PRINTED: 04/24/2008
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: 09G191	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/28/2008
NAME OF PROVIDER OR SUPPLIER: I D I		STREET ADDRESS, CITY, STATE, ZIP CODE: 2553 36TH STREET, SE WASHINGTON, DC 20024	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS This recertification survey was conducted on March 25 through March 28, 2008. The survey was initiated utilizing the fundamental survey process. A random sampling of two clients from the residential population of four clients with varying degrees of disabilities was identified. On March 26, 2008 at 4:30 PM, the survey was extended in the area of active treatment due to observed client maladaptive behaviors. The findings of this survey were based on observations at the group home and two day programs, interviews with day program staff and residential staff, the review of clinical and administrative records and the review of the facility's unusual incident reports.	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, interviews with staff, and the review of records, the facility's governing body failed to provide general operating direction over the facility. The findings include: 1. The governing body failed to ensure the alarm system installed on the patio door was maintained in an operable condition. On March 25, 2008 at 7:15 AM, upon entering the facility, the door alarm was activated. Interview with the shift leader revealed that an alarm had	W 104		

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	Continued From page 1 been placed on each exit door as a proactive strategy to minimize the risk of Client #1's targeted behavior of attempted elopement. On March 27, 2008 at approximately 4:10 PM, a metal bar was observed on the patio door which required being disengaged prior to opening the door. The alarm however did not activate when the door was opened. Interview with staff revealed that the alarm on the patio door was not operable. 2. The facility failed to ensure that a thorough investigation was conducted concerning Client #1's elopement from the facility. According to the facility's investigative report dated 11/09/07, a staff indicated that he checked all door alarms upon his arrival on duty on 11/4/07 and all alarms were operating properly. The review of the facility's investigative report dated 11/09/07 indicated the interviews with staff on duty revealed their time sequences, events and the information concerning where the clients were at the time of the client's elopement were inconsistent. There was no evidence however that a thorough investigation was conducted to determine how the alarm on the exit door in the client's bedroom was disarmed and the client eloped from the facility undetected by staff. 2. The governing body failed to ensure the contract pharmacy services provided medication timely for Client #2. [See W120]	W 104	**W104** **This Standard will be met as evidenced by:** 1. The alarm system on the patio door has been replaced. Home Manager will conduct routine monitoring checks of all alarms on a regular basis. Home Manager will conduct staff training as needed to ensure that staff report all concerns immediately. Home Manager will follow-up to ensure timely repairs. 2. QMRP conducted investigation regarding the elopement of client #1. Findings revealed that client #1 disabled the alarm system himself. As a result of this incident a new alarm system has been installed. The new alarm device requires a code to disable the alarm. 3. The governing body will ensure that the pharmacy services are provided timely manner. See response to W120.	4.10.08 ongoing
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client.	W 120		

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W 120	Continued From page 2 This STANDARD is not met as evidenced by: Based on interview and record review, the contracted pharmacy failed to ensure that one of two clients in the sample (Client #2) received a medication timely to treat his illness. The finding includes: An unusual incident report from Client #2's day program which was dated November 6, 2007 revealed he had been sleepy for two days and had a large amount of green mucous coming from his nostrils. The day program correspondence recommended that the client be evaluated by the primary care physician (PCP) and that he have medical clearance prior to returning to his day program. The review of group home records failed to indicate if the client was assessed by the nurse during the evening of 11/06/07 to follow-up on the day program medical correspondence. Record review however revealed a nursing progress note dated November 7, 2007 at 8:30 PM which stated the client was evaluated at the emergency room on 11/07/07 due to a persistent nasal congestion and coughing. Client #2 was diagnosed with Pneumonia and Levaquin 500 mg tab, 10 tabs, take 1 tab daily PO QD was prescribed. Additionally, Tessalon Perles 200 mg; twenty (20), take one every six to eight hours as needed for cough was prescribed. The review of the policy revealed "Medications deemed necessary of an emergency will be to be communicated to the pharmacist as STAT. The pharmacist will make provisions for the billing and prompt delivery of such items. Clients should	W 120	**W120** **This Standard will be met as evidenced by:** RN met will all nurses assigned to the home. RN reviewed importance of ordering medications and providing timely follow-up on all reported medical concerns. RN has provided instructions to all LPN staff on the STAT medications and procedures to be implemented whenever STAT orders are required. RN will continue to monitor and conduct routine file audits to further ensure compliance with this standard.	4.24.08 [illegible]

