Received 1-3-11

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FORM APPROVEI
OMB NO. 0938-039

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G171	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 12/03/2010
NAME OF PROVIDER OR SUPPLIER CARECO 11		STREET ADDRESS, CITY, STATE, ZIP CODE 1701 24TH STREET, NE WASHINGTON, DC 20002	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS	W 000		
	A monitoring survey was conducted on December 3, 2010, to review the adequacy of adaptive equipment being used by the clients residing in the facility. The facility has a residential population of four females with various levels of mental retardation.			
	The findings of the survey were based on observation, interviews and record review, as well as a review of client and administrative records, including incident reports.			
W 104	483.410(a)(1) GOVERNING BODY	W 104		
	The governing body must exercise general policy, budget, and operating direction over the facility.			
	This STANDARD is not met as evidenced by: Based on observation, interview and record review, the governing body failed to maintain general operating direction over the facility, as evidenced by the deficiencies cited throughout this report for four of four clients residing in the facility. (Client #1, #2, #3, #4)		W104 This STANDARD will be met as follows: Cross reference response to W436 Careco has implemented a new Adaptive Equipment Protocol to ensure each client has safe and operable adaptive equipment. QMRP's, Nurses and RD's have been/will be trained on its implementation. The protocol includes tracking adaptive equipment. Quality Assurance will monitor the tracking of adaptive equipment at least quarterly or as needed. 1/3/11	
	The findings include:			
	[Cross refer to 436]. The governing body failed to ensure the monitoring of, and timely provision of adaptive equipment, in accordance with its established policies, as evidenced below:			
	Interviews conducted with the house manager (HM) and the qualified mental retardation professional (QMRP) via telephone on December			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Tiffany D. Sanders Interim Director of DD Services 12/31/10

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

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W 104	Continued From page 1 3, 2010, at 7:30 a.m. and 8:00 a.m. respectively, revealed that the facility has a tracking form to be completed by the direct care staff weekly, to ensure cleanliness and repairs for all adaptive equipment. The form should then be submitted to the QMRP for follow-up. Review of the agency's 2007 adaptive equipment policy on December 3, 2010, at 8:30 a.m. verified that the QMRP is the primary responsible person for managing adaptive equipment needs. The agency created an Adaptive Equipment, Acquisition, Maintenance, or Repair Request and Tracking Form to be completed by the QMRP to track the timeliness of acquisition and repairs. At the time of the survey, however, there was no evidence that the governing body exercised over-site and/or assistance to the QMRP to ensure this practice was implemented. Interview with the QMRP during the exit conference at approximately 4:30 p.m. verified that the facility had the forms, however, they were not being completed as required.	W 104		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility's qualified mental retardation professional (QMRP) failed to ensure each client's adaptive equipment was integrated, coordinated and monitored, for three of four clients residing in the facility. (Clients #1, #2 and	W 159		

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W 159	Continued From page 2 #3) The findings include: 1. [Cross-refer to W210] The QMRP failed to ensure the physical therapist (PT) reassessed Client #3's use of a walker. 2. [Cross-refer to W189] The QMRP failed to ensure that each employee was provided with effective initial and continuing training that enabled the employee to perform his or her duties effectively and competently. 3. [Cross refer to W436[The QMRP failed to coordinate services to ensure that assistive devices recommended by the physical therapist for Client #1 and #2 were continuously available for their use, as evidenced below: a. Interview with the QMRP on December 3, 2010 at 3:35 p.m., revealed that the repositioning wedges for both Clients #1 and #2, and the knee braces for Client #1 had been delivered to the facility. The QMRP further revealed that the items were observed in the nurse's office. According to the QMRP, shortly after the adaptive equipment arrived, the PT came to the facility to instruct the direct support staff on how to use it. At the time of the survey, however, the positioning wedges and the night time leg braces could not be located. Additionally, the record of the training provided by the PT on how to use the aforementioned assistive devices was not available for review.	W 159	W159 This STANDARD will be met as follows: 1. Cross reference response to W210 2. Cross reference response to W189 3. Cross reference response to W436 4. Cross reference response to W436 5. A new QMRP has been assigned to Client #2. The QMRP will follow-up with the SLP on the discrepancy with Client #2's cup. 1/6/11 6. Cross reference response to W436	

