

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

PRINTED: 12/29/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/12/2008
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NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1938 FIRST STREET NW WASHINGTON, DC 20001
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W 000	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted from December 10, 2008 through December 12 2008. The survey was initiated using the fundamental survey process. A random sample of four clients was selected from a client population of eight males with various disabilities.</p> <p>The findings of the survey were based on observations at the group home and three day programs, interviews with management and direct care staff in the residence and the review of the administrative records including the facility's incident management system.</p>	W 000	<p><i>Receweld 1/22/09</i></p> <p>GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002</p>		
W 120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>The facility must assure that outside services meet the needs of each client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that outside services met the needs of one of four clients included in the sample. (Clients #3)</p> <p>The finding includes:</p> <ol style="list-style-type: none"> 1. The facility failed to ensure that the day program staff implemented infection control practices. [See W455] 2. The facility failed to ensure the day program's medication nurse provided privacy to Client #3's during the medication administration. [See W130] 	W 120		<p>Please see the answer to W-455</p> <p>Please see the answer to W - 130</p>	
W 130	<p>483.420(a)(7) PROTECTION OF CLIENTS</p>	W 130			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Lyney Stephen</i>	TITLE <i>President</i>	(X6) DATE <i>1/9/09</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 130	<p>Continued From page 1</p> <p>RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure privacy during the administration of medications for four of four clients included in the sample. (Clients #1, #2, #3, and #4)</p> <p>The findings include:</p> <p>1. On December 10, 2008 at 5:26 PM, the Licensed Practical Nurse (LPN) was observed to administer Client #2's medication while Client #8 and a staff sat on the sofa across from the medication cabinet. At 5:31 PM, the LPN was observed to administer Client #4's medications while Client #1 and #6 sat on the sofa across from the medication cabinet. At 5:43 PM, the LPN was observed to administer Client #1's medication while Client #2, #4, #6, and a staff sat on the sofa across from the medication cabinet. At approximately 6:05 PM, the LPN was observed to administer Client #3's medications while Client #4 exhibited maladaptive behaviors (public masturbation) on the sofa across from the medication cabinet.</p> <p>Interview with the LPN on the same day at approximately 6:30 PM acknowledged that the clients were not provided privacy during the medication administration pass.</p> <p>2. On December 11, 2008 at 11:55 PM,</p>	W 130	<p>Medication cabinet will be moved to another location of the basement which provides privacy to individual. Meanwhile alternative measures are taken to provide privacy until new area is ready.</p>	1-5-09
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W 130	<p>Continued From page 2</p> <p>observations at the day program revealed Client #3 was administered his medication by the day program nurse. Further observations revealed six (6) staffs and fifteen (15) clients were present when the medication was given. Interview with the Support Service Coordinator (SSO) on the same day at approximately 12:20 PM revealed that nurse have always administered Client #3's medication in the classroom. There was no evidence that Client #3 was given the opportunity for privacy during his medication administration.</p> <p>Note: It should be noted that the same nurse that administered Client #3's medication in the group home was the same nurse that administered the Client #3's noon medication at the day program. Additionally, there was a nursing station available within the facility to allow for privacy.</p>	W 130	<p>Day Program director was contacted by the DCHC QMRP and the findings were shared. Please see attached plan of correction. DCHC QMRP and H/M will continue to do a spot check and also quarterly monitoring <i>SEE ATTACHMENT A</i></p>	1-8-09
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W 159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by: Based on observations, interviews with the Qualified Mental Retardation Professional (QMRP) and record review, the QMRP failed to ensure integration, coordination and monitoring of each client's active treatment regimen.</p> <p>The findings include:</p> <p>1. The facility's QMRP failed to ensure the Client #1's bathroom grab bars were installed timely as evidenced below:</p>	W 159	<p>In-service training was given to the QMRP to ensure that in future adaptive equipment are installed in a timely manner as recommended by specialists. Bathroom grab bars were installed on 12-11-08 <i>SEE ATTACHMENT B</i></p>	12-11-08
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W 159 Continued From page 3
On December 12, 2008 at approximately 2:45 PM, interview with the QMRP and the review of the Physical Therapist (PT) assessment dated April 26, 2008 revealed the following recommendation:

It was recommended that two grab bars be installed in the bathroom that Client #1 used for his safety.

