STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G153	A. BUILDING _____ B. WING _____	11/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMP CARE I I	1329 LONGFELLOW STREET NW WASHINGTON, DC 20011

(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 A recertification survey was conducted from November 7, 2012 through November 8, 2012. A sample of two clients was selected from a population of four males with varying degrees of intellectual disabilities. This survey was initiated utilizing the full survey process. The findings of the survey were based on observations in the home and at two day programs, interviews with one client, direct support staff, nursing and administrative staff, as well as a review of client and administrative records, including incident reports. [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]	W 000	Received 11/30/12 Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002	
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that each client was provided opportunities for choice and self-management during meals, for three of four clients residing in the facility. (Clients #1, #2 and #4) The finding includes: On November 7, 2012, beginning at 3:41 p.m., direct support staff #1 (DSS1) was observed to place the clients snacks on the dining table. The snacks consisted of barbecue ruffle chips,	W 247		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Odessa Hankins	Adm. Asst.	11/30/12

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 247	Continued From page 1 cheddar popcorn and bite size bananas. At approximately 3:45 p.m., DSS1 poured water for Client #1's into their cups and #4's and placed the cups of water on the table during snack time. Clients #1 and #4 ate their snacks and drank their water independently without the use of adaptive feeding equipment. Staff took the clients napkins and cups to the sink after the completion of their snacks. At 3:52 p.m., DSS2 picked up Client #2's cup of water and held the cup up to the client's mouth as he drank the water during snack time. Client #2 ate his bananas independently. At 6:20 p.m., DSS1 was observed to set the table prior to dinner by placing the table cloth, eating utensils and table mats on the dining table. Again, Client #1 and #4 ate independently. At approximately 6:40 p.m., Client #2 scooped his food up and brought the food to his mouth independently during dinner. Client #2 was also observed to pick up his cup of juice, held the cup independently to his mouth and drank his juice at dinner time. At approximately 6:50 p.m., DSS2 was observed to take Client #1's and #2's plate to the kitchen sink after their dinner meal. Interview with the DSS1 and DSS2 on November 7, 2012, at approximately 6:55 p.m., who assisted with preparing the snacks and dinner meals, both revealed Clients #1, #2 and #4 were more than capable of choosing and getting their own snacks. DSS1 stated that Client #1 and #4 was very capable of setting the table during snack/dinner time and taking their plates/cups to the kitchen sink after they have completed their meals. DSS1 stated that she usually encouraged the clients to participate in meal preparation. Continue interview with DSS2 revealed that Client #2 could hold his own cup while drinking his	W 247	**W 247** - Staff have been trained on implementation of active treatment and Individual Program Plans (IPPs) for all four clients in the facility, so as to promote independence. - Staff have also been trained on choice, dignity and respect, and self-management. - Once monthly, the facility's House Manager will observe staff during meals, active treatment, and implementation of IPPs to ensure that staff are supporting the clients in exercising independence through task participation, and allowing provision of choices - Staff will be trained quarterly by the facility's Qualified Intellectual Disabilities Professional (QIDP) in implementation of active treatment, provision of choices, and promoting self-management	11/28/12 11/28/12 11/28/12 11/28/12

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W 247	Continued From page 2 beverage. DSS2 stated that she should have encouraged the client to hold his own cup of water during snack time. At the time of the survey, the facility's staff failed to allow clients to exercise their independence and allow options of choice and self-management.	W 247		
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 observation, interview and record review, the facility failed to ensure that client's received continuous active treatment to support achievement of individual program plan (IPP) objectives identified by the interdisciplinary team (IDT), for one of two clients included in the sample. (Client #2) The finding includes: 1. Cross refer to W371. The facility failed to implement Client #2's self-medication programs, as detailed below: a. Observation of the evening medication administration on November 7, 2012, at	W 249		

