Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G226	A. BUILDING ____ B. WING ____	04/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DC HEALTH CARE	6508 EASTERN AVE NE WASHINGTON, DC 20012

(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 000	INITIAL COMMENTS A licensure survey was conducted from April 24, 2012 through April 26, 2012. A sample of three residents was selected from a population of six men with profound intellectual disabilities. The findings of the survey were based on observations in the home and two day programs, interviews with direct support staff, administrative staff and one resident's legal guardian, 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	Received 5/17/12 Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002	
I 075	3503.3(d) BEDROOMS AND BATHROOMS Each bedroom shall be equipped with at least the following items for each resident: (d) Night stand. This Statute is not met as evidenced by: Based on observation and interview, the group home for persons with intellectual disabilities (GHPID) failed to ensure that each bedroom was equipped with a night stand for each resident, for six of six residents of the facility. (Residents #1, #2, #3, #4, #5, and #6) The finding includes: During the inspection of the environment on April 26, 2012, beginning at 11:15 p.m., there were no nightstands observed in the bedrooms of Residents #1, #2, #3, #4, #5, and #6. The house	I 075 I075	As of 05/17/12 each bedroom was provided with a night stand for all the individuals in the house.	05/17/12

Health Regulation & Licensing Administration

Marta Cisani

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

TITLE Deputy Director | D.C.H.C

(X6) DATE 5/17/12

Health Regulation & Licensing Administration

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I 075	Continued From page 1 manager (HM), and the management staff who was present at the time of the inspection, acknowledged that nightstands were not provided for the residents.	I 075		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the interior of the group home for persons with intellectual disabilities (GHPID) was in an orderly manner for six of six residents in the facility. (Residents #1, #2, #3, #4, #5, and #3) The finding include: The facility failed to ensure that the oven was maintained in good condition, as evidenced below: On April 26, 2012, at 12:02 p. m., observation of the oven revealed there was no gasket was installed on the interior of the door to prevent heat from escaping and causing the oven to work harder to maintain its temperature setting. Interview with the maintenance supervisor April 26, 2012, at 12:04 p. m., acknowledged that the oven door gasket was missing and needed to be replaced.	I 090		
		I090	The interior gasket for the oven was ordered and replaced as of 05/16/12. QIDP and HM will ensure that any future maintenance needs are immediately informed to the maintenance supervisor and taken care in a timely manner. Please see attachment [A].	05/16/12

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I 422	Continued From page 2	I 422		
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 all staff, including those employed by the residents day programs, implemented mealtime protocols in accordance with residents' Individual Support Plans (ISPs), for one of the three residents in the sample. (Resident #1)	I 422		
	The findings include: Resident #1 was observed eating lunch at his day program on April 24, 2012, beginning at 12:48 p.m. A day program staff (DPS1) brought a lunch plate to the resident and walked over to another resident nearby to assist him. Another day program staff (DPS2) informed Resident #1 that his meal consisted of chicken (pureed), spinach (pureed), mashed potatoes, apples sauce and 2% milk. DPS2 was then observed using a coated teaspoon with a built-up handle to spoon feed the resident. Only the staff held the spoon with its adaptive handle throughout the meal. DPS2 first scooped enough food to fill Resident #1's teaspoon 1/2 - 2/3 full. However, as the lunch progressed, DPS2 scooped a larger amount of food onto each spoonful. By the end of the main course, at 1:04 p.m., he was filling the bowl of the teaspoon to almost full with food. Resident #1 finished his meal at 1:10 p.m. When asked if the resident had a formal mealtime	I 422	An In-Service training was completed for Direct Support Professionals at day program on 04/27/12 by the QIDP on the implementation of the meal time protocol of Client#1. The purpose of the eating protocol was discussed to ensure the safety of the Individual. The QIDP will ensure that day program follows all the required protocols to ensure the safety of the Individual. The QIDP/HM will continue to make weekly times x2 then monthly and quarterly visits during meal time to ensure the same. Also an in-service training was provided to all the DSP at the day program by the Day program nurse on 04/24/12 for the same. Please see attachment [B & C].	04/27/12 And 04/24/12

