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

PRINTED: 06/26/2007
FORM APPROVED
OMB NO. 0938-0391

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	06/14/2007

NAME OF PROVIDER OR SUPPLIER: IDI

STREET ADDRESS, CITY, STATE, ZIP CODE: 3020 STANTON ROAD, SE, WASHINGTON, DC 20020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from June 12, 2007 through June 14, 2007. The survey was initiated using the fundamental survey process. A random sample of four clients was selected from a residential population of seven female clients with varying degrees of disabilities. The findings of the survey were based on observations at the residence and one day program. Also the findings were based on staff interviews in both the group home and day program, as well as a review of habilitation and administrative records, to include the facility's unusual incident reports.	W 000		
W 148	483 420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to notify parents or guardians of significant incidents for two of the eight clients residing in the facility. (Clients #3 and #4) The finding includes: Review of the facility's unusual incident reports and investigations on June 12, 2007 at approximately 8:25 AM, revealed evidence that the facility failed to notify family members immediately of the following significant incidents:	W 148	**W148** **This Standard will be met as Evidenced by:** Client #3 does not have family involvement. A legal guardian was appointed after the incident on 4/17/07. QMRP will continue to notify family members and/or legal guardians of significant incidents in a timely manner. In the event the QMRP is unavailable a designated person will be assigned to complete the task. QMRP and/or designee will document all notifications. Routine file audits will be completed to further ensure compliance with this standard.	6-29-07 ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy Branch
TITLE: ARS
(X6) DATE: 7/5/07

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 148	Continued From page 1 a. On April 17, 2007, Client #3 vomited, was sent to the emergency room and subsequently was admitted to the hospital. b. On March 16, 2007, Client #3 was reported to be unresponsive. The primary care physician was notified and instructed to staff to transport the client to the emergency room for further evaluation. c. On July 27, 2006, staff discovered Client #3's right thumb swollen. The client was taken to the local emergency room. e. On August 4, 2006, staff was given Client #4 a bath and blood was dripping from the clients toe. Client was sent to local emergency room.	W 148		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview, review of unusual incidents, and review of medical records, the facility failed to ensure that all unusual incidents including injuries of unknown origin were reported immediately to the administrator and other officials according to district law (22 DCMR, Chapter 35, Section 3519.10) for three of the seven clients residing in the facility. (Clients #1, #3 and #4) The findings include:	W 153	**W153** **This Standard will be met as evidenced by:** **QMRP/designee will ensure that all incidents are reported immediately to the Administrator and other officials according to district law (22 DCMR) Chap. 35, Section 3519.10)** **QMRP/designee will maintain verification (i.e. fax confirmation) on file for review.**	6/21/07 ongoing

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W 153	Continued From page 2 Review of the incident reports on June 12, 2007 at 8:25 AM, revealed the following incidents that had not been reported as required: a. On May 6, 2007, direct care staff discovered an open would on Client #4's stomach. The nurse treated the wound. b. On April 9, 2007, staff discovered a swollen bump on Client #3's lower eyelid. The on duty nurse treated the bump with cold compresses. c. On April 24, 2007, staff discovered an open area on Client #4's right elbow. d. On August 4, 2006, staff was given Client #4 a bath and blood was dripping from the clients toe. The client was sent to local emergency room. e. On September 23, 2006, staff discovered scratches on Client #1's right cheek.	W 153		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure all unusual incidences of injuries of unknown origin were thoroughly investigated. The findings include: Review of the facility's Unusual Incident Reports log book on 6/14/07 at approximately 1:37 PM revealed the following incidents and/or injuries of	W 154	**W154** **This Standard will be met as evidenced by:** All incidents will be investigated by the QMRP. Also reference response to W153.	6.21.07 ongoing

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W 154	Continued From page 3 unknown origin had not been investigated as evicence below: a. May 6, 2007, direct care staff discovered an open would on Client #4's stomach. The nurse treated the wound. b. On April 24, 2007, staff discovered an open area on Client #4's right elbow. d. On August 4, 2006, staff was given Client #4 a bath and blood was dripping from the clients toe. The client was sent to local emergency room. c. On September 23, 2006, staff discovered scratches on Client #1's right cheek.	W 154		6.28.07 ongoing
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, staff interview and record review, the facility Qualified Mental Retardation Professional (QMRP), failed to adequately monitor, integrate and coordinate each client's health and safety. The findings include: 1. The facility's QMRP failed to ensure that direct care staff were trained in order to perform their jobs efficiently. [See W189] 2. The facility QMRP failed to ensure each client	W 159	**W159** **This Standard will be met as evidenced by:** (1) Reference response to W189. (2) Reference response to W214. (3) Reference response to W217. (4) Reference response to W227. (5) Reference response to W234. (6) Reference response to W237. (7) Reference response to W247. (8) Reference response to W249	