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W 120	Continued From page 3 allow a two to four hour window for the delivery of STATS". According to an 8:00 PM nursing progress note on 11/8/07, the facility was still waiting to receive the Levaquin. The MAR review revealed the client did not receive the first dosage of the antibiotic (Levaquin) until November 9, 2008, 48 hours after it was prescribed at the emergency room. There was no evidence the contracted pharmacy ensured that Client #1 received his prescribed antibiotic within timeframe established in the facility's medication policy.	W 120		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to establish and/or implement policies that ensured the health and safety of one (Client #1) of the two clients in the sample. The findings include: 1. The facility failed to implement its established policy on investigating and reporting of unusual incident reports. Review of the facility's "Incident Management" policy on March 26, 2008 at 3:45 PM revealed that the results of investigations should be reported to the Incident Management Coordinator within four days. The policy further documented that the results of investigations should be	W 149	**W149** **This Standard will be met as evidenced by:** 1. All staff will receive further training on the Incident Management policy. The knife was used to prepare food and was on the counter. Client #1 was able to maneuver around the (FC) and obtain during mealtime 2. Reference response to W120.	5.14.08 ongoing

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W 149	Continued From page 4 forwarded to the Health Regulatory Administration and MRDDA Incident Management Unit within five working days. The review of an unusual incident report dated October 17, 2007 revealed that the facility coordinator sustained an abrasion to the left side of his stomach, while he was recovering a knife from Client #1. The incident report revealed the client picked up the knife when dropped off his plate in the kitchen sink after eating his lunch. According to the investigative report, it was not clear how the client was able to have access to the knife. To prevent potential harm to himself or others, the facility coordinator (FC) attempted to redirect the client to drop the knife; however he was not successful. As the FC attempted to recover the knife from the client, the client began to swing the knife from side to side and caused an abrasion to the FC's side. The client eventually dropped the knife in the kitchen sink. The FC was evaluated and treated at the emergency room and was released on the same day. The review of the investigative report of the incident revealed it was not completed until October 31, 2007, fourteen days after the incident. Additionally, the incident was not reported to the Department of Health until October 31, 2007. At the time of the survey, there was no evidence the facility implemented its Incident Management policy as outlined. 2. The facility failed to implement its policy for "Ordering and Delivery Schedule" of medication. The review of the policy revealed "Medications deemed necessary of an emergency will be to be	W 149		

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W 149	Continued From page 5 communicated to the pharmacist as STAT. The pharmacist will make provisions for the billing and prompt delivery of such items. Clients should allow a two to four hour window for the delivery of STATS". The review of an unusual incident report dated November 7, 2007 revealed Client #2 was treated at the Emergency Room on that date for nasal congestion and persistent coughing. He was diagnosed with Pneumonia. Levaquin 500 mg tab, 10 tabs, take 1 tab daily take one tab PO QD was prescribed. Tessalon Perles 200 mg; twenty (20), take one every six to eight hours as needed for cough. According to a nursing progress notes written by the 8:00 PM medication nurse on 11/8/07, the facility was still waiting to receive the Levaquin. The MAR review revealed the client did not receive the first dosage of the antibiotic until November 9, 2008, 48 hours after it was prescribed in the emergency room. There was no evidence the facility's policy for "Ordering and Delivery Schedule" of medication was implemented as written.	W 149		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the facility failed to ensure Client #1's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP) for Clients #1 and #2.	W 159	**This Standard will be met evidenced by:** 1. Reference response to W249, 4 and 5 programs were consistently implemented. 2. Reference response to W474.	5.14.08 ongoing

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W 159	Continued From page 6	W 159		
	The findings include: 1. The QMRP failed to ensure toothbrushing programs were consistently implemented. [See W249, 4 - 5] 2. The QMRP failed to coordinate the implementation of Client #1's therapeutic diet texture. [See W474]		**W189** **This Standard will be met as evidenced by:** 1. All staff will be scheduled to attend the MANDT training techniques. Home Manager is responsible for coordinating and scheduling staff participation in the scheduled training. Training Department will continue to distribute monthly status reports and encourage participation as needed. QMRP and Home Manager will monitor staff implementation of the techniques and provide feedback as needed to further ensure that each employee is able to perform his or her duties effectively, efficiently and competently.	5.30.08 ongoing
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, interview and record, the facility failed to ensure continuing training was provided to each employee to enable them to perform duties effectively and competently for two (Client #1) of two clients in the sample. The findings include: 1. The facility failed to ensure staff had current training on the implementation of the MANDT techniques which were included in Client #1's Behavior Support Plan (BSP). Interview with staff revealed Client #1 was required to have one on one supervision due to his elopement behavior. Staff further indicated that the client usually escorted to the day program by the same staff, however when in the home any ATS staff may be assigned to provide one on one supervision for Client #1.	W 189	2. Staff will be scheduled for the next Nutrition Management training. Both QMRP and Home Manager will conduct routine meal observations to further ensure that food textures are served in	

