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

PRINTED: 04/23/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	09G035		04/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MULTI SERVICES, INC	3112 13TH STREET NW WASHINGTON, DC 20010

(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 April 3, 2013 through April 5, 2013. A sample of three clients was selected from a population of six 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 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		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure each staff was effectively trained on universal precautions (hand washing) and failed to ensure recreational materials were maintained in a sanitary environment to avoid sources and transmission of infection, for one of the three clients in the sample. (Client #1) The finding includes:	W 189	RN will train all staff on Universal Precautions and Infection Control. In the future, QIDP and Residential Manager will ensure all staff is practicing Universal Precautions and Infection Control protocol by monitoring performance daily.	4/26/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Constance C. Reese
TITLE: Program Director
(X6) DATE: 5/1/13

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 189	Continued From page 1 The facility failed to ensure staff received effective and ongoing infection control training (hand washing) and failed to ensure recreational materials were maintained in a sanitary manner, as evidenced below: a. On April 3, 2013, beginning at 3:35 p.m., evening observations revealed the following: 3:59 p.m. - As the surveyor was seated at the dining table, Client #1 walked over to the dining table, leaned over and licked the top of the surveyor's head. Relief Manager (RM1) who was within arm's length of Client #1 replied by saying, "that's not nice." RM1 stated that it was part of his behaviors. 4:25 p.m. - Client #1 was observed to grab the numbers cube (tabletop game) from off of the dining table and licked the cube two (2) times. Client was verbally prompted by direct support professional (DSP3) to go downstairs to the basement. The cube was not sanitized by DSP3. Moments later, Client #1 picked up the cube and placed the cube on the activity shelf. 4:30 p.m. - Client #1 was observed to lick the television screen located in the basement. DSP3 provided no redirection to Client #1. b. On April 3, 2013, at 4:22 p.m., Client #1 was observed with a white gauze pad covered with a bandage just above his right eye. The client pulled the bandage off and placed the bandage inside his mouth. Direct support professional (DSP3) immediately verbally prompted the client to remove the bandage from his mouth. Client #1 opened his mouth; DSP3 pulled the bandage	W 189		

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W 189 I	Continued From page 2 from the client's mouth with his bare hand and placed the bandage the bandage inside the trash can. After assisting the client to remove the bandage from his mouth, DSP3 was observed to assist the client with coloring a picture. It should be note that DSP3 was not observed to wash his hands prior to the coloring activity. Interview with DSP3 on the same day at approximately 7:00 p.m., revealed that he usually wiped down the recreational games (i.e. numbers cube) immediately after Client #1 was observed to lick the games. DSP3 further revealed that he did not wipe down numbers cube nor did he wash his hands afterwards. Continued interview DSP3 revealed with that he did take the bandage out of I Client #1's mouth with his bare hand and did not wash his hands after putting the bandage inside the trash can. Additionally, DSP3 stated that he has had training on infection control procedures but could not recall the date the training was completed. Review of the in-service training records on April 5, 2013, beginning at 11:02 a.m., revealed that all staff including direct support professional (DSP3) received training on universal precautions which included MRSA infection, Hepatitis B, hand washing and body fluids on September 21, 2012. Observations on April 3, 2013, however, revealed the training had not been effective.	W 189		
W 252	1483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.	W 252	Psychologist will retrain all staff on BSP and documentation of Client #1's maladaptive behaviors. In the future, all staff will receive continuous training on documentation of al Client's maladaptive behaviors.	4/26/13

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W 252	Continued From page 3	W 252		

This STANDARD is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure staff documented incidents of maladaptive behaviors, for one of the three clients in the sampled. (Client #1)

The finding includes:

The facility failed to ensure baseline data was collected as recommended by the psychologist, as outlined below:

On April 3, 2013, beginning at 3:35 p.m., evening observations revealed Client #1 exhibited the following maladaptive behaviors:

3:59 p.m. - As the surveyor was seated at the dining table, Client #1 walked over to the dining table, leaned over and licked the top of the surveyor's head. Relief Manager (RM1) who was within arm's length of Client #1 replied by saying, "that's not nice." RM1 stated that it was part of his behaviors.

4:25 p.m. - Client #1 was observed to grab the numbers cube off of the dining table and licked the cube two (2) times. Client was verbally prompted by direct support professional (DSP3) to go downstairs to the basement.

4:30 p.m. - Client #1 was observed to lick the television screen located in the basement. DSP3 provided no redirection to Client #1.