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W 159	Continued From page 4 was assess and/or reassess clie its' developmental and behavioral sl engths and needs. [See W214] 3. The facility QMRP failed to en ure that a nutritional assessment was upda ed for one client in the sample. [See W217] 4. The facility's QMRP failed dev elop IPP objectives identified by the comp ehensive functional assessment. [See W 27] 5. The facility QMRP failed to en ure that written training programs specified the n ethods to be used to ensure proper implemen ation of the programs. [See W234] 6. The facility's QMRP failed to e sure that physical therapy programs were esigned to provide clear instructions on how to measure clients performance. [See W237] 7. The facility's QMRP failed to e sure that each client was provided an opportunit to have choose her adaptive equipment during m als. [See W247] 8. The facility's QMRP failed to e isure continuos active treatment. [See W249]	W 159	**W189** **This Standard will be met as evidenced by:** QMRP/Home Manager will conduct/coordinate additional training as need to include but not limited Physical Therapist, Occupational Therapist, Psychologist, and Speech Therapist to address the various programs and implementation concerns outlined. (Walking program, functional communication, mealtime protocols, and range of motion). Staff will receive training on "Active Treatment" and providing ongoing opportunities toward accomplishing a specific skill and documenting appropriately onto the data sheets.	7-6-07 ongoing
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each em oloyee with initial and continuing training that enables the employee to perform his or her d ities effectively, efficiently, and competently. This STANDARD is not met as e idenced by: Based on interview and record re iew, the facility	W 189	QMRP/Home Manager will continue to monitor staff competency and provide feedback and direction as needed to ensure compliance with this standard.	

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W 189	Continued From page 5 failed to ensure that each empl yee had been provided with adequate training hat enables the employees to perform his or her duties effectively, efficiently and competently. The findings include: 1. The facility failed to ensure t at staff were trained on client #3's on going u e of her walker for ambulation support as evidel ced below: On June 12 and 13, 2007 direct care staff were observed on three occasions to assist the client with ambulation to and from her bedroom by holding her underneath her arm . On each occasions, after the client was a ated, the staff was observed to go back to the lient's bedroom, get her walker and place it in the living room. Interview with the Qualified Ment al Retardation Professional (QMRP) revealed t at Client #3 did use her walker regularly and had an ambulation program in which she should be encouraged to "walk two laps around the length of the facility". According to the QMRP, these a ditional opportunities for Client #3 to use her walker can reinforce Client #3's walking prog ram. 2. Interview with the QMRP and record review on June 14, 2007 at approximately 2 :00 PM revealed that Client #4 had a functional co nmunication objective: "Given her low tech de ice, [the client] will touch the icon/picture of [the client] is eating or [the client] is sleeping with mi imal physical assistance 8 of 10 trials for the n xt 180 days". Review of the April 2007 data sh et indicated that the direct care staff were implem nting the program using one trail. Accordi g to the QMRP,	W 189	W189, Continued ... Documentation sheets have been corrected to reflect # of trials and staff have received appropriate training. QMRP/Home Manager will continue to check documentation on a weekly basis to ensure ongoing compliance with this standard.	

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W 189	Continued From page 6 she recognized that the direct care staff documented one trial; and therefore, she noted on the data sheet that "In-service will be given for correct data collection". Review of the May 2007 data sheet for May 2007 revealed that ten trails were being documented. Review of the June 2007 data sheet only reflect that the direct care staff were only documenting one trail again, the same as the month of April. There was no evidence that the in-service training for Client #4's communication data collection was effective.	W 189		
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to assess and/or reassess clients' developmental and behavioral strengths and needs for three of the four clients in the sample. (Clients #1, #3 and #4) The findings include: 1. The facility failed to ensure that the adaptive supports and equipement were available to ensure effective program implementation to meet clients' needs. [See W436] 2. Interview and record review on June 14, 2007 at approximately 10:30 AM revealed that Client #4's last Occupational Therapy (OT)Assessment was completed on September 4, 2004. According to the Qualified Mental Retardation Professional (QMRP) a new OT assessment had been completed for the clients upcoming	W 214	**W214** **This Standard will be met as Evidenced by:** (1). Reference response to W436. (2). QMRP will file updated Occupational assessment for client #4. QMRP will address all recommendations and maintain documentation on for review.	6-29-07 ongoing

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W 214	Continued From page 7 Individual Support Plan (ISP) m eting scheduled for the end of June 2007. Howe ver, the assessment was available for re view. Further review of the expired OT assess ment recommended an annual evalua ion.	W 214		
W 217	483.440(c)(3)(v) INDIVIDUAL P OGRAM PLAN The comprehensive functional a sessment must include nutritional status. This STANDARD is not met as videnced by: Based on observation, interview nd record review, the facility failed to ensur that a nutritional assessment was com leted for one of the four clients in the sample. (C ent #3) The finding includes: Interview the QMRP and record r view on June 13, 2007 revealed a nutritionist neal observation form dated June 12, 2006. This orm noted that the nutritional consultant docume ted concerns that Client #4 had loss weight. T e nutritionist recommended that the client's int ke of foods be monitored and documented daily, and that her weight be monitored weekly. Re iew of the physician's order reviewed a diet ry order for nutritional suppliments and four s nall meals a day. Although the ISP included a nutritional assessment, dated February 14, 2006, it failed to incuce the current nutritional stat s identified above. Note: It should be further noted t at Client #4 has a history of weight loss and was noted in her Health Care Maintenance Progra n.	W 217	**W217** **This Standard will be met as Evidenced by:** QMRP and medical staff continue to monitor client #3's weight and food intake. QMRP will ensure that the Nutritionist addresses all concerns related to weight loss and dietary orders for supplements, as well as current nutritional status. Nursing staff also will continue to monitor and provide additional services as recommended by the Primary Care Physician. QMRP will continue to monitor client #4's status and document (i.e. monthly, quarterly notes, interventions, concerns and recommendations as well as actions taken to address the specific situation.	6·29·07 ongoing
W 227	483.440(c)(4) INDIVIDUAL PROG RAM PLAN	W 227		

