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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09 H32		04/20/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	3312 4TH STREET, NE WASHINGTON, DC 20032

(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 recertification survey was conducted from April 18 through April 20, 2007. The survey was initiated using the fundamental survey process. A random sample of four clients was selected from a population of eight clients with mental retardation. A focused review was conducted for one additional client in the area of Health Care Services. The findings of this survey were based on residential and day program observations, staff and client interviews, habilitation and administrative record review, incl de incident reports.			
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 observations, interviews and review of records, the facility's governing body provided general operating direction over the facility, except in the following areas: The findings include: 1. Cross Refer to W331. The governing body failed to ensures that the nursing staff implemented their policies entitled "Hospital Admissions", designed to ensure the health and safety of the clients. 2. Cross Refer to W124 and W263. The governing body failed to ensure residents specially-constituted committee Human Rights	W 104	W104 This Standard will be met as evidenced by: (1) Cross reference response to W331. (2) Cross reference response to W124 and W263.	6-11-07

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2007 MAY 23 P 3:15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nancy Branch	DRS	5/14/07

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

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W 104	Continued From page 1 Committee) reviewed all aspects of facility practices, to affirm and protect clients' rights. 3. Cross Refer to W338. The governing body failed to ensure that nursing staff secured timely medical follow-up for Client #1. 4. Cross Refer to W140. The governing body failed to establish policies and procedures to ensure a complete accounting of Client #1,#2 and #3's funds that were entrusted to the facility. 5. Cross Refer to W159. The governing body failed to ensure that the Qualified Mental Retardation Professional (QMRP) coordinated services to meet the clients' needs. 6. The governing body failed to ensure the maintenance of the facility's environment, as evidenced by: a. Broken and/or torn window screens and windows were found on the exterior windows in the facility. b. The floor tiles in both bathrooms are broken, not sealed properly and ants were observed crawling in and out of cracked molding. c. Several of hospital beds in the client's rooms were inoperable. The lifting/tilting mechanism did not work. d. An old weather stained and molding couch was being stored in back yard. e. An overflow of leaves, twigs and small branches were observed sticking out from the storm gutters around the entire roof line of the	W 104	W104, continued from page 1, (3) Cross reference response to W338; securing timely medical follow-up for client #1. (4) Cross reference response to W140; policies and procedures to ensure complete accounting of client #1, #2 and #3's funds. (5) Cross reference response to W159; QMRP coordination of services (6) Governing body will address all maintenance and environmental concerns outlined in (a) thru Home Manager will conduct weekly environmental reviews of the home, report all problems and concerns on a weekly basis. Maintenance Director will continue to monitor on an ongoing basis to further ensure compliance with this standard.	5-31-07 ongoing 6-6-07 ongoing

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W 104	Continued From page 2 facility. f. Ants were observed crawling in and out of several small cracks along the shower stalls and tubs in both bathrooms. g. Several of the clothing items found being stored in the client's closets and on the bed linens were soiled with bodily fluids.	W 104		
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 interview and record review, the facility failed to ensure nursing quarterly assessments were signed for one of the four clients in the sample. (Client #1) The finding includes: Review of the nursing quarterly assessments on April 19, 2007 at approximately 2:35 PM, revealed that the nursing second quarterly assessment was not signed or dated by its author. In an interview with the Licensed Practical Nurse (LPN) on April 19, 2007 at approximately 2:45 PM, it was acknowledged that the nursing second quarterly assessment was signed and dated.	W 114	W114 This Standard will be met as evidenced by: All nursing quarterly assessments have been reviewed and signed. RN will continue to review and conduct routine audits to further ensure compliance with this standard.	4-26-07 ongoing
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of	W 124	W124	

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W 124	Continued From page 3 treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the facility failed to ensure the right of each client or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment for one of four clients in the sample. (Client #1) The findings include: 1. Observation of the morning medication administration on April 18, 2007 at approximately 7:00AM, revealed Client #1 received Prozac 20 mg by mouth every morning. Interview with the nursing staff on April 18, 2007 at approximately 7:05AM revealed that the medication was prescribed for behavior management. Review of the client's physicians orders dated February 27, 2007on April 19, 2007 at approximately 10:00AM revealed that Prozac 20mg by mouth was incorporated in a Behavior Support Plan (BSP) dated February 1, 2006, to address behaviors associated with aggression and Obsessive Compulsive Disorder (OCD). Interview with the Acting Qualified Mental Retardation Professional (AQMRP) on April 18, 2007 at approximately 4:30PM revealed that Client #1 did not have a legal guardian. The review of Client #1's Psychological Assessment dated June 6, 2006, indicated that he was not able to make independent decisions regarding residential or day placement, medical treatment plans or financial matters and can not give informed consents. There was no documented evidence	W 124	W124 Continued from page 3. This Standard will be met as evidenced by: (1) Client #1 has a legal guardian assigned who is available to provide consent for client #1. Client #1's guardian is aware of her brothers medical condition, treatment plans and right to refuse treatment She remains very actively involved with all aspects of his life. QMRP will obtain written verification of guardianship status and ensure that documentation clearly shows that client #'s legal guardian was informed.	6-6-07 ongoing

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W 124	Continued From page 4 that the facility informed Client #1 or a legally-authorized representative, as appropriate, of the health benefits and risks of treatment associated with the use of his psychotropic medications and corresponding BS'. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity. 2. Interview with the AQMRP and review of a medical consult dated August 4, 2006 on April 19, 2007 at approximately 4:35PM revealed that Client#1 had a colonoscopy performed on August 4, 2006. There was no documented evidence that the facility informed Client #1 or a legally-authorized representative, as appropriate, of the health benefits and risks of treatment associated with the colonoscopy examination. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity.	W 124	W124 Continued... from page 4. (2) Client #1's sister provided written consent for the colonoscopy procedure. Also reference response to #(1) W124.	
W 126	483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the clients' right to be taught to manage their financial affairs to the extent of their capabilities for three of four clients in the sample. (Clients #2,#3 and #4) The findings include:	W 126	W126 This Standard will be met as evidenced by:	

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W 126	Continued From page 5 1. Cross refer to W140. Interview with the Acting Qualified Mental Retardation Professional (AQMRP) on April 19, 2007 at approximately 5:15PM revealed that Client #2 had not received a comprehensive money management assessment that outlined his current skills and specific needs in this area. Review of Client #2's Individual Support Plan (ISP) dated June 7, 2006, at approximately 5:20PM on April 19, 2007 confirmed the AQMRP's statement. There was no evidence that the Client #2 was taught to manage his finances to the extent of his capability. 2. Cross refer to W140. Interview with the AQMRP on April 19, 2007 at approximately 5:25PM revealed that Client #3 had not received a comprehensive money management assessment that outlined his current skills and specific needs in this area. Review of Client #3's ISP dated July 12, 2006, at approximately 5:30PM on April 19, 2007 confirmed the AQMRP's statement. There was no evidence that the Client #3 was taught to manage his finances to the extent of his capability. 3. Cross refer to W140. Interview with the AQMRP on April 19, 2007 at approximately 5:35 PM revealed that Client #4 had not received a comprehensive money management assessment that outlined his current skills and specific needs in this area. Review of Client #4's ISP dated June 7, 2006, at approximately 5:40 PM on April 19, 2007 confirmed the AQMRP's statement. There was no evidence that the Client #4 was taught to manage his finances to the extent of his capability.	W 126	W126, continued from page 5. (1) Cross reference response to W140; comprehensive money management assessment (2) Cross reference response to W140. Money management assessments will be updated. A formal money management program will be developed if warranted. (3) Cross reference response to W140 and W126 #2. W140	5.31.07 ongoing 5.31.07 ongoing 6.1.07 ongoing
W 140	483.420(b)(1)(i) CLIENT FINANCES	W 140		

