

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

PRINTED: 05/08/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/08/2011
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NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010
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W 000 INITIAL COMMENTS

A recertification survey was conducted from April 4, 2011 through April 8, 2011. A sample of four clients was selected from a population of seven men with various cognitive and intellectual disabilities. This survey was initiated utilizing the fundamental process; however, due to concerns in the areas of health care services, the process was extended on April 7, 2011 to review the facility's level of compliance in the Condition of Participation (CoP) for Health Care Services.

The findings of the survey were based on observations and interviews with staff in the home and at two day programs, as well as a review of client and administrative records, including incident reports.

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's qualified intellectual disabilities professional (QIDP) failed to ensure the coordination of services to promote the health and safety of three of the four clients in the sample. [Clients #1, #2, and #3]

The findings include:

- [Cross-refer to W214] The facility's QIDP failed to fully assess each client's behavior management needs, for one of the four clients in

W 000

Reviewed 5/13/11
Department of Health
Health Regulation & Licensing Administration
Intermediate Care Facilities Division
825 North Capitol St., N.E.
Washington, D.C. 20002

W 159

1. Cross reference W214

6/1/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Cristina A. Reese - Program Director TITLE
3-13-11 (X5) DATE

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 159	Continued From page 1 the sample. (Client #2) 2. [Cross-refer to W249] The facility's QIDP failed to ensure continuous active treatment, for three of the four clients in the sample. (Clients #1, #3 and #4) 3. [Cross-refer to W436] The facility's QIDP failed to ensure that clients had recommended adaptive equipment furnished timely and available for use, for two of the four clients in the sample. (Clients #1 and #2) 4. [Cross-refer to W460] The facility's QIDP failed to ensure clients received their prescribed modified diets as ordered by the physician, for one of the four clients in the sample. (Client #3)	W 159	
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, staff interview and record review, the facility failed to fully assess each client's behavior management needs, for one of the four clients in the sample. (Client #2) The finding includes: During Client #2's lunch at the day program on April 4, 2011, he was observed refusing to hold a sip cup to drink his milk, between 1:00 p.m. - 1:14 p.m. During that same time period, he also repeatedly refused to hold his spoon to continue feeding himself. He had fed himself from 12:51	W 214	QIDP will consult with the Behavioral Specialist and the Nutritionist to develop a mealtime protocol addressing Client #2's refusal to hold his cup, spoon and posture. Group home and day program staff will be trained on this protocol. 8/1/11

8/1/11

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W 214	<p>Continued From page 2</p> <p>p.m. until 1:00 p.m. Day program staff suggested there was a behavioral component (i.e. "showing off"). The day program case manager stated "he wants to be fed" (referring to the client).</p> <p>Later that day, at 5:53 p.m., Client #2 was observed seated at the dinner table. He looked down at his plate but was not self-feeding. At 5:58 p.m., a direct support staff placed a coated teaspoon in the client's hand and began providing hand over hand assistance. She then released his hand and he stopped feeding himself. She offered him verbal prompts but he still refused to feed himself. The house manager (HM) intervened, offering Client #2 verbal encouragement to feed himself. After a few minutes of coaxing, the HM told the client "I'm not going to feed you." There was no mealtime protocol observed in use at the dinner table or earlier that day at the day program.</p> <p>When interviewed on April 4, 2011, at 11:08 a.m., the qualified intellectual disabilities professional (QIDP) stated that Client #2 could feed himself therefore he did not have a mealtime protocol or training program. She then replied "no" when asked if the facility had assessed his mealtime skills.</p> <p>Client #2's records were reviewed on April 8, 2011, beginning at 10:31 a.m. The review revealed no evidence that the facility had assessed the client's mealtime skills (i.e. posture and refusals to feed himself) to determine whether establishing a training program (formal or informal) or protocol might be indicated. Additional interview with the QIDP that afternoon, at 3:35 p.m., revealed that she did not want</p>	W 214		

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W 214	Continued From page 3 residential staff to feed him, partly because "once you start to feed him, then he might expect staff to feed him from then on...he knows which staff he can get over on" and those that he cannot. At 2:54 p.m., however, review of the client's behavior support plan (BSP) dated September 2, 2010, and psychological evaluation had revealed no evidence that the client's periodic refusal to feed his self had been assessed.	W 214			
W 242	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to train all clients in personal skills essential for independence, for one of the four clients in the sample. (Client #2) The finding includes: On April 4, 2011, Client #2 was observed eating lunch at his day program, beginning at 12:51 p.m. Throughout the meal, the client leaned forward, bringing his head down to the plate so his mouth was even with the edge of the plate. Similar observations were made later that day in the home, while he ate a snack and his dinner, at 3:27 p.m. and 6:00 p.m., respectively. Staff in	W 242	Cross reference W214	6/1/11	

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W 242	Continued From page 4 both settings were not observed to offer him any guidance or direction regarding his body posture and/or sitting up. There was no mealtime protocol observed in use at the dinner table or earlier that day at the day program. When interviewed on April 4, 2011, at 11:08 a.m., the qualified intellectual disabilities professional (QIDP) stated that Client #2 could feed himself therefore he did not have a mealtime protocol or training program. She then replied "no" when asked if the facility had assessed his mealtime skills. Client #2's records were reviewed on April 8, 2011, beginning at 10:31 a.m. The review revealed no evidence that the facility had addressed the client's mealtime skills, including posture during meals. [Also see W214]	W 242			
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure continuous active treatment, for three of the four clients in the sample. (Clients #1, #3 and #4)	W 249			