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W 227	Continued From page 8 The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on observations, client and staff interview, and record review, the facility failed develop Individual Program Plan (IPP) objectives identified by the comprehensive functional assessment for one of the four clients in the sample. (Client #1) The findings include: During the entrance conference on June 12, 2007 at approximately 9:00 AM, the QMRP indicated that Client #1 received psychotropic medications for her maladaptive behaviors. On June 12, 2007 at approximately 11:00 AM, Client #1 was observed lying on a bean bag at the day program. Interview with the day program staff revealed that the client had episodes of head banging that morning. The staff indicated that the client was the beanbag to help her calm down. During the record verification process, on June 13, 2007, it was confirmed by the client's current physician orders that the client received Cymbalta 60 mg once a day to manage her maladaptive behaviors (tantrums). On June 13, 2007 at approximately 4:45 PM, Client #1 was observed banging her head against her wheelchair headrest. Interview with the QMRP revealed that the client had exhibited head banging behaviors and this maladaptive	W 227	**W227** **This Standard will be met as evidenced by:** QMRP in coordination with the Psychologist will ensure that head banging behaviors are included in client # 1's Behavior Support Plan. QMRP will coordinate training for both residential and day program staff as needed. Both QMRP and Psychologist will continue to monitor documentation and make changes as needed to meet the needs of client #1.	6-13-07 ongoing

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W 227	Continued From page 9 behaviors had been recommended by the Interdisciplinary team in November 2006 to add head banging to the current Behavior Support Plan. Review of the BSP, dated November 15, 2006, failed to revealed that this behavior had been added.	W 227		
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 that written training programs specified the methods to be used to ensure proper implementation of the programs for two of the four clients included in the sample. (Clients #1 and #3) The findings include: 1. The facility failed to ensure that Client #1 and #3's Physical Therapy training programs specified the methods to be used as evidenced below: a) Interview with the Qualified Mental Retardation Professional (QMRP) and record review on June 14, 2007 at approximately 1:30 PM revealed that Client #3 had an objective: "Given physical assistance, [the client] will tolerate shoulder flexion, abduction and external rotation 10 out of 10 trials holding 15 minutes each 3 days per week for 12 consecutive month". According to the objective, the client was to participate in this program for 10 trials (2 1/2 hours each session), three times per week. Further record review failed to include instructions to the direct care	W 234	**W234** **This Standard will be met as evidenced by:** QMRP will consult with the Physical Therapist. Program objective will be modified/changed to include specific instructions for implementation and documentation to better meet client #1 and #3's needs. Pictures were supplied by the Physical Therapist and placed in the program book for reference. QMRP/Physical Therapist will provide ongoing training as needed. QMRP/Home Manager/Nurse will continue to provide ongoing monitoring during mealtimes and provide direction and feedback as needed for all staff to further ensure compliance with this standard.	6-29-07 ongoing

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W 234	Continued From page 10 staff on how this program should be implemented. b) On June 12 and 13, 2007, Client #1 was observed sitting in a wheelchair. Review of the Physical Therapy assessment dated November 8, 2006, revealed a program objective which stated, "given physical assistance, [the client] will tolerate lower extremity exercises 12/12 trials, three days per week for 12 consecutive months". Staff are instructed to "refer to pictures" attached to skilled acquisition program. There were no pictures attached to skill acquisition sheet to demonstrate how the program for lower extremity exercises should be performed. c) On June 12 and 13, 2007, Client #1 was observed sitting in a wheelchair. Review of the Physical Therapy assessment dated November 8, 2006, revealed a program objective which stated, "given physical assistance, [the client] will tolerate left sidelying, right sidelying or supine position 5/5 trials, three days per week for 12 consecutive months". Staff were instructed to "refer to pictures" attached to skilled acquisition program. There were no pictures attached to skill acquisition sheet to demonstrate how the program to side lying positions were to be implemented.	W 234		6-29-07 ongoing
W 237	483.440(c)(5)(iv) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify the type of data and	W 237	**W237** **This Standard will be met as Evidenced by:** **Reference response to W234 and W189.**	

