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

PRINTED: 11/21/2008
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
	09G123	A. BUILDING _____ B. WING _____	11/05/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
I D I	491 53RD STREET, SE WASHINGTON, DC 20019

(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 I. A recertification survey was conducted from 11/3/2008, through 11/5/2008. The survey was initiated utilizing the fundamental survey process, but it was later extended in the condition of Health Care Services. The facility was found to have failed in meeting the condition of participation in Client Protections. Eight female clients with varying degrees of disabilities reside in this facility. Four of the eight clients were randomly selected for the sample. 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. Observations at the day program on the afternoon of 11/4/2008 resulted in a situation of an Immediate Jeopardy (IJ) with regards to client feeding and serving of proper food textures. The facility was notified of the emergent situation at 4:30pm and immediate steps were taken by the facility to ensure the health and safety of Client #3. As such, the IJ was lifted by the facility enacting a plan and implementing the following corrective measures: 1. The director of Residential Services along with the Director of Nursing, and the Qualified Mental Retardation Professional (QMRP) will conduct a site visit on 11/6/2008. 2. The facility ' s staff will be provided all the necessary training onsite at the day program as needed/warranted.	W 000		

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

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days wing 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 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ram participation.

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

PRINTED: 11/21/2008
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
	09C123	A. BUILDING _____ B. WING _____	11/05/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	431 49RD STREET, SE WASHINGTON, DC 20019

(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	Continued From page 1 3. Client #3 will remain home from her day program until further notice and the day program staff is able to demonstrate the skills and competency needed to implement the meal time protocol. 4. A case conference will be scheduled to determine further actions and/or follow-up to ensure safe feeding practices at the day program. II. On 11/1/2008, the State Agency (SA) was notified via telephone by the facility ' s Program Director (PD) of the death of Client #1. According to the information presented by the PD, Client #1 had been hospitalized at a local hospital ' s Intensive Care Unit (ICU) unit since 10/17/2008 at the time of her death. An on-site investigation was conducted by the SA, concurrently with this recertification survey, to verify compliance with federal regulatory requirements prior to Client #1's death.	W 000	**W120** **This Standard will be met as evidenced by:** Cross reference response to W474 QMRP/Home Manager will visit/monitor/conduct observations at each day program site at least twice monthly. QMRP/Home Manager will address problems and/or concerns as they arise. QMRP/Home Manager monitoring will include but not limited to; individual's habilitation, mealtime monitoring, active treatment services and record review.	11-6-08 ongoing
W 120	483.410(c)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: [Cross Reference W474] Based on observations, staff interview, and record review, the facility failed to effectively monitor each client's day program to ensure their safety during mealtime for one of the four clients in the sample. [Client #3] The finding includes:	W 120	Day program staff indicated that that client #3's feeding techniques were implemented in accordance to the mealtime protocol and signs and symptoms of aspiration were also monitored in accordance to the guidelines. QMRP/Home Manager and Nursing staff will continue to monitor meal times. Verification of meal monitoring will be maintained in the Meal Monitoring Book.	

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

PRINTED: 11/21/2008
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
	09G123	A. BUILDING _____ B. WING _____	11/05/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	431 53RD STREET, SE WASHINGTON, DC 20019

(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 120	Continued From page 2 Observation at Client #3 ' s day program on 11/4/2008 at 1:15pm revealed she was not provided her meals in the pureed texture as prescribed in her dietary orders and she was observed coughing, expelling food from either her mouth or nose, exhibiting teary eyes and gasping for air during coughs. In addition, at no time was staff observed to provide her liquids in between her solids. Record review at the day program on the same day revealed Client #3 ' s Mealtime Protocol dated 7/31/2008 detailed the following: 1. Staff should " Monitor for signs and symptoms of aspiration such as watery eyes, unusual cough, food coming from nose, fatigue, shortness of breath, wheezing, chest noises/pain bluish discoloration of the face/skin, excessive sweating, foul-smelling breath, rapid heart rate, fever. " 2. To implement " Safe Feeding Techniques ", staff should " Allow small single sips of beverage between small single bites of pureed solid food and small sips of beverage after meal completion. " 3. Staff should " allow time for her to chin tuck to swallow each bite/sip (eliminates aspiration) before presenting next mouthful ". Client #3 was not offered any beverage between each spoon of food and the staff failed to allow her to " chin tuck " or clear her mouth of food between each spoon full as recommended. Additional record review revealed not only was she prescribed a " pureed/thin liquid " diet on	W 120		