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W 189	Continued From page 7 The review of unusual incident reports, interview with staff and the review of behavioral data revealed that at time Client #1 also exhibited physically aggression and sometimes property destruction. The review of Client #1's BSP dated June 30, 2007 revealed an objective to decrease episodes of physical aggression and/or property destruction to zero incidents per month for twelve consecutive months. According to intervention strategies, staff should use escort procedures as designated in MANDT, beginning with the least restrictive procedures. "Staff using MANDT techniques must be trained by a certified trainer and hold current certification." Interview with staff and the review of training records revealed the four (primarily the weekend staff) of the nine staff providing coverage in the group home, had no current training on MANDT. 2. The facility failed to ensure that staff were effectively trained on food textures. On March 25, 2008 at 4:46 PM, staff was observed to serve bite-size raw vegetable salad to the clients and to offer the a choice of salad dressings. The review of Client #1's 90 day physician's orders dated February 27, 2008 indicated the client was prescribed a regular, finely chopped diet, with added fiber with a raw vegetable salad during lunch and dinner. Observation of the raw vegetable salads served to Client #1 on 3/25/08 and also at dinner on 3/27/08 revealed that it was served in bite-size pieces rather than finely chopped. There was no evidence that each each staff had been effectively trained on food textures.	W 189	W189, continued... accordance to the prescribed diet orders/meal time protocols. QMRP/Home Manager/Nurse will schedule training on the signs and symptoms of illness. QMRP/Home Manager will review with all staff the importance of reporting and documenting changes in the client's condition. QMRP/Home Manager will also actively observe the individuals and address concerns as they arise.	

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W 189	Continued From page 8 3. The facility failed to ensure that direct care staff were effectively trained on signs and symptoms of illness. An unusual incident report from Client #2's day program which was dated November 6, 2007 revealed he had been sleepy for two days and had a large amount of green mucous coming from his nostrils. The day program correspondence recommended that the client be evaluated by the primary care physician (PCP) and that he have medical clearance prior to returning to his day program. Record review however revealed a nursing progress note dated November 7, 2007 at 8:30 PM which stated the client was evaluated at the emergency room on 11/07/07 due to a persistent nasal congestion and coughing. Client #2 was diagnosed with pneumonia. There was no evidence signs of symptoms of illness were reported to the group home nurse for monitoring prior to the notification from the day program.	W 189		
W 234	483.440(c)(5)(i) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure Client #1's behavior support plan provided clear instructions on how stategies were to be implemented. The finding includes: The facility failed to provide failed to provide	W 234	**W234** **This Standard will be met as evidenced by:** The QMRP will coordinate and discuss this component with the behavior specialist to determine if additional instructions/interventions are required to meet the needs of client #1 and to ensure that instructions are clear to any staff working with the individual. Training will be provided for staff as needed.	4-30-08 ongoing

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W 234	Continued From page 9 instructions on how to get Client #1 up from sitting on the ground. The review of an unusual incident report dated March 27, 2008 revealed Client #1 bit the 1:1 staff who was assigned to be with him at his day program staff on Monday through Friday. Interview with the staff revealed the client bit him as he attempted to get him up from the ground when took him on a community walk. According to the behavior support plan dated June 30, 2007, the client has a targeted behavior of agitation (yelling and falling to the floor). The strategy for addressing the behavior is that "staff should appear to ignore him while discreetly monitoring him. Try not to make eye contact with him, give additional attention, or talk to him. However, monitor him for further escalation, and if necessary, encourage him to be still and calm down using calm, verbal directives. Interview with staff revealed that the client has been observed to sit on the ground/street as well as on the floor. At the time of the survey however, the BSP did not included interventions to assist the staff in getting the client up when sitting on the ground/street, timely while maintaining the client's and the staff's personal safety.	W 234		
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.	W 249	**W249** **This Standard will be met as evidenced by:** 1. QMRP provided follow-up to the incident to include but not limited to additional training and oversight. Client #1 is routinely assigned to a staff person who is directly responsible for consistent monitoring. Further, whenever the assigned person leaves for any reason a designated person is assigned to take over client #1's monitoring. 2. Reference response to W234. 3. Reference response to W249, #1. 4. The batteries on client #1's toothbrush were changed at the time of the survey. In addition, new replacement toothbrushes and back-	3-31-08 ongoing