Interview with RM1 on the same day beginning at

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W 252	Continued From page 4 6:05 p.m. revealed that Client #1 had targeted behaviors that included physical aggression and food snatching. Further interview revealed Client #1's behavior of licking items was a new behavior and the facility had been collecting baseline data I for a couple of months. At approximately 6:10 p.m., interview with DSP3 also verified that Client #1's behavior of licking items was being baselined. When asked, RM1 and DSP3 stated that they both failed to document the client's behavior of licking items on the baseline data sheets. On April 5, 2013, at approximately 10:15 a.m., review of the facility's behavior data collection sheets for Client #1 revealed both RM1 and DSP3 failed to document the behaviors of licking items observed on April 3, 2013. It should be noted that interview with the qualified intellectual disabilities professional (QIDP1) on April 5, 2013, at approximately 10:30 a.m., revealed the targeted behavior of licking items was being baseline. QIDP1 indicated that this behavior existed in the past but was discontinued due to low infrequent behaviors. QIDP1 stated Client #1 behavior of licking items had increased tremendously over the past several weeks.	W 252		
W 331	I 483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's nursing services failed to ensure one out of the three sampled client's	W 331	RN will retrain all staff on Client #1's diet. Staff will receive training by the nutritionist's recommendations and how to implement the exchange list when food substitutes are needed.	5/10/13

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W 331	Continued From page 5 prescribed diet was changed in accordance with the dietician's recommendations. (Client #1) The finding includes: On April 3, 2013, beginning at 5:20 p.m., dinner observations revealed Client #1 served himself Mac and cheese, collard greens, corn bread (about the size of a deck of cards), baked fish, milk and water with hand over hand assistance. At approximately 5:40 p.m., the client ate 100% of his food. Five minutes later, direct support professional (DSP4) was observed to serve Client #1 another full serving of Mac and cheese and baked fish. Again, the client ate 100% of the second serving. Client #1's physician's orders (POs) dated April 2013 was reviewed on April 4, 2013, at 3:50 p.m. According to the POs, Client #1 was prescribed low sodium, no concentrated sweets diet with single portions. The registered nurse (RN1) was interviewed on April 4, 2013, at 3:57 p.m., to ascertain why Client #1 was still receiving extra portions during meals. RN1 stated that she received an email from the dietician on March 22, 2013, and she recommended discontinuing Client #1's extra portions during meals because the client's body mass index (BMI) was out of range (28.9). The normal range of the client's BMI was 18.5 - 24.9. RN1 then stated that the new order that was not conveyed to the qualified intellectual disabilities professioanl #1 (QIDP1). When asked if staff had been made aware of the client's diet change, RN1 responded by saying "no."	W 331		

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w 331 I	Continued From page 6 Interview with direct support professional (DSP1) on April 5, 2013, at 12:05 p.m., revealed that she was not made aware of any changes made to Client #1's diet. On April 5, 2013, at approximately 9:00 a.m., RN1 was observed to provide staff training to the overnight and morning shifts on Client #1's diet change.	W 331		
W 441	1483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on observation, interview and review of the fire drill records, clients who were being trained, assisted and supported failed to use different escape routes during fire drills, for six of six clients included in the facility. (Clients #1, #2, #3, #4, #5 and #6) The finding includes: Evening observations conducted on April 3, 2013, beginning at 3:35 p.m., revealed all six (6) clients ambulated independently. Interview with the qualified intellectual disabilities professional (QIDP1) on April 4, 2013, at 2:38 p.m., revealed that the facility had at least five (5) methods of egress (back door on the 3rd floor, back door on the 2nd floor, front door, back door and basement door exits). It should be noted that during the environmental walk-thru on April 5, 2013, at 11:15 a.m., Client #3's bedroom was located on the 3rd floor. There was also a second fire exit observed in the basement 1 storage room.	W 441	Staff will be trained on the use of fire escape routes during fire drills. The QIDP and Residential Manager will ensure that all escape routes are used for fire drills by monitoring fire drill documentation.	5/10/13