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

PRINTED: 11/21/2008
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
	090123	A. BUILDING _____ B. WING _____	11/05/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	491 53RD STREET, SE WASHINGTON, DC 20019

(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 120	Continued From page 3 8/29/2008, but her current Speech & Language assessment recommended on 10/23/2007 that she be provided " monthly monitoring of feeding to ensure safe feeding " . Interview with the residential director on 11/4/2008 at 4:35p revealed she was not sure if the monthly monitoring was supposed to be by the home or by the Speech pathologist. In effect, there had been no monthly monitoring of Client #3 ' s feeding as recommended by the Speech Pathologist. There was no evidence on file or presented at the time of survey to substantiate that the facility ensured Client #3's day program was providing meals in the form and consistency as prescribed in her dietary orders.	W 120		
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based observations, interviews, and record reviews, the facility failed to ensure client ' s received their meals in the form and texture as prescribed in their dietary orders (See W127). The effects of these systemic practices results in the failure of the facility to protect its clients from potential neglect, harm and to ensure their general safety and well being.	W 122	**W122** **This Condition will be met as evidenced by:** QMRP will coordinate additional staff training both at the day program and residential site. QMRP/Home Manager and Nurse will continue to monitor mealtimes and file documentation into the Mealtime Monitoring Book. QMRP will provide staff training to include but not limited to; Behavior support plans, urinary tract infections/perineal care, and dignity. QMRP will conduct visits to the day program sites at least twice monthly. QMRP will report and complete all incident summaries in a timely manner.	11-10-08 11-30-08
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian,	W 124	HMCP will be updated for client #3 to include change/check every two hours as needed.	12-4-08

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

PRINTED: 11/21/2008
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
	09G123	A. BUILDING _____ B. WING _____	11/06/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	431 53RD STREET, SE WASHINGTON, DC 20019

(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 124	Continued From page 4 of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that client ' s rights were maintained and upheld for one of four sampled clients. [Client #3] The finding includes: Record review on 11/5/2008 at 9:45 am revealed, Client #3 had a history of recurring Urinary Tract Infections (UTI) dating back to 11/2007. Client #3 ' s medical records revealed she contracted a urinary tract infection on 9/4/2008, 5/21/2008, and 2/28/2008. The facility ' s bathing protocol provided that " each individual will receive a shower daily ... make sure there are no medical reasons why the individuals cannot receive a shower. " On the contrary, Client #3 was recommended to be provided " strict genital hygiene " by her Urologist on three separate occasions dating back to 11/2007. A second " signed " bathing protocol was presented which detailed that Client #3 approved that she be bathed/showered every " other " day. Note: according to the review of the document and interview with the QMRP, the client gave her consent by placing her thumbprint on the document. Further record review revealed Client #3's Psychological assessment dated 103/2007 details she "...functions within the profound range of mental retardation cognitively and does not	W 124	**W124** **This Standard will be met as evidenced by:** QMRP will coordinate additional training to address perineal care and strict adherence to genital hygiene. QMRP will review bathing protocols and modify as needed to support the needs of the people. QMRP/Home Manager will continue to monitor staff activities, provide direction and feedback as needed to ensure compliance with this standard. QMRP will review and discuss with client #3's advocate her habilitation, planning, treatment, financial and medical matters. QMRP will maintain documentation to support review of such reviews either via sign in sheet or signatures on a specific document. QMRP will also continue to discuss with each individual the benefits and risks of treatment including ramifications of refusal of treatment.	12.5.08 ongoing 12-10-08 ongoing

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

PRINTED: 11/21/2008
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
	090123	A. BUILDING _____ B. WING _____	11/05/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	401 53RD STREET, SE WASHINGTON, DC 20019