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W 159	Continued From page 3	W 159		
	b. The QMRP failed to coordinate with the physical therapist (PT) regarding the recommendation for bean bags to reposition Client #2, as evidenced below:			
	Review of Client #2's annual PT assessment dated June 23, 2010 on December 3, 2010 at 1:30 p.m. revealed a recommendation to consider purchasing two bean bags to reposition her. Interview with the QMRP at 1:45 p.m. revealed that the recommendation to purchase the bean bags had not been addressed.			
	4. [Cross refer to W436]. The QMRP failed to coordinate services to ensure bed rail pads were obtained as recommended for Clients #1 and #2.			
	5. The QMRP failed to ensure the discrepancy of Client #2's drinking cups was addressed with the SLP as evidenced below:			
	On December 3, 2010, at 8:27 a.m., mealtime observations revealed Client #2 being given small drops of beverage from a nosey cup.			
	On the same day at 2:45 p.m., interview with the direct support staff and the QMRP revealed that there were several nosey cups available for Client #2. Continued discussion with the QMRP revealed that on April 5, 2010, the SLP trained the direct care staff on the client's mealtime protocol. Reportedly, on that date, the SLP instructed the staff to provide all liquids to the client from the nosey cup.			
	On December 3, 2010, at 2:42 p.m., the review of Client #2's SLP assessment and the corresponding mealtime protocol, both dated			

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W 159	Continued From page 4 February 13, 2010, revealed that a spout cup was recommended for drinking. At the time of the survey, there was no evidence that the QMRP had addressed the discrepancy regarding the different type of drinking cups identified by the SLP for Client #2. 6. [Cross refer to W436] The QMRP failed to coordinate services to ensure Client #3's hospital bed was maintained in good repair.	W 159		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure effective training of each staff on the use of adaptive equipment, for two of four clients residing in the facility. (Clients #1 and #2) The finding includes: The facility failed to ensure that the nurse administering the morning medication used adaptive equipment, in accordance with the clients' feeding protocols, as evidenced below: Observation on December 3, 2010, beginning at approximately 8:05 a.m., revealed the nurse administering medications to Clients #1 and #2 from a regular teaspoon. Observations of the morning mealtime, at 8:10 a.m. and 8:15 a.m. respectively, revealed direct support staff feeding Clients #1 and Client #2 with a Teflon coated	W 189	W189 This STANDARD will be met as follows: QMRP/RN will train the nurses in the home on the appropriate adaptive equipment in the home. In the future the QMRP will be responsible to notifying the nurse of any changes to adaptive equipment. 1/8/11	

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W 189	Continued From page 5 teaspoon. Staff interview during breakfast revealed that the Teflon coated teaspoons were recommended because of the clients' tendency to bite down on the spoon when it is presented. Review of the mealtime protocols at approximately 3:30 p.m. verified that both Client #1 and #2 are to be fed with a Teflon coated teaspoon. Interview with the qualified mental retardation professional (QMRP) on December 3, 2010 at 4:15 p.m. revealed that all personnel who engage with the clients are to use the prescribed adaptive equipment. Review of the training record and interview with the QMRP on December 3, 2010, at 2:10 p.m., verified there was no evidence the nurse had received effective training on the use of required adaptive equipment.	W 189		
W 210	483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the physical therapy (PT) assessment addressed ambulation using a walker for one of the four clients residing in the facility. (Client #3.) The finding includes:	W 210	W210 This STANDARD will be met as follows: QMRP will have the PT for Client #3 reassesses the need for a walker. QMRP will continue to be responsible for following up on adaptive equipment needs. 1/8/11	

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W 210	Continued From page 6	W 210		
	On December 3, 2010 at 8:45 a.m. and at 12:21 PM, a one to one staff was observed to assist Client #3 as she ambulated from the living room to her bedroom, using her rolling walker.			
	On the same day at approximately 12:25 p.m., staff revealed that in the past, the client had a rolling walker with a seat, however refused to use it.			
	On December 3, 2010 at 1:25 p.m., review of Client #3's annual PT assessment dated July 12, 2009 revealed, "She can ambulate with a rolling walker with a seat." According to the client's annual PT assessment dated June 3, 2010, at 1:42 p.m. the client required assistance with transfers and ambulation, however "She would not ambulate this day, and she has a custom molded wheelchair." Continued review of the 2010 PT assessment, however, revealed it failed to identify a walker as adaptive equipment recommended or used by the client. At the time of the survey, there was no evidence that the client's ability to use a walker during ambulation had been re-assessed by the PT.			
W 436	483.470(g)(2) SPACE AND EQUIPMENT	W 436		
	The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.			
	This STANDARD is not met as evidenced by: Based on observation, staff interview and record			