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W 249	Continued From page 3 approximately 6:00 p.m., revealed direct support staff #2 (DSS2) was observed to place Client #2's beverage on the dining table prior to the medication administration. At 6:11 p.m., licensed practical nurse #1 (LPN1) was observed to punch medications into the medication cup from the bubble pack and physically administered the medications to Client #2. LPN1 was also observed to physically give the client his beverage to drink. Interview with the qualified intellectual disabilities professional (QIDP) and review of Client #2's individual support plan (dated July 7, 2012) was conducted on November 8, 2012, at 2:46 p.m. and 5:55 p.m. respectively. According to the QIDP and individual support plan, given physical assistance, Client #2 will get a cup and fill it with water when it is time to take his medications 60% of recorded trials per month. Interview with DPS2 on November 8, 2012, at approximately 6:02 p.m., confirmed that she prepared Client #2's beverage prior to the medication pass on November 7, 2012. Interview with LPN1 who administered the medications on November 8, 2012, at approximately 6:10 p.m., revealed that Client #2's self-medication program was not implemented. At the time of the survey, the facility failed to ensure Client #2 was provided the opportunity to participate in his recommended self-medication program. 2. On November 7, 2012, beginning at 3:32 p.m., Client #2 was observed to walk back and forth from the living room area to the kitchen. Direct support staff #1 (DSS1) who was assigned to	W 249	**W 249, 1** - All Direct Support Staff (DSS) and Licensed Practical Nurse #1 (LPN1) have been re-trained on implementation of self-medication program and other active treatment goals pertaining to medication administration for all four clients in the facility. **11/28/12** - Once monthly, the facility's QIDP will observe medication passes for both the morning and evening to ensure that the nursing staff are adhering to program objectives as spelled out in the IPPs for each client **11/28/12** - DSS and all medication pass nurses will be trained semi-annually on implementation of self-medication administration programs for all four clients in the facility **11/28/12**	

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W 249	Continued From page 4 Client #2, verbally prompted the client to sit down and relax. The client made a mumbling sound which was difficult to understand. At approximately 4:05 p.m., interview with DSS1 revealed Client #2 was non-verbal but understood simple verbal directions. Further interview revealed the client was hungry and that's why he continued to walk back and forth to the kitchen. Client #2 was given his snack (chopped bananas). At approximately 4:10 p.m., Client #2 was observed to wet his pants and was immediately taken to the bathroom to be changed. At 6:25 p.m., Client #2 was informed by DSS2 that it was time to eat dinner. On November 8, 2012, at 2:56 p.m., review of Client #2's records revealed an individual program plan (IPP) dated July 7, 2012, that included a goal to enhance functional communication skills. The IPP stated that, "given program staff assistance, Client #2 will participate in picture exchange program to label four basic wants and needs such as eat, drink, bathroom, and TV for 3 out of 4 trials offered 75% mastery as measured by program documentation. Further review of the IPP goal revealed that staff was to place a picture on the board depicting basic want or needs during the actual daily living activity. For example, [client] it is time to eat, drink, watch TV and used the bathroom. The goal was to be documented and implemented on every Wednesday. The house manager (HM) and DSS1 were interviewed on November 8, 2012, at approximately 3:00 p.m., to ascertain information regarding Client #2's picture exchange program. They both indicated that they were not aware that	W 249	**W 249, 2** - All Direct Support Staff (DSS) have been trained on implementation of client #2's picture exchange program. Staff have also been trained on implementation of Individual Program Plans (IPPs) for all four clients in the facility. **11/28/12** - The facility's QIDP will once monthly observe staff during implementation of IPPs so as to ensure that staff are correctly implementing the goals or plans as specified for all four clients **11/28/12** - The facility's QIDP will train staff semi-annually or as needed on implementation of Individual Program Plans (IPPs) for all four clients in the facility. **11/28/12**	