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I 422	Continued From page 3 protocol (none was observed in the lunch room), DPS2 replied "yes." When asked if he had received training on the mealtime protocol, he hesitated a moment and then replied "yeah." DPS1 was interviewed at approximately 1:25 p.m. He too indicated that he had received training on Resident #1's mealtime protocol. At 1:30 p.m., interview with the day program director revealed that the resident's prescribed food texture was changed to pureed, after a recent modified barium swallow study revealed a risk of aspiration. Both the director and DPS1 stated that the qualified intellectual disabilities professional (QIDP) visited the day program regularly. Observations during lunch at the day program differed from the supports that were observed in the home later that day. For example, on April 24, 2012, at 6:22 p.m., a direct support staff in the home (S4) was observed placing a similar coated teaspoon with a built-up handle into Resident #1's hand. S4 offered verbal instruction and encouragement for the resident to begin self-feeding. After the resident did not start eating and he relaxed his grip on the spoon, S4 returned the spoon to the resident's hand, placed his hand over the resident's hand and together, they scooped food from the dinner plate. In addition, the amount of food that they scooped for each bite was smaller; each spoonful was approximately half full. When interviewed on April 24, 2012, at 2:00 p.m., the QIDP stated that an Eating Protocol was incorporated in Resident #1's ISP, dated July 5, 2011. The resident's day program had been given a copy of his latest Eating Protocol (EP) immediately after it was revised on February 8,	I 422		

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I 422	Continued From page 4	I 422		

2012. It was her understanding that the day program nurse had trained day program staff on the revised EP, which she then presented for review.

On April 24, 2012, beginning at 2:05 p.m., review of Resident #1's EP (revised February 8, 2012) confirmed that it was designed to reduce his risk of aspiration. Continued review revealed the following:

1. Resident #1 should be given the adaptive teaspoon with a built-up handle and for 15 minutes, staff are to encourage him "to self-feed. After the first 15 minutes, if needed, staff may provide hand-over-hand assist...should only occur if <resident's name> refuses to feed himself, becomes fatigued or is physically unable to feed himself." DPS2 had not encouraged the resident to feed himself nor did he attempt to use hand-over-hand level of assistance before he spoon fed the resident.

2. Continued review of the EP revealed that Resident #1 "should be encouraged to take small bites (1/2 teaspoon) and eat slowly." DPS2 was observed providing the resident bites that were 2/3 to 1 teaspoon full in size during his lunch.

A follow-up interview with the QIDP on April 25, 2012, at 12:14 p.m., revealed that while she had visited the day program twice since the February 8, 2012 revisions were made to Resident #1's EP, she had not observed a meal to verify day program staff implemented the protocol as written.

The GHPD failed to ensure that staff at Resident #1's day program provided assistance during meals in accordance with his established Eating

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NAME OF PROVIDER OR SUPPLIER: DC HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE: 6508 EASTERN AVE NE WASHINGTON, DC 20012		

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I 422	Continued From page 5 Protocol. This is a repeat deficiency. See Federal Deficiency Report dated March 31, 2011.	I 422		

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

PRINTED: 05/09/2012
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
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W 000	INITIAL COMMENTS	W 000		
	A recertification survey was conducted from April 24, 2012 through April 26, 2012. A sample of three clients was selected from a population of six men with profound intellectual disabilities. This survey was initiated utilizing the fundamental survey process. The findings of the survey were based on observations in the home and two day programs, interviews with direct support staff, administrative staff and one client's legal guardian, 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 120	483.410(c)(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 observation, staff interview and record review, the facility failed to ensure that all outside services provided clients with recommended supports and interventions, for one of the three clients in the sample. (Client #1) The findings include: Client #1 was observed eating lunch at his day program on April 24, 2012, beginning at 12:48 p.m. A day program staff (DPS1) brought a lunch plate to the client and walked over to another	W 120		

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

Manuel Cinson | Deputy Director | D-C-MC | 5/17/12

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G225		04/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DC HEALTH CARE	6508 EASTERN AVE NE WASHINGTON, DC 20012

