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

PRINTED: 05/04/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G124	A. BUILDING _____ B. WING _____	04/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
I D I	1230 CONGRESS STREET, SE WASHINGTON, DC 20020

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W 000	INITIAL COMMENTS A recertification survey was conducted from April 17, 2007 through April 19, 2007. The survey was initiated using the fundamental survey process. A random sample of four clients was selected from a residential population of eight male clients with varying degrees of disabilities. The findings of the survey were based on observations at the residence and two day programs. Also the findings were based on client and staff interviews in both the group home and day programs, as well as a review of habilitation and administrative records, to include the facility's unusual incident reports.	W 000		
W 114	483.410(c)(4) CLIENT RECORDS Any individual who makes an entry in a client's record must make it legibly, date it, and sign it. This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to date clients consultation forms for one of the four clients in the sample. (Client #1) The finding includes: During the review of Client #1's medical record on April 19, 2007, it was noted that the pharmacist had reviewed the client's medication regimen on October 2, 2006. At that time, the pharmacist recommended that the physician consider discontinuing one of the client's gastrointestinal medications (Zantac). Although review of the medical records reflected that the Primary Care Physician (PCP) affixed his initials on the pharmacy report, there was no date to reflect if	W 114	W114 This Standard will be met as evidenced by: Primary Care Physician will be directed to date all entries. Routine record reviews/audits will be completed by medical staff to further ensure compliance with this standard.	5-16-07 ongoing

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2007 MAY 30 P 2:19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy Branch — TITLE: DES. — (X6) DATE: 5-14-07

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

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W 114	Continued From page 1 the PCP had reviewed the recommendations prior to discontinuing the Zantac in April 2007.	W 114		
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to notify parents or guardians of significant incidents for four of the eight clients residing in the facility. (Clients #2, #3, #4 and #7) The finding includes: Review of the facility's unusual incident reports and investigations on February 20, 2007 at approximately 9:00 AM, revealed evidence that the facility failed to notify family members immediately of the following significant incidents: a. On December 12, 2006, staff discovered a bruise on Client #3's back and reported the bruise to the nurse on duty. The nurse observed bruise on December 10, 2006 and did not report the incident as stated in the policy. b. On April 5, 2006, staff discovered fresh blood "humps" on Client #4's left hand. c. On December 10, 2006, Client #7 was involved in a vehicle accident while returning from the barber shop.	W 148	W148 This Standard will be met as evidenced by: QMRP will notify parents and guardians of significant incidents, immediately. QMRP will document notifications in accordance to policy and procedures. Routine QA audits will be completed to further ensure compliance with this standard.	5-30-07 ongoing

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W 148	Continued From page 2 d. The direct care staff reported that upon the Client #2's arrival to his day program on September 29, 2006 he appeared to be asleep. The nurse reported that the client "felt cold" upon examination/assessment. The local Emergency Medical Service (EMS) was called and the client was taken to the local emergency room.	W 148		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to establish and/or implement policies that ensure the health and safety for eight of the eight client reside in the facility. (Clients #1, #2, #3, #4 #5, #6, #7 and #8) The finding includes: The facility failed to ensure the implementation of their incident management policy. Interview was conducted with the Qualified Mental Retardation Professional (QMRP) on April 17, 2007 at 9:45 AM to ascertain if the facility had a written incident management policy. The QMRP presented the policy which was reviewed on April 17, 2007. The policy failed to address injuries of unknown origin. (See W153)	W 149	W149 This Standard will be met as evidenced by: Reference response to W153.	5.30.07 ongoing
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as	W 153	W153	

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W 153	Continued From page 3 injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview, review of unusual incidents, and review of medical records, the facility failed to ensure that all unusual incidents including injuries of unknown origin were reported immediately to the administrator and other officials according to district law (22 DCMR, Chapter 35, Section 3519.10) for three of the four clients in the sample. (Clients #2, #3 and #4) The finding includes: On April 17, 2007 at 9:45 AM, review of the facility's incident reports revealed the following injuries of unknown origin that were not reported immediately to the administrator and to the government officials as required. a. The direct care staff reported that upon the Client #2's arrival to his day program on September 29, 2006 he appeared to be asleep. The nurse reported that the client "felt cold" upon examination/assessment. The local Emergency Medical Service (EMS) was called and the client was taken to the local emergency room. b. On April 5, 2006, staff discovered fresh blood "humps" on Client #4's left hand. c. On December 12, 2006, staff discovered a bruise on Client #3's back and reported the bruise to the nurse on duty. The nurse observed bruise on December 10, 2006 and did not report the	W 153	W153, continued.. This Standard will be met as evidenced by • QMRP will receive additional training on incident management procedures. • Also, reference response to W148. • QMRP will report all incidents to the administrator and to the government officials as required.	5-30-07 ongoing