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W 249	Continued From page 10 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure as soon as the interdisciplinary team formulated the individual program plan (IPP) two of two clients (Client #1 and #2) in the sample received a continuous active treatment plan consisting of needed interventions to achieve identified objectives. The findings include: 1. The facility failed to implement Client #1's Behavior Support plan effectively to prevent his elopement. On March 25, 2008, at 7:15 AM, upon entering the facility, the door alarm was activated. Interview with the shift leader revealed that an alarm had been placed on each exit door as a proactive strategy to minimize the risk of Client #1's targeted behavior of elopement. According to the intervention strategy in the client's Behavior Support Plan (BSP), attempted elopement should be addressed before it occurs by making sure that the client is supervised at all times. There was no evidence the required level of supervision was implemented which resulted in the client's elopement from the group home as evidenced by the following: Review of an usual incident report on 3/25/08 at 3:50 PM revealed that Client #1 eloped from the facility on 11/04/07. The investigative report dated November 9, 2007 revealed the following details concerning the incident:	W 249	W249, continued... up batteries are maintained in the home. QMRP/Home Manager will provide additional training for all staff on reporting and addressing such concerns as they arise. 5. Client #2 has an operable toothbrush to maintain his dental hygiene. Staff received training on the individual program plans and recommendations to brush twice daily. Both QMRP and Home Manager will continue to monitor to ensure ongoing compliance with this standard. Also, reference response to W249, #1 & #4.	

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W 249	Continued From page 11 10:30 AM - Staff observed Client #1 sleeping in his bedroom; 10:31 AM - One of three direct care staff assigned to the shift left the facility. The other two direct care staff sat in the living room, which was adjacent to Client 1's bedroom; and 10:42 AM - The emergency exit door in Client #1's bedroom was observed standing open and the alarm system had been deactivated. Client #1 was observed to be missing from his bedroom. Two direct care staff searched in and around the facility however, did not find the client. The staff also searched the neighborhood by van, however were unable to locate him. Staff then notified the police and the facility coordinator (FC). 2. The facility failed to ensure that Client #1's BSP included interventions to effectively address his behavior of sitting on the ground when on community outings. [See W 234] 3. The facility failed to ensure staff supervised Client #1 to prevent his physical injury. The review of an unusual incident report dated February 8, 2008 revealed that Client #1 went down stairs while all staff were upstairs and got his cigarettes from the secured location. Once back upstairs staff observed him searching for a lighter. According to the client's Psychological Assessment dated 6/8/07, he has a smoking schedule which allows him to have no more than 10 cigarettes per day due to medical reasons. The BSP dated June 30, 2007 indicated that due	W 249		

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	09G191		03/28/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 249	Continued From page 12 to the client's targeted behavior of attempted elopement, staff should be proactive by making sure he is supervised at all times. Witness statements of the incident revealed when staff attempted to retrieve the cigarettes from the client, he began screaming and ran downstairs. While trying to close the door before staff could reach him, the client struck his forehead on the door causing a cut in the middle of his forehead. The review of the nursing assessment of the injured area revealed the client sustained a 10 mm x 4 mm wound on his upper face during the incident. There was no evidence the strategy in Client #1's BSP which required that he be be supervised at all times was implemented,which placed him at risk for injury and/or elopement. 4. The facility failed to ensure that Clients #1 was provided with an operable toothbrush to encourage his participation in his toothbrushing objective. During the observations of the environment on March 28, 2008 at approximately 3: 45 PM, Client #1's battery operated toothbrush was noted to be inoperable. Interview with the Assistant Director of Residential Services revealed that it was probably the batteries. The review of the individual program plan (IPP) revealed Client #1 had a goal to improve his activities of daily living skills. According to the objective, "Given verbal prompts, Mr. ...will brush his teeth with battery - operated toothbrush on 80 % of trials recorded per month by June 2008. Record review revealed the client had refused to	W 249		

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W 249	Continued From page 13 participate in the objective on 88% of recorded trials in February 2008 and on 100% of the recorded trials in March 2008. The toothbrush was observed to be operable on March 28, 2008. There was no evidence however, that the client was consistently provided with the tool (operable toothbrush) required by the IPP to effectively implement the objective. 5. The facility failed to ensure that Client #2 was provided with an operable toothbrush to maintain his dental hygiene. Observation of Client #2 on March 25, 2008 at 7:30 AM revealed that he appeared to be edentulous. Interview with staff and the review of records reveled that he had dentures but did not like to wear them. Observation of Client #2's battery operated toothbrush on March 27, 2008 at approximately 3:42 PM revealed it was not operable. The review of his Individual Support plan (ISP) dated June 29, 2007 revealed a recommendation that he be encourage by staff to brush his gums at least twice daily. Further record review revealed the health management care plan included this recommendation as a goal. There was no evidence the client was consistently provided with toothbrush in good repair to maintain his oral hygiene as recommended by the IDT.	W 249		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.	W 252		