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W 140	Continued From page 6 The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. This STANDARD is not met as evidenced by: Based on staff interview and review of records, the facility failed to establish and maintain a system that ensures a complete and accurate accounting of clients' funds that are entrusted to the facility for three of the four clients in the sample. (Clients #1,#2 and #3) The findings include: 1. Review of Client #1's bank statements on April 20, 2007 at approximately 12:00PM revealed the following withdrawals were made: a. January 23, 2007 - $255.70 b. June 21, 2006 - $45.00 There was no documented evidence presented or on file at the time of survey to substantiate why these withdrawals were made. There were also no receipts on file at the time of survey to validate expenditures. 2. Review of Client #2's bank statements on April 20, 2007 at approximately 12:20PM revealed the following withdrawals were made: a. January 23,2007 - $255.70 b. January 13,2007 - $50.00 c. January 06,2007 - $200.00	W 140	W140, continued from page 6 This Standard will be met as evidenced by: (1.) Receipts for purchases made will be filed in client #'s record. Home Manager will ensure that all receipts, and funds entrusted are accounted for and maintained on file. Routine file audits will continue to further ensure compliance with this standard. (2) Reference response to W140 #1.	6-1-07 ongoing

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W 140	Continued From page 7 There was no evidence presented or on file at the time of survey to substantiate why these withdrawals were made. There were also no receipts on file at the time of survey to validate expenditures. 3. Review of Client #3's bank statements on April 20, 2007 at approximately 12:35PM revealed the following withdrawals were made: a. June 9, 2006 - $400.00 b. June 21, 2006 - $45.00 There was no documented evidence presented or on file at the time of survey to substantiate that the facility has kept an accurate accounting of all client's funds. There were also no receipts on file at the time of survey to validate expenditures. [Note: Several receipts were found attached to the June 9, 2006 withdrawal, but the dollar figure for these expenditures totaled $326.85 which leaves $73.15 unaccounted.]	W 140	W140, Continued.... 3. Reference response to W140 #1. Additionally, all receipts/totals will be re-caculated for accuracy.	6-1-07 ongoing
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to consistently document the reporting of client injuries of unknown origin to the designated administrator, and to report incidents that pose a	W 153	W153 This Standard will be met as evidenced by:	

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W 153	Continued From page 8 risk to client health or safety to governmental agencies, as required by DC regulation (22 DCMR Chapter 35 Section 3519.10). The finding includes: 1. Review of an unusual incident report dated January 5, 2007 on April 18, 2007 at approximately 9:50AM revealed that Client #5 was physically assaulted by another patient as an in-patient in the hospital. Further review revealed that the District of Columbia Metropolitan Police Department (DCMPD) had to come to the hospital to assess Client #5 for injuries. Review of the unusual incident failed to evidence that this incident had not been reported to governmental agencies as required.	W 153	W153, Continued . . . ① QMRP will ensure that all incidents are reported to governmental agencies and documentation maintained on file to support/verify appropriate reporting to governmental agencies. All staff will receive additional training to include but not limited to; incident reporting and documentation.	6.1.07 ongoing
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed that each client's active treatment program was coordinated, integrated and monitored by the Qualified Mental Retardation Professional (QMRP). The findings include: 1. Cross Refer to W249. The QMRP failed to ensure Client's #1,#2,#3 and #4 received consistant opportunities to develop and learn new skills based on comprehensive assessments.	W 159	This Standard will be met as Evidenced by: 1. Cross reference response to W249. (2) Reference response to W153. (3) Reference response to W126 (4) Reference response to W436	6.1.07 ongoing

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W 159	Continued From page 9 2. Cross refer to W153. The QMRP failed to ensure that each employee had Initial and continuing training in incident management. 3. Cross refer to W126. The QMRP failed to ensure that Client's #2, #3 and #4 had money management assessments. 4. Cross Refer to W436. The QMRP failed to ensure adaptive equipment recommended by the interdisciplinary team was provided and maintained in good repair for four of four clients in the sample. (Clients #1, #2, 3 and #4)	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, staff interview and record review, the facility failed to ensure initial and continuing training for each employee to enable them to perform duties effectively, efficiently, and competently to address the needs of eight of eight clients in the facility.(Clients #1,#2,#3,#4,#5,#6,#7 and #8) The finding includes: Interview with the House Manager and record review on April 20, 2007 at approximately 11:20AM revealed no documented evidence that the new staff hired over the past certification year received training specific training on Resident's rights to ensure the health and well-being of its residents.	W 189	W189 This standard will be met as evidenced by: QMRP/Home Manager will conduct additional training for all staff to include but not limited to; • Behavior Supports • Seizure Management • Incident Reporting procedures • Monitoring adaptive Equipment.	6.6.07 ongoing

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W 189	Continued From page 10	W 189	W189, Continued...	
	2. Interview with the House Manager and record review on April 20, 2007 at approximately 11:10AM revealed no documented evidence that the new staff hired over the past certification year received training specific training in any of the client's behavior management plans.		■ Magnet Vagal Stimulator ■ Documentation ■ Infection Control ■ Emergency Procedures	
W 192	483.430(e)(2) STAFF TRAINING PROGRAM	W 192	W192	
	For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.		This Standard will be met as evidenced by;	6-6-07 ongoing
	This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to effectively train staff to implement emergency measures for one of the four clients in the sample. (Client #1)		Reference response to W189.	
	The finding includes:		In addition, Home Manager QMRP will ensure that training schedules are maintained and completed on an ongoing and/or as needed basis.	
	Interview with the House Manager and record review on April 20, 2007 at approximately 10:50 AM revealed no documented evidence that the new staff hired over the past certification year to provide direct care services to Client #1 had been trained to use the Magnet and Vagal Stimulator designed to manage Client #'s seizures.			
W 193	483.430(e)(3) STAFF TRAINING PROGRAM	W 193	Staff will be monitored and provided feedback as needed to ensure	
	Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.			