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W 153	Continued From page 4 incident as stated in the policy. d. On May 9, 2006, the staff discovered a scratch on the upper lip and chin area of Client #1. The wound was cleaned with soap and water.	W 153		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to investigate injuries of unknown origin for two of four clients in the sample. (Clients #1 and 3) The findings include. Review of the unusual incident reports on April 17, 2007 at 9:45 AM, revealed the following documented injuries of unknown origin that had not been reported and/or investigated: a. On December 12, 2006, staff discovered a bruise on Client #3's back and reported the bruise to the nurse on duty. The nurse observed bruise on December 10, 2006 and did not report the incident as stated in the policy. b. On May 9, 2006, the staff discovered a scratch on the upper lip and chin area if Client #1. The wound was cleaned with soap and water.	W 154	W154 This Standard will be met as evidenced by: Reference response to W153 and W148.	5-30-07 ongoing
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a	W 159	W159	

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W 159	Continued From page 5 qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed, to adequately monitor, integrate and coordinate each client's active treatment. The findings include: 1. On March 17, 2007 during evening observations, Client #3 remained in his wheelchair from 4:10 PM until 7:45 PM. Interview with the direct care staff and the Licensed Practical Nurse (LPN) on April 18, 2007 at approximately 5:00 PM indicated that it was time for evening medications or dinner time and the client should not be repositioned out of his wheelchair, at this time. Review of an Physical Therapy assessment dated July 5, 2006 however revealed a recommendation for the client to be provided opportunities to be repositioned in an alternative seating (i.e., bean bag or recliner chair) every two hours during waking hours.	W 159	W159 This Standard will be met as evidenced by: • QMRP will provide additional training for all staff on repositioning • QMRP/Home Manager will purchase additional positioning equipment as needed. • Nursing staff/Managers will continue to monitor and provide oversight to further ensure compliance with standard.	5.18.07 ongoing
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to ensure the comprehensive functional assessment identified each clients specific developmental and behavioral needs, for one of the four clients	W 214	W214 This Standard will be met as evidenced by:	

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W 214	Continued From page 6 included in the sample. (Client #3) The finding includes: Review of Client #3's physician order on April 18, 2007 revealed that the client had been prescribed and administered Ativan 2 mg to address combative and non-compliant behaviors during medical appointments. Interview with the Qualified Mental Retardation Professional (QMRP) and the Licensed Practical Nurse (LPN) confirmed that the Ativan was administered to address non-compliant behaviors exhibited by the client during medical appointments. Interview with staff and review of the client's record however, failed to provide evidence that the behaviors exhibited were assessed and/or addressed by a least restrictive technique.	W 214	W214, continued... • QMRP/medical staff will review and discuss prescribed medications with the Psychiatrist. • Least restrictive techniques will be reviewed and reassessed to determine if any other strategies can be utilized to address client #3's non-compliant behavior. • All recommendations will be reviewed at next scheduled Human Rights committee meeting. • QMRP/medical staff will document all actions taken.	5.31.07 ongoing
W 240	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure that there were clear, written instructions for implementing clients physical therapy program for one of the four clients in the sample. (Client #4) The finding includes: On April 17, 2007 at approximately 7:00 PM, direct care staff was observed performing lower leg stretches to Client #4. Interview with the direct care staff indicated that he was performing lower extremities exercise to Client #4 due to his	W 240	W240 This Standard will met as evidenced by:	

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W 240	Continued From page 7 "stiffness". Review of the Individual Program Plan revealed that the client has an objective which stated, "given physical assistance, [the client] will tolerate lower extremity exercises (hip flexion and abduction, knee flexion and ankle dorsiflexion) 10/10 trials. . . Review of the task analysis sheet indicated that the direct care staff should document the number of trials for each exercise. Review of the data sheet from January 2007 through April 2007 revealed that the direct care staff were documenting on however the direct care staff failed to identify the specific exercises completed. Further interview with the Qualified Mental Retardation Professional (QMRP) indicated that the data sheet should include the name of each exercise. The QMRP further indicated that he would make modifications to the data sheet and re-inservice staff.	W 240	• QMRP will complete additional training for all direct care staff. • QMRP will continue to monitor program implementation and documentation. • QMRP will provide necessary follow-up (i.e. disciplinary action, training, guidance) as needed to further ensure ongoing compliance with this standard.	5.18.07 ongoing
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, staff interview, and record review, the facility failed to ensure that each client was provided an opportunity to have a choice during their snack time for one of the four clients in the sample. (Client #1) The finding includes: Observations on April 17, 2007 at approximately 10:00 AM, direct care staff was observed giving Client #1 pudding as a snack. Interview with the direct care staff on April 18, 2007 revealed that	W 247	W247 This Standard will be met as evidenced by: QMRP/Home Manager will provide additional training for staff outlining expectations on providing opportunities and choices.	5.18.07 ongoing