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W 436	Continued From page 7 review, the facility failed to furnish and maintain in good condition wheelchairs, bed pads, knee braces and positioning wedges, as prescribed, for three of the four clients in the facility. (Clients #1, #2, and #3) The findings include: On December 3, 2010, observations, interviews and record reviews revealed the following concerns were identified: 1. The facility failed to ensure assistive devices recommended by the physical therapist (PT) for Client's #1 and #2 were available for their use, as evidenced below: Interview with the QMRP on December 3, 2010 at 3:35 p.m., revealed that the repositioning wedges for both Clients #1 and #2, and the knee braces for Client #1 had been delivered to the facility. The QMRP further revealed that the items were observed in the nurse's office. According to the QMRP, shortly after the adaptive equipment arrived, the PT came to the facility to instruct the direct support staff on how to use it. At the time of the survey, however, the positioning wedges and the night time leg braces could not be located. 2. The facility failed to ensure recommended bed rails pads for Clients #1 and #2 were provided as evidenced below: Observation of the hospital beds in the facility on	W 436	W436 This STANDARD will be met as follows: 1. There was no evidence that Client #1's knee braces or wedges had been ordered. Client #1 has an appointment at NRH to be refitted. Wedges have been ordered for Client #1 and Client #2. QMRP will be responsible for tracking the status according to the Adaptive Equipment Policy and Protocol 1/10/11 2. QMRP will be expected obtain all adaptive equipment in a timely fashion. Client #1 and Client #2's bed rails have been ordered. The vendor is expecting delivery on 1/3/10 and will deliver the pads once they are received. 1/7/11	

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W 436	Continued From page 8 December 3, 2010 at 9:05 a.m. revealed no rail pads were attached. Interview with direct support staff during this time revealed the hospital beds belonged to Clients #1 and #2, and that no bed rail pads were available. On December 3, 2010, at 9:45 a.m. and 11:37 a.m. respectively review of QMRP monthly summaries (May 2010-November 2010) revealed that the adaptive equipment for Clients # 1 and #2 included bed rail pads. It was verified by review of the PT assessments dated June 3, 2010 and June 23, 2010 respectively. Interview with the QMRP at 3:37 p.m., acknowledged that bed rail pads were not available for the clients. 3. The facility failed to ensure Client #3's hospital bed was maintained in good repair. On December 3, 2010 at 9:12 a.m., observation of Client #3's hospital bed revealed it made a "humming-like" sound when the remote control device was activated to raise or lower the bed. The height of the bed remained unchanged. Interview with the QMRP on the same day at 2:05 p.m. revealed that she was not aware that the remote control could not raise or lower Client #3's bed. On December 3, 2010 at 11:40 a.m., review of Client #3's annual PT assessment dated June 3, 2010 revealed, "The frame height does not adjust." At the time of the survey, there was no evidence the client's bed was monitored to ensure timely repairs.	W 436	3. Client #3's hospital bed has been repaired. Staff will be expected to document all needed repairs. QMRP has been trained on the timely acquisition of adaptive equipment. 12/16/10	

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W 436	Continued From page 9 4. The facility failed to ensure the wheelchairs of Clients #1 and #3 were maintained in good repair. Upon arrival to the group home on December 3, 2010, at approximately 7:00 AM, Clients #1, #2 and #3 were observed sitting in their wheelchairs in the dining room. According to the staff, Client #1 and #3 would be remaining home for the day awaiting scheduled wheelchair repairs. The house manager (HM) indicated that Client #1's new custom molded wheelchair was scheduled to be delivered on December 16, 2010. At 7:30 a.m., staff informed the surveyors that Client #3's right brake failed to fully engage against the right rear tire, which allowed the wheel to move. Staff reported that the brakes had been repaired several weeks prior, however due to client's behavior of shaking her leg and frequent movement in and out of chair, she had damaged the brakes. Therefore, one to one staff remains within arm's reach of the client at all times. On December 3, 2010, at 3:30 p.m., record review revealed that on October 29, 2010, Client #3 received a comprehensive evaluation of the wheelchair, which determined the chair she was using at that time needed repairs. According to the evaluation, the equipment vendor was investigating the purchase date of the client's current wheelchair to determine if she was eligible for a new wheelchair. At the time of the survey, the facility failed to ensure Client #3's wheelchair was maintained in good repair. 5. The facility failed to ensure the shower chair was maintained in good repair.	W 436	4. Client #1 has received a loaner chair to use in the absence of her wheelchair. According to the vendor, Client #2's new wheelchair has been ordered and has a new delivery date of 1/7/11. Client #3 brakes have been repaired. A 719A form was completed and submitted to the vendor on 12/19/10 for a new wheelchair for Client #3. QMRP will follow up on the timely acquisition of the wheelchair. 12/19/10 5. A 719A form has been submitted for a new shower chair. The QMRP will continue to follow-up on the status of the shower chair. DSP's will be trained on the monitoring of adaptive equipment. 1/12/11	