(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 124	Continued From page 5 evidence the capacity to make decisions on her behalf regarding her habilitation, planning, placement, treatment, financial, and medical matters." There was no evidence presented or on file to substantiate that Client #3 was competent to make an informed decision regarding her healthcare and there was no evidence Client #3 ' s advocate was informed of this decision. Interview with the facility ' s nurse and subsequent record review on 11/5/2008 at 11:22 am revealed Client #3 does have a legal advocate acting on her behalf, but the facility failed to ensure the provisions of this regulatory requirement and failed to notify the respective advocate and/or legal guardian of the attendant risks of treatment.	W 124		
W 127	483.420(a)(5) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure client ' s received their meals in the form and texture as prescribed in their dietary orders, for one of the eight sampled clients. [Clients #1 and #6] The finding includes: Observation at Client #3 ' s day program on 11/4/2008 at 1:15pm revealed she was provided two small bite sized pieces of wheat bread prior to being fed her lunch. Client #3 was observed to cough while ingesting each of the two small	W 127	**W127** **This Standard will be met as evidenced by:** Reference response to W120 and W122. The day program staff interviewed reported that client #3 coughed briefly during her meal which is "normal". She did not experience any signs of distress and consumed her meal without incident. She further reported that at no time did her eyes become watery, nor did she show any signs of distress during the meal. She further stated that she was never instructed to abort the meal. 1. The QMRP provided additional training at the day program and continues to provide oversight to ensure that all safety precautions are implemented during meals. No problems have been noted related to feeding and adherence to the mealtime protocol to date.	11-7-08

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

PRINTED: 11/21/2008
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
	09G123	A. BUILDING _____ B. WING _____	11/08/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	431 53RD STREET, SE WASHINGTON, DC 20019

(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 127	Continued From page 6 pieces of bread. Client #3 was not observed coughing at any time prior to her eating the bread. The attending staff was then observed to cut the remaining slice of bread into bite sized pieces and mixed it into Client #3 ' s meal. Client #3 ' s cough became more severe as she was being fed the spoons of pureed food mixed with the bite sized pieces of bread. She was observed cocking her head back and breathing rather harshly as she leaned forward with each cough as she continued to be served her food. In addition, her eyes became watery and she expelled several small bits of food during each episode of coughing. The attending staff had to wipe her mouth of this debris on three seperate occasions after she had finished coughing. As the observation continued, the staff provided Client #3 with four heaping spoons of food continuously, while asking Client #3 to hurry up and eat. Each additional spoon of food was provided with Client #3 barely completing three to four chews of the previous spoon of food. It was at this point that Client #3 ' s cough began to get progressively worse and very deep throated in response. The attending staff was asked to hold off on the meal so that the medical records could be reviewed. Record review at the day program on the same day revealed Client #3 ' s Mealtime Protocol dated 7/31/2008 detailed: 1. Staff should " Monitor for signs and symptoms of aspiration such as watery eyes, unusual cough, food coming from nose, fatigue, shortness of breath, wheezing, chest noises/pain bluish discoloration of the face/skin, excessive sweating, foul-smelling breath, rapid heart rate, fever. "	W 127	W127 Continued... 2. The feeder denied that client #3 was fed with heaping spoons of food in a continuous pattern. She reported that she has worked with client #3 for over five years and is familiar with the mealtime protocol and the instructions. Reference response to #1 W127. 3. QMRP/ Home Manager and Nursing staff continue to monitor meal and to ensure adherence to meal protocol at the residential setting. QMRP/Home Manager will ensure that ongoing and consistent monitoring of client #3. QMRP/Home Manager will monitor each day program site at least twice monthly. QMRP/Home Manager will monitor various aspects of each individual's habilitation to include but not limited to; mealtime monitoring, active treatment services and record review	12-5-08 mw

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

PRINTED: 11/21/2008
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
	09G123	A. BUILDING _____ B. WING _____	11/05/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
I D I	431 53RD STREET, SE WASHINGTON, DC 20019

(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 127	Continued From page 7 2. To implement " Safe Feeding Techniques ", staff should " Allow small single sips of beverage between small single bites of pureed solid food and small sips of beverage after meal completion. " 3. Staff should " allow time for her to chin tuck to swallow each bite/sip (eliminates aspiration) before presenting next mouthful ". As presented in the observations, Client #3 was not offered any beverage between each spoon of food and the staff failed to allow her to " chin tuck " or clear her mouth of food between each spoon full as recommended. Additional record review revealed not only was she prescribed a " pureed/thin liquid " diet on 8/29/2008, but her Speech & Language assessment recommended on 10/23/2007 that she be provided " monthly monitoring of feeding to ensure safe feeding ". Interview with the residential director on 11/4/2008 at 4:35p revealed she was not sure if the monthly monitoring was supposed to be by the home or by the Speech pathologist. In effect, there had been no monthly monitoring of Client #3 ' s feeding as recommended by the Speech Pathologist. There was no evidence on file or presented at the time of survey to substantiate that the facility had taken the necessary intervention and monitoring to ensure Client #3 was being provided her meals in the form and consistency as prescribed in her dietary orders.	W 127		
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	W 148		

