STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G056	A. BUILDING _____ B. WING _____	07/01/2009

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COMP CARE I I	1321 EMERSON STREET NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A re-certification survey was conducted from June 30, 2009, through July 1, 2009. The survey was initiated using the fundamental survey process. A random sample of three clients was selected from a client population of five males with various disabilities. The findings of the survey were based on observations at the group home and three day programs, interviews with management and staff, and the review of administrative records, including the facility's incident management system.	W 000	Received 7/28/09 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 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the governing body failed to exercise general policy and operating direction over the facility for five of the five clients residing in the facility. (Client's #1 - #5) The findings include: 1. Cross refer to W331. The facility's governing body failed to an effective monitoring system to ensure that outside services administered Client #3's prescribed medications. 2. Cross refer to W262. The facility's governing body failed to ensure that restrictive measures were reviewed and approved by the HRC committee prior to the implementation of such	W 104	**W 104.1** **Cross Reference W 331** **W 104.2** **Cross Reference W 262**	

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

Dr. Rodwell Brock | Administrator | 7/27/09

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 104	Continued From page 1 measures for all five residents residing in the facility. (Clients #1, #2, #3, #4, and #5)	W 104		
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to maintain client's rights and/or ensure each client was encouraged to exercise their rights, for one of five clients residing in the facility. (Clients #4) The finding includes: [Cross Refer W262] Interview with the Residential Director (RD) on the June 30, 2009 at approximately 11:00 AM, revealed that the facility had door alarms on the second and third level rear exit doors. According to the RD the alarms were on the doors because Client #4 was known to walk away from the facility. Review of the Human Rights Committee (HRC) minutes on the same day at 1:55 PM did not evidence that the door alarms had been presented to the committee for review and approval prior to being used as a restrictive measure. Furthermore, there was no evidence that the legally sanctioned representatives for any of the	W 125	**W 125** **The use of the door alarm will be presented to the Human Rights Committee (HRC) for review.** **The families and/or guardians of the five clients shall be informed of the use of the door alarms on the second and third level exit rear doors. Consent for the use of the alarms shall be sought.** **08/30/09**	

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W 125	Continued From page 2 clients had been notified of the facility's intent and use of the door alarm.	W 125		
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 establish and/or implement policies that ensured the client's health and safety, for one of the five clients that resided in the facility. (Client #2) The finding includes: The facility failed to ensure the implementation of its "Incident Management" policy as outlined below: On July 1, 2009 at approximately 12:40 PM, interview with the Registered Nurse (RN) and record review at Client #2's day program revealed a "Health Concern Communique" (HCC) was issued to the residential facility on June 4, 2009. The HCC provided the following details: "O/E today we noticed his right foot lateral area had an open wound draining serosanguineous percolate - area was cleaned with normal saline & non-adhesive dry [guaze] applied/taped securely. He [Client #2] stated he fell the other day at home." Interview with the facility's Qualified Mental Retardation Professional (QMRP) on July 1, 2009	W 149		

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W 149	Continued From page 3 at 4:00 PM, revealed he did not know how Client #2 sustained the injury. Further interview revealed that an incident report was not written after he received notification from the day program of the client's injury. Record review at the residential facility on the same day at approximately 4:10 PM, revealed a document entitled "Incident Handling and Reporting Procedures for Persons Served by DDS" that provided guidance on how to manage unusual incidents. According to the QMRP, the agency policy was to use these procedures. Additionally, the information outlined in "Section A - Life threatening Situation" provides for the following intervention: " If an injury is NOT life threatening, apply first aid, as necessary, then proceed to section C." Section C describes that the agency must then complete an incident report. At the time of the survey, the facility failed to ensure an incident report was generated to notify the agency administrator and other officials of Client #2's injury which was discovered by the day program in accordance with the agency's incident management policy.	W 149	**W 149** **The Qualified Mental Retardation Professional (QMRP) will on a weekly basis review "Health Concern Communique (HCC)" from day programs to ensure that incident reports are written for injuries of unknown origin and an investigation completed.** **The Facility's LPN will be trained on incident management policies and procedures.**	
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.	W 153		

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W 153	Continued From page 4 This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure the timely notification of an injury of unknown origin in accordance with District policies for one of three sampled clients. (Client #2) The finding includes: The facility failed to ensure that all injuries of unknown origin were reported to the department of health as required by the District of Columbia Municipal Regulations (Title 22 Chapter 35; 3519.10) as identified below: On July 1, 2009 at approximately 12:40 PM, interview and record review with the Registered Nurse (RN) at Client #2's day program revealed a "Health Concern Communique" (HCC) was issued to the residential facility on June 4, 2009. The HCC provided the following details: "O/E today we noticed his right foot lateral area had an open wound draining serosanguineous percolate - area was cleaned with normal saline & non-adhesive dry [guaze] applied/taped securely. He [Client #2] stated he 'fell the other day at home'." Interview with the facility's Qualified Mental Retardation Professional (QMRP) on July 1, 2009 at 4:00 PM revealed he did not know how Client #2 sustained the injury. Further interview revealed that an incident report was not written after he received notification from the day program of the client's injury. At the time of the survey, the facility failed to ensure an incident report was generated to notify	W 153	**W 153** **Cross Reference W149**	