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W 252	Continued From page 14 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure data relative to the accomplishment of the program objective was documented in measurable terms for Client #1. The finding includes: Cross refer to W249, 4 Client #1 had a goal to improve his activities of daily living skills. According to the objective, "Given verbal prompts, Mr.....will brush his teeth with battery -operated toothbrush on 80 % of trials recorded per month by June 2008. The program was scheduled to be run daily, however the data frequency was two times a week. On March 27, 2008 at approximately 3: 45 PM, Client #1's battery operated toothbrush was noted to be inoperable. Staff indicated that it was probably the batteries that caused it not to work. Data collected 2 x a week for the months of February 2008 revealed the client refused the task on 88% of trials and at times refused to allow staff to assist him in brushing his teeth. The review of program data revealed that the client refused to participate in the toothbrushing objective on 6/6 day attempted in March 2008. On 3/5/008 staff documented that the client hollered and screamed when staff prompted him to get his teeth brushed. Although the data collection allowed space for comments regarding the client's lack of participation in the objective, there was no further information documented for March 2008. There was no evidence information critical to monitoring the client performance/acceptance of the objective was maintained.	W 252	**W252** **This Standard will be met as evidenced by:** Reference response to **W249, #4.** The QMRP will receive additional training on program monitoring and change. Further, the staff will receive additional training to address client 1's non- compliance, frequency of program implementation, documentation and reporting responses and/or problems. QMRP will review current objectives and make modifications as needed. QMRP will also highlight the designated days the program should be implemented to ensure that it is consistent with the IPP. QMRP/Home Manager will provide ongoing monitoring to further ensure compliance with this standard.	5.14.08 ongoing
W 322	483.460(a)(3) PHYSICIAN SERVICES	W 322		

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W 322	Continued From page 15 The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to provide preventive and general medical care for one of two clients in the sample. (Client #2) The findings include: The review of an unusual incident report dated November 7, 2007 revealed Client #2 was referred to the emergency room due to a persistent nasal congestion and coughing. He was diagnosed with pneumonia and was discharged from the ER in stable condition with prescriptions for two medications to treat the pneumonia. The ER prescribed Levaquin 500 mg; ten (10), take one tablet daily. Additionally Tessalon Perles 200 mg; twenty (20, take one every six to eight hours as needed for cough was prescribed. Interview with the nurse revealed the primary care physician was notified and gave telephone order to give the Levaquin as recommended by the ER and to give the Tessalon Perles 200 mg; twenty (20), take one every six hours as needed for cough. Further interview with the nurse and the review of the MAR revealed the Pharmacy did not provide the Levaquin until November 9, 2007, two days later. There was no evidence the client received the Tessalon Perles.	W 322	**W322** **This Standard will be met as evidenced by:** The RN has taken immediate steps to address the nurse who failed to adhere to the physician orders. The RN will continue to monitor medical services and provide direction and feedback to staff to ensure that each individual receives services as indicated by hi/her health plan. Also, reference response to W120.	3.31.08 ongoing
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing	W 331	**W331** **This Standard will be met as evidenced by:** Reference response to W120. RN will provide additional training for LPN staff on signs & symptoms of illness, timely documentation and assessment, and follow-up actions to be taken whenever concerns arise.	4.24.08 ongoing

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W 331	Continued From page 16 services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide nursing services in accordance with the needs of one of the two clients in the sample. (Client #2) The finding includes: 1. The facility's nursing services failed to ensure that Client #1 was monitored timely for abnormal respiratory symptoms: An unusual incident report on March 25, 2008 at 10:55 AM revealed on November 7, 2007 the Client #2 was assessed at the emergency room (ER) for excessive mucous from nostril and coughing. The client was diagnosed with Pneumonia, provided with prescriptions, and recommended to have follow-up with the primary care physician in one week. A communication from Client #2's day program (DP) to the group home dated November 6, 2007 revealed that he had been sleepy for two days and was observed having a large amount of green mucous coming from his nostrils. The client was recommended to be assessed by his primary care physician and to return to the DP with medical clearance. There was no documented evidence that the client was assessed by the nurse at the group home on November 6, 2007 to address the aforementioned day program nurse's communication. Upon arrival at the group home in the morning of November 7, 2007, the facility coordinator (FC) also observed the aforementioned symptoms. The Director of	W 331	W331 continued... RN will conduct routine file reviews and follow-up to further ensure that the nursing services are implemented in accordance to the individual needs.	

