

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

PRINTED: 05/08/2008  
FORM APPROVED  
OMB NO: 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>09G203</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/02/2008</b>
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NAME OF PROVIDER OR SUPPLIER  <b>INDIVIDUAL DEVELOPMENT, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6010 DIX STREET, NE WASHINGTON, DC 20019</b>
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W 000	INITIAL COMMENTS  This recertification survey was conducted from May 1 thru May 2, 2008. This survey was initiated utilizing a fundamental survey process. Seven males and one female with varying degrees of disabilities reside in this facility. The survey sample was derived from a random sampling of four of the eight clients. The survey findings were based on observations in the group home and at one day program. In addition, the findings were based on interviews with one client, residential, nursing, administrative and day program staff. Review of records, including investigations of unusual incidents was also conducted.	W 000		RECEIVED DEPARTMENT OF HEALTH & HUMAN SERVICES ADMINISTRATION 2008 MAY 28 P 3:02
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES  The facility must assure that outside services meet the needs of each client.  This STANDARD is not met as evidenced by: Based on observations, staff interview, and record review, the facility failed to effectively monitor each client's day program to assure that the needs were met for two of four clients in the sample. (Client #2 and Client #4 )  The findings include:  1. Observation at the during the lunch mealtime on May 1, 2008 at approximately 12:35 PM revealed that Client #4 was served his prescribed diet in a divided paper plate with a plastic spoon. Further observation revealed that Client #4 was spoon-fed nectar thicken liquids from a paper cup. In an interview with the day program staff on May 1, 2008 at approximately 1:15 PM it was acknowledged that Client #4 did have a plastic	W 120	<p><b>W120</b></p> <p><b>This Standard will be met as evidenced by:</b></p> <ol style="list-style-type: none"> <li>1. QMRP met with day program staff regarding the use of client #4's and #2's adaptive equipment. QMRP will conduct routine visits to the day program and conduct observations of the mealtimes to ensure proper adaptive equipment is utilized in accordance to this standard. Ongoing.</li> <li>2. Reference response to W120 #1.</li> </ol>	530-08 ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Money branch</i>	TITLE <b>DPS</b>	(X6) DATE <b>5/1/08</b>
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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 120	<p>Continued From page 1</p> <p>coated coated spoon and a spouted sports cup to use at the day program during mealtime. Further interview revealed that the adaptive equipment was locked in a cabinet and that the staff with excess to the key was not on duty. Review of the Individual Support Plan (ISP) dated October 17, 2007 on May 2, 2008 at approximately 9:25AM revealed that it was recommended that Client #4 utilize a plastic coated coated spoon and a spouted sports cup during mealtime. Review of the Mealtime Protocol dated August 15, 2007 on May 2, 2008 at approximately 9:50AM revealed a recommendation for Client #4 use a plastic coated spoon and a spouted sports cup at mealtime because he was at risk for aspiration. There was no evidence Client #4 used a plastic coated spoon and a spouted sports cup as recommended by the ISP in the day program.</p> <p>2. Observation at the during the lunch mealtime on May 1, 2008 at approximately 1:05 PM revealed that Client #2 was served his prescribed diet in a divided paper plate with a plastic spoon. Further observation revealed that Client #2 was spoon-fed honey thicken liquids from a paper cup. In an interview with the day program staff on May 1, 2008 at approximately 1:20 PM it was acknowledged that Client #2 did have a Teflon coated spoon and a sports cup to use at the day program during mealtime. Further interview revealed that the adaptive equipment was locked in a cabinet and that the staff with excess to the key was not on duty. Review of the Individual Support Plan (ISP) dated October 17, 2007 on May 2, 2008 at approximately 9:30AM revealed that it was recommended that Client #2 utilize a Teflon coated spoon and a sports cup during mealtime. Review of the Mealtime Protocol dated August 16, 2007 on May 2, 2008 at approximately</p>	W 120			

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W 120	Continued From page 2 10:00AM revealed a recommendation for Client #2 use a Teflon coated spoon and a sports cup at mealtime because he was at risk for aspiration. There was no evidence Client #2 used a Teflon coated spoon and a sports cup as recommended by the ISP in the day program.	W 120		
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS &  The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to notify parents and/or guardians of significant incidents, for one of the two clients in the sample. (Client #1)  The finding includes:  The facility's incident reports were reviewed on May 1, 2008 at approximately 10:30 AM. An incident dated August 5, 2007 documented that Client #4 was coughing. Although the nurses attended to the client, the the cough worsen. The Physician was notified and instructed the staff to transport the client to the hospital. The client was admitted. He was discharged on August 8, 2007. Review of the incident report form failed to show evidence that the clients family was informed of the change in his condition that required a hospital admission.	W 148	<b>W148</b> <b>This Standard will be met as Evidenced by:</b>  QMRP will continue to notify family members and document the information onto the form. <b>Incident Management</b> Coordinator will also check and verify notification as needed. Family members were made aware of the health status of client #4.	5.4.08 ongoing
W 153	483 420(d)(2) STAFF TREATMENT OF CLIENTS	W 153		

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W 153

Continued From page 3

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 review of records, the facility failed to ensure that all unusual incidents including injuries of unknown origin were reported immediately to the administrator and other officials according to district law (22 DCMR, Chapter 35, Section 3519.10) for three of the three clients in the sample. (Client #4)

The finding includes:

The facility's incident reports were reviewed on May 1, 2008. An incident dated Mach 4, 2007 documented that Client #4 had a small wound on his right knee. Review of the provider's internal investigation, the origin of the wound was unknown. Additionally, the incident report failed to show evidence that the state agency was made aware on the injury of unknown origin.

W.153

**W153**  
**This Standard will be met as evidenced by:**

This Standard will be met as evidenced by:

QMRP/Incident Manager will ensure that all notifications are made in accordance to district law (22 DCMR, Chapter 35, Section 3519.10).

Routine file audits will also be conducted to further ensure ongoing compliance with this standard.

5.4.08  
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 interview, and record review, the Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination of

W 159

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W 159	Continued From page 4 services for eight of eight clients in the facility. (Clients #1, #2, #3,#4, #5,#6, #7 and #8)  The findings include:  1. Cross Refer to W 120.1 The QMRP failed to coordinate services with Client #4's day program to ensure the use of the mealtime adaptive equipment recommended by the (IDT) as evidenced by:  Observation at the during the lunch mealtime on May 1, 2008 at approximately 12:35 PM revealed that Client #4 was served his prescribed diet in a divided paper plate with a plastic spoon. Further observation revealed that Client #4 was spoon-fed nectar thicken liquids from a paper cup. In an interview with the day program staff on May 1, 2008 at approximately 1:15 PM it was acknowledged that Client #4 did have a plastic coated coated spoon and a spouted sports cup to use at the day program during mealtime. Further interview revealed that the adaptive equipment was locked in a cabinet and that the staff with excess to the key was not on duty. Review of the Individual Support Plan (ISP) dated October 17, 2007 on May 2, 2008 at approximately 9:25AM revealed that it was recommended that Client #4 utilize a plastic coated spoon and a spouted sports cup during mealtime. Review of the Mealtime Protocol dated August 15, 2007 on May 2, 2008 at approximately 9:50AM revealed a recommendation for Client #4 use a plastic coated spoon and a spouted sports cup at mealtime because he was at risk for aspiration. There was no evidence Client #4 used a plastic coated coated spoon and a spouted sports cup as recommended by the ISP in the day program.	W 159	<b>W159</b> <b>This Standard will be met as evidenced by:</b>  1. Cross reference response to W120 for client #4 and #2. 2. Cross reference response to W242 in reference to training in area of toothbrushing. 3. Cross reference response to W440, evacuation drills. 4. Cross reference response to W441 and W440. 5. Cross reference W436, adaptive equipment for client #2,#3, and #4.	5.30.08 ongoing	

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W 159	<p>Continued From page 5</p> <p>2. Cross Refer to W 120.2 The QMRP failed to coordinate services with Client #2's day program to ensure the use of the mealtime adaptive equipment recommended by the (IDT) as evidenced by:</p> <p>Observation at the during the lunch mealtime on May 1, 2008 at approximately 1:05 PM revealed that Client #2 was served his prescribed diet in a divided paper plate with a plastic spoon. Further observation revealed that Client #2 was spoon-fed honey thicken liquids from a paper cup. In an interview with the day program staff on May 1, 2008 at approximately 1:20 PM it was acknowledged that Client #2 did have a Teflon coated spoon and a sports cup to use at the day program during mealtime. Further interview revealed that the adaptive equipment was locked in a cabinet and that the staff with excess to the key was not on duty. Review of the Individual Support Plan (ISP) dated October 17, 2007 on May 2, 2008 at approximately 9:30AM revealed that it was recommended that Client #2 utilize a Teflon coated spoon and a sports cup during mealtime. Review of the Mealtime Protocol dated August 16, 2007 on May 2, 2008 at approximately 10:00AM revealed a recommendation for Client #2 use a Teflon coated spoon and a sports cup at mealtime because he was at risk for aspiration. There was no evidence Client #2 used a Teflon coated spoon and a sports cup as recommended by the ISP in the day program.</p> <p>2. Cross Refer to W242. The QMRP failed to ensure that Client #2 received training in toothbrushing to the extent of his capability as recommended by his/her Dentist as evidenced by:</p>	W 159			