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W 193	Continued From page 11 This STANDARD is not met as evidenced by: Based on observations, staff interviews and the review of records, the facility staff failed to demonstrate competency in implementation of Client #1 and #2's Behavior Support Plan (BSP). The finding includes: Interview with the House Manager and record review on April 20, 2007 at approximately 11:10AM revealed no documented evidence that the new staff hired over the past certification year received training specific training on any of the client's behavior management plans.	W 193	that they are able to demonstrate the skills and competency needed to provide appropriate supports for all clients. W193 This Standard will be met as evidenced by: Reference response to W189 Also, it should be noted that both client #1 and #2 behaviors have improved over the past year. Documentation of all completed trainings will be maintained on file.	6-6-07 ongoing
W 212	483.440(c)(3)(i) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the presenting problems and disabilities and where possible, their causes. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to include the Axis I diagnosis for a client receiving psychotropic medication for two of the four clients in the sample (Clients #1 and #3). The findings include: 1. Observation of the morning medication administration on April 18, 2007 at approximately 7:00AM, revealed Client #1 received Prozac 20 mg PO every morning. Interview with the nursing staff on April 18, 2007 at approximately 7:05AM revealed that the medication was prescribed for behavioral management. Review of the client's physicians orders dated February 21, 2007 on April 19, 2007 at approximately 1:15PM revealed that Prozac 20mg PO was prescribed to address	W 212	W212 This Standard will be met as evidenced by:	

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NAME OF PROVIDER OR SUPPLIER: IDI		STREET ADDRESS, CITY, STATE, ZIP CODE: 3312 4TH STREET, SE WASHINGTON, DC 20032	

(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 212	Continued From page 12 behaviors associated with aggression and Obsessive Compulsive Disorder (OCD). Review of Client#1's medical record on April 19, 2007 at approximately 2:00PM revealed no documented evidence of a psychiatric assessment. 2. Observation of the morning medication administration on April 18, 2007 at approximately 7:50AM, revealed Client #3 received Prozac 40 mg PO, Ravia 25mg PO and Seroquel 300mg PO. Interview with the nursing staff on April 18, 2007 at approximately 8:00AM revealed that the medication was prescribed for behavioral management. Review of the client's physicians orders dated February 21, 2007 revealed that the psychotropic medications were prescribed to address behaviors associated with Intermittent Explosive Disorder(IED) and mood disorder. Review of Client#3's medical record on April 19, 2007 at approximately 3:30PM revealed no documented evidence of a psychiatric assessment.	W 212	W212 . . . Psychiatric Assessment for client #3 was evidently purged. • Psychiatric Assessment for client #1 will be filed and/or another Assessment will be completed as needed. Do NOT Remove will be stamped on all documents remain in the file. • QMRP's will receive additional training on purging/filing etc. . .	6.8.07 ongoing
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that each client's behavior intervention technique, including the use of behavior modification drugs was conducted with the written informed consent of the client, parents (if the client is a minor) or legal guardian for one of four clients in the sample.	W 263		

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	09 3192		04/20/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	3312 4TH STREET, SE WASHINGTON, DC 20032

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W 263	Continued From page 13 (Client #1) The finding includes: Observation of the morning medication administration on April 18, 2007 at approximately 7:00AM, revealed that Client #1 received Prozac 20 mg by mouth every morning. Interview with the nursing staff on April 18, 2007 at approximately 7:05AM revealed that the medication was prescribed for behavior management. Review of the client's physicians orders dated February 27, 2007on April 19, 2007 at approximately 10:00AM revealed that Prozac 20mg by mouth was incorporated in a Behavior Support Plan (BSP) dated February 1, 2006, to address behaviors associated with aggression and Obsessive Compulsive Disorder (OCD). Interview with the Acting Qualified Mental Retardation Professional (AQMRP) on April 18, 2007 at approximately 4:30PM revealed that Client #1 did not have a legal guardian. The review of Client #1's Psychological Assessment dated June 6, 2006, indicated that he was not able to make independent decisions regarding residential or day placement, medical treatment plans or financial matters and can not give informed consents. There was no documented evidence that the facility informed Client #1 or a legally-authorized representative, as appropriate, of the health benefits and risks of treatment associated with the use of his psychotropic medications and corresponding BSP. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity.	W 263	W263 Continued... This Standard will be met as Evidenced by: Client #1 has a legal guardian. Documentation will be obtained and placed in record. Client #1's sister signed written consent Human Rights Committee will continue to review and discuss risks and benifits of treatment QMRP will ensure that documentation to support informed consent is maintained on file.	6.6.07 ongoing
W 312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior	W 312		

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NAME OF PROVIDER OR SUPPLIER IDI		STREET ADDRESS, CITY, STATE, ZIP CODE 3312 4TH STREET, SE WASHINGTON, DC 20032	

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W 312	Continued From page 14 must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the use of behavior modification medications prescribed to complete medical appointments was incorporated in the individual program plan (IPP) for one of the four clients in the sample (Client#4). The finding includes: Review of Client #4's physician's orders on April 20, 2007 at approximately 12:45PM revealed that on April 13, 2007, Client #4 was ordered and received Valium 10mg by mouth prior to bloodwork and a chest x-ray. Interview with the Licensed Practical Nurse (LPN) on April 20, 2007 at approximately 1:00 PM revealed that Client#4 did not have a desensitization program for medical appointments. Review of the Client #4's Individual Support Plan (ISP) dated June 7, 2006 on April 20, 2007 at approximately 1:15PM failed to evidence a program that addresses the client's non-compliant behaviors at medical appointments to justify the use of the sedative medication. There was no documented evidence that the use of behavior modification medications prescribed to complete medical appointments was incorporated in the ISP.	W 312	W312 This standard will be met as evidenced by: Client #4 will be further evaluated to determine if behavior support plan and/or desensitization program for medical appointments is needed. Non-compliance behaviors during medical appointments will also be reviewed and documented in order to obtain more information in this area.	6.1.07 ongoing
W 322	483.480(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care.	W 322	W322	

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	09[illegible]192		04/20/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ID I	3312 4TH STREET, SE WASHINGTON, DC 20032

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W 322	Continued From page 15 This STANDARD is not met as evidenced by: Based on staff interview, and record review the facility failed to order laboratory studies on one of four clients in the sample who is on anti-convulsant medications. (Client #1) The finding includes: Observation of the morning medication administration on April 18, 2007 at approximately 7:00AM, revealed that Client #1 received Keppra 1500 mg by mouth, Primidone 250 mg by mouth and Topamax 300 mg by mouth. Interview with the nursing staff on April 18, 2007 at approximately 7:15AM revealed that Client #1 was administered the anti-convulsant medications for seizure management. Review of the Medication Administration Records (MARs) on April 18, 2007 at approximately 11:00AM revealed that the client was prescribed Keppra 1500 mg by mouth twice a day, Primidone 250 mg by mouth in the morning/500mg in the evening and Topamax 300 mg by mouth twice a day for seizure management. Review of the physicians orders dated February 27, 2007 or April 19, 2007 at approximately 10:15AM revealed that the medications were prescribed for seizure management. There was no documented evidence that laboratory studies were performed to monitor the client's anti-convulsant medications.	W 322	W322 Continued... This Standard will be met as evidenced by: RN will review lab results. Laboratory studies for client #1 will be performed as outlined by the primary care physician. RN will review and discuss monitoring tracking of labs with LPN staff assigned to the home. RN will conduct routine audits and follow-up to further ensure compliance with this standard.	6.1.07 ongoing
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.	W 331		