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W 153	Continued From page 5 the agency administrator and other officials of Client #2's injury which was discovered by the day program.	W 153		
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 staff interview and record review, the facility failed to ensure the timely investigation of an injury of unknown origin for one of three sampled clients. (Client #2) The finding includes: The facility failed to initiate an investigation to address all injuries of unknown origin as required by the District of Columbia Municipal Regulations (Title 22 Chapter 35; 3519.6) as identified below: On July 1, 2009 at approximately 12:40 PM, interview and record review with the Registered Nurse (RN) at Client #2's day program revealed a "Health Concern Communique" (HCC) was issued to the residential facility on June 4, 2009. The HCC provided the following details: " O/E today we noticed his right foot lateral area had an open wound draining serosanguineous percolate - area was cleaned with normal saline & non-adhesive dry [guaze] applied/taped securely . [Client #2] stated he 'fell the other day at home'." Interview with the facility's Qualified Mental Retardation Professional (QMRP) on July 1, 2009 at 4:01 PM revealed he did not know how Client	W 154	**W 154** **Cross Reference W 149**	

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W 154	Continued From page 6 #2 sustained the injury and did not initiate an investigation to determine the possible causes of the injury after he received notification from the day program. At the time of the survey, the facility failed to initiate an investigation to determine the cause of Client #2's injury which was discovered by the day program.	W 154		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observations, interviews with the Qualified Mental Retardation Professional (QMRP) and record review, the QMRP failed to ensure integration, coordination and monitoring of client's active treatment regimen for two of the three client's in the sample. (Client #1 and #3) The findings include: 1. The Qualified Mental Retardation Professional (QMRP) failed to ensure recommended behavior supports were incorporated into Client #3's day treatment program to address his maladaptive behaviors as evidenced below: On June 30, 2009 at approximately 11:15 AM, interview with the day program case manager revealed that Client #3 was sent home from the day program on May 27, 2009 for throwing a chair twice in his classroom. According to the case manager this was not a new behavior. Further	W 159		

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W 159	Continued From page 7 interview with the day program coordinator revealed that on June 29, 2009, Client #3 threw a chair on three separate occasions and physically attacked the receptionist. The case manager further commented that on both of these days the client was sent home from the day program. Interview with the facility's QMRP on July 1, 2009 at 4:00 PM, revealed he was aware of the aforementioned incidents, further stating Client #3 had several other aggressive outburst at his day program in which staff sustained injuries. The incidents were as follows: a. September 26, 2008, Client #3 threw a chair at the day program staff and hit her in the breast. The day program staff was directed to consult the nurse for treatment of her injury. The nurse offered to take the staff to the emergency room and the staff declined and commented "The pain is not to bad". b. February 11, 2009, Client #3 grabbed a day program staff's right arm and bit her. The staff was taken to the day program nurse for an initial assessment and taken to Providence Hospital emergency room for further treatment. c. April 7, 2009, Client #3 punched a day program staff person in her right eye. The staff who was injured was released from work early to seek medical attention due to persistent head pain. According to the QMRP, he had received notification from the day program and followed up with the day program case manager. The QMRP commented that a case conference was held April 20, 2009 to address these behavioral	W 159	**W 159.1 a, b, c** **On July 6, 2009 the Qualified Mental Retardation Professional (QMRP) held a case conference with client #1's day program on the subject of completing the one-on-one request package. The package has been completed and will be forwarded to MAA and DDS after an Interdisciplinary Team (IDT) meeting on August 1st, 20009.** **08/21/09**	

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W 159	Continued From page 8 outbursts. Reportedly in this case conference the team reached a consensus that the client was in need of "one on one" services for Client #3's safety. The recommendation included putting a referral package together requesting one on one services for Client #3 and the package was to be forwarded to the residential provider for approval. On July 1, 2009 at approximately 1:30 PM, review of Client #3's records revealed a Department of Disabilities Services (DDS) note dated May 29, 2009 that stated the following: "DDS visited the day program to discuss the concerns of Client #3's physical aggressive behavior and noted the 1:1 is still pending. Day program will discuss a report to be submitted to the residence for DDS and MAA approval. The SC will like to have a case conference with the attorney to discuss this concern and retrieval of 1:1 to put in place safeguards until 1:1 is finished. DDA will contact the attorney and find out if he has an advocate to attend a meeting. Client #3 had an incident where he had to be picked up from the day program as he was throwing chairs." On the same day at approximately 2:00 PM, review of Client #3's Individual Behavior Support Plan dated August 22, 2008 revealed that his targeted behaviors included "throwing chairs (this involves forcefully moving chairs and/or throwing them without apparent regard for possible damage to property or injury to persons.) and physical aggression (i.e. hitting, kicking and punching) At the time of the survey, there was no evidence that a referral package had been completed by the QMRP and submitted to DDS and MAA to	W 159		

