen where the air condition sat in, was observed to be detached from its foundation. 2. There was severe paint chipping observed around the window frame located on the outside where the air condition sat.	I 091	**I 091. 1** **The window has been repaired.** **I 091. 2** **The air condition area has been painted.** **The facility will on a quarterly basis conduct internal environmental audits to ensure that all maintenance issues are resolved.**	10/15/09
I 135	3505.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift. This Statute is not met as evidenced by: Based on interview and the review of fire drill reports, the GHMRP failed to hold evacuation drills at least quarterly for each shift of personnel, on one of five shifts of drills reviewed. The finding includes: Interview with the house manager (HM) on September 29, 2009, at 2:30 p.m., revealed the GHMRP had five shifts of direct care personnel. The shifts were identified as weekdays 8 AM - 4 PM, 3 PM - 10 PM, 10 PM - 8 AM and 10 AM - 10 PM on the weekend. Review of the fire drill reports from November 2008 to October 2009 was conducted on September 29, 2009, at 2:32 p.m. Further review of the fire drill reports from February 2009 to September 2009 revealed that no fire drills were conducted during the 8 AM to 4 PM shifts during	I 135	**I 135** **Cross reference W 440.**	

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I 135	Continued From page 2 the week. Interview with the HM on September 30, 2009, at 10:05 p.m. acknowledged that fire drills were not in the fire drill log book for this period. At the time of the survey, the GHMRP failed to provide evidence of fire drills conducted quarterly as required.	I 135		
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that each employee, prior to employment and annually thereafter, provided evidence of a physician's certification that documented a health inventory had been performed and that the employee's health status would allow him or her to perform the required duties, for one of three nurses. The finding includes: Interview with the qualified mental retardation professional (QMRP) and review of the personnel records on October 1, 2009, revealed the GHMRP failed to provide evidence that current health certificates were on file for one of the three nurses. (Nurse #1)	I 206	**I 206** **Nurse #1 has completed an annual physical.** **The administrator will on a monthly basis review personnel records to ensure that required documents are current.** **A thirty-day notice will be provided to employees prior to the expiration of a document or documents.**	11/30/09

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	HFD03-0127	A. BUILDING _____ B. WING _____	10/01/2009

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I 379	Continued From page 3	I 379		
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 review of the incident reports, the GHMRP failed to ensure that all incidents that presented a risk to residents' health or safety were reported to the Department of Health (DOH), Health Regulation Administration timely, for one of two residents included in the sample. (Resident #2) The finding includes: Interview with the facility's qualified mental retardation professional (QMRP) and review of the facility's incidents reports, including available corresponding investigative reports, on September 30, 2008 at 10:50 a.m. revealed the following: On July 15, 2009, at approximately 5:00 p.m., 911 personnel (police) was called to transport Resident #2 to CPEP who at the time was, observed attacking staff and severely destroying property (i.e. throwing a chair, kicking and breaking the dining table). Continued review of the facility's incidents failed to provide evidence	I 379	**I 379** **The incident of July 15, 2009 was reported to the Department of Health (DOH) in a timely manner. This was specified on the incident report. The QMRP followed-up with verbal notification the day after the incident.** **This issue was abated during the exit meeting on October 1, 2009.** October 1, 2009.	10/01/09

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I 379	Continued From page 4 that the incident was reported to the Department of Health timely as required.	I 379		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, staff interview and record verification, the Group Home for the Mentally Retarded (GHMRP) failed to provide professional services that included 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, for two of two residents included in the sample. (Residents #1 and #2) The findings include: 1. Observation of the medication administration pass on September 30, 2009, at 7:42 a.m., revealed Resident #1 was administered Phenobarbital 15mg, Alprazolam XR 2mg, Dilantin 50mg, and Clonopin 1 mg by mouth. Review of the physician orders dated February 2009, revealed an order to obtain quarterly phenobarbital levels. Further review of the client's medical record revealed that the last laboratory study for the aforementioned medication was conducted on January 10, 2009.	I 401		