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W 331	Continued From page 16 This STANDARD is not met as evidenced by: Based on observation, staff interview and record review the facility failed to ensure nursing services in accordance with the needs of two of two clients in the sample. (Client #1 and #2) The findings include: 1. The facility's nursing services failed to implement the facility's policy and procedures entitled " Hospital Admissions" as evidenced by: Interview with the Licensed Practical Nurse (LPN) on April 18, 2007 at approximately 8:35AM revealed that Client #5 was transported to the emergency room on April 6, 2007 and admitted on the same day for further treatment and evaluation. Further interview revealed that the client was still in the hospital during the time of the survey. Review of nursing progress notes on April 18, 2007 at approximately 8:54AM revealed no documented evidence on file to substantiate that communication had transpired between the facility and the hospital. Review of the facility's Health Protocol Manual addressing the requirements for " Hospital Admission " on April 20, 2007 at approximately 10:35AM included the following procedure: (5) Contact the hospital, physician, social worker, or other appropriate persons for information on the individual 's condition daily. There was no documented evidence that the nursing staff implemented the facility's policy. [Note: Late entry progress notes regarding Client #5's hospitalization was documented on	W 331	W331 This Standard will be met as evidenced by: RN has provided additional training and review for all LPN staff outlining the expectations of documentation and follow-up whenever a client is hospitalized 4.26.07 ongoing - LPN staff are expected to monitor and track recommended appointments using medical tracking form. - RN will monitor and provide feedback and direction as needed - Also reference response to W 332 regarding laboratory studies. Client #2's protime	

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W 331	Continued From page 17 April 18, 2007 at 10:00AM during the survey] 2. The facility's nursing services failed to obtain timely laboratory follow-up for Client #2 as evidenced by: Review of the physician's orders dated February 27, 2007 on April 19, 2007 at approximately 11:20AM revealed that Client #2 was prescribed Zocor 20mg by mouth at bedtime for hypercholesterolemia. Further review revealed that laboratory studies for lipid levels was ordered every six months. Review of laboratory studies on April 19,2007 at approximately 11:25AM revealed that the last documented lipid level was dated June 7, 2006. There was no evidence that the laboratory studies for lipid levels was performed as recommended by the physician. 3. The facility's nursing services failed to obtain timely laboratory follow-up for Client #2 as evidenced by: Review of the physician's orders dated September 21, 2006 on April 19, 2007 at approximately 11:30AM revealed that Client #2 was ordered laboratory studies for protime levels three times a week for three weeks. Review of laboratory studies on April 19,2007 at approximately 11:35AM revealed that the protime level were performed twice the week of October 1, 2006 and twice the week of October 8, 2006. There was no evidence that the laboratory studies for protime levels was performed as recommended by the physician. 4. The facility's nursing services failed to ensure that Client #1's endocrinology appointment was conducted timely as evidenced below:	W 331	W331, Continued... and lipid studies will be followed as ordered by the physician. (3) Reference response to W 322.	6.1.07 ongoing

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NAME OF PROVIDER OR SUPPLIER: IDI

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W 331	Continued From page 18 Review of Client#1's medical evaluation dated June 6, 2006 at approximately 10:00AM revealed that the client has a diagnosis of hypothyroidism and is prescribed Synthroid 100mg by mouth daily. Review of an endocrinology consult dated May 11, 2006 on April 19,2007 at approximately 1:30PM revealed a recommendation that the client return to the endocrinology clinic in six months. Further review revealed that the client did not go to the endocrinology clinic until February 16, 2007.	W 331		
W 340	483.480(c)(5)(i) NURSING SERVICES Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on interview and record review, the facility's nursing services failed to implement an effective system to ensure training to clients and staff in preventive health measures for eight of eight clients in the facility. (Client #1#2, #3, #4, #5, #6,#7and #8) The finding includes: Interview with the nursing staff and record review on April 20, 2007 at approximately 11:00AM revealed no documented evidence that the new staff hired over the past certification year received training specific to infection control procedures to ensure the health and well-being of its clients.	W 340	W340 This Standard will be met as evidenced by: Infection Control procedures will be reviewed and discussed with all staff. Home Manager will monitor to ensure that appropriate infection control measures are implemented at all times. Home Manager will track employee training schedules and provide necessary training as needed.	5-18-07 ongoing

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NAME OF PROVIDER OR SUPPLIER: IDI		STREET ADDRESS, CITY, STATE, ZIP CODE: 3312 4TH STREET, NE WASHINGTON, DC 20032	

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W 436	483.470(g)(2) SPACE AND EQUIPMENT 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, interview and record review, the facility failed to ensure wheelchairs were maintained in good repair for two of four clients in the sample. (Clients #1 and #2) The findings include: 1. Observation of Client#1's wheelchair on April 18, 2007 at approximately 8:30AM revealed that the right armrest of the wheelchair was torn. In an interview with the Acting Qualified Mental Retardation Professional (AQMRP) on April 18, 2007 at approximately 7:00PM it was acknowledged that the wheelchair needed to be repaired. There was no evidence that Client#1's wheelchair was maintained in good repair. 2. Observation of Client#2's wheelchair on April 19, 2007 at approximately 2:00PM revealed that the rubber covering around both handles on the wheelchair were torn. Further observation revealed that the edges were torn around the footbox. In an interview with the AQMRP on April 18, 2007 at approximately 7:10PM it was acknowledged that the wheelchair needed to be repaired. There was no evidence that Client#2's wheelchair was maintained in good repair.	W 436	W436 This Standard will be met as evidenced by: (1) 719a has been completed for designated repairs. CMSP will track and monitor until completed. Documentation of actions taken to address wheelchair repairs will be maintained in clients record. (2) Reference response to H 1 W436. Also, staff will receive additional training on wheelchair maintenance and documenting status of wheelchair as outlined on wheelchair monitoring form.	4-26-07 ongoing

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I 000	INITIAL COMMENTS A licensure survey was conducted from 4/18/2007 through 4/19/2007. Eight males with varying degrees of disabilities reside in the facility. Four of the six residents were randomly selected for the sample. The findings of the survey were based on observations at the group home, interviews with staff and residents, and the review of records including the incident reports.	I 000		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each CHIMRP 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 staff interview the residential facility was found to be out of compliance with this section as identified below: 1. Broken and/or torn window screens and windows were found on the exterior windows in the facility. 2. The floor tiles in both bathrooms are broken, not sealed properly and ants were observed crawling in and out of cracked molding. 3. Several of hospital beds in the client's rooms were inoperable. The lifting/tilting mechanism did not work. 4. An old weather stained and molding couch was being stored in back yard. 5. An overflow of leaves, twigs and small branches were observed sticking out from the storm gutters around the entire roofline of the facility.	I 090	3504.1 This Statute will be met as evidenced by; Reference response to federal deficiency report W104	6.11.07 ongoing