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W 159	<p>Continued From page 6</p> <p>Review of Client #2's dental consult dated December 12, 2007 on May 2, 2008 at approximately 11:05 AM revealed a recommendation by the dentist for the client to "brush teeth after each meal and before bedtime". In an interview with the QMRP on May 2, 2008 at approximately 12:20 PM it was acknowledged that Client #2 did not have a toothbrushing program as recommended by the dentist. There was no evidence that the client received training in toothbrushing, to the extent of his capability.</p> <p>3. Cross Ref to W 440. The QMRP failed to ensure that evacuation drills were conducted quarterly on all shifts as evidenced by:</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on May 1, 2008 at approximately 9:00AM revealed that the staff schedules for the weekday and weekend shifts are as follows:</p> <p>Day shift: 6:00 AM - 2:00 PM Evening shift: 2:00 PM to 10:00 PM Night shift: 10:00 PM to 6:00 AM</p> <p>Review of the available fire drill records dated from May, 2007, to April, 2008 on May 1, 2007 at approximately 9:15 AM revealed that fire drills were not conducted on the day shift during the third quarter. There was no evidence that every shift of personnel conducted an evacuation drill at least quarterly.</p> <p>4. Cross Ref to W 441. The QMRP failed to ensure that evacuation drills were conducted under varying conditions as evidenced by:</p> <p>On May 2, 2008 at approximately 9:55AM review</p>	W 159			

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W 159	<p>Continued From page 7</p> <p>of fire drill records and interview with the Qualified Mental Retardation Professional (QMRP) revealed that during the past year, staff had not practiced exiting through all six egresses of the facility. Most fire drills were conducted via the front, back and side exits. There was no evidence that evacuation drills were being held under varied conditions.</p> <p>5. Cross Refer to W 436. The QMRP failed to ensure Client's #2, #3 and #4's adaptive equipment was maintained in good repair as evidenced by:</p> <p>a. Observation of Client #2's wheelchair on May 1, 2008 at approximately 3:00 PM revealed that the left arm rest on the wheelchair was torn. In an interview with the Qualified Mental Retardation Professional(QMRP) on May 1, 2008 at approximately 3:20 PM it was acknowledged that Client #3's wheelchair's left arm rest was torn. There was no evidence that the adaptive equipment was maintained in good repair</p> <p>b. Observation of Client #3's wheelchair on May 1, 2008 at approximately 3:05 PM revealed that the left foot rest padding was coming apart from the metal frame. In an interview with the QMRP on May 1, 2008 at approximately 3:25 PM it was acknowledged that the left foot rest padding was coming apart from the metal frame on Client #3's wheelchair. There was no evidence that the adaptive equipment was maintained in good repair</p> <p>c. Observation of Client #4's wheelchair on May 1, 2008 at approximately 3:10 PM revealed that the footbox and right arm rest were torn. In an interview with the QMRP on May 1, 2008 at</p>	W 159		
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W 159	Continued From page 8 approximately 3:26 PM it was acknowledged that the footbox and right arm rest were torn on Client #4's wheelchair. There was no evidence that the adaptive equipment was maintained in good repair	W 159		
W 192	<b>483.430(e)(2) STAFF TRAINING PROGRAM</b>  For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.  This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to effectively train staff to implement emergency measures for eight of eight clients in the facility. (Clients #1, #2, #3, #4, #5, #6, #7 and #8)  The finding includes:  1. Interview with the Program Manager on May 1, 2007 at approximately 4:50 PM revealed that all nursing staff members were not trained in CPR. Record review on May 1, 2008 at approximately 4:55PM revealed that two out of ten direct care staff did not have current CPR certifications. (LPN#2 and LPN #3)  2. Interview with the Program Manager on May 1, 2007 at approximately 5:00 PM revealed that all direct care staff members were not trained in CPR. Record review on May 1, 2008 at approximately 5:10 PM revealed that two out of seventeen direct care staff did not have a current CPR certification. There was no documented evidence that all direct care staff had CPR training and current CPR certifications. (Staff #3	W 192	<b>W192</b> <b>This Standard will be met as Evidenced by:</b>  LPN #1 and #2 currently have updated CPR certifications as required. Staff #3 and #4 are scheduled to attend First Aid certification on May 28, 2008.  Home Manager will continue to coordinate and schedule staff for required training. The Training Department will continue to schedule trainings on a monthly basis and or as needed, send reminders to managers and staff, and track attendance to further ensure ongoing compliance with this standard.	G-2-08 ongoing

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W 192	Continued From page 9 and Staff #4)  3. Interview with the Program Manager on May 1, 2007 at approximately 5:15 PM revealed that all staff was not trained in First Aid. Record review on January 16, 2008 at approximately 5:20 PM revealed that two out of seventeen staff did not have current First Aid certifications. There was no documented evidence that all direct care staff had First Aid training and current First Aid certifications. (Staff #3 and Staff #4)	W 192		
W 242	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN  The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.  This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to ensure that one out of four clients in the sample received training in toothbrushing, to the extent of their capability. (Client #2)  The finding includes:  Review of Client #2's dental consult dated December 12, 2007 on May 2, 2008 at approximately 11:05 AM revealed a recommendation to "brush teeth after each meal and before bedtime". In an Interview with the Qualified Mental Retardation Professional (QMRP) on May 2, 2008 at approximately 12:20	W 242	<p><b>W242</b> <b>This Standard will be met as evidenced by:</b></p> <p>QMRP will develop and implement a toothbrushing program for client #2 as recommended.</p> <p>QMRP will train staff as needed on the implementation of program.</p>	5.30.08 ongoing

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W 242	Continued From page 10 PM it was acknowledged that Client #2 did not have a toothbrushing program as recommended by the dentist. There was no evidence that the client received training in toothbrushing, to the extent of his capability.	W 242		
W 249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that as soon as the interdisciplinary team formulated client's individual program plan, each client received continuous active treatment services, in sufficient number and frequency to support the achievement of the objectives identified in the Individual Program Plan (IPP), for one of the two clients included in the sample. (Client #1)</p> <p>The findings include:</p> <p>Interview with the Qualified Mental retardation Professional on May 2, 2008, at approximately 11:00 AM revealed that Client #1's Individual Support Plan (ISP) was held on April 25, 2008. At that time, the team approved for new programs to be implemented, however review of the clients program documentation failed to show evidence that the following programs had been</p>	W 249	<p><b>W249</b></p> <p><b>This Standard will be met as evidenced by:</b></p> <p>This was an oversight by the QMRP. Program Plans and services are currently being implemented as outlined in the individual program plan. QMRP will monitor and document response to training on a monthly basis.</p>	5-16-08 ongoing

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W 249	Continued From page 11 implemented:  1. Client #1 will wear her dentures for one hour daily given hand over hand assistance on 80% of the trials presented for six consecutive months by 4/09  2. Three times per week, Client #1 will play different computer games using her computer with a staff person for 15 minutes daily 80% of the trials presented for six consecutive months by 4/09  The QMRP acknowledged that the aforementioned programs had not been implemented.	W 249		
W 325	482.460(a)(3)(iii) PHYSICIAN SERVICES  The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician.  This STANDARD is not met as evidenced by: Based on staff interview and record verification, the facility failed to provide routine laboratory testing as determined necessary by the physician for one of the four clients included in the sample. (Client #4)  The findings include:  1. Review of Client #4's physician's orders (POS) dated December 5, 2007, on May 1, 2008 at approximately 1:30 PM revealed an order for the client to have a urinalysis. In an interview with the Licensed Practical Nurse (LPN) on May 1, 2008	W 325	<p><b>W325</b> <b>This Standard will be met as evidenced by:</b></p> <p>The urine culture and sensitivity and laboratory tests have been completed for client #4.</p> <p>LPN staff will continue to monitor laboratory schedules and follow-up as recommended. Documentation will be maintained on file. In addition, RN will conduct routine file audits to further ensure compliance with this standard.</p>	5.22.08 original