- a. 12 inches long vertically
- b. 36 inches long the wall side

It should be noted that during the survey, the wall side grab bars were installed. The installation occurred 8 months after the PT's initial recommendation.

2. The facility's QMRP failed to ensure that the adaptive equipment was maintained in good repair. [See W436]
3. The facility's QMRP failed to ensure that each employee had been provided with adequate training that enabled the employee to perform his or her duties effectively, efficiently and competently. [See W189]
4. The facility's QMRP failed to ensure that data was collected in the form and required frequency. [See W252]

W 159

Please see the answer to W -436

Please see the answer to W-189

Please see the answer to W- 252

W 189 483.430(e)(1) STAFF TRAINING PROGRAM

W 189

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.

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W 189	<p>Continued From page 4</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that each employee had been provided with adequate training that enabled the employee to perform his or her duties effectively, efficiently and competently.</p> <p>The findings include:</p> <p>The facility failed to ensure that staffing supports were implemented as recommended for Client #1 when using the stairs.</p> <p>Observations on December 10, 2008 at approximately 4:32 PM revealed one direct care staff assisted Client #1 with ambulating using a gaitbelt off the van downstairs to the basement. Further observations at approximately 6:37 PM, the direct care staff was observed to use the gaitbelt to assist Client #1 from the living room to the top of the stairs leading to the basement. Client #1 appeared to be unsteady and the gaitbelt appeared to move from his waist up to his chest area.</p> <p>On December 12, 2008 at approximately 3:30 PM, interview with the QMRP and the review of the Physical Therapist (PT) assessment dated April 26, 2008 revealed that Client #1 was recommended to have the following staffing supports:</p> <p>"Client #1 is required minimal to moderate assistance to negotiate the stairs. Two staff members, one in the front and one behind, when [the client] is ascending and descending stairs". At no time during the survey were staff observed</p>	W 189	<p>All direct care staff were in-serviced on 12-17-08 to implement the outlined physical therapist recommendation that, every time client # 1 ambulates ascending and descending stairs two staff should assist him.</p> <p>Please see recent in-service training done on 12-17-08.</p> <p>Q.M.R.P and H.M will continue to monitor and train staff on quarterly basis and as needed.</p> <p><i>SEE ATTACHMENT C1, C2</i></p>	12-17-08
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W 189	Continued From page 5 to provide the recommended support when Client #1 was using the stairs .	W 189		
W 252	<p>483.440(e)(1) PROGRAM DOCUMENTATION</p> <p>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>This STANDARD is not met as evidenced by: Based on observations interview, and record review, the facility failed to ensure that data was collected in the form and required frequency for one of four clients included in the sample. (Client #4)</p> <p>The finding includes:</p> <p>On December 10, 2008 at 5:50 PM, Client #4 was observed sitting on the sofa with his hands inside his pants. The client was encouraged to go upstairs to his bedroom for privacy. At 5:55 PM, Client #4 was observed again with his hands inside his pants and again was verbally prompted to go upstairs to his bedroom by the House Manager (HM). Interview with the HM on the same day at approximately 5:58 PM revealed that public masturbation was one of Client #4's targeted behaviors.</p> <p>On December 12, 2008 at approximately 10:51 AM, review of Client #4's Behavior Support Plan</p>	W 252	<p>DCHC Staff are required to collect Data when ever any Target behavior is observed. Data collection for public masturbation is on ongoing issue with this individual staff are trained about the above. However, there was an oversight on the part of staff. QMRP retrained staff on 12-17-08 to ensure that data is collected each time behavior is observed.</p> <p>In addition the Psychologist In-serviced staff on 1-6-09 about the importance of behavior documentation for every individual in the facility requiring behavior data collection</p> <p><i>SEE ATTACHMENT D1 & D2</i></p>	12-17-08 & 1-6-08

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W 252	Continued From page 6 (BSP) dated February 18, 2008 confirmed that public masturbation was a target behavior. Further review of the BSP revealed that any observation of public masturbation was to be documented as it occurred.	W 252		
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, client and staff interviews, and record review, the facility failed to furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of recommended equipment for two of four clients included in the sample. (Client #1 and #3) The findings include: 1. The facility staff failed to ensure Client #3 was encouraged to wear his prescribed eye glasses as evidenced below. Observations conducted from December 10, 2008 through December 12, 2008 revealed that Client #1 was not encouraged or offered to wear his eye glasses in the facility and/or the day	W 436	An In-service training was given on 1-6-09 to the staff to ensure that client# 3 wears his eye glasses during awakening hours. A form has been developed for staff to document the frequency of refusing to put on the glasses. The same will be shared with the day program. SEE ATTACHMENT E14 E2	1-06-09