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

PRINTED: 11/21/2008
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
	09G123	A. BUILDING _____ B. WING _____	11/05/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
I D I	431 53RD STREET, SE WASHINGTON, DC 20019

(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 148	Continued From page 8 limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that client advocates were informed of emergent treatment and preventive care for one of four sampled clients. [Clients #4] The finding includes: Review of the unusual incident reporting system on 11/3/2008 at 4:48 pm revealed Client #4 fell and was taken to the ER on 9/7/2008. She was treated for a " contusion to left forehead and small abrasions. " In addition, Client #4 was taken to the ER after taking part in a car accident on 7/28/2008. Interview with the facility ' s Qualified Mental Retardation Professional (QMRP) on 11/3/2008 at 5:05 pm revealed that Client #4 had an advocate and the unusual incident report book was incomplete. In addition, according to the QMRP, there were several unusual incidents at the main office that were still waiting to be filed. The QMRP further indicated that the remaining documents were to be filed on 11/4/2008, however, were not filed. At the time of survey, there was no evidence presented or filed in the records to substantiate an advocate was informed of Client #4's emergency treatments.	W 148	**W148** **This Standard will be met as evidenced by:** Review of the incident report dated 9.7.08 indicates that [redacted] guardian was notified of the reported incident on 9.7.08 at 7:30pm. This information is further documented in the MCIS system. All incidents have been filed. The QMRP will complete all incident summaries in a timely manner and ensure that all documents are filed in accordance to the designated guidelines. The facility will continue to notify/inform family members and/or guardians and periodically update them as needed.	12.1.08
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.	W 159		

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

PRINTED: 11/21/2008
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
	09G123	A. BUILDING _____ B. WING _____	11/05/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	431 33RD STREET, SE WASHINGTON, DC 20019

(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 159	Continued From page 9 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 client's active treatment regimen. The findings include: 1. 1. The 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] 2. The QMRP failed to ensure that each client's Individual Support Plan (ISP) and Individual Program Plan were developed in accordance with the recommendations for the annual ISP meeting. [See W249] 3. Interview on 10/5/2008 with the QMRP at approximately 11:00 AM, revealed that Client #2 ' s Individual Support Plan (ISP) meeting occurred on 11/21/2008. Review of Client #2's program records on 10/5/2008, failed to provide evidence of an Individual Program Plan (IPP) and corresponding program data collections had been developed for Client #2's habilitation plan. Interview with the Program Director revealed that the agency's practice was as follows: a. The IPP was to have been developed two days after the ISP meeting by the QMRP. b. The IPP was to be provided to the direct care staff	W 159	**W159** **This Standard will be met as evidenced by:** 1. Reference response to W189. 2. Reference response to W249. 3. Client #2's IPP has been implemented and staff trained on the new programs. The QMRP will maintain timely implementation of the IPP and corresponding data sheets within three days following the ISP meeting. 4. Reference response to W124, W189, W322,W331, and W340. 5. Reference response to W193. 6. Reference response to W189 and W474.	12-10-08

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

PRINTED: 11/21/2008
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
	090123	A. BUILDING _____ B. WING _____	11/05/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	431 53RD STREET, SE WASHINGTON, DC 20019

(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 159	Continued From page 10 c. The QMRP was supposed to train the direct care staff on Client's #2' new programmatic objectives as they prepare for implementation. d. Within 7 days management expects the client specified goals and objectives to be implemented and data collection to have started in accordance with the IDT recommendations. Further review of Client #2's habilitation records failed to evidence the interdisciplinary team recommended program objectives were implemented after the ISP meeting. At the time of the survey, the facility QMRP failed to ensure Client #2's continuous active treatment. 4. Record review on 11/4/2008 at 5:44pm revealed Client #3 was provided treatment to alleviate a Urinary Tract Infection on 3/4/2008, 5/26/2008, and 9/10/2008. In addition, Client #3 was seen by the Urologist on 11/8/2007, 2/18/2008 and again on 8/20/2008. The recommendation of each consult was as follows: a. Urology 8/20/2008- Recommended that the facility, " continue strict genital hygiene ... follow up in 6 months ". b. Urology 2/18/2008 - Recommendation #1 " Observe good hygiene " and Recommendation #2, " Change often ". c. Urology 11/8/07 - Recommended that the facility " Observe good genital hygiene - change often ". On each consult, the Urologist recommended that the facility ensure " good hygiene " which was elevated to " continue strict hygiene " on the	W 159		