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W 237	Continued From page 11 frequency of data collection nec ssary to be able to assess progress toward the d sired objectives. This STANDARD is not met as videnced by: Based on interview and record r view, the facility failed to ensure that active treatr ent programs were designed to provide clear i structions on how to measure clients performa nce for one of two clients in the sample. (Clien #3) The findings include: The facility failed to ensure that t e data collection system for Client #3's physical therapy objective provided information n cessary to assess progress toward the obje tive. a. Interview with the QMRP and record review on June 14, 2007 at approximately :30 PM, revealed that Client #3 had an o jective to improve her shoulder range of m tion. Review of the data sheet task analysis for the months of February 2007 to June 2007 did not outline clear directions for the direct care staff to have the ability to implement this objective Additionally, for the 5 month period reflects th t each month the task procedures was change . Reportedly the QMRP changed the data she t to reflect duration of range of motion for th month on May 2007. This objective failed to ha e clear define implementation instructions in or er to measure the client's level of participation a d progress. Note: It should be further noted t at the data sheet only reflected that one trail was accomplished on this objective e ch session instead of the designated 10 trail .	W 237		

DEPARTMENT OF HEALTH AND HUMA N SERVICES
CENTERS FOR MEDICARE & MEDICAI I SERVICES

PRINTED: 06/26/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G122	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/14/2007
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W 237	Continued From page 12 b. Interview with the QMRP and ecord review on June 14, 2007 at approximately :50 PM revealed that Client #3 had a goal to impr ve her functional communication skills. Review of the ISP revealed that the objectives stated that "[the client] will manipulate a 4 icon low tech dev ce to express her feelings with minimal verbal/physical prompts when specific questions as aske in 4 out of 4 trails 1 time daily". Rev ew of the data sheet for the nonth of June 2007 failed to have a task analys s outlining clear directions giving the direct care s aff the ability to implement this objective. Furthe review of the data sheet failed to reflect the pr gram frequency and frequency in which data was o be recorded.	W 237		
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan mus include opportunities for client choice an self-management. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that clients' Individual Program Plan (IPP) included training in personal skills for one of the four clients in the sample. (Client #1) The finding includes: During meal observations on June 12, 2007 at 7:10 AM and 5:06 PM, direct care staff were observed feeding Client #1. The direct care staff informed the client what food items were being served. Review of Client #1's Individual Support Plan (ISP) dated November 15, 2006 revealed that the client can feed herself with hand over	W 247	**W247** **This Standard will be met as Evidenced by:** QMRP will ensure that client #1's individual program plan addresses client #1's needs in this area. QMRP will provide additional staff training as needed. QMRP will review mealtime mealtime protocols (W189) and expectations of performance (support and assisting individuals to accomplish tasks) during mealtimes. Adherence to choice making will be emphasized with all staff members. Also, reference response to W249 (1).	6.29.07 ongoing

DEPARTMENT OF HEALTH AND HUMA I SERVICES
CENTERS FOR MEDICARE & MEDICAII SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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W 247	Continued From page 13 hand assistance. Interview with he Qualified Mental Retardation Professional QMRP) and House Manager on June 13, 200 7 at approximately 11:00 AM indicate t that the client had a choice of adaptive feeding utensils. Record verification of an Occupa ional Therapy evaluation dated January 5, 200 revealed that the Client #1 feeds herself with h and over hand assistance. According to the fee ling protocol dated June 21, 2006 indicated th at the direct care staff should allow the client to us the hand of her choice and to scoop the food ind pendently. Record verification of the IPP da ed November 15, 2006 failed to identified a pro gram to address the clients basis activities of dail living skills.	W 247		
W 249	483.440(d)(1) PROGRAM IMPL MENTATION As soon as the interdisciplinary t am has formulated a client's individual pr gram plan, each client must receive a contin ous active treatment program consisting of eeded interventions and services in sun cient number and frequency to support the ach evement of the objectives identified in the individ al program plan. This STANDARD is not met as e videnced by: Based on observation, staff inter iew, and record review, the facility failed to ensur that three out of the four clients in the sample r ceived continuos active treatment progr ms to address their needs. (Client #1, #3 and #) The findings include: 1. On June 12, 2007 at approxin ately 7:30 AM	W 249	**W249** **This Standard will be met as evidenced by:** (1) Reference response to W247. QMRP will review all mealtime program objectives and protocols, & provide additional training as needed. Also reference responses to W234 and W189.	7-6-07 ongoing

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

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FORM APPROVED
OMB NO. 0938-0391

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W 249	Continued From page 14 and dinner at 5:00 PM the direct care staff was observed feeding Client #4 her meal on both occasions. Interview with the House Manager (HM) revealed that Client #4 had a personal management goal to participate in the meal time experience. Review of the objective stated, "Given hand over hand assistance, [the client] (during dinnertime) will tolerate holding an eating utensil for 2 minutes on three out of four trials for three consecutive months". According to the review of the data sheets the program frequency was required daily and the data was to be collected two times weekly (Thursday and Saturday). At no time during the dinner meal did the direct care staff offer Client #4 the opportunity to participate in her meal time experience. Note: It should be further noted that staff commented to management, "We were trying to hurry up and finish, and was nervous because the surveyors were watching". 2. On June 12, 2007 breakfast at approximately 7:30 AM and dinner at 5:00 PM the direct care staff was observed to feed Client #4 her meal. After her meals the direct staff removed her plate and utensils from the table into the kitchen. Interview with the HM revealed that Client #3 had a program to remove her plate from the table after dinner. Review of the client's Individual Program Plan (IPP) revealed an objective that "Given physical assistance, [the client] will take her plate to the kitchen after dinner on 80% of the trials recorded per month for 6 consecutive months by July 2007. According to the review of the data sheets the	W 249		