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	W 441 Continued From page 7	W 441		
	Review of the facility's fire drill records on April 4, 2013, beginning at 2:57 p.m., revealed that all of the fire drills were conducted utilizing the back door on the 2nd floor, front door, back door and basement door. Further review of the fire drill records revealed that the back door on the 3rd floor and the basement door inside the storage room were not used from April 6, 2012 to present. At 2:56 p.m., interview with QIDP1 revealed the laundry facilities are located in the basement and that the client's actively participate in cleaning their clothes. Moments later, QIDP1 confirmed that the back door on the 3rd floor and basement door inside the storage room were not utilized during the past year. At the time of the survey, there was no evidence on file at the time of survey to substantiate that all exits were used.			
W 454	483.470(1)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observation and interview, the facility 1failed to ensure recreational materials (numbers cube) were maintained in a sanitary manner, for one of three clients in the sample. (Client #1) The finding includes: On April 3, 2013, beginning at 3:35 p.m., evening observations revealed the following: 3:59 p.m. - As the surveyor was seated at the	W 454	Cross Reference W189	4/26/13

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W 454	, Continued From page 8 dining table, Client #1 walked over to the dining table, leaned over and licked the top of the surveyor's head. Relief Manager (RM1) who was within arm's length of Client #1 replied by saying, "that's not nice." RM1 stated that it was part of his behaviors. 4:25 p.m. - Client #1 was observed to grab the numbers cube (tabletop game) from off of the dining table and licked the cube two (2) times. Client was verbally prompted by direct support professional (DSP3) to go downstairs to the basement. The cube was not sanitized by DSP3. Moments later, Client #1 picked up the cube and placed the cube on the activity shelf. 4:30 p.m. - Client #1 was observed to lick the television screen located in the basement. DSP3 provided no redirection to Client #1. Interview with DSP3 on the same day at approximately 7:00 p.m., revealed that he usually wiped down the recreational games (i.e. numbers cube) immediately after Client #1 was observed to lick the games. DSP3 further revealed that he did not wipe down numbers cube nor did he wash his hands afterwards. Additionally, DSP3 stated that he has had training on infection control procedures but could not recall the date the training was completed. Review of the in-service training records on April 5, 2013, beginning at 11:02 a.m., revealed that all staff including direct support professional (DSP3) received training on universal precautions which included MRSA infection, Hepatitis B, hand washing and body fluids on September 21, 2012. Observations on April 3, 2013, however, revealed	W 454		

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W 454	I Continued From page 9 the training had not been effective.	W 454		
W 455	483.470(1)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure effective infection control procedures (hand washing) was implemented, for one of the three clients included in the sample. (Client #1) The finding includes: The facility's staff failed to ensure proper infection control procedures (hand washing) was used after retrieving a bandage from Client #1's mouth, as evidenced below: On April 3, 2013, at 4:22 p.m., Client #1 was observed with a white gauze pad covered with a bandage just above his right eye. The client pulled the bandage off and placed the bandage inside his mouth. Direct support professional (DSP3) immediately verbally prompted the client to remove the bandage from his mouth. Client #1 opened his mouth, DSP3 pulled the bandage from the client's mouth with his bare hand and placed the bandage the bandage inside the trash can. After assisting the client to remove the bandage from his mouth, DSP3 was observed to assist the client with coloring a picture. It should be note that DSP3 was not observed to wash his hands prior to the coloring activity.	W 455	Cross Reference W189	4/26/13

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W 455	Continued From page 10 Interview with DSP3 on the same day at 7:00 p.m., revealed that he did take the bandage out of the client's mouth with his bare hand and placed the bandage inside the trash can. Further interview with DSP3 revealed he did not wash his hands after putting the bandage inside the trash can. When asked, DSP3 stated that he has had training on infection control procedures but could not recall the date training was completed. Review of the in-service training records on April I 5, 2013, beginning at 11:02 a.m., revealed that all staff including direct support professional (DSP3) received training on universal precautions which included MRSA infection, Hepatitis B, hand washing and body fluids on September 21, 2012. Observations on April 3, 2013, however, revealed the training had not been effective.	W 455		
W 460 I	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This **STANDARD** is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure each client received a nourishing well-balanced diet and failed to substitute baked fished for another meat with similar nutritive value during dinner, for one of the three sampled clients. (Client #3) The finding includes: On April 3, 2013, beginning at 5:20 p.m., dinner ,observations revealed Client #3 served himself	W 460	Nutritionist will retrain all staff on substitutions and exchange list. Then QIDP and Residential Manager will ensure each client receives a balanced diet by monitoring food preparation at mealtime.	5/10/13

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W 460 Continued From page 11 W 460

Mac and cheese, collard greens, corn bread (about the size of a deck of cards), milk and water with hand over hand assistance family style dining. The client was offered baked fish but refused it. At approximately 5:32 p.m., interview with direct support professional (DSP2) revealed that Client #3 did not want any baked fish. At 1 5:46 p.m., Client #3 finished his dinner and ate 100% of his Mac and cheese, four (4) pieces of corn bread and less than 5% of his collard greens. The client however, was not offered any other meat as a substitution for the baked fish throughout the remainder of the dinner.