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W 325	Continued From page 12 at approximately 1:45 PM it was acknowledged that Client #4 did not have the laboratory test performed. There was no evidence that the urinalysis was scheduled or obtained as recommended by the physician.  2. Review of Client #4's POS dated December 5, 2007, on May 1, 2008 at approximately 1:50 PM revealed an order for the client to have a urine for culture and sensitivity obtained. In an interview with the LPN on May 15, 2008 at approximately 1:55 PM it was acknowledged that Client #4 did not have the laboratory test performed. There was no evidence that the urine for culture and sensitivity was scheduled or obtained as recommended by the physician.	W 325		
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 observations, interview and record review, the facility failed to ensure that clients adaptive equipment was maintained in good repair for three of four clients in the sample. (Clients #2, #3 and #4)  The findings included:  1. Observation of Client #2's wheelchair on May 1, 2008 at approximately 3:00 PM revealed that the left arm rest on the wheelchair was torn. In an	W 436	<p><b>W436</b> <b>This Standard will be met as evidenced by:</b></p> <p>A 719a form has been completed for the repair of client #3 and #4's wheelchairs. The QMRP will monitor and track all wheelchair repairs and document the both the status and interventions taken in the monthly progress report for each person.</p> <p>QMRP will consult with DDS case manager for further support if needed.</p> <p>Home Manager, QMRP and staff will continue to monitor the status of all wheelchairs and adaptive equipment and report concerns as they arise.</p>	5-29-08 original

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W 436	<p>Continued From page 13</p> <p>interview with the Qualified Mental Retardation Professional(QMRP) on May 1, 2008 at approximately 3:20 PM it was acknowledged that Client #3's wheelchair's left arm rest was torn . There was no evidence that the adaptive equipment was maintained in good repair.</p> <p>2. Observation of Client #3's wheelchair on May 1, 2008 at approximately 3:05 PM revealed that the left foot rest padding was coming apart from the metal frame. In an interview with the QMRP on May 1, 2008 at approximately 3:25 PM it was acknowledged that the left foot rest padding was coming apart from the metal frame on Client #3's wheelchair. There was no evidence that the adaptive equipment was maintained in good repair.</p> <p>3. Observation of Client #4's wheelchair on May 1, 2008 at approximately 3:10 PM revealed that the footbox and right arm rest were torn. In an interview with the QMRP on May 1, 2008 at approximately 3:26 PM it was acknowledged that the footbox and right arm rest were torn on Client #4's wheelchair. There was no evidence that the adaptive equipment was maintained in good repair.</p>	W 436		
W 440	<p>483.470(i)(1) EVACUATION DRILLS</p> <p>The facility must hold evacuation drills at least quarterly for each shift of personnel.</p> <p>This STANDARD is not met as evidenced by: Based on record review, the facility failed to hold evacuation drills quarterly on all shifts.</p> <p>The finding includes:</p>	W 440	<p><b>W440</b> <b>This Standard will be met as evidenced by:</b></p> <p>Home Manager will monitor and track the number of fire drills, evacuations and various conditions in which drill are conducted. Home Manager will provide feedback and additional training as needed to ensure that all staff participate in the fire evacuation process.</p> <p>Home Manager will maintain all information in the fire safety manual.</p>	5.15.08 ongang

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W 440	Continued From page 14 Interview with the Qualified Mental Retardation Professional (QMRP) on May 1, 2008 at approximately 9:00AM revealed that the staff schedules for the weekday and weekend shifts are as follows:  Day shift: 6:00 AM - 2:00 PM Evening shift: 2:00 PM to 10:00 PM Night shift: 10:00 PM to 6:00 AM  Review of the available fire drill records dated from May, 2007, to April, 2008 on May 1, 2007 at approximately 9:15 AM revealed that fire drills were not conducted on the day shift during the third quarter. There was no evidence that every shift of personnel conducted an evacuation drill at least quarterly.	W 440		
W 441	483.470(i)(1) EVACUATION DRILLS  The facility must hold evacuation drills under varied conditions.  This STANDARD is not met as evidenced by: Based on staff interview and record verification, the facility failed to hold evacuation drills under varied conditions.  The finding includes:  On May 2, 2008 at approximately 9:55AM review of fire drill records and interview with the Qualified Mental Retardation Professional (QMRP) revealed that during the past year, staff had not practiced exiting through all six egresses of the facility. Most fire drills were conducted via the front, back and side exits. There was no evidence that evacuation drills were being held under varied conditions.	W 441	<b>W441</b> <b>This Standard will be met as evidenced by:</b>  Reference response to W440.	5.15.08 on going

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1 000	<p><b>INITIAL COMMENTS</b></p> <p>This recertification survey was conducted from May 1 thru May 2, 2008. This survey was initiated utilizing a fundamental survey process. Seven males and one female with varying degrees of disabilities reside in this facility. The survey sample was derived from a random sampling of four of the eight residents. The survey findings were based on observations in the group home and at one day program. In addition, the findings were based on interviews with one resident, residential, nursing, administrative and day program staff. Review of records, including investigations of unusual incidents was also conducted.</p>	1 000		
1 090	<p><b>3504.1 HOUSEKEEPING</b></p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on observation, the GHMRP failed to ensure the interior of the facility was maintained in a safe, clean, orderly, attractive and sanitary manner.</p> <p>On May 2, 2008 an environment inspection was conducted and revealed the following deficiencies:</p> <ol style="list-style-type: none"> <li>1. Leaking showerhead in large hallway bathroom;</li> <li>2. Faint peeling on white wooden fence on side</li> </ol>	1 090	<p><b>1090</b> <b><u>3504.1 Housekeeping</u></b></p> <p><b>This Statute will be met as evidenced by:</b></p> <p>All interior deficiencies have been repaired. Home Manager will conduct weekly home inspections and document all concerns on the Weekly Maintenance Repair Request Form. This information will be submitted to the Maintenance department for immediate attention.</p>	<p>5-7-08 ongoing</p>

Health Regulation Administration

*Nancy Grund*

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

TITLE  
*DDS*

(X6) DATE  
*5/15/08*

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I 090	Continued From page 1  patio;  3. Fence webbing detached from steel poles in the front of the facility; and  4. Steel poles, old paint cans, plastic laundry basket, water hose and wooden planks outside of storage shed.	I 090		
I 135	<b>3505.5 FIRE SAFETY</b>  Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift.  This Statute is not met as evidenced by: Based on staff interview and record review, the GHMRP failed to hold evacuation drills quarterly on all shifts.  The findings includes:  1. Interview with the Qualified Mental Retardation Professional (QMRP) on May 1, 2008 at approximately 9:00AM revealed that the staff schedules for the weekday and weekend shifts are as follows:  Day shift: 6:00 AM - 2:00 PM Evening shift: 2:00 PM to 10:00 PM Night shift: 10:00 PM to 6:00 AM  Review of the available fire drill records dated from May, 2007, to April, 2008 on May 1, 2007 at approximately 9:15 AM revealed that fire drills were not conducted on the day shift during the third quarter. There was no evidence that every shift of personnel conducted an evacuation drill at least quarterly.	I 135	<b><u>1135</u></b> <b><u>3505.5 Fire Safety</u></b>  <b>This Statute will be met as evidenced by:</b>  <b>Reference response to W440.</b>	5-15-08 ongoing

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I 135	Continued From page 2  2. On May 2, 2008 at approximately 9:55AM review of fire drill records and interview with the QMRP revealed that during the past year, staff had not practiced exiting through all six egresses of the facility. Most fire drills were conducted via the front, back and side exits. There was no evidence that evacuation drills were being held under varied conditions.	I 135		
I 206	<b>3509.6 PERSONNEL POLICIES</b>  Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties.  This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all staff had current health certificates on file.  The findings include:  1. Review of personnel records on May 2, 2007 at approximately 7:00 AM revealed no documented evidence of current health certifications for two direct care staff. In an interview with the Program Manager on May 1, 2007 at approximately 5:25 PM it was acknowledged that the health certifications were not available during the survey. (Staff #1 and Staff #2)  2. Review of personnel records on May 2, 2007	I 206	<b>1206</b> <b>3509.6 Personnel Policies</b>  The health certificates for staff #1 and #2 as well as LPN #1 have been obtained. Human Resource Department will continue to track and monitor health certificates expiration dates, send notices and remove employees from the work schedule as needed for non-compliance.	5.8.08 ongoing