DEPARTMENT OF HEALTH AND HUMA N SERVICES
CENTERS FOR MEDICARE & MEDICAI SERVICES

PRINTED: 06/26/2007
FORM APPROVED
OMB NO. 0938-0391

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W 249	Continued From page 15 program frequency was required daily and the data documentation was to be recorded two times weekly. At no time during breakfast, snack and dinner did the direct care staff allow Client #3 the opportunity to participate in this program objective. Note: The HM indicated that Client #3 objective should be modified to allow her to "hand the plate over the counter to the staff in the kitchen. . .", due to her ambulation concerns. 3. The facility's direct care staff failed to consistently implement Client #3's Behavior Support Plan as written as evidenced below: On June 12, 2007 at 4:42 PM, 5:25 PM and 6:50 PM Client #3 was observed biting her right hand with no staff intervention. Although the QMRP was sitting near the client, from 5:50 PM to 6:00 PM, the client was allowed to continuously bite her hands. At approximately 6:0 PM, the QMRP commented to the client "let me get up and maybe you will stop". Interview with the HM revealed that Client #3 had a Behavior Support Plan (BSP) with an objective to "Reduce incidents of self stimulatory hand-biting". The HM described a proactive strategies which required the staff to engage the client in activities prior to the onset of the behavior. However, if the hand biting behavior is occurs to intervene. Review of the BSP, dated August 25, 2006, outlined the following: a) Say to the client "Stop": b) Staff should use "touch control, if she did not	W 249		

DEPARTMENT OF HEALTH AND HUMA N SERVICES
CENTERS FOR MEDICARE & MEDICAI D SERVICES

PRINTED: 06/26/2007
FORM APPROVED
OMB NO. 0938-0391

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W 249	Continued From page 16 comply to the verbal request; c) The staff were to immediateh divert any hand-biting or hand mouthing b moving the client hand away from her mouth . d) Staff were to redirect the clie t to a task. At no time during the earlier mer tioned observation did the direct care s aff and/or the QMRP implement this program s written. Note: None of the hand biting in idents observed by the staff and the QMRP were documented on the program data sheets. 4. On June 12 and June 13, 20(7 Staff was observed giving Client #3 a table top bead activity. According to interview with several direct care staff on June 12 and June 13, 2007, the client enjoyed manipulating the bead activity. Interview the House Manager an I review of the client's Individual Program Plan (PP) on June 14, 2007 at 11:00 AM revealed that the client had an objective to"Choose between two presented leisure/recreation activities with gestural assistance for four consecutive months by January 2006". The two leisure activities identified in the IPP were a water activity or the busy beads. There was no observed evidence that the direct care staff were providing the clie t with a choice between the two identified activit . 5. During meal observations on June 12, 2007 at 7:10 AM and 5:05 PM, direct care staff were observed feeding Client #1. The direct care staff informed the client what food iten s were being served. Review of Client #1's Individual Support	W 249	2.Reference response to W249 (1). QMRP will review program objective to determine if modifications are needed. Also, reference W189, training. 3.Reference response to W189 and W227 regarding client #3's behavior support plan. 4. Reference response to W189. QMRP/Home Manager will continue to monitor staff interactions and encourage choice making. 5.Reference response to W189, W322 and W247. 6. Reference response to W189.	7-6-07 ongoing

DEPARTMENT OF HEALTH AND HUMA N SERVICES
CENTERS FOR MEDICARE & MEDICAII SERVICES

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OMB NO. 0938-0391

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W 249	Continued From page 17 Plan (ISP) dated November 15, : .006 revealed that the client can feed herself w th hand over hand assistance. Interview with he Qualified Mental Retardation Professional (QMRP) and House Manager on June 13, 20(7 at approximately 11:00 AM indicate 1 that the client had a choice of adaptive feeding utensils. Record verification of an Occupa ional Therapy evaluation dated January 5, 200 revealed that the Client #1 feeds herself with t and over hand assistance. According to the fee ding protocol dated June 21, 2006 indicated th at the direct care staff should allow the client to us the hand of her choice and to scoop the food ind pendently. Record verification of the IPP da ed November 15, 2006 failed to identified a pro gram to address the clients basis activities of dail living skills. 6. The staff failed to consitently ncourage the client to the walker as recomme ded as evidenced below: On June 12 and 13, 2007 direct are staff were observed on three occasions to : ssist the client with ambulation to and from her edroom by holding her underneath her arms On each occasions, after the client was se ated, the staff was observed to go back to the client's bedroom, get her walker and place it in the living room. Interview with the Qualified Ment l Retardation Professional (QMRP) revealed th at Client #3 did use her walker regularly and had an ambulation program in which she should be ncouraged to "walk two laps around the length of the facility". According to the QMRP, these a ditional opportunities for Client #3 to use her walker can reinforce Client #3's walking prog ram	W 249		