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W 331	Continued From page 17 Nursing (DON) was notified and requested that the client be taken to the ER for evaluation. Client #2 was diagnosed with Pneumonia on November 7, 2007 and Levaquin 500 mg tab, 10 tabs, take one tab PO QD was prescribed. Tessalon Perles 200 mg; twenty (20), take one every six to eight hours as needed for cough. Record review revealed a nursing progress note dated November 7, 2007 at 8:30 PM revealed the client was evaluated at the emergency room due to a persistent nasal congestion and coughing. There was no evidence, however that the client was monitored timely for signs and symptoms of his illness by the facility's nursing services. 2. The facility's nursing services failed to ensure that Client #2 was monitored to determine his need for a medication prescribed to treat his cough PRN (as needed). The review of a nursing progress note indicated that Client #2 was taken to the ER on 11/7/07 due to a persistent nasal congestion and coughing and was diagnosed with pneumonia. Record review revealed a November 7, 2007 telephone order from the Primary Care Physician (PCP) for Tessalon Perles 200 mg, (20) tab, take 1 tab po Q 6 hrs PRN for cough. Although the Medication Administration Record (MAR) review revealed "Tessalon Perles 200 mg Q 8 hours as needed for cough, there was no evidence the client received any dosages of the Tessalon Perles 200 mg. A nursing progress note dated 11/14/07 at 9:00 PM which revealed "no coughing....". Further record review however revealed no documentation that the status of the client's coughing had been otherwise monitored to determine the necessity for the medication.	W 331		

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W 418	483.470(b)(4)(ii) CLIENT BEDROOMS The facility must provide each client with a clean, comfortable mattress. This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure that one of the two of the four clients residing in the facility were provided with a comfortable mattress. (Clients #2 and #4) The findings include: Observations of the environment was conducted with the Assistant Director of Residential Services on March 28, 2008 at approximately 3:30 PM. During this time, the following concerns were identified: a. Client #2's bed mattress was observed to have springs which were palpable through the bedspread . There was no evidence that the client was provided with a comfortable mattress. b. Client #4's mattress was observed to have palpable the bed springs. Several holes were also observed in the mattress. There was no evidence that the client was provided with a comfortable mattress or that the mattress was maintained in good condition. The Assistant Director of Residential Services indicated the the mattresses were relatively new and that the present condition of the mattresses had not been reported by staff. She stated that the mattress would be replaced on the next day. There was no evidence that the facility had maintained the mattresses in good repair.	W 418	**W418** **This Standard will be met as evidenced by:** New bed mattresses have been purchased for both client #2 and #4. Home Manager has been instructed to conduct routine checks of all mattresses on an ongoing basis to ensure that they are clean, comfortable and maintained in good condition.	3.31.08 ongoing
W 436	483.470(g)(2) SPACE AND EQUIPMENT	W 436		

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W 436	Continued From page 20 consistently provide with an operable assistive device (toothbrush) as recommended by the IDT. 2. Observation of Client #2's battery operated toothbrush on March 27, 2008 at approximately 3:42 PM revealed it was not operable. The review of his Individual Support plan (ISP) dated June 29, 2007 revealed a recommendation that he be encouraged by staff to brush his gums at least twice daily. Further record review revealed the health management care plan included this recommendation as a strategy for goal to improve his dental hygiene. There was no evidence the client was consistently provided with a toothbrush in good repair to maintain his oral hygiene as recommended by the IDT. Although the care plan did not specify the battery operated toothbrush was required, there was no evidence that the chosen battery operated toothbrush was consistently maintained in an operable condition. (Note: On March 28, 2008 the toothbrush was operable.)	W 436	W436 This Standard will be met as evidenced by: Reference response to W249. 4	4.30.08 ongoing
W 474	483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to ensure each food was provided in the prescribed texture for one of the two clients in the sample. (Client #1) The findings include: On March 25, 2008 at 4:46 PM, staff was observed to serve a raw vegetable salad into the	W 474	**W474** **This Standard will be met as evidenced by:** Reference response to W189.	5.30.08 ongoing