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Merri Munch

TITLE: DES

(X6) DATE: 5-14-07

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I 091	Continued From page 1	I 091		
I 091	3504.2 HOUSEKEEPING Housekeeping and maintenance equipment shall be well constructed, properly maintained and appropriate to the function for which it is to be used. This Statute is not met as evidenced by: Based on observation and staff interview the residential facility was found to be out of compliance with this section as identified below: During the environmental inspection on 4/19/2007 the protective rubber seal/cover around the drain for the garbage disposal in the kitchen sink was torn and not in place.	I 091	3504.2 Housekeeping This Statute will be met as evidenced by: Reference response to W104 federal Deficiency report for 3504.3, 35504.4,	6.11.07 ongoing
I 092	3504.3 HOUSEKEEPING Each GHMRP shall be free of insects, rodents and vermin. This Statute is not met as evidenced by: Based on observation and staff interview the residential facility was found to be out of compliance with this section as identified below: During the environmental inspection on 4/19/2007, ants were observed crawling in and out of several small cracks along the shower stalls and tubs in both bathrooms	I 092		
I 093	3504.4 HOUSEKEEPING Each GHMRP that is cited by the Department of Consumer and Regulatory Affairs for violation of § 3504.3 shall contract with a licensed	I 093	3504.4	

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1093	Continued From page 2 exterminator within seventy-two hours (72 hrs.) of receipt of written notice to provide for elimination of any infestation. This Statute is not met as evidenced by: Based on staff interview and record review the residential facility was found to be out of compliance with this section as identified below: There was no evidence presented on file at the time of survey to substantiate that the Group Home for Mentally Retarded Persons (GHMRP) had contracted the services of a licensed exterminator to monitor and ensure a pest free environment. [Reference Licensure Deficiency Citation 3504.3]	1093	3504.4 This Statute will be met as evidenced by: GRMRP has always maintained contracted services of a licensed exterminator to monitor and ensure pest free environment. 4.2.07 ongoing ■ QMRP and Home Manager will receive additional training in this area.	
1098	3504.9 HOUSEKEEPING Each GHMRP shall provide appropriate procedures, personnel, and equipment in order to ensure sufficient clean linen supplies and the proper sanitary washing and handling of linen and personal clothing of each resident. This Statute is not met as evidenced by: Based on staff interview and record review the residential facility was found to be out of compliance with this section as identified below: During the environmental inspection on 4/19/2007, several of the clothing items found being stored in the Resident's closets and on the bed linen were soiled of bodily fluids.	1098	3504.9 ■ Home Manager will consistently check clothing supplies and inventory of personal items. 4.27.07 ongoing ■ All staff will receive additional inservice training regarding expectations of performance, client clothing, and maintaining clean/safe environment.	
1104	3504.11 HOUSEKEEPING	1104		

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IDI	3312 4TH STREET, SE WASHINGTON, DC 20032

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I 104	Continued From page 3 Each GHMRP shall maintain at least one (1) additional set of the linens specified in §3504.10 for each resident. This Statute is not met as evidenced by: Based on staff interview and record review the residential facility was found to be out of compliance with this section as identified below: During the environmental inspection on 4/19/2007, there were approximately 3 extra bed sheets and pillow cases, but no additional comforters to service the needs of the eight males residing in the facility. The facility's House Manager indicated that she was newly assigned to the facility and that she would address this oversight immediately.	I 104	3504.10; reference response to 3509.9 and 3504.15.	
I 108	3504.15 HOUSEKEEPING Each GHMRP shall assure that each resident has at least seven (7) changes of clothing appropriate to his or her daily activities. This Statute is not met as evidenced by: Based on staff interview and record review the residential facility was found to be out of compliance with this section as identified below: On 4/19/2007 an environmental inspection was performed to assess the level of care for all eight of the Residents residing in the facility. During that inspection it was found that the facility failed to consistently provide all eight residents with dress suits, dress shirts/ties, dress shoes, winter sweaters, winter coats, dress slacks, and coordinating casual wear. Some of the clothing was tattered, frayed and appeared to be	I 108	I108 3504.15 Housekeeping This Statute will be met as evidenced by: All needed clothing items will be purchased. Home Manager and direct care staff will monitor residents clothing and report when items are needed.	5.18.07 ongoing

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NAME OF PROVIDER OR SUPPLIER: IDI	STREET ADDRESS, CITY, STATE, ZIP CODE: 3312 4TH STREET, SE WASHINGTON, DC 20032		

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I 108	Continued From page 4 inconsistently sized for a single individual (i.e., XL and Small shirts in same closet, etc.). Interview with the facility's House Manager on 4/19/2007 at 12:14pm revealed these Residents do attend formal outings, but she is also aware that there is a shortage of the appropriate formal clothing for all eight residents.	I 108	1108 Continued....	
I 165	3507.4(c) POLICIES AND PROCEDURES The manual shall incorporate policies and procedures for at least the following: (c) Health and safety, which covers fire safety and evacuation, infection control, medication, and procedures for emergency and the death of a resident; This Statute is not met as evidenced by: Based on staff interview and record review the residential facility was found to be out of compliance with this section as identified below: Record review on 4/20/2007 revealed that Resident #5 was hospitalized on 4/6/2007 and was in the hospital during the time of the survey. There was no evidence on file to substantiate that any communication had transpired between the facility and the hospital to ensure his/her health and well-being. Further record review revealed that Section H(7) of the IDI Health Protocol Manual addressing the requirements for "Hospital Admission" detailed the following procedure: (5) Contact the hospital, physician, social worker, or other appropriate persons for information on the individual's condition daily.	I 165	1165 3507.4(c) Policies and Procedures This Statute will be met as evidenced by: Reference response to Federal Deficiency report W331.	4.26.07 ongoing

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	09G192		04/20/2007

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I 165	Continued From page 5	I 165		
	a. Supply hospital with Hospital Contacts during emergency/Hospitalization (PRM 029) form to document the requested information. The Group Home for Mentally Retarded Persons (GHMRP) failed to implement Section H(7) of their company policy.			
I 180	3508.1 ADMINISTRATIVE SUPPORT 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: Based on observation, interview and record review the facility failed that each client's active treatment program was coordinated, integrated and monitored by the Qualified Mental Retardation Professional (QMRP) The findings include:	I 180	1180 3508.1 This Statute will be met as evidenced by:	
	1. Cross Refer to W249. The QMRP failed to ensure Client's #1,#2,#3 and #4 received consistent opportunities to develop and learn new skills based on comprehensive assessments.		(1.) Cross reference response response to W249.	6-11-07-ongoing
	2. Cross refer to W153. The QMRP failed to ensure that each employee had initial and continuing training in incident management.		(2.) Cross reference response to W153.	
	3. Cross refer to W126. The QMRP failed to ensure that Client's #2, #3 and #4 had money management assessments.		(3.) Cross reference response response to W126.	
	4. Cross Refer to W436. The QMRP failed to ensure adaptive equipment recommended by the interdisciplinary team was provided and		(4.) Cross reference response to 436	