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W 247	Continued From page 8 the client enjoys the snack he received. During the environmental inspection on April 18, 2007, there was a variety of snacks in the pantry and the refrigerator. At no time during snacktime was the client given the opportunity to select a snack from the variety of food choices.	W 247	QMRP/Home Manager/Nurse will monitor staff interactions and provide feedback as needed.	
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 observations, staff interview and record review, the facility failed to provide continuous active treatment for two of the four clients in the sample. (Clients #1 and #3) The findings include: 1. The facility failed to ensure that Client #3 participated in activities of daily living programs in accordance with his Individual Program Plan (IPP). During meal observations from April 17 - 19, 2007, the direct care staff was observed feeding Client #3 and then wiping his mouth. Interview with the direct care staff on indicated that the client had limited range of motion in his arms. Review of the IPP, dated July 31, 2006, revealed a program objective which stated, "given hand	W 249	W249 This Standard will be met as evidenced by: #1 thru #4 • QMRP will provide additional training on all active treatment programs. • QMRP will provide ongoing monitoring and oversight provide feedback and direction as needed to support the achievement of the identified objectives. • QMRP will continue to review program implementation weekly/monthly basis. • Also reference response to W159 regarding positioning.	5.18.07 ongoing

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W 249	Continued From page 9 over hand assistance, [the client] will wipe his mouth on 80% of the trials recorded per month for six consecutive month by January 2007. There was no evidence that Client #3 received continuous active treatment in accordance with his IPP. 2. The facility failed to ensure that Client #1 participated in active treatment programs in accordance with his IPP as evidenced below: During the breakfast and dinner observations on April 17, 2007, staff fed Client #1. Review of his IPP dated September 13, 2006 revealed a program goal to improve his activities of daily living by (a) Given hand over hand assistance, [Client name] will hold his cup during mealtime on 80% of the trials recorded; and (b) Given hand over hand assistance, [Client name] will bring his spoon to his mouth during mealtime on 80% of the trials recorded. The observation was brought to the attention of the Qualified Mental Retardation Professional (QMRP) on March 19, 2007. He acknowledged the staff did not follow the IPP recommendations. 3. The facility failed to provide opportunities to Client #3 to be repositioned as recommended by the Interdisciplinary Team (IDT). On March 17, 2007 during evening observations, Client #3 remained in his wheelchair from 4:10 PM until 7:45 PM. Interview with the direct care staff and the Licensed Practical Nurse (LPN) on April 18, 2007 at approximately 5:00 PM, indicated that it was time for evening medications or dinner time and the client should not be	W 249		

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W 249	Continued From page 10 repositioned out of his wheelchair, at this time. Review of an Physical Therapy assessment dated July 5, 2006 however revealed a recommendation for the client to be provided opportunities to be repositioned in an alternative seating (i.e., bean bag or recliner chair) every two hours during waking hours. The QMRP confirmed the repositioning protocol for the client. 4. The facility failed to provide continuous active treatment for Client #3 to use his assistive devices (hand cones). The facility failed to allow Client #3 to use his assistive devices as identified by the interdisciplinary team. On April 17, 2007 at 8:00 AM, Client #3 was observed with his left hand clinched closed. Interview with the direct care staff indicated that the client did not have much range of motion in his hands. The direct care staff informed the surveyor that the client no longer used the Swanson hand cones. Review of an Occupational Therapy assessment dated May 26, 2006 revealed a recommendation for the client to wear a left Swanson handcone for up to three hours, twice a day. It should be noted that the client had achieved the previous program objective (to wear the hand cones). There was no evidence that during the survey the client used the assistive devices as recommended.	W 249	W249, continued... • QMRP will modify/change programs as needed. W264 This Standard will be met as evidenced by • QMRP will review and discuss all medication changes with Human Rights Committee, prior to use of more restrictive techniques.	5-31-07 ongoing
W 264	483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and	W 264		