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

PRINTED: 11/21/2008
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
	09G123	A. BUILDING _____ B. WING _____	11/05/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	431 53RD STREET, SE WASHINGTON, DC 20019

(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 159	Continued From page 11 most recent consult. Despite the recommendations, Client #3 ' s urinary tract infections continued to resurface. Interview with the facility ' s nurse and subsequent record review on 11/5/2008 at 11:22am revealed, the facility ' s nursing staff failed to ensure that all staff were effectively trained to manage and provide proper care and treatment to Client #3 ' s UTI. Further record review revealed Client #3 ' s Health Management Care Plan required that she be " changed every (two) 2 hours " and despite Client #3 ' s approval that she be bathed every " other " day, the facility ' s bathing protocol provided that " each individual will receive a shower daily " . In addition, the survey team was provided a data collection sheet which logged the number of showers Client #3 was receiving. The only month covered on this document was for the month of 11/2008. Please note, Client #3 ' s medical history reflected her treatment and care for her recurring UTI had been ongoing since 11/2007. There was no evidence presented or on file at the time of survey to substantiate that the facility ' s QMRP ensured the proper and necessary coordination of services to prevent the recurrence of Client #3 ' s urinary tract infections. [Reference W124, W189, W322, W331, and W340] 5. The facility ' s QMRP failed to ensure that staff were competent to implement Client #7 ' s Behavior Support Plan. [See W193] 6. The facility ' s QMRP failed to ensure that staff were effectively trained to implement Client #3 ' s Mealtime Feeding Protocol. [See W189 and W474]	W 159		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM	W 189		

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

PRINTED: 11/21/2008
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
	09G123	A. BUILDING _____ B. WING _____	11/05/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
I D I	421 53RD STREET, SE WASHINGTON, DC 20019

(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 189	Continued From page 12 The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure staff was effectively trained to ensure client ' s health and safety as outlined in their habilitation plans. [Clients #3, #7, and #8] The finding includes: 1. Record review on 11/4/2008 at 5:44pm revealed Client #3 was provided treatment to alleviate a Urinary Tract Infection on 3/4/2008, 5/28/2008, and 9/10/2008. In addition, Client #3 was seen by the Urologist on 11/8/2007, 2/18/2008 and again on 8/20/2008. On each consult, the Urologist recommended that the facility ensure " good hygiene " . Despite the recommendations, Client #3 ' s urinary tract infections continued to resurface. Interview with the facility ' s nurse and subsequent record review on 11/5/2008 at 11:22am revealed, the facility failed to ensure that all staff were effectively trained to manage and provide proper care and treatment to Client #3 ' s UTI. [Cross Reference W340] 2. Observation on 11/3/2008 and staff interview on 11/5/2008 revealed staff failed to effectively implement Client #7 ' s BSP as written. The facility failed to present any evidence at the time of survey to substantiate that all staff had received training on how to effectively manage	W 189	W189 **This Standard will be met as evidenced:** 1.Ongoing training on good hygiene practices have been completed throughout the year. Nursing staff will supervise and monitor showers to ensure administration of good perineal care and hygiene. Primary Care Physician conducted in-service training on 11.26.08 on Urinary Tract Infections, Prevention and treatments. 2. QMRP will coordinate additional staff training on the implementation of client #7's BSP. QMRP/Home Manager will provide direction and oversight as needed to further ensure implementation of the BSP as outlined. Also, reference response to W120 and W474. 3. Reference response to W120.	11-26-08 ongoing 12-12-08 ongoing

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

PRINTED: 11/21/2008
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
	09G123	A. BUILDING _____ B. WING _____	11/05/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	491 53RD STREET, SE WASHINGTON, DC 20019