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W 249	Continued From page 5 the client had a picture exchange program. The surveyor presented the objective for the program to the HM (which was located in Client #2's record). Moments later, the HM called the qualified intellectual disabilities professional (QIDP) via telephone and inquired about the program. According to the HM, the QIDP stated that the picture exchange program was a formal goal and that the materials for the program were located in Client #2's bedroom. The HM was observed to go to Client #2's bedroom and retrieve the picture exchange materials for the program. At the time of the survey, there was no evidence that the facility implemented Client #2's communication skills program, as recommended on July 7, 2012.	W 249		
W 371	483.460(k)(4) DRUG ADMINISTRATION The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure clients were taught to administer their own medications, for one of the two clients included in the sample. (Client 2) The finding includes: Observation of the evening medication	W 371		

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W 371	Continued From page 6 administration on November 7, 2012, at approximately 6:00 p.m., revealed direct support staff #2 (DSS2) was observed to place Client #2's beverage on the dining table prior to the medication administration pass. At 6:11 p.m., licensed practical nurse #1 (LPN1) was observed to punch medications into the medication cup from the bubble pack and physically administered the medications to Client #2. LPN1 was also observed to physically give the client his beverage to drink. Interview with the qualified intellectual disabilities professional (QIDP) and review of Client #2's individual support plan (dated July 7, 2012) was conducted on November 8, 2012, at 2:46 p.m. and 5:55 p.m. respectively. According to the QIDP and individual support plan, given physical assistance, Client #2 will get a cup and fill it with water when it is time to take his medications 60% of recorded trials per month. Interview with DPS2 on November 8, 2012, at approximately 6:02 p.m., confirmed that she prepared Client #2's beverage prior to the medication pass on November 7, 2012. Interview with LPN1 who administered the medications on November 8, 2012, at approximately 6:10 p.m., revealed that Client #2's self-medication program was not implemented. At the time of the survey, the facility failed to ensure Client #2 was provided the opportunity to participate in his recommended self-medication program.	W 371	**W 371** - Please refer to **W249, 1**	
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel.	W 440		

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W 440	Continued From page 7 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to hold evacuation drills quarterly on all shifts, for four of the four clients residing in the facility. (Clients #1, #2, #3 and #4) The finding includes: The facility failed to conduct simulated fire drills at least four times (4) a year for each shift, as evidenced below: On November 7, 2012, at 1:02 p.m., interview with the house manager (HM) revealed that there were four designated shifts (3:00 p.m. - 10:00 p.m. and 10:00 p.m. - 8:30 a.m.), Monday through Friday and two designated shifts (10:00 a.m. - 10:30 p.m. and 10:00 p.m. - 10:30 a.m.) for Saturday/Sunday. Review of the facility's fire drill records on November 7, 2012, beginning at 1:05 p.m., revealed that no drills were held during the weekend shifts (10:00 a.m. - 10:30 p.m. and 10:00 p.m. - 10:30 a.m.) from January 2012 through June 2012 and from October 2011 through December 2011. On November 8, 2012, at approximately 6:00 p.m. the fire drills records were reviewed again at the request of the QIDP and the HM. After the second review of the fire drill records, they both acknowledged that fire drills were not conducted during the weekend shifts (10:00 a.m. - 10:30 p.m. and 10:00 p.m. - 10:30 a.m.) from January 2012 through June 2012 and from October 2011 through December 2011.	W 440	**W 440** - A new fire drill calendar will be put in place specifying the frequency of drills to be conducted per shift. - Staff will be trained on the new calendar and documentation of fire drills conducted. - The facility's House Manager will, on a monthly basis review the fire drill records to ensure that staff are conducting drills at least quarterly for each shift of personnel. - The facility's QIDP will on a quarterly basis conduct audit of the fire drill records to ensure that the facility is complying with regulatory standards pertaining to fire drills	12/01/12 12/01/12 12/01/12 12/01/12

