Received 9/9/08

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION
825 NORTH CAPITOL ST., N.E., 2ND FLOOR
WASHINGTON D.C. 20002

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

PRINTED: 09/05/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G122		R 09/03/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	3820 STANTON ROAD, SE WASHINGTON, DC 20020

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDE 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	{W 000}		
	A follow-up survey to the 7/25/2008 recertification survey was completed on 9/3/2008. The survey was conducted to determine if the facility had regained compliance with the federal requirements in the Conditions of Governing Body and Management, Client Protection, Facility Staffing, and Health Care Services. The results of the survey were based on observation, staff interviews, as well as a review of the client and administrative records, including a review of the unusual incident reports. The facility was found to be in a state of continued non-compliance with the Conditions of Participation in the areas of Governing Body, Client Protections and Health Care Services.		W102 **This Condition will be met as evidenced by:** The facility reviewed all concerns related to the day program and implementation of the meal protocols. Previous interventions outlined in the plan of correction continue as outlined. On 9.8.08 meal observations were completed at the day program by the IDI team members to include but not limited to; Director of Residential Services, Assistant Director Residential Services, RN and Director of Nursing Services. The concerns and observations were discussed with the day program staff. Further as a result of the meal observations and the ongoing concerns related to the safety the clients were removed from the day program and are currently being provided active treatment services in the home.	
{W 102}	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.	{W 102}	Further meetings and case conferences will be scheduled with the day program. A case conference will be scheduled on behalf of each individual to discuss staffing and training needs at the day program. The DDS Case Manager has been aware of the situation and is currently searching for a new day program to meet the needs of the individuals. The QMRP will continue receive training to enhance her ability to evaluate staff competency and take appropriate actions to address and document concerns to protect the health and safety of the people. The QMRP will continue to conduct weekly monitoring/site visits to the day program sites. Meal observations continue to be conducted by the LPN's, Home Manager and QMRP. QMRP/Home Manager will coordinate training with specialists on an ongoing basis as needed to further ensure that the staff are competent and able to demonstrate the skill necessary to meet the needs of the people.	9-9-08 ongoing
	This CONDITION is not met as evidenced by: The facility must ensure that specific governing body and management requirements are met. On 8/29/2008, a follow-up survey was completed to re-assess the facility's level of compliance with the Re-certification follow-up that was completed on 7/25/2008. Based on observations, staff interviews and record reviews both at the day program and the group home, it was determined that the facility's governing body failed to maintain general operating direction over the facility to ensure			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: DRS (X6) DATE: 9/9/08

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 102}	Continued From page 1 client health and safety [Cross reference W104, W127, W158 and W318]. The results of these systemic practices revealed the facility's Governing Body failed to adequately govern the facility in a manner that would ensure clients were free from harm.	{W 102}		
{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 staff interviews and record verification during the re-visit on 8/29/2008, the governing body failed to ensure that the facility consistently exercised general policy and operation direction over the facility. The findings include: 1. During the revisit on 8/25/2008 the facility was again found to have not implemented the corrective actions to secure accurate assessments and effective training as detailed in their Plan of Correction (POC) dated 8/25/2008. The facility failed to present any evidence at the time of the revisit to substantiate that all staff received training to address each clients' needs with regards to the approved meal time feeding protocols. [Cross Reference W159] 2. The facility's Governing Body failed to ensure that outside services (day program) were correctly implementing meal time protocols as prescribed by the facility. [See W120 & W127]	{W 104}	**W104** **This Standard will be met as evidenced by:** The POC dated 8.25.08 detailed a response to W159.1 which states that "the QMRP failed to ensure that residential and day program staff were trained effectively and competently implement client #2's diet orders. The response indicates that training was conducted at both the day program and residential sites. Training for all individuals was completed. The RN from the home and the RN from the day program also provided a joint training to staff at the day program site. This information was filed in each person book at the time of the revisit. The surveyor reported to the ADRS that he would be returning to review the documents on Tuesday, September 2, 2008. However, the surveyor did not return as originally stated, nor did he call to report changes to the revisit process.	9.3.08
W 111	483.410(c)(1) CLIENT RECORDS	W 111		