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W 159	Continued From page 9 secure the IDT team's recommendation for one on one services at his day program. 3. The QMRP failed to ensure that staff received initial and continuing training to each employee to enable them to perform duties effectively, efficiently and competently. [See W189] 4. The QMRP failed to ensure the implementation of an effective system of documenting a client's progress on his program objectives. [See W252]	W 159	**W 159.3** **Cross Reference W 189** **W 159.4** **Cross Reference W 252**	
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each employee had been provided with adequate training that enables the employee to perform his or her duties effectively, efficiently and competently for two of the three clients in the sample. (Client's #1, #3) The findings include: 1. The facility failed to ensure staff were trained to effectively document Client #1's exercise objectives in accordance with his Individual Program Plan (IPP). (See W252) 2. The facility failed to ensure that all staff who provide direct support to Client #3 was trained in Crisis Prevention Techniques in accordance with his behavior support plan.	W 189	**W 189.1** **Staff will be in-serviced on effective documentation of client's progress regarding program objectives. The House Manager will on a weekly basis review the program books to ensure proper and effective documentation.** **The QMRP will on a quarterly basis or as needed in-service staff on the subject of effective data collection.** **08/19/09**	

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W 189	Continued From page 10 On June 30, 2009 at approximately 11:15 AM, interview with the day program case manager revealed Client #3 was sent home from the day program on May 27, 2009 for throwing a chair twice in his classroom. According to the case manager this was not a new behavior. Further interview with the day program coordinator revealed that on June 29, 2009 Client #3 threw a chair on three separate occasions and physically attacked the receptionist. The case manager further commented that on both of these days the client was sent home from the day program. Interview with the facility's Qualified Mental Retardation Professional (QMRP) on July 1, 2009 at 4:00 PM, revealed Client #3 had several other aggressive outburst at his day program in which staff at the day program sustained injuries. The incidents were as follows: a. September 26, 2008. Client #3 threw a chair at the day program staff and hit her in the breast. The day program staff was directed to seek the day program nurse for treatment of her injury. The nurse offered to take the staff to the emergency room and the staff declined and commented "The pain is not to bad" b. February 11, 2009, Client #3 grabbed a day program staff's right arm and bit her. The staff was taken to the day program nurse for an initial assessment and taken to Providence Hospital emergency room for further treatment. c. April 7, 2009, Client #3 punched a day program staff person in her right eye. The staff who was injured was released from work early to seek medical attention due to persistent head pain.	W 189		

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W 189	Continued From page 11 On the same day at approximately 2:00 PM, review of Client #3's Behavior Support Plan (BSP) dated January 11, 2009, revealed his target behaviors included "throwing chairs (this involves forcefully moving chairs and/or throwing them without apparent regard for possible damage to property or injury to persons) and physical aggression (i.e. hitting, kicking and punching). Further review of the BSP in the section "Procedures to address aggression" indicated the following: " If [the client] continues to be aggressive and follows his target, guide and accompany [Client #3] in another direction away from the person he is trying to follow. Only staff trained in the crisis prevention techniques approved by the DDS, may accompany him away from the area". " If [the client] continues to be aggressive and is not amenable to redirection, then a preferred staff person should remain close to him, out of his arm's reach. Be ready to intervene as needed, if this is feasible at such a time. Only staff trained in the crisis prevention techniques approved by the DDS may use the least restrictive techniques and only those strategies that are necessary to ensure [Client #3] safety and that of peers and staff." Review of the in-service training log on the same day at approximately 3:20 PM, did not evidence Crisis Intervention Techniques strategies training was provided to the residential staff and/or the day treatment staff who routinely work with Client #3. At the time of survey, there was no evidence the	W 189		

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W 189	Continued From page 12 facility had ensure the necessary training in the area of Crisis Prevention and Intervention techniques in accordance with Client #3's BSP to ensure his safety. 3. The facility failed to ensure that staff was effectively trained to document Client #3's refusal of food in accordance with his mealtime protocol. On June 30, 2009 at approximately 5:19 PM, Client #3 was offered his dinner which consisted of shredded beef, mash potatoes with gravy and broccoli. Client #3 refused to eat his meal. Staff repeatedly ask him to come to the table to eat his food. He continued to refuse. Client #3 repeatedly requested "cheese and hot dogs". The QMRP redirected him and informed him that he was not allowed to eat cheese and hot dogs. At approximately 5:26 PM staff was observed to give Client #3 a cup of Jello Pudding to eat. Client #3 took the pudding into the living room, sat on the couch and ate it. The staff commented, "We will wrap his food up and put it into the refrigerator and offer it to him later." On July 1, 2009 at 12:00 PM, the surveyor opened the microwave and found a plate of food with the same food items that were served the previous evening. Interview with the Residential Director (RD) confirmed that the plate of food in the microwave belonged to Client #3. The RD stated that she would follow-up with the evening staff to find out why Client #3 did not eat his dinner. Later interview on the same day with the RD at approximately 2:45 PM revealed, Client #3 was provided a sandwich as a substitute. However, it	W 189	**W 189.2** **Staff were trained on Crisis Prevention Techniques (CPI) on July 14 and 15. Their CPI cards will be mailed to the residential provider in three to four weeks.** **08/30/09**	

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W 189	Continued From page 13 could not be determine the type of sandwich that was provided. On the same day at 3:15 PM, review of Client #3's mealtime protocol dated December 3, 2008 revealed, staff are to "document Client #3's refusal to eat food presented and report to medical personnel and the QMRP of the residential facility". Review of the client records did not evidence that staff documented the client's continued refusal and the substitution provided. It should be noted that review of Client #3's nutritional assessment dated December 29, 2008 failed to include a list of the client's food preference with appropriate substitutions for the staff's usage when he refuses his meals. According to the QMRP, staff were trained on the clients mealtime protocols by the nutritionist back on October 10, 2008. At the time of this survey, there was no evidence that this training was effective.	W 189	**W 189.3** **The nutritionist will train staff on how to effectively document food refusals and substitutes.** **The House Manager (HM) will on weekly basis work with staff in ensuring that the food substitute list is efficiently utilized and food substitutes consistently documented.** **08/19/09**	
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 staff interview and record review, the facility failed to ensure the implementation of an effective system of documenting a client's progress on his program objectives for one of the three client's in the sample. (Clients #1)	W 252		