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W 436	<p>Continued From page 7 program.</p> <p>Interview with the House Manager and Qualified Mental Retardation Professional (QMRP) on December 11, 2008 at approximately 2:30 PM revealed that Client #3 had eye glasses that were to be worn at the day program and when reading. Further interview with the QMRP at 3:14 PM revealed that Client #3 often refused to wear his glasses. When the surveyor asked to see documentation to verify Client #1's refusals, the QMRP was not able to provide any data.</p> <p>Review of Client #1's medical record conducted on December 11, 2008 at 2:58 PM revealed a "Protocol for Adaptive Equipment" dated December 1, 2008. According to the protocol, Client #3 was to wear his eye glasses during the daytime, afternoon, and evenings with the exception of shower/bedtime. Further review of the protocol revealed that "the client should be encouraged to wear his eye glasses because he usually doesn't want to wear them".</p> <p>2. The facility failed to ensure that Client #1's gaitbelt was maintained in good repair.</p> <p>Evening observations on December 10, 2008 from 4:32 PM to 7:05 PM, revealed the direct care staff had difficulty assisting Client #1 with ambulating using his gaitbelt as evidenced below:</p> <p>At approximately 4:32 PM, the direct care staff was observed to use Client #1's gaitbelt to assist him in ambulating from the van and downstairs to the basement. The gaitbelt appeared to be loose.</p> <p>At approximately 4:44 PM, the direct care staff was observed to use the gaitbelt to assist Client</p>	W 436	<p>Two new gait belts which fit comfortably around the client's waist without moving up to his chest were obtained. On 12-11-08, the facility also obtained an extra gait belt as a back up</p>	12-11-08
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W 436	<p>Continued From page 8</p> <p>#1 to the bathroom. The gaitbelt was observed to move from around his waist up to his chest.</p> <p>At approximately 6:22 PM, the direct care staff was observed to use the gaitbelt to assist Client #1 from the dining room into the living room. The gaitbelt was observed to be loose.</p> <p>At approximately 6:37 PM, the direct care staff was observed to use the gaitbelt to assist Client #1 from the living room to the top of the stairs leading to the basement. Client #1 appeared to be unsteady and the gaitbelt appeared to move from his waist up to his chest area.</p> <p>Observation at the day program on December 11, 2008 at approximately 10:54 AM, revealed Client #1 sitting at the table with his peers. Further observation revealed there were four knots tied in Client #1's gaitbelt.</p> <p>Interview with the day program staff and day program coordinator at approximately 10:58 AM revealed that Client #1 used the gaitbelt for ambulation. Further interview with the day program staff revealed the client had an unsteady gait when he ambulated and it was a safety support.</p> <p>Interview with the QMRP at approximately 3:05 PM revealed that the client had two gaitbelts. The QMRP escorted the surveyor into Client #1's bedroom and the QMRP removed a gaitbelt from the closet. According to the QMRP, the gaitbelt was Client #1's back up. Further interview revealed that the back up belt had no safety buckle and was missing one hand strap. According to the QMRP the client was in need of two new gaitbelts.</p>	W 436		
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W 440	<p>483.470(i)(1) EVACUATION DRILLS</p> <p>The facility must hold evacuation drills at least quarterly for each shift of personnel.</p> <p>This STANDARD is not met as evidenced by: Based on interview and the review of fire drill reports, the facility failed to hold evacuation drills at least quarterly for each shift of personnel.</p> <p>The finding includes:</p> <p>Interview with the House Manager on December 10, 2008 at 1:44 PM revealed the facility had three shifts of direct care personnel. The shifts were identified as weekdays 6:30 AM - 10:30 AM, 2:30 PM - 10:30 PM, and 10:30 PM - 6:30 PM and on weekends were the same as the weekdays shifts.</p> <p>Review of the fire drill reports from September 2008 to November 2008 revealed that no fire drills were conducted during the 10:30 PM - 6:30 AM shifts during the week. Interview with the Qualified Mental Retardation Professional (QMRP) on December 12, 2008 at approximately 2:15 PM acknowledged that fire drills were not conducted during this shift. At the time of the survey, the facility failed to provide evidence of fire drills conducted quarterly as required.</p>	W 440	<p>An In-service training was done on 12-10-08 discussing the importance of fire drills, Q.M.R.P and program manager will make sure that each shift does the fire drill at least once every quarter Identifying the time, what the individuals were doing, how the weather was etc. SEE ATTACHMENT F1 & F2</p>	12-10-08
W 455	<p>483.470(l)(1) INFECTION CONTROL</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record</p>	W 455		