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W 111	Continued From page 2 The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure an accurate compilation of clients' assessments, their required follow-ups and the subsequent staff trainings for four of the four sampled clients residing in the facility. (Clients #4, #5, #7 and #8) The finding includes: On 8/29/08, a second follow-up to the original recertification survey conducted 6/12/2008 was initiated. During the survey, the House Manager (HM) and the Assistant Director (AD) sat in to represent the facility as the newly hired Qualified Mental Retardation Professional (QMRP) was not available. In review of the deficient practices cited in W159 with the facility's AD, the Plan of Correction (POC) detailed that "training was conducted at the day program site and residential site on Client #2's diet orders ... documentation will be maintained in the individual record for review." Further interview with the AD and the HM revealed all eight of the clients in the facility have been individually prescribed a meal time feeding protocol. A sample of four other clients (Clients #4, #5, #6 and #8) was randomly selected to assess the corrective action plan the facility enacted to address the citations levied in W102, W122 and in W318. The facility failed to provide evidence that staff received training on the meal time protocol requirements on any other	W 111	Nursing staff, QMRP and Home Manager continue to visit the day program sites and conduct monitoring of meals as well as programming. No significant problems have been documented by the QMRP, Home Manager and Nurse. In addition, a meeting was held at the day program (8.15.08) whereby the needs of all individuals were reviewed and recommendations made to address individual concerns. 2. Reference response to W120 and W127.	9.9.08 ongoing

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W 111	Continued From page 3 clients with the exception of Client #2. The facility took copies of the training sign-in sheets from Client #2 ' s records filed them in each of the other client ' s records. There was no evidence that the training addressed the specific needs of each client. The facility ' s AD and HM reviewed several other records and was not able to provide any evidence of client specific training. [Cross Reference W120 & W127]	W 111	**W111** **This Standard will be met as evidenced by:** The facility provided required follow-up as outlined in the POC. Training was conducted at the day program site on individual meal protocols, aspiration precautions were added and to all individual protocols and staff at both the residential and day program sites were in-serviced. This information was in the record at the time of the visit and reflected the actual experience of the person being served. It is unclear as to why client #2's training sheet was found in the book. Staff interviewed did not confirm this information. Cross reference response to W120 and W127.	9-9-08 ongoing
W 114	483.410(c)(4) CLIENT RECORDS Any individual who makes an entry in a client's record must make it legibly, date it, and sign it. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure an effective system of recording keeping with regards to the certification of individual assessments for four of the four sampled clients residing in the facility. (Clients #4, #5, #7 and #8) The finding includes: On 8/29/08, a second follow-up to the original recertification survey conducted 6/12/2008 was initiated. During the survey, the House Manager (HM) and the Assistant Director (AD) sat in to represent the facility as the newly hired Qualified Mental Retardation Professional (QMRP) was not available. During the 7/25/2008 follow-up W104 was cited for the facility " failing to ensure that outside consultants had completed [the] necessary assessments, revisions, and training. " In reviewing the facility ' s corrective action plan for this citation several newly created meal time protocols were reviewed and none of the new meal time feeding protocols were neither signed	W 114		