(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 189	Continued From page 13 Client #7 ' s tantrums, non-compliance and physical aggression. [See W193] 3. The facility failed to ensure that staff were properly trained to implement Client #3 ' s Mealtime Feeding Protocol. [See W120 and W474] 4. Observation on 11/3/2008 at approximately 4:40 PM revealed the direct care staff transferring Client #4 from her wheelchair to a large bean bag chair in the living room. Prior to transferring the client from her wheelchair, the direct care staff was observed to place a bed chuck over the bean bag chair. On 11/5/2008 at approximately 9:30 AM, Client #6 was observed lying on a bed chuck on a bean bag in her bedroom. Interview with the QMRP revealed the staff was trained in the area of client dignity and rights. According to the QMRP, each staff was informed to use bed chucks only when the client's were in their bed. The facility failed to ensure client ' s rights and personal dignity was effective.	W 189	4. Bed chucks will no longer be used. QMRP will provide training on client rights and personal dignity. QMRP/Home Manager will monitor staff activities and provide direction and feedback to be sure staff are able to perform their duties effectively, efficiently and competently.	
W 193	483.430(e)(3) STAFF TRAINING PROGRAM 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 observations, staff interviews and the review of records, the facility staff failed to demonstrate competency in implementation of Client #7's Behavior Support Plan (BSP).	W 193	W193 This Standard will be met as evidenced by: Reference response to W189 #2, W120 and W474. QMRP will also consult with the Behavior Specialist to clarify "adaptive activity". QMRP will provide training for staff.	11-28-08

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

PRINTED: 11/21/2008
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
	09G123	A. BUILDING _____ B. WING _____	11/05/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	431 33RD STREET, SE WASHINGTON, DC 20019

(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 193	Continued From page 14 The findings include: Observation on the evening of 11/3/2008 between the hours of 4:30pm and 6:40pm revealed Client #7 was yelling, screaming, kicking staff, and being non-compliant with staff directives to either eat dinner or take her medication. In addition, Client #7 repeatedly stated she wanted to go on a van ride and became increasingly agitated and physically aggressive with staff by kicking and hitting staff when they requested that she take her medication. During the observation, the attending staff verbally agreed to take her on a van ride. In addition, the attending staff was observed asking the Client to stand, got her dressed in warm clothing and wheeled her into her bedroom as she screamed to be taken for her van ride. The evening med-nurse was waiting for her when she entered her room. Although Client #7 appeared visibly shaken and upset, the nurse was able to administer her medication and she was taken out on her van ride immediately following. Staff spoke about Client #7 ' s aggressiveness within earshot of her room while she was being administered her medications. Record review on 11/4/2008 revealed, Client #7 ' s BSP dated 7/31/2008 recommended the following: 1. The recommended intervention to manage Client #7 ' s " tantrumming behavior " of " yelling, screaming, and sticking out her tongue" was that " CLIENT #7 should be redirected to an adaptive activity and praised for task performance and completion. " 2. The recommended intervention to manage Client #7 ' s " physical aggression " of "	W 193		

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

PRINTED: 11/21/2008
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
	09G123	A. BUILDING _____ B. WING _____	11/05/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	431 53RD STREET, SE WASHINGTON, DC 20019

(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 193	Continued From page 15 kicking/hitting others, spitting and scratching others " was that " if [Client #7 continues to be stimulated, staff should use non-exclusionary time out by verbally directing [Client #7] to go to an unoccupied area of her home to calm down. " In addition, this plan documented, " after [Client #7] has calmed down she should be redirected to an adaptive activity and praised for her task performance and completion. Her previous maladaptive behavior should not be mentioned. " Further observation on the evening of 11/3/2008 revealed that staff failed to afford Client #7 the opportunity " to take part in an adaptive activity " and staff failed to provide any measure of praise for her performance and/or completion of the task to manage her " tantrumming " behavior(s). In addition, staff failed to implement " a non-exclusionary time out by verbally directing her to an unoccupied area of her home " after she engaged in three acts of physical aggression (kicking) towards staff. Staff also failed to direct Client #7 to " an adaptive activity and praise for her task performance and completion " as required by the plan whenever she engaged in physical activity as well. Staff interview on 11/5/2008 at 12:29pm revealed staff was not sure what an " adaptive activity " was and wasn ' t sure what response to provide. The staff and the house manager indicated they were not familiar with that terminology. Upon further interview, the Qualified Mental Retardation Professional (QMRP) interjected that an adaptive activity could be interpreted as Client #7 taking part in reading a book or playing a board game or any " sensory based " activity. Additional record review revealed the facility ' s QMRP's interpretation of what constitutes an adaptive	W 193		