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W 455	<p>Continued From page 10</p> <p>review, the facility failed to ensure effective infection control procedures were implemented for one of four clients included in the sample. (Client #1)</p> <p>The finding includes:</p> <p>The facility failed to ensure that the day program staff encourage client to wash their hands before meals.</p> <p>Observations conducted at the day program on December 11, 2008 at 12:23 PM revealed Client #1 was served chopped hamburger, rice, string beans, bread, and a beverage while sitting at the table. The client was observed to use his fingers to push the remaining food onto the spoon. At no time was Client #1 encouraged to wash his hands prior to food consumption. Interview with the day program's Service Support Coordinator (SSC) on the same day at approximately 12:30 PM acknowledged that Client #1 did not wash his hands prior to eating.</p>	W 455	<p>Day Program director was contacted by DC Healthcare QMRP and the findings were shared. Staff training on infection control / handwashing techniques was done on 1-8-09 by UCP training coordinator. Please see attached. DCHC QMRP and H. Manger will continue to do a sport check and also quarterly monitoring.</p> <p><i>SEE ATTACHMENT 91492</i></p>	1-8-09
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Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0094	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/12/2008
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NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1938 FIRST STREET NW WASHINGTON, DC 20001
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1 000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from December 10, 2008 through December 12 2008. The survey was initiated using the fundamental survey process. A random sample of four residents was selected from a resident population of eight males with various disabilities.</p> <p>The findings of the survey were based on observations at the group home and three day programs, interviews with management and direct care staff in the residence and the review of the administrative records including the facility's incident management system.</p>	1 000		
1 081	<p>3503.9 BEDROOMS AND BATHROOMS</p> <p>Each bathroom shall be equipped to facilitate training toward maximum self-help by residents including individuals with physical disabilities and shall have appliances, fixtures or devices which shall be appropriate to the needs of each person who lives and works in the</p> <p>This Statute is not met as evidenced by: Based on observation, the GHRMP failed to ensure each bathroom was equipped with appliances, fixtures or devices that were appropriate to the needs of each person who lived and worked in home.</p> <p>The finding includes:</p> <p>On December 12, 2008 at approximately 2:45 PM, interview with the QMRP and the review of the Physical Therapist (PT) assessment dated April 26, 2008 revealed the following recommendation:</p>	1 081	<p>In-service training was given to the QMRP to ensure that in future adaptive equipment are installed in a timely manner as recommended by specialists. Bathroom grab bars were installed on 12-11-08</p> <p>SEE ATTACHMENT B</p>	1-8-09

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Erney Stephen* TITLE: *President* (X6) DATE: *1/9/09*

Health Regulation Administration

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I 081	Continued From page 1 It was recommended that two grab bars be installed in the bathroom that Client #1 used for his safety. a. 12 inches long vertically b. 36 inches long the wall side It should be noted that during the survey, the wall side grab bars were installed. The installation occurred 8 months after the PT's initial recommendation.	I 081		
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 GHMRP failed to ensure that the residence was maintained safe, clean, attractive and sanitary manner and free from an accumulation of dirt. The findings include: Internal 1. A long nail was observed protruding from the left side of the dinning room chair. 2. A shower chair observed in the main level bathroom was observed worn and had loose leg supports. 3. The leather furniture in the basement had	I 090 I090/1 I090/2 I090/3	Protruding nail from the dinning room chair was fastened on 12-16-08. H/M and Q.M.R.P will do a monthly or as needed maintenance check within the facility to ensure all the items with the facility are in good repair. The worn shower chair was discarded on 12-11-08 and was replaced by a new shower chair on the same day. The H/M and the Q.M.R.P will continue to monitor facilities adaptive comments on a monthly basis or sooner if needed. The leather furniture is in the basement will either be replaced with a new cushion or the whole furniture will be replaced by 2-15-09.	12-16-08 12-11-08 2-15-09