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W 249	<p>Continued From page 5 The findings include:</p> <p>1. Facility staff failed to consistently implement Client #1's training program for self-feeding skills, as evidenced by the following:</p> <p>On April 4, 2011, Client #1's assigned one-to-one staff was observed providing hand over hand support while assisting the client with his snack and dinner, at 4:12 p.m. and 5:58 p.m., respectively. On April 5, 2011, at 8:15 a.m., a trained medication employee (TME) was observed spoon-feeding Client #1 his medications that were mixed in with apple sauce. At 9:10 a.m., the TME was asked about the client's built-up handed spoon. She stated that it was her understanding that he received hand over hand assistance with meals but it was not expected during medication administration.</p> <p>On April 5, 2011, at 2:37 p.m., review of Client #1's Individual Support Plan (ISP), dated June 29, 2010, revealed the following training program: "<client's name> will use a spoon with minimum physical assistance on 80% of opportunities."</p> <p>The facility failed to ensure that staff provided Client #1 the opportunity to practice his spoon-feeding skills consistently, and when activities would support the achievement of his training program goal.</p> <p>2. Facility staff failed to implement Client #3's Behavior Support Plan for Medical Appointments (BSPMA), as evidenced by the following:</p> <p>Record review on April 7, 2011 at 1:15 p.m. revealed Client #3 failed to maintain his</p>	W 249	<p>1. Client #1 will be provided the opportunity to practice his spoon-feeding skills and activities that would support the achievement of his training goals. All TME staff will be trained on program goal during medication administration. The QDIP and Residential Manager will observe 2x's weekly Client #1's self-feeding program during mealtime to ensure appropriate implementation. QA will monitor quarterly for improvement in Client #1's feeding program.</p> <p>2. The facility staff will be trained to implement Client #3's Behavior Support Plan for medical appointments. In the future, BSP's will be implemented for all medical appointments. Residential Manager will accompany Client #3 and staff on medical appointments quarterly to make observation and document results of Client #3's BSPMA for improvement in behavior.</p>	6/1/11	6/1/11

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W 249	<p>Continued From page 6</p> <p>November 10, 2010Dental appointment. The assessment detailed "Patient was uncooperative and we were not able to perform complete oral examination."</p> <p>Further record review on April 8, 2011 at 12:43 p.m. revealed Client #3's Behavior Support Plan for Medical Appointments (BSPMA) dated November 26, 2007 recommended several proactive strategies to manage his non-compliant behavior at medical appointments.</p> <p>A few of the interventions are identified below:</p> <p>A. " Appropriate (nursing) staff should request that [Client #3 ' s] physician (either the PCP or the treating medical professional) evaluate [Client #3] and determine if he is going to need sedation to be given prior to each appointment. "</p> <p>B. " Arrangements should be made ahead of time for an appropriate area to be available immediately when [Client #3 ' s] arrives at the clinic so any disruptive behavior can be contained, if necessary, without exposing [Client #3 ' s] to unnecessary public attention or embarrassment should he become agitated. If at all possible, a room away from other medical activity and away from where he can directly view the upcoming needles, dental equipment, etc. and/or overhead discussions of medical procedures should be used while he waits. "</p> <p>C. " [Client #3 ' s] favorite reinforcers should be available during the appointment. "</p> <p>D. " Staff should complete the data sheets provided with this plan for EACH medical or</p>	W 249			

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W 249	Continued From page 7 dental appointment and blood draw, noting who accompanied him; what sedation was given by whom, and the time of administration; the time the appointment took place; the exact circumstances; and his exact behaviors. " There was no evidence presented or on file at the time of survey to substantiate this plan was being implemented to ensure Client #3 could complete his medical appointments. Interview with qualified intellectual disability professional (QIDP), house manager (HM) and licensed practical nurse (LPN) on April 8, 2011 at 12:46 p.m. confirmed the 2007 BSPMA was the current plan in place. In addition, the QDIP confirmed that the BSPMA was not currently being implemented nor were there any data collection measures in place for any of his medical/dental appointments as recommended by the BSPMA. The facility failed to ensure the continuous implementation of Client #3 ' s BSPMA to ensure compliance with all medical appointments as a means of maintaining his health and safety.	W 249			
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.	W 331	3. Cross reference W371	6/1/11	

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W 331	<p>Continued From page 8</p> <p>This STANDARD is not met as evidenced by: Based on staff interview, and record review, the facility failed to ensure nursing services were provided in accordance with the needs of two of the four clients in the sample. (Clients #1 and #4)</p> <p>The findings include:</p> <p>1. [Cross-refer to W368] The facility's nursing services failed to ensure that Clients #1 and #4 received timely treatment, in accordance with physician's orders. Specifically, Client #1 did not begin receiving treatment with Mupirocin 2% ointment until seven days after it was prescribed (May 12, 2010) for the treatment of Methicillin-Resistant Staphylococcus aureus (MRSA). Client #4 did not begin receiving treatment with Lamisil until seven days after the medication was delivered to the facility from the pharmacy (December 23, 2010) for the treatment of nail fungus.</p> <p>2. The facility's nursing services failed to document timely treatment and assessment of Client #1's skin condition, as evidenced by the following:</p> <p>On April 4, 2011, at approximately 8:13 a.m., interview with a direct support staff person providing one-to-one support for Client #1 revealed that the client was being tested later that day for MRSA. The house manager (HM) confirmed this during the Entrance conference later that morning, at 8:49 a.m. Client #1's medical records were reviewed on April 6, 2011, beginning at 2:39 p.m. Review of the client's medical chart revealed lab reports with positive</p>	W 331	<div data-bbox="834 821 1317 1104" style="border: 1px solid black; padding: 5px;"> <p>1. In the future, whenever there is a lapse between the date of the physician order and the start date of treatment the nursing staff will be instructed to document reasons and follow-up with the DON and PCP especially when medications cannot be obtained due to insurance disapproval. A protocol will be developed to ensure that medications and treatment issues are resolved immediately.</p> </div> <div data-bbox="834 1241 1317 1360" style="border: 1px solid black; padding: 5px;"> <p>DON will monitor medical records and pharmacy medication formulas monthly for consistency in providing timely treatments.</p> </div>	<div data-bbox="1333 1062 1442 1104" style="border: 1px solid black; padding: 2px;">5/23/11</div> <div data-bbox="1333 1329 1442 1371" style="border: 1px solid black; padding: 2px;">5/23/11</div>