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

PRINTED: 11/21/2008
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
	09G123	A. BUILDING _____ B. WING _____	11/05/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	431 53RD STREET, SE WASHINGTON, DC 20019

(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 193	Continued From page 16 activity was not present anywhere in the client ' s record or mirrored by the Psychologist or Behavioral Specialist on any assessment on file at the time of survey. Furthermore, neither the current psychological assessment nor the BSP provided any definition of what constituted an adaptive activity. The facility failed to ensure that all staff were effectively trained to implement Client #7 ' s BSP as outlined and failed to ensure that maladaptive behaviors were not being reinforced by staff who were not effectively trained to manage Client #7 ' s behavior.	W 193		
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 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 observation, staff interview and record review, the facility Human Rights Committee failed to reviewed, approved or monitor the recommended use of sedation for a medical procedure for one of four clients in the sample. (Clients #2) The finding includes: On 11/4/2008 at approximately 1:40 PM, interview	W 264		

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

PRINTED: 11/21/2008
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
	09G123	A. BUILDING _____ B. WING _____	11/05/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
I D I	431 53RD STREET, SE WASHINGTON, DC 20019

(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 264	Continued From page 17 the nurse and the review of the agency's Human Rights Committee minutes dated June 25, 2008, revealed a discussion occurred on whether Client #2's was to be approved for sedation for a Evaluation of the ME Function Test and BSER. According to the nurse, Client #2 was scheduled for a Audiologist consultation on July 15, 2008. Review of the consultation finding from that visit included the following recommendation: "Return sedated (if medically/legally permissible) for immittance and updated BSER. Patient must be still and compliant." Review of the HRC minutes dated September 2008 did not include any documented evidence that the committee reviewed and approved the recommended sedation for the July 2008 audiological consultation. According to the nurse a second evaluation was scheduled for 11/21/2008, but, Client #2 was uncooperative during the second assessment. At the time of the survey, there was no evidence that the HRC had addressed the use of sedation prior to the scheduling of the second BSER evaluation as recommended.	W 264	**W264** **This Standard will be met as evidenced by:** Sedation for client #2 will be reviewed and discussed at the next scheduled Human Rights Meeting. QMRP/Nursing staff will address all recommendations as outlined.	12.18.08
W 321	483.460(a)(2) PHYSICIAN SERVICES The medical care plan of treatment must be integrated 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 ensure proper nursing care with regards to ensuring proper hygiene to prevent the recurrence of Urinary Tract Infections was integrated into the Individual Program Plan	W 321		

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

PRINTED: 11/21/2008
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
	09G128	A. BUILDING _____ B. WING _____	11/06/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	431 53RD STREET, SE WASHINGTON, DC 20019

(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 321	Continued From page 18 for one of the four sampled Clients. [Client #3] The findings include: Observation of the medication pass on the evening of 11/3/2008 at 6:44pm revealed Client #3 received 500mg of Amoxicillin as part of her medication regimen. Interview with medication nurse on 11/3/2008 at 6:50pm revealed Client #3 was prescribed the antibiotic to treat her Urinary Tract Infection. Record review on 11/4/2008 at 5:11pm revealed Client #3 previously was treated for a UTI on 9/4/2008, 5/21/2008, 2/26/2008, and seen by a Urologist for a UTI on 11/8/2007. Interview with the facility ' s LPN and continued record review on 11/5/2008 at 9:55am revealed Client #3's Health Management Care Plan covers the care and treatment of recurring urinary tract infections. The nurse further indicated that Client #3 was to be checked every two (2) hours and changed if it ' s necessary. In addition, she indicated that Client #3 has had her fluids restricted on 8/29/2008 from 1000cc to 880cc. She pointed out that this further fluid restriction would make the situation even more inflammatory. Considering Client #3 ' s history of recurring urinary tract infections and her recent fluid restriction from 1000cc to 880cc, there was no evidence presented or on file at the time of survey to substantiate that there was effective medical oversight in managing Client #3 ' s recurring urinary tract infections in particularly with regards to ensuring her " strict hygiene " as recommended by the Urologist on 8/20/2008. Furthermore, the Health Management Care Plan recommended that Client #3 be changed every 2	W 321	W321 **This Standard will be met as evidenced:** Reference response to W189. The HMCP was updated to reflect check/change adult protective garment at least every two hours or as needed. Nurse/QMRP will provide training for staff working with the individual.	12-10-08 mapm19