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I 401	Continued From page 5 Interview with the license practical nurse (LPN) on September 30, 2009 at 1:00 p.m., confirmed that Resident #1 did not receive his quarterly laboratory study for phenobarbital as recommended. 2. On September 30, 2009, at 7:06 a.m., observations of the medication administration pass revealed Resident #2 was administered Haldol 2 mg, Cogentin 1 mg, Risperdal 2 mg, and Depakote 500 mg by mouth. Review of Resident #2's medical record on September 30, 2009, at 3:06 p.m., revealed Physician's Orders (POs) dated October 2009. The POs revealed Resident #2 had diagnoses of seizure disorder, intermittent explosive disorder, and schizophrenia paranoid and was prescribed the aforementioned medications. Further review of the POs revealed an order for folic acid serum labs to be tested monthly. Review of the labs on the same day at approximately 3:30 p.m., revealed the most current folic acid serum laboratory study was conducted on September 2009 which was slightly high. The next laboratory study conducted prior to September 2009 wa in March 2009 in which the labs were within normal limits. Interview with the facility's licensed practical nurse (LPN) on September 30, 2009, approximately 3:40 p.m., revealed acknowledged that Resident #2's folic acid serum labs were not tested monthly as prescribed by the primary care physician.	I 401	I 401. 1 & 2 Cross reference W 325	
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training	I 422		

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I 422	Continued From page 6 and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interviews and record review, facility staff failed to ensure continuous implementation of clients' behavior support plans, for two of two clients included in the sample. (Resident's #1 and #2) The findings include: 1. On September 28, 2009, at 6:37 p.m., Resident #1 was observed sitting in the living room on the floor. Further observation revealed Resident #1 making a loud noise and biting his hands. At 6:43 p.m., Staff #1 assisted Client #1 into the dining room to eat. After Resident#1 sat down, he began to yell then proceeded to walk back into the living room. Staff #1 took Resident #1's ice tea into the living room and offered it to him. At 6:49 p.m., Staff #1 assisted the client into the dining room. Once Staff #1 placed Resident #1's bib around his neck, he began to yell and bite his wrist. At 6:54 p.m., Staff #1 took Client #1 for a walk outside. At 6:58 p.m., Resident#1 returned from his walk and began to yell and bite his hand. At 7:02 p.m., Resident#1 was observed biting his wrist and Staff #1 asked him to stop. Interview with the Qualified Mental Retardation Professional (QMRP) on September 28, 2009, at approximately 4:50 p.m., revealed that Resident #1 had a Behavior Support Plan (BSP) to address his maladaptive behaviors. Record verification of Resident #1's BSP dated June 1, 2009, on September 29, 2009 at 10:40 a.m., revealed the client had maladaptive	I 422	I 422.1 Cross reference W249.1	

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I 422	Continued From page 7 behaviors of hand biting, screaming and pica. Further review of the BSP revealed staff were to record Antecedent Behavior Consequence (ABC) on the data collection sheets daily. Review of the data collection sheets on September 29, 2009, at approximately 3:00 PM, revealed that Client #1 bit his hand from 4:00 p.m. to 4:07 p.m. and from 7:30 p.m. to 7:30 p.m. Further review of the data collections sheets revealed that the Resident #1 screamed from 4:00 p.m. to 4:01 p.m. and from 8 p.m. to 8:10 p.m. There was no evidence that staff implemented these intervention strategies as recommended by the psychologist. 2. Observations On September 28, 2009, beginning at 4:35 p.m. to 6:48 p.m., revealed staff failed to implement Resident #1's BSP as follows: - At 4:35 p.m., Upon entering the facility to start the annual recertification process, Resident #2 was observed to immediately walked over from the dining area to the front door to greet the surveyors by saying "get out, I don't want you her. You need to leave now." - At approximately 4:36 p.m., Staff #1 who was not indentified as Resident #2's 1:1 staff at that time, immediately intervened by redirecting Client #2 to another area of the home. Client #2's identified 1:1 staff remained in the dining area during this time. - At 5:07 p.m., the qualified mental retardation professional (QMRP) was observed to transport Resident #2 on a community walk. Staff #2 (assigned to Resident #2) was observed to	I 422	I 422.2 Cross reference W249.2	