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W 436	Continued From page 10 Observation on December 3, 2010 at 9:03 a.m., revealed scaling paint and rust on the frame of the shower chair in the rear bathroom. On December 3, 2010, at 2:43 p.m. the house manager presented a 719A dated December 1, 2010 for a new shower chair. At the time of the survey, however, the facility failed to ensure the shower chair was maintained in good repair.	W 436		

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I 000	INITIAL COMMENTS A monitoring survey was conducted on December 3, 2010, to review the adequacy of adaptive equipment being used by the clients residing in the facility. The facility has a residential population of four females with various levels of mental retardation. The findings of the survey were based on observation, interviews and record review, as well as a review of resident and administrative records, including incident reports.	I 000		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure that the environment was free from potential safety hazards. The finding includes: On December 3, 2010, at approximately 9:03 a.m., the surveyors observed that the shower in the rear bathroom had a threshold that was several inches tall and did not appear to be barrier-free. Staff interview at approximately 9:05 a.m. revealed that it was necessary to lift the shower chair over the threshold.	I 090	I090 This STATUTE will be met as follows: Careco will have the PT assess the shower and make recommendations on how the elevated threshold should be addressed for safety precautions. 1/7/11	
I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate	I 180		

Health Regulation Administration

Interim Director of DD Services TITLE 12/31/10 (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	HFD03-0233		12/03/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARECO 11	1701 24TH STREET, NE WASHINGTON, DC 20002

(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) COMPLETE DATE
I 180	Continued From page 1 administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on observation, interview, and record review, the facility's qualified mental retardation professional (QMRP) failed to ensure each resident's adaptive equipment was integrated, coordinated and monitored, for three of four residents residing in the facility. (Residents #1, #2 and #3) The findings include: 1. [Cross-refer to W210] The QMRP failed to ensure the physical therapist (PT) reassessed Resident #3's use of a walker. 2. [Cross-refer to W189] The QMRP failed to ensure that each employee was provided with effective initial and continuing training that enabled the employee to perform his or her duties effectively and competently. 3. [Cross refer to W436[The QMRP failed to coordinate services to ensure that assistive devices recommended by the physical therapist for Residents #1 and #2 were continuously available for their use, as evidenced below: a. Interview with the QMRP on December 3, 2010 at 3:35 p.m., revealed that the repositioning wedges for both Residents #1 and #2, and the knee braces for Resident #1 had been delivered to the facility. The QMRP further revealed that the items were observed in the nurse's office. According to the QMRP, shortly after the adaptive	I 180	I180 This STATUTE will be met as follows: 1. Cross reference response to Federal Deficiency W210 1/8/11 2. Cross reference response to Federal Deficiency W189 1/8/11 3. Cross reference response to Federal Deficiency W436 1/8/11	

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I 180	Continued From page 2 equipment arrived, the PT came to the facility to instruct the direct support staff on how to use it. At the time of the survey, however, the positioning wedges and the night time leg braces could not be located. Additionally, the record of the training provided by the PT on how to use the aforementioned assistive devices was not available for review. b. The QMRP failed to coordinate with the physical therapist (PT) regarding the recommendation for bean bags to reposition Resident #2, as evidenced below: Review of Resident #2's annual PT assessment dated June 23, 2010 on December 3, 2010 at 1:30 p.m. revealed a recommendation to consider purchasing two bean bags to reposition her. Interview with the QMRP at 1:45 p.m. revealed that the recommendation to purchase the bean bags had not been addressed. 4. Cross refer to W436. The QMRP failed to coordinate services to ensure bed rail pads were obtained as recommended for Residents #1 and #2. 5. The QMRP failed to ensure the discrepancy of Resident #2's drinking cups was addressed with the SLP as evidenced below: On December 3, 2010, at 8:27 a.m., mealtime observations revealed Resident #2 being given small drops of beverage from a nosey cup. On the same day at 2:45 p.m., interview with the direct support staff and the QMRP revealed that there were several nosey cups available for Resident #2. Continued discussion with the	I 180	4. Cross reference response to Federal Deficiency W436 1/8/11 5. Cross reference response to Federal Deficiency W159 1/6/11	

