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

PRINTED: 07/20/2011
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
	09G183		07/08/2011

NAME OF PROVIDER OR SUPPLIER: D C HEALTH CARE

STREET ADDRESS, CITY, STATE, ZIP CODE: 248 WALNUT STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS	W 000		
	A recertification survey was conducted from 7/6/2011 through 7/8/2011. The survey was completed utilizing the fundamental survey process. A random sampling of three clients was selected from a residential population of six males with varying degrees of disabilities.		7/29/11 Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002	
	The findings of the survey were based on observations and interviews in the home and at one day program, as well as a review of the client and administrative records, including the incident reports.			
W 156	483.420(c)(4) STAFF TREATMENT OF CLIENTS	W 156		
	The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.			
	This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure all investigations into serious reportable incidents were completed within five working days for one of six clients residing in the facility. [Client #4]		The mentioned incident was followed up and investigated by D.C.H.C. incident management team. However, as per D.O.H regulations all incidents have to be investigated within 5 working days which was an oversight. We as a provider agency are overwhelmed with D.D.S every day changing regulation and requirements which diverted our attention. A meeting with Incident Management coordinator was held on 07/21/11 and from now on preliminary investigation will be completed within 5 working days and final report will be completed on or before 25 days. D.C.H.C - policy was also revised to meet both requirements-(D.O.H & D.D.S) Please See Attachment "A"	07/21/11
	The finding includes:			
	Review of Client #4 's records on 7/6/2011 at 12:37 p.m. revealed he was taken to a local hospital for emergent care on 2/1/2011 due to breathing difficulties. The facility 's log/incident report identified this occurrence as a " serious reportable " event. Further review of this client 's records on the same day at approximately			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mamta Tiwari | TITLE: Deputy Director DCHC | (X6) DATE: 7/29/11

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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	09G163		07/08/2011

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W 156	Continued From page 1 12:44 p.m. revealed the investigation was completed on 2/28/2011. Interview with the facility's Qualified Intellectual Disability Professional (QIDP) on 7/6/2011 at approximately 12:45 p.m. confirmed the date of the investigation was 2/28/2011. The facility failed to ensure all investigations were completed within five working days as required by this section.	W 156		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's Qualified Intellectual Disability Professional (QIDP) failed to ensure the coordination of services to promote the health and safety of three of three sampled clients. [Clients #1, #2 and #3] The findings include: 1. The QIDP failed to ensure all investigations into serious reportable incidents were completed within five working days for one of six clients residing in the facility. [See W156] 2. The QIDP failed to ensure all staff was competent in implementing clients' behavior support plans for one of the three sampled clients. [See W193]	W 159	1. Please see answer to W-156 on page 1 of 11. 2. Please see answer to W-193 on page 4 of 11.	07/21/11 07/11/11

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W 159	Continued From page 2	W 159		
	3. The QIDP failed to ensure the consistent implementation of a client's communication program for one of three sampled clients. [See W194]		3. Please see answer to W-194 on page 5 of 11.	07/12/11
	4. The QIDP failed to ensure the implementation of a client's communication program for one of three sampled clients. [See W249]		4. Please see answer to W-194 on page 5 of 11.	07/12/11
	5. The QIDP failed to ensure staff collected accurate data on a client's behavior support plan for one of three sampled clients. [See W252]		5. Please see answer to W-193 on page 4 of 11.	07/11/11
	6. The QIDP failed to ensure clients utilized their prescribed adaptive equipment as prescribed for one of three sampled clients. [See W436]		6. Please see answer to W-436 on page 10 of 11.	07/12/11
W 193	483.430(e)(3) STAFF TRAINING PROGRAM	W 193		
	Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.			
	This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure all staff were competent in implementing clients' behavior management protocols for one of three sampled clients. [Client #1]			
	The finding includes:			
	Observation on 7/6/2011 at 5:34 p.m. revealed Client #1 was chewing small sections of material he was able to tear away from the heel tab of his right shoe. Client #1 was observed taking the			