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W 331	<p>Continued From page 9</p> <p>MRSA results in February 2010, May 2010, January 2011 and February 2011. Further review of the medical records that afternoon revealed the following:</p> <p>a. According to a nurse progress note dated January 4, 2010, the facility's RN documented that a swab culture was taken from a "wound on the lower right shin area measuring approximately 2 cm in diameter." On January 7, 2011, the RN documented in a nursing note that he had spoken by telephone with the primary care physician (PCP). The PCP reported that the culture had shown positive results for MRSA. The PCP recommended "treat him with Chlorhexedine liquid soap to wash body 2-3 times a week. will order the liquid soap." Review of Client #1's January 2011 MAR revealed that he did not begin treatment with the body wash until the evening shift of January 12, 2011, five days later. [Note: Even though the RN wrote the progress note on January 7, 2011, there was no evidence of a corresponding telephone order.]</p> <p>b. The next nurse progress note, entered by a licensed practical nurse (LPN) on January 12, 2011, included the following: "Bilateral skin lesions on lower legs. Each are approximately 1 cm in measurement... each area was cleaned with water and covered with 2 x 2 gauze dressing. Concern will be monitored." There was no evidence that the LPN notified his supervisors and/or the PCP that the client now had lesions on both legs (instead of just the right shin).</p> <p>c. The next progress note, entered by the RN, was dated January 14, 2011. It reflected the two lesions and the treatment with "body wash three</p>	W 331	<p>2a. The physician order was dated 1/10/11 and treatment started on 1/12/11 however; in the future if treatment is not initiated within 24 hours the reason will be documented by the primary nurse. Universal Precautions will be implemented immediately.</p> <p>2b. The nursing staff will receive additional training on documentation and communication with PCP, DON and Day Program.</p> <p>2c. Nursing staff will document on a daily basis until a particular health issue is resolved. Additional training for the nursing staff will be provided.</p>	<p>5/23/11</p> <p>5/24/11</p> <p>5/24/11</p>

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W 331	<p>Continued From page 10</p> <p>time per week." Continued review revealed that seven days passed before a nurse assessed Client #1's skin lesions. [Note: According to the client's MAR, employees applied the body wash in January 2011. On January 21, 2001, the RN entered a progress note indicating that both ulcers were scabbed and no longer needed dressing.]</p> <p>3. The facility's nursing services failed to notify Client #1's day program timely after laboratory test results showed active MRSA skin infection, as evidenced by the following:</p> <p>a. On April 4, 2011, at 1:24 p.m., Client #1's day program director alleged that residential staff had not informed the day program when the client contracted MRSA skin infection in early 2010. She stated that day program staff had received training on universal precautions and infection control practices; however, it would have been appropriate to alert their staff so people could be more vigilant. She further stated that she did not want clients attending the day program if/when they had open skin lesions or had active nasal MRSA infection. The day program director presented a memorandum, dated February 23, 2011, that documented that the home kept sending Client #1 to day program without first presenting a note from the PCP certifying that he was cleared to return.</p> <p>b. Similarly, on April 6, 2011, beginning at 2:39 p.m., review of Client #1's residential medical and habilitation records revealed that a swab culture was taken from a wound on January 3, 2011. The home learned that the lab results were positive for MRSA. The client, however,</p>	W 331	<p>3a. The primary care nurse of the facility will be responsible to communicate with the day program staff of any changes in the Clients' health status including medication changes and treatment. Additional training will be provided to the nursing staff and day program.</p> <p>3b. Cross reference W331 (3a)</p>	<p>5/24/11</p> <p>5/24/11</p>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 08G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/08/2011
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NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20018
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(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
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W 331 Continued From page 11
continued attending his day program through January 12, 2011. There was no evidence in the record that the facility notified his day program before January 13, 2011 that the client had developed a skin lesion on January 3, 2011 or that the results had come back positive on January 7, 2011.

W 331

W 368 483.460(k)(1) DRUG ADMINISTRATION
The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.

W 368

This STANDARD is not met as evidenced by:
Based on staff interview and record review, the facility failed to ensure that all prescribed medications and/or treatments were administered timely after being ordered by the physician, for two of the four clients in the sample. (Clients #1 and #4)

The findings include:

1. On April 4, 2011, at approximately 8:13 a.m., interview with Client #1's one-to-one direct support staff person revealed that the client would be tested that day for MRSA (skin). The test that day was to determine whether he was free of infection. Review of Client #1's medical records on April 6, 2011, beginning at 2:38 p.m., revealed a telephone order dated May 12, 2010, when the primary care physician ordered "Mupirocin 2% ointment Apply to both nostrils twice a day for 5 days." Client #1's May 2010 MAR reflected that the ointment was first administered on May 19, 2010, seven days after the order.