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W 114	Continued From page 4 nor dated by the individual who drafted the assessment. [Cross Reference W120 & W127]	W 114		
{W 120}	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observations, staff interview, and record review, the facility failed to effectively monitor each client's day program to ensure that their meal time feeding programs were being implemented to ensure client safety for two of the two clients in the sample. [Client #4 and #5] The finding includes: The following citations are reflective of continuous deficient practices as cited in the 7/25/2008 follow-up: The follow-up survey dated 7/25/2008 detailed systematic mealtime issues, as it related to the day program ' s failure to protect client #2's health and safety at mealtimes. On 8/29/2008, a second revisit was conducted and the similar mealtime issues were identified for Clients #4 and #5. On 8/25/2008 the group home submitted a Plan of Correction (POC) that outlined the Qualified Mental Retarded Professional (QMRP) would ensure the oversight of this deficient practice by 8/22/2008. As of 9/3/2008 continuing problems were observed with Clients #4 and #5: 1. Client #4 was observed being served a ground textured meal with a plastic spoon. The staff was observed to provide this client with	{W 120}	W114 This Standard will be met as evidenced by: Meal time protocols include information extracted from the assessments. The mealtime protocols have not been viewed as an "entry" into an individual's record. As such signatures were not indicated on the protocols. All assessments continue to be signed and dated as outlined in the regulatory requirement. No systemic problem has been identified previously.	9.9.08 ongoing

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{W 120}	Continued From page 5 spoons of food and at varying intervals, sips of water out of a small plastic cup (approximately 4oz). There would be two to five spoons of food between servings of water. Review of the 8/28/2008 Meal Time Protocol revealed she was to have her solids and liquids served in an alternating fashion. In addition, this protocol required an unbreakable teaspoon, a sponge handle and a divided plate. Client #4 was not served with a unbreakable spoon nor was it equipped with a sponge handle. Interview with the Day Program staff revealed Client #4 was not able to feed herself and had been at this functioning level for more than the pastyear. It is not clear why this client had been provided a sponge handle and divided plate, beingshe did not feed herself and required full staff assistance. 2. Client #5 's new Meal Time Protocol dated 8/27/2008 required that Client #5 be provided with 8 ounces of nectar thickened water, must be fed at 90 degrees, presented ½ to 1 teaspoon [of food] at a time with chin upwards, allowther to swallow before presenting another spoonful, and when she shows signs of fullness such as turning her head away, do not force her to finish her meal. Observation on 9/3/2008 revealed Client #5 was not provided her liquids at a nectar consistency. According to staff interview, he does not use the measuring cups that came with the " thickener " , but uses a regular plastic spoon for measurement. Client #5 was also observed leaning forward for the duration of her meal and there was a considerable spillage of food and beverage during her feeding. Also, shewas observed taking in more spoons of foodwith additional food being in her mouth. During the later part of the meal, Client #5 turned away several times appearing to refuse more offers of	{W 120}	W114 Continued... The RN will review all protocols for accuracy and sign/date to verify information is consistent with the physician orders, and Speech/P.T./OT recommendations. Feeding Team Meetings will be conducted on a monthly basis. Mealtime protocols, weight loss/gain, positioning, adaptive equipment needs, recommendations will be reviewed as needed to further ensure needs of the individuals are met.	9.9.08 ongoing 9.25.08 ongoing

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{W 120}	Continued From page 6 food. The staff was observed to grab her lower jaw/chin and attempt to force feed her the additional spoons of food. After three attempts, the staff gave up and proceeded to serve Client #5 her serving of " Resource " (nutritional supplement).	{W 120}	W120 This Standard will be met as evidenced by:	
{W 122}	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: On 8/29/2008 a follow-up survey was completed to access the facility's level of compliance with correcting the deficiencies identified during the recertification follow-up which was completed on 7/25/2008. Based on observations, interview and record review, it was determined that the facility failed to ensure the safety of clients who were at risk of aspiration [See W127 and W194]. The effects of these systemic practices results in the failure of the facility to protect its clients from harm and to ensure their general safety and well being.	{W 122}	On 9.8.08 Director of Residential Services/RN's and other team members conducted a site visit at the day program. The purpose of the visit was to monitor and further evaluate the mealtime process/protocols. Following the observations the team members met with the day program staff to discuss the observations. Corrective actions and the need for additional staff training was also discussed. It was agreed that another meeting will be scheduled with the day program to discuss in further detail the issues related to adaptive equipment, positioning, food consistency and mealtime supervision as it relates to each individual.	9.8.08 ongoing
{W 127}	483.420(a)(5) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop and	{W 127}		

