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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G122	A. BUILDING B. WING	06/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	3020 STANTON ROAD, SE WASHINGTON, DC 20020

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W 000	INITIAL COMMENTS Surveyor: 17815 A recertification survey was conducted from June 9, 2008 through June 12, 2008. The survey was initiated using the fundamental survey process. A random sample of four clients was selected from a resident population of eight women with various disabilities. In addition, a focused review was conducted of a fifth client's food and beverage texture and consistency. On June 9, 2008, at 6:27 PM, the facility was informed that Client #2's health and safety were at risk due to improper feeding technique. The Registered Nurse intervened immediately. Staff were retrained that evening and again on the following day. On June 12, 2008, at 3:15 PM, the survey was extended in the Condition of Health Care Services following deficiencies identified during the review of client seizure records, lab reports and neurology records. The findings of the survey were based on observations, interviews with one individual's sister and another individual's court-appointed guardian, interviews with staff in the home and at two day programs, as well as a review of client and administrative records, including incident reports. The determination was made that the facility was not in compliance with the Conditions of Participation in Governing Body, Client Protections, Facility Staffing and Health Care Services.	W 000	Received on 7/17/08 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.	W 102	W102	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nancy Branch	ARS	7.17.08

An[illegible]ciency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other saf[illegible]ds 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 102	Continued From page 1	W 102	W 102, Continued...	
	Surveyor: 17815 The facility's governing body failed to maintain general operating direction over the facility to ensure client health and safety [Cross-refer to W104, W127, W149, W158 and W318]. The results of these systemic practices revealed the facility's Governing Body failed to adequately govern the facility in a manner that would ensure clients were free from harm.		Cross reference response to W104, W127, W149, W158 and W318.	7.23.08 ongoing
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.	W 104	W104	
	Surveyor: 17815 Based on staff interviews, and record verification the governing body failed to ensure that the facility consistently exercised general policy, and operating direction over the facility. The findings include: 1. Cross-refer to W111. The governing body failed to develop policies and procedures to maintain a sufficient number of staff to ensure that clients were monitored to prevent injuries and address behavior management needs when transporting medically-fragile clients safely in/off the van during medical appointements. 2. Cross Reference W159. The governing body		(1.) Cross reference response to W111. (2.) Cross reference W159.	7/10/08 ongoing

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W 104	Continued From page 2 failed to enure that the Qualified Mental Retardation Professional (QMRP) ensured that a rolling walker was obtained as recommended by the Physical Therapist (PT) one of one client in the investigation. 3. Cross Reference W436.The Governing Body failed to ensure that the recommended adaptive equipment had been provided and maintained in accordance to their recommended needs for one of one client in the investigation. 4. Cross Reference W 322. The Governing Body failed to ensure that the facility's medical services provided a through medical examination to ensure that optimal health care and services were provided for one of one client in the investigation. 5. Cross Reference W 331. The governing body failed to ensure that the facility's nursing staff provided nursing services in accordance with the needs of one of one client in the investigation.	W 104	W104 (3.) Reference response to W436 (4.) Cross reference response to W322 5. cross reference W 331	7-10-08 ongoing
W 111	483.410(c)(1) CLIENT RECORDS The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Surveyor: 17815 Based on record review and interview, the facility failed to maintain a record keeping system that documented recent health care services provided and reflected current health management care plans, for three of the four clients in the sample. (Clients #1, #2 and #4)	W 111	W111 This Standard will be met as evidenced by:	

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W 111	Continued From page 3 The findings include: 1. The facility's nursing staff failed to ensure Client #1's Health Management Care Plan (HMCP) reflected her custom-molded shoes, as follows: The review of unusual incidents on June 9, 2008 revealed that Client #1 had sustained falls since her admission to the group home on January 31, 2008. The HMCP, updated May 23, 2008, documented osteoporosis and a history of fall as areas of concern. The goal was that the client would be free from falls/injuries. The HMCP did not, however, reflect the PT's February 29, 2008 recommendation that she have custom-molded shoes.	W 111	W111 1. Client #1 was measured for custom molded shoes on July 10, 2008.	7.10.08
	2. The facility's nursing staff failed to ensure Client #2's HMCP reflected her podiatry treatment orders, as follows: On June 11, 2008, at approximately 2:10 PM, review of Client #2's nurse progress notes revealed that on February 14, 2008, the podiatrist had discovered a "dark discoloration" on her fifth right toe. The podiatrist recommended monitoring until healed. On February 18, 2008, a nurse wrote that the "fifth toe right foot appears to be healing fine." However, on April 14, 2008, the podiatrist returned for the next examination. The podiatrist wrote "There is tissue protruding from fifth toe right foot, nurse made aware of tissue protruding from fifth toe right foot..." Subsequent review of the client's HMCP, updated May 6, 2008, failed to show evidence that nursing staff had addressed what now appeared to be a recurring health concern.		2. Podiatry treatment orders will be reviewed and the HMCP updated as needed. Nursing staff will show evidence that the health concern has been addressed.	6.26.08

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W 111	Continued From page 4 3. The facility's nursing staff failed to ensure Client #5's HMCP reflected food and beverage texture and consistency orders, as follows: Cross-refer to W194.2. Client #5 had a pronounced tongue thrust. On June 10, 2008, at approximately 7:52 AM, the medication nurse presented her with a cup of water. She had difficulty drinking the water, as her head titled to the side, and water fell onto her bib. "Nectar-thickened liquids" was reflected on her mealtime protocol, MARs, and the Nutrition and Speech/ Language Assessments. However, Client #5's Health Management Care Plan, dated February 12, 2008 and physician's orders for June 2008 did not reflect the order. There was no evidence that facility nurses had sought to clarify the order prior to the survey. 4. Client #4 experienced multiple seizures on January 14, 2008 which led to her admission to a hospital. On June 12, 2008, the client's neurology records were reviewed, beginning at 9:15 AM. Recent medical reports and documentation of alleged communications with medical professionals were missing from her record, as follows: a. There was a consultation form indicating that Client #4 was seen by the neurologist on January 8, 2008. The neurologist wrote "see note" for the findings and recommendations. There was no note attached, however, and further review of her medical records failed to show evidence of the neurologist's report. b. Also on June 12, 2008, at approximately 9:25 AM, there was a consultation form indicating that Client #4 underwent an EEG procedure on	W 111	(3) Cross reference response to W194.2. • Nurses will be provided additional training on adherence to mealtime protocol. • HMCP and physician orders will be updated to reflect Nectar-thickened liquids. (4) a. Nurse will follow-up with the Nuerologist to secure a copy and/verification of Nuerologist visit/recommendations. b. Nurse will contact Nuerologist to secure another copy of the EEG reports. • RN will continue to conduct file reviews and address concerns as they arise.	7.23.08 ongoing 6.24.08

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W 111	Continued From page 5 January 12, 2008. The neurology clinic indicated "report to follow." There was no EEG report attached to the consultation form and further review of her medical records failed to show evidence of the EEG report. c. Client #4's records indicated that on January 24, 2008, the neurologist ordered testing the serum levels of her anticonvulsant medications. She was prescribed Tegretol, Depakote and Keppra. A telephone order dated January 24, 2008 indicated that her primary care physician (PCP) concurred; he ordered "Get all anticonvulsant levels and LFT test." Lab reports indicated that the client's Tegretol and Depakote were tested; however, her serum Keppra levels had not been tested since October 3, 2007. On June 12, 2008, at approximately 12:15 PM, the RN stated that the Director of Nursing, the pharmacist and eventually the neurologist and PCP had all stated that Keppra levels were not needed. After examining the client's chart, however, the RN acknowledged that conversations with those professionals, reportedly clarifying the lab order, had not been documented appropriately in Client #4's record. At the exit conference later that afternoon, the DON corroborated what the RN had stated. She did not, however, present documentation of contacts with the neurologist and/or PCP regarding clarifying the order.	W 111	W111 c. Anticonvulsant levels include Tegretol and Depakote. Keppra does not require lab monitoring per the RN. Thus, no clarification of orders is required.	6.13.08
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:	W 120	W120 This Standard will be met as evidenced by:	

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W 120	Continued From page 6 Surveyor: 17815 Based on observations, staff interview, and record review, the facility failed to effectively monitor each client's day program to ensure that needs were met, for one of four clients in the sample. (Client #2) The findings include: On June 9, 2008, Client #2 was observed at her day program, between 11:00 AM - 12:15 PM. The following deficient practices were observed: 1. Cross-refer to W436.3. On June 9, 2008, at approximately 11:02 AM, Client #2's direct support staff at her day program stated that her wheelchair safety harness must be secured at all times. However, her right arm and shoulder were outside of the harness at that time of observation. Interview with the Qualified Mental Retardation Professional (QMRP) on June 12, 2008 revealed that the client was known to independently move her arm out from under the harness. Further interview and record review showed no evidence that the QMRP had addressed this issue with the day program. In addition, there was no evidence that the client's alleged habit of removing the safety harness had been addressed by her interdisciplinary team. 2. Cross-refer to W474. On June 9, 2008, at 11:31 AM, Client #2 was presented a lunch plate at the day program that included pureed beef burger with gravy. The burger and gravy was of a thin and watery consistency. Later that day, at 6:38 PM, review of her mealtime protocol, dated October 12, 2007, revealed that she was to receive foods "pureed with added fiber, pudding consistency." This was consistent with her	W 120	W120, continued... 1. Cross reference response to W436.3 • QMRP will consult with the Physical Therapist for re-evaluation of the chest harness. • QMRP will follow-up with the day program to ensure that the services and information are consistent with those provided by the facility. 2. Cross reference response to W474. • QMRP will continue to conduct routine visits to the day program, communicate changes as they occur address problems as they arise.	7.22.08 ongoing 6.20.08 ongoing

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W 120	Continued From page 7 physician's orders, dated June 1, 2008 ("pureed to pudding consistency"). The facility failed to ensure that foods served at the day program were of the texture prescribed by Client #2's physician. 3. Cross-refer to W127. Client #2 was observed coughing during her lunch meal at her day program on June 9, 2008. Her direct support staff indicated that this was not unusual; the client reportedly coughed frequently during meals. Interview with the two day program nurses a short time later revealed that neither was aware that the client often coughed during meals. Even though the two nurses said her coughing should have been brought to their attention, day program direct support staff had failed to notify them. There was no evidence that the client's risk of aspiration had been monitored effectively by day program staff.	W 120	W120, continued • QMRP will coordinate additional staff training as need on the modifiable protocol and adherence to the prescribed diet plan.	
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Surveyor: 17815 The facility failed to implement effective policies and procedures to ensure Client #1's safety [See W149]; failed to ensure that all injuries of unknown source were investigated thoroughly [See W154]; and failed to ensure the safety of clients who were at risk of aspiration [See W127 and W194]. The effects of these systemic practices results in the failure of the facility to protect its clients from harm and to ensure their general safety and well	W 122	W122 This Standard will be met as evidenced by: Reference response to W149 W154, and W127 and W194.	7.25.08 ongoing

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W 122	Continued From page 8 being.	W 122		
W 127	483.420(a)(5) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Surveyor: 17815 Based on observation, interview and record review, the facility failed to ensure the health and safety of one client by making certain that all meals were served in accordance with prescribed dietary orders, for one of the four clients in the sample. (Client #2) The findings include: A mealtime protocol had been developed to address Client #2's assessed risk of aspiration. Observations at the day program and in the home, however, revealed a failure to protect her health and safety. The mealtime protocol failed to provide clear, written instructions to ensure the client's health and safety. In addition, staff did not provide the meals in accordance with the protocol, as follows: 1. Client #2's mealtime protocol, dated October 12, 2007, did not provide clear, written instructions, as follows: a. On June 9, 2008, Client #2 was observed having lunch at her day program. At 11:44 AM, the client held her WonderFlo spout cup with her right hand and was observed guzzling Boost Plus	W 127	W127 This Standard will be met as evidenced by: 1. Client #2's mealtime protocol will be reviewed speech therapist and occupational therapist will be consulted as needed.	6.30.08 ongoing

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W 127	Continued From page 9 nutritional supplement at a very fast pace. The client coughed repeatedly while drinking. At one moment, the staff person told her to "be careful... you have to rest, drink a bit, and then rest." The staff person placed her hand behind Client #2's head, pulled it forward slightly, because the client had tilted her head backwards, hyperextending her neck. Despite the one verbal prompt, the client did not slow her drinking pace and the coughing continued. The staff person turned to this surveyor and stated "when she puts this cup in her mouth, she doesn't want to... release the cup" until it is empty. At 11:54 AM, the client coughed repeatedly while drinking some apple-cranberry juice at a fast pace. When asked if the client coughed often, the two direct support staff who were assisting at lunch replied yes. At 1:35 PM, review of Client #2's mealtime protocol revealed the following: "Staff should assist her with drinking... Place the cup in her right hand allowing her to take sips of beverage between bites and after meal is completed." The protocol did not further elaborate on how staff should assist her. There were no instructions that addressed the hyperextended neck or when she drank fluids at a fast pace. b. Client #2's mealtime protocol included the following: "feed her slowly; monitor for signs of aspiration such as... coughing, choking, watery eyes." The protocol did not, however, instruct staff on how they should respond if she showed signs of aspiration. At approximately 2:00 PM, interview with the two day program nurses revealed that they expected staff to bring the client to the nurse's station if she showed signs of aspiration. The nurses and a	W 127	W127, continued... to document concerns noted during meals and LPN's are required to actively monitor meal time feeding and address concerns as they arise. QMRP will follow up with the day program staff as needed to ensure that additional staff training is completed. QMRP will consult with the Nutritionist, OT and Physical Therapist as needed.	6.30.08 ongoing

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W 127	Continued From page 10 day program case manager were immediately informed of the observed fast drinking pace with coughing. They were also informed that the direct support staff had indicated that coughing was a frequent occurrence. At the time, neither nurse had been told that the client had coughed at lunch. They both indicated that they were previously unaware that she frequently coughed during meals. The case manager stated that they would ask the group home for further clarification on how to address her rapid drinking while hyperextending her neck. 2. Observations at the day program and in the home revealed staff did not feed Client #2 foods that were of the consistency ordered by the primary care physician and included in the mealtime protocol, as follows: a. On June 9, 2008, at 11:31 AM, Client #2 was presented her lunch plate at the day program. She was served, among other food items, pureed beef burger with gravy. The burger and gravy was of a thin and watery consistency. Her mealtime protocol indicated that she was to receive foods "pureed with added fiber, pudding consistency." This was consistent with her physician's orders, dated June 1, 2008 ("pureed to pudding consistency"). It should be noted that the client repeatedly refused attempts by staff to feed her the food. She was presented Boost Plus nutritional supplement instead. At approximately 2:05 PM, two day program nurses were informed that Client #2's food was not of a pudding consistency, as ordered. The nurses and a case manager stated that they would ensure that lunches served in the future would be of the prescribed consistency.	W 127	W127, continued... 2. Reference response to W127.1	

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W 127	Continued From page 11 b. On June 9, 2008, at 6:21 PM, residential staff was observed mixing Client #2's dinner foods (pureed chicken, green beans and mashed potatoes) together into a wide-rimmed beverage glass. After the client ate a few spoonfuls of the food mixture, she refused to continue. The staff stirred Vanilla Boost Plus into the mixture, rendering it the consistency of a thick soup. This too, was not the "pudding" consistency ordered by the primary care physician. In the minutes that followed, Client #2 coughed several times while being fed the mixture (see complete description in the paragraphs that follow). At approximately 6:27 PM, the surveyor brought the client's coughing to the RN's attention, and informed her that the client's food had not been of pudding consistency. 3. Staff in the home did not give Client #2 her liquids in the prescribed WonderFlo spout cup, as follows: On June 9, 2008, at 6:24 PM, a direct support staff person was observed stirring Boost Plus into Client #2's pureed food, instead of using the prescribed WonderFlo spout cup. The staff person was then observed pouring the mixture into Client #2's mouth from a wide-rimmed beverage glass. The client's neck was hyperextended and the client coughed. Without pausing, the staff said "good girl" and kept pouring the mixture into her mouth. The staff emptied the rest of the Boost Plus into the glass, which rendered the mixture to a soupy texture. Once the feeding resumed, Client #2 coughed hard and food came out onto her bib. The staff said "I didn't tell you to spit it out" and continued	W 127	3. Reference response to W127. #1.	