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I 206	Continued From page 3  at approximately 7:10 AM revealed no documented evidence of a current health certification for one consultant working in the GHMRP. In an interview with the Program Manager on May 2, 2007 at approximately 5:30 PM it was acknowledged that the health certification was not available during the survey. (LPN#1)	I 206		
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 facility failed to effectively train staff to implement emergency measures for eight of eight residents in the facility. (Resident's #1,#2, #3,#4, #5,#6, #7 and #8)  The findings include:  1. Interview with the Program Manager on May 1, 2007 at approximately 4:50 PM revealed that all nursing staff was not trained in CPR. Record review on May 1, 2008 at approximately 4:55PM revealed that two out of ten direct care staff did not have current CPR certifications. There was no documented evidence that all nursing staff had CPR training and current CPR certifications. (LPN#2 and LPN #3)  2. Interview with the Program Manager on May 1, 2007 at approximately 5:00 PM revealed that all staff was not trained in CPR. Record review on May 1, 2008 at approximately 5:10 PM revealed that two out of seventeen direct care staff did not	I 227	<u>1227</u> <u>3510(d) Staff Training</u>  Reference response to W192.	6.2.08 ongoing

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I 227	Continued From page 4  have a current CPR certification. There was no documented evidence that all direct care staff had CPR training and current CPR certifications. (Staff #3 and Staff #4)  3. Interview with the the Program Manager on May 1, 2007 at approximately 5:15 PM revealed that all staff revealed that all staff was not trained in First Aid. Record review on January 16, 2008 at approximately 5:20 PM revealed revealed that two out of seventeen staff did not have current First Aid certifications. There was no documented evidence that all direct care staff had First Aid training and current First Aid certifications. (Staff #3 and Staff #4)	I 227		
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: The GHMRP failed to ensure that qualified professional staff carried out and monitored necessary professional interventions, in accordance with clients needs, the goals and objectives of every individual habilitation plan, as determined to be necessary by the	I 395	<u>1395</u> <b>3520.2(e) Profession Services: General Provisions</b>  <b>This Statute will be met as evidenced by:</b>  <b>Reference response to W325 of the Federal Deficiency Report.</b>	5-22-08 original

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1395	Continued From page 5  interdisciplinary team for one of four residents in the sample. ( Resident #4 )  The findings include:  1. Review of Resident #4's physician's orders (POS) dated December 5, 2007, on May 1, 2008 at approximately 1:30 PM revealed an order for the client to have a urinalysis. In an interview with the Licensed Practical Nurse (LPN) on May 1, 2008 at approximately 1:45 PM it was acknowledged that Resident #4 did not have the laboratory test performed. There was no evidence that the urinalysis was scheduled or obtained as recommended by the physician.  2. Review of Resident #4's POS dated December 5, 2007, on May 1, 2008 at approximately 1:50 PM revealed an order for the client to have a urine for culture and sensitivity obtained. In an interview with the LPN on May 15, 2008 at approximately 1:55 PM it was acknowledged that Resident #4 did not have the laboratory test performed. There was no evidence that the urine for culture and sensitivity was scheduled or obtained as recommended by the physician.	1395		
1422	<b>3521.3 HABILITATION AND TRAINING</b>  Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident 's Individual Habilitation Plan.  This Statute is not met as evidenced by: Based on observation, staff interviews and record review, the Qualified Mental Retardation Professional (QMRP) failed to ensure that one of four residents were provided the opportunities for continuous active treatment in accordance with	1422	<u><b>1422</b></u> <u><b>3521.3 Habilitation and Training</b></u>  <b>This Statute will be met as evidenced by:</b>  <b>Reference response to W436, W120 and W249 of the Federal Deficiency Report.</b>	5-27-08 ongoing

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I 422	<p>Continued From page 6</p> <p>their individual program plans (IPPs). (Residents #2 and #4)</p> <p>The findings include:</p> <p>1. The QMRP failed to coordinate services with Resident #4's day program to ensure the use of the mealtime adaptive equipment recommended by the (IDT) as evidenced by:</p> <p>Observation at the during the lunch mealtime on May 1, 2008 at approximately 12:35 PM revealed that Resident #4 was served his prescribed diet in a divided paper plate with a plastic spoon. Further observation revealed that Resident #4 was spoon-fed nectar thicken liquids from a paper cup. In an interview with the day program staff on May 1, 2008 at approximately 1:15 PM it was acknowledged that Resident #4 did have a plastic coated coated spoon and a spouted sports cup to use at the day program during mealtime. Further interview revealed that the adaptive equipment was locked in a cabinet and that the staff with excess to the key was not on duty. Review of the Individual Support Plan (ISP) dated October 17, 2007 on May 2, 2008 at approximately 9:25AM revealed that it was recommended that Resident #4 utilize a plastic coated coated spoon and a spouted sports cup during mealtime. Review of the Mealtime Protocol dated August 15, 2007 on May 2, 2008 at approximately 9:50AM revealed a recommendation for Resident #4 use a plastic coated coated spoon and a spouted sports cup at mealtime because he was at risk for aspiration. There was no evidence Resident #4 used a plastic coated coated spoon and a spouted sports cup as recommended by the ISP in the day program.</p> <p>2. The QMRP failed to coordinate services with</p>	I 422		

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I 422	<p>Continued From page 7</p> <p>Resident #2's day program to ensure the use of the mealtime adaptive equipment recommended by the (IDT) as evidenced by:</p> <p>Observation at the during the lunch mealtime on May 1, 2008 at approximately 1:05 PM revealed that Resident #2 was served his prescribed diet in a divided paper plate with a plastic spoon. Further observation revealed that Resident #2 was spoon-fed honey thicken liquids from a paper cup. In an interview with the day program staff on May 1, 2008 at approximately 1:20 PM it was acknowledged that Resident #2 did have a Teflon coated spoon and a sports cup to use at the day program during mealtime. Further interview revealed that the adaptive equipment was locked in a cabinet and that the staff with excess to the key was not on duty. Review of the Individual Support Plan (ISP) dated October 17, 2007 on May 2, 2008 at approximately 9:30AM revealed that it was recommended that Resident #2 utilize a Teflon coated spoon and a sports cup during mealtime. Review of the Mealtime Protocol dated August 16, 2007 on May 2, 2008 at approximately 10:00AM revealed a recommendation for Resident #2 use a Teflon coated spoon and a sports cup at mealtime because he was at risk for aspiration. There was no evidence Resident #2 usec a Teflon coated spoon and a sports cup as recommended by the ISP in the day program.</p> <p>3. The QMRP failed to ensure that Residents #2, #3 and #4's adaptive equipment was maintained in good repair as evidenced by:</p> <p>a. Observation of Resident #2's wheelchair on May 1, 2008 at approximately 3:00 PM revealed that the left arm rest on the wheelchair was torn. In an interview with the Qualified Mental Retardation Professional(QMRP) on May 1, 2008</p>	I 422		

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I 432	Continued From page 9 the sample. (Resident #2 )  The finding includes:  Review of Resident #2's dental consult dated December 12, 2007 on May 2, 2008 at approximately 11:05 AM revealed a recommendation to "brush teeth after each meal and before bedtime". In an Interview with the Qualified Mental Retardation Professional (QMRP) on May 2, 2008 at approximately 12:20 PM it was acknowledged that Resident #2 did not have a toothbrushing program as recommended by the dentist. There was no evidence that the client received training in toothbrushing, to the extent of his capability.	I 432		

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I 422	Continued From page 8  at approximately 3:20 PM it was acknowledged that Resident #2's wheelchair's left arm rest was torn. There was no evidence that the adaptive equipment was maintained in good repair.  b. Observation of Resident#3's wheelchair on May 1, 2008 at approximately 3:05 PM revealed that the left foot rest padding was coming apart from the metal frame. In an interview with the QMRP on May 1, 2008 at approximately 3:25 PM it was acknowledged that the left foot rest padding was coming apart from the metal frame on Resident #3's wheelchair. There was no evidence that the adaptive equipment was maintained in good repair.  c. Observation of Resident #4's wheelchair on May 1, 2008 at approximately 3:10 PM revealed that the footbox and right arm rest were torn. In an interview with the QMRP on May 1, 2008 at approximately 3:26 PM it was acknowledged that the footbox and right arm rest were torn on Resident #4's wheelchair. There was no evidence that the adaptive equipment was maintained in good repair.	I 422		
I 432	<b>3521.7(c) HABILITATION AND TRAINING</b>  The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas:  (c) Personal hygiene (including washing, bathing, shampooing, brushing teeth, and menstrual care);  This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure habilitation and training on oral hygiene was provided for one of four residents in	I 432	<b>1432</b> <b>35.21.7 Habilitation and Training</b>  <b>This Statute will be met as evidenced by:</b>  <b>Reference response to Federal Deficiency report W159, W249 and W242.</b>	<i>5.28.08 ongoing</i>