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W 264	Continued From page 11 programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. This STANDARD is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to implement Human Rights Committee (HRC) recommendations to review, monitor and make suggestions to the facility about its practices and programs as they relate to protection of client rights and any other areas that the committee believes that could be an infringement of the clients' rights for one of four clients in the sample (Client #3) The finding includes: Review of Client #3's physician order on April 18, 2007 revealed that the client received Ativan 2 mg prior to a medical appointment. Interview with the Qualified Mental Retardation Professional (QMRP) revealed that the client's guardian signed a consent authorizing the sedation. Review of the HRC minutes, did not evidence that the HRC reveiwed or approved the use of medication for sedation as an intervention to address the Client's behavior. There was no evidence that the facility ensured that restrictive measures had been approved by the HRC prior to its use.	W 264	W264, Continued... • QMRP will follow recommendations made by the committee • QMRP will ensure that all information supporting the rights of the clients are documented and available for review.	5.31.07 ongoing
W 278	483.450(b)(1)(iii) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR	W 278	W278 This Standard will be met as evidenced by Reference response to W264.	5.31.07 ongoing

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W 278	Continued From page 12 Procedures that govern the management of inappropriate client behavior must insure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that prior to the use of a more restrictive technique, the client's record documents that the use of more positive techniques proved to be ineffective for one of four clients in the sample. (Client #3) The findings include: Review of Client #3's physician order on April 18, 2007 revealed that the client had been prescribed and administered Ativan 2 mg to address combative and non-compliant behaviors during medical appointments. Interview with the Qualified Mental Retardation Professional (QMRP) and the Licensed Practical Nurse (LPN) confirmed that the Ativan was administered to address non-compliant behaviors exhibited by the client during medical appointments. Interview with staff and review of the client's record however, failed to provide evidence that the behaviors exhibited were assessed and/or addressed by a least restrictive technique.	W 278	W288	
W 288	483.450(b)(3) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Techniques to manage inappropriate client behavior must never be used as a substitute for	W 288		

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W 288	Continued From page 13 an active treatment program. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that techniques to manage inappropriate client behavior were not used as a substitute for the active treatment program for one of the four clients in the sample. (Client #3) The finding includes: There was no evidence that Client #3's interdisciplinary team (IDT) had instituted an assessment or developed a behavioral support plan for Client's non-compliance behaviors during medical appointments prior to the use of restrictive measures. [See W214]	W 288	W288, continued... This Standard will be met as evidenced by Reference response to W214.	5.31.07 ongoing
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure general and preventive care for two of the four clients included in the sample. (Client #1 and #3) The findings include: 1. During the review of Client #1's medical record on April 19, 2007, it was noted that the pharmacist reviewed the Client's medication regimen on October 2, 2006. At that time, the pharmacist recommended that the physician	W 322	W322 This Standard will be met as evidenced by:	

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W 322	Continued From page 14 consider discontinuing one of the clients gastrointestinal medications (Zantac). Further review of the medical record revealed that the Primary Care Physician (PCP) did not address the pharmacist recommendation until April 2, 2007, when the medication was discontinued. 2. On May 16, 2006, Client #1 was evaluated by the Audiologist. A complete evaluation could not be performed. The Audiologist recommended that the client be sedated for the next visit. A nursing note dated February 27, 2007, indicated that the primary care physician was contacted to approve the recommendation for sedation made by the Audiologist. The PCP indicated that there was no need for the sedation. Further review of the record failed to evidence any alternative methods developed or implemented to ensure that Client #1 completed his audiology evaluation. 3. On March 17, 2007 during evening observations, Client #3 remained in his wheelchair from 4:10 PM until 7:45 PM. Interview with the direct care staff and the Licensed Practical Nurse (LPN) on April 18, 2007 at approximately 5:00 PM indicated that it was time for evening medications or dinner time and the client should not be repositioned out of his wheelchair, at this time. Review of a Physical Therapy assessment dated July 5, 2006 however revealed a recommendation for the client to be provided opportunities to be repositioned in an alternative seating (i.e., bean bag or redliner chair) every two hours during waking hours. 4. On April 17, 2007 at 8:00 AM, Client #3 was observed with his left hand clinched closed. Interview with the direct care staff indicated that the client did not have much range of motion in	W 322	W322 ▪ Nursing staff will review all recommendations, and document follow-up actions taken. ▪ RN will discuss findings will primary care physician. All identified concerns will be addressed. ▪ Documentation pertaining to audiological appt and recommended medications changes will also be reviewed. ▪ RN/medical staff will continue to review client services recommendations, and provide additional training as needed to ensure general and preventive care is provided at all times.	5.31.07 ongoing