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1180	Continued From page 6 maintained in good repair for four of four clients in the sample. (Clients #1, #2, 3and #4) 5. The QMRP failed to ensure Client #1 received an annual occupational assessment as recommended by the Occupational Therapist (OT) as evidenced by: Review of an Occupational Assessment dated July 27, 2004 on April 19, 2007 at approximately 3:00PM revealed a recommendation that Client #1 receive an annual occupational assessment. 6. The QMRP failed to ensure Client #2 received an annual occupational assessment as recommended by the OT as evidenced by: Review of an Occupational Assessment dated July 5, 2005 on April 19, 2007 at approximately 3:10PM revealed a recommendation that Client #2 receive an annual occupational assessment. 7. The QMRP failed to ensure Client #4 received an annual occupational assessment as recommended by the OT as evidenced by: Review of an Occupational Assessment dated July 5, 2005 on April 19, 2007 at approximately 3:20PM revealed a recommendation that Client #4 receive an annual occupational assessment. 8. The QMRP failed to ensure Client #4 received an annual recreational assessment as recommended by the Recational Therapists evidenced by: Review of an Occupational Assessment dated July 5, 2005 on April 19, 2007 at approximately 3:20PM revealed a recommendation that Client	1180	1180 Continued... 5. QMRP will obtain occupational Therapy assessments as recommended. #6, #7, #8. reference response to #5 1180.	6.11.07 ongoing

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I 180	Continued From page 7 #4 receive an annual occupational assessment.	I 180		
I 189	3508.7 ADMINISTRATIVE SUPPORT Each GHMRP shall maintain records of residents' funds received and disbursed. This Statute is not met as evidenced by: Based on staff interview and record review the residential facility was found to be out of compliance with this section as identified below: Resident Finances (Withdrawals) 1. Review of Resident #2 bank statements revealed the following withdrawals were made: a. 1/23/2007 - $255.70 b. 1/13/2007 - $50.00 c. 1/08/2007 - $200.00 There was no evidence presented or on file at the time of survey to substantiate why these withdrawals were made. There were also no receipts on file at the time of survey to validate expenditures. 2. Review of Resident #1 bank statements revealed the following withdrawals were made: a. 1/23/2007 - $255.70 b. 6/21/06 - $45.00 There was no evidence presented or on file at the time of survey to substantiate why these withdrawals were made. There were also no receipts on file at the time of survey to validate expenditures. Note: There was a note on file which stated that the $45.00 withdrawal was for a Marvin Gaye performance, but there was no collaborating evidence of a concert ticket or	I 189	Administrative Support 3508.7 This Statute will be met as evidenced by. Reference response to Federal deficiency report W140 and W126.	6.1.07 ongoing

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I 189	Continued From page 8 anything else that indicated this client attended that event. 3. Review of Resident #3 bank statements revealed the following withdrawal were made: a. 6/09/2006 - $400.00 b. 6/21/2006 - $45.00 There was no evidence presented or on file at the time of survey to substantiate that the facility has kept an accurate accounting of all resident's funds. There were also no receipts on file at the time of survey to validate expenditures. Note: Several receipts were found attached to the 6/9/2006 withdrawal, but the dollar figure for these expenditures totaled $326.85 which leaves $73.15 unaccounted for.	I 189		
I 220	3510.1 STAFF TRAINING Each employee who has no previous experience working with individuals with mental retardation shall be required to successfully complete orientation training appropriate to the needs of the residents in the GHMRP. This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for Mental Retardation (GHMRP) failed to ensure that new staff received training to ensure the health and well-being of its residents as identified below: There was no evidence presented or on file at the time of survey to substantiate that staff has been provided the necessary training to use Resident #1's Magnet and Vagal Stimulator as required to ensure his health and safety. [Reference Licensure Deficiency Citation 3510.4(b)]	I 220	3510.1 Staff Training This Statute will be met as evidenced by: Reference response to Federal Deficiency report W189.	6-6-07 ongoing

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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 staff interview and record review, the Group Home for Mental Retardation (GHMRP) failed to ensure that all training documentation included the required agenda for each training session. The facility's House Manager on 4/20/2007 at 1:35pm was interviewed about staff being trained to manage Resident #1's Magnetic Vagal Stimulator and she indicated that staff has been trained but that the documents may be at the main office. The facility failed to present the necessary agenda and record of staff participation at the time of survey as required by this section.	I 223	3510.4 Staff Training This Statute will be met as evidenced by: Reference response to Federal Deficiency Report W189	
I 224	3510.5(a) STAFF TRAINING Each training program shall include, but not be limited to, the following: (a) Overview of mental retardation including, but not limited to, definition, causes of mental retardation, associated health impairments, and frequently used medications, the history of care of individuals with mental retardation, and daily living skills; This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for Mental Retardation (GHMRP) failed to ensure that new staff received effective training on the health and well-being	I 224	1224 3510.5 (a) Staff Training STAFF Training This Statute will be met as evidenced by: Reference response to Federal Deficiency report W189.	6.6.07 ongoing

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I 224	Continued From page 10 requirements of caring for the mentally retarded. The finding includes: Record review on 4/20/2007 revealed that none of the new staff hired over the past certification year received training specific to the overview of mental retardation and its corresponding service needs to ensure the health and well-being of its residents.	I 224	1224	
I 226	3510.5(c) STAFF TRAINING This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for Mental Retardation (GHMRP) failed to ensure that new staff received effective training on infection control as identified below: Record review on 4/20/2007 revealed that none of the new staff hired over the past certification year received training specific to infection control procedures to ensure the health and well-being of its residents.	I 226	1226 STAFF Training (c) This Statute will be met as evidenced by. Reference response to Federal Deficiency Report W 340.	
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (c) Infection control for staff and residents; This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for Mental Retardation (GHMRP) failed to ensure that new staff received effective training on emergency procedures as identified below:	I 227	1227 3510.5 (d) This Statute will be met as evidenced by: Reference response to Federal Deficiency report W 340 and W189. Also, GHMRP will	5.25.07 ongoing

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I 227	Continued From page 11 Record review on 4/20/2007 revealed that none of the new staff hired over the past certification year received training specific to the care of clients during times of emergency and/or disaster planning to ensure the health and well-being of its residents.	I 227	I227, continued... ensure that staff receive emergency and/or disaster planning at the time of hire and as needed to ensure that they are able to demonstrate knowledge and understanding of emergency procedures.	
I 228	3510.5(e) STAFF TRAINING Each training program shall include, but not be limited to, the following: (e) Resident's rights; This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for Mental Retardation (GHMRP) failed to ensure that new staff received training on Resident's rights as identified below: Record review on 4/20/2007 revealed that none of the new staff hired over the past certification year received client specific training on Resident's rights to ensure the health and well-being of its residents.	I 228	I228 3510.5 (e)(f) Staff Training This Statute will be met as evidenced by: All staff at time of hire receive training on residents rights. Documentation will be filed to support training provided to all employees. in this area. Home Manager will file documents upon receipt and provide additional training as needed to all staff to ensure that the rights of the consumers are protected at all times	6.1.07 ongoing
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by:	I 229		