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W 127	Continued From page 12 presenting the dinner at a fast pace. With that cough, at approximately 6:27 PM, this surveyor summoned the nearby RN's attention. The RN, who had not been observing the meal at that time, intervened immediately. She asked the staff about the client's WonderFlo cup. While pointing, the staff said it was in the kitchen. The staff then walked to the kitchen, opened another can of Boost Plus, poured it into the spout cup and returned to the client. The client had finished her dinner and was now drinking the supplement from her spout cup. No additional coughing was observed. While the RN reviewed the mealtime protocol, the surveyor informed her that the food had been presented at a rapid pace, that the client had coughed repeatedly and that the food had not been of pudding consistency. The RN pulled staff aside and reviewed the protocol with them. She then shared the information with the Qualified Mental Retardation Professional, who stated that they would retrain all of their staff. On June 10, 2008, at approximately 5:00 PM (before the dinner meal), the RN and the LPN on duty provided a more indepth in-service training for all of the staff regarding the danger posed to health and safety if/when a client aspirates food or beverage and therefore, the importance of adhering to the clients' mealtime protocols.	W 127		
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.	W 149	W149	

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W 149	Continued From page 13 This STANDARD is not met as evidenced bv: Surveyor: 12301 Based on interview and record review, the facility failed to implement policies that ensured the health and safety of one of the four clients in the sample. (Client #1) The findings include: Client #1 was admitted to the facility on January 31, 2008. Her records indicated an history of falls, including "status post fracture of the right humerus." Interview with Qualified Mental Retardation Professional (QMRP) on June 9, 2008, at 4:10 PM, revealed that the client's previous Behavior Support Plan (BSP) developed by her former provider had incorporated using one-on-one staffing. The QMRP said she had reviewed with her staff the existing BSP at the time of admission. The QMRP further indicated that the client received one-on-one supervision during awake hours (6 AM - 10 PM). This was verified as in accordance with her updated Individual Support Plan (ISP), dated May 23, 2008. During the first several months after Client #1 was admitted to the facility, she had four documented falls, some of which resulted in injuries. The survey revealed that the facility had failed to implement a system to effectively prevent Client #1 from sustaining injuries, as follows: 1. An incident report documented that approximately one week after admission, on February 7, 2008, at 3:30 PM, she fell while boarding a van and sustained bruises to her face. The client's Health Management Care Plan	W 149	W149, continued... This Standard will be met as evidenced by: Reference response to W153 and W154.	7.23.08 ongoing

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W 149	Continued From page 14 (HMCP), dated February 1, 2008, stated that due to her seizure disorder, she had potential for sustaining injuries. The HMCP instructed staff to implement "fall precautions, daily," however, it did not specify or otherwise describe what fall precautions should be implemented. 2. An incident report documented that on February 10, 2008, at 2:15 PM, Client #1 fell while getting up from the sofa after awakening from a nap. She sustained slight swelling above her eyebrow. Staff reportedly saw her as she was getting up but was unable to reach her before she fell. 3. Cross-refer to W252. Another incident report, dated March 3, 2008, at 6:15 PM, documented that Client #1 had a tantrum while having her hair washed. She reportedly fell to the floor and reopened an existing sore on her knee. The incident report failed to indicate how or whether staff intervened in accordance with her BSP. There was no record of the March 3, 2008 behavioral episode in the client's behavior data. The corresponding investigation report, dated March 10, 2008, failed to indicate whether the staff's response to the tantrum behavior had been in accordance with the strategies outlined in the BSP. It should be noted that there was no evidence that the facility determined whether additional safety precautions might be indicated to prevent future incidents. 4. Review of in-service training records revealed that on March 21, 2008, the QMRP provided training to the direct support staff on one-on-one duties and responsibilities. However, on March	W 149	3) Cross reference W252 4) QMRP/Home Manager will review current one on one schedule and provide training as needed.	6.27.08 ongoing

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W 149	Continued From page 15 24, 2008, at 7:55 AM, staff discovered a bruise to Client #1's upper right face, under the eye. The source of the injury was not known. 5. On April 2, 2008, Client #1 fell on her knee after her foot reportedly got caught on a chair while ambulating. The corresponding investigation report, dated April 6, 2008, included a recommendation for PT training. In-service training records, however, indicated that the PT provided training on May 17, 2008, approximately 6 weeks after the April 2, 2008 fall, and after she experienced yet another fall (on May 1, 2008) that resulted in a sprained ankle. 6. An incident report documented that on May 1, 2008, at approximately 8:00 AM, Client #1 was heard making "loud vocalizations" in her bedroom. Staff entered the bedroom and found her seated on the floor, with an abrasion to her right knee, and a swollen right ankle. Evaluation at the emergency room revealed a right ankle sprain. The origin of the client's injuries were unknown. According to her March 2008 BSP and her Individual Support Plan (ISP), she was to receive one-on-one staff supervision during awake hours between 6 AM - 10 PM. When interviewed further, the QMRP acknowledged that the client had been alone at the time of her injuries. 7. On June 9, 2008, review of Client #1's record revealed that she was evaluated by the physical therapist (PT) on February 22, 2008. The assessment report, dated February 29, 2008, indicated that she "would benefit from custom-molded shoes as soon as possible secondary to severely pronated ankles... staff should be trained on proper lifting techniques	W 149	W149, continued... Fall precautions will be added to client #1's HMCP and staff training will be provided as needed. Incident Management Coordinator will continue to track and review all incidents and provide feedback as needed. Incident Manager will provide additional training as needed to include but not limited to; - Incident reporting procedures - Documentation and notifications.	7.23.08 ongoing

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W 149	Continued From page 16 when she flops onto the floor." The PT further wrote that he had discussed his recommendations and clinical plans with the QMRP, House Manager, direct support staff and the relevant interdisciplinary team members on February 29, 2008. However, on June 9, 2008, interview with the QMRP revealed that the PT recommendations had not been achieved timely, as follows: a) Staff in-service training records indicated that the PT trained staff on May 17, 2008, 2 1/2 months after the assessment and almost 4 1/2 months after she was admitted. b) The client remained without the molded shoes. She was scheduled for an appointment on July 10, 2008, 3 1/2 months after the PT assessment. It should be noted that the 719A form for the custom-molded shoes was dated May 19, 2008 more than 2 months after the PT discussed the need for shoes with the QMRP. 8. Cross-refer to W153. Staff who were on duty at the time that Client #1's injuries of unknown origin were discovered on May 1, 2008, at 8:00 AM, failed to implement the facility's incident management policy to ensure timely reporting. The policy states that the QMRP and Director should be notified immediately of all emergencies and it also stated that incident reports should be completed before the end of the shift. However, the QMRP, State agency and the facility's Director of Residential Services were notified more than 24 hours later, on May 2, 2008 (at 8:00 AM, 2:29 PM and 2:50 PM, respectively). In summary, the June 9, 2008 interview with the QMRP revealed that it was known that Client #1	W 149	8. Cross reference W153	

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W 149	Continued From page 17 required close supervision and had a history of injuries due to falls when she was admitted. However, review of incident reports revealed that she had experienced four falls between January 31, 2008 - May 1, 2008. Even though she had one-on-one staff assigned between 6 AM - 10 PM, there were 3 injuries documented since her BSP was updated in March 2008, 2 of which were of unknown origin. In addition, the client remained without her prescribed custom molded shoes at the time of the survey. There was no evidence that the facility implemented measures timely to ensure the client's safety.	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: Surveyor: 17815 Based on interview and record verification, facility staff failed to consistently report injuries of unknown origin to the administrator and outside sources within the required time frame. The finding includes: According to an incident report dated May 1, 2008, the primary care physician instructed the nurse to send Client #1 to an emergency room. The corresponding investigation report indicated that she was seen at the ER at 9:30 AM on the same morning (May 1, 2008). Further review of	W 153	W153 This Standard will be met as evidenced by:	7.14.08 ongoing

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W 153	Continued From page 18 the incident report, however, revealed that the written report was prepared at 2:00 PM on the following day (May 2, 2008). According to the incident report, the Qualified Mental Retardation Professional (QMRP), State agency and the facility's Director of Residential Services were notified more than 24 hours later, on May 2, 2008 (at 8:00 AM, 2:29 PM and 2:50 PM, respectively). The facility's incident management policy states that the QMRP and Director should be notified immediately of all emergencies and it also states that incident reports should be completed before the end of the shift. There was no evidence that staff implemented their policies, as written, to ensure timely notification of this incident.	W 153	W153, continued... Reference response to W149.8	
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: Surveyor: 17815 Based on interview and record review, the facility failed to thoroughly investigate an incident of neglect, for one of the eight clients residing in the facility. (Client #1) The finding includes: Interview with Qualified Mental Retardation Professional (QMRP) on June 9, 2008, beginning at 4:10 PM, revealed that Client #1 was admitted to the facility on January 31, 2008. Both her previous and her current Behavior Support Plans (BSPs) incorporated the use of one-on-one staffing during awake hours, specifically from 6	W 154	W154 This Standard will be met as evidenced by: Reference response to W149.	7.14.08 ongoing

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W 154	Continued From page 19 AM - 10 PM. This was verified as being in accordance with her updated Individual Support Plan (ISP), dated May 23, 2008. On June 9, 2008, an incident report documented that on May 1, 2008, at approximately 8:00 AM, Client #1 was heard making "loud vocalizations" in her bedroom. Staff entered the bedroom and found her seated on the floor, with an abrasion to her right knee, and a swollen right ankle. Evaluation at the emergency room revealed a right ankle sprain. The incident report did not indicate how the client sustained the injuries. Upon further interview, the QMRP acknowledged that Client #1 had been alone at the time of her injuries. Later that afternoon, review of the corresponding investigation report, dated May 5, 2008, revealed that even though Client #1's plan prescribed one-on-one supervision, beginning at 6:00 AM, the investigation report failed to address this issue.	W 154	W154, - QMRP will provide additional staff training on incident reporting procedures, one-on-one duties and responsibilities with emphasizes on monitoring and oversight. - QMRP Home Manager will continue to monitor staff interactions and interventions to further ensure compliance with this standard.	
W 158	483.430 FACILITY STAFFING The facility must ensure that specific facility staffing requirements are met. This CONDITION is not met as evidenced by: Surveyor: 17815 Based on observations, interviews and record review, the facility failed to ensure clients' health and safety [Cross-refer to W127 and W149]; the facility's Qualified Mental Retardation Professional (QMRP) failed to effectively coordinate services to meet the needs of its clients [Cross-refer to W159]; and the facility failed to ensure that each employee	W 158	W158 Reference response to W127 and W149 and W159.	7.23.08 ongoing

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W 158	Continued From page 20 demonstrated competency in implementation of clients' mealtime protocols [Cross-refer to W194]. The effects of these systemic practices results in the failure of the facility to ensure the availability of adequately trained staff, to ensure client health, safety and well being.	W 158		
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: Surveyor: 17815 Based on observation, staff interview and record verification, the Qualified Mental Retardation Professional (QMRP) failed to coordinate and monitor services for four of the eight clients residing in the facility. (Clients #1, #2, #4 and #5) The findings include: 1. Cross-refer to W194. The QMRP failed to ensure that residential and day program staff were trained to effectively and competently implement Clients #2, #3 and #5s' diet orders. 2. Cross-refer to W240. The QMRP failed to ensure that Client #4's mealtime protocol, dated April 13, 2008, provided staff with clear instructions on how to assist her while eating with a spoon. 3. Cross-refer to W120. The QMRP failed to ensure that day program staff fed Client #2 foods that were pureed to a pudding consistency, in	W 159	W159 This Standard will be met as evidenced by: 1. Cross reference response to W194. 2. Cross reference response to W240 3. Cross reference response to W120	7.24.08 organy

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W 159	Continued From page 21 accordance with her mealtime protocol. In addition, the QMRP failed to ensure that day program staff monitored her for signs of aspiration and kept the client's wheelchair safety harness properly secured at all times. 4. Cross-refer to W194.2. Although nectar-thickened liquids was reflected on Client #5's mealtime protocol, MARs, and her Nutrition and Speech/ Language Assessments, it was noted that her Health Management Care Plan, dated February 12, 2008 and her physician's orders for June 2008 did not reflect the order. There was no evidence that the QMRP had sought to clarify the order prior to the survey. 5. Cross-refer to W149. The QMRP failed to ensure timely supports and services necessary to ensure Client #1's safety. Review of incident reports revealed that she had experienced numerous falls between her date of admission (January 31, 2008) and May 1, 2008. Even though she had a one-on-one staff assigned between 6 AM - 10 PM, there were 3 injuries documented since her Behavior Support Plan was updated in March 2008. Other injuries had occurred in February. In addition, the client remained without her prescribed orthopedic shoes more than 3 months after the PT's February 29, 2008 recommendation. 6. The QMRP failed to establish an effective communication system between the home and Client #4's day program, as follows: On June 9, 2008, at approximately 12:00 PM, direct support staff at Client #4's day program reported that the client had been without a transfer sling in her wheelchair for the past two or	W 159	4) Cross reference response to W194.2 5) Cross reference response to W149. 6. Reference response to W120. • Home Manager/QMRP will implement an effective monitoring process to ensure that client #4 is provided a transfer sling at all times.	7.23.08 ongoing