		W-159		
		1.	The mentioned incident was followed up and Investigated by D.C.H.C. incident management team. However, as per D.O.H regulations all incidents have to be investigated within 5 working days which was an oversight. We as a provider agency are overwhelmed with D.D.S every day changing regulation and requirements which diverted our attention. A meeting with Incident Management coordinator was held on 07/21/11 and from now on preliminary investigation will be completed within 5 working days and final report will be completed on or before 25 days. D.C.H.C - policy was also revised to meet both requirements- (D.O.H & D.D.S) (Please see Attachment "A")	07/21/11
		2.	An In-Service training was done with all Direct Care Staff, House Manager and QMRP on 07-11-11 by the psychologist regarding Client #1's behavior and data collection. The Q.I.D.P & House Manager will monitor the above daily and re-train staff on a quarterly basis or sooner if needed. The Program Manager will check program implementation on routine visits. Staff will be quizzed and role play will be done to make sure every one understands and implements the program properly. (Please see Attachment # B)	07/11/11
		3.	An In-Service training was done on 07-12-11 by Speech Pathologist for all staff, House Manager and Q.I.D.P regarding the implementation and documentation of IPP programs. The QIDP/House Manager will ensure that all programs are implemented and documented daily. Staff will be re-trained on a quarterly basis or earlier if needed. Program Manager will check the above on her routine visits. (Please see Attachment "D1 & D2")	07/12/11

		4.	An In-Service training was done on 07-12-11 by Speech Pathologist for all staff, House Manager and Q.I.D.P regarding the implementation and documentation of IPP programs. The QIDP/House Manager will ensure that all programs are implemented and documented daily. Staff will be re-trained on a quarterly basis or earlier if needed. Program Manager will check the above on her routine visits. (Please see Attachment "D2")	07/12/11
		5.	An In-Service training was done with all Direct Care Staff, House Manager and QMRP on 07-11-11 by the psychologist regarding Client #1's behavior and data collection. The Q.I.D.P & House Manager will monitor the above daily and re-train staff on a quarterly basis or sooner if needed. The Program Manager will check program implementation on routine visits. Staff will be quizzed and role play will be done to make sure every one understands and implements the program properly. (Please see Attachment # B)	07/11/11
		6.	An In-Service training was done with all the 07-12-11. Direct Care Staff on 07-12-11 regarding use of adaptive equipment. (Individuals #2'c neck collar). The QIDP and the House Manager will monitor on a daily basis to ensure the proper use of the Neck Collar (on 2 hours & off 1 hour during awakening hours). Also, Program Manager will check the above on her routine visit to the facility to ensure that adaptive equipment are used properly and effectively in conjunction with prescribed treatment plan. (Please See Attachment # C)	07/12/11

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W 193	Continued From page 3 material out of his mouth and manipulating them in his hands on three occasions within a ten to fifteen minute period as he sat in the living room waiting for the evening medication pass and dinner. Staff was present and observed the client's behavior and failed to intervene. Record review on 7/8/2011 at 2:23 p.m. revealed his Behavior Support Plan (BSP) dated 2/11/2011 recommended, " [Client #1] requires a behavior support plan to address clothes ripping, chewing inedible objects and agitation ... " The plan goes on to outline that staff should provide a verbal redirection when they observe him ripping clothes and to provide a physical prompt if the verbal redirection was ineffective. The plan further delineates that staff should have Client #1 place his hands in his lap for two minutes if the verbal redirection was ineffective. Finally, the intervention requires that after ten minutes, Client #1 should be provided an activity that allows him to use his hands in a constructive manner and to be rewarded for it afterwards. Additional review of the plan revealed a similar intervention strategy was in place to address him " chewing inedible objects " as well. Neither of these two interventions was implemented by the staff on the evening of 7/6/2011. Interview with the facility's Qualified Intellectual Disability Professional (QIDP) on 7/8/2011 at approximately 2:28 p.m. confirmed the facility's staff should always implement the behavior support plan whenever Client #1 begins to rip any clothing and chewing of inedible objects. The QIDP also indicated she would ensure staff received additional training to manage Client #1's maladaptive behaviors.	W 193	An In-Service training was done with all Direct Care Staff, House Manager and QMRP on 07-11-11 by the psychologist regarding Client #1's behavior and data collection. The Q.I.D.P & House Manager will monitor the above daily and re-train staff on a quarterly basis or sooner if needed. The Program Manager will check program implementation on routine visits. Staff will be quizzed and role play will be done to make sure every one understands and implements the program properly. (See Attachment # B)	07/11/11