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I 229	Continued From page 12 Based on staff interview and record review, the Group Home for Mental Retardation (GHMRP) failed to ensure that new staff received training on Resident's Behavior Management Plans as identified below: Record review on 4/20/2007 revealed that none of the new staff hired over the past certification year received client specific training on any of the Resident's behavior management plans.	I 229	Both Home Manager and QMRP will provide additional training on behavior support plans, 1230 3510.5 (g) Staff Training	
I 230	3510.5(g) STAFF TRAINING Each training program shall include, but not be limited to, the following: (g) Habilitation planning and implementation; This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for Mental Retardation (GHMRP) failed to ensure that new staff received training on a Resident's habilitation program(s) as identified below: Record review on 4/20/2007 revealed that none of the new staff hired over the past certification year to be the 1:1 assigned staff for Resident #1 received client specific training on how to manage his seizures and on how to implement his behavior management plan.	I 230	1230 This Statute will be met as evidenced by. Reference response to Federal Deficiency Report W189 & W194.	6.1.07 ongoing
I 231	3510.5(h) STAFF TRAINING Each training program shall include, but not be limited to, the following: (h) Orientation programs for each new employee which shall include philosophy, organization,	I 231	1231 3510.5 (h)	

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I 231	Continued From page 13 programs, practices and goals of the GHMRP as well as a review of applicable laws regulations and agreements important to the operation of the GHMRP for the care and treatment of persons with mental retardation in the District of Columbia; and. This Statute is not met as evidenced by: Based on staff interview and record review the residential facility was found to be out of compliance with this section as identified below: Record review on 4/20/2007 revealed that none of the new staff hired over the past certification year received client specific training or was presented with the Regulatory requirements of this chapter (Chapter 35) and any of the requirements of this section as presented above.	I 231	1231 This Statute will be met as evidenced by: ■ QMRP will ensure that all staff receive training on client specific areas. ■ QMRP will maintain record of all completed trainings.	6.1.07 ongoing
I 232	3510.5(i) STAFF TRAINING Each training program shall include, but not be limited to, the following: (i) Training of the residents in the maintenance of oral health and hygiene. This Statute is not met as evidenced by: Based on staff interview and record review the residential facility was found to be out of compliance with this section as identified below: Record review on 4/20/2007 revealed that none of the new staff hired over the past certification year received client specific training on how to maintain the oral health and hygiene of eight of eight residents residing in the facility.	I 232	1232 3510.5 (i) STAFF TRAINING This Statute will be met as evidenced by: Reference response to 3508.1 and 3510.4.	6.1.07 ongoing

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I 260	Continued From page 14	I 260		
I 260	3512.1 RECORDKEEPING: GENERAL PROVISIONS Each Residence Director shall maintain current and accurate records and reports as required by this section. This Statute is not met as evidenced by: Based on staff interview and record review the residential facility was found to be out of compliance with this section as identified below The Residence Director failed to ensure the accurate accounting of Resident's funds and failed to ensure the accurate record keeping of staff training. [Reference Licensure Deficiency Citations 3508.1 and 3510.4]	I 260		
I 261	3512.2 RECORDKEEPING: GENERAL PROVISIONS Each record shall be kept in a centralized file and made available at all times for inspection and review by personnel of authorized regulatory agencies. This Statute is not met as evidenced by: Based on staff interview and record review the residential facility was found to be out of compliance with this section as identified below: Record review on 4/20/2007 revealed the employee records, staff training records and client finances were not maintained as required by this section. [Reference Licensure Deficiency Citations 3508.1, 3510.4]	I 261	1261 3512.2 Recordkeeping: General Provisions. This Statute will be met as evidenced by: Reference response to (3508.1 and 3510.4)	6.1.07 ongoing
I 391	3520.2(a) PROFESSION SERVICES: GENERAL PROVISIONS	I 391		

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I 391	Continued From page 15 Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (a) Medicine; This Statute is not met as evidenced by: Based on staff interview, and record review the facility failed to order laboratory studies on one of four clients in the sample who is on anti-convulsant medications. (Client #1) The finding includes: Observation of the morning medication administration on April 18, 2007 at approximately 7:00AM, revealed that Client #1 received Keppra 1500 mg by mouth, Primidone 250 mg by mouth and Topamax 300 mg by mouth. Interview with the nursing staff on April 18, 2007 at approximately 7:15AM revealed that Client #1 is administered the anti-convulsant medications for seizure management. Review of the Medication Administration Records (MARs) on April 18, 2007 at approximately 11:00AM revealed that the client is prescribed Keppra 1500 mg by mouth twice a day, Primidone 250 mg by mouth in the morning/500mg in the evening and Topamax 300 mg by mouth twice a day for seizure management. Review of the physicians orders dated February 27, 2007 on April 18, 2007 at	I 391	I391 3520.2 (a) This Statute will be met as evidenced by: Reference response to Federal Deficiency report W331 & W322.	6.1.07 ongoing

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G192	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/20/2007
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I 391	Continued From page 18 approximately 10:15AM revealed that the medications were prescribed for behavior management. There was no documented evidence that the physician ordered laboratory studies to monitor the client's antipsychotic medications.	I 391		
I 395	3520.2(e) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (e) Nursing; This Statute is not met as evidenced by: Based on observation, staff interview and record review the facility failed to ensure nursing services in accordance with the needs of two of two clients in the sample. (Client #1 and #2) The findings include: 1. The facility's nursing services failed to implement the facility's policy and procedures entitled " Hospital Admissions" as evidenced by: Interview with the Licensed Practical Nurse (LPN) on April 18, 2007 at approximately 8:35AM revealed that Client #5 was transported to the emergency room on April 8, 2007 and admitted	I 395	I395 3520.2 (e) PROFESSIONAL SERVICES: GENERAL PROVISIONS. (1) Reference response to Federal Deficiency Report W332. (2) Reference response to Federal Deficiency report W312. (3) Reference response to Federal Deficiency report W331 and 322.	6-11-07 ongoing