Interview with DSP4 on the same day at 7:10 p.m. revealed that Client #3 did not like baked fish. When asked why another meat of similar nutritive value was not substituted for the baked fish, DSP4 responded by saying, "I served what was on the menu." DSP4 then added that the client could have more corn bread, collard greens and Mac and cheese to make up for the baked fish. The qualified intellectual disabilities professional (QIDP1) was interviewed on the same day at approximately 7:15 p.m., to ascertain whether the facility had a substitution menu. QIDP1 stated that there was a substitution menu (food exchange list) that the facility used when client's refused certain foods. QIDP1 then acknowledged that Client #3 should have been offered another meat when he refused to eat the baked fish.

Review of the dinner menu on April 4, 2013, at approximately 3:20 p.m., revealed there was a "food exchange list" prepared by the dietician for staff to use when client's refused certain foods. It should be noted that review of Client #3's

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W 460	Continued From page 12 nutritional assessment dated October 7, 2012, on April 4, 2013, at 5:13 p.m., revealed that the client is currently over his ideal body weight by almost 4 pounds. According to his weight chart, Client weighed 148 pounds in December 2012. At the time of the survey, the facility staff failed to ensure that Client #3 received a nourishing well-balanced diet during dinner time.	W 4601		

Health Regulation & Licensing Administration

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
1000	INITIAL COMMENTS A licensure survey was conducted from April 3, 2013 through April 5, 2013. A sample of three residents was selected from a population of six males with varying degrees of intellectual disabilities. The findings of the survey were based on observations in the home and two day programs, interviews with one resident, 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]	1 000		
1040	3502.1 MEAL SERVICE / DINING AREAS Each GHMRP shall provide each resident with a nourishing, well-balanced diet. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHIID failed to ensure each resident received a nourishing well-balanced diet and failed to substitute baked fished for another meat with similar nutritive value during dinner, for one of the three sampled residents. (Resident #3) The finding includes: On April 3, 2013, beginning at 5:20 p.m., dinner observations revealed Resident #3 served himself Mac and cheese, collard greens, com bread (about the size of a deck of cards), milk and water with hand over hand assistance family style dining. The resident was offered baked fish	1 040	Cross Reference W460	5/10/13

Health Regulation & Licensing Administration

Constance A. Reese Program Director

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE 5/1/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	HFD03-0006		04/05/2013

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I 040	Continued From page 1 but refused it. At approximately 5:32 p.m., interview with direct support professional (DSP2) revealed that Resident #3 did not want any baked fish. At 5:46 p.m., Resident #3 finished his dinner and ate 100% of his Mac and cheese, four (4) pieces of corn bread and less than 5% of his collard greens. The resident however, was not offered any other meat as a substitution for the baked fish throughout the remainder of the dinner. Interview with DSP4 on the same day at 7:10 p.m. revealed that Resident #3 did not like baked fish. When asked why another meat of similar nutritive value was not substituted for the baked fish, DSP4 responded by saying, "I served what was on the menu." DSP4 then added that the resident could have more corn bread, collard greens and Mac and cheese to make up for the baked fish. The qualified intellectual disabilities professional (QIDP1) was interviewed on the same day at approximately 7:15 p.m., to ascertain whether the GHIID had a substitution menu. QIDP1 stated that there was a substitution menu (food exchange list) that the GHIID used when resident's refused certain foods. QIDP1 then acknowledged that Resident #3 should have been offered another meat when he refused to eat the baked fish. Review of the dinner menu on April 4, 2013, at approximately 3:20 p.m., revealed there was a "food exchange list" prepared by the dietician for staff to use when resident's refused certain foods. It should be noted that review of Resident #3's nutritional assessment dated October 7, 2012, on April 4, 2013, at 5:13 p.m., revealed that the resident is currently over his ideal body weight by almost 4 pounds. According to his weight chart, Resident weighed 148 pounds in December	I 040		