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I 180	Continued From page 3 QMRP revealed that on April 5, 2010, the SLP trained the direct care staff on the resident's mealtime protocol. Reportedly, on that date, the SLP instructed the staff to provide all liquids to the resident from the nosey cup. On December 3, 2010, at 2:42 p.m., the review of Resident #2's SLP assessment and the corresponding mealtime protocol, both dated February 13, 2010, revealed that a spout cup was recommended for drinking. At the time of the survey, there was no evidence that the QMRP had addressed the discrepancy regarding the different type of drinking cups identified by the SLP for Resident #2. 6. Cross refer to W436. The QMRP failed to coordinate services to ensure Resident #3's hospital bed was maintained in good repair.	I 180		
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure effective training to each staff on the use of adaptive equipment, for two of four residents residing in the facility. (Residents #1 and #2) The finding includes: The GHMRP failed to ensure that the nurse administering the morning medication used adaptive equipment, in accordance with the residents' feeding protocols, as evidenced below: Observation on December 3, 2010, beginning at	I 222	I222 This STATUTE will be met as follows: Cross reference response to Federal Deficiency W189 1/8/11	

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I 222	Continued From page 4 approximately 8:05 a.m., revealed the nurse administering medications to Residents #1 and #2 from a regular teaspoon. Observations of the morning mealtime, at 8:10 a.m. and 8:15 a.m. respectively, revealed direct support staff feeding Residents #1 and Resident #2 with a Teflon coated teaspoon. Staff interview during breakfast revealed that the Teflon coated teaspoons were recommended because of the residents' tendency to bite down on the spoon when it is presented. Review of the mealtime protocols at approximately 3:30 p.m. verified that both Resident #1 and #2 are to be fed with a Teflon coated teaspoon. Interview with the qualified mental retardation professional (QMRP) at 4:15 p.m. revealed that all personnel who engage with the residents are to use the prescribed adaptive equipment.	I 222		
I 223	3510.4 STAFF TRAINING Each training program agenda and record of staff participation shall be maintained in the GHMRP and available for review by regulatory agencies. This Statute is not met as evidenced by: Based on interview, and record review, the GHMRP failed to ensure a program agenda and a record of staff participation was maintained in the facility and available for review by regulatory agencies for two of four residents. (Residents #1 and #2) The finding includes: The GHMRP failed to maintain a record of	I 223	I223 This STATUTE will be met as follows: Training records are expected to be maintained in the home and should be available for review. Management staff will be in-serviced on training records and training records and training agenda's.	

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I 223	Continued From page 5 training provided by the physical therapist (PT) on the use of repositioning wedges and knee braces, as evidenced below: Interview with the QMRP on December 3, 2010 at 3:35 p.m., revealed that the repositioning wedges for both Resident #1 and #2, and the knee braces for Resident #1 had been delivered to the GHMRP. The QMRP further revealed that the items were observed in the nurse's office. According to the QMRP, shortly after the adaptive equipment arrived, the PT came to the GHMRP to instruct the direct support staff on how to use it. At the time of the survey, however, the positioning wedges and the night time leg braces could not be located. Additionally, the record of the training provided by the PT on how to use the aforementioned assistive devicee was not available for review.	I 223		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the physical therapy (PT) assessment addressed ambulation using a walker for one of the four residents residing in the facility. (Resident #3.)	I 401	1/3/11 I401 This STATUTE will be met as follows: Cross reference response to Federal Deficiency W210. 1/8/11	

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I 401	Continued From page 6 The finding includes: On December 3, 2010 at 8:45 a.m. and at 12:21 PM, a one to one staff was observed to assist Resident #3 as she ambulated from the living room to her bedroom, using her rolling walker. On the same day at approximately 12:25 p.m., staff revealed that in the past, Resident #3 had a rolling walker with a seat, however refused to use it. On December 3, 2010 at 1:25 p.m., review of Resident #3's annual PT assessment dated July 12, 2009 revealed, "She can ambulate with a rolling walker with a seat." According to the resident's annual PT assessment dated June 3, 2010, at 1:42 p.m. the resident required assistance with transfers and ambulation, however "She would not ambulate this day, and she has a custom molded wheelchair." Continued review of the 2010 PT assessment, however, revealed it failed to identify a walker as adaptive equipment recommended or used by the resident. At the time of the survey, there was no evidence that the resident's ability to use a walker during ambulation had been re-assessed by the PT.	I 401		