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W 193	Continued From page 4	W 193		
	The facility failed to ensure staff was effectively trained to manage Client #1 's maladaptive behaviors as outlined in his behavior support plan.			
W 194	483.430(e)(4) STAFF TRAINING PROGRAM	W 194		
	Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible.			
	This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to demonstrate the skills necessary to ensure the consistent implementation of a client's communication program for one of three sampled clients. [Client #3]			
	The findings includes:		An In-Service training was done on 07-12-11 by Speech Pathologist for all staff, House Manager and Q.I.D.P regarding the implementation and documentation of IPP programs.	07-12-11
	[Cross Reference W249]		The QIDP/House Manager will ensure that all programs are implemented and documented daily. Staff will be re-trained on a quarterly basis or earlier if needed. Program Manager will check the above on her routine visits. (Please See Attachment "D1, D2")	
	Observation on 7/6/2011 beginning at 4:26 p.m. revealed the facility's staff failed to implement Client #3's communication program. Record review on 7/8/2011 at 1:55 p.m. revealed his Speech and Language Pathology (SLP) assessment dated 8/16/2010 recommended that "[Client #3] should receive training on his communication goal." Interview with the Qualified Intellectual Disability Professional (QIDP) on 7/8/2011 at approximately 2:22 revealed she drafted the written plan to take place daily and ensured the staff received training on the written plan.			

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W 194	Continued From page 5	W 194		
	The facility staff failed to demonstrate the skills necessary to consistently implement Client #3 's communication program.			
W 249	483.440(c)(1) PROGRAM IMPLEMENTATION	W 249		
	As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.			
	This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to implement a client's communication program for one of three sampled clients. [Client #3]			
	The finding includes:			
	Observation on 7/6/2011 beginning at 4:26 p.m. revealed Client #3 would vocalize and gesture to staff on several occasions throughout the evening as a means of communication. Throughout the survey, his attempts at communication were not always consistently understood by staff.		An In-Service training was done on 07-12-11 by Speech Pathologist for all staff, House Manager and Q.I.D.P regarding the implementation and documentation of IPP programs.	07-12-11
	Record review on 7/8/2011 at 1:55 p.m. revealed his Speech and Language Pathology (SLP) assessment dated 8/16/2010 recommended that " [Client #3] should receive training on his communication goal. " The plan outlines that when Client #3 arrives home from his day		The QIDP/House Manager will ensure that all programs are implemented and documented daily. Staff will be re-trained on a quarterly basis or earlier if needed. Program Manager will check the above on her routine visits. (Please See Attachment "D1, D2")	

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W 249	Continued From page 6 program, he should be provided a " picture schedule related to his afternoon routine. " The plan goes on to provide direction for how staff should review the picture schedule based on the afternoon activity he was engaged in. The written data collection sheets for this program indicate the plan should be implemented daily. This programmatic intervention was not observed being implemented during the survey. Interview with the facility ' s Qualified Intellectual Disability Professional (QIDP) on 7/8/2011 at approximately 2:22 p.m. confirmed the facility ' s staff was not implementing this plan as written. The QIDP also indicated she would ensure staff received additional training on this program to ensure the improvement of Client #3 ' s communication skills. The facility failed to ensure Client #3 ' s communication plan was implemented as written.	W 249		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure staff collected accurate data on a client ' s behavior support plan for one of three sampled clients. [Client #1] The findings includes:	W 252		

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W 252	Continued From page 7 [Cross Reference W193] Record review on 7/8/2011 at approximately 2:25 p.m. revealed the facility's staff documented that Client #1 exhibited none of his targeted maladaptive behaviors of clothes ripping, eating inedible objects and agitation on the evening of 7/6/2011. On 7/6/2011 at 4:46 p.m. Client #1 was observed vocalizing loudly, foot stomping and slapping the right side of his face with his right hand on no less than six occasions. He was also observed ripping parts of his shoe off and chewing it later on that evening. Interview with the facility's Qualified Intellectual Disability Professional (QIDP) on 7/8/2011 at approximately 2:29 p.m. confirmed the facility's staff should always document his behavior whenever Client #1 begins to rip any clothing, chew inedible objects, or exhibit any agitation. The QIDP also indicated she would ensure staff received additional training to manage Client #1's maladaptive behaviors. The facility failed to ensure staff was effectively trained to document Client #1's maladaptive behaviors as outlined in his behavior support plan.	W 252	An In-Service training was done with all Direct Care Staff, House Manager and QMRP on 07-11-11 by the psychologist regarding Client #1's behavior and data collection. The Q.I.D.P & House Manager will monitor the above daily and re-train staff on a quarterly basis or sooner if needed. The Program Manager will check program implementation on routine visits. Staff will be quizzed and role play will be done to make sure every one understands and implements the program properly. (See Attachment # B)	07-11-11
W 383	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the security of the	W 383		