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W 120	Continued From page 1 client nearby to assist him. Another day program staff (DPS2) informed Client #1 that his meal consisted of chicken (pureed), spinach (pureed), mashed potatoes, apples sauce and 2% milk. DPS2 was then observed using a coated teaspoon with a built-up handle to spoon feed the client. Only the staff held the spoon with its adaptive handle throughout the meal. DPS2 first scooped enough food to fill Client #1's teaspoon 1/2 - 2/3 full. However, as the lunch progressed, DPS2 scooped a larger amount of food onto each spoonful. By the end of the main course, at 1:04 p.m., he was filling the bowl of the teaspoon to almost full with food. Client #1 finished his meal at 1:10 p.m. When asked if the client had a formal mealtime protocol (none was observed in the lunch room), DPS2 replied "yes." When asked if he had received training on the mealtime protocol, he hesitated a moment and then replied "yeah." DPS1 was interviewed at approximately 1:25 p.m. He too indicated that he had received training on Client #1's mealtime protocol. At 1:30 p.m., interview with the day program director revealed that the client's prescribed food texture was changed to pureed, after a recent modified barium swallow study revealed a risk of aspiration. Both the director and DPS1 stated that the qualified intellectual disabilities professional (QIDP) visited the day program regularly. Observations during lunch at the day program differed from the supports that were observed in the home later that day. For example, on April	W 120	An In-Service training was completed for Direct Support Professionals at day program on 04/27/12 by the QIDP on the implementation of the meal time protocol of Client#1. The purpose of the eating protocol was discussed to ensure the safety of the Individual. The QIDP will ensure that day program follows all the required protocols to ensure the safety of the Individual. The QIDP/HM will continue to make weekly times x2 then monthly and quarterly visits during meal time to ensure the same. Also an in-service training was provided to all the DSP at the day program by the Day program nurse on 04/24/12 for the same. Please see attachment [B & C].	04/24/12 & 04/27/12

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W 120 Continued From page 2

24, 2012, at 6:22 p.m., a direct support staff in the home (S4) was observed placing a similar coated teaspoon with a built-up handle into Client #1's hand. S4 offered verbal instruction and encouragement for the client to begin self-feeding. After the client did not start eating and he relaxed his grip on the spoon, S4 returned the spoon to the client's hand, placed his hand over the client's hand and together, they scooped food from the dinner plate. In addition, the amount of food that they scooped for each bite was smaller; each spoonful was approximately half full.

When interviewed on April 24, 2012, at 2:00 p.m., the QIDP stated that Client #1's day program had been given a copy of his Eating Protocol (EP) immediately after it was revised on February 8, 2012. It was her understanding that the day program nurse had trained day program staff on the revised EP, which she then presented for review.

On April 24, 2012, beginning at 2:05 p.m., review of Client #1's EP (revised February 8, 2012) confirmed that it was designed to reduce his risk of aspiration. Continued review revealed the following:

1. Client #1 should be given the adaptive teaspoon with a built-up handle and for 15 minutes, staff are to encourage him "to self-feed. After the first 15 minutes, if needed, staff may provide hand-over-hand assist...should only occur if <client's name> refuses to feed himself, becomes fatigued or is physically unable to feed himself." DPS2 had not encouraged the client to feed himself nor did he attempt to use

W 120

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W 120	Continued From page 3 hand-over-hand level of assistance before he spoon fed the client. 2. Continued review of the EP revealed that Client #1 "should be encouraged to take small bites (1/2 teaspoon) and eat slowly." DPS2 was observed providing the client bites that were 2/3 to 1 teaspoon full in size during his lunch. A follow-up interview with the QIDP on April 25, 2012, at 12:14 p.m., revealed that while she had visited the day program twice since the February 8, 2012 revisions were made to Client #1's EP, she had not observed a meal to verify day program staff implemented the protocol as written. The facility failed to ensure that staff at Client #1's day program provided assistance during meals in accordance with his established Eating Protocol. This is a repeat deficiency. See Federal Deficiency Report dated March 31, 2011.	W 120		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that each staff was effectively trained trained on the procedures outlined in the stand-pivot transfer protocol for one of the three clients in the sample. (Client #2)	W 189		