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(W 127)	Continued From page 7 implement systems to ensure the health and safety of one client by ensuring that all their meals were served in accordance with the prescribed dietary requirements; for two of the two clients in the sample. (Client #4 & #5) The findings include: The previous survey dated 7/25/2008 outlined systematic issues, as it related to the group home and the day program's failure to protect Client #2's health and safety at mealtimes. On 8/25/2008 the group home submitted a Plan of Correction (POC) that outlined the following: 1. The nutritionist, OT, PT and Speech Therapist completed site visits to address and assess meal time safety and feeding techniques. 2. Mealtime protocols were modified and clearly outline aspiration risks as well as the action steps to be taken. As described in the 7/25/2008 deficiency report, similar problems were identified with both Clients #4 and #5 as presented below: 1. Client #4 was observed being served a ground textured meal with a plastic spoon. The staff was observed to provide this client with spoons of food and at varying intervals, sips of water out of a small plastic cup (approximately 4oz). There would be two to five spoons of food between servings of water. Review of the 8/28/2008 Meal Time Protocol revealed she was to have her solids and liquids served in an alternating fashion. In addition, this protocol	(W 127)	W120. Continued... The DDS Case Manager was informed and is in the process of identifying a new day program site to meet the needs of the individuals. The individuals have been removed from the current day program and are being provided day activities/active treatment in the home. **W127** **This Standard will be met as evidenced by:** Reference response to W120. Also, Case Conferences will be scheduled on behalf of each person to discuss the level of supervision needed during meals at the day program sites as well as training needs. Additional funding will be requested as needed and day program agreements modified as warranted to reflect the recommended changes.	9-8-08 ongoing

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{W 127}	Continued From page 6 required an unbreakable teaspoon, a sponge handle and a divided plate. Client #4 was not served with a unbreakable spoon nor was it equipped with a sponge handle. Interview with the Day Program staff revealed Client #4 was not able to feed herself and had been at this functioning level for more than the past year. It is not clear why this client had been provided a sponge handle and divided plate, being she did not feed herself and requires full staff assistance. 2. Client #5 ' s new Meal Time Protocol dated 8/27/2008 required that Client #5 be provided with the following: § 8 ounces of nectar thickened water § Must be fed at 90 degrees, § Presented ½ to 1 teaspoon [of food] at a time with chin upwards, § Allow her to swallow before presenting another spoonful ... § ...and when she shows signs of fullness such as turning her head away, do not force her to finish her meal. Observation on 9/3/2008 revealed Client #5 was not provided her liquids at a nectar consistency, but at a consistency similar to regular milk. According to staff interview, he does not use the measuring cups that came with the " thickener ", but uses a regular plastic spoon for measurement. Client #6 was also observed leaning forward for the duration of her meal and as such, there was considerable spillage of food and beverage during her feeding. In addition, she	{W 127}	**W127** **This Standard will be met as evidenced by:** Reference response to W120. Also, Case Conferences will be scheduled on behalf of each person to discuss the level of supervision needed during meals at the day program sites as well as training needs. Additional funding will be requested as needed and day program agreements modified as warranted to reflect the recommended changes.	9.10.08. ongoing

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{W 127}	Continued From page 9 was observed taking in additional spoons of food while still having additional food in her mouth. The staff did not allow her to completely ingest her food prior to providing another. During the later part of the meal, Client #5 was observed to turn her head away several times appearing to refuse the additional spoons of food the staff was attempting to feed her. The staff was observed to grab her lower jaw/chin and attempt to force feed her the additional spoons of food. After three attempts, the staff gave up and proceeded to provide Client #5 her serving of " Resource " (nutritional supplement) again with heavy spillage. There was no evidence presented or on file during the follow-up to substantiate that the facility ensured the proper oversight and training as exemplified by the ineffective implementation of the meal time protocols.	{W 127}		
{W 158}	483.430 FACILITY STAFFING The facility must ensure that specific facility staffing requirements are met. This CONDITION is not met as evidenced by: On July 25, 2008 a follow-up survey was completed to access the facility's level of compliance with correcting deficiencies cited emanating from the recertification survey completed on June 12, 2008. Based on observations, interviews and record review, it was determined the facility continued to fail to ensure clients' health and safety [Cross reference W127]; the facility's Qualified Mental Retardation Professional (QMRP) failed to effectively coordinate services to meet the needs of its clients [Cross reference W159]; and the	{W 158}	**W158** **This Condition will be met as evidenced by:** **Cross reference response to W127 and W159 and W194.**	9.9.08