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W 159	Continued From page 22 three weeks. Observations revealed that there was no sling on the wheelchair at that moment. Staff further indicated that the client was heavy and that the sling was needed for safe transfers from her wheelchair. The QMRP and home manager were interviewed in the home on June 12, 2008, at 10:55 AM. They indicated that this had been an ongoing issue between the day program and the home; however, the QMRP said she thought that the issue had been resolved. Further interview revealed that she was previously unaware that Client #4 did not have the transfer sling on her wheelchair in recent weeks. She stated that it was the morning shift leader's responsibility to ensure that the sling was in the wheelchair prior to departure; however, upon further discussion, she acknowledged that there was no checklist or other system established by which she could verify that the sling was being used daily.	W 159	W159, continued.. Additional staff training will be provided as needed to ensure the established guidelines are implemented.	
W 194	483.430(e)(4) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible. This STANDARD is not met as evidenced by: Surveyor: 17815 Based on observation, interview and record verification, staff failed to demonstrate competency in implementing clients' feeding protocols, for three of the eight clients residing in the facility. (Clients #2, #3 and #5) The findings include: 1. The facility failed to ensure staff displayed	W 194	W194 This Standard will be met as evidenced by:	

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W 194	Continued From page 23 competency in implementing Client #2's diet order, as follows: a. On June 9, 2008, Client #2 was observed eating lunch at her day program, beginning at 11:31 AM. Her meal included pureed beef burger with gravy that was of a thin and watery texture. At 1:34 PM, review of her mealtime protocol, dated October 12, 2007, revealed that her foods should be pureed to a "pudding consistency." This was consistent with her physician's orders, dated June 1, 2008. Signatures on the back of the mealtime protocol indicated that day program staff had received training 6 months earlier, on November 29, 2007. b. On June 9, 2008, at 6:21 PM, Client #2 was presented her dinner. Residential staff was observed mixing her dinner foods (pureed chicken, green beans and mashed potatoes) together into one wide-rimmed beverage glass. After the client declined spoonfuls of the food mixture, the staff stirred some Vanilla Boost Plus into the mixture, rendering it the consistency of a thick soup. As previously noted, her food was to be pureed to a pudding consistency. Because Client #2 was observed to cough during the end of her dinner, the RN was informed by this surveyor that her food had been presented at a rapid pace, she had coughed repeatedly and that her food had not been of pudding consistency. The RN pulled staff aside and reviewed the protocol with them. She then shared the information with the Qualified Mental Retardation Professional, who stated that they would retrain all of their staff. On June 10, 2008, at approximately 5:00 PM	W 194	W194, continued... a. Additional staff training will be provided to ensure adherence to the meal protocol. b. Reference response to W120.1 and 2 ■ Additional staff training will be provided for the nursing and ATS staff on adherence to mealtime protocol & food consistencies ■ QMRP/Home Manager will continue to conduct routine meal monitoring observations, provide feedback and instruction as needed to ensure ongoing compliance w/ this standard.	7.24.08 ongoing

JUL-16-2008 18:45 FROM: TO:2024429430 P.27

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W 194	Continued From page 24 (before the dinner meal), the RN and the LPN on duty provided a more indepth in-service training for all of the staff regarding the danger posed to health and safety if/when a client aspirates food or beverage and therefore, the importance of adhering to the clients' mealtime protocols. On June 11, 2008, staff in-service training records were reviewed, beginning at 10:00 AM. The most recent training on clients' mealtime protocols, prior to this survey, had been documented on March 21, 2008. Even though there had been some training provided, the observations and staff interviews indicated that the March 21, 2008 training had been ineffective. 2. The facility failed to ensure that nursing staff displayed competency in implementing Client #5's diet order, as follows: The morning medication pass was observed on June 10, 2008. At approximately 7:54 AM, the medication nurse placed a cup of unthickened water up to Client #5 and she drank. The client had a pronounced tongue thrust. At 9:40 AM, review of her Medication Administration Record (MAR) for June 2008 revealed she was to receive all fluids thickened to a nectar consistency. On June 12, 2008, further review of her record revealed a Speech/ Language Assessment, dated March 12, 2008, and a Nutrition Assessment, dated February 8, 2008, both of which indicated that she was to receive "pureed food and nectar-thick liquids" because she "cannot tolerate thin liquids or foods of liquid consistency" due to her tongue thrust. 3. Cross-refer to W322.4. There was no evidence that nursing staff had received training on proper implementation of Client #3's G-tube	W 194	W194, continued... 2. Cross reference response to W111. • RN will continue to conduct routine observations during mealtimes and medication administration to further ensure ongoing compliance with this standard. Nursing staff will be required to attend the next scheduled Nutrition Training.	6.18.08 ongoing

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W 194	Continued From page 25 feeding orders. On two occasions, different nurses were observed giving the client less water than was prescribed by the PCP and nutritionist.	W 194		
W 240	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Surveyor: 17815 Based on observation, interviews and record review, the facility failed to ensure that mealtime protocols provided clear, written instructions to staff for the training of clients, for one of the four clients in the sample. (Clients #4) The finding includes: Client #4's mealtime protocol, dated April 13, 2008 did not define or describe with sufficient detail how staff were to use the prescribed unbreakable spoon, as follows: On June 9, 2008, a day program staff person was observed spoon feeding Client #4 her lunch. Later that day, at 6:10 PM, the Qualified Mental Retardation Professional (QMRP) was observed assisting the client with dinner. The QMRP placed the spoon in the client's hand and asked her to hold it. The client held the spoon lightly and the QMRP proceeded with providing hand over hand assistance through most of the meal. When interviewed on June 12, 2008, at 11:25 AM, the QMRP confirmed that Client #4 should receive hand over hand assistance during meals. She acknowledged that this was not indicated on the mealtime protocol. When discussing the day	W 240	W 240 This Standard will be met as evidenced by: • Reference response to W120. • QMRP will ensure that the meal time protocols are updated to reflect specific information on the level of supports/ assistance needed during meal times. • QMRP will provide a copy of the information to the day program staff and conduct training as needed.	7.22.08 ongoing

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W 240	Continued From page 26 program observations, the QMRP stated that day program staff should have known to encourage Client #4 to participate with hand over hand support because it had been a training objective in the past. She further indicated that she had not observed the client at day program during lunchtime.	W 240	W 240, continued...	
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: Surveyor: 17815 Based on observation, interview and record review, the facility failed to ensure that each client received continuous active treatment services, including needed interventions, for one of the four clients in the sample. (Client #1) The findings include: Client #1 was admitted on January 31, 2008 with a Behavior Support Plan (BSP) that was developed by her former provider. It included one-on-one supervision. Her new BSP, dated March 2008 also incorporated one-on-one staffing, between 6 AM and 10 PM. The BSP listed the following targeted behaviors: physical aggression, self-injury (including "deliberately throwing herself to the floor"); tantrums, attempts	W 249	W249 This Standard will be met as evidenced by:	

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W 249	Continued From page 27 to abscond, securing food in excess of her nutritional recommendations and non-compliance. The BSP said staff should record all incidents of targeted behaviors. There was no evidence that staff implemented Client #1's Behavior Support Plan (BSP), as follows: 1. The psychologist wrote the following in Client #1's annual psychological assessment, dated May 22, 2008: "...Data for February is not available. Further, data for March and April is also missing..." 2. An incident report, dated March 3, 2008, at 6:15 PM, documented that Client #1 had a tantrum while having her hair washed . She fell to the floor and reopened an existing sore on her knee. The incident report failed to indicate how or whether staff intervened in accordance with the plan, at the time of the tantrum. There was no behavioral data available to verify proper implementation of the BSP. The corresponding investigation report, dated May 5, 2008, failed to indicate whether the staff's response to the tantrum behavior had been in accordance with strategies outlined in the BSP.	W 249	W249. continued... Reference response to W154, and W149.	7.23.08 ongoing
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: Surveyor: 17815 Based on interview and record review, the facility failed to document behavior data in accordance	W 252	W252 This standard will be met as evidenced by:	

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W 252	Continued From page 28 with the Behavior Support Plan (BSP) for one sampled client (out of four) with a BSP (Client #1). The finding includes: Client #1 was admitted to the facility on January 31, 2008. Interview with Qualified Mental Retardation Professional (QMRP) on June 9, 2008 revealed that the client's previous BSP developed by her former provider had incorporated using one-on-one staffing. The behavior specialist observed the client on February 4, 2008 and issued a new BSP, dated March 2008. The BSP listed the following targeted behaviors: physical aggression, self-injury (including "deliberately throwing herself to the floor"); tantrums, attempts to abscond, securing food in excess of her nutritional recommendations and non-compliance. The BSP said staff should record all incidents of targeted behaviors. This, however, was not performed, according to the psychologist. Review of Client #1's annual psychological assessment, dated May 22, 2008 revealed the following: "...Data for February is not available. Further, data for March and April is also missing..." However, an incident report, dated March 3, 2008, at 6:15 PM documented that Client #1 had a tantrum while having her hair washed. She fell to the floor and reopened an existing sore on her knee. The incident report failed to indicate how or whether staff had intervened appropriately at the time of the tantrum. The client's behavior data did not reflect the March 3, 2008 incident. When the QMRP was interviewed on June 11,	W 252	W252, continued. . . Client #1's behavior support documentation has been filed. QMRP will continue to monitor documentation and implementation of the behavior support plan and address issues as they arise.	6.13.08 ongoing

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W 252	Continued From page 29 2008, at approximately 12:35 PM, she stated that the data had been in the facility; however, the behavior specialist had not requested it. Additional information was not provided before the survey ended.	W 252		
W 318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Surveyor: 17815 Based on observation, interviews, and record review, the facility failed to ensure that staff in the home and at day program demonstrated competency in implementing clients' mealtime protocols [Cross-refer to W127 and W194]; failed to provide preventive and general health care services to meet the needs of the clients [Cross-refer to W322]; failed to establish systems to ensure that nursing services were provided in accordance with clients' health and safety needs [Cross-refer to W331]; and, failed to ensure timely medical follow-up and referrals to ensure health services were provided to meet the needs of the clients [Cross-refer to W338]. The results of these systemic practices results in the demonstrated failure of the facility to provide health care services.	W 318	W318 This Standard will be met as evidenced by: Cross-refer to W127 and W194 and W322, W331, W338	7.23.08 ongoing
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care.	W 322	W322	

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W 322	Continued From page 30 This STANDARD is not met as evidenced by: Surveyor: 17815 Based on observation, staff interview and record review, the facility failed to provide preventive and general medical care for three of the four clients in the sample. (Clients #2, #3 and #4) The findings include: 1. Incident reports indicated that Client #4 had ongoing seizure activity, some of which led to referrals to hospital emergency rooms for further observation and assessment. For example, the client was taken to a hospital ER on January 14, 2008 after experiencing 3 back-to-back seizures that evening. The client's medical records were reviewed, beginning on June 11, 2008 at 5:08 PM. She was prescribed the following anticonvulsant medications; Tegretol, Keppra and Depakote; the Depakote was added to her regimen on August 8, 2007. The following deficient practices were identified: a. Cross-refer to W338.4. The facility failed to refer Client #4 for serum anticonvulsant testing timely and in accordance with physician's orders (POs). For example, on January 24, 2008 the neurologist increased her daily dosage of Depakote and requested updated anticonvulsant levels. Also on January 24, 2008, the primary care physician (PCP) concurred and ordered labs for anticonvulsants. Her Tegretol and Depakote levels were not tested until 6 weeks later (March 11, 2008). Results of labs performed on March 11, 2008 and March 26, 2008 revealed continued sub-therapeutic Depakote levels. On March 27, 2008, the neurologist requested updated labs. Client #4's serum Depakote was tested on May 19, 2008, more than 7 weeks after the order.	W 322	W322, continued... This standard will be met as evidenced by a. Cross-refer W338.4	7.18.08 ongoing

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W 322	Continued From page 31 [Note: The neurologist and PCP also ordered liver function tests on January 24, 2008. This was not performed, however, until 4 months later, on May 19, 2008.] b. The facility did not ensure that Client #4 was seen by the neurologist at the recommended frequency. On January 24, 2008, the neurologist prescribed an increase in her Depakote. She was to have labs drawn and return to the clinic on March 4, 2008. The labs were not scheduled timely and she did not return for the March 4, 2008 appointment. She did return on March 27, 2008, at which time the neurologist noted that her labs reflected continued sub-therapeutic Depakote levels. The neurologist increased her daily Depakote dosage again. [Note: Her seizure records indicated 8 seizures in January 2008, 5 seizures in February 2008 and 3 more seizures in March 2008.] c. Cross-refer to 111.3. The facility failed to ensure Client #4's records included the results of all recent neurological test results. d. The facility failed to implement an effective tracking system to summarize the extent of Client #4's seizure activity, as follows: At 5:08 PM, review of a Seizure Summary Chart indicated that Client #4 had experienced 2 seizures in October 2007 and 1 seizure in November 2007. However, review of individual Seizure Observation Report forms revealed that she had experienced 3 seizures each month. In addition, the neurologist wrote the following on an October 30, 2007 consultation form: "... is doing well, no seizures..." There was no evidence that the PCP and neurologist were provided data that	W 322	W 322, continued.. c. Cross-refer to 111.3 d. Nurses are responsible for reviewing and summarizing the information. All discrepencies will be addressed. RN will continue to conduct routine file audits to ensure ongoing compliance with this standard.	7.18.08 ongoing

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W 322	Continued From page 32 accurately reflected the number of seizures occurring. 2. The facility also failed to refer Client #2 for serum anticonvulsant testing timely and in accordance with physician's orders (POs). Her POs reflected ongoing lab orders to obtain serum Tegretol levels every 3 months. On June 11, 2008, beginning at 11:02 AM, review of lab reports revealed a 6-month gap in testing, between August 16, 2007 and February 14, 2008. Her seizure records indicated she was taken to an emergency room on September 30, 2007 after a seizure. She experienced another seizure in November 2007 as well. 3. Even though Client #2 was at risk of aspiration during meals, there was no evidence that the medical team had effectively monitored the implementation of her mealtime protocol, to ensure her health and safety. Cross-refer to W127, W331.1. Client #2's mealtime protocol, dated October 12, 2007, and her ongoing POs, prescribed foods pureed to a pudding consistency. Staff also were instructed to "monitor for signs" of aspiration. During the survey, staff at the day program and in the home were observed feeding her foods that were not of a pudding consistency. Client #2 was observed coughing during her meals at the day program and at home. Staff in both locations reported that it was not unusual for her to cough. Nursing staff, however, in both locations stated they were unaware of her coughing. Review of the mealtime protocol revealed no clear instructions for staff to follow if/when they observed her coughing.	W 322	3. Cross-refer W127, W331.1 • Reference response to W120. • Nurse and QMRP to conduct routine visits to day program to conduct monitoring of meals. • Additional staff training will be provided at both the residential and day program sites to include but not limited to;	