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STREET ADDRESS, CITY, STATE, ZIP CODE: 6508 EASTERN AVE NE, WASHINGTON, DC 20012

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W 189	Continued From page 4 The finding includes: On April 24, 2012, at 6:39 a.m., a direct support staff (S1) approached Client #2 who was seated on the living room sofa. S1 leaned forward, facing the client, placed his arms to either side of the client's upper body, and lifted him, transferring him to a wheelchair that he had placed adjacent to (and parallel to) the sofa. S1 then pushed the client's wheelchair into an adjacent room and transferred him into a standard office-style chair before a nurse administered his medications. A short time later, at 6:52 a.m., two other staff were observed using a different method of transferring Client #2. After the client had finished receiving his medications, two direct support staff (S2 and S3) asked him to "stand up" from the office-style chair. The client's empty wheelchair had been placed directly in front of him and was positioned so the seat faced him. S2 and S3 repeated their verbal instructions while positioning themselves to either side of him. They were then observed pulling on the client's upper arms. The staff were having difficulty lifting him and so the house manager joined them. Together, the three employees transferred Client #2 back into his wheelchair and he was wheeled out of the nurse's area. Client #2's physical therapy annual assessment dated March 27, 2012 was reviewed on April 25, 2012, beginning at 3:55 p.m. According to the client's Physical Therapy Assessment, dated March 27, 2012, he was to be "assisted to stand by two staff." On April 25, 2012, at 4:05 p.m., interview with	W 189	An in-service training was completed for all the Direct Support Professionals on 04/27/12 and 04/30/12 on PT recommendations and instructions for proper transfer for Client#2. Reviewed the responsibilities of the DSP's to follow the ambulation and fall prevention protocol immediately after the change. QIDP and House Manager will continue to ensure the DSP will follow recommendations as instructed. QIDP/PT will conduct In-service training quarterly and on ongoing basis as needed. Please see Attachment [D & E].	04/27/12 and 04/30/12

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W 189	Continued From page 5 Client #2's physical therapist (PT) revealed that staff were expected to always use a two-person transfer. The PT then demonstrated how to safely use a two-person transfer, where each staff was to support the client's upper arm by using their upper arm, while simultaneously grasping the client's pants waist band in the back using their other hand. The facility's staff in-service training records were reviewed on April 24, 2012 and April 26, 2012, at 5:12 p.m. and 4:16 p.m. respectively. There was documented evidence that the PT had trained staff initially after the recommendation. Observations in the facility, however, on the morning of April 24, 2012, revealed staff failed to demonstrate the skills and techniques needed for safely transferring Client #2. It should be noted that the PT provided additional training for the staff that were on duty the evening of April 26, 2012.	W 189		
W 455	483.470(i)(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 were implemented, for 4 of the 6 clients residing in the facility (Clients #3, #4, #5 and #6), the house manager and 13 of the 13 direct support staff (S1, S2, S3, S4, S5, S6, S7, S8, S9, S10, S11, S12 and S13).	W 455		