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{W 158}	Continued From page 10	{W 158}		
	facility failed to ensure that each employee demonstrated competency in implementation of clients' mealtime protocols [Cross reference W194]: The effects of these systemic practices results in the failure of the facility to ensure the availability of adequately trained staff, to ensure client health safety and well being.			
{W 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 verification, the Qualified Mental Retardation Professional (QMRP) failed to coordinate and monitor services for two of the eight clients residing in the facility. (Clients #4 and #5) The findings include: 1. The QMRP failed to ensure that the day program staff was trained to effectively and competently implement Clients #4 and #5 's meal time protocols to ensure client health and safety. [Cross reference W194 and W127]. 2. The QMRP failed to ensure that day program staff ensured Client #5 was fed at a 90 degree angel and received her liquids at a nectar consistency. [Cross reference W120 & W127] 3. The Qualified Mental Retardation Professional (QMRP) failed to ensure that the day	{W 159}		

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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 R 09/03/2008
NAME OF PROVIDER OR SUPPLIER IDI		STREET ADDRESS, CITY, STATE, ZIP CODE 3020 STANTON ROAD, SE WASHINGTON, DC 20020	

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{W 159}	Continued From page 11 program staff alternated the serving of the solids and liquids during meals as required in the meal time protocol for Client #4. [Cross reference W120 & W127]	{W 159}		
W 186	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure an effective compliment of staff in the implementation of a client's meal time feeding protocol for two of two sampled clients. (Clients #4 & Client #5) The finding includes: During lunch observations on 9/2/2008, and again on 9/3/2008, observations at the day program revealed that only one staff was available during lunch to assist approximately six (6) clients with their meals. It should be noted that both Clients #4 and #5 were identified as being at risk for aspiration and meal time feeding protocols were developed to address this risk. During the observation, the attending staff was seen feeding Client #4 her meal and also taking time on occasions to assist another client (sitting at the table) with her meal. Throughout the observation period on 9/2/2008, and again on 9/3/2008, the other residents (approximately 5) had to sit at the table with their meals in front of them and wait for	W 186	**W159** **This Standard will be met as evidenced by:** 1. Cross Reference response to W194 and W127. 2. Cross reference response to W120 and W127. 3. Cross reference responses to W120 and W127. **W186** **This Standard will be met as evidenced by:** Cross reference response to W127, W120 and W104.	9.9.08 9.10.08

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	09G122		R 09/03/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	3620 STANTON ROAD, SE WASHINGTON, DC 20020

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W 186	Continued From page 12 their turn to be served. Note: Review of the Meal Time Protocol dated 8/28/2008 required that Client #4 have her solids and liquids served in an alternating fashion. The day program ' s staff failed to ensure that requirement. On 9/3/2008, at approximately 12:30pm, there were approximately ten (10) residents in the lunch room and one staff was present at the time the survey team entered the lunch room. The survey team introduced themselves to the staff and at approximately 12:35pm, a second staff member entered the room and the first staff member gave him instructions on which client ' s required feeding. According to staff interview on 9/3/2008, all the residents for this lunch period were normally in the lunch room by 12:15pm. There was no evidence presented or on file at the time of survey to substantiate that the facility had enacted measures to ensure an effective compliment of staff to properly implement the meal time feeding protocols for Client ' s#4 and Clients #5. [Cross Reference W120 & W127]	W 186		
{W 194}	483.430(e)(4) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible. This STANDARD is not met as evidenced by: Based on observation, interview and record verification, staff failed to demonstrate competency in implementing clients' feeding protocols, for one of the four clients in the sample. (Clients #2)	{W 194}		