Cross reference W331 (1)

5/23/11

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NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 3112 13TH STREET NW WASHINGTON, DC 20010		
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W 368	<p>Continued From page 12</p> <p>2. The facility failed to ensure that all clients received their medications in the manner prescribed in their physician ' s order sheets as evidence below:</p> <p>Record review on April 8, 2011 at 1:06 p.m. revealed Client #4 ' s Podiatry assessment dated December 9, 2010 revealed the following findings: " grossly elongated nails x 10 [with] significant sub-sengrial (sic) debris and odor ... hyperkeratotic skin of hallix (sic) B/L. " The assessment goes on to further recommend " Lamisil x12 weeks or more ... " Further record review on the same day at 1:22 p.m. revealed the December 2010 medication administration record (MAR) reflected the Lamisil was not initiated until December 29, 2010, approximately nineteen (19) days after it was originally ordered.</p> <p>interview with the facility ' s registered nurse (RN) on the same day at 1:28 p.m. confirmed there was a gap between date of the written order and the date the medication was initiated.</p> <p>The facility failed to ensure all medications were administered as prescribed.</p>	W 368	<p>Cross reference W331 (1)</p>	5/23/11
W 371	<p>483.460(k)(4) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise.</p> <p>This STANDARD is not met as evidenced by: Based on observations, interviews and the</p>	W 371	<p>The TME's will be trained on Client #4's self-administration program. QIDP and House Manager will ensure that Clients are taught and provided the opportunity to implement their self-medication administration goals.</p>	6/1/11

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W 371 Continued From page 13
 review of records, the facility failed to implement an effective system to ensure that each client participated in a self-medication training program as recommended by the interdisciplinary team, for one of the four clients in the sample (Client #4)

The finding includes:

The morning medication administration pass was observed on April 5, 2011, beginning at 8:08 a.m. Clients received their medications in the office shared by the nurses and administrative staff. At 8:41 a.m., the trained medication employee (TME) finished punching Client #4's medications into a medication cup and she called the client's name. The client, who had been elsewhere in the facility, came into the office. The client poured a glass of water, swallowed the medications and drank water. The TME then administered Artificial Tears and documented the administration in the client's medication administration record (MAR).

After the medication administration pass was completed, review of Client #4's MARs revealed a data collection sheet that was labeled "March 2011." The data sheet reflected a training program that involved a 6-step task analysis, including "punch out medication from blister packs." Further review of the data sheet revealed that data was to be collected three times weekly (Mon., Wed. and Fri.) in the evening. Entries made by the evening nurse in March documented that the client had consistently performed that task (punch out medications from blister packs) with "physical assistance."

Later that same morning, at 9:14 a.m., when

W 371

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W 371 W 436	<p>Continued From page 14</p> <p>asked about Client #4's ability to punch his own medications, the TME confirmed that he could do so with physical assistance. She then acknowledged that she had not provided him with the opportunity to punch his own medications earlier that day.</p> <p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to ensure that clients had recommended adaptive equipment furnished timely and available for use, for two of the four clients in the sample. (Clients #1 and #2)</p> <p>The findings include:</p> <p>1. During the Entrance conference on April 4, 2011, beginning at approximately 8:39 a.m., the house manager (HM) indicated that Client #1 was prescribed a sip cup with lid for use when drinking beverages. Observations during the survey, however, revealed that staff did not consistently use one. For example, Client #1 was observed receiving his lunch in the home on April 6, 2011. At 12:52 p.m., the one-to-one staff person presented apple juice in a small white plastic tumbler. The client took a quick drink then pulled his head and upper body away. This was</p>	W 371 W 436	<p>An additional sip cup will be purchased for Client #1. Staff will be trained on mealtime adaptive equipment. In the future, QIDP and House Manager will ensure that adaptive equipment is furnished timely and available for use.</p>
			<p>(X5) COMPLETION DATE</p> <p>6/1/11</p>

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W 436	<p>Continued From page 15</p> <p>repeated two more times; each time the client quickly pulled his head back and there was no coughing observed while drinking the apple juice. When asked about a sip cup with lid, the one-to-one staff said the sip cup was being used for the client's nutritional supplement (it was on the table nearby) and there was only one sip cup available in the facility.</p> <p>It should be noted that on April 6, 2011, at 2:39 p.m., review of Client #1's medical book revealed a Swallowing Evaluation Assessment, dated July 14, 2008, which contained the following: "...mild to moderate oral stage dysphasia... no signs or symptoms of aspiration..."</p> <p>2. Client #2 was observed at his day program on April 4, 2011. At 12:51 p.m., staff presented a pureed lunch that consisted of meatballs, salad and apple sauce. At 12:55 p.m., the client was observed feeding himself independently with a regular, white plastic disposable teaspoon. Later that day, observations in the home revealed that Client #2 used a coated teaspoon at 3:25 p.m. to eat vanilla pudding for snack and at 5:58 p.m. to eat his pureed dinner.</p> <p>On April 8, 2011, at 3:00 p.m., interview with the qualified Intellectual disabilities professional (QIDP) revealed that using a coated teaspoon was prescribed due a Swallow Study performed on September 21, 2010. The QIDP reported having seen Client #2 using a coated teaspoon during a visit to the day program in January 2011. She further stated that she was previously unaware that he sometimes used a disposable plastic teaspoon and pledged to pursue the issue with the day program.</p>	W 436	<p>A coated spoon will be purchased for Client #2's day program. In the future, Client #2 will use the coated spoon during mealtimes at home and day program.</p>	6/1/11