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W 322	Continued From page 15 his hands. The direct care staff informed the surveyor that the client no longer used the Swanson hand cones. Review of an Occupational Therapy assessment dated May 26, 2006 revealed a recommendation for the client to wear a left Swanson handcone for up to three hours, twice a day. It should be noted that the client had achieved the previous program objective (to wear hand cones).	W 322		
W 325	482.460(a)(3)(iii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician. This STANDARD is not met as evidenced by: Based on observations, staff interview and record verification, the facility failed to provide routine laboratory testing as determined necessary by the physician for one of the four clients in the sample (Client #3) The finding includes: The facility failed to ensure that Client #3 obtained laboratory studies as prescribed by the physician's orders. Observations during the breakfast and dinner on April 17, 2007 revealed that the client was being fed by direct care staff. Interview with the direct care staff indicated that the client receives a low fat, low cholesterol ground diet. Review of the meal time protocol and current physician orders confirmed the diet order.	W 325	W325 This Standard will be met as evidenced by: • All nurses will receive additional training on monitoring and tracking of laboratory studies. • Nursing staff will continue to use the laboratory tracking form and coordinate testing as needed. • Laboratory testing will be completed for client #3.	5.24.07 ongoing

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W 325	Continued From page 16 On April 17, 2007 at 6:10 PM, Client #3 was administered Zocor 80 mg. Interview with the medication nurse indicated that the client received Zocor for the management of an elevated cholesterol levels. Review of the client #3's physician orders dated March 2007 revealed an order for laboratory studies to include lipid panel, every six months. Record verification indicated that the client received a lipidprofile on July 17, 2007. There was no evidence that the facility had any updated laboratory profiles.	W 325	W325... continued... • Nursing staff will provide necessary follow-up action to ensure that all laboratory results are received in a timely manner. • RN will conduct routine file reviews to further ensure compliance with this standard.	
W 331	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 staff interview and record review the facility failed to ensure nursing services in accordance with the needs of two of four clients in the sample. (Clients #1 and #3) The findings include: 1. The facility's nurse failed to ensure that Client #3 obtained laboratory studies as prescribed by the physician's orders. [See W325] 2. The facility's nurse failed to ensure that the health status was reviewed by the Registered Nurse (RN) on a quarterly or more frequent basis. [See W336] 3. The facility's nurses failed to ensure recommendations made by consultants were addressed with the Primary Care Physician in an timely manner to ensure Client #1 received a complete audiology examination as evidenced by	W 331	W331 This Standard will be met as evidenced by: (1) Reference response to W325. (2) Reference response to W336 (3) Reference response to W264. Alternate methods will be reviewed and discussed.	5-24-07 ongoing

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W 331	Continued From page 17 the following: On May 16, 2006, Client #1 was evaluated by the Audiologist. A complete evaluation could not be performed. The Audiologist recommended that the client be sedated for his next visit. A nursing note dated February 27, 2007, (seven months later) indicated that the primary care physician was contacted for approval for sedation made by the audiologist. The PCP indicated that there was no need for the sedation. Further review of the record failed to evidence any alternative methods developed or implemented to ensure that Client #1 completed his audiology evaluation.	W 331		
W 336	483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the health status was reviewed by the Registered Nurse (RN) on a quarterly or more frequent basis for one of the four clients in the sample. (Client #3) The finding includes: Review of Client #3's medical record on April 18, 2007 revealed a Nursing Quarterly Assessment dated April 17, 2007, however the review of the body systems was incomplete.	W 336	W336 This Standard will be met as evidenced by RN will ensure that review of body systems is completed on a quarterly basis. Routine file reviews will be conducted on regular basis. All identified concerns will be addressed in a timely manner.	5.8.07 ongoing
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT	W 356		

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W 356	Continued From page 18 The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to schedule timely dental appointments for one of the four clients in the sample. (Client #3) The finding includes: On April 17, 2007, Client #3 was observed with brown stains on his teeth. Record review of the dental consultation dated April April 26, 2006 revealed that the client had "calculus deposits". The dentist recommended scaling on the next visit after the receipt of payment authorization. There was no evidence that the recommended dental services had been performed.	W 356	W356 This Standard will be met as evidenced by: RN will follow-up on status of dental consultation. Contacts and follow-up actions will be documented. Client #3 will be scheduled for cleaning as recommended.	5.30.07 ongoing
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record verification, the facility failed to teach use adaptive equipment.	W 436	W436 This Standard will be met as evidenced by:	