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W 252	Continued From page 14 The finding includes: The facility failed to ensure that direct care staff collected consistent data on Client #1's exercise objective in accordance with the individual program plan. On July 1, 2009 at approximately 2:00 PM, interview with the Qualified Mental Retardation Professional (QMRP) and record review revealed that Client #1 has an individual program objective to enhance his physical fitness. The objective states that "Client #1 will ride the stationary bike for 5 minutes per session for three consecutive trials on 60% of the recorded trials. Review of the data for the month of June 2009 revealed that data was not collected on the 2nd, 16th and the 23rd. According to the QMRP, the frequency of this objective was three times a week and the data was to have been collected at that time. Reportedly, in-service training occured on Janaury 15, 2009 and April 15, 2009. At the time of the survey, there was no evidence that this objective was being implemented and recorded consistently.	W 252	**W 252** **The nutritionist will provide food preference and substitute lists for client #3.** **The nutritionist will train staff on how to effectively utilize and document the food preference list and utilization of the substitute lists.** **08/19/09**	
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:	W 262		

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W 262	Continued From page 15 Based on observation, staff interview and record review, the facility failed to ensure programs that incorporate restrictive techniques had been reviewed, approved and monitored by its specially constituted committee prior to implementation, for five of the five clients residing in the facility. (Client #1, #2, #3, #4 and #5) The findings include: Observation in the group home on June 30, 2009 at approximately 3:40 PM, revealed Client #4 was observed to exit the group home from the second level rear door unsupervised. Observation on July 1, 2009 at approximately 3:15 PM, on a second occasion, Client #4 was observed to open the basement door and exit the facility into the back yard unsupervised. On the first occasion, Client #4 was only moments later observed by the staff and redirected by the staff to return into the facility. Client #4 responded without incident and walked back into the facility. On the second occasion, the surveyor alerted the nurse that Client #4 was walkinig out the basement door leading out to the back yard. Interview with the Residential Director (RD) on the June 30, 2009 at approximately 11:00 AM, revealed that the facility has door alarms on the second and third level rear exit doors. Further interview with the RD revealed that the rear door alarm on the second level near the kitchen was disconnected. However, the RD further commented that the third floor alarm remained activated. According to the RD the alarms were on the doors because "Client #4 was known to	W 262		

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W 262	Continued From page 16 walk away from the facility". On July 1, 2009 at 3:50 PM, interview with the Qualified Mental Retardation Professional (QMRP), the RD,and the Administrative Assistant via telephone revealed, the door alarm on the main level had been recently deactivated. According to the QMRP, he had requested that all door alarms be shut off. The QMRP further commented that the use of the alarms had not been presented to the Human Rights Committee and approved for use. Further interview with the Administrative Assistant revealed that the Owner/CEO was aware of the use of these restrictive measures and believed the door alarms were a protection and were being used for each clients safety. According to interview with the QMRP, Client #4's behavior of walking out of the facility unsupervised was a new behavior that had not been assessed. Review of the agency's HRC minutes did not evidenced that the facility's use of the door alarms had been presented and approved by the HRC prior to their usage.	W 262	**W 262** **The facility is collecting baseline data on client #4 behavior of attempting to elope. Such data will be presented to the psychologist for assessment.** **The use of door alarms will be presented to the HRC for review.** **08/19/09**	
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review the facility's failed to provide preventative and general care for one of the three Client's in the sample.(Client #3) The finding includes:	W 322		

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W 322	Continued From page 17 The facility failed to provide oversight to ensure that Client #3 was administered his medications as prescribed. (See W331 and W369)	W 322	**W 322** **Please refer to W 331.2 and W369**	
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 interviews 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 three clients in the sample . (Client #1 and Client #3) The findings include: 1. Cross Refer to W369. The facility's nurses failed to ensure that their system for drug administration assured that all drugs are administered without error. 2. The facility's nursing staff failed to ensure that Client #3 received his noon dosage of medication when absent from his day program as evidenced below: On June 30, 2009 at approximately 1:40 PM, interview with the day program nurse revealed that Client #3 receives Tegretol 300 mg at noon. Further interview with the day program nurse confirmed the client was absent several days from the day program for the months of May and June, 2009. Interview on July 1, 2009 at 2:45 PM with the	W 331	**W 331. 1** **Please refer to W369.**	