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W 474	Continued From page 21 client's individual serving bowl and to offer the clients a choice of salad dressing. The vegetables in the salad were observed to be in bite-size pieces. The review of the 90 day orders dated February 27, 2008 on revealed Client #1 was prescribed to have a regular, finely chopped diet, with added fiber. Further review revealed an order for the client to have a raw vegetable salad with lunch and dinner. Observation of the raw vegetable salads served to the client during the survey revealed they were not finely chopped. There was no evidence that each food provided to the client was in the texture prescribed by the physician.	W 474		

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I 000	INITIAL COMMENTS This relicensure survey was conducted on March 25 through March 28, 2008. The survey was initiated utilizing the fundamental survey process. A random sampling of two residents from the residential population of four residents with varying degrees of disabilities was identified. The findings of this survey were based on observations at the group home and two day programs, interviews with day program staff and residential staff, the review of clinical and administrative records and the review of the facility's unusual incident reports. On March 26, 2008 at 4:30 PM, the survey was extended in the area of active treatment due to observed client maladaptive behaviors.	I 000		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure the interior and exterior of each GHMRP were maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. The findings include: 1. Scaling paint was observed on the wall directly above the tile on wall of the shower in the master bathroom. Scaling paint was observed on the left	I 090	**3504.1:** **This statute will be met as evidenced by:** 1. The wall directly above the tile on the wall of the shower room in the master bedroom was painted; and the damaged on the side of the bath cabinet has been repaired. A new cabinet will be purchased. 2. Another bedroom lamp was purchased for client #2. 3. The metal closet door track was replaced and secured. 4. A new bath mat was purchased.	3.29.08 ongoing

Health Regulation Administration
Nancy Branch
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: DRS

(X6) DATE: 5.4.08

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I 090	Continued From page 1 side of the commode. Heavy damage was observed on the side of the bath cabinet. 2. The facility failed to ensure adequate lighting. (a) During observation of Resident #2's bedroom, revealed a shade but no lamp. Staff indicated that the lamp was broken. Staff then brought in a floor lamp. Observation of the lighting in the living room revealed No overhead lighting or lamp was available. (b) Observation in the bedroom of Residents #3 and #4 revealed the room was dimly lit. Further observation revealed no light bulb in the socket of the wall lamp above #4's bed. 3. During the observations of the environment ton March 27, 2008 the metal closet door became completely detached from the tract when it was opened. Interview with the Assistant Director of Residential Services that the closet door had been repaired before but that the problem as recurred. The door was observed to be secured in the tract when observed on March 28, 2008. There was no evidence that the door had been monitored to ensure that it remained in good repair. 4. Heavy mildew stain was observed on the bottom of the bath mat in the bathroom located off the hallway on the second floor. The mat was replaced on 3/28/08. 5. Failed to monitor battery operated toothbrushes to ensure that remained operable. Observation revealed the following: (a) Resident 3's ..not operable (b) Resident 2's ..not operable (c) Resident #1's toothbrush was not operable.	I 090	#5. Toothbrushes for client #1, #2, #3, and #4 were replaced and additional batteries purchased. Reference W249 #4. 6. Reference W104 7:reference W 418 The Home Manager will continue to conduct weekly home inspections and report/document all maintenance concerns in a timely manner. QMRP will provide follow-up as needed to ensure ongoing compliance with this standard.	3-29-08 ongoing

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I 090	Continued From page 2 Interview with staff revealed he had a goal to improve his activities of daily living skills. The objective stated "Given verbal prompts, Mr.... Will brush his teeth with a battery operated toothbrush on 80% of trials per month by June 2008. Data collected 2 x a week for the months of February 2008 revealed he refused on 88% of trials and at times refused to allow staff to assist him in brushing his teeth. Review of program data for March 2008 revealed he had refused on 100 % of trials. Data for 3/5/008 revealed the resident hollered and screamed when staff attempted to get him to brush his teeth. The toothbrushes were provided with replacement batteries on 3/28/08. 6. On March 27, 2008 at approximately 4:10 PM, a bar was observed on the door which need to be disengaged prior to opening the door to the patio. Upon opening the door, the alarm did not activate. Interview with staff however revealed that the alarm on the patio door was not operable. 7. The springs in the mattress on Resident #2 bed were palpable.	I 090		3-31-08 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. This Statute is not met as evidenced by: Based on interview and record review, the	I 206	**3509.6** **This Statute will be met as evidenced by:** An updated Health certificate has been obtained and filed. The Administrative Assistant will continue to monitor, track and follow-up as needed to secure health certificates and other required documents prior to the expiration date.	