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

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{W 194}	Continued From page 13	{W 194}		
	The findings include:		**W194** **This Standard will be met as evidenced by:**	
	The 7/25/2008 revisit outlined systematic mealtime issues, as it related to the day programs failure to protect client #2's health and safety at mealtimes. Similarly, Clients #4 and #5 was observed with similar findings during mealtimes as outlined below:		QMRP will receive training to address staff competencies, implementation of protocols, follow-up actions and documentation.	9.10.08
	1. Client #4 ' s staff failed to ensure that methodology of serving her solids and liquids was implemented as written. [See W120 and W127]		1. Reference response to W120 and W127 2. Cross reference response to W120 and W127.	9.9.08
	2. Client #5 ' s staff failed to ensure that she received her meals in an upright position and failed to ensure her liquids were served at a nectar consistency. [See W120 and W127]			
{W 318}	483.460 HEALTH CARE SERVICES	{W 318}		
	The facility must ensure that specific health care services requirements are met.		**W318** **This Condition will be met as evidenced by:**	
	This CONDITION is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure that staff in the home and at day program demonstrated competency in implementing clients' mealtime protocols [Cross reference W127 and W194]; failed to provide preventive and general health care services to meet the needs of the clients [Cross reference W322]; and failed to establish systems to ensure that nursing services were provided in accordance with clients' health and safety needs [Cross reference W331];		Cross reference response to W127, W194, W322 and W331.	9.9.08
	The results of these systemic practices results in			

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{W 318}	Continued From page 14	{W 318}		
	the demonstrated failure of the facility to provide health care services.			
{W 322}	483.460(a)(3) PHYSICIAN SERVICES	{W 322}		
	The facility must provide or obtain preventive and general medical care.			
	This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to provide preventive and general medical care for one of the four clients in the sample. (Client #6)			
	The findings include:			
	Observations, interviews and record reviews during the June 12, 2008 recertification survey, revealed that Client #2 was at risk of aspiration during meals. There was no evidence, at that time, that the medical team had effectively monitored the implementation of her mealtime protocol, to ensure her health and safety. As found with the 6/12/2008 recertification survey and as found in the 7/25/2008 follow-up, the facility failed to provide any evidence that the medical team had reviewed and/or monitored the newly developed meal time protocols that were drafted on 8/26/2008 and provided to the day program on 8/28/2008 for both Clients #4 and #5. The day program failed to provide any evidence that staff had been trained on the " new " protocols and staff was observed to incorrectly implement the meal time protocols on both 9/2/2008 and again on 9/3/2008. [Cross Reference W120 and W127]			
{W 474}	483.480(b)(2)(iii) MEAL SERVICES	{W 474}		

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(W 474)	Continued From page 15 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 that food was provided in the prescribed texture, for one of the two clients in the sample. (Client #5) The findings include: Client #5 's new Meal Time Protocol dated 8/27/2008 required that Client #5 be provided with " 8 ounces of nectar thickened water ". Observation on 9/3/2008 revealed Client#5 was not provided her liquids at a nectar consistency, but at a consistency similar to regular milk. According to staff interview, he does not use the measuring cups that came with the " thickener ", but uses a regular plastic spoon for measurement. There was no evidence presented or on file at the time of the follow-up to substantiate that the facility implemented effective training on the requirements of providing a nectar consistency liquid to Client #5.	(W 474)	**W322** **This Standard will be met as evidenced by:** Cross reference W120 and W127.	9.9.08
			W474 **This Standard will be met as evidenced by:** **Cross reference responses to W120 and W127.**	9.9.08 ongoing