Health Regulation & Licensing Administration

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I 000	INITIAL COMMENTS A licensure survey was conducted from November 7, 2012 through Novmeber 8, 2012. A sample of two residents was selected from a population of four males with varying degrees of intellectual disabilities. The findings of the survey were based on observations in the home and at two programs, interviews with one client, direct support staff, nursing and administrative staff, as well as a review of resident and administrative records, including incident reports. [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]	I 000		
I 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 interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to hold evacuation drills quarterly on all shifts, for four of four residents residing in the GHPID. (Residents #1, #2, #3 and #4) The finding includes: The GHPID failed to conduct simulated fire drills at least four times (4) a year for each shift, as evidenced below: On November 7, 2012, at 1:02 p.m., interview with the house manager (HM) revealed that there	I 135		

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I 135	Continued From page 1 were four designated shifts (3:00 p.m. - 10:00 p.m. and 10:00 p.m. - 8:30 a.m.), Monday through Friday and two designated shifts (10:00 a.m. - 10:30 p.m. and 10:00 p.m. - 10:30 a.m.) for Saturday/Sunday. Review of the GHPID's fire drill records on November 7, 2012, beginning at 1:05 p.m., revealed that no drills were held during the weekend shifts (10:00 a.m. - 10:30 p.m. and 10:00 p.m. - 10:30 a.m.) from January 2012 through June 2012 and from October 2011 through December 2011. On November 8, 2012, at approximately 6:00 p.m. the fire drills records were reviewed again at the request of the QIDP and the HM. After the second review of the fire drill records, they both acknowledged that fire drills were not conducted during the weekend shifts (10:00 a.m. - 10:30 p.m. and 10:00 p.m. - 10:30 a.m.) from January 2012 through June 2012 and from October 2011 through December 2011.	I 135	**I 135** - A new calendar will be put in place specifying the frequency of drills per shift - Staff will be trained on the new calendar, and documentation of fire drills conducted. - The facility's House Manager will, on a monthly basis review the fire drill records to ensure that staff are conducting drills at least quarterly for each shift of personnel. - The facility's QIDP will on a quarterly basis conduct audit of the fire drill records to ensure that the facility is complying with regulatory standards pertaining to fire drills	12/01/12 12/01/12 12/01/12 12/01/12
I 206	3509.6 PERSONNEL POLICIES 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 group home for persons with intellectual disabilities (GHPID) failed to ensure that all employees and	I 206		

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I 206	Continued From page 2 health care professionals had current health certificates on file, for 1 of 12 direct support staff. (Staff #4) The finding includes: On November 8, 2012, beginning at 4:18 p.m., review of the personnel records for all employees, including licensed professional health consultants, revealed Staff #4's health inventory/certificate had expired on October 3, 2012. At approximately 5:45 p.m., the qualified intellectual disabilities professional (QIDP) who looked through the personnel records, confirmed the aforementioned findings. No additional information was made available for review before the survey ended later that evening approximately 7:00 p.m.	I 206	**I 206** - Staff #4 resigned from Comprehensive Care II. Up to the date of resignation, Staff #4 failed to submit a current health certificate - The facility's Program Coordinator (PC) will on a monthly basis review staff records to ensure that expired documents are updated within thirty days of expiration. - Thirty days prior to expiration of a document/certification, a formal notice of reminder will be sent to all staff requesting to provide a current version of such document/certificate. Staff who fail to provide the requested document will be suspended.	11/15/12 12/01/12 12/01/12
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans; This Statute is not met as evidenced by: Based on interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to have on file for review, current training in cardiopulmonary resuscitation (CPR) for two of twelve employees. (Employees #1 and #2) The finding includes:	I 227		