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

PRINTED: 11/21/2008
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
	09G123	A. BUILDING _____ B. WING _____	11/05/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	431 53RD STREET, SE WASHINGTON, DC 20019

(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 321	Continued From page 19 hours, not " checked " every two hours. There was no evidence on file at the time of survey to substantiate that the facility ensured the proper care or enacted an effective program plan to medically ensure that Client #3 ' s urinary tract infections were not a recurring problem. [See W159]	W 321		
W 474	483.460(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review the facility failed to ensure the provision of a pureed diet for one of four sampled clients. [Client #3] The finding includes: Observation at Client #3 ' s day program on 11/4/2008 at 1:15pm revealed she was provided two small bite sized pieces of wheat bread prior to being fed her lunch. Client #3 was observed to cough while ingesting each of the two small pieces of bread. Client #3 was not observed coughing at any time prior to her eating the bread. The attending staff was then observed to cut the remaining slice of bread into bite sized pieces and mixed it into Client #3 ' s meal. Client #3 ' s cough became more severe as she was being fed the spoons of pureed food mixed with the bite sized pieces of bread. She was observed cocking her head back and breathing rather harshly as she leaned forward with each cough as she continued to be served her food. In addition, her eyes became watery and she expelled several small bits of food during each	W 474	W474 This Standard will be met as evidenced by: Reference response to W120, W124.	12-10-08

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

PRINTED: 11/21/2008
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
	09G123	A. BUILDING _____ B. WING _____	11/05/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
I D I	431 53RD STREET, SE WASHINGTON, DC 20019

(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 474	Continued From page 20 episode of coughing. The attending staff had to wipe her mouth of this debris on three separate occasions after she had finished coughing. As the observation continued, the staff provided Client #3 with four heaping spoons of food continuously, while asking Client #3 to hurry up and eat. Each additional spoon of food was provided with Client #3 barely completing three to four chews of the previous spoon of food. It was at this point that Client #3 ' s cough began to get progressively worse and very deep throated in response. The attending staff was asked to hold off on the meal so that the medical records could be reviewed. Record review at the day program on the same day revealed Client #3 ' s Mealtime Protocol dated 7/31/2008 detailed: 1. Staff should " Monitor for signs and symptoms of aspiration such as watery eyes, unusual cough, food coming from nose, fatigue, shortness of breath, wheezing, chest noises/pain bluish discoloration of the face/skin, excessive sweating, foul-smelling breath, rapid heart rate, fever. " 2. To implement " Safe Feeding Techniques ", staff should " Allow small single sips of beverage between small single bites of pureed solid food and small sips of beverage after meal completion. " 3. Staff should " allow time for her to chin tuck to swallow each bite/sip (eliminates aspiration) before presenting next mouthful ". As presented in the observations, Client #3 was not offered any beverage between each spoon of	W 474		

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

PRINTED: 11/21/2008
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
	09G123	A. BUILDING _____ B. WING _____	11/05/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	431 83RD STREET, SE WASHINGTON, DC 20019

(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 474	Continued From page 21 food and the staff failed to allow her to " chin tuck " or clear her mouth of food between each spoon full as recommended. Additional record review revealed not only was she prescribed a " pureed/thin liquid " diet on 8/29/2008, but her Speech & Language assessment recommended on 10/23/2007 that she be provided " monthly monitoring of feeding to ensure safe feeding ". Interview with the residential director on 11/4/2008 at 4:35pm revealed she was not sure if the monthly monitoring was supposed to be by the home or by the Speech pathologist. In effect, there had been no monthly monitoring of Client #3 ' s feeding as recommended by the Speech Pathologist. There was no evidence on file or presented at the time of survey to substantiate that the facility had taken the necessary intervention and monitoring to ensure Client #3 was being provided her meals in the form and consistency as prescribed in her dietary orders.	W 474		