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W 331	Continued From page 18 facility's nurse verified Client #3 received a noon dosage of Tegretol at his day program. Further interview with the nurse did not evidence a clear system had been established to ensure the client was administered his prescribed noon dosage of Tegretol when not attending his day program. On the same day at 3:00 PM, review of the Medication Administration Record (MAR) received from the day program revealed that for the month of May 2009, Client #3 was absent from the program on 6th and 21st. Review of the May MAR from the group home, did not verify that on either of these days the client was administered his noon dosage of Tegretol. Further review of the day program's June MARs revealed that Client #3 was absent from the day program on the 4th and 18th. Review of the June MAR's for the group home did not verify that on either of these days the client was administered his noon dosage of Tegretol as prescribed. At the time of the survey, the facility failed to establish an effective system of oversight to ensure Client #3 was administered his noon dosage of Tegretol as prescribed.	W 331	**W 331.2** **On any day client #3 is absent from his day program, the facility nurse will pick up the noon meds from the day program and administer them at home.** **The facility will on a monthly basis review the MAR from the day program to ensure that client #3 is receiving his medicines as prescribed.** **08/19/09**	
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the facility failed to ensure their system for drug administration assured that all drugs are administered without error for two of	W 369		

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W 369	Continued From page 19 three clients in the sample. (Client #1 and Client #3) The findings include: 1. Observation of the medication pass on June 30, 2009 at approximately 7:55 AM revealed Licensed Practical Nurse #1 (LPN) did not administer Nasonex nasal spray to Client #3 at the time of the medication pass. Review of the June 2009 Medication Administration Record (MAR) and physician's orders (POS) dated June, 2009 on June 30, 2009 at approximately 8:25 AM revealed Client #3 was ordered Nasonex nasal spray; two(2) sprays in each nostril every day. In an interview with LPN #1 on June 30, 2009 at approximately 8:35 AM, it was acknowledged Client #3 was to have been administered Nasonex nasal spray; two(2) sprays in each nostril every day. There was no evidence that all drugs were administered without error. [Note: LPN #1 administered Client #3's Nasonex nasal spray; two(2) sprays in each nostril on June 30, 2009 at approximately 8:40 AM after the surveyor revealed the medication error.] 2. Observation of the medication pass on June 30, 2009 at approximately 8:20 AM revealed that LPN #1 did not administer Nasonex nasal spray to Client #1 at the time of the medication pass. Review of the MAR dated June, 2009 and the POS dated June, 2009 on June 30, 2009 at	W 369	**W 369.1** **The facility's Registered Nurse (RN) will in-service the Licensed Practical Nurses (LPNs) on the principles of medication administration.** **The RN will once quarterly observe the LPNs during meds pass so as to ensure compliance.** **08/19/09**	

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W 369	Continued From page 20 approximately 8:27 AM, revealed Client #1 was ordered Nasonex nasal spray; two(2) sprays in each nostril every day. In an interview with LPN #1 on June 30, 2009 at approximately 8:36 AM, it was acknowledged Client #1 was to have been administered Nasonex nasal spray; two(2) sprays in each nostril every day. There was no evidence that all drugs were administered without error. [Note: LPN #1 administered Client #1's Nasonex nasal spray; two(2) sprays in each nostril on June 30, 2009 at approximately 8:42 AM after the surveyor revealed the medication error.]	W 369	**W 369.2** **Cross Reference W 369.1**	
W 474	483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure client's received their meal(s) in the form and consistency as required for one of three clients in the sample. (Client #2) The finding includes: The facility failed to ensure that Client #2 was provided his prescribed diet as evidenced below: Observation on June 30, 2009 at approximately 6:00 PM revealed, all five Clients residing in the facility was served the same textured portions of shredded beef for their dinner.	W 474		

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W 474	Continued From page 21 Interview with the facility's Qualified Mental Retardation Professional (QMRP)and record review on July 1, 2009 at approximately 3:30 PM revealed Client #2's Nutritional assessment dated March 29,2009 recommended the following: "Regular diet, no added salts, chopped texture". Further record review revealed Client #2's Speech Pathology assessment dated April 30, 2009 detailed the following mealtime observation: "[Client #2] is prescribed a regular diet texture consistency ... Direct care program staff provides [Client #2] support, assistance and supervision as needed to ensure safe and adequate dietary intake. This decreases the likelihood of him experiencing choking, aspiration or aspiration related illnesses. " Additional record review revealed Client #2's current physician's orders dated June 2009 provided for a texture of "finely chopped" foods. According to both the House Manager (HM) and QMRP on July 1, 2009 at approximately 3:24 PM, Client #2's foods should have been served in a "finely chopped" texture for his dinner the previous night. There was no evidence that the facility made any effort to clarify the food texture for Client #2. There was also no evidence that the QMRP coordinated with the Nutritionist, the Speech Pathologist and Primary care physician to ensure staff provided his food in the form and consistency appropriate to meet his needs.	W 474	**W 474** **Client #2's diet texture has been clarified to be chopped, instead of finely chopped. Staff are adhering to the current diet texture.** **The QMRP will on a monthly basis review the clients' records to ensure that recommendations are consistent across disciplines.** **07/22/09**	

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I 000	INITIAL COMMENTS A re-licensure survey was conducted from June 30, 2009, through July 1, 2009. A random sample of three residents was selected from a resident population of five males with various disabilities. The findings of the survey were based on observations at the group home and three day programs, interviews with management and staff, and the review of administrative records, including the facility's incident management system.	I 000		
I 056	3502.14 MEAL SERVICE / DINING AREAS Each GHMRP shall train staff in the storage, preparation and serving of food, the cleaning and care of equipment, and food preparation in order to maintain sanitary conditions at all times. This Statute is not met as evidenced by: Based on staff interview and record review, the GHMRP failed to ensure staff who prepared meals received their food handler's certification for two of the four staff records reviewed. (Staff #5 and #12) The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of four personnel files on July 1, 2009 at approximately 10:30 AM revealed two of the four staff who was assigned to prepare food for the home did not have a valid food handler's certification on file. (Staff #5 and #12)	I 056	**I 056** **The facility will schedule the two staff to take the food handling course.** **08/30/09**	