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W 436	Continued From page 19 The finding includes: The facility failed to allow Client #3 to use his assistive devices as identified by the interdisciplinary team. On April 17, 2007 at 8:00 AM, Client #3 was observed with his left hand clinched closed. Interview with the direct care staff indicated that the client did not have much range of motion in his hands. The direct care staff informed the surveyor that the client no longer used the Swanson hand cones. Review of an Occupational Therapy assessment dated May 26, 2006 revealed a recommendation for the client to wear a left Swanson handcone for up to three hours, twice a day. It should be noted that the client had achieved the previous program objective (to wear hand cones). There was no evidence that during the survey that the client used the assistive devices as prescribed.	W 436	W436 QMRP will consult with the Occupational Therapist regarding the use of Swanson handcone. All recommendations will be followed as outlined. QMRP/Occupational Therapist will provide staff training as indicated. QMRP will monitor progress and address program changes as needed.	5-31-07 ongoing

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I 000	INITIAL COMMENTS A licensure survey was conducted from April 17, 2007 through April 19, 2007. The survey was initiated using the fundamental survey process. A random sample of four residents was selected from a residential population of eight male residents with varying degrees of disabilities. The findings of the survey were based on observations at the residence and two day programs. Also the findings were based on residents and staff interviews in both the group home and day programs, as well as a review of habilitation and administrative records, to include the facility's unusual incident reports.	I 000		
I 056	3502.14 MEAL SERVICE / DINING AREAS Each GHMRP shall train staff in the storage, preparation and serving of food, the cleaning and care of equipment, and food preparation in order to maintain sanitary conditions at all times. This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each GHMRP staff was trained in the storage, preparation and serving of food, the cleaning and care of equipment, and food preparation in order to maintain sanitary conditions at all times. The finding includes: Review of the personnel and training files on April 19, 2007, reflected that the GHMRP failed to provide adequate staff trained in Food Handler's,	I 056	1056 3502: Meal Services This Statute will be met as evidenced; QMRP/Home Manager will coordinate and schedule staff for Food Handlers training as needed. QMRP/Home Manager will ensure that documentation is maintain on file for review.	6.8.07 ongoing
I 058	3502.16 MEAL SERVICE / DINING AREAS	I 058		

Health Regulation Administration

Nancy Brunel

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

TITLE DRB

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I 058	Continued From page 1 A review and consultation by a dietitian or nutritionist shall be conducted at least quarterly to ensure that each resident who has been prescribed a modified diet receives adequate nutrition according to his or her Individual Habilitation Plan. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that residents with modified diets had been reviewed at least quarterly by the consulting dietitian for two of four residents. (Residents #3 and #4) The findings include: 1. Review of Resident #4's nutrition assessment dated October 23, 2006 indicated a regular ground pureed meat diet. The current physician's order confirmed the nutritionist recommended diet. There has been no monitoring of the modified diet. 2. Review of Resident #3's nutrition assessment dated July 17, 2006 indicated a low fat, low cholesterol ground, bite size pieces of bread diet. The current physician's order confirmed the nutritionist recommended diet. There has been no monitoring of the modified diet. There was no evidence that the nutritionist had conducted quarterly reviews to ensure that the residents received adequate nutrition in accordance with her needs.	I 058	1058 3507.16 Meal Service This Statute will be met as evidenced by: (#1 & #2.) Nutritionist will complete all outstanding quarterly reviews. QMRP will continue to review and report on quarterly status. QMRP will request documentation whenever needed.	5.31.07 ongoing
I 161	3507.2 POLICIES AND PROCEDURES The manual shall be approved by the governing body of the GHMRP and shall be reviewed at	I 161	1161 3507.2 Policies & Procedures	

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I 161	Continued From page 2 least annually. This Statute is not met as evidenced by: Based on record review, the GHMRP governing body failed to review its policies and procedures annually. The finding includes: Review of the policy and procedure manual on April 18, 2007 revealed an approval date of 2005.	161	This Statute will be met as evidenced by: Policy and Procedure manual was reviewed and approved in October 2006. Updated information will be filed in policy and procedure manual for review.	5.1.07 ongoing
I 164	3507.4(b) POLICIES AND PROCEDURES The manual shall incorporate policies and procedures for at least the following: (b) Physical environment, which covers housekeeping, maintenance, household items and furnishings; This Statute is not met as evidenced by: Based on the review of records the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that their Policies and Procedures' Manual included a policy to address physical environment to include housekeeping, maintenance, and household items and furnishings. The finding includes: Review of the personnel policies and procedures on April 18, 2007, revealed the GHMRP failed to have a policy on cleaning the kitchen and physical environment.	I 164	I164 3507.4 b This Statute will be met as evidenced by: The kitchen and physical environment policy will be filed in the policy and procedure book. GHMRP/Home Manager will conduct further training in this area.	5.31.07 ongoing
I 169	3507.4(g) POLICIES AND PROCEDURES	I 169		