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W 436	Continued From page 16 There was no evidence that the facility ensured a sufficient number of sip cups and/or coated teaspoons were available, and consistently used, with Clients #1 and #2, respectively.	W 436		
W 460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure clients received their prescribed modified diets as ordered by the physician for one of four sampled clients. (Client #3) The finding includes: Dinner observations on April 4, 2011, at 5:50 p.m., revealed Client #3 received a meal of chicken, green beans, noodles and white bread. On April 5, 2011, at 12:08 p.m., Client #3 received a meal of regular size portions of sliced turkey, broccoll and cauliflower, scalloped potatoes, wheat bread, milk and fruit cocktail for lunch at his day program. Record review on April 6, 2011, at 2:44 p.m. revealed Client #3's weight chart reflected a five lbs weight loss between December 2010 and the end of January 2011. Further review of Client #3's medical records revealed the quarterly physician's assessment dated February 18, 2011 revealed the primary care physician (PCP)	W 460	The nutritionist will train residential staff on special diets. The QIDP and Residential Manager will ensure that Client #3 receives double portions as recommended by his PCP.	6/1/11

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W 460	<p>Continued From page 17</p> <p>prescribed that the facility "change diet to regular double portion." A review of Client #3's dietary records and menu revealed this prescribed diet change was not put into effect.</p> <p>Interview with the house manager (HM) and the qualified intellectual disabilities professional (QIDP) on April 7, 2011, at 10:25 a.m., revealed Client #3 could have seconds if he desires to have it, but he was prescribed a regular diet. In addition, the HM further added that everyone in the home was on a regular diet with no special prescribed diets.</p> <p>Additional interview and review of the posted menus with the HM on the same day at 10:33 a.m. confirmed the prescribed "double portions" was not being instituted for Client #3 as prescribed on February 18, 2011. The dietary menu for Client #3 revealed he was presently being provided a "Regular, High Fiber" diet.</p> <p>The facility failed to ensure that all clients received a well-balanced diet as prescribed by their PCP to ensure their nutritional needs.</p>	W 460		

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1 000 INITIAL COMMENTS 1 000

A licensure survey was conducted from April 4, 2011 through April 8, 2011. A sample of four residents was selected from a population of seven men with various degrees of cognitive and intellectual disabilities.

The findings of the survey were based on observations and interviews with residents and staff in the home and at two day programs, as well as a review of resident and administrative records, including incident reports.

1 075 3503.3(d) BEDROOMS AND BATHROOMS 1 075

Each bedroom shall be equipped with at least the following items for each resident:

(d) Night stand.

This Statute is not met as evidenced by:
Based on observation and interview, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure that each bedroom was equipped with a night stand for each resident, for two of the seven residents of the facility. (Resident #2 and #3)

The finding includes:

During the inspection of the environment on April 5, 2011, beginning at 1:15 p.m., there were no nightstands observed in the bedroom being shared by Residents #2 and #3. The house manager (HM), who was present at the time of the inspection, acknowledged that nightstands had not been provided for the two residents. On April 8, 2011, at 5:53 p.m., the HM stated that

Two nightstands will be placed in the bedroom shared by Clients #2 and #3. The QIDP and Residential Manager will ensure that all bedrooms be equipped with nightstands.

6/1/11

Health Regulation Administration
Curtis A. Rees Program Director TITLE
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X8) DATE
5/13/11

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I 075	Continued From page 1 Residents #2 and #3 remained without nightstands in their bedroom.	I 075		
I 160	3507.1 POLICIES AND PROCEDURES Each GHMRP shall have on site a written manual describing the policies and procedures it will follow which shall be as detailed as is necessary to meet the needs of each resident served and provide guidance to each staff member. This Statute is not met as evidenced by: Based on interview, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to have a complete, written policies and procedures manual on site and available for review (specifically, an infection Control policy), for seven of the seven residents of the facility. (Residents #1, #2, #3, #4, #5, #6 and #7) The findings include: On April 4, 2011, interviews with a direct support staff person and the house manager (HM), at approximately 8:13 a.m. and 8:49 a.m., respectively, revealed that Resident #1 had been treated recently for Methicillin-Resistant Staphylococcus aureus (MRSA). Review of the resident's medical records on April 6, 2011, beginning at 2:39 p.m., revealed lab reports with positive MRSA results in February 2010, May 2010, January 2011 and February 2011. Further review of the medical records revealed the following: e. According to a nurse progress note dated January 4, 2010, the facility's RN documented that a swab culture was taken from a "wound on the lower right shin area measuring	I 160	a. The facility will revise its Infection Control Policy to specifically address MRSA and develop a protocol. Staff will receive additional training on MRSA.	8/1/11

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I 160	Continued From page 2	I 160		
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approximately 2 cm in diameter." On January 7, 2011, the RN documented in a nursing note that he had spoken by telephone with the primary care physician (PCP). The PCP reported that the culture had shown positive results for MRSA. The PCP recommended "treat him with Chlorhexidine liquid soap to wash body 2-3 times a week. will order the liquid soap."

b. The next nurse progress note, entered by a licensed practical nurse (LPN) on January 12, 2011, included the following: "Bilateral skin lesions on lower legs. Each are approximately 1 cm in measurement... each area was cleaned with water and covered with 2 x 2 gauze dressing. Concern will be monitored." There was no evidence that the LPN notified his supervisors and/or the PCP that the resident now had lesions on both legs (instead of just the right shin).

c. The next progress note, entered by the RN, was dated January 14, 2011. It reflected the two lesions and the treatment with "body wash three time per week." Continued review revealed no evidence that a nurse assessed Resident #1's skin lesions before another week had passed, when the RN entered a progress note dated January 21, 2011.