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W 322	Continued From page 33 administered a half can of Isosource. Throughout the process, including flushes before and after each supplement and food source, the nurse used a total of 250 ml of water. He stated that the 250 ml was a minimum, and that the client was not on a fluid restriction. On June 10, 2008, beginning at 12:36 PM, Client #3's physician's orders (POs) were reviewed to verify the medication pass and tube-feeding process. The June 2008 POs reflected three separate and distinct feeding orders, as follows: "Free water flushes with 250 ml 4 times daily after each feeding..." "Flush tube with 15 ml water before and after each medication and 5 ml water between each medication every shift." "2 scoops Beneprotein three times daily via G-tube..." Both nurses had begun the process by securing 250 ml, which they administered at various times throughout the feeding process. Both nurses failed to implement the second order (flushing with 15 ml between each medication). The afternoon nurse failed to administer 250 ml after the feeding and the morning nurse had used a portion of the 250 ml for dissolving the protein powder. The facility's RN was interviewed on June 10, 2008, beginning at approximately 12:55 PM. She stated that Client #3's POs had been written to reflect the what the nutritionist had recommended. The RN stated that she would seek clarification of the orders with the nutritionist. The nutritionist was in the facility the next day. At 9:53 AM, the RN said that she had just spoken	W 322	322, continued... adherence to G-tube/ medication feeding. RN will provide additional training on G-tube medication and feeding procedures in accordance to physician orders. RN will conduct routine observations of g-tube feeding to ensure ongoing compliance with this standard.	7.18.08 ongoing

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W 322	Continued From page 34 Both nurses had begun the process by securing 250 ml, which they administered at various times throughout the feeding process. Both nurses failed to implement the second order (flushing with 15 ml between each medication). The afternoon nurse failed to administer 250 ml after the feeding and the morning nurse had used a portion of the 250 ml for dissolving the protein powder. The facility's RN was interviewed on June 10, 2008, beginning at approximately 12:55 PM. She stated that Client #3's POs had been written to reflect the what the nutritionist had recommended. The RN stated that she would seek clarification of the orders with the nutritionist. The nutritionist was in the facility the next day. At 9:53 AM, the RN said that she had just spoken with the nutritionist, who confirmed that they were indeed separate orders. Her expectation was that the client would receive a full 250 ml of free water at the very end of the food administration process. The 5-15 ml flushes in-between each supplement and/or medication was in addition to the 250 ml after the meal. There was no evidence that the primary care physician and/or the supervisory nurses had monitored the G-tube feeding process to ensure accurate implementation of her POs, prior to the survey.	W 322		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by:	W 331	W 331 This Standard will be met as evidenced by:	

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W 331	Continued From page 35 Surveyor: 17815 Based on interview and record review, the facility failed to ensure nursing services in accordance with the needs of four of the eight clients residing in the facility. (Clients #1, #2, #4 and #5) The findings include: 1. Facility nurses failed to develop and implement a system for monitoring of Client #2's coughing and other potential signs of aspiration, as follows: a. Cross-refer to W127. Client #2 was observed coughing during her lunch meal at her day program on June 9, 2008. Her direct support staff indicated that this was not unusual; the client reportedly coughed frequently during meals. Interview with the two day program nurses a short time later revealed that neither was aware that the client often coughed during meals. Even though the two nurses said her coughing should have been brought to their attention, day program direct support staff had failed to notify them. b. While being fed dinner that evening, Client #2 was again observed coughing. The staff person continued presenting her with additional food as she coughed and did not alert a nurse to the situation. A surveyor alerted the RN, who was present in the facility at the time but not observing the meal directly; the RN intervened immediately. c. When asked the next day, at 3:14 PM, a direct support staff person who sometimes fed Client #2 her meals indicated that the client coughed frequently. According to the client's mealtime protocol, staff were to monitor for signs of aspiration, including coughing. The protocol did	W 331	W331 - mealtime protocols - signs symptoms of aspiration - medication administration - Monitoring tracking lab reports a. Cross reference response to W127. b. Cross reference response to c. It is desirable for the client to cough during meals to clear the air way. Only if the individual shows signs of distress such as respiratory, shortness	7.23.08 ongoing

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W 331	Continued From page 36 not, however, instruct staff on how to respond if/when they observed coughing or other signs. The client's Health Management Care Plan (HMCP), dated May 6, 2008, directed staff to adhere to the feeding protocol and to monitor for signs of aspiration. The HMCP did not, however, elaborate on how staff should respond to coughing. d. On June 10, 2008, at 2:53 PM, interview with the facility's RN revealed that staff were expected to alert the nurse on duty (24/7) if Client #2 or any of her peers were coughing during a meal. Staff had not, however, informed the nurse the previous evening. She further indicated that she was unaware of any coughing during Client #2's meals in recent months at home or at the day program. Further review of the client's record and follow-up interviews with the RN and Qualified Mental Retardation Professional revealed no evidence of a verifiable monitoring and reporting system to ensure the client ' s health and safety. 2. The facility's nursing staff failed to ensure Client #2 received dental care/ oral hygiene after every meal and before bedtime in accordance with the dentist's orders, as follows: On June 10, 2008, at 2:11 PM, review of Client #2's dental records revealed that on February 13, 2008, the dentist increased the frequency of daily oral care to "brush teeth after meals and before bedtime." Her Health Management Care Plan (HMCP), updated May 6, 2008, indicated staff should "assist with oral hygiene PRN." Review of staff documentation revealed that she typically had her teeth brushed before and after breakfast and then again at approximately 8:00 PM, as she prepared for bed. At approximately 2:22 PM,	W 331	W331, continued... of breath, etc... staff are instructed to notify/alert the nurse on duty who will provide the necessary interventions. (2) Nursing staff/QMRP/ Home Manager will monitor dental care to ensure that dental hygiene is provided in accordance to the recommendations. HMCP will be updated to include the recommendations and staff training will be provided as needed.	6-30-08 ongoing

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W 331	Continued From page 37 interview with the QMRP revealed that Client #2 did not receive oral care after lunch while at the day program. The afternoon LPN stated that day programs would not normally provide tooth brushing unless there were a "special order." The QMRP and RN stated that they follow the dentist's recommendations. At 2:24 PM, a direct support staff person assigned to the evening shift confirmed that the client's teeth were brushed before and after breakfast and at approximately 8:00 PM. There was no evidence that nursing staff ensured that Client #2's teeth were brushed daily at the frequency recommended by the dentist. 3. Cross-refer to W322.4. Facility nurses failed to seek clarification of Client #3's G-tube feeding orders. Afternoon and morning medication nurses were observed administering less water than was ordered by the PCP and nutritionist, to ensure adequate hydration.	W 331	3. Cross-refer W322.4	
W 338	483.460(c)(3)(v) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must result in any necessary action (including referral to a physician to address client health problems). This STANDARD is not met as evidenced by: Surveyor: 17815 Based on record review and interview, facility nurses failed to refer clients to medical specialists and clinics timely, for two of the four clients in the sample. (Clients #2 and #4) The findings include:	W 338	W338 This Standard will be met as evidenced by:	

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W 338	Continued From page 38 1. Facility nurses failed to refer Client #2 for urinalysis testing in accordance with orders, as follows: a. On June 10, 2008, at 2:52 PM, review of Client #2's Health Management Care Plan (HMCP), dated September 25, 2007 (updated periodically, through May 6, 2008), revealed she had recurrent urinary tract infections (UTIs). The HMCP indicated that when she developed a UTI, she was to have urinalysis testing shortly after treatment with antibiotics, to ensure that the treatment was effective. Review of Client #2's medical chart revealed that she had been treated with Cipro for a UTI, beginning on October 12, 2007. Review of her lab reports failed to show evidence of a follow-up urinalysis during the weeks that followed her antibiotic treatment. When interviewed on June 11, 2008, at approximately 12:10 PM, the RN confirmed that, as standard practice, the client should have had additional urinalysis approximately 2 - 3 weeks after the antibiotic treatment was completed. The RN reviewed the lab records and acknowledged that the next documented urinalysis was performed on May 30, 2008, 7 months after the previous urinalysis. b. Client #2's ongoing physician's orders (POs) included having routine urinalysis tests performed every 6 months. Urinalysis testing on October 10, 2007 indicated an infection, for which she received antibiotic treatment. Another lab report, dated February 14, 2008, indicated that the"test was cancelled - patient unable to void." However, the next documented attempt to obtain a urine sample was on May 30, 3008, 3 ½ months after the failed attempt in February, and 7 months after her last successful urinalysis.	W 338	W338, continued... a. RN will provide additional training on follow-up recommendations/interventions, adherence to lab schedules RN will conduct routine file reviews to further ensure compliance with this standard. b. RN will review expectations with the nurses and provide additional follow-up as needed, to ensure ongoing compliance w/ this standard.	7.18.08

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W 338	Continued From page 39 2. Facility nurses failed to refer Client #2 for serum anticonvulsant testing timely and in accordance with orders, as follows: On June 9, 2008, at 5:37 PM, Client #2 received 20 ml of Tegretol oral solution (400 mg equivalent). The medication nurse stated that the medication was prescribed to control seizures. The next morning, review of her POs confirmed that she had seizure disorder. The POs reflected ongoing lab orders to obtain serum Tegretol levels every 3 months. On June 11, 2008, beginning at 11:02 AM, review of her lab reports revealed a 6-month gap in testing her serum Tegretol levels, between August 16, 2007 and February 14, 2008. 3. Facility nurses failed to send Client #2 to the emergency room (ER) after experiencing 3 seizures within the same day, in accordance with their established seizure protocol, as follows: On June 10, 2008, Client #2's seizure and neurology records were reviewed, beginning at 3:34 PM. She was seen by the neurologist on May 1, 2008. The corresponding consultation report form indicated that she had experienced three seizures on April 14, 2008. On June 11, 2008, at 2:30 PM, a nursing progress notes dated April 14, 2008 reflected: "3 back to back seizures of 30 seconds each ... lab Tegretol was 6.00 WNL ... notified <primary care physician> and the Director of Nursing made aware. " The April 14, 2008 Seizure Activity Checklist also reflected 3 seizures on that day. At 2:37 PM, review of the agency's Protocol for Seizure Disorder revealed that if a client experienced a"third seizure in 24 hours, send client to the emergency room." The	W 338	W338, continued... 2. RN will provide additional training as needed, on adherence to the lab schedule. Appropriate disciplinary action will be applied for nurses who fail to adhere to the guidelines set forth. 3. RN will review and revise current protocol as needed. Seizures observed by client #2 did not present any sings of distress and her vitals were w/in normal limits.	

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W 338	Continued From page 40 client's records did not, however, reflect a visit to the ER on April 14 or 15, 2008. At 2:50 PM, the RN confirmed the seizure protocol was current and that clients should be taken to an ER if they experience a third seizure in one day. After examining the seizure record, the RN acknowledged that Client #2 had not been taken to the ER in accordance with the protocol.	W 338	W338	
	4. Facility nurses failed to refer Client #4 for serum anticonvulsant testing timely and in accordance with orders, as follows:		4.	
	Cross-refer to W111.3. According to Client #4's records, on January 24, 2008, the neurologist and her PCP ordered "Get all anticonvulsant levels and LFT test."		Cross reference W111.3.	
	a. Lab records indicated that Client #4's serum anticonvulsant levels were tested on March 11, 2008, more than 6 weeks after they were ordered.		a. Cross reference W338 and W322.	7.18.08 ongoing
	b. Even though the January 24, 2008 lab orders said to test "all anticonvulsants," her serum levels of Keppra (one of the three anticonvulsants prescribed) were not tested. [Note: Interviews with nurses suggested that Keppra levels were not needed.]		b. Cross-reference response to	
	c. According to lab reports, Client #4 had serum liver function tests performed on May 19, 2008, which was almost 4 months after the January 24, 2008 orders.		c. Cross-reference response to W322	
	It should be noted that when Client #4 returned to the neurologist on March 27, 2008, the neurologist documented"Depakote level is low 29.1 ... please do Valproic Acid level and LFT." The neurologist repeated the previous order for			

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W 338	Continued From page 41 liver function testing. This was, as noted above, achieved on May 19, 2008, or approximately 5 weeks after the second appointment. 5. Facility nurses failed to refer Client #4 for urinalysis testing in accordance with orders, as follows: On June 12, 2008, at 10:20 AM, review of Client #4's medical chart revealed that on January 7, 2008, a urinalysis test had indicated bacterial infection. She was then prescribed Augmentin 500 mg twice daily for 10 days. Review of her lab reports failed to show evidence (to date) of a follow-up urinalysis in the 6 months that followed. At 11:47 AM, review of Client #4's HMCP, dated January 9, 2008 and incorporated in her January 11, 2008 ISP, revealed that she had recurrent urinary tract infections (UTIs). The HMCP indicated that after receiving treatment with antibiotics, she was to have follow-up urinalysis testing to ensure the treatment was effective. There was no evidence that facility nurses scheduled follow-up urinalysis in accordance with her HMCP.	W 338		
W 340	483.460(c)(5)(i) NURSING SERVICES Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Surveyor: 12301 Based on interview and record review, the facility's nursing staff failed to document that all	W 340	W 340 This Standard will be met as evidenced by:	7.19.08 ongoing

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W 340	Continued From page 42 staff had received training in preventive health measures (i.e. infection control/ herpes management), for one of the four clients in the sample. (Client #3) The finding includes: The review of unusual incidents on June 9, 2008 revealed that Client #3 received treatment for herpes infection at a hospital on December 20, 2007. Interview with the home manager indicated that she provided infection control/ herpes training to staff at the time of discharge. On June 10, 2008, at 3:00 PM, further interview revealed that there was no documentation available for review to verify the training.	W 340	W340, continued... • QMRP/Nurse will coordinate and conduct additional training on infection control/ herpes. • Home Manager has been instructed to file all trainings immediately upon completion	7.18.08 ongoing
436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Surveyor: 12301 Based on observation, interview and record review, the facility failed to ensure devices and aids identified by the interdisciplinary team (IDT) as needed by the client were maintained in good repair and ensured that clients received appropriate training, for four of the eight clients residing in the facility. (Clients #1, #2, #3 and #5) The findings include:	W 436	W436 This Standard will be met as evidenced by:	