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I 040	Continued From page 2 2012. At the time of the survey, the GHIID staff failed to ensure that Resident #3 received a nourishing well-balanced diet during dinner time.	I 040		
1226	3510.5(c) 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 observation, interview and record review, the GHIID failed to ensure each staff was effectively trained on universal precautions (hand washing) and failed to ensure recreational materials were maintained in a sanitary environment to avoid sources and transmission of infection, for one of the three residents in the sample. (Resident #1) The finding includes: The GHIID failed to ensure staff received effective and ongoing infection control training (anwasng)anaeopensurerecreaona materials were maintained in a sanitary manner, as evidenced below: a. On April 3, 2013, beginning at 3:35 p.m., evening observations revealed the following: 3:59 p.m. - As the surveyor was seated at the dining table, Resident #1 walked over to the dining table, leaned over and licked the top of the surveyor's head. Relief Manager (RM1) who was within arm's length of Resident #1 replied by	1226	Cross Reference W189	4/26/13

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I226	Continued From page 3 saying, "that's not nice. " RM1 stated that it was part of his behaviors. 4:25 p.m. - Resident #1 was observed to grab the numbers cube (tabletop game) from off of the dining table and licked the cube two (2) times. Resident was verbally prompted by direct support professional (DSP3) to go downstairs to the basement. The cube was not sanitized by DSP3. Moments later, Resident #1 picked up the cube and placed the cube on the activity shelf. 4:30 p.m. - Resident #1 was observed to lick the television screen located in the basement. DSP3 provided no redirection to Resident #1, b. On April 3, 2013, at 4:22 p.m., Resident #1 was observed with a white gauze pad covered with a bandage just above his right eye. The resident pulled the bandage off and placed the bandage inside his mouth. Direct support professional (DSP3) immediately verbally prompted the resident to remove the bandage from his mouth. Resident #1 opened his mouth; DSP3 pulled the bandage from the resident's mouth with his bare hand and placed the bandage the bandage inside the trash can. After assisting the resident to remove the bandage from his mouth, DSP3 was observed to assist the resident with coloring a picture. It should be note that DSP3 was not observed to wash his hands prior to the coloring activity. Interview with DSP3 on the same day at approximately 7:00 p.m., revealed that he usually wiped down the recreational games (i.e. numbers cube) immediately after Resident #1 was observed to lick the games. DSP3 further revealed that he did not wipe down numbers cube nor did he wash his hands afterwards. Continued	I226		

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1226	Continued From page 4 interview DSP3 revealed with that he did take the bandage out of Resident #1's mouth with his bare hand and did not wash his hands after putting the bandage inside the trash can. Additionally, DSP3 stated that he has had training on infection control procedures but could not recall the date the training was completed. Review of the in-service training records on April 5, 2013, beginning at 11:02 a.m., revealed that all staff including direct support professional (DSP3) received training on universal precautions which included MRSA infection, Hepatitis B, hand washing and body fluids on September 21, 2012. Observations on April 3, 2013, however, revealed the training had not been effective.	I226		
1401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHIID's nursing services failed to ensure one out of the three sampled resident's prescribed diet was changed in accordance with the dietician's recommendations. (Resident #1) The finding includes: On April 3, 2013, beginning at 5:20 p.m., dinner observations revealed Resident #1 served himself Mac and cheese, collard greens, corn bread (about the size of a deck of cards), baked	I401	Cross Reference W 331	5/10/13

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I401	Continued From page 5 fish, milk and water with hand over hand assistance. At approximately 5:40 p.m., the resident ate 100% of his food. Five minutes later, direct support professional (DSP4) was observed i to serve Resident #1 another full serving of Mac and cheese and baked fish. Again, the resident ate 100% of the second serving. Resident #1's physician's orders (POs) dated April 2013 was reviewed on April 4, 2013, at 3:50 p.m. According to the POs, Resident #1 was prescribed low sodium, no concentrated sweets diet with single portions. The registered nurse **(RN1)** was interviewed on April 4, 2013, at 3:57 p.m., to ascertain why Resident #1 was still receiving extra portions during meals. **RN1** stated that she received an email from the dietician on March 22, 2013, and she recommended discontinuing Resident #1's extra portions during meals because the resident's body mass index (BMI) was out of range (28.9). The normal range of the resident's **BMI** was 18.5 - 24.9. RN1 then stated that the new order that was not conveyed to the qualified intellectual disabilities professioanl #1 (QIDP1). When asked if staff had been made aware of the resident's diet change, RN1 responded by saying "ru: " Interview with direct support professional (DSP1) on April 5, 2013, at 12:05 p.m., revealed that she was not made aware of any changes made to Resident #1's diet. On April 5, 2013, at approximately 9:00 a.m., RN1 was observed to provide staff training to the overnight and morning shifts on Resident #1's diet change.	I401		