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W 383	Continued From page 8 medication cabinet as required for six of six clients residing in the facility. [Clients #1, #2, #3, #4, #5, #6] The finding includes: Observation on 7/7/2011 at 12:40 p.m., revealed the facility's Qualified Intellectual Disability Professional (QIDP) was able to access the locked medication cabinet to procure the current MARs for review by this surveyor. Interview with the QIDP on 7/7/2011 at approximately 12:41 p.m. confirmed she had access to the medication cabinet and that she was not a nurse nor was she a certified Trained Medication Employee (TME). The facility failed to ensure only authorized personnel had access to the medication storage area.	W 383	An In-Service training was done on 07/22/11 with D.C.H.C Q.M.R.P/House Manager regarding medication and medication cabinet. Under no circumstances they are to open medicine cabinet unless they have license to do so. Staff in question is undergoing T.M.E. training and has been practicing medication administration skills in the presence of R.N. (that is how she had learned to access the med cabinet) However, she has not yet received her licence therefore, she should have not even approached the medicine cabinet. A written warning was given to involved staff. Medication cabinet lock was changed and supervisory R.N's will make sure not to use actual med cabinet for training purposes. D.C.H.C will make sure this kind of incidents do not happen ever in the future by making sure that only licensed people have access. (Please see attachment "E")	07/22/11
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 review; the facility failed to ensure clients utilized their prescribed adaptive equipment as prescribed for one of three sampled clients. [Client #2] The finding includes:	W 436		

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W 436	Continued From page 9 Observation on 7/6/2011 beginning at 4:26 p.m. revealed Client #2 arrived home from his day program wearing a soft (cream colored) collar as he was being escorted into the facility by his attending staff. Client #1 was later observed throughout the evening having a snack, resting in a recliner in the living room and later eating dinner. The collar was removed for a brief two minute period by the Qualified Intellectual Disability Professional (QIDP) when she was trying to explain to this surveyor the purpose of the collar. She indicated he wore it to help support his head, due to his lack of neck strength to keep his head in an upright position. Client #2 was observed wearing the collar for the remainder of the evening. Record review on 7/8/2011 at 1:31 p.m. revealed Client #2 's Physical Therapy assessment dated 2/16/2011 recommended that " [Client #2] should continue to use the soft cervical collar for two hours and have it removed for one hour. The staff will check for red areas around his neck after removal of the collar. " Further observation on 7/8/2011 beginning at approximately 1:32 p.m. confirmed the facility was not effectively managing the use of Client #1 's collar. Client #2 was observed wearing the soft collar up until approximately 4:55 p.m., and it was never observed to be removed from his neck. Interview with the facility 's Qualified Intellectual Disability Professional (QIDP) on 7/8/2011 at approximately 5:05 p.m. confirmed the facility 's staff should have implemented the treatment plan	W 436	An In-Service training was done with all the Direct Care Staff on 07-12-11 regarding use of adaptive equipment. (Individuals #2'c neck collar). The QIDP and the House Manager will monitor on a daily basis to ensure the proper use of the Neck Collar (on 2 hours & off 1 hour during awakening hours). Also, Program Manager will check the above on her routine visit to the facility to ensure that adaptive equipment are used properly and effectively in conjunction with prescribed treatment plan. (Please See Attachment "C")	07-12-11

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W 436	Continued From page 10 outlined by the Physical Therapist for the use of the soft collar. The QIDP further indicated that she would have the staff take part in additional training to ensure the effective use of Client #2 's collar. The facility failed to ensure Client #2 's collar was being utilized as prescribed to ensure his health and safety.	W 436		