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W 436	Continued From page 43 1. The facility failed to ensure that Client #1 had custom-molded shoes as prescribed by her interdisciplinary team, as follows: Review of unusual incident reports revealed that Client # 1 had sustained several falls between her date of admission (January 31, 2008) and May 1, 2008. On June 9, 2008, the client was observed ambulating with an unsteady gait at her day program and in the home. On June 10, 2008, review of her physical therapy evaluation, dated February 29, 2008, revealed a recommendation for custom-molded shoes due to "severely pronated ankles." On June 12, 2008, interview with the Qualified Mental Retardation Professional (QMRP) revealed that the team had agreed and an appointment for an evaluation (i.e. measurements, etc.) for custom-molded shoes was scheduled for July 10, 2008. The QMRP presented a 719A form for the shoes, dated May 19, 2008. To date, the client remained without custom-molded shoes. 2. The facility failed to ensure that Client #2 was offered liquids in a Wonderflo spout cup, as follows: Cross-refer to W127.3. On June 9, 2008, a direct support staff person was observed feeding Client #2 Boost Plus nutritional supplement (liquid) mixed with pureed foods at dinner. The mixture was thinner than the prescribed pudding consistency. She fed her the soupy mixture from a regular beverage glass, pouring it into her mouth from above, instead of using the Wonderflo spout cup as prescribed. When the RN intervened (after a surveyor alerted her to the client's coughing), the staff person said the Wonderflo cup was in the kitchen. Interviews with	W 436	436, continued... 1. Client #1 will be scheduled for further evaluation of molded shoes. QMRP will provide follow-up as needed to be sure adaptive equipment needs for Client #1 are met. 2. Reference response to W127.3.	7.10.08 ongoing 6.30.08 ongoing

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W 436	Continued From page 44 other direct support staff the next day indicated that mixing Client #2's food with liquid supplement and feeding her in that manner had been a routine occurrence. 3. The facility failed to ensure that Client #2 received training and appropriate staff support in the use of a safety harness, as follows: On June 9, 2008, beginning at approximately 11:01 AM, Client #2 was observed at her day program. Her right arm and shoulder were positioned outside of the safety harness on her wheelchair. When asked about the harness, a direct support staff surmised that she had repositioned her arm because it was hot outdoors. [Note: At the time, the air indoors felt comfortable to this surveyor.] Further interview with the day program staff revealed that her safety harness should be secured at all times "for protection," to prevent her from leaning too far forward. On June 12, 2008, at 10:43 AM, the QMRP, RN and home manager all concurred that Client #2's safety harness should be secured at all times. They further indicated that the client was known to independently move her arm out from under the harness. The QMRP stated that she had reviewed this topic with residential staff at a recent (March 31, 2008) training. There was no evidence, however, that the facility had verified whether the harness was kept properly secured while the client was at day program. In addition, there was no evidence that the client's alleged habit of removing the safety harness had been addressed by her interdisciplinary team, to include a training program if indicated. 4. The facility failed to ensure that Client #3 had an air mattress as prescribed by her	W 436	W436, continued... 3. Reference response to W111. QMRP will consult with the Physical Therapist for further evaluation and recommendation regarding Client #2's safety harness. QMRP will provide additional training as needed. 4. Air mattress will be ordered as prescribed for client #3.	

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W 436	Continued From page 45 interdisciplinary team, as follows: Interview with the group home manager on June 11, 2008, at 3:10 PM, revealed a new air mattress had been requisitioned for Client #3 after her previous one was discarded (due to a foul odor). At that time, there was no air mattress on the client's bed. Review of Client #3's ISP, dated June 15, 2007, revealed a recommendation that she have an air mattress "to assist in the prevention of skin breakdown." The ISP maintenance schedule indicated the mattress should be monitored daily and that it should be replaced as needed. On June 12, 2008, at 4:15 PM, the home manager presented a 719A form that was dated May 20, 2008, 3 weeks earlier. The home manager stated that the form had not yet been submitted as they were awaiting the primary care physician's signature. 5. The facility failed to ensure that Client #5's wheelchair was maintained in good repair, as follows: Observation of Client #5 seated in her wheelchair on June 9, 2008, at 5:38 PM, revealed the treads on the left front and rear wheels were very worn. The vinyl on the the edges of the foot box was torn and the vinyl covering on the front end of the right armrest was missing. Further observation at 6:51 PM revealed a large hole (2 to 3 inches in diameter) in the center of the molded seat from which the foam was exposed. Staff interview indicated that the seat of the client's chair was repaired approximately nine months before the survey and that the client had damaged her own wheelchair again. At the time of the survey, there was no evidence measures had been implemented to ensure that Client #5's wheelchair	W 436	W436. 5) QMRP/Home Manager will follow-up to secure all necessary repairs. QMRP/Home Manager will provide additional in-service training on monitoring, reporting and documenting the status of client #5's wheelchair. Direct Care staff are required to check/inspect chairs on a daily basis and clean nightly.	7.22.08 ongoing

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W 436	Continued From page 46 was maintained in good repair.	W 436	W436. continued...	
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: Surveyor: 17815 Based on observation, staff interviews and record review, the facility failed to ensure each food was provided in the prescribed texture, for one of the four clients in the sample. (Client #2) The findings include: 1. On June 9, 2008, at 11:31 AM, Client #2 was presented her lunch plate at the day program. She was served, among other food items, pureed beef burger with gravy. The burger and gravy was of a thin and watery consistency. 2. Later that day, at 6:21 PM, residential staff was observed mixing Client #2's dinner foods (pureed chicken, green beans and mashed potatoes) together into one wide-rimmed beverage glass. After the client declined spoonfuls of the food mixture, the staff stirred some Vanilla Boost Plus into the mixture, rendering it the consistency of a thick soup. At 6:38 PM, review of her mealtime protocol, dated October 12, 2007, revealed that she was to receive foods "pureed with added fiber, pudding consistency." This was consistent with her physician's orders, dated June 1, 2008 ("pureed to pudding consistency"). Prior to the survey, the facility failed to ensure that foods served in the home and at day program were of the texture	W 474	QMRP/Home Manager will continue to monitor the status of all adaptive equipment and report on the status monthly. W474 This Standard will be met as evidenced by: 1. Reference response to W120, W194 and W111. 2. Reference response to W120, W194 & W111	7.23.08 ongoing

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G122		06/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	3020 STANTON ROAD, SE WASHINGTON, DC 20020

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W 474	Continued From page 47 prescribed by Client #2's physician.	W 474		

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I 000	INITIAL COMMENTS Surveyor: 17815 A licensure survey was conducted from June 9, 2008 through June 12, 2008. A random sample of four residents was selected from a resident population of eight women with various degrees of disabilities. In addition, a focused review was conducted of a fifth resident's mealtime protocol. The findings of this survey were based on observations, interviews with one resident's sister and another resident's court-appointed guardian, interviews with staff in the home and at two day programs, as well as the review of clinical and administrative records, including incident reports.	I 000		
I 002	3500.2 GENERAL PROVISIONS Each GHMRP licensee and residence director shall demonstrate that he or she understands that the provisions of D.C. Law 2-137, D.C. Code, Title 6, Chapter 19 govern the care and rights of mentally retarded persons in addition to this chapter. This Statute is not met as evidenced by: Surveyor: 17815 Based on observations, interviews and record review, the GHMRP licensee and residence director failed to demonstrate that he or she understood that the provisions of Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) govern the care and rights of mentally retarded persons. The findings include: 1. The facility failed to demonstrate protection of residents' rights to receive an updated Individual	I 002	I002 3500.2 This Statute will be met as evidenced by:	

Health Regulation Administration

Nancy Branch
LA' 'ORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE DRS

(X6) DATE 7/17/08

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I 002	Continued From page 1 Support Plan (ISP) within 30 days after admission [Title 7, Chapter 13, § 7-1305.04(a), formerly § 6-1964], as follows: Resident #1 was admitted to the GHMRP on January 31, 2008. The resident's interdisciplinary team developed her new ISP on May 23, 2008, almost 4 months after admission. 2. The facility failed to demonstrate protection of residents' rights to receive habilitation, care or both in accordance with their Individual Support Plans (ISPs) [Title 7, Chapter 13, § 7-1305.04(c), formerly § 6-1964(c)], as follows: a. Cross-refer to I422.1. Resident #1 was admitted on January 31, 2008 with a Behavior Support Plan (BSP) as part of her Individual Support Plan (ISP), that was developed by her former provider. There was no evidence that staff implemented Resident #1's BSP. b. Cross-refer to I422.2. The facility failed to ensure that Resident #1 had custom-molded shoes as prescribed by her interdisciplinary team. c. Cross-refer to I422.3. The facility failed to ensure that Resident #2 received training and appropriate staff support in the use of a safety harness. d. Cross-refer to I422.4. The facility failed to ensure that Resident #3 had an air mattress as prescribed by her interdisciplinary team. e. Cross-refer to I422.5. The facility failed to ensure that Resident #5's wheelchair was maintained in good repair. 3. The facility failed to demonstrate protection of	I 002	2. a. Cross-refer to I422.1 b. Cross-refer to I422.2 c. Cross-refer to I422.3 d. Cross-refer to I422.4 e. Cross-refer to I422.5 3.	

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I 002	Continued From page 2 residents' rights to receive a nourishing, well-balanced, varied and appetizing diet, and where ordered by a physician and/or nutritionist, to a specialized diet [Title 7, Chapter 13, § 7-1305.05(f), formerly § 6-1965(f)], as follows: a, Cross-refer to I500.2. GHMRP staff failed to implement Resident #2's diet orders and mealtime protocol as written. b. Cross-refer to I401.4. GHMRP staff failed to provide water to Resident #3 via her G-tube in the amounts prescribed by the primary care physician. 4. The facility failed to demonstrate protection of residents' rights to receive prompt and adequate medical attention [Title 7, Chapter 13, § 7-1305.05(g), formerly § 6-1965(g)], as follows: a. Cross-refer to I401.7. Resident #2 was not sent to the emergency room after experiencing 3 seizures within the same day, as indicated by the GHMRP's seizure protocol. b. Cross-refer to I401.2/.6 Resident #2 was not referred timely for medical procedures and/or recommended follow-up, for seizure management and post-treatment of urinary tract infections. c. Cross-refer to I401.1/.8 Resident #4 was not referred timely for medical procedures and/or recommended follow-up, for seizure management and post-treatment of urinary tract infections. d. Cross-refer to I401.5 Resident #2 did not receive recommended dental treatment.	I 002	1002, continued... Cross refer to 1500.2 b. Cross-refer to 1401.4 4. Reference response to 1305.05 (g). a. Cross-refer to 1401.7. b. Cross-refer to 1401.2/6 c. Cross-refer to 1401.1/8 d. Cross-refer to 1401.5	7.23.08 ongoing

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I 002	Continued From page 3 5. The facility failed to demonstrate protection of residents' rights to notify the director immediately of all incidents (example: injuries) and to thoroughly investigate an injury of unknown origin [Title 7, Chapter 13, § 7-1305.10(e), formerly § 6-1970(e)], as follows: Interview with Qualified Mental Retardation Professional (QMRP) on June 9, 2008, beginning at 4:10 PM, revealed that Client #1 was admitted to the facility on January 31, 2008. Both her previous and her current Behavior Support Plans (BSPs) incorporated the use of one-on-one staffing during awake hours, specifically from 6 AM - 10 PM. This was verified as being in accordance with her updated Individual Support Plan (ISP), dated May 23, 2008. On June 9, 2008, an incident report documented that on May 1, 2008, at approximately 8:00 AM, Client #1 was heard making "loud vocalizations" in her bedroom. Staff entered the bedroom and found her seated on the floor, with an abrasion to her right knee, and a swollen right ankle. Evaluation at the emergency room revealed a right ankle sprain. The incident report did not indicate how the client sustained the injuries. Upon further interview, the QMRP acknowledged that Client #1 had been alone at the time of her injuries. Later that afternoon, review of the corresponding investigation report, dated May 5, 2008, revealed that even though Client #1's plan prescribed one-on-one supervision, beginning at 6:00 AM, the investigation report failed to address this issue. 6. The facility failed to demonstrate protection of residents' rights to have their personal records	I 002	5. Cross refer to 1305.10 6.	

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I 002	Continued From page 4 kept complete and current [Title 7, Chapter 13, § 7-1305.12, formerly § 6-1972], as follows: a. Cross-refer to I292.1/.2/.3 The GHMRP nursing staff failed to update and keep current the Health Management Care Plans of Residents #1, #2 and #5. b. Cross-refer to I292.4/.5/.6 The GHMRP failed to ensure that Resident #4's record included a summary of each significant contact by a professional person with a customer (i.e. neurological records and alleged telephone conversations with primary care physician and other professionals). 7. The facility failed to ensure Resident #1's safety, as follows: Cross-refer to I500.1. A June 9, 2008 interview with the QMRP revealed that Resident #1 was admitted to the facility on January 31, 2008. At that time, it was known that Resident #1 required close supervision and had a history of injuries due to falls. However, review of incident reports revealed that she had experienced numerous falls between January 31, 2008 - May 1, 2008. Even though she had one-on-one staff assigned between 6 AM - 10 PM, there were 3 injuries documented since her Behavior Support Plan was updated in March 2008. Two (2) of injuries were of unknown origin. In addition, the resident had an impaired gait due to severely pronated feet. On February 29, 2008, the physical therapist recommended custom-molded shoes. She had not yet been evaluated by the orthopedic specialist and remained without the specialized shoes more than 3 months later. There was no evidence that the facility implemented measures timely to ensure the resident's safety.	I 002	a. Cross-refer 1292.1/2/3, b. Cross-refere to 1292.4/5/6 7. Reference response to Federal deficiency report W436.	7.23.08 7.23.08

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I 047	3502.5 MEAL SERVICE / DINING AREAS Each GHMRP shall be responsible for ensuring that meals, which are served away from the GHMRP, are suited to the dietary needs of residents as indicated in the Individual Habilitation Plan. This Statute is not met as evidenced by: Surveyor: 17815 Based on observation, staff interviews and record review, the facility failed to ensure that food was provided at the day program in the prescribed texture, for one of the four residents in the sample. (Resident #2) The finding includes: Cross-refer to I500.2. On June 9, 2008, at 11:31 AM, Resident #2 was presented her lunch plate at the day program. She was served, among other food items, pureed beef burger with gravy. The burger and gravy was of a thin and watery consistency. Interviews with the GHMRP RN and Qualified Mental Retardation Professional, as well as review of staff training records, failed to show evidence that the GHMRP continuously monitored lunch meals at the day program, to ensure that residents received meals in accordance with their dietary orders.	I 047	1047 3502.5 This statute will be met as evidenced by: Cross-refer to I500.2	7.22.08
I 055	3502.13 MEAL SERVICE / DINING AREAS Each GHMRP shall train the staff in the use of proper feeding techniques and monitor their appropriate use to assist residents who require special feeding procedures or utensils.	I 055	1055 3502.13	

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I 055	Continued From page 6 This Statute is not met as evidenced by: Surveyor: 17815 Based on observation, interview and record verification, staff failed to demonstrate competency in implementing residents' feeding protocols, for three of the eight residents residing in the facility. (Residents #2, #3 and #5) Cross-refer to I229. The facility failed to ensure staff displayed competency in implementing the diet orders for Residents #2, #3 and #5.	I 055	1055, continued... This Statute will be met as evidenced by: Cross-refer to 1229.	7.23.08
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: Surveyor: 12301 Based on observation and interview, the GHMRP failed to maintain the interior of the facility in a clean, orderly, and attractive manner. The findings include: On June 11, 2008, observation of the the environment beginning at 2:40 PM revealed the following: 1. One trash can had a large tear on the side. Two trash can lids were torn and one can lid was not available. 2. The upholstery on the arms of the love seat and the two arm chairs located in the foyer were very worn	I 090	1090 3504.1 This Statute will be met as evidenced by: 1. The trash can has been replaced. 2. Upholstery will be repaired/replaced as needed.	6.20.08 ongoing

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I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced bv: Surveyor: 17815 Based on review of personnel records that were made available, the GHMRP failed to document having discussed the contents of job descriptions with every employee at the beginning of employment and at least annually thereafter. The findings include: On June 11, 2008, beginning at 8:47 AM, review of personnel records revealed: 1. no evidence of job description reviews at time of hire (or otherwise) for 2 of the 13 direct support staff (S5 and S6); and, 2. there was no evidence of annual reviews of job descriptions for 2 of the other 11 direct support staff (S1 and S3). This is a repeat deficiency. See deficiency report dated June 14, 2007	I 203	1203 3509.3 This Statute will be met as evidenc 1. Job descriptions are completed at the time of hire and annually thereafter; Home Manager will ensure that all documents are filed and available for review.	6-20-08 ongoing
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.	I 206	1206 3509.6.	