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

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W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observations, interview and record review, the facility failed to ensure that each client's Individual Program Plan (IPP) objectives were documented consistently, accurately and in the frequency required by the IPP for two of four clients included in the sample. (Clients #3 and #4) The findings include: 1. Interview the house manager and record review on June 14, 2007 at 11:00 AM revealed Client #3 has an objective to"choose between two presented leisure/recreation activities with gestural assistance for four consecutive months by January 2006. The program implementation was required daily. Review of the data sheets for the month of June reflected that direct care staff were not documenting data consistently as required by the data frequency schedule. 2. The facility failed to record program implementation data for each as required by the programs. [See W249]	W 252	**W252** **This Standard will be met as Evidenced by:** **Reference response to W189 and W249.**	6-29-07 ongoing
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care.	W 322		

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

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W 322	Continued From page 19 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure general and preventive care for one of the four client's in the sample. (Client #4) The finding includes: Observation on June 12, 2007 at approximately 5:00 PM, revealed direct care staff setting up the dining room table in preparation for the client's dinner. A plastic stand with meal time protocols were placed at each place setting. Staff was observed to bring Client #4 to the table and immediately began to feed her a pureed diet of pork chops, mixed vegetables and rice. Interview with the direct care staff revealed that the client was prescribed four small meals each day. The direct care staff further commented "two meals at the group home and two meals at the day program". Additionally, review of the meal time protocol indicated that Client #4 was to be given a nutritional supplement 3 times a day. Review of the physician's diet orders did not reveal at what time the four small meals were to occur to coincide with the mealtime protocol. Further review of the physician's order prescribed conflicting time with the meal time protocol in which the client was to receive nutritional supplement supports. Note: Client #4 Health Care Management Plan (HCMP) identified concerns that this client had a history of weight loss. The HCMP risk management procedures indicated that staff and nurses' were to record food intake and output. [Also See W217]	W 322	**W322** **The Standard will be met as Evidenced by:** Nurse in conjunction with the Nutritionist will discuss and review current orders and consult with the Physician to ensure that all orders and protocols are consistent and meet the needs of the person. QMRP in coordination with the Nurse and Nutritionist will conduct additional staff training as needed. Medical staff will continue to monitor HMCP risk and procedures modify as needed to meet the needs of the person. Also reference response to W217.	6-29-07 ongoing

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CENTERS FOR MEDICARE & MEDICAI SERVICES

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W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide each client with nursing services in accordance with their needs. The findings include: 1. The facility's nursing staff failed to ensure updated physician's orders were provided to the day program. (See W120) 2. The facility's nursing staff failed to ensure that the physician's orders reflected the special meal schedule for Client #4. (See W322) 3. Interview with the nurse on June 13, 2007 at approximately 6:00 PM revealed that direct care staff were responsible for taking client #3 to the bathroom every two hours and recording her output. Further interview with the nurse revealed that the nursing staff were responsible for monitoring this program. Review of the client's Health Care Management Plan identified constipation, and incontinence (bowel and urine) as ongoing concerns. Review of the data collection sheet revealed a program for the month of June 2007 with an objective that "staff will escort [the client] to the bathroom every 2 hours." According to the data sheets, staff were not documenting daily and there was evidence of the client's output at her day program.	W 331	**W331** **This Standard will be met as Evidenced by:** (1). Reference response to W120. Updated Physician's Orders were provided to the day program. (2) Reference response to W322. (3). Reference response to W189 Staff are to inform the nurse on duty each time the clients have a bowel movement. The nurse in turn must document information immediately. ATS staff are expected to document output in the same manner. QMRP/Nurse will follow-up with day program provide documentation sheet if needed to record client #3's output during the day time. QMRP/Nurse will review the current documentation process modify and change as needed to ensure ongoing and consistent documentation. All staff will be provided additional training as needed.	6.29.07 ongoing

DEPARTMENT OF HEALTH AND HUMAI I SERVICES
CENTERS FOR MEDICARE & MEDICAIE SERVICES

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W 331	Continued From page 21 4. The nursing staff failed to mo itor Client #2's pleasure feeding intake. On June 12, 2007 at 7:15 AM an 5:05 PM, Client #2 was observed being tube fed. Interview with the nursing staff at 5:30 PM indic ited that the client received pleasure feedings while in the community. Further interview wi the House Manager revealed that when the lients were on community outings, Client #2 cri d and whined when the other clients received s acks. According to the community outi g log sheet, the client participates in community c tings at least two times per week. According t the QMRP. It was brought to the attention of th nutritionist. A recommended was made by the utritionist for the client to receive pleasure fea ings once a week while in the community. Th client should receive low fat pudding, yogurt o jello; however, there was no documentation to v rify that the client was receiving pleasure fee ings.	W 331		
W 336	483.460(c)(3)(iii) NURSING SER ICES Nursing services must include, fo those clients certified as not needing a medica care plan, a review of their health status whic must be on a quarterly or more frequent basis epending on client need. This STANDARD is not met as e idenced by: Based on interview and record re iew, the facility failed to ensure that the health st tus was reviewed by the Registered Nurs (RN) staff on a quarterly or more frequent basis or one of the three client in the sample. (Clien #1) The finding includes:	W 336	**W336** **This Standard will be met as Evidenced by:** **RN has completed the quarterly nursing exam as scheduled.**	6.15.07 ongoing