d. There were no nurse progress notes in Resident #1's medical chart for the months of February 2011, March 2011, or thus far in April 2011. His chart did, however, reflect a positive swab culture for MRSA on February 25, 2011 and that Hibiclens body wash was again ordered by the PCP on March 2, 2011. There was no evidence of active monitoring by the facility's nursing staff during the February - March 2011 period.

b. Cross reference W331 (2a)	5/23/11
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c. Cross reference W331 (2b)	5/24/11
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2d. Cross reference W331 (2c)	5/24/11
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I 180 Continued From page 3 I 180

e. On April 7, 2011, at approximately 2:50 p.m., the facility's RN examined Resident #1's medical chart and MAR and confirmed that there were no nurse progress notes from beyond January 28, 2011. When asked if nurses were expected to enter notes, the RN replied "not every day, only if there is a concern." The qualified intellectual disabilities professional (QIDP) was present at the time and she affirmed what the RN had just stated. There was no evidence, however, that nursing staff had kept a written record of additional assessment, treatment and/or communications with his PCP after January 28, 2011, even though the record showed ongoing treatment for MRSA, with follow-up laboratory studies.

When the facility's Infection Control policy (not dated) was reviewed on April 7, 2011, at 4:28 p.m., there were pages missing (pages 2 and 4) from the policy. The HM then presented another document that he reported having located in the policies manual. The document, however, appeared to be an outline used for staff in-service training (not the actual policies). The QIDP indicated that she would check with the agency's main office for a complete, current Infection Control policy. No additional information was presented before the survey ended the following afternoon (April 8, 2011).

I 180 3508.1 ADMINISTRATIVE SUPPORT I 180

Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans.

This Statute is not met as evidenced by:

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I 180	<p>Continued From page 4</p> <p>Based on observation, staff interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure adequate administrative staff to effectively meet the needs of three of the four residents in the sample. (Residents #1, #2 and #3)</p> <p>The findings include:</p> <ol style="list-style-type: none"> [Cross-refer to W214] The facility's QIDP failed to fully assess each resident's behavior management needs, for one of the four residents in the sample. (Resident #2) [Cross-refer to W249] The facility's QIDP failed to ensure continuous active treatment, for three of the four residents in the sample. (Residents #1, #3 and #4) [Cross-refer to W436] The facility's QIDP failed to ensure that residents had recommended adaptive equipment furnished timely and available for use, for two of the four residents in the sample. (Residents #1 and #2) [Cross-refer to I041] The facility's QIDP failed to ensure residents received their prescribed modified diets as ordered by the physician, for one of the four residents in the sample. (Resident #3) 	I 180	<table border="1"> <tr> <td data-bbox="820 798 1282 850">1. Cross reference W214</td> <td data-bbox="1282 798 1323 850">8/1/11</td> </tr> <tr> <td data-bbox="820 934 1282 987">2. Cross reference W249</td> <td data-bbox="1282 934 1323 987">8/1/11</td> </tr> <tr> <td data-bbox="820 1081 1282 1134">3. Cross reference W436</td> <td data-bbox="1282 1081 1323 1134">8/1/11</td> </tr> <tr> <td data-bbox="820 1249 1282 1302">4. Cross reference W460</td> <td data-bbox="1282 1249 1323 1302">8/1/11</td> </tr> </table>	1. Cross reference W214	8/1/11	2. Cross reference W249	8/1/11	3. Cross reference W436	8/1/11	4. Cross reference W460	8/1/11	
1. Cross reference W214	8/1/11											
2. Cross reference W249	8/1/11											
3. Cross reference W436	8/1/11											
4. Cross reference W460	8/1/11											

I 208	<p>3509.6 PERSONNEL POLICIES</p> <p>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.</p>	I 208		
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I 206	Continued From page 5	I 206		
	<p>This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure that two of the ten consultants (pharmacist and podiatrist) had current health certificates.</p> <p>The findings include:</p> <p>1. On April 5, 2011, beginning at 3:15 p.m., review of the personnel records revealed the GHPID failed to have evidence of a current health inventory/ certificate for the pharmacist.</p> <p>On April 6, 2011, at approximately 4:25 p.m., the qualified intellectual disabilities professional (QIDP) presented a letter, dated February 20, 2011, on which the contracted pharmacy's Director of Pharmacy Operations, wrote "the employee appears to be free from infectious or communicable diseases and is able to work." The letter did not, however, indicate that a physician had certified the pharmacist's health status. At approximately 4:52 p.m., the QIDP examined the letter and confirmed that the letter did not indicate whether or not the Director of Operations was a licensed physician. She then agreed to seek further evidence of a health inventory performed by a physician.</p> <p>2. Cross-refer to I271. There was no evidence that the podiatrist providing in-home treatment services for Residents #2, #3, #4, #5, #6 and #7 had a current health inventory/ certificate.</p>		<p>The pharmacist will provide a current health certificate indicating that a licensed physician has certified the health status. All consultants will provide a physical certified by a licensed physician.</p> <p>6/1/11</p> <p>1. All consultants will be required to update credentials at the time of annual contract renewal. QA will monitor credentials quarterly for renewal dates and expired physical certificates.</p> <p>6/1/11</p> <p>Cross reference I271</p> <p>5/11/11</p>	