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I 395	Continued From page 17	I 395	1395, Continued...	
	on the same day. Further interview revealed that the client was still in the hospital during the time of the survey. Review of nursing progress notes on April 18, 2007 at approximately 8:43AM revealed no documented evidence on file to substantiate that any communication had transpired between the facility and the hospital to ensure this client's health and well-being since the client was transported to the emergency room. Review of the facility's Health Protocol Manual addressing the requirements for " Hospital Admission " on April 20, 2007 at approximately 10:35AM detailed the following procedure:		(4) Reference response to federal Deficiency report W322 and W331:	6.1.07 ongoing
	(5) Contact the hospital, physician, social worker, or other appropriate persons for information on the individual's condition daily.		(5) Reference response to #4 3520.E	
	a. Supply hospital with Hospital Contacts during emergency/Hospitalization (PRI 1029) form to document the requested information.			
	There was no documented evidence that the nursing staff implemented the facility's policy.			
	[Note: Late entry progress note regarding Client #5's hospitalization was documented on April 18, 2007 at 10:00AM during the survey]			
	2. The facility's nursing services failed to develop a desensitization program for medical appointments for Client#4 as evidenced by:		(2) Reference response to federal Deficiency report W312.	6.1.07 ongoing
	Review of Client #4's physician's orders on April 20, 2007 at approximately 12:45PM revealed that on April 13, 2007, Client #4 was ordered and received Valium 10 mg by mouth prior to bloodwork and a chest x-ray. Interview with the Licensed Practical Nurse (LPN) on April 20, 2007			

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I 395	Continued From page 18 at approximately 1:00 PM revealed that Client #4 did not have a desensitization program for medical appointments. Review of the Client #4's Individual Support Plan (ISP) dated June 7, 2006 on April 20, 2007 at approximately 1:15PM failed to evidence a program that addresses the client's non-compliant behaviors at medical appointments to justify the use of the sedative medication. There was no documented evidence that the use of behavior modification medications prescribed to complete medical appointments was incorporated in the ISP. 3. The facility's nursing services failed to obtain timely laboratory follow-up for Client #2 as evidenced by: Review of the physician's orders dated February 27, 2007 on April 19, 2007 at approximately 11:20AM revealed that Client #2 was prescribed Zocor 20mg by mouth at bedtime for hypercholesterolemia. Further review revealed that laboratory studies for lipid levels was ordered every six months. Review of laboratory studies on April 19,2007 at approximately 11:25AM revealed that the last documented lipid level was dated June 7, 2006. There was no evidence that the laboratory studies for lipid levels was performed as recommended by the physician. 4. The facility's nursing services failed to obtain timely laboratory follow-up for Client # 2 as evidenced by: Review of the physician's orders dated September 21, 2006 on April 19, 2007 at approximately 11:30AM revealed that Client #2 was ordered laboratory studies for protime levels three times a week for three weeks.	I 395		

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I 395	Continued From page 19 Review of laboratory studies on April 19,2007 at approximately 11:35AM revealed that the protime level were performed twice the week of October 1, 2006 and twice the week of October 8, 2006. There was no evidence that the laboratory studies for protime levels was performed as recommended by the physician. 5. The facility's nursing services failed to ensure that Client #1's endocrinology appointment was conducted timely as evidenced below: Review of Client#1's medical evaluation dated June 5, 2006 at approximately 10:20AM revealed that the client has a diagnosis of hypothyroidism and is prescribed Synthroid 100mg by mouth daily. Review of an endocrinology consult dated May 11, 2006 on April 19,2007 at approximately 1:30PM revealed a recommendation that the client return to the endocrinology clinic in six months. Further review revealed that the client did not go to the endocrinology clinic until February 16, 2007.	I 395		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observation, interview and record verification, the facility failed to ensure the right of each client or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment for	I 500	1500: Residents Rights 3523.1	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G1a2	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/20/2007
NAME OF PROVIDER OR SUPPLIER: IDI	STREET ADDRESS, CITY, STATE, ZIP CODE: 3312 4TH STREET, SE WASHINGTON, DC 20032		

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I 500	Continued From page 20 two of four clients in the sample (Clients #1and #4) The findings include: 1. Observation of the morning medication administration on April 18, 2007 at approximately 7:15 AM, revealed Client #1 received Prozac 20 mg. Interview with the nursing staff on April 18, 2007 at approximately 7:20 AM revealed that the aforementioned psychotropic medication was used in conjunction with a Behavior Support Plan (BSP) to address targeted behaviors that included aggression. Review of the physician's orders dated February 21, 2007 on April 19, 2007 at approximately 10:20AM revealed that the medication was prescribed to treat targeted behaviors associated with Obsessive Compulsive Disorder (OCD) and aggression. Interview with the Acting Qualified Mental Retardation Professional (AQMRP) on April 19, 2007 at approximately 4:30PM, revealed that the client did not have the ability to make informed decisions regarding his treatment needs however his sister signed all medical consents. Further interview revealed that the client's sister is not his legal guardian. The review of Client 1's Psychological assessment, dated June 6, 2006, on April 19, 2007 at approximately 4:45PM, indicated that he was not competent to make independent decisions concerning his residential or day placement, program plan, medical treatment, or financial matters and could not give informed consent. There was no evidence that the facility informed Client #1 or a legally-authorized representative, as appropriate, of the health benefits and risks of treatment associated with the use of his psychotropic medication and corresponding BSP. Additionally, the facility failed to provide evidence that	I 500	3523.1 Residents Rights (1) Reference response to W263, W124, W104, W126 of Federal Deficiency Report.	6.6.07 ongoing

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I 500	Continued From page 21 substituted consent had been obtained from a legally recognized individual or entity. 2. Review of a medical consult dated August 4, 2007 on April 19, 2007 at approximately 1:30PM revealed that Client#1 had a colonoscopy on August 4, 2007. Interview with the Acting Qualified Mental Retardation Professional (AQMRP) on April 19, 2007 at approximately 4:30PM, revealed that the client did not have the ability to make informed decisions regarding his treatment needs however his sister signed all medical consents. Further interview revealed that the client's sister is not his legal guardian. The review of Client 1's Psychological assessment, dated June 8, 2001, on April 19, 2007 at approximately 4:45PM, indicated that he was not competent to make independent decisions concerning his residential or day placement, program plan, medical treatment, or financial matters and could not give informed consent. There was no evidence that the facility informed Client #1 or a legally-authorized representative, as appropriate, of the health benefits and risks of treatment associated with the colonoscopy procedure. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity. 3. Review of the physician's orders dated April 13, 2007 on April 19, 2007 at approximately 10:35AM revealed that Client #4 was prescribed Valium 10mg PO for bloodwork and a chest x-ray prior to a colonoscopy procedure. Review of the April, 2007, Medication Administration Record (MAR) on April 19,2007on April 19, 2007 at approximately 10:50AM, revealed that Client #4 was administered Valium 10mg PO for sedation	I 500	3523.1 (2) Reference response to #1 I500. (3) Reference response to Federal Deficiency report W126, W124, W263, W331, W322	6/11/07 ongoing

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I 500	Continued From page 22 on April 13, 2007. Interview with the AQMRP) on April 19, 2007 at approximately 4:50PM, revealed that the client did not have the ability to make informed decisions regarding his treatment needs. The review of Client # 4's Psychological assessment, dated June 5, 2006 on April 19, 2007 at approximately 5:00PM, indicated that he was not competent to make independent decisions concerning his residential or day placement, program plan, medical treatment, or financial matters and could not give informed consent. There was no evidence that the facility informed Client #4 or a legally-authorized representative, as appropriate, of the health benefits and risks of treatment associated with the use of Valium. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity.	I 500		