DEPARTMENT OF HEALTH AND HUMA N SERVICES
CENTERS FOR MEDICARE & MEDICAI I SERVICES

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W 336	Continued From page 22 Interview with the facility's Licens ed Practical Nurse on June 12, 2007 at appro ximately 2:00 PM revealed that the Registered Nurse (RN) should complete quarterly nursin rexams. Review of Client #1's medical rec ord revealed a quarterly nursing assessment da ed February 2007 with the next quarterly sche fuled May 2007. There was no evidence that the c lient's health status had been reviewed quarte y by the RN as scheduled.	W 336		
W 436	483.470(g)(2) SPACE AND EQU PMENT The facility must furnish, maintain in good repair, and teach clients to use and to m ike informed choices about the use of denture , eyeglasses, hearing and other communicatior aids, braces, and other devices identified by th interdisciplinary team as needed l y the client. This STANDARD is not met as e idenced by: Based on observation, interview a id record review, the facility failed to mainta n adaptive equipment in good repair for two (ne of the four clients in the sample. (Clients #1, #3 and #4) The finding includes: 1. Observation at Client #4's day rogram revealed that the client had a very large hole in her wheelchair. Interview with the day program staff indicated that the client rubs he seat of her wheelchair with her fingers until it reates a hole exposing the inner foam. Further nterview with the day program staff revealed tha the client's left arm support padding was worn ex osing the inner foam as well.	W 436	**W436** **This Standard will be met as Evidenced by:** 719a has been submitted to secure necessary wheelchair repairs for client #1, and #4. QMRP will follow-up on status of pending repairs. QMRP will consult with Physical Therapist to ensure that quarterly monitoring of adaptive equipment is included as part of the quarterly progress reports. QMRP will consult with Physical Therapist regarding client #4's lap tray usage, document and implement recommendations as outlined. QMRP will also consult with Physical Therapist to determine if further strategies and/or modifications can be made to reduce wear of wheelchair.	7-6-07 ongoing

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	(9G122		06/14/2007

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STREET ADDRESS, CITY, STATE, ZIP CODE: 3020 STANTON ROAD, SE WASHINGTON, DC 20020

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W 436	Continued From page 23 Interview with the Qualified Ment I Retardation Professional (QMRP) revealed th at 719 A had been filled out for the repair the v eek before the survey. Further interview reveale I the the Physical Therapist had not been nonitoring each clients adaptive supports as a pa t of his quarterly monitoring. Reportedly Client #4 s wheelchair seat has been replacement on m ore than one occasion. According to the QMR), the previous repairs were due to the Client's s ame seat rubbing behavior. 2. Review of the speech and lan uage training instructions for the use of her Tal ing Communication Device recomme nded by the Speech and Language Therapist ndicated that the client should use either her la or on her lap tray during the use of the commu ication device during programming. Interview with the House Manage on June 14, 2007 revealed that Client #4 had a lap top tray that she was required to use for p ogramming. Reportedly the client's day progra n returned the lap top tray and the client had not used it for some time. According to the HM, the tray was in her bedroom, however the lap tra was discovered in a outside storage c oset. Interview with the QMRP reveale I that the client's was not consistently using the lap tray. the QMRP indicated that the use of the tray may possibly deter Client #4's from rul bing her seat cushion. Review of the physical therapy as sessment dated February 7, 2007 failed to include I the client's lap top tray as a support for her use during active treatment programming. There w s no	W 436	W436, Continued ATS staff are expected to monitor and document status of the wheelchair on a weekly basis, alert the QMRP immediately of any concerns to ensure timely and efficient repairs. QMRP will coordinate additional training for all staff to ensure ongoing compliance with this standard.	

DEPARTMENT OF HEALTH AND HUMAI I SERVICES
CENTERS FOR MEDICARE & MEDICAIT SERVICES

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W 436	Continued From page 24 documented evidenced that Cller t #4 was in need of the lap top tray for programma ic support. 3. The facility failed to maintain Client #1's headrest in good repair. Observations throughout the surv ey revealed that Client #1's headrest was sitting vi rtically on the top of her wheelchair. Interview v ith the QMRP and House Manager indicated th t the Physical Therapist monitors wheelchair re airs. Review of the physical therapy section, ther was no evidence of any reviews since the annual ISP meeting held on November 16, 2(07.	W 436		

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I 000	INITIAL COMMENTS A licensure survey was conducted from June 12, 2007 through June 14, 2007. The survey was initiated using the fundamental survey process. A random sample of four residents were selected from a residential population of seven female clients with varying degrees of disabilities. The findings of the survey were based on observations at the residence and one day program. Also the findings were based on staff interviews in both the group home and day program, as well as a review of habilitation and administrative records, to include the facility's unusual incident reports.	I 000		
I 056	3502.14 MEAL SERVICE / DINING AREAS Each GHMRP shall train staff in the storage, preparation and serving of food, the cleaning and care of equipment, and food preparation in order to maintain sanitary conditions at all times. This Statute is not met as evidenced by: Based on observation and staff interview, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that meat were stored properly and in sanitary conditions. The finding includes: On June 12, 2007 at 2:10 PM, a package of meat was sitting on the kitchen counter. At 3:00 PM, direct care staff began cooking the meat in preparation for dinner.	I 056	**1056** **3502.14 Meal Service/Dining Areas** This Statute will be met as evidenced by: Home Manager/Nutritionist will conduct additional training for all staff on proper storage and maintaining sanitary conditions. Home Manager will monitor meal preparation techniques to ensure ongoing compliance with this standard.	6-29-07 ongoing
I 136	3505.6 FIRE SAFETY Each GHMRP shall maintain records of each	I 136		