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NAME OF PROVIDER OR SUPPLIER: I D I	STREET ADDRESS, CITY, STATE, ZIP CODE: 2553 36TH STREET, SE WASHINGTON, DC 20024		

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I 206	Continued From page 3 GHMRP failed to ensure that a current health certificate was maintained on file for one consultant (the pharmacist). The finding includes: The review of health records for consultants on March 27, 2008 revealed that the pharmacist provided a "Tuberculosis Symptom Surveillance"form dated June 17, 2007, in lieu of a health certificate. Interview with the Qualified Mental Retardation Professional revealed health certificate was provided with the files for review. At the time of the survey, there was no evidence a certification was available for the pharmacist to confirm that his health status would allow him to perform the required duties.	I 206		
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on observation, interview and record, the GHMRP failed to ensure continuous, ongoing in-service training programs scheduled for all personnel to enable them to perform duties effectively and competently for one (Resident #1) of two residents in the sample. The findings include: 1. The GHMRP failed to ensure staff had current training on the implementation of the MANDT techniques which were included in Resident #1's Behavior Support Plan (BSP). 2. The GHMRP failed to ensure that staff were effectively trained on food textures.	I 222	**3510.3 (1), (2) and (3)** **This Statute will be met as evidenced by:** Reference response to Federal Deficiency report W189. Also, reference response to Federal Deficiency Report W474.	4.30.08 ongoing

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I 222	Continued From page 4 [See Federal Deficiency Report - W474] 3. The facility failed to ensure that direct care staff were effectively trained on signs and symptoms of illness.	I 222		
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to 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 in accordance with the reporting requirement in 3519.5. The finding includes: The facility failed to timely report an injury sustained by the facility coordinator which he	I 379	**3519.10** **This Statute will be met as evidenced by:** **Reference W149**	5.14.08 ongoing

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I 379	Continued From page 5 sustained while attempting to recover a knife from Client #1. The review of an unusual incident report dated October 17, 2007 revealed that the facility coordinator (FC)sustained an abrasion to the left side of his stomach, while he was recovering a knife from Client #1. According to the incident report, the client picked up the knife when he wen to put his plate at the kitchen sink after lunch. According to the investigative report, it was not clear how the client was able to have access to the knife. To prevent potential to himself or other, the FC attempted to redirect the client to drop the knife, however he was not successful. As the FC attempted to recover the knife from the client, the client began to swing the knife from side to side and causing an abrasion to the FC's side. The client eventually dropped the knife in the kitchen sink. The FC was evaluated and treated at the emergency room and was released on the same day. The review of the facility's investigative report revealed that the incident was reported to the Director of Residential Services on October 17, 2007. There was no evidence, however that the Department of Health was notified of the incident until October 31, 2007.	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.	I 401		

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I 401	Continued From page 6 This Statute is not met as evidenced by: Based on observation, interview and record verification, the GHMRP failed to ensure professional services were provided timely for two two residents (Residents #1 and #2) in sample. The findings include: 1. The GHMRP failed to provide preventive and general medical care for Resident #2. [See Federal Deficiency Report - W322] 2. The GHMRP failed to provide nursing services in accordance with the needs of Resident #2. [See Federal Deficiency Report - W331] 3. The GHMRP failed to the dietary texture needs were addressed for Resident #1. [See Federal Deficiency Report - W474]	I 401	3520.3 **This Statute will be met as evidenced by:** **1.Reference W322** **2.Reference W331** **3.Reference W474**	4.24.08 ongoing
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 by: Based on observation, interview and record review, the GHMRP failed to provide habilitation, training and assistance to residents in accordance with the Individual Habilitation Plan of two of two residents in the sample. (Residents #1 and #2) The findings include: 1. The GHMRP failed to ensure that Resident #1's behavior support plan interventions for attempted elopement were effectively implemented.	I 422	3521.3 **This Statute will be met as evidenced by:** **1. Reference: W249** **2. Reference W252**	4.24.08 ongoing

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I 422	Continued From page 7 [See Federal Deficiency Report - Citations W249] 2. The GHMRP failed to ensure data relative to the accomplishment the toothbrushing program objectives of Clients #1 and #2 was documented in measurable terms. [See Federal Deficiency Report - Citation W252]	I 422		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on on observation, interview and record review, the GHMRP failed to ensure that the rights of each resident were protected. The findings include: See Federal Deficiency Report - Citation W104, W120, W149, W249, W322, ,W331, and W474.	I 500	**3523.1** **This Statute will be met as evidenced by:** **Reference: W104, W120, W149, W249, W322, W331 and W474**	5.14.08 ongoing