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I 169	Continued From page 3 The manual shall incorporate policies and procedures for at least the following: (g) Resident life, which covers clothing, management of funds, resident rights, discipline, behavior management, services, parental and guardian involvement, visitation, staff treatment of residents, and resident work. This Statute is not met as evidenced by: The finding includes: Review of the personnel policies and procedures on April 18, 2007, the GHMRP failed to have a policy on sorting and washing clothes.	I 169	1169. 3507.4 (g) Reference response to 3507.4 (b).	
I 202	3509.2 PERSONNEL POLICIES Each staff person shall have a written job description, which details each of his or her major responsibilities and duties and supervisory control. This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current job descriptions for all employees. The findings include: Review of the personnel files on April 18, 2007, the GHMRP failed to provide current job descriptions for the three direct care staff ([redacted], [redacted], and [redacted]).	I 202	1202 3509.2 This Statute will be met as evidenced by: * Home Manager will ensure that all job descriptions are up-to-date. * Home Manager will check job descriptions on a monthly basis.	4.30.07 ongoing

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G124	A. BUILDING _____ B. WING _____	04/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	1230 CONGRESS STREET, SE WASHINGTON, DC 20020

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I 204	Continued From page 4	I 204	1202, Continued...	
I 204	3509.4 PERSONNEL POLICIES Each employee shall be given a copy of his or her job description to review and sign at the beginning of employment. This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current job descriptions for all employees. The findings include: Review of the personnel files on January 18, 2007, the GHMRP failed to provide current job descriptions for the three direct care staff ([redacted], [redacted], and [redacted]).	I 204	3509.2 • QMRP will conduct routine file audits and provide feedback as needed to further ensure compliance with this standard.	
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 review of records, the GHMRP failed to ensure each employee had a current physician's certification that indicated a health inventory had been performed and documented the employee's health status would allow him/her to preform their required duties. The finding includes:	I 206	1206 3509.6 Personnel Policies This Statute will be met as evidenced by: • Human Resource department will ensure that physician certifications are updated. • Human Resources will continue to request updated health	5.11.07 ongoing

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I 206	Continued From page 5 Review of the personnel files on April 18, 2007, the GHMRP failed to provide physician's certification for three direct care staff ([redacted] and [redacted]) and a medication nurse ([redacted]).	I 206	I206 • certifications 90 days prior to expiration. • Staff who fail to submit requested documentation will be removed from the work schedule until compliance with standard has been met.	
I 291	3514.2 RESIDENT RECORDS Each record shall be kept current, dated, and signed by each individual who makes an entry. This Statute is not met as evidenced by: Based on record review the GHMRP failed to ensure each residents records were dated. The finding includes: See Federal Deficiency Report - Citation W114	I 291	I291 3514.2 This Statute will be met as evidenced by: Reference response to W114 of the Federal Deficiency Report.	5.16.07 ongoing
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5 each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident's health, welfare, living arrangement, well being or in any otherway places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next workday. This Statute is not met as evidenced by: Based on interview record review, the GHMRP failed to ensure the Department of Health, was notified of unusual incidents or events that substantially interfered with each resident's health and welfare within twenty-four hours or the next	I 379	I379 3519.10 Emergencies This Statute will be met as evidenced by: Reference response to Federal Deficiency Report W336 and 3502.16	

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I 379	Continued From page 6 work day. The finding includes: Refer to Federal Deficiency Report W153 and W154	I 379	3519.10 Emergencies. Reference response to Federal Deficiency Report W153 and W154.	
I 404	3520.6 PROFESSION SERVICES: GENERAL PROVISIONS Each professional service provider shall assist, as appropriate, each other person who is working with a resident in the GHMRP so that relevant professional instructions can be implemented through-out the resident ' s programs and daily activities. This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for the Mentally Retarded Person (GHMRP) failed to ensure the implementation of recommendations made by the occupational Therapist and Physical Therapist. The finding includes: See Federal Deficiency Report - Citation W240	I 404	1404 3520.6. This Statute will be met as evidenced by: Reference response to Federal Deficiency Report W240.	5.30.07 ongoing
I 407	3520.9 PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall obtain from each professional service provider a written report at least quarterly for services provided during the preceding quarter. This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for Mentally Retarded Persons'	I 407	1407 3520.9 This Statute will be met as evidenced by:	