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I 422	Continued From page 8 transport Resident #1 on a community walk during this time. - At 5:52 p.m., Resident #2 returned back from his community walk. He was observed to go upstairs to wash his hands without a 1:1 staff accompanying him. - At 5:56 p.m., Resident #2 was observed upstairs in his bedroom while an assigned different 1:1 staff (Staff #1) was observed in the kitchen preparing dinner. - At 6:04 p.m., Resident #2 was upstairs in his bedroom while his Staff #1 was observed in the living room looking out the window. - At 6:06 p.m., Staff #1 was observed to go upstairs to Resident #2's bedroom to ask him if he wanted to assist with dinner preparation. The client stated, maybe next time. Staff #1 returned back to the kitchen/dining area. - At 6:08 p.m., the QMRP was observed in Resident#2's bedroom encouraging him to come down to the dining area to eat dinner. Resident #2 stated that he would eat after the surveyors leave. Shortly afterwards, Resident #2 was observed to come to the dining to eat his dinner. - At 6:20 p.m., Resident #2 finished his dinner and placed his dishes in the dishwasher after rinsing them off. - At 6:21 p.m., Resident #2 returned back to his bedroom alone. - At 6:23 p.m., the QMRP stated to Staff #1 to go upstairs to sit with Resident #2. Staff #1 was observed to place a seat outside of Resident #2's	I 422		

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I 422	Continued From page 9 bedroom door. Interview with Staff #1 on September 28, 2009, at 5:16 p.m., revealed Resident #2's second shift 1:1 called off and that Staff #2 was his assigned 1:1 staff for today. Further interview with Staff #1 revealed that Staff #2 had worked with Resident #2 several times, but was not an assigned staff for this facility. Interview with the QMRP on the same day at approximately 5:53 p.m., revealed Staff #1 was the assigned 1:1 staff for Resident#2 for the evening of September 28, 2009. The QMRP further stated that Staff #1 was identified as the assigned 1:1 staff when Resident#2's original 1:1 staff was absent. Additional interview with the QMRP on September 29, 2009, at approximately 3:00 p.m., revealed Resident #2's received 1:1 staffing from 8:00 a.m. to 12:00 a.m., to address his maladaptive behaviors of physical aggression (mainly toward women), absconding, self-injurious behaviors, and making false allegations. Review of Resident #2's behavior support plan (BSP) dated June 2, 2009, on September 29 approximately 3:40 p.m., confirmed the QMRP's interview of the aforementioned maladaptive behaviors. Further review of Resident #2's BSP revealed the 1:1 staff duties and responsibilities were as follows: a. Being "physically present arm's length" from Resident #2 during waking hours (from time he is awake till he goes to sleep), while at the day program, while on community outings and while in the community to ensure prevention of physical	I 422		

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I 422	Continued From page 10 aggression against others, injury against himself and absconding. b. Always ensuring that Resident #2 remains at least three arms lengths of distance from visitors. c. Providing timely and discreet cues to the visitor/s not to stand with back turn to Resident #2. At the time of the survey, there was no evidence that Resident #2's 1:1 staff implemented his BSP as recommended. Note: It should be noted that the BSP also recommended that Resident#2 be assigned a male 1:1 staff person who is of equal (or greater) physical stature as Resident#2 (i.e. at least matching his height and weight). During an interview on September 29, 2009, at approximately 3:30 p.m., interview with Staff #3 (female) revealed that she sometimes serves as Resident #2's 1:1 staff during the second shift weekly. It should be further noted that one of the surveyors was a female in which Resident#2 showed aggression toward while entering the facility.	I 422		