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W 192	Continued From page 9 and Staff #4)  3. Interview with the Program Manager on May 1, 2007 at approximately 5:15 PM revealed that all staff was not trained in First Aid. Record review on January 16, 2008 at approximately 5:20 PM revealed that two out of seventeen staff did not have current First Aid certifications. There was no documented evidence that all direct care staff had First Aid training and current First Aid certifications. (Staff #3 and Staff #4)	W 192		
W 242	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN  The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.  This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to ensure that one out of four clients in the sample received training in toothbrushing, to the extent of their capability. (Client #2)  The finding includes:  Review of Client #2's dental consult dated December 12, 2007 on May 2, 2008 at approximately 11:05 AM revealed a recommendation to "brush teeth after each meal and before bedtime". In an Interview with the Qualified Mental Retardation Professional (QMRP) on May 2, 2008 at approximately 12:20	W 242	<p><b>W242</b> <b>This Standard will be met as evidenced by:</b></p> <p>QMRP will develop and implement a toothbrushing program for client #2 as recommended.</p> <p>QMRP will train staff as needed on the implementation of program.</p>	5.30.08 ongoing

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W 000	INITIAL COMMENTS  This recertification survey was conducted from May 1 thru May 2, 2008. This survey was initiated utilizing a fundamental survey process. Seven males and one female with varying degrees of disabilities reside in this facility. The survey sample was derived from a random sampling of four of the eight clients. The survey findings were based on observations in the group home and at one day program. In addition, the findings were based on interviews with one client, residential, nursing, administrative and day program staff. Review of records, including investigations of unusual incidents was also conducted.	W 000		RECEIVED DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION  2008 MAY 28 P 3:02
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES  The facility must assure that outside services meet the needs of each client.  This STANDARD is not met as evidenced by. Based on observations, staff interview, and record review, the facility failed to effectively monitor each client's day program to assure that the needs were met for two of four clients in the sample. (Client #2 and Client #4 )  The findings include:  1. Observation at the during the lunch mealtime on May 1, 2008 at approximately 12:35 PM revealed that Client #4 was served his prescribed diet in a divided paper plate with a plastic spoon. Further observation revealed that Client #4 was spoon-fed nectar thicken liquids from a paper cup. In an interview with the day program staff on May 1, 2008 at approximately 1:15 PM it was acknowledged that Client #4 did have a plastic	W 120	W120  This Standard will be met as evidenced by:  1. QMRP met with day program staff regarding the use of client #4's and #2's adaptive equipment. QMRP will conduct routine visits to the day program and conduct observations of the mealtimes to ensure proper adaptive equipment is utilized in accordance to this standard. Ongoing.  2. Reference response to W120 #1.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Maely Branch	TITLE DRS	(X6) DATE 5/19/08
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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 120	<p>Continued From page 1</p> <p>coated coated spoon and a spouted sports cup to use at the day program during mealtime. Further interview revealed that the adaptive equipment was locked in a cabinet and that the staff with excess to the key was not on duty. Review of the Individual Support Plan (ISP) dated October 17, 2007 on May 2, 2008 at approximately 9:25AM revealed that it was recommended that Client #4 utilize a plastic coated coated spoon and a spouted sports cup during mealtime. Review of the Mealtime Protocol dated August 15, 2007 on May 2, 2008 at approximately 9:50AM revealed a recommendation for Client #4 use a plastic coated spoon and a spouted sports cup at mealtime because he was at risk for aspiration. There was no evidence Client #4 used a plastic coated spoon and a spouted sports cup as recommended by the ISP in the day program.</p> <p>2. Observation at the during the lunch mealtime on May 1, 2008 at approximately 1:05 PM revealed that Client #2 was served his prescribed diet in a divided paper plate with a plastic spoon. Further observation revealed that Client #2 was spoon-fed honey thicken liquids from a paper cup. In an interview with the day program staff on May 1, 2008 at approximately 1:20 PM it was acknowledged that Client #2 did have a Teflon coated spoon and a sports cup to use at the day program during mealtime. Further interview revealed that the adaptive equipment was locked in a cabinet and that the staff with excess to the key was not on duty. Review of the Individual Support Plan (ISP) dated October 17, 2007 on May 2, 2008 at approximately 9:30AM revealed that it was recommended that Client #2 utilize a Teflon coated spoon and a sports cup during mealtime. Review of the Mealtime Protocol dated August 16, 2007 on May 2, 2008 at approximately</p>	W 120			

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W 120	Continued From page 2 10:00AM revealed a recommendation for Client #2 use a Teflon coated spoon and a sports cup at mealtime because he was at risk for aspiration. There was no evidence Client #2 used a Teflon coated spoon and a sports cup as recommended by the ISP in the day program.	W 120		
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS &  The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to notify parents and/or guardians of significant incidents, for one of the two clients in the sample. (Client #1)  The finding includes:  The facility's incident reports were reviewed on May 1, 2008 at approximately 10:30 AM. An incident dated August 5, 2007 documented that Client #4 was coughing. Although the nurses attended to the client, the the cough worsen. The Physician was notified and instructed the staff to transport the client to the hospital. The client was admitted. He was discharged on August 8, 2007. Review of the incident report form failed to show evidence that the clients family was informed of the change in his condition that required a hospital admission.	W 148	<b>W148</b> <b>This Standard will be met as Evidenced by:</b>  QMRP will continue to notify family members and document the information onto the form. <b>Incident Management</b> Coordinator will also check and verify notification as needed. Family members were made aware of the health status of client #4.	5.4.08 ongoing
W 153	483 420(d)(2) STAFF TREATMENT OF CLIENTS	W 153		

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W 153	Continued From page 3 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 review of records, the facility failed to ensure that all unusual incidents including injuries of unknown origin were reported immediately to the administrator and other officials according to district law (22 DCMR, Chapter 35, Section 3519.10) for three of the three clients in the sample. (Client #4)  The finding includes:  The facility's incident reports were reviewed on May 1, 2008. An incident dated Mach 4, 2007 documented that Client #4 had a small wound on his right knee. Review of the provider's internal investigation, the origin of the wound was unknown. Additionally, the incident report failed to show evidence that the state agency was made aware on the injury of unknown origin.	W.153	<b>W153</b> <b>This Standard will be met as evidenced by:</b>  This Standard will be met as evidenced by:  QMRP/Incident Manager will ensure that all notifications are made in accordance to district law (22 DCMR, Chapter 35, Section 3519.10).  Routine file audits will also be conducted to further ensure ongoing compliance with this standard.	5.4.08 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: Basad on interview, and record review, the Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination of	W 159		

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W 159	<p>Continued From page 4 services for eight of eight clients in the facility. (Clients #1, #2, #3,#4, #5,#6, #7 and #8)</p> <p>The findings include:</p> <p>1. Cross Refer to W 120.1 The QMRP failed to coordinate services with Client #4's day program to ensure the use of the mealtime adaptive equipment recommended by the (IDT) as evidenced by:</p> <p>Observation at the during the lunch mealtime on May 1, 2008 at approximately 12:35 PM revealed that Client #4 was served his prescribed diet in a divided paper plate with a plastic spoon. Further observation revealed that Client #4 was spoon-fed nectar thicken liquids from a paper cup. In an interview with the day program staff on May 1, 2008 at approximately 1:15 PM it was acknowledged that Client #4 did have a plastic coated coated spoon and a spouted sports cup to use at the day program during mealtime. Further interview revealed that the adaptive equipment was locked in a cabinet and that the staff with excess to the key was not on duty. Review of the Individual Support Plan (ISP) dated October 17, 2007 on May 2, 2008 at approximately 9:25AM revealed that it was recommended that Client #4 utilize a plastic coated spoon and a spouted sports cup during mealtime. Review of the Mealtime Protocol dated August 15, 2007 on May 2, 2008 at approximately 9:50AM revealed a recommendation for Client #4 use a plastic coated spoon and a spouted sports cup at mealtime because he was at risk for aspiration. There was no evidence Client #4 used a plastic coated coated spoon and a spouted sports cup as recommended by the ISP in the day program.</p>	W 159	<p><b>W159</b> <b>This Standard will be met as evidenced by:</b></p> <ol style="list-style-type: none"> <li>1. Cross reference response to W120 for client #4 and #2.</li> <li>2. Cross reference response to W242 in reference to training in area of toothbrushing.</li> <li>3. Cross reference response to W440, evacuation drills.</li> <li>4. Cross reference response to W441 and W440.</li> <li>5. Cross reference W436, adaptive equipment for client #2,#3, and #4.</li> </ol>	5-30-08 ongoing
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W 159	<p>Continued From page 5</p> <p>2. Cross Refer to W 120.2 The QMRP failed to coordinate services with Client #2's day program to ensure the use of the mealtime adaptive equipment recommended by the (IDT) as evidenced by:</p> <p>Observation at the during the lunch mealtime on May 1, 2008 at approximately 1:05 PM revealed that Client #2 was served his prescribed diet in a divided paper plate with a plastic spoon. Further observation revealed that Client #2 was spoon-fed honey thicken liquids from a paper cup. In an interview with the day program staff on May 1, 2008 at approximately 1:20 PM it was acknowledged that Client #2 did have a Teflon coated spoon and a sports cup to use at the day program during mealtime. Further interview revealed that the adaptive equipment was locked in a cabinet and that the staff with excess to the key was not on duty. Review of the Individual Support Plan (ISP) dated October 17, 2007 on May 2, 2008 at approximately 9:30AM revealed that it was recommended that Client #2 utilize a Teflon coated spoon and a sports cup during mealtime. Review of the Mealtime Protocol dated August 16, 2007 on May 2, 2008 at approximately 10:00AM revealed a recommendation for Client #2 use a Teflon coated spoon and a sports cup at mealtime because he was at risk for aspiration. There was no evidence Client #2 used a Teflon coated spoon and a sports cup as recommended by the ISP in the day program.</p> <p>2. Cross Refer to W242. The QMRP failed to ensure that Client #2 received training in toothbrushing to the extent of his capability as recommended by his/her Dentist as evidenced by:</p>	W 159			