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I 206	Continued From page 8 This Statute is not met as evidenced by: Surveyor: 17815 Based on interview and record review, the GHMRP failed to ensure that all staff obtained annual health certificates/ inventories. The findings include: Review of the personnel records on June 11, 2008, beginning at 8:47 AM, revealed the following: 1. The health certificates/ inventories on file for the QMRP had expired on June 7, 2008. 2. There were no health certificates/ inventories made available for review for 2 of the 13 direct support staff (S2 and S6) as well as 2 of the 5 LPNs (N2 and N3). 3. The health certificate/ inventory on file for an LPN (N1) had expired in March 2008. This is a repeat deficiency. See deficiency report dated June 14, 2007.	I 206	I206 This Statute will be met as evidenced by: 1. Human Resource Department will continue to monitor and track health certificates, 6.13.08 Human Resource Department will continue to send required notices prior to expiration date. Health certicates for identified staff were on file at the time of the review.	
I 223	3510.4 STAFF TRAINING Each training program agenda and record of staff participation shall be maintained in the GHMRP and available for review by regulatory agencies. This Statute is not met as evidenced by: Surveyor: 17815 Based on interview and record verification, the GHMRP failed to maintain the agenda and signature sheet of attendees for every staff in-service training session.	I 223	I223 3510.4 This Statute will be met as evidenced by:	

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I 223	Continued From page 9 The finding includes: Resident #1 was admitted to the facility on January 31, 2008. Her records indicated an ongoing history of falls, including "status post fracture of the right humerus." Interview with Qualified Mental Retardation Professional (QMRP) on June 9, 2008, at 4:10 PM, revealed that the resident's previous Behavior Support Plan (BSP) developed by her former provider had incorporated the use of one-on-one staffing. The QMRP said she had reviewed with her staff the existing BSP at the time of admission. However, review of staff in-service training records on June 11, 2008, beginning at 10:00 AM revealed no evidence that an agenda and signature sheet of attendees had been used to document the training. A request was made: however, no additional information was provided. It should be noted that review of incident reports revealed that Resident #1 had experienced four falls between January 31, 2008 - May 1, 2008.	I 223	1223 Reference response to federal deficiency report W149, W153 and W154.	
I 226	3510.5(c) STAFF TRAINING This Statute is not met as evidenced by: Surveyor: 17815 Based on interview and record review, the facility's nursing staff failed to document that all staff had received training in preventive health measures (i.e. infection control/ herpes management), for one of the four residents in the sample. (Resident #3) The finding includes: The review of unusual incidents on June 9, 2008	I 226	1226 3510.5 (c) This Statute will be met as evidenced by Reference response to W federal deficiency report.	

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I 226	Continued From page 10 revealed that Resident #3 received treatment for herpes infection at a hospital on December 20, 2007. Interview with the home manager indicated that she provided infection control/ herpes training to staff at the time of discharge. On June 10, 2008, at 3:00 PM, further interview revealed that there was no documentation available for review to verify the training.	I 226		
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (c) Infection control for staff and residents; This Statute is not met as evidenced by: Surveyor: 17815 Based on interview and review of personnel records made available, the GHMRP failed to ensure that all staff had received certification in cardiopulmonary resuscitation (CPR), in accordance with agency policies. The findings include: On June 11, 2008, beginning at 8:47 AM, review of personnel files and staff in-service training records revealed the following: 1. The CPR certification for 1 of the 13 direct support staff (S3) had expired on December 20, 2007. 2. The CPR certification for 1 of the other 5 LPNs (N1) had expired in February 2008. 3. There was no documented evidence of CPR certifications (past or current) for:	I 227	ST 1227 3510.5 This Statute will be met as evidenced by: All staff will be required to attend the next scheduled CPR/training Training Manager will continue to monitor and track compliance and take appropriate actions as needed to ensure that all assigned staff maintain	7.23.08

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I 227	Continued From page 11 a. 1 of the 12 other direct support staff (S6), and b. 2 of the 3 LPNs (N2 and N3) employed.	I 227	I227, continued Current CPR certifications.	
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Surveyor: 17815 Based on observation, interview and record verification, the GHMRP failed to ensure that staff demonstrated competency in implementing residents' feeding protocols, for three of the eight residents residing in the facility. (Residents #2, #3 and #5) The findings include: 1. The facility failed to ensure staff displayed competency in implementing Resident #2's diet order, as follows: a. On June 9, 2008, Resident #2 was observed eating lunch at her day program, beginning at 11:31 AM. Her meal included pureed beef burger with gravy that was of a thin and watery texture. At 1:34 PM, review of her mealtime protocol, dated October 12, 2007, revealed that her foods should be pureed to a "pudding consistency." This was consistent with her physician's orders, dated June 1, 2008. Signatures on the back of the mealtime protocol indicated that day program	I 229	I229 3510.5 (f) This Statute will be met as evidenced by: 1. Reference response to federal deficiency report W120, W111 and W149,	7.10.08

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I 229	Continued From page 12 staff had received training 6 months earlier, on November 29, 2007. b. On June 9, 2008, at 6:21 PM, Resident #2 was presented her dinner. Residential staff was observed mixing her dinner foods (pureed chicken, green beans and mashed potatoes) together into one wide-rimmed beverage glass. After the resident declined spoonfuls of the food mixture, the staff stirred some Vanilla Boost Plus into the mixture, rendering it the consistency of a thick soup. As previously noted, her food was to be pureed to a pudding consistency. Because Resident #2 was observed to cough during the end of her dinner, the RN was informed by this surveyor that her food had been presented at a rapid pace, she had coughed repeatedly and that her food had not been of pudding consistency. The RN pulled staff aside and reviewed the protocol with them. She then shared the information with the Qualified Mental Retardation Professional, who stated that they would retrain all of their staff. On June 10, 2008, at approximately 5:00 PM (before the dinner meal), the RN and the LPN on duty provided a more indepth in-service training for all of the staff regarding the danger posed to health and safety if/when a resident aspirates food or beverage and therefore, the importance of adhering to the residents' mealtime protocols. On June 11, 2008, staff in-service training records were reviewed, beginning at 10:00 AM. The most recent training on residents' mealtime protocols, prior to this survey, had been documented on March 21, 2008. Even though there had been some training provided, the observations and staff interviews indicated that the March 21, 2008 training had been ineffective.	I 229		

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I 229	Continued From page 13 2. The facility failed to ensure that nursing staff displayed competency in implementing Resident #5's diet order, as follows: The morning medication pass was observed on June 10, 2008. At approximately 7:54 AM, the medication nurse placed a cup of unthickened water up to Resident #5 and she drank. The resident had a pronounced tongue thrust. At 9:40 AM, review of her Medication Administration Record (MAR) for June 2008 revealed she was to receive all fluids thickened to a nectar consistency. On June 12, 2008, further review of her record revealed a Speech/ Language Assessment, dated March 12, 2008, and a Nutrition Assessment, dated February 8, 2008, both of which indicated that she was to receive "pureed food and nectar-thick liquids" because she "cannot tolerate thin liquids or foods of liquid consistency" due to her tongue thrust. 3. Cross-refer to W322.4. There was no evidence that nursing staff had received training on proper implementation of Resident #3's G-tube feeding orders. On two occasions, different nurses were observed giving the resident less water than was prescribed by the PCP and nutritionist.	I 229	3. Cross reference response to W322.4	7.23.08
I 292	3514.3 RESIDENT RECORDS Each record shall include, but not be limited to, the requirements of D.C. Law 2-137, D.C. Code § 6-1972 (1989 Repl. Vol.). This Statute is not met as evidenced by: Surveyor: 17815 Based on interview and record review, the GHMRP failed to maintain resident records in	I 292	I292 3514.3 This Statute will be met as evidenced by:	

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I 292	Continued From page 14 accordance with requirements of D.C. Law 2-137 (now Title 7, Chapter 13), for one of the four residents in the sample. (Resident #4) The findings include: Title 7, Chapter 13; D.C. Code 7-1305.12 (formerly 6-1972) Complete records for each customer shall be maintained and shall be readily available to professional persons and to the staff workers who are directly involved... These records shall include: (9) "A summary of each significant contact by a professional person with a customer" Resident #4 experienced multiple seizures on January 14, 2008 which led to her admission to a hospital. On June 12, 2008, the resident's neurology records were reviewed, beginning at 9:15 AM. Recent medical reports and documentation of alleged communications with medical professionals were missing from her record, as follows: 1. The facility's nursing staff failed to update Resident #1's Health Management Care Plan (HMCP) to reflect her custom-molded shoes. Review of unusual incidents on June 9, 2008 revealed that Resident #1 had sustained falls since her admission to the group home on January 31, 2008. The HMCP, updated May 23, 2008, documented osteoporosis and a history of fall as areas of concern. The goal was that the resident would be free from falls/injuries. The HMCP did not, however, reflect the physical therapist's February 29, 2008 recommendation that she have custom-molded shoes.	I 292	1292 Reference response to federal deficiency report W322 and W338.	7.23.08

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I 292	Continued From page 15 2. The facility's nursing staff failed to update Client #2's HMCP to reflect her podiatry treatment orders. On June 11, 2008, at approximately 2:10 PM, review of Resident #2's nurse progress notes revealed that on February 14, 2008, the podiatrist had discovered a "dark discoloration" on her fifth right toe. The podiatrist recommended monitoring until healed. On February 18, 2008, a nurse wrote that the "fifth toe right foot appears to be healing fine." However, on April 14, 2008, the podiatrist returned for the next examination. The podiatrist wrote "There is tissue protruding from fifth toe right foot, nurse made aware of tissue protruding from fifth toe right foot..." Subsequent review of the resident's HMCP, updated May 6, 2008, failed to show evidence that nursing staff had addressed what now appeared to be a recurring health concern. 3. The facility's nursing staff failed to ensure Resident #5's HMCP was updated to reflect food and beverage texture and consistency orders. Resident #5 had a pronounced tongue thrust. On June 10, 2008, at approximately 7:52 AM, the medication nurse presented her with a cup of water. She had difficulty drinking the water, as her head titled to the side, and water fell onto her bib. "Nectar-thickened liquids" was reflected on her mealtime protocol, MARs, and the Nutrition and Speech/ Language Assessments. However, Resident #5's HMCP, dated February 12, 2008 and physician's orders for June 2008 did not reflect the order. There was no evidence that facility nurses had sought to clarify the order prior to the survey. 4. There was a consultation form indicating that Resident #4 was seen by the neurologist on January 8, 2008. The neurologist wrote "see note" for the findings and recommendations.	I 292	1292, continued.. Reference response to W120, W111, W149, W153 W154, W322 W338, W127.	7.23.08

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I 292	Continued From page 16 There was no note attached, however, and further review of her medical records failed to show evidence of the neurologist's report. 5. Also on June 12, 2008, at approximately 9:25 AM, there was a consultation form indicating that Resident #4 underwent an EEG procedure on January 12, 2008. The neurology clinic indicated "report to follow." There was no EEG report attached to the consultation form, however, and further review of her medical records failed to show evidence of the EEG report. 6. Resident #4's records indicated that on January 24, 2008, the neurologist ordered testing the serum levels of her anticonvulsant medications. She was prescribed Tegretol, Depakote and Keppra. A telephone order dated January 24, 2008 indicated that her primary care physician (PCP) concurred; he ordered "Get all anticonvulsant levels and LFT test." Lab reports indicated that the resident's Tegretol and Depakote were tested; however, her serum Keppra levels had not been tested since October 3, 2007. On June 12, 2008, at approximately 12:15 PM, the RN stated that the Director of Nursing, the pharmacist and eventually the neurologist and PCP had all stated that Keppra levels were not needed. After examining the resident's chart, however, the RN acknowledged that conversations with those professionals, reportedly clarifying the lab order, had not been documented appropriately in Resident #4's record. At the exit conference later that afternoon, the DON corroborated what the RN had stated. She did not, however, present documentation of contacts with the neurologist and/or PCP regarding clarifying the order.	I 292	5.	

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I 379	Continued From page 17	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: Surveyor: 17815 Based on interview and record verification, facility staff failed to consistently report significant incidents to the Department of Health within the required time frame. The finding includes: According to an incident report dated May 1, 2008, the primary care physician instructed the nurse to send Resident #1 to an emergency room. The corresponding investigation report indicated that she was seen at the ER at 9:30 AM on the same morning (May 1, 2008). Further review of the incident report, however, revealed that the written report was prepared at 2:00 PM on the following day (May 2, 2008). According to the incident report, the Department of Health was notified via fax transmittal more than 24 hours later, at 2:29 PM on May 2, 2008. Subsequent review of the Department of Health, Health Regulation Administration incident records confirmed that there had been no immediate	I 379	1379 3519.10 This Statute will be met as evidenced by Reference response to federal deficiency report W154, W153, W322, W318 W338	7.22.08 ongoing

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I 379	Continued From page 18 telephone notification. The first documented notification was the fax received more than 24 hours after the incident occurred.	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: Surveyor: 17815 Based on observation, staff interview and record review, the facility failed to provide preventive and general medical care for three of the four residents in the sample. (Residents #2, #3 and #4) The findings include: 1. Incident reports indicated that Resident #4 had ongoing seizure activity, some of which led to referrals to hospital emergency rooms for further observation and assessment. For example, the resident was taken to a hospital ER on January 14, 2008 after experiencing 3 back-to-back seizures that evening. The resident's medical records were reviewed, beginning on June 11, 2008 at 5:08 PM. She was prescribed the following anticonvulsant medications; Tegretol, Keppra and Depakote; the Depakote was added to her regimen on August 8, 2007. The following deficient practices were identified: a. The facility failed to refer Resident #4 for serum anticonvulsant testing timely and in	I 401	This Statute will be met as evidenced by: Reference response Appropriate medical care was provided for client #2, #3, and #4. Health status of client #4 was stable and no adverse side effects noted following the seizure activity. Protocol will be reviewed and revised as needed.	7-22-08 ongoing

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I 401	Continued From page 19 accordance with physician's orders (POs). For example, on January 24, 2008 the neurologist increased her daily dosage of Depakote and requested updated anticonvulsant levels. Also on January 24, 2008, the primary care physician (PCP) concurred and ordered labs for anticonvulsants. Her Tegretol and Depakote levels were not tested until 6 weeks later (March 11, 2008). Results of labs performed on March 11, 2008 and March 26, 2008 revealed continued sub-therapeutic Depakote levels. On March 27, 2008, the neurologist requested updated labs. Resident #4's serum Depakote was tested on May 19, 2008, more than 7 weeks after the order. [Note: The neurologist and PCP also ordered liver function tests on January 24, 2008. This was not performed, however, until 4 months later, on May 19, 2008.] b. The facility did not ensure that Resident #4 was seen by the neurologist at the recommended frequency. On January 24, 2008, the neurologist prescribed an increase in her Depakote. She was to have labs drawn and return to the clinic on March 4, 2008. The labs were not scheduled timely and she did not return for the March 4, 2008 appointment. She did return on March 27, 2008, at which time the neurologist noted that her labs reflected continued sub-therapeutic Depakote levels. The neurologist increased her daily Depakote dosage again. [Note: Her seizure records indicated 8 seizures in January 2008, 5 seizures in February 2008 and 3 more seizures in March 2008.] c. Cross-refer to I292. The facility failed to ensure Resident #4's records included the results of all recent neurological test results. d. The facility failed to implement an effective	I 401	c. Cross-refer to I292.	