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I 090	Continued From page 1	I 090		
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 facility failed to ensure the integrity of the physical environment as required by this section. The finding includes: During the environmental inspection on June 30, 2009 at approximately 9:55 AM, the ceiling in the " TV Room " appeared to be water damaged with parts of the plaster missing from the ceiling.	I 090	**I 090** **The ceiling in the TV room has been repaired.** **The facility's maintenance team will on a monthly basis conduct environmental audits of the facility to ensure that all maintenance issues are resolved.** **08/30/09**	
I 095	3504.6 HOUSEKEEPING Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach of each resident. This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to enact and enforce the necessary measures to ensure the proper storage of all caustic agents. The finding includes: During the environmental observation and interview with the Residential Director (RD) on July 1, 2009 at approximately 11:59 AM, cleaning and caustic agents (i.e. clorox, pine sol and	I 095	**I 095** **A cabinet has been installed in the basement were all cleaning and caustic agents shall be locked. Direct Support Staff have been strongly advised to always lock up cleaning agents.** **The House Manager will on a weekly basis conduct environmental tour of the facility to ensure that staff are adhering to keeping all cleaning detergents and caustic agents out of the reach of the clients.** **08/30/09**	

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I 095	Continued From page 2 laundry detergent) were observed being stored in the laundry room in the basement unlocked.	I 095		
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 each staff and consultant had a current health certificate for three out of twenty-six files reviewed. The findings includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of thirteen (13) employee records on July 1, 2009 at approximately 9:30 AM revealed one (1) of the thirteen staff records reviewed was without a current health certificate. (Staff #11) Additionally, further interview with the QMRP on the same day at 11:25 am and the review of thirteen (13) consultant records revealed, two (2) consultants (i.e. Director of Nursing and the nutritionist) were noted not to have current health certifications.	I 206	**I 206** **Staff #11, the nutritionist, and the Director of Nursing have been requested to provide current health certificates by August 5, 2009.** **The Assistant Administrator shall on a monthly basis conduct audits of personnel records and consultants to ensure that all required documents/certifications are current.** **08/30/09**	
I 222	3510.3 STAFF TRAINING	I 222		

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I 222	Continued From page 3 There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that staff received ongoing training that enable them to perform their duties effectively, efficiently and competently for three of the three resident's in the sample. (Residents #1, and #3) The findings include: 1. The facility failed to ensure staff were trained to effectively document Resident #1's exercise objectives data in accordance with his Individual Program Plan (IPP). (See Federal Deficiency Report Citation W252) 2. The facility failed to ensure that all staff who provide direct support to Resident #3 was trained in Crisis Prevention Techniques in accordance with his behavior support plan. On June 30, 2009 at approximately 11:15 AM, interview with the day program case manager revealed Resident #3 was sent home from the day program on May 27, 2009 for throwing a chair twice in his classroom. According to the case manager this was not a new behavior. Further interview with the day program coordinator revealed that on June 29, 2009 Resident #3 threw a chair on three separate occasions and physically attacked the receptionist. The case manager further commented that on both of these days the resident was sent home from the day program. Interview with the facility's Qualified Mental Retardation Professional (QMRP) on July 1, 2009	I 222	**I 222.1** **Cross Reference W252.**	

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I 222	Continued From page 4 at 4:00 PM, revealed Resident #3 had several other aggressive outburst at his day program in which staff at the day program sustained injuries. The incidents were as follows: a. September 26, 2008. Resident #3 threw a chair at the day program staff and hit her in the breast. The day program staff was directed to seek the day program nurse for treatment of her injury. The nurse offered to take the staff to the emergency room and the staff declined and commented "The pain is not to bad" b. February 11, 2009, Resident #3 grabbed a day program staff's right arm and bit her. The staff was taken to the day program nurse for an initial assessment and taken to Providence Hospital emergency room for further treatment. c. April 7, 2009, Resident #3 punched a day program staff person in her right eye. The staff who was injured was released from work early to seek medical attention due to persistent head pain. On the same day at approximately 2:00 PM, review of Resident #3's Behavior Support Plan (BSP) dated January 11, 2009 revealed his target behaviors included "throwing chairs (this involves forcefully moving chairs and/or throwing them without apparent regard for possible damage to property or injury to persons) and physical aggression (i.e. hitting, kicking and punching). Further review of the BSP in the section for procedures to address aggression indicated the following: "4. If [the resident] continues to be aggressive and follows his target, guide and accompany [Resident #3] in another direction away from the	I 222		