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W 159	<p>Continued From page 6</p> <p>Review of Client #2's dental consult dated December 12, 2007 on May 2, 2008 at approximately 11:05 AM revealed a recommendation by the dentist for the client to "brush teeth after each meal and before bedtime". In an interview with the QMRP on May 2, 2008 at approximately 12:20 PM it was acknowledged that Client #2 did not have a toothbrushing program as recommended by the dentist. There was no evidence that the client received training in toothbrushing, to the extent of his capability.</p> <p>3. Cross Ref to W 440. The QMRP failed to ensure that evacuation drills were conducted quarterly on all shifts as evidenced by:</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on May 1, 2008 at approximately 9:00AM revealed that the staff schedules for the weekday and weekend shifts are as follows:</p> <p>Day shift: 6:00 AM - 2:00 PM Evening shift: 2:00 PM to 10:00 PM Night shift: 10:00 PM to 6:00 AM</p> <p>Review of the available fire drill records dated from May, 2007, to April, 2008 on May 1, 2007 at approximately 9:15 AM revealed that fire drills were not conducted on the day shift during the third quarter. There was no evidence that every shift of personnel conducted an evacuation drill at least quarterly.</p> <p>4. Cross Ref to W 441. The QMRP failed to ensure that evacuation drills were conducted under varying conditions as evidenced by:</p> <p>On May 2, 2008 at approximately 9:55AM review</p>	W 159		
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W 159	<p>Continued From page 7</p> <p>of fire drill records and interview with the Qualified Mental Retardation Professional (QMRP) revealed that during the past year, staff had not practiced exiting through all six egresses of the facility. Most fire drills were conducted via the front, back and side exits. There was no evidence that evacuation drills were being held under varied conditions.</p> <p>5. Cross Refer to W 436. The QMRP failed to ensure Client's #2, #3 and #4's adaptive equipment was maintained in good repair as evidenced by:</p> <p>a. Observation of Client #2's wheelchair on May 1, 2008 at approximately 3:00 PM revealed that the left arm rest on the wheelchair was torn. In an interview with the Qualified Mental Retardation Professional(QMRP) on May 1, 2008 at approximately 3:20 PM it was acknowledged that Client #3's wheelchair's left arm rest was torn. There was no evidence that the adaptive equipment was maintained in good repair</p> <p>b. Observation of Client #3's wheelchair on May 1, 2008 at approximately 3:05 PM revealed that the left foot rest padding was coming apart from the metal frame. In an interview with the QMRP on May 1, 2008 at approximately 3:25 PM it was acknowledged that the left foot rest padding was coming apart from the metal frame on Client #3's wheelchair. There was no evidence that the adaptive equipment was maintained in good repair</p> <p>c. Observation of Client #4's wheelchair on May 1, 2008 at approximately 3:10 PM revealed that the footbox and right arm rest were torn. In an interview with the QMRP on May 1, 2008 at</p>	W 159		

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W 159	Continued From page 8 approximately 3:26 PM it was acknowledged that the footbox and right arm rest were torn on Client #4's wheelchair. There was no evidence that the adaptive equipment was maintained in good repair	W 159		
W 192	<p>483.430(e)(2) STAFF TRAINING PROGRAM</p> <p>For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to effectively train staff to implement emergency measures for eight of eight clients in the facility. (Clients #1, #2, #3, #4, #5, #6, #7 and #8)</p> <p>The finding includes:</p> <p>1. Interview with the Program Manager on May 1, 2007 at approximately 4:50 PM revealed that all nursing staff members were not trained in CPR. Record review on May 1, 2008 at approximately 4:55PM revealed that two out of ten direct care staff did not have current CPR certifications. (LPN#2 and LPN #3)</p> <p>2. Interview with the Program Manager on May 1, 2007 at approximately 5:00 PM revealed that all direct care staff members were not trained in CPR. Record review on May 1, 2008 at approximately 5:10 PM revealed that two out of seventeen direct care staff did not have a current CPR certification. There was no documented evidence that all direct care staff had CPR training and current CPR certifications. (Staff #3</p>	W 192	<p><b>W192</b> <b>This Standard will be met as Evidenced by:</b></p> <p>LPN #1 and #2 currently have updated CPR certifications as required. Staff #3 and #4 are scheduled to attend First Aid certification on May 28, 2008.</p> <p>Home Manager will continue to coordinate and schedule staff for required training. The Training Department will continue to schedule trainings on a monthly basis and or as needed, send reminders to managers and staff, and track attendance to further ensure ongoing compliance with this standard.</p>	6-2-08 ongoing

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W 192

Continued From page 9 and Staff #4)

3. Interview with the Program Manager on May 1, 2007 at approximately 5:15 PM revealed that all staff was not trained in First Aid. Record review on January 16, 2008 at approximately 5:20 PM revealed that two out of seventeen staff did not have current First Aid certifications. There was no documented evidence that all direct care staff had First Aid training and current First Aid certifications. (Staff #3 and Staff #4)

W 192

W 242

483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN

W 242

The individual program plan must include, for those clients who lack them, training in personal skills: essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.

This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to ensure that one out of four clients in the sample received training in toothbrushing, to the extent of their capability. (Client #2)

The finding includes:

Review of Client #2's dental consult dated December 12, 2007 on May 2, 2008 at approximately 11:05 AM revealed a recommendation to "brush teeth after each meal and before bedtime". In an Interview with the Qualified Mental Retardation Professional (QMRP) on May 2, 2008 at approximately 12:20

W242

**This Standard will be met as evidenced by:**

QMRP will develop and implement a toothbrushing program for client #2 as recommended.

QMRP will train staff as needed on the implementation of program.

5.30.08 ongoing

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W 242	Continued From page 10 PM it was acknowledged that Client #2 did not have a toothbrushing program as recommended by the dentist. There was no evidence that the client received training in toothbrushing, to the extent of his capability.	W 242			
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION  As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that as soon as the interdisciplinary team formulated client's individual program plan, each client received continuous active treatment services, in sufficient number and frequency to support the achievement of the objectives identified in the Individual Program Plan (IPP), for one of the two clients included in the sample. (Client #1)  The findings include:  Interview with the Qualified Mental retardation Professional on May 2, 2008, at approximately 11:00 AM revealed that Client #1's Individual Support Plan (ISP) was held on April 25, 2008. At that time, the team approved for new programs to be implemented, however review of the clients program documentation failed to show evidence that the following programs had been	W 249	<b>W249</b> <b>This Standard will be met as evidenced by:</b>  This was an oversight by the QMRP. Program Plans and services are currently being implemented as outlined in the individual program plan. QMRP will monitor and document response to training on a monthly basis.		5-16-08 ongoing

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W 249	Continued From page 11 implemented:  1. Client #1 will wear her dentures for one hour daily given hand over hand assistance on 80% of the trials presented for six consecutive months by 4/09  2. Three times per week, Client #1 will play different computer games using her computer with a staff person for 15 minutes daily 80% of the trials presented for six consecutive months by 4/09  The QMRP acknowledged that the aforementioned programs had not been implemented.	W 249			
W 325	482.460(a)(3)(iii) PHYSICIAN SERVICES  The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician.  This STANDARD is not met as evidenced by: Based on staff interview and record verification, the facility failed to provide routine laboratory testing as determined necessary by the physician for one of the four clients included in the sample. (Client #4)  The findings include:  1. Review of Client #4's physician's orders (POS) dated December 5, 2007, on May 1, 2008 at approximately 1:30 PM revealed an order for the client to have a urinalysis. In an interview with the Licensed Practical Nurse (LPN) on May 1, 2008	W 325	<b>W325</b> <b>This Standard will be met as evidenced by:</b>  The urine culture and sensitivity and laboratory tests have been completed for client #4.  LPN staff will continue to monitor laboratory schedules and follow-up as recommended. Documentation will be maintained on file. In addition, RN will conduct routine file audits to further ensure compliance with this standard.		5.22.08 ongm