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W 455	Continued From page 6 The findings include: On April 24, 2012, at 7:38 a.m., the morning medication nurse (LPN1) used a lancet to obtain a small droplet of blood from Client #4's index finger. After she took a reading on a glucometer, LPN1 carried the lancet into the bathroom located in the dining area (and adjacent to Client #1's and Client #4's bedrooms). The nurse disposed the lancet in a waste basket next to the sink. As LPN1 walked out of the bathroom, she acknowledged that she had discarded the lancet into the waste basket. Further examination of this issue revealed the following deficient practices: 1. On April 24, 2012, at approximately 11:15 a.m., one of the facility's registered nurses (RN1) stated that nurses were expected to dispose of "sharps" in a standard, red disposal container labeled for biohazard waste. On April 26, 2012, at 10:47 a.m., the qualified intellectual disabilities professional (QIDP) and the facility's program manager (PM) acknowledged that LPN1 had improperly disposed of the lancet two days earlier. [Note: They further stated that another nurse (LPN2) had come to the facility that morning (April 24, 2012), retrieved the lancet from the waste basket and placed it in a biohazard disposal container that she (LPN2) reportedly carried with her on a routine basis.] 2. On April 24, 2012, at approximately 11:17 a.m., RN1 looked throughout the facility's medication closet and stated that she was unable to locate a "sharps disposal box," adding that she did not think there was a box in the facility. At 1:55 p.m.,	W 455	An In-Service training was completed for nurses by Nursing Director/RN on 04/27/12 regarding the safe handling and the disposal the sharp objects in a standard biohazard waste. Director of Nursing will continue monitor nurses on ongoing basis (unannounced). Also please see attached policy and procedure regarding the safe handling and disposal of "Sharps". Please see Attachment [F & G].	04/27/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	09G226		04/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 455	Continued From page 7 RN1 presented an empty biohazard disposal container which she indicated was new and she had just brought it to the facility. 3. On April 24, 2012, at 1:56 p.m., RN1 agreed to locate a facility policy that governs the safe handling and disposal of "sharps." On April 26, 2012, at 10:50 a.m., the QIDP and the PM also agreed to find said policy. No policy was presented during the survey. During the Exit conference held on April 26, 2012, beginning at 4:26 p.m., the survey team was again told that a policy on "sharps" existed and that said policy would be sent to the State agency via facsimile. As of May 1, 2012 (post-survey), however, there was no evidence that the facility had established policies and procedures regarding the safe handling and disposal of "sharps." 4. On April 24, 2012, at 1:57 p.m., RN1 agreed to seek documentation of in-service training(s) provided for the facility's medication nurses regarding the safe handling and disposal of "sharps." On April 24, 2012 and April 26, 2012, at 5:12 p.m. and 4:16 p.m. respectively, review of in-service training records revealed no evidence that facility nurses had received said training.	W 455		
W9999	FINAL OBSERVATIONS The following observation was made during the survey process. It is recommended that this area be reviewed and a determination be made regarding appropriate action to prevent a potential non-compliant practice: Interview with the qualified intellectual disabilities professional (QIDP) on April 24, 2012, at 9:01 a.m., revealed that Client #4 had a percutaneous	W9999		

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W9999	Continued From page 8 endoscopic gastrostomy (PEG) placement on March 17, 2012, due to his low body weight and risk of aspiration during food and fluid intake by mouth. The client returned to the group home on the day of the PEG placement. Record review on April 26, 2012, at 9:45 a.m., revealed that the primary care physician prescribed Client #4 to be administered Jevity 1.5 Cal, 2 cans in the a.m. and at noon, and Jevity 1.5 Cal, 3 cans in the evening via gastrostomy tube (GT). At the time of the survey, the medication administration record (MAR) noted administration of the feedings at 7:00 a.m., 12:00 p.m., and 6:00 p.m. The PEG was prescribed to be flushed with 30 cc of water prior to each feeding and 240 cc of water after each feeding. Additionally, the client was prescribed 480 cc of water via GT at 10:00 a.m., 3:00 p.m., and 9:00 p.m. On March 23, 2012, the dietitian documented an acknowledgement of the physician's order for the cans of Jevity 1.5 cal and the 240 cc water flushes, noted that the client would be monitored, and that an updated nutritional assessment would be provided for the client. At the time of the survey, however, there was no evidence that a nutritional assessment had been conducted for the client since the client's PEG placement.	W9999	The assessment from Nutritionist completed on 05/15/12. An initial review by the nutritionist was completed of client#4's dietary changes on 03/23/12. QIDP will ensure that all future PMD orders are completed within 24 hours. An in-service training by the Program Manager to QIDP was done on 04/30/12 reviewing all the procedures of discharge, change in client's status and follow up. Program Manager will ensure that any change is immediately addressed. Please see attachment [H & I].	05/15/12 & 04/30/12