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I 222	Continued From page 5 person he is trying to follow. Only staff trained in the crisis prevention techniques approved by the DDS, may accompany him away from the area. 5. If [the resident] continues to be aggressive and is not amenable to redirection, then a preferred staff person should remain close to him, out of his arm's reach. Be ready to intervene as needed, if this is feasible at such a time. Only staff trained in the crisis prevention techniques approved by the DDS may use the least restrictive techniques and only those strategies that are necessary to ensure [Resident #3] safety and that of peers and staff." Review of the in-service training log on the same day at approximately 3:20 PM, did not evidence Crisis Intervention Techniques strategies training was provided to the residential staff and/or the day treatment staff who routinely work with Resident #3. At the time of survey, there was no evidence the facility had ensure the necessary training in the area of Crisis Prevention and Intervention techniques in accordance with Resident #3's BSP to ensure his safety. 3. The facility failed to ensure that staff was effectively trained to document Resident #3's refusal of food in accordance with his mealtime protocol. On June 30, 2009 at approximately 5:19 PM, Resident #3 was offered his dinner which consisted of shredded beef, mash potatoes with gravy and broccoli. Resident #3 refused to eat his meal. Staff repeatedly ask him to come to the table to eat his food. He continued to refuse. Resident #3 repeatedly requested "cheese and	I 222	**I 222.2** **Cross Reference W189.2.**	

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I 222	Continued From page 6	I 222		

hot dogs". The QMRP redirected him and informed him that he was not allowed to eat cheese and hot dogs.

At approximately 5:26 PM staff was observed to give Resident #3 a cup of Jello Pudding to eat. Resident #3 took the pudding into the living room, sat on the couch and ate it. The staff commented, "We will wrap his food up and put it into the refrigerator and offer it to him later."

On July 1, 2009 at 12:00 PM, the surveyor opened the microwave and found a plate of food with the same food items that were served the previous evening. Interview with the Residential Director (RD) confirmed that the plate of food in the microwave belonged to Resident #3. The RD stated that she would follow-up with the evening staff to find out why Resident #3 did not eat his dinner.

Later interview on the same day with the RD at approximately 2:45 PM revealed, Resident #3 was provided a sandwich as a substitute. However, it could not be determine the type of sandwich that was provided.

On the same day at 3:15 PM, review of Resident #3's mealtime protocol dated December 3, 2008 revealed, staff are to "document Resident #3's refusal to eat food presented and report to medical personnel and the QMRP of the residential facility".

Review of the resident records did not evidence that staff documented the resident's continued refusal and the substitution provided. It should be noted that review of Resident #3's nutritional assessment dated December 29, 2008 failed to include a list of the resident's food preference

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I 222	Continued From page 7 with appropriate substitutions for the staff's usage when he refuses his meals. According to the QMRP, staff were trained on the residents mealtime protocols by the nutritionist back on October 10, 2008. At the time of this survey, there was no evidence that this training was effective.	I 222	**I 222.3** **Cross reference W 252**	
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure each staff had a current CPR and First Aid certification for two out of thirteen staff files reviewed. (Staffs #5 and #12) The findings include: The GHMRP failed to ensure each staff was certified in CPR and First Aide as evidenced below: 1. Interview with the Qualified Mental Retardation Professional (QMRP) and review of thirteen (13) employee files on July 1, 2009 at approximately 9:44 AM revealed Staff #5 and Staff #12 were currently employed and working without a valid CPR certification. 2. Interview with the Qualified Mental	I 227	**I 227.1** **Staff #5 and Staff #12 have completed trainings in CPR. The Assistant Administrator shall on a monthly basis review personnel records to ensure that required documents are updated on a timely basis.** **I 227.2** **Staff # 5 has completed First Aid Training.** **07/15/09**	

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I 227	Continued From page 8 Retardation Professional (QMRP) and review of thirteen employee files on July 1, 2009 at approximately 9:49 AM revealed Staff #5 was currently employed and was working without a valid First Aid certification.	I 227		
I 375	3519.6 EMERGENCIES Each GHMRP shall document each emergency and enter the follow-up actions into the resident ' s permanent record, which shall be made available for review by authorized individuals. This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure the timely investigation of an injury of unknown origin for one of three sampled residents. (Resident #2) The finding includes: On July 1, 2009 at approximately 12:40 PM, interview and record review with the Registered Nurse (RN) at Resident #2's day program revealed a "Health Concern Communique" (HCC) was issued to the residential facility on June 4, 2009. The HCC provided the following details: " O/E today we noticed his right foot lateral area had an open wound draining serosanguineous percolate - area was cleaned with normal saline & non-adhesive dry [guaze] applied/taped securely . [Resident #2] stated he 'fell the other day at home'." Interview with the facility's Qualified Mental Retardation Professional (QMRP) on July 1, 2009 at 4:01 PM revealed he did not know how Resident #2 sustained the injury and did not initiate an investigation to determine the possible	I 375		

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I 375	Continued From page 9 causes of the injury after he received notification from the day program. At the time of the survey, the facility failed to initiate an investigation to determine the cause of Resident #2's injury which was discovered by the day program.	I 375	**I 375** **Cross reference W149**	
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 staff interview and record review, the facility failed to ensure the timely notification of an injury of unknown origin in accordance with District policies for one of three residents in the sample. (Resident #2) The finding includes: The facility failed to ensure that all injuries of unknown origin were reported to the Department of Health as required by the District of Columbia Municipal Regulations (Title 22 Chapter 35; 3519.10) as identified below: On July 1, 2009 at approximately 12:40 PM, interview and record review with the Registered	I 379		