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I 136	Continued From page 1 simulated fire drill. This Statute is not met as evidenced by: Interview and record review revealed that the GHMRP failed to ensure fire drill records were monitored and accurately completed. The findings include: The simulated fire drill records were reviewed on June 13, 2006 and revealed the following: a. There was no area on the fire drill form to reflect when problems were identified. b. There were no fire drill records from March 2007 to June 2007 the fire drill form did not reflect that the designated reviewer had monitored the drills during this period to determine if and when problems were occurring.	I 136	**1136** **3505.6 Fire Safety** This Statute will be met as evidenced by: a. Fire drill forms will be reviewed and changed as needed to reflect identified problems. b. All staff will receive additional training in fire drills, expectation, and documentation. Fire Drills are to be completed on a monthly basis on each shift. QMRP/Home Manager will monitor fire drills on a monthly basis to ensure ongoing compliance with this standard.	6.29.07 ongoing
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 by: Based on record review, the GHMRP failed to have on file for review current job descriptions for all employees annually. The finding includes: Review of the personnel files conducted on June 14, 2007, revealed that GHMRP failed to provide evidence current signed job descriptions for	I 203		

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I 203	Continued From page 2 fifteen (15) direct care staff, the House Manager and the QMRP.	I 203	**3509.3 Personnel Policies** **This Statute will be met as evidenced by:** Home Manager completed review of job descriptions with all staff. Copies of signed job descriptions are filed. Each staff is required to review and sign the job descriptions at the time of hire and annually thereafter. Home Manager will review status of job descriptions on a monthly basis and update with staff as needed to ensure compliance with this standard.	6-22-07 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 record review, the GHMRP failed to have on file for review current health certificates for all employees annually. The findings include: On June 14, 2007, review of health certificates revealed failure by the GHMRP to show evidence of current health certification for the following: - two direct care staff [[redacted]]; - one nurse consultant [[redacted]]; - primary care physician; - psychiatrist; - nutritionist; - speech pathologist; and - recreation specialist.	I 206		
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel.	I 222		

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I 222	Continued From page 3 This Statute is not met as evidenced by: Based on observations, interview and record verification, the GHMRP failed to ensure continuous, ongoing in-service training programs were conducted for all personnel The finding includes: See Federal Deficiency Report Citation W189	I 222	1206 3509.6 **This Statute will be met as evidenced by:** **Health certificates for staff, Primary Care Physician, Speech Pathologist, Nutritionist, and Psychiatrist will be filed.** **Human Resource Department will continue to monitor and track compliance of health certificates, send notices 90-days prior to expiration dates and remove individuals from the work schedule if compliance has not been met.** **Office Assistant will continue to monitor and track consultant health certificates. Reference procedures for compliance as mentioned above.**	6-28-07 ongoing
I 395	3520.2(e) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (e) Nursing; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure its nurses had current licenses on file. The finding includes: Review of the personnel records on June 14, 2007 revealed that the GHMRP failed to have current license on file for one License Practical Nurse(LPN) employed by the agency ([redacted]), nutritionist and recreation specialist.	I 395	**1222** **3510.3 Staff Training** **Reference response to Federal Deficiency Report Citation W189.**	6-29-07 ongoing

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I 401	Continued From page 4	I 401	**1395**	
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on interview and record review the GHMRP failed to provided ongoing diagnostic and evaluation for services for three of four residents in the sample. The findings include: See Federal Deficiency Report Citation W331, W322	I 401	**3520.2 (e) Profession Services: General Provisions** This Statute will be met as evidenced by: Current licenses will be obtained and filed for review. **1401** **3520.3 Profession Services: General Provisions** This Statute will be met as evidenced by: Reference response to Federal Deficiency Report Citation W331, W322.	6-22-07 ongoing 6-29-07 ongoing
I 407	3520.9 PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall obtain from each professional service provider a written report at least quarterly for services provided during the preceding quarter. This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for Mentally Retarded Persons' (GHMRP) Registered Nurse, failed to provide evidence of a written quarterly report one of the four residents in the sample. (Resident #1) The finding includes: See Federal Deficiency Report - Citation W336	I 407	**1407** **3520.9 Profession Services: General Provisions** This Statute will be met as evidenced by: Reference response to Federal Deficiency Report-Citation W336.	6-29-07 ongoing

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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 treatment and services in accordance with two of the six residents' Individual Habilitation Plans. (Resident #1, #2, #3 and #4) The findings include: See Federal Deficiency Report - Citations W214, W217, W227, W234, W237, W247 and W249.	I 422	**1422** **3521.3 Habilitation and Training** This Statute will be met as evidenced by: Reference response to Federal Deficiency Report-Citations W214, W217, W227, W234, W237, W247, and W249.	7-6-07 ongoing