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I 401	Continued From page 20 tracking system to summarize the extent of Resident #4's seizure activity, as follows: At 5:08 PM, review of a Seizure Summary Chart indicated that Resident #4 had experienced 2 seizures in October 2007 and 1 seizure in November 2007. However, review of individual Seizure Observation Report forms revealed that she had experienced 3 seizures each month. In addition, the neurologist wrote the following on an October 30, 2007 consultation form: "... is doing well, no seizures..." There was no evidence that the PCP and neurologist were provided data that accurately reflected the number of seizures occurring. 2. The facility also failed to refer Resident #2 for serum anticonvulsant testing timely and in accordance with POs. Her POs reflected ongoing lab orders to obtain serum Tegretol levels every 3 months. On June 11, 2008, beginning at 11:02 AM, review of lab reports revealed a 6-month gap in testing, between August 16, 2007 and February 14, 2008. Her seizure records indicated she was taken to an emergency room on September 30, 2007 after a seizure. She experienced another seizure in November 2007 as well. 3. Even though Resident #2 was at risk of aspiration during meals, there was no evidence that the medical team had effectively monitored the implementation of her mealtime protocol, to ensure her health and safety. Cross-refer to I500.2. Resident #2's mealtime protocol, dated October 12, 2007, and her ongoing POs, prescribed foods pureed to a pudding consistency. Staff also were instructed to "monitor for signs" of aspiration. During the	I 401	I401 2. Cross-refer federal deficiency to W322. 3. Cross-refer to I500.2	7.18.08 ongoing

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I 401	Continued From page 21 survey, staff at the day program and in the home were observed feeding her foods that were not of a pudding consistency. Resident #2 was observed coughing during her meals at the day program and at home. Staff in both locations reported that it was not unusual for her to cough. Nursing staff, however, in both locations stated they were unaware of her coughing. Review of the mealtime protocol revealed no clear instructions for staff to follow if/when they observed her coughing. 4. The medical team failed to ensure that Resident #3 received hydration as ordered by the primary care physician, as follows: On June 9, 2008, at approximately 5:05 PM, the medication nurse was observed preparing Resident #3's tube feeding. He mixed crushed calcium carbonate into 5 ml water, stirred and then administered the calcium. He flushed the G-tube with 10 ml water, followed by a half can of Isosource HN. He completed the process by flushing the G-tube with another 235 ml water. Resident #3's tube feeding was observed again on the following morning, June 10, 2008, beginning at 8:06 AM. The nurse stirred crushed calcium carbonate into water and administered it. The nurse then stirred two scoops of protein powder into water and administered the protein. He then administered a half can of Isosource. Throughout the process, including flushes before and after each supplement and food source, the nurse used a total of 250 ml of water. He stated that the 250 ml was a minimum, and that the resident was not on a fluid restriction. On June 10, 2008, beginning at 12:36 PM, Resident #3's POs were reviewed to verify the	I 401	1401, continued RN will provide additional training and disciplinary action as needed. RN will continue to conduct file audits on an ongoing basis.	7.22.08

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I 401	Continued From page 22 medication pass and tube-feeding process. The June 2008 POs reflected three separate and distinct feeding orders, as follows: "Free water flushes with 250 ml 4 times daily after each feeding..." "Flush tube with 15 ml water before and after each medication and 5 ml water between each medication every shift." "2 scoops Beneprotein three times daily via G-tube..." Both nurses had begun the process by securing 250 ml, which they administered at various times throughout the feeding process. Both nurses failed to implement the second order (flushing with 15 ml between each medication). The afternoon nurse failed to administer 250 ml after the feeding and the morning nurse had used a portion of the 250 ml for dissolving the protein powder. The facility's RN was interviewed on June 10, 2008, beginning at approximately 12:55 PM. She stated that Resident #3's POs had been written to reflect the what the nutritionist had recommended. The RN stated that she would seek clarification of the orders with the nutritionist. The nutritionist was in the facility the next day. At 9:53 AM, the RN said that she had just spoken with the nutritionist, who confirmed that they were indeed separate orders. Her expectation was that the resident would receive a full 250 ml of free water at the very end of the food administration process. The 5-15 ml flushes in-between each supplement and/or medication was in addition to the 250 ml after the meal. There was no evidence that the primary care physician and/or the supervisory nurses had	I 401		

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I 401	Continued From page 23 monitored the G-tube feeding process to ensure accurate implementation of her POs, prior to the survey. In addition, there was no evidence that facility nurses sought clarification of the order prior to the survey. 5. The facility's nursing staff failed to ensure Resident #2 received dental care/ oral hygiene after every meal and before bedtime in accordance with the dentist's orders. On June 10, 2008, at 2:11 PM, review of Resident #2's dental records revealed that on February 13, 2008, the dentist increased the frequency of daily oral care to "brush teeth after meals and before bedtime." Her Health Management Care Plan (HMCP), updated May 6, 2008, indicated staff should "assist with oral hygiene PRN." Review of staff documentation revealed that she typically had her teeth brushed before and after breakfast and then again at approximately 8:00 PM, as she prepared for bed. At approximately 2:22 PM, interview with the QMRP revealed that Resident #2 did not receive oral care after lunch while at the day program. The afternoon LPN stated that day programs would not normally provide tooth brushing unless there were a "special order." The QMRP and RN stated that they follow the dentist's recommendations. At 2:24 PM, a direct support staff person assigned to the evening shift confirmed that the client's teeth were brushed before and after breakfast and at approximately 8:00 PM. There was no evidence that nursing staff ensured that Resident #2's teeth were brushed daily at the frequency recommended by the dentist. 6. Facility nurses failed to refer Resident #2 for urinalysis testing in accordance with orders, as follows:	I 401		

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I 401	Continued From page 24 a. On June 10, 2008, at 2:52 PM, review of Resident #2's HMCP, dated September 25, 2007 (updated periodically, through May 6, 2008), revealed she had recurrent urinary tract infections (UTIs). The HMCP indicated that when she developed a UTI, she was to have urinalysis testing shortly after treatment with antibiotics, to ensure that the treatment was effective. Review of Resident #2's medical chart revealed that she had been treated with Cipro for a UTI, beginning on October 12, 2007. Review of her lab reports failed to show evidence of a follow-up urinalysis during the weeks that followed her antibiotic treatment. When interviewed on June 11, 2008, at approximately 12:10 PM, the RN confirmed that, as standard practice, the client should have had additional urinalysis approximately 2 - 3 weeks after the antibiotic treatment was completed. The RN reviewed the lab records and acknowledged that the next documented urinalysis was performed on May 30, 2008, 7 months after the previous urinalysis. b. Resident #2's ongoing POs included having routine urinalysis tests performed every 6 months. Urinalysis testing on October 10, 2007 indicated an infection, for which she received antibiotic treatment. Another lab report, dated February 14, 2008, indicated that the"test was cancelled - patient unable to void." However, the next documented attempt to obtain a urine sample was on May 30, 3008, 3 ½ months after the failed attempt in February, and 7 months after her last successful urinalysis. 7. Facility nurses failed to send Resident #2 to the emergency room (ER) after experiencing 3 seizures within the same day, in accordance with their established seizure protocol. On June 10, 2008, Resident #2's seizure and neurology	I 401		

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I 401	Continued From page 25 records were reviewed, beginning at 3:34 PM. She was seen by the neurologist on May 1, 2008. The corresponding consultation report form indicated that she had experienced three seizures on April 14, 2008. On June 11, 2008, at 2:30 PM, a nursing progress notes dated April 14, 2008 reflected: "3 back to back seizures of 30 seconds each ... lab Tegretol was 6.00 WNL ... notified <primary care physician> and the Director of Nursing made aware. " The April 14, 2008 Seizure Activity Checklist also reflected 3 seizures on that day. At 2:37 PM, review of the agency's Protocol for Seizure Disorder revealed that if a client experienced a"third seizure in 24 hours, send client to the emergency room." The client's records did not, however, reflect a visit to the ER on April 14 or 15, 2008. At 2:50 PM, the RN confirmed the seizure protocol was current and that residents should be taken to an ER if they experience a third seizure in one day. After examining the seizure record, the RN acknowledged that Resident #2 had not been taken to the ER in accordance with the protocol. 8. Facility nurses failed to refer Resident #4 for urinalysis testing in accordance with orders. On June 12, 2008, at 10:20 AM, review of Resident #4's medical chart revealed that on January 7, 2008, a urinalysis test had indicated bacterial infection. She was then prescribed Augmentin 500 mg twice daily for 10 days. Review of her lab reports failed to show evidence (to date) of a follow-up urinalysis in the 6 months that followed. At 11:47 AM, review of Resident #4's HMCP, dated January 9, 2008 and incorporated in her January 11, 2008 ISP, revealed that she had recurrent urinary tract infections (UTIs). The HMCP indicated that after receiving treatment with antibiotics, she was to have follow-up urinalysis testing to ensure the treatment was	I 401		

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I 401	Continued From page 26 effective. There was no evidence that facility nurses scheduled follow-up urinalysis in accordance with her HMCP.	I 401		
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced bv: Surveyor: 17815 Based on observation, interview and record review, the GHMRP failed to ensure that each resident received habilitation, training and assistance in accordance with the Individual Support Plan (ISP), for four of the eight residents of the facility. (Residents #1, #2, #3 and #5) The finding includes: 1. Resident #1 was admitted on January 31, 2008 with a Behavior Support Plan (BSP) as part of her Individual Support Plan (ISP), that was developed by her former provider. It included one-on-one supervision. Her new BSP, dated March 2008 also incorporated one-on-one staffing, between 6 AM and 10 PM. The BSP listed the following targeted behaviors: physical aggression, self-injury (including "deliberately throwing herself to the floor"); tantrums, attempts to abscond, securing food in excess of her nutritional recommendations and non-compliance. The BSP said staff should record all incidents of targeted behaviors. There was no evidence that staff implemented Resident #1's Behavior Support Plan (BSP), as follows: a. The psychologist wrote the following in Resident #1's annual psychological assessment,	I 422	1422 3521.3. This Statute will be met as evidenced by; Reference response W149, W153. W154. W249 W149, W159. W322.	7.22.08 ongoing

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I 422	Continued From page 27 dated May 22, 2008: "...Data for February is not available. Further, data for March and April is also missing..." b. An incident report, dated March 3, 2008, at 6:15 PM, documented that Resident #1 had a tantrum while having her hair washed . She fell to the floor and reopened an existing sore on her knee. The incident report failed to indicate how or whether staff intervened in accordance with the plan, at the time of the tantrum. There was no behavioral data available to verify proper implementation of the BSP. The corresponding investigation report, dated May 5, 2008, failed to indicate whether the staff's response to the tantrum behavior had been in accordance with strategies outlined in the BSP. 2. The facility failed to ensure that Resident #1 had custom-molded shoes as prescribed by her interdisciplinary team. Review of unusual incident reports revealed that Resident # 1 had sustained several falls between her date of admission (January 31, 2008) and May 1, 2008. On June 9, 2008, the resident was observed ambulating with an unsteady gait at her day program and in the home. On June 10, 2008, review of her physical therapy evaluation, dated February 29, 2008, revealed a recommendation for custom-molded shoes due to "severely pronated ankles." On June 12, 2008, interview with the Qualified Mental Retardation Professional (QMRP) revealed that the team had agreed and an appointment for an evaluation (i.e. measurements, etc.) for custom-molded shoes was scheduled for July 10, 2008. The QMRP presented a 719A form for the shoes, dated May 19, 2008. To date, the resident remained without custom-molded shoes.	I 422	1422 b. Reference response to W436, W153, W154 W149, W249, W322 W240, W252 c. Reference response to 1422. b	7.23.08 ongoing

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I 422	Continued From page 28 3. The facility failed to ensure that Resident #2 received training and appropriate staff support in the use of a safety harness. On June 9, 2008, beginning at approximately 11:01 AM, Resident #2 was observed at her day program. Her right arm and shoulder were positioned outside of the safety harness on her wheelchair. When asked about the harness, a direct support staff surmised that she had repositioned her arm because it was hot outdoors. [Note: At the time, the air indoors felt comfortable to this surveyor.] Further interview with the day program staff revealed that her safety harness should be secured at all times "for protection," to prevent her from leaning too far forward. On June 12, 2008, at 10:43 AM, the QMRP, RN and home manager all concurred that Resident #2's safety harness should be secured at all times. They further indicated that the resident was known to independently move her arm out from under the harness. The QMRP stated that she had reviewed this topic with residential staff at a recent (March 31, 2008) training. There was no evidence, however, that the facility had verified whether the harness was kept properly secured while the resident was at day program. In addition, there was no evidence that the resident's alleged habit of removing the safety harness had been addressed by her interdisciplinary team, to include a training program if indicated. 4. The facility failed to ensure that Resident #3 had an air mattress as prescribed by her interdisciplinary team. Interview with the group home manager on June 11, 2008, at 3:10 PM, revealed a new air mattress had been requisitioned for Resident #3 after her previous one was discarded (due to a foul odor). At that time, there was no air mattress on the resident's bed. Review of Resident #3's ISP, dated June	I 422	I422, continued... 3. Reference response to I422.a 4. Reference response to W436.	7.23.08 ongoing