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I 407	Continued From page 7 (GHMRP), failed to provide evidence of a nursing and nutrition quarterly reports two of the four residents in the sample. (Residents #3 and #4) The finding includes: See Federal Deficiency Report - Citation W336 and 3502.16	I 407	1407 3520.9, continue... Reference response to Federal Deficiency Report W336 and 3502.16	5.8.07 ongoing
I 421	3521.2 HABILITATION AND TRAINING Each GHMRP shall provide habilitation and training to residents in the most normalizing environment and the least restrictive circumstances. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the GHMRP failed to ensure habilitation and training for one of the four residents included in the sample. (Resident #3) The finding includes: See Federal Deficiency Report - Citations W214 and W288	I 421	1421 3521.2 Habilitation/Training This Statute will be met as evidenced by: Reference response to Federal Deficiency Report W214 and W288.	5.31.07 ongoing
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, staff interview and record review, the GHMRP failed to ensure habilitation and training was provided to its residents that would enable them to acquire and maintain life skills needed to cope more effectively with the	I 422	1422 3521.3 Habilitation/Training This Statute will be met as evidenced by: Reference response to Federal Deficiency Report W249.	5.31.07 ongoing

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I 422	Continued From page 8 demands of their environments and to achieve their optimum levels of physical, mental and social functioning. The finding includes: See Federal Deficiency Report - Citations W249	I422		
I 430	3521.7(a) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (a) Eating and drinking (including table manners, use of adaptive equipment, and use of appropriate utensils); This Statute is not met as evidenced by: The finding includes: See Federal Deficiency Report - Citations W249	I 430	I430 3521.7(a) Reference response to Federal Deficiency Report W249.	
I 437	3521.7(g) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (g) Communication (including language development and usage, signing, use of the telephone, letter writing, and availability and utilization of communications media, such as books, newspapers, magazines, radio, television, telephone, and such specialized equipment as may be required); This Statute is not met as evidenced by: The finding includes:	I 437	I437 3521.7(g) Habilitation/Training 3521.7(a) This Statute will be met as evidenced by: Reference response to Federal Deficiency Report citations W249 and W436.	5.18.07 ongoing

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I 437	Continued From page 9 See Federal Deficiency Report - Citations W249	I 437		
I 445	3521.7(o) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (o) Motor and perceptual skills (including balance) posture, and gross and fine motor skills); This Statute is not met as evidenced by: The finding includes: See Federal Deficiency Report - Citations W436	I 445		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on record review, the GHMRP failed to ensure each residents rights for eight of the eight in the facility. (Residents #1, #2, #3, #4, #5, #6, #7, and #8) The finding includes See Federal Deficiency Report - Citation W148, W149, W153, W154, W156 and W262	I 500	I500 3523.1 Residents Rights This Statute will be met as evidenced by: Reference response to Federal Deficiency Report - Citations W148, W149, W153, W154, W156 and W262.	5/31/07 ongoing

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R 000	INITIAL COMMENTS: A licensure survey was conducted from April 17, 2007 through April 19, 2007. The survey was initiated using the fundamental survey process. A random sample of four residents was selected from a residential population of eight male residents with varying degrees of disabilities. The findings of the survey were based on observations at the residence and two day programs. Also the findings were based on resident and staff interviews in both the group home and day programs, as well as a review of habilitation and administrative records, to include the facility's unusual incident reports.	R 000		
R 120	4701.1(a) BACKGROUND CHECK REQUIREMENT No facility shall employ or use the contract services of an unlicensed person if: (a) The person has been convicted of a criminal offense listed in section 4705.1 of these rules within the seven (7) years prior to a criminal background check conducted pursuant to these rules; or... This Statute is not met as evidenced by: Based on interview and record review the GHMRP failed to have background check for all staff employed. The finding includes: Interview with the house manager and review of the staff personnel records revealed that one direct care staff ([redacted]) assigned to this facility failed to have criminal background checks.	R 120	Background Checks This Statute will be met as evidenced by: Human Resource Department completes background checks for each potential employee prior to employment. Human Resource Department will ensure that background check is filed and made available for review	4.18.07 ongoing

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

STATE FORM [redacted] 442J11 — If continuation sheet 1 of 2

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