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W 325	Continued From page 12 at approximately 1:45 PM it was acknowledged that Client #4 did not have the laboratory test performed. There was no evidence that the urinalysis was scheduled or obtained as recommended by the physician.  2. Review of Client #4's POS dated December 5, 2007, on May 1, 2008 at approximately 1:50 PM revealed an order for the client to have a urine for culture and sensitivity obtained. In an interview with the LPN on May 15, 2008 at approximately 1:55 PM it was acknowledged that Client #4 did not have the laboratory test performed. There was no evidence that the urine for culture and sensitivity was scheduled or obtained as recommended by the physician.	W 325		
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 observations, interview and record review, the facility failed to ensure that clients adaptive equipment was maintained in good repair for three of four clients in the sample. (Clients #2, #3 and #4)  The findings included:  1. Observation of Client #2's wheelchair on May 1, 2008 at approximately 3:00 PM revealed that the left arm rest on the wheelchair was torn. In an	W 436	<p><b>W436</b> <b>This Standard will be met as evidenced by:</b></p> <p>A 719a form has been completed for the repair of client #3 and #4's wheelchairs. The QMRP will monitor and track all wheelchair repairs and document the both the status and interventions taken in the monthly progress report for each person.</p> <p>QMRP will consult with DDS case manager for further support if needed.</p> <p>Home Manager, QMRP and staff will continue to monitor the status of all wheelchairs and adaptive equipment and report concerns as they arise.</p>	5.29.08 ongang

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W 436	Continued From page 13 interview with the Qualified Mental Retardation Professional(QMRP) on May 1, 2008 at approximately 3:20 PM it was acknowledged that Client #3's wheelchair's left arm rest was torn . There was no evidence that the adaptive equipment was maintained in good repair.  2. Observation of Client #3's wheelchair on May 1, 2008 at approximately 3:05 PM revealed that the left foot rest padding was coming apart from the metal frame. In an interview with the QMRP on May 1, 2008 at approximately 3:25 PM it was acknowledged that the left foot rest padding was coming apart from the metal frame on Client #3's wheelchair. There was no evidence that the adaptive equipment was maintained in good repair.  3. Observation of Client #4's wheelchair on May 1, 2008 at approximately 3:10 PM revealed that the footbox and right arm rest were torn. In an interview with the QMRP on May 1, 2008 at approximately 3:26 PM it was acknowledged that the footbox and right arm rest were torn on Client #4's wheelchair. There was no evidence that the adaptive equipment was maintained in good repair.	W 436		
W 440	483.470(i)(1) EVACUATION DRILLS  The facility must hold evacuation drills at least quarterly for each shift of personnel.  This STANDARD is not met as evidenced by: Based on record review, the facility failed to hold evacuation drills quarterly on all shifts.  The finding includes:	W 440	<b>W440</b> <b>This Standard will be met as evidenced by:</b>  Home Manager will monitor and track the number of fire drills, evacuations and various conditions in which drill are conducted. Home Manager will provide feedback and additional training as needed to ensure that all staff participate in the fire evacuation process.  Home Manager will maintain all information in the fire safety manual.	5.15.08 ongang

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W 440 Continued From page 14  
Interview with the Qualified Mental Retardation Professional (QMRP) on May 1, 2008 at approximately 9:00AM revealed that the staff schedules for the weekday and weekend shifts are as follows:

Day shift: 6:00 AM - 2:00 PM  
Evening shift: 2:00 PM to 10:00 PM  
Night shift: 10:00 PM to 6:00 AM

Review of the available fire drill records dated from May, 2007, to April, 2008 on May 1, 2007 at approximately 9:15 AM revealed that fire drills were not conducted on the day shift during the third quarter. There was no evidence that every shift of personnel conducted an evacuation drill at least quarterly.

W 441 483.470(i)(1) EVACUATION DRILLS  
The facility must hold evacuation drills under varied conditions.

This STANDARD is not met as evidenced by:  
Based on staff interview and record verification, the facility failed to hold evacuation drills under varied conditions.

The finding includes:

On May 2, 2008 at approximately 9:55AM review of fire drill records and interview with the Qualified Mental Retardation Professional (QMRP) revealed that during the past year, staff had not practiced exiting through all six egresses of the facility. Most fire drills were conducted via the front, back and side exits. There was no evidence that evacuation drills were being held under varied conditions.

W 440

W 441

**W441**  
**This Standard will be met as evidenced by:**

Reference response to W440.

5.15.08  
ongoing

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1 000	INITIAL COMMENTS  This recertification survey was conducted from May 1 thru May 2, 2008. This survey was initiated utilizing a fundamental survey process. Seven males and one female with varying degrees of disabilities reside in this facility. The survey sample was derived from a random sampling of four of the eight residents. The survey findings were based on observations in the group home and at one day program. In addition, the findings were based on interviews with one resident, residential, nursing, administrative and day program staff. Review of records; including investigations of unusual incidents was also conducted.	1 000		
1 090	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, the GHMRP failed to ensure the interior of the facility was maintained in a safe, clean, orderly, attractive and sanitary manner.  On May 2, 2008 an environment inspection was conducted and revealed the following deficiencies:  1. Leaking showerhead in large hallway bathroom;  2. Faint peeling on white wooden fence on side	1 090	<u>1090</u> <u>3504.1 Housekeeping</u>  <b>This Statute will be met as evidenced by:</b>  All interior deficiencies have been repaired. Home Manager will conduct weekly home inspections and document all concerns on the Weekly Maintenance Repair Request Form. This information will be submitted to the Maintenance department for immediate attention.	5.7.08 ongoing

Health Regulation Administration

*Nancy Brunel*

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

TITLE  
DTS

(X6) DATE  
5/15/08

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1 090	Continued From page 1  patio;  3. Fence webbing detached from steel poles in the front of the facility; and  4. Steel poles, old paint cans, plastic laundry basket, water hose and wooden planks outside of storage shed.	1 090		
1 135	3505.5 FIRE SAFETY  Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift.  This Statute is not met as evidenced by: Based on staff interview and record review, the GHMRP failed to hold evacuation drills quarterly on all shifts.  The findings includes:  1. Interview with the Qualified Mental Retardation Professional (QMRP) on May 1, 2008 at approximately 9:00AM revealed that the staff schedules for the weekday and weekend shifts are as follows:  Day shift: 6:00 AM - 2:00 PM Evening shift: 2:00 PM to 10:00 PM Night shift: 10:00 PM to 6:00 AM  Review of the available fire drill records dated from May, 2007, to April, 2008 on May 1, 2007 at approximately 9:15 AM revealed that fire drills were not conducted on the day shift during the third quarter. There was no evidence that every shift of personnel conducted an evacuation drill at least quarterly.	1 135	<u>1135</u> <u>3505.5 Fire Safety</u>  <b>This Statute will be met as evidenced by:</b>  <b>Reference response to W440.</b>	5.15.08 on going

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I 135	Continued From page 2  2. On May 2, 2008 at approximately 9:55AM review of fire drill records and interview with the QMRP revealed that during the past year, staff had not practiced exiting through all six egresses of the facility. Most fire drills were conducted via the front, back and side exits. There was no evidence that evacuation drills were being held under varied conditions.	I 135		
I 206	<b>3509.6 PERSONNEL POLICIES</b>  Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties.  This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all staff had current health certificates on file.  The findings include:  1. Review of personnel records on May 2, 2007 at approximately 7:00 AM revealed no documented evidence of current health certifications for two direct care staff. In an interview with the Program Manager on May 1, 2007 at approximately 5:25 PM it was acknowledged that the health certifications were not available during the survey. (Staff #1 and Staff #2)  2. Review of personnel records on May 2, 2007	I 206	<u><b>1206</b></u> <u><b>3509.6 Personnel Policies</b></u>  The health certificates for staff #1 and #2 as well as LPN #1 have been obtained. Human Resource Department will continue to track and monitor health certificates expiration dates, send notices and remove employees from the work schedule as needed for non-compliance.	5.8.08 <i>ongoing</i>