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I 227	Continued From page 3 On November 8, 2012, beginning at 4:20 p.m., review of the personnel records revealed that Employee #1's CPR expired on (9/7/12) and Employee #2's CPR expired on (10/29/12). At approximately 5:45 p.m., the qualified intellectual disabilities professional (QIDP) who looked through the personnel records, confirmed the aforementioned findings. No additional information was made available for review before the survey ended later that evening approximately 7:00 p.m.	I 227	**I 227** - Employee #1 and Employee #2 have provided current CPR cards. - The facility's Program Coordinator (PC) will on a monthly basis review staff records to ensure that expired documents are updated within thirty days of expiration. - Thirty days prior to expiration of a document/certification, the facility's PC will send a formal notice of reminder to staff requesting to provide a current version document/certificate. Staff who fail to provide the requested document will be suspended.	11/28/12 12/01/12 12/01/12
I 422	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, interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that resident's training objective was implemented in accordance with their individual support plan (ISP), for one of the two residents included in the sample. (Resident #2) The finding includes: Based on observation, interview and record review, the GHPID failed to ensure that resident's received continuous active treatment to support achievement of individual program plan (IPP) objectives identified by the interdisciplinary team (IDT), for one of two residents included in the sample. (Resident #2) The finding includes: Cross refer to W371. The GHPID failed to	I 422		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0127	A. BUILDING _____ B. WING _____	11/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMP CARE I I	1329 LONGFELLOW STREET NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 422	Continued From page 4 implement Resident #2's self-medication programs, as detailed below: a. Observation of the evening medication administration on November 7, 2012, at approximately 6:00 p.m., revealed direct support staff #2 (DSS2) was observed to place Resident #2's beverage on the dining table prior to the medication administration pass. At 6:11 p.m., licensed practical nurse #1 (LPN1) was observed to punch medications into the medication cup from the bubble pack and physically administered the medications to Resident #2. LPN1 was also observed to physically give the resident his beverage to drink. Interview with the qualified intellectual disabilities professional (QIDP) and review of Resident #2's individual support plan (dated July 7, 2012) was conducted on November 8, 2012, at 2:46 p.m. and 5:55 p.m. respectively. According to the QIDP and individual support plan, given physical assistance, Resident #2 will get a cup and fill it with water when it is time to take his medications 60% of recorded trials per month. Interview with DPS2 on November 8, 2012, at approximately 6:02 p.m., confirmed that she prepared Resident #2's beverage prior to the medication pass on November 7, 2012. Interview with LPN1 who administered the medications on November 8, 2012, at approximately 6:10 p.m., revealed that Resident #2's self-medication program was not implemented. At the time of the survey, the GHPID failed to ensure Resident #2 was provided the opportunity to participate in his recommended self-medication program. 2. On November 7, 2012, beginning at 3:32 p.m.,	I 422	**I 422, 1** - All Direct Support Staff (DSS) and Licensed Practical Nurse #1 (LPN1) have been re-trained on implementation of self-medication program and other active treatment goals pertaining to medication administration for all four clients in the facility. **11/28/12** - Once monthly, the facility's QIDP will observe medication passes for both the morning and evening to ensure that the nursing staff are adhering to program objectives as spelled out in the IPPs for each client **11/28/12** - DSS and all medication pass nurses will be trained semi-annually on implementation of self-medication administration programs for all four clients in the facility **11/28/12**	