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0188	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/08/2011
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 000	INITIAL COMMENTS A random sampling of three residents was selected from a residential population of six males with varying degrees of disabilities. The findings of the survey were based on observations and interviews in the home and at one day program, as well as a review of the resident and administrative records, including the incident reports.	I 000		
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 staff interview, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure the facility's environment was maintained as required to ensure the health and safety of six of six residents. [Residents #1, #2, #3, #4, #5, and #6] The findings include: Observation and interview with the facility's maintenance personnel on 7/6/2011 beginning at 2:20 p.m. revealed the following deficient conditions: 1. The tile and edges around the hall bath between Resident #2 and Resident #3's bedroom was observed to have black, brown and rust colored stains around the caulking points. The tiling along the back wall was also broken	I 090	1. The black, brown and rust colored strains around the tile and edges of the hall bathroom tub was removed and tiling along the back wall which was broken was repaired on 07-06-11 during the inspection. The QIDP and the House Manager will ensure that all repairs are maintained and areas are clean without any deposits on daily basis.	07-06-11

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I 090	Continued From page 1 along the caulking line and appeared to be coming off the walls exposing the grout behind it. 2. The exterior venting hole from the dryer in the basement appeared to be filled with lint and it was not properly capped to prevent vermin from using it as an entry point into the facility. 3. The gutters around the roofline appeared to be filled with debris, twigs and branches. One portion of the roof near the rear of the facility was overrun with fallen branches, twigs and leaves which overflowed into the gutters on that part of the roof line.	I 090 2.	Lint from the exterior venting hole of the dryer in the basement was removed and it was capped on 07-06-11.The QIDP and the House Manager will check on a weekly basis and remove any lint or foreign objects present. Also will monitor that the vent has a proper fitted cap to prevent any vermin to enter the vent. Also, maintenance person is to check these on a monthly basis.	07/06/11
		3.	All the Debris, twigs and branches that filled the gutters around the roof line were removed and cleaned and the branches of the trees near the roof line were cut and removed on 07-07-11. Maintenance person will check the gutters on a monthly basis (except winter time).	07/07/11
I 183	3508.4 ADMINISTRATIVE SUPPORT Each GHMRP shall have a Residence Director who meets the requirements of § 3509.1 and who shall manage the GHMRP in accordance with approved policies and this chapter. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility's Qualified Intellectual Disability Professional (QIDP) failed to ensure the coordination of services to promote the health and safety of three of three sampled residents [Residents #1, #2 and #3] The findings include: 1. The QIDP failed to ensure all investigations into serious reportable incidents were completed within five working days for one of six residents residing in the facility. [See W156] 2. The QIDP failed to ensure all staff was competent in implementing residents' behavior support plans for one of the three sampled	I 183 3.		
		1.	Please see answer on W-156 on page 1 of 11	07/21/11
		2.	Please see answer on W-193 on page 4 of 11	07/11/11

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I 183	Continued From page 2 residents. [See W193]	I 183		
	3. The QIDP failed to ensure the consistent implementation of a resident's communication program for one of three sampled residents. [See W194]	3	Please see answer on W-194 on page 5 of 11	07/12/11
	4. The QIDP failed to implement a resident's communication program for one of three sampled residents. [See W249]	4.	Please see answer on W-194 on page 5 of 11	07/12/11
	5. The QIDP failed to ensure staff collected accurate data on a resident's behavior support plan for one of three sampled residents. [See W252]	5.	Please see answer on W-193 on page 4 of 11	07/12/11
	6. The QIDP failed to ensure residents utilized their prescribed adaptive equipment as prescribed for one of three sampled residents. [See W436]	6.	Please see answer on W-436 on page 10 of 11	07/12/11
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure staff was effectively trained to implement a resident's behavior support plan, communication program and use of adaptive equipment for three of three sampled residents. [Residents #1, #2	I 229		