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I 090	Continued From page 2 ripped cushions.	I 090		
I 135	<p>3505.5 FIRE SAFETY</p> <p>Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift.</p> <p>This Statute is not met as evidenced by: Based on interview and the review of fire drill reports, the GHMRP failed to hold evacuation drills at least quarterly for each shift of personnel.</p> <p>The finding includes:</p> <p>Interview with the House Manager on December 10, 2008 at 1:44 PM revealed the GHMRP had three shifts of direct care personnel. The shifts were identified as weekdays 6:30 AM - 10:30 AM, 2:30 PM - 10:30 PM, and 10:30 PM - 6:30 PM and on weekends were the same as the weekdays shifts.</p> <p>Review of the fire drill reports from September 2008 to November 2008 revealed that no fire drills were conducted during the 10:30 PM - 6:30 AM shifts during the week. Interview with the Qualified Mental Retardation Professional (QMRP) on December 12, 2008 at approximately 2:15 PM acknowledged that fire drills were not conducted during this shift. At the time of the survey, the GHRMP failed to provide evidence of fire drills conducted quarterly as required.</p>	I 135	<p>An In-service training was done on 12-10-08 discussing the importance of fire drills, Q.M.R.P and program manager will make sure that each shift does the fire drill at least once every quarter Identifying the time, what the individuals were doing, how the weather was etc. SEE ATTACHMENT F1a2</p>	12-10-08
I 203	<p>3509.3 PERSONNEL POLICIES</p> <p>Each supervisor shall discuss the contents of job descriptions with each employee at the beginning</p>	I 203		

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I 203	<p>Continued From page 3</p> <p>employment and at least annually thereafter.</p> <p>This Statute is not met as evidenced by: Based on annual review of personnel records, the GHMRP failed to have on file job descriptions for all employees.</p> <p>The findings include:</p> <p>Review of the personnel files conducted on December 11, 2008 revealed the GHMRP failed to provide evidence of annually signed job descriptions for two(2) direct care staff. (Staff #1 and #2)</p>	I 203	<p>The two direct care staff in question signed their job description on 12-30-08- (Please see attached) <i>H1 & H2</i></p>	12-30-08
I 222	<p>3510.3 STAFF TRAINING</p> <p>There shall be continuous, ongoing in-service training programs scheduled for all personnel.</p> <p>This Statute is not met as evidenced by: Based on observations, interview and record verification, the GHMRP failed to ensure continuous, ongoing in-service training programs were conducted for all personnel.</p> <p>The findings include:</p> <p>The GHRMP failed to ensure that staffing supports were implemented as recommended for Resident #1 when using the stairs.</p> <p>Observations on December 10, 2008 at approximately 4:32 PM revealed one direct care staff assisted Resident #1 with ambulating using a gaitbelt off the van downstairs to the basement. Further observations at approximately 6:37 PM, the direct care staff was observed to use the gaitbelt to assist Resident #1 from the living room to the top of the stairs leading to the basement.</p>	I 222	<p>All direct care staff were in-serviced on 12-17-08 to implement the outlined physical therapist recommendation that, every time client # 1 ambulates ascending and descending stairs two staff should assist him. Please see recent in-service training done on 12-17-08. Q.M.R.P and H.M will continue to monitor and train staff on quarterly basis and as needed. <i>SEE ATTACHMENT C14C2</i></p>	12-17-08

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I 222	<p>Continued From page 4</p> <p>Resident #1 appeared to be unsteady and the gaitbelt appeared to move from his waist up to his chest area.</p> <p>On December 12, 2008 at approximately 3:30 PM, interview with the QMRP and the review of the Physical Therapist (PT) assessment dated April 26, 2008 revealed that Resident #1 was recommended to have the following staffing supports:</p> <p>"Resident #1 is required minimal to moderate assistance to negotiate the stairs. Two staff members, one in the front and one behind, when [the resident] is ascending and descending stairs". At no time during the survey were staff observed to provide the recommended support when Resident #1 was using the stairs .</p> <p>Further interview with the QMRP revealed that staff had been trained by the PT. Review of the in-service training log however, failed to confirm that this training had been conducted.</p>	I 222		