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I 206	Continued From page 3  at approximately 7:10 AM revealed no documented evidence of a current health certification for one consultant working in the GHMRP. In an interview with the Program Manager on May 2, 2007 at approximately 5:30 PM it was acknowledged that the health certification was not available during the survey. (LPN#1)	I 206		
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 facility failed to effectively train staff to implement emergency measures for eight of eight residents in the facility. (Resident's #1, #2, #3, #4, #5, #6, #7 and #8)  The findings include:  1. Interview with the Program Manager on May 1, 2007 at approximately 4:50 PM revealed that all nursing staff was not trained in CPR. Record review on May 1, 2008 at approximately 4:55PM revealed that two out of ten direct care staff did not have current CPR certifications. There was no documented evidence that all nursing staff had CPR training and current CPR certifications. (LPN#2 and LPN #3)  2. Interview with the Program Manager on May 1, 2007 at approximately 5:00 PM revealed that all staff was not trained in CPR. Record review on May 1, 2008 at approximately 5:10 PM revealed that two out of seventeen direct care staff did not	I 227	<u>1227</u> <u>3510(d) Staff Training</u>  <b>Reference response to W192.</b>	6-2-08 ongoing

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I 227	Continued From page 4  have a current CPR certification. There was no documented evidence that all direct care staff had CPR training and current CPR certifications. (Staff #3 and Staff #4)  3. Interview with the the Program Manager on May 1, 2007 at approximately 5:15 PM revealed that all staff revealed that all staff was not trained in First Aid. Record review on January 16, 2008 at approximately 5:20 PM revealed revealed that two out of seventeen staff did not have current First Aid certifications. There was no documented evidence that all direct care staff had First Aid training and current First Aid certifications. (Staff #3 and Staff #4)	I 227		
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: The GHMRP failed to ensure that qualified professional staff carried out and monitored necessary professional interventions, in accordance with clients needs, the goals and objectives of every individual habilitation plan, as determined to be necessary by the	I 395	<u>1395</u> <b>3520.2(e) Profession Services: General Provisions</b>  <b>This Statute will be met as evidenced by:</b>  <b>Reference response to W325 of the Federal Deficiency Report.</b>	5-22-08 ongang

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1395	Continued From page 5  interdisciplinary team for one of four residents in the sample. ( Resident #4 )  The findings include:  1. Review of Resident #4's physician's orders (POS) dated December 5, 2007, on May 1, 2008 at approximately 1:30 PM revealed an order for the client to have a urinalysis. In an interview with the Licensed Practical Nurse (LPN) on May 1, 2008 at approximately 1:45 PM it was acknowledged that Resident #4 did not have the laboratory test performed. There was no evidence that the urinalysis was scheduled or obtained as recommended by the physician.  2. Review of Resident #4's POS dated December 5, 2007, on May 1, 2008 at approximately 1:50 PM revealed an order for the client to have a urine for culture and sensitivity obtained. In an interview with the LPN on May 15, 2008 at approximately 1:55 PM it was acknowledged that Resident #4 did not have the laboratory test performed. There was no evidence that the urine for culture and sensitivity was scheduled or obtained as recommended by the physician.	1395		
1422	3521.3 HABILITATION AND TRAINING  Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan.  This Statute is not met as evidenced by: Based on observation, staff interviews and record review, the Qualified Mental Retardation Professional (QMRP) failed to ensure that one of four residents were provided the opportunities for continuous active treatment in accordance with	1422	<u>1422</u> <u>3521.3 Habilitation and Training</u>  <b>This Statute will be met as evidenced by:</b>  <b>Reference response to W436, W120 and W249 of the Federal Deficiency Report.</b>	5-27-08 ongoing

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I 422	Continued From page 6 their individual program plans (IPPs). (Residents #2 and #4)  The findings include:  1. The QMRP failed to coordinate services with Resident #4's day program to ensure the use of the mealtime adaptive equipment recommended by the (IDT) as evidenced by:  Observation at the during the lunch mealtime on May 1, 2008 at approximately 12:35 PM revealed that Resident #4 was served his prescribed diet in a divided paper plate with a plastic spoon. Further observation revealed that Resident #4 was spoon-fed nectar thicken liquids from a paper cup. In an interview with the day program staff on May 1, 2008 at approximately 1:15 PM it was acknowledged that Resident #4 did have a plastic coated coated spoon and a spouted sports cup to use at the day program during mealtime. Further interview revealed that the adaptive equipment was locked in a cabinet and that the staff with excess to the key was not on duty. Review of the Individual Support Plan (ISP) dated October 17, 2007 on May 2, 2008 at approximately 9:25AM revealed that it was recommended that Resident #4 utilize a plastic coated coated spoon and a spouted sports cup during mealtime. Review of the Mealtime Protocol dated August 15, 2007 on May 2, 2008 at approximately 9:50AM revealed a recommendation for Resident #4 use a plastic coated coated spoon and a spouted sports cup at mealtime because he was at risk for aspiration. There was no evidence Resident #4 used a plastic coated coated spoon and a spouted sports cup as recommended by the ISP in the day program.  2. The QMRP failed to coordinate services with	I 422		

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I 422	<p>Continued From page 7</p> <p>Resident #2's day program to ensure the use of the mealtime adaptive equipment recommended by the (IDT) as evidenced by:</p> <p>Observation at the during the lunch mealtime on May 1, 2008 at approximately 1:05 PM revealed that Resident #2 was served his prescribed diet in a divided paper plate with a plastic spoon. Further observation revealed that Resident #2 was spoon-fed honey thicken liquids from a paper cup. In an interview with the day program staff on May 1, 2008 at approximately 1:20 PM it was acknowledged that Resident #2 did have a Teflon coated spoon and a sports cup to use at the day program during mealtime. Further interview revealed that the adaptive equipment was locked in a cabinet and that the staff with excess to the key was not on duty. Review of the Individual Support Plan (ISP) dated October 17, 2007 on May 2, 2008 at approximately 9:30AM revealed that it was recommended that Resident #2 utilize a Teflon coated spoon and a sports cup during mealtime. Review of the Mealtime Protocol dated August 16, 2007 on May 2, 2008 at approximately 10:00AM revealed a recommendation for Resident #2 use a Teflon coated spoon and a sports cup at mealtime because he was at risk for aspiration. There was no evidence Resident #2 usec a Teflon coated spoon and a sports cup as recommended by the ISP in the day program.</p> <p>3. The QMRP failed to ensure that Residents #2, #3 and #4's adaptive equipment was maintained in good repair as evidenced by:</p> <p>a. Observation of Resident #2's wheelchair on May 1, 2008 at approximately 3:00 PM revealed that the left arm rest on the wheelchair was torn. In an interview with the Qualified Mental Retardation Professional(QMRP) on May 1, 2008</p>	I 422		

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1422	Continued From page 8  at approximately 3:20 PM it was acknowledged that Resident #2's wheelchair's left arm rest was torn. There was no evidence that the adaptive equipment was maintained in good repair.  b. Observation of Resident#3's wheelchair on May 1, 2008 at approximately 3:05 PM revealed that the left foot rest padding was coming apart from the metal frame. In an interview with the QMRP on May 1, 2008 at approximately 3:25 PM it was acknowledged that the left foot rest padding was coming apart from the metal frame on Resident #3's wheelchair. There was no evidence that the adaptive equipment was maintained in good repair.  c. Observation of Resident #4's wheelchair on May 1, 2008 at approximately 3:10 PM revealed that the footbox and right arm rest were torn. In an interview with the QMRP on May 1, 2008 at approximately 3:26 PM it was acknowledged that the footbox and right arm rest were torn on Resident #4's wheelchair. There was no evidence that the adaptive equipment was maintained in good repair.	1422		
1432	3521.7(c) HABILITATION AND TRAINING  The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas:  (c) Personal hygiene (including washing, bathing, shampooing, brushing teeth, and menstrual care);  This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure habilitation and training on oral hygiene was provided for one of four residents in	1432	<b>1432</b> <b>35.21.7 Habilitation and Training</b>  <b>This Statute will be met as evidenced by:</b>  <b>Reference response to Federal Deficiency report W159, W249 and W242.</b>	5/28/08 ongoing

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I 432	Continued From page 9 the sample. (Resident #2 )  The finding includes:  Review of Resident #2's dental consult dated December 12, 2007 on May 2, 2008 at approximately 11:05 AM revealed a recommendation to " brush teeth after each meal and before bedtime". In an Interview with the Qualified Mental Retardation Professional (QMRP) on May 2, 2008 at approximately 12:20 PM it was acknowledged that Resident #2 did not have a toothbrushing program as recommended by the dentist. There was no evidence that the client received training in toothbrushing, to the extent of his capability.	I 432		