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I 422	Continued From page 29 15, 2007, revealed a recommendation that she have an air mattress "to assist in the prevention of skin breakdown." The ISP maintenance schedule indicated the mattress should be monitored daily and that it should be replaced as needed. On June 12, 2008, at 4:15 PM, the home manager presented a 719A form that was dated May 20, 2008, 3 weeks earlier. The home manager stated that the form had not yet been submitted as they were awaiting the primary care physician's signature. 5. The facility failed to ensure that Resident #5's wheelchair was maintained in good repair. Observation of Resident #5 seated in her wheelchair on June 9, 2008, at 5:38 PM, revealed the treads on the left front and rear wheels were very worn. The vinyl on the the edges of the foot box was torn and the vinyl covering on the front end of the right armrest was missing. Further observation at 6:51 PM revealed a large hole (2 to 3 inches in diameter) in the center of the molded seat from which the foam was exposed. Staff interview indicated that the seat of the resident's chair was repaired approximately nine months before the survey and that the resident had damaged her own wheelchair again. At the time of the survey, there was no evidence measures had been implemented to ensure that Resident #5's wheelchair was maintained in good repair.	I 422	Reference response to W436 of the federal deficiency report	7.23.08
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws.	I 500	I500 3523.1	

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I 500	Continued From page 30 This Statute is not met as evidenced bv: Surveyor: 17815 Based on interview and record review, the facility failed to implement policies that ensured the health and safety of two of the four residents in the sample. (Residents #1 and #2) The findings include: 1. Resident #1 was admitted to the facility on January 31, 2008. Her records indicated an history of falls, including "status post fracture of the right humerus." Interview with Qualified Mental Retardation Professional (QMRP) on June 9, 2008, at 4:10 PM, revealed that the resident's previous Behavior Support Plan (BSP) developed by her former provider had incorporated using one-on-one staffing. The QMRP said she had reviewed with her staff the existing BSP at the time of admission. The QMRP further indicated that the resident received one-on-one supervision during awake hours (6 AM - 10 PM). This was verified as in accordance with her updated Individual Support Plan (ISP), dated May 23, 2008. During the first several months after Resident #1 was admitted to the facility, she had four documented falls, some of which resulted in injuries. The survey revealed that the facility had failed to implement a system to effectively prevent Resident #1 from sustaining injuries, as follows: a. An incident report documented that approximately one week after admission, on February 7, 2008, at 3:30 PM, she fell while boarding a van and sustained bruises to her face. The resident's Health Management Care Plan	I 500	1500 This Statute will be met as evidenced by: Reference response to 1422.a	7.23.08

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I 500	Continued From page 31 (HMCP), dated February 1, 2008, stated that due to her seizure disorder, she had potential for sustaining injuries. The HMCP instructed staff to implement "fall precautions, daily," however, it did not specify or otherwise describe what fall precautions should be implemented. b. An incident report documented that on February 10, 2008, at 2:15 PM, Resident #1 fell while getting up from the sofa after awakening from a nap. She sustained slight swelling above her eyebrow. Staff reportedly saw her as she was getting up but was unable to reach her before she fell. c. Cross-refer to federal deficiency W252. Another incident report, dated March 3, 2008, at 6:15 PM, documented that Resident #1 had a tantrum while having her hair washed. She reportedly fell to the floor and reopened an existing sore on her knee. The incident report failed to indicate how or whether staff intervened in accordance with her BSP. There was no record of the March 3, 2008 behavioral episode in the resident's behavior data. The corresponding investigation report, dated March 10, 2008, failed to indicate whether the staff's response to the tantrum behavior had been in accordance with the strategies outlined in the BSP. It should be noted that there was no evidence that the facility determined whether additional safety precautions might be indicated to prevent future incidents. d. Review of in-service training records revealed that on March 21, 2008, the QMRP provided training to the direct support staff on one-on-one duties and responsibilities. However, on March 24, 2008, at 7:55 AM, staff discovered a bruise to	I 500	c. Cross reference response to W252 of the federal deficiency report.	7.22.08

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I 500	Continued From page 32 Resident #1's upper right face, under the eye. The source of the injury was not known. e. On April 2, 2008, Resident #1 fell on her knee after her foot reportedly got caught on a chair while ambulating. The corresponding investigation report, dated April 6, 2008, included a recommendation for PT training. In-service training records, however, indicated that the PT provided training on May 17, 2008, approximately 6 weeks after the April 2, 2008 fall, and after she experienced yet another fall (on May 1, 2008) that resulted in a sprained ankle. f. An incident report documented that on May 1, 2008, at approximately 8:00 AM, Resident #1 was heard making "loud vocalizations" in her bedroom. Staff entered the bedroom and found her seated on the floor, with an abrasion to her right knee, and a swollen right ankle. Evaluation at the emergency room revealed a right ankle sprain. The origin of the resident's injuries were unknown. According to her March 2008 BSP and her Individual Support Plan (ISP), she was to receive one-on-one staff supervision during awake hours between 6 AM - 10 PM. When interviewed further, the QMRP acknowledged that the resident had been alone at the time of her injuries. g. On June 9, 2008, review of Resident #1's record revealed that she was evaluated by the physical therapist (PT) on February 22, 2008. The assessment report, dated February 29, 2008, indicated that she "would benefit from custom-molded shoes as soon as possible secondary to severely pronated ankles... staff should be trained on proper lifting techniques when she flops onto the floor." The PT further wrote that he had discussed his	I 500	1500 Cross reference response to 1422 a. for e. f. and g.	7.23.08

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I 500	Continued From page 33 recommendations and clinical plans with the QMRP, House Manager, direct support staff and the relevant interdisciplinary team members on February 29, 2008. However, on June 9, 2008, interview with the QMRP revealed that the PT recommendations had not been achieved timely, as follows: 1) Staff in-service training records indicated that the PT trained staff on May 17, 2008, 2 1/2 months after the assessment and almost 4 1/2 months after she was admitted. 2) The resident remained without the molded shoes. She was scheduled for an appointment on July 10, 2008, 3 1/2 months after the PT assessment. It should be noted that the 719A form for the custom-molded shoes was dated May 19, 2008 more than 2 months after the PT discussed the need for shoes with the QMRP. h. Cross-refer to federal deficiency W153. Staff who were on duty at the time that Resident #1's injuries of unknown origin were discovered on May 1, 2008, at 8:00 AM, failed to implement the facility's incident management policy to ensure timely reporting. The policy states that the QMRP and Director should be notified immediately of all emergencies and it also stated that incident reports should be completed before the end of the shift. However, the QMRP, State agency and the facility's Director of Residential Services were notified more than 24 hours later, on May 2, 2008 (at 8:00 AM, 2:29 PM and 2:50 PM, respectively). In summary, the June 9, 2008 interview with the QMRP revealed that it was known that Resident #1 required close supervision and had a history of injuries due to falls when she was admitted. However, review of incident reports revealed that	I 500	1500 Cross reference response to W153 federal deficiency report. Also reference response to 1427. a.	7-23-08 ongoing

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I 500	Continued From page 34 she had experienced four falls between January 31, 2008 - May 1, 2008. Even though she had one-on-one staff assigned between 6 AM - 10 PM, there were 3 injuries documented since her BSP was updated in March 2008, 2 of which were of unknown origin. In addition, the resident remained without her prescribed custom molded shoes at the time of the survey. There was no evidence that the facility implemented measures timely to ensure the resident's safety. 2. A mealtime protocol had been developed to address Resident #2's assessed risk of aspiration. Observations at the day program and in the home, however, revealed a failure to protect her health and safety. The mealtime protocol failed to provide clear, written instructions to ensure the resident's health and safety. In addition, staff did not provide the meals in accordance with the protocol, as follows: a. Resident #2's mealtime protocol, dated October 12, 2007, did not provide clear, written instructions, as follows: 1) On June 9, 2008, Resident #2 was observed having lunch at her day program. At 11:44 AM, the resident held her WonderFlo spout cup with her right hand and was observed guzzling Boost Plus nutritional supplement at a very fast pace. The resident coughed repeatedly while drinking. At one moment, the staff person told her to "be careful... you have to rest, drink a bit, and then rest." The staff person placed her hand behind Resident #2's head, pulled it forward slightly, because the resident had tilted her head backwards, hyperextending her neck. Despite the one verbal prompt, the resident did not slow her drinking pace and the coughing continued. The staff person turned to this surveyor and	I 500		

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I 500	Continued From page 35 stated "when she puts this cup in her mouth, she doesn't want to... release the cup" until it is empty. At 11:54 AM, the resident coughed repeatedly while drinking some apple-cranberry juice at a fast pace. When asked if the resident coughed often, the two direct support staff who were assisting at lunch replied yes. At 1:35 PM, review of Resident #2's mealtime protocol revealed the following: "Staff should assist her with drinking... Place the cup in her right hand allowing her to take sips of beverage between bites and after meal is completed." The protocol did not further elaborate on how staff should assist her. There were no instructions that addressed the hyperextended neck or when she drank fluids at a fast pace. 2) Resident #2's mealtime protocol included the following: "feed her slowly; monitor for signs of aspiration such as... coughing, choking, watery eyes." The protocol did not, however, instruct staff on how they should respond if she showed signs of aspiration. At approximately 2:00 PM, interview with the two day program nurses revealed that they expected staff to bring the resident to the nurse's station if she showed signs of aspiration. The nurses and a day program case manager were immediately informed of the observed fast drinking pace with coughing. They were also informed that the direct support staff had indicated that coughing was a frequent occurrence. At the time, neither nurse had been told that the resident had coughed at lunch. They both indicated that they were previously unaware that she frequently coughed during meals. The case manager stated that they would ask the group home for further clarification on how to address her rapid	I 500		

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I 500	Continued From page 36 drinking while hyperextending her neck. b. Observations at the day program and in the home revealed staff did not feed Resident #2 foods that were of the consistency ordered by the primary care physician and included in the mealtime protocol, as follows: 1) On June 9, 2008, at 11:31 AM, Resident #2 was presented her lunch plate at the day program. She was served, among other food items, pureed beef burger with gravy. The burger and gravy was of a thin and watery consistency. Her mealtime protocol indicated that she was to receive foods "pureed with added fiber, pudding consistency." This was consistent with her physician's orders, dated June 1, 2008 ("pureed to pudding consistency"). It should be noted that the resident repeatedly refused attempts by staff to feed her the food. She was presented Boost Plus nutritional supplement instead. At approximately 2:05 PM, two day program nurses were informed that Resident #2's food was not of a pudding consistency, as ordered. The nurses and a case manager stated that they would ensure that lunches served in the future would be of the prescribed consistency. 2) On June 9, 2008, at 6:21 PM, residential staff was observed mixing Resident #2's dinner foods (pureed chicken, green beans and mashed potatoes) together into a wide-rimmed beverage glass. After the resident ate a few spoonfuls of the food mixture, she refused to continue. The staff stirred Vanilla Boost Plus into the mixture, rendering it the consistency of a thick soup. This too, was not the "pudding" consistency ordered by the primary care physician.	I 500		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0001	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/12/2008
NAME OF PROVIDER OR SUPPLIER I D I	STREET ADDRESS, CITY, STATE, ZIP CODE 3020 STANTON ROAD, SE WASHINGTON, DC 20020		

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I 500	Continued From page 37 In the minutes that followed, Resident #2 coughed several times while being fed the mixture (see complete description in the paragraphs that follow). At approximately 6:27 PM, the surveyor brought the resident's coughing to the RN's attention, and informed her that the resident's food had not been of pudding consistency. c. Staff in the home did not give Resident #2 her liquids in the prescribed WonderFlo spout cup, as follows: On June 9, 2008, at 6:24 PM, a direct support staff person was observed stirring Boost Plus into Resident #2's pureed food, instead of using the prescribed WonderFlo spout cup. The staff person was then observed pouring the mixture into Resident #2's mouth from a wide-rimmed beverage glass. The resident's neck was hyperextended and the resident coughed. Without pausing, the staff said "good girl" and kept pouring the mixture into her mouth. The staff emptied the rest of the Boost Plus into the glass, which rendered the mixture to a soupy texture. Once the feeding resumed, Resident #2 coughed hard and food came out onto her bib. The staff said "I didn't tell you to spit it out" and continued presenting the dinner at a fast pace. With that cough, at approximately 6:27 PM, this surveyor summoned the nearby RN's attention. The RN, who had not been observing the meal at that time, intervened immediately. She asked the staff about the resident's WonderFlo cup. While pointing, the staff said it was in the kitchen. The staff then walked to the kitchen, opened another can of Boost Plus, poured it into the spout cup and returned to the resident. The resident had finished her dinner and was now drinking the	I 500		

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I 500	Continued From page 38 supplement from her spout cup. No additional coughing was observed. While the RN reviewed the mealtime protocol, the surveyor informed her that the food had been presented at a rapid pace, that the resident had coughed repeatedly and that the food had not been of pudding consistency. The RN pulled staff aside and reviewed the protocol with them. She then shared the information with the Qualified Mental Retardation Professional, who stated that they would retrain all of their staff. On June 10, 2008, at approximately 5:00 PM (before the dinner meal), the RN and the LPN on duty provided a more indepth in-service training for all of the staff regarding the danger posed to health and safety if/when a resident aspirates food or beverage and therefore, the importance of adhering to the residents' mealtime protocols.	I 500		

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	HFD03-0001		06/12/2008

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R 122	4701.2 BACKGROUND CHECK REQUIREMENT Except as provided in section 4701.6, each facility shall obtain a criminal background check, and shall either obtain or conduct a check of the District of Columbia Nurse Aide Abuse Registry, before employing or using the contract services of an unlicensed person. This Statute is not met as evidenced by: Surveyor: 17815 Based on the review of personnel records, the GHMRP failed to ensure or obtain criminal background checks prior to employing unlicensed persons. The finding includes: Review of the personnel files on June 11, 2008, beginning at 8:47 AM, revealed no evidence of any criminal background check for 1 of the 13 direct support staff (S6).	R 122	R22... This Statute will be met as evidenced by:	
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: Surveyor: 17815 Based on the review of personnel records, the GHMRP failed to ensure criminal background checks for the previous seven (7) years, in all jurisdictions in which the employees had worked or resided within the seven (7) years prior to the check.	R 125	R 125 4701.5 This Statute will be met as evidenced by:	6.13.08 ongoing

Health Regulation Administration

Nancy Branch

LAB ORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE DRS

(X6) DATE 7/17/08

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R 125	Continued From page 1 The finding includes: Review of the personnel files on June 11, 2008, beginning at 8:47 AM, revealed no evidence of a comprehensive criminal background check for 1 of the 13 direct support staff (S4). A DC check was documented. However, she had worked in Virginia during 2004 and there was no evidence of a background check for that jurisdiction. This is a repeat deficiency. See deficiency report dated June 14. 2007.	R 125	R125 Background check for 1 of the 13 direct support staff (S4) was completed at the time of the survey.	7.16.08