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1271	Continued From page 6	1271		
1271	<p>3513.1(b) ADMINISTRATIVE RECORDS</p> <p>Each GHMRP shall maintain for each authorized agency's inspection, at any time, the following administrative records:</p> <p>(b) Personnel records for all staff including job descriptions either at the GHMRP or in a central office and made available upon request;</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure that all the required administrative records were available for inspection, for one of the ten consultants providing services.</p> <p>The finding includes:</p> <p>On April 4, 2011, during the entrance conference at 10:21 a.m., the qualified intellectual disabilities professional (QIDP) agreed to make available for review the personnel records of all employees, including licensed professional health consultants. On April 5, 2011, at 10:46 a.m., the QIDP indicated that a podiatrist came to the facility to provide assessment and treatment services for six of the seven residents (Residents #2, #3, #4, #5, #6 and #7). On April 5, 2011, beginning at 3:15 p.m., review of the personnel records for health care professionals revealed no evidence of a current administrative record for the podiatrist. The QIDP said she would follow-up with the agency's main office.</p> <p>On April 8, 2011, at 11:11 a.m., the QIDP stated that she had not received a personnel record for the podiatrist. She said she would ask whether the agency had entered into a written agreement</p>	1271	<p>The podiatrist will provide a current health certification and sign a written agreement with the agency. The GHPID will ensure that all required administrative records for all consultants are available.</p>	5/11/11

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I 271	Continued From page 7 with the podiatrist and seek evidence of a current health certificate. No additional information was presented before the survey ended later that afternoon.	I 271		
I 274	3513.1(e) ADMINISTRATIVE RECORDS Each GHMRP shall maintain for each authorized agency's inspection, at any time, the following administrative records: (e) Signed agreements or contracts for professional services: This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to have on file for review, written agreements or contracts, for one of the ten licensed consultants (the podiatrist) that provided in-home services, for six of the seven residents of the facility. (Residents #2, #3, #4, #5, #6 and #7) The finding includes: Cross-refer to I271. On April 5, 2011, beginning at 3:15 p.m., review of the personnel records for health care professionals revealed no evidence of a current administrative record for the podiatrist. The qualified intellectual disabilities professional (QIDP) indicated that a podiatrist came to the facility to provide assessment and treatment services for six of the seven residents (Residents #2, #3, #4, #5, #6 and #7). There was no evidence presented before the survey ended (three days later) to verify that the GHPID had entered into a written agreement or contract with the podiatrist.	I 274	Cross reference I274	5/11/11

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I 401 3520.3 PROFESSION SERVICES: GENERAL PROVISIONS I 401

Cross reference W214

6/1/11

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 observation, staff interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure comprehensive evaluation of each resident's behavior management needs, for one of the four residents in the sample. (Resident #2)

The finding includes:

During Resident #2's lunch at the day program on April 4, 2011, he was observed refusing to hold a sip cup to drink his milk, between 1:00 p.m. - 1:14 p.m. During that same time period, he also repeatedly refused to hold his spoon to continue feeding himself. He had fed himself from 12:51 p.m. until 1:00 p.m. Day program staff suggested there was a behavioral component (i.e. "showing off"). The day program case manager stated "he wants to be fed" (referring to the resident).

Later that day, at 5:53 p.m., Resident #2 was observed seated at the dinner table in the GHPID. He looked down at his plate but was not self-feeding. At 5:58 p.m., a direct support staff placed a coated teaspoon in the resident's hand and began providing hand over hand assistance. She then released his hand and he stopped feeding himself. She offered him verbal prompts but he still refused to feed himself. The house

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I 401	Continued From page 9 manager (HM) intervened, offering Resident #2 verbal encouragement to feed himself. After a few minutes of coaxing, the HM told the resident "I'm not going to feed you." There was no mealtime protocol observed in use at the dinner table or earlier that day at the day program. When interviewed on April 4, 2011, at 11:08 a.m., the qualified Intellectual disabilities professional (QIDP) stated that Resident #2 could feed himself therefore he did not have a mealtime protocol or training program. She then replied "no" when asked if the facility had assessed his mealtime skills. Resident #2's records were reviewed on April 8, 2011, beginning at 10:31 a.m. The review revealed no evidence that the facility had assessed the resident's mealtime skills (i.e. posture and refusal to feed himself) to determine whether establishing a training program (formal or informal) or protocol might be indicated. Additional interview with the QIDP that afternoon, at 3:35 p.m., revealed that she did not want residential staff to feed him, partly because "once you start to feed him, then he might expect staff to feed him from then on...he knows which staff he can get over on" and those that he cannot. At 2:54 p.m., however, review of the resident's behavior support plan (BSP) dated September 2, 2010, and psychological evaluation had revealed no evidence that the resident's periodic refusal to feed his self had been assessed.	I 401		
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with	I 422		

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I 422	<p>Continued From page 10</p> <p>the resident ' s Individual Hsbilitation Plan.</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group Home for Persons with intellectual Disabilities (GHPID) failed to ensure that residents received training, habilitation and assistance as prescribed in their Individual Support Plan, for three of the four residents in the sample. (Residents #1, #3 and #4)</p> <p>The findings include:</p> <p>1. Facility staff failed to consistently implement Resident #1's training program for self-feeding skills, as evidenced by the following:</p> <p>On April 4, 2011, Resident #1's assigned one-to-one staff was observed providing hand over hand support while assisting the resident with his snack and dinner, at 4:12 p.m. and 5:58 p.m., respectively. On April 5, 2011, at 8:15 a.m., a trained medication employee (TME) was observed spoon-feeding Resident #1 his medications that were mixed in with apple sauce. At 9:10 a.m., the TME was asked about the resident's built-up handed spoon. She stated that it was her understanding that he received hand over hand assistance with meals but it was not expected during medication administration.</p> <p>On April 5, 2011, at 2:37 p.m., review of Resident #1's Individual Support Plan (ISP), dated June 29, 2010, revealed the following training program: "<resident's name> will use a spoon with minimum physical assistance on 80% of opportunities."</p> <p>The facility failed to ensure that staff provided Resident #1 the opportunity to practice his</p>	I 422	<p>1. Cross reference W436 #2</p>	6/1/11
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1422 Continued From page 11

1422

spoon-feeding skills consistently, and when activities would support the achievement of his training program goal.