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I 379	Continued From page 10 Nurse (RN) at Resident #2's day program revealed a "Health Concern Communique" (HCC) was issued to the residential facility on June 4, 2009. The HCC provided the following details: "O/E today we noticed his right foot lateral area had an open wound draining serosanguineous percolate - area was cleaned with normal saline & non-adhesive dry [guaze] applied/taped securely. He [Resident #2] stated he 'fell the other day at home'." Interview with the facility's Qualified Mental Retardation Professional (QMRP) on July 1, 2009 at 4:00 PM revealed he did not know how Resident #2 sustained the injury. Further interview revealed that an incident report was not written after he received notification from the day program of the resident's injury. Record review at the residential facility on the same day at approximately 4:10 PM, revealed a document entitled "Incident Handling and Reporting Procedures for Persons Served by DDS" provided guidance on how to manage unusual incidents. The information outlined in "Section A - Life threatening Situation" provides for the following intervention: " If an injury is NOT life threatening, apply first aid, as necessary, then proceed to section C." Section C describes that the agency must then complete an incident report. At the time of the survey, the facility failed to ensure an incident report was generated to notify the agency administrator and other officials of Resident #2's injury which was discovered by the day program.	I 379	**I 379** **Cross reference W149**	

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I 401	Continued From page 11	I 401		
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: The GHMRP failed to provide professional services that included treatment services designed to prevent deterioration or further loss of function by the resident, for two of three residents in the sample. (Resident #1 and Resident #3) The findings include: 1. Observation of the medication pass on June 30, 2009 at approximately 7:55 AM revealed Licensed Practical Nurse #1 (LPN) did not administer Nasonex nasal spray to Resident #3 at the time of the medication pass. Review of the June, 2009 Medication Administration Record (MAR) and physician's orders (POS) dated June, 2009 on June 30, 2009 at approximately 8:25 AM revealed Resident #3 was ordered Nasonex nasal spray; two(2) sprays in each nostril every day. In an interview with LPN #1 on June 30, 2009 at approximately 8:35 AM, it was acknowledged Resident #3 was to have been administered Nasonex nasal spray; two(2) sprays in each nostril every day. There was no evidence that all drugs were	I 401		

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I 401	Continued From page 12 administered without error. [Note: LPN #1 administered Resident #3's Nasonex nasal spray; two(2) sprays in each nostril on June 30, 2009 at approximately 8:40 AM after the surveyor revealed the medication error.] 2. Observation of the medication pass on June 30, 2009 at approximately 8:20 AM revealed that LPN #1 did not administer Nasonex nasal spray to Resident #1 at the time of the medication pass. Review of the MAR dated June, 2009 and the POS dated June, 2009 on June 30, 2009 at approximately 8:27 AM revealed Resident #1 was ordered Nasonex nasal spray; two(2) sprays in each nostril every day. In an interview with LPN #1 on June 30, 2009 at approximately 8:36 AM, it was acknowledged Resident #1 was to have been administered Nasonex nasal spray; two(2) sprays in each nostril every day. There was no evidence that all drugs were administered without error. [Note: LPN #1 administered Resident #1's Nasonex nasal spray; two(2) sprays in each nostril on June 30, 2009 at approximately 8:42 AM after the surveyor revealed the medication error.]	I 401	**I 401 (1 &2)** **Cross reference W369.1**	
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal	I 500		

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I 500	Continued From page 13 laws. This Statute is not met as evidenced by: Based on observations, interviews and record review, the GHMRP failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) that governs the care and rights of persons with mental retardation. The findings include: The GHMRP failed to maintain resident's rights and/or ensure each resident was encouraged to exercise their rights, for one of five residents residing in the facility. (Resident #4) The finding includes: [Cross Refer W125] Interview with the Residential Director (RD) on the June 30, 2009 at approximately 11:00 AM, revealed that the facility had door alarms on the second and third level rear exit doors. According to the RD the alarms were on the doors because Resident#4 was known to walk away from the facility. Review of the Human Rights Committee (HRC) minutes on the same day at 1:55 PM did not evidence that the door alarms had been presented to the committee for review and approval prior to being used as a restrictive measure. Furthermore, there was no evidence that the legally sanctioned representatives for any of the clients had been notified of the facility's intent and use of the door alarm.	I 500	**I 500** **Cross reference W125**	

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R 000	INITIAL COMMENTS A re-licensure survey was conducted from June 30, 2009, through July 1, 2009. A random sample of three residents was selected from a population of five males with various disabilities. The findings of the survey were based on observations at the group home and three day programs, interviews with management and staff, and the review of administrative records, including the facility's incident management system.	R 000		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on the review of records, the GHMRP failed to ensure criminal background checks disclosed the criminal history of any prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check or three of the thirteen files reviewed. The findings include: Review of the personnel records on 7/1/09 at 10:00 AM revealed that the GHMRP failed to provide evidence that ensured full criminal background checks were on file for three (3) of	R 125	**R 125** **The residential provider has set up a forty-eight hour global criminal background check system which is geared towards conducting criminal background checks for prospective employees.** **Criminal background checks have been completed for staff #6, #8, and #9.** **07/22/09**	

Health Regulation Administration

Dr Rodney Buckley — TITLE Adm. — (X6) DATE 7/27/09

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

Health Regulation Administration

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R 125	Continued From page 1 thirteen (13) direct care staff files reviewed. (Staff #6, #8, and #9)	R 125		