		I-183		
		1.	The mentioned incident was followed up and Investigated by D.C.H.C. incident management team. However, as per D.O.H regulations all incidents have to be investigated within 5 working days which was an oversight. We as a provider agency are overwhelmed with D.D.S every day changing regulation and requirements which diverted our attention. A meeting with Incident Management coordinator was held on 07/21/11 and from now on preliminary investigation will be completed within 5 working days and final report will be completed on or before 25 days. D.C.H.C - policy was also revised to meet both requirements- (D.O.H & D.D.S) (Please see Attachment "A")	07/21/11
		2.	An In-Service training was done with all Direct Care Staff, House Manager and QMRP on 07-11-11 by the psychologist regarding Client #1's behavior and data collection. The Q.I.D.P & House Manager will monitor the above daily and re-train staff on a quarterly basis or sooner if needed. The Program Manager will check program implementation on routine visits. Staff will be quizzed and role play will be done to make sure every one understands and implements the program properly. (Please see Attachment # B)	07/11/11
		3.	An In-Service training was done on 07-12-11 by Speech Pathologist for all staff, House Manager and Q.I.D.P regarding the implementation and documentation of IPP programs. The QIDP/House Manager will ensure that all programs are implemented and documented daily. Staff will be re-trained on a quarterly basis or earlier if needed. Program Manager will check the above on her routine visits. (Please see Attachment "D1 & D2")	07/12/11

		4.	An In-Service training was done on 07-12-11 by Speech Pathologist for all staff, House Manager and Q.I.D.P regarding the implementation and documentation of IPP programs. The QIDP/House Manager will ensure that all programs are implemented and documented daily. Staff will be re-trained on a quarterly basis or earlier if needed. Program Manager will check the above on her routine visits. (Please see Attachment "D2")	07/12/11
		5.	An In-Service training was done with all Direct Care Staff, House Manager and QMRP on 07-11-11 by the psychologist regarding Client #1's behavior and data collection. The Q.I.D.P & House Manager will monitor the above daily and re-train staff on a quarterly basis or sooner if needed. The Program Manager will check program implementation on routine visits. Staff will be quizzed and role play will be done to make sure every one understands and implements the program properly. (Please see Attachment # B)	07/11/11
		6.	An In-Service training was done with all the 07-12-11. Direct Care Staff on 07-12-11 regarding use of adaptive equipment. (Individuals #2'c neck collar). The QIDP and the House Manager will monitor on a daily basis to ensure the proper use of the Neck Collar (on 2 hours & off 1 hour during awakening hours). Also, Program Manager will check the above on her routine visit to the facility to ensure that adaptive equipment are used properly and effectively in conjunction with prescribed treatment plan. (Please See Attachment # C)	07/12/11

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I 229	Continued From page 3 and #3] The findings includes: 1. [See Federal Deficiency Citation W193] The Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure staff was effectively trained to implement Resident #1 's behavior support plan to address his targeted maladaptive behaviors of clothes ripping, eating inedible objects, and agitation. 2. [See Federal Deficiency Citation W194] The GHPID failed to ensure staff demonstrated the skills necessary to ensure the consistent implementation of a resident ' s communication program for one of three sampled residents. 3. [See Federal Deficiency Citation W436] The GHPID failed to ensure staff was effectively trained to utilize Resident #2 ' s supportive neck collar to ensure the proper support of his head and neck throughout the course of the day.	I 229	1. An In-Service training was done with all Direct Care Staff , House Manager and QMRP on 07-11-11 by the psychologist regarding Client #1's behavior and data collection. The Q.I.D.P & House Manager will monitor the above daily and re-train staff on a quarterly basis or sooner if needed. The Program Manager will check program implementation on routine visits. Staff will be quizzed and role play will be done to make sure every one understands and implements the program properly. (See Attachment # B)	07-11-11
			2. An In-Service training was done on 07-12-11 by Speech Pathologist for all staff, House Manager and Q.I.D.P regarding the implementation and documentation of IPP programs. The QIDP/House Manager will ensure that all programs are implemented and documented daily. Staff will be re-trained on a quarterly basis or earlier if needed. Program Manager will check the above on her routine visits. (Please See Attachment "D1, D2")	07-12-11
			3. An In-Service training was done with all the Direct Care Staff on 07-12-11 regarding use of adaptive equipment. (Individuals #2's neck collar). The QIDP and the House Manager will monitor on a daily basis to ensure the proper use of the Neck Collar (on 2 hours & off 1 hour during awakening hours). Also, Program Manager will check the above on her routine visit to the facility to ensure that adaptive equipment are used properly and effectively in conjunction with prescribed treatment plan. (Please See Attachment "C")	07-12-11