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I 422	Continued From page 5 Resident #2 was observed to walk back and forth from the living room area to the kitchen. Direct support staff #1 (DSS1) who was assigned to Resident #2, verbally prompted the resident to sit down and relax. The resident made a mumbling sound which was difficult to understand. At approximately 4:05 p.m., interview with DSS1 revealed Resident #2 was non-verbal but understood simple verbal directions. Further interview revealed the resident was hungry and that's why he continued to walk back and forth to the kitchen. Client #2 was given his snack (chopped bananas). At approximately 4:10 p.m., Resident #2 was observed to wet his pants and was immediately taken to the bathroom to be changed. At 6:25 p.m., Client #2 was informed by DSS2 that it was time to eat dinner. On November 8, 2012, at 2:56 p.m., review of Resident #2's records revealed an individual program plan (IPP) dated July 7, 2012, that included a goal to enhance functional communication skills. The IPP stated that, "given program staff assistance, Resident #2 will participate in picture exchange program to label four basic wants and needs such as eat, drink, bathroom, and TV for 3 out of 4 trials offered 75% mastery as measured by program documentation. Further review of the IPP goal revealed that staff was to place a picture on the board depicting basic want or needs during the actual daily living activity. For example, [resident] it is time to eat, drink, watch TV and used the bathroom. The goal was to be documented and implemented on every Wednesday. The house manager (HM) and DSS1 were interviewed on November 8, 2012, at approximately 3:00 p.m., to ascertain information regarding Resident #2's picture exchange	I 422	**I 422, 2** - All Direct Support Staff (DSS) have been trained on implementation of client #2's picture exchange program. Staff have also been trained on implementation of Individual Program Plans (IPPs) for all four clients in the facility. - The facility's QIDP will once monthly observe staff during implementation of IPPs so as to ensure that staff are correctly implementing the goals or plans as specified for all four clients - The facility's QIDP will train staff semi-annually or as needed o the implementation of Individual Program Plans (IPPs) for all four clients in the facility.	**11/28/12** **11/28/12** **11/28/12**

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I 422	Continued From page 6 program. They both indicated that they were not aware that the resident had a picture exchange program. The surveyor presented the objective for the program to the HM (which was located in Resident #2's record). Moments later, the HM called the qualified intellectual disabilities professional (QIDP) via telephone and inquired about the program. According to the HM, the QIDP stated that the picture exchange program was a formal goal and that the materials for the program were located in Resident #2's bedroom. The HM was observed to go to Resident #2's bedroom and retrieve the picture exchange materials for the program. At the time of the survey, there was no evidence that the GHPID implemented Resident #2's communication skills program, as recommended on July 7, 2012.	I 422		
I 436	3521.7(f) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (f) Health care (including skills related to nutrition, use and self-administration of medication, first aid, care and use of prosthetic and orthotic devices, preventive health care, and safety); This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure each resident was taught to administer their medications, for one of the two residents included in the sample. (Resident #2) The finding includes:	I 436		

Health Regulation & Licensing Administration

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I 436	Continued From page 7 Observation of the evening medication administration on November 7, 2012, at approximately 6:00 p.m., revealed direct support staff #2 (DSS2) was observed to place Resident #2's beverage on the dining table prior to the medication administration. At 6:11 p.m., licensed practical nurse #1 (LPN1) was observed to punch medications into the medication cup from the bubble pack and physically administered the medications to Resident #2. LPN1 was also observed to physically give the resident his beverage to drink. Interview with the qualified intellectual disabilities professional (QIDP) and review of Resident #2's individual support plan (dated July 7, 2012) was conducted on November 8, 2012, at 2:46 p.m. and 5:55 p.m. respectively. According to the QIDP and individual support plan, given physical assistance, Resident #2 will get a cup and fill it with water when it is time to take his medications 60% of recorded trials per month. Interview with DPS2 on November 8, 2012, at approximately 6:02 p.m., confirmed that she prepared Resident #2's beverage prior to the medication pass on November 7, 2012. Interview with LPN1 who administered the medications on November 8, 2012, at approximately 6:10 p.m., revealed that Resident #2's self-medication program was not implemented. At the time of the survey, the GHPID failed to ensure Resident #2 was provided the opportunity to participate in his recommended self-medication program.	I 436	**I 436** - All Direct Support Staff (DSS) and Licensed Practical Nurse #1 (LPN1) have been re-trained on implementation of self-medication program and other active treatment goals pertaining to medication administration for all four clients in the facility. **11/28/12** - Once monthly, the facility's QIDP will observe medication passes for both the morning and evening to ensure that the nursing staff are adhering to program objectives as spelled out in the IPPs for each client **11/28/12** - DSS and all medication pass nurses will be trained semi-annually on implementation of self-medication administration programs for all four clients in the facility **11/28/12**	