2. Facility staff failed to implement Resident #3's Behavior Support Plan for Medical Appointments (BSPMA), as evidenced by the following:

Record review on April 7, 2011 at 1:15 p.m. revealed Resident #3 failed to maintain his November 10, 2010 Dental appointment. The assessment detailed "Patient was uncooperative and we were not able to perform complete oral examination."

Further record review on April 8, 2011 at 12:43 p.m. revealed Resident #3's Behavior Support Plan for Medical Appointments (BSPMA) dated November 26, 2007 recommended several protective strategies to manage his non-compliant behavior at medical appointments.

A few of the interventions are identified below:

A. " Appropriate (nursing) staff should request that [Resident #3 's] physician (either the PCP or the treating medical professional) evaluate [Resident #3] and determine if he is going to need sedation to be given prior to each appointment. "

B. " Arrangements should be made ahead of time for an appropriate area to be available immediately when [Resident #3 's] arrives at the clinic so any disruptive behavior can be contained, if necessary, without exposing [Resident #3 's] to unnecessary public attention or embarrassment should he become agitated. If at all possible, a room away from other medical activity and away from where he can directly view

2. Cross reference W249 #2

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I 422	<p>Continued From page 12</p> <p>the upcoming needles, dental equipment, etc. and/or overhead discussions of medical procedures should be used while he waits. "</p> <p>C. " [Resident #3 ' s] favorite reinforcers should be available during the appointmant. "</p> <p>D. " Staff should complete the data sheets provided with this plan for EACH medical or dental appointment and blood draw, noting who accompanied him; what sedation was given by whom, and the time of administration; the time the appointment took place; the exact circumstances; and his exact behaviors. "</p> <p>There was no evidence presented or on file at the time of survey to substantiate this plan was being implemented to ensure Resident #3 could complete his medical appointments.</p> <p>Interview with qualified intellectual disability professional (QIDP), house manager (HM) and licensed practical nurse (LPN) on April 8, 2011 at 12:46 p.m. confirmed the 2007 BSPMA was the current plan in place. In addition, the QDIP confirmed that the BSPMA was not currently being implemented nor were there any data collection measures in place for any of his medical/dental appointments as recommended by the BSPMA.</p> <p>The facility failed to ensure the continuous implementation of Resident #3 ' s BSPMA to ensure compliance with all medical appointments as a means of maintaining his health and safety.</p> <p>3. [Cross-refer to Federal Deficiency Report - Citation W371] During observations of the morning medication administration pass on April 4, 2011, the trained medication employee failed</p>	I 422	<p>3. Cross reference W371</p>	<p>6/1/11</p>
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I 422	<p>Continued From page 13</p> <p>to give Resident #4 the opportunity to punch his own medications, in accordance with his self-medication training program.</p> <p>4. Facility staff failed to ensure that residents' prescribed adaptive equipment was furnished timely and available for use, as evidenced by the following:</p> <p>a. During the Entrance conference on April 4, 2011, beginning at approximately 8:39 a.m., the house manager (HM) indicated that Resident #1 was prescribed a sip cup with lid for use when drinking beverages. Observations during the survey, however, revealed that staff did not consistently use one. For example, Resident #1 was observed receiving his lunch in the home on April 8, 2011. At 12:52 p.m., the one-to-one staff person presented apple juice in a small white plastic tumbler. The resident took a quick drink then pulled his head and upper body away. This was repeated two more times; each time the resident quickly pulled his head back and there was no coughing observed while drinking the apple juice. When asked about a sip cup with lid, the one-to-one staff said the sip cup was being used for the resident's nutritional supplement (it was on the table nearby) and there was only one sip cup available in the facility.</p> <p>It should be noted that on April 6, 2011, at 2:39 p.m., review of Resident #1's medical book revealed a Swallowing Evaluation Assessment, dated July 14, 2008, which contained the following: "...mild to moderate oral stage dysphasia... no signs or symptoms of aspiration..."</p> <p>b. Resident #2 was observed at his day program on April 4, 2011. At 12:51 p.m., staff presented a</p>	I 422	<p>4a. Cross reference W436</p> <p>6/1/11</p> <p>4b. Cross reference W436</p> <p>6/1/11</p>

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1422	<p>Continued From page 14</p> <p>pureed lunch that consisted of meatballs, salad and apple sauce. At 12:55 p.m., the resident was observed feeding himself independently with a regular, white plastic disposable teaspoon. Later that day, observations in the home revealed that Resident #2 used a coated teaspoon at 3:25 p.m. to eat vanilla pudding for snack and at 5:58 p.m. to eat his pureed dinner.</p> <p>On April 8, 2011, at 3:00 p.m., interview with the qualified intellectual disabilities professional (QIDP) revealed that using a coated teaspoon was prescribed due a Swallow Study performed on September 21, 2010. The QIDP reported having seen Resident #2 using a coated teaspoon during a visit to the day program in January 2011. She further stated that she was previously unaware that he sometimes used a disposable plastic teaspoon and pledged to pursue the issue with the day program.</p> <p>There was no evidence that the facility ensured a sufficient number of sip cups and/or coated teaspoons were available, and consistently used, with Residents #1 and #2, respectively.</p>	1422		
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