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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G123	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/21/2007

NAME OF PROVIDER OR SUPPLIER: IDI

STREET ADDRESS, CITY, STATE, ZIP CODE: 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 000	INITIAL COMMENTS A recertification survey was conducted from November 19, 2007 through November 21, 2007. A random sample of four clients was selected from a residential population of eight females with mental retardation and other disabilities. The survey findings were based on observations in the group home and at one day program, interviews and a review of records, including unusual incident reports.	W 000		
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, 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 observation, interview and record review, the facility failed to ensure the rights of each client to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment, for one of the four clients (Client #1) included in the sample. The findings include: 1. Observation of the evening medication administration on November 19, 2007, beginning at 6:29 PM revealed Client #1 received medications including Clonazepam and Risperdal. Interview with the nurse during the medication administration revealed the	W 124	W124 This Standard will be met as evidenced by: • QMRP will review and discuss use of medications and habilitative services with client #1's brother. • QMRP will obtain informed consent. • QMRP will coordinate and complete necessary paperwork to ensure that a legal guardian is obtained for client #1 if needed.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: DRS (X6) DATE: 12.14.07

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

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W 124	Continued From page 1 aforementioned medications were used to address the client's behavior management. Interview with the Qualified Mental Retardation Professional (QMRP) on November 19, 2007 at 6:38 PM was conducted to ascertain information about Client #2's ability to give informed consent for the use of medications and habilitation services. According to the QMRP, Client #1 was not capable of giving informed consent for the use of her medications and habilitation services. The interview was verified by the client's Psychological Evaluation (dated September 29, 2007) on November 21, 2007 at 11:57 AM that documented Client #1 did "not evidence the capacity to make decisions on her behalf regarding her habilitation planning, placement, treatment, financial, and medical matters." The Psychological Evaluation further documented that the client "could not execute a durable power of attorney." Additionally, interview with the QMRP revealed that Client #1 had family involvement (brother) but did not have a legal guardian. Further interview with the QMRP and review of the client's records failed to provide documented evidence that informed consent was obtained for the use of the client's psychotropic medication. At the time of the survey, the facility failed to provide evidence that Client #1's treatment needs, including the benefits and potential side effects associated with the medications, and the right to refuse treatment, had been explained to her and/or a legally authorized representative. 2. Review of Client #1's medical record on November 21, 2007 at 7:52 PM revealed that the	W 124	▲ QMRP will obtain informed consent prior to use of B and/or participation in treatment. ▲ QMRP will also review and discuss risks/benefits of treatment. ▲ Document will remain on file for review. (2) QMRP will review and discuss with the medical team, & request verification of consent. Once document obtained it will be filed into client #1's record for review. In future, QMRP/Nurse will request copies of all documents prior to procedures.	1-5-08 ongoing 1-5-08 ongoing

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W 124	Continued From page 2 client had been seen by the Urologist. The Urologist recommended to schedule the client for a Cystoscopy. Further review of the medical record revealed that a Cystoscopy was completed on August 8, 2007. Interview with the QMRP on November 21, 2007 revealed that Client #1's brother signed a consent at the hospital, however, there was no documented evidence of the consent for Client #1's Cystoscopy. At the time of the survey, the facility failed to provide evidence that Client #1's treatment needs, and the right to refuse treatment, had been explained to her and/or a legally authorized representative.	W 124		
W 130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure each client's right to privacy, for four of the eight clients (Clients #1, #2 #3 and #8) that resided in the facility. The findings include: 1. Observation of the evening medication administration on November 19, 2007 at 7:47 PM revealed Client #2 in her bedroom receiving her medications. While receiving her medications, Clients #1, #3, and #8 were also in her bedroom. Additionally, one staff and two surveyors were also present while Client #2's medication was being administered. The facility's nurse was	W 130	W130 This Standard will be met as evidenced by: RN will provide additional training for Nursing staff on adhering to privacy during medical/nursing treatments.	12.23.07 ongoing

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W 130	Continued From page 3 observed to apply Triamcinolone Acetoride to Client # 2's scalp and Lubrifresh PM ointment was applied to her left eye. It should be noted that the client's bedroom door was widetopened during the observation of the medication administration. The client also was observed to receive her oral medications; Keppra and Lamictal (prescribed for seizures). At the time of the survey, the facility failed to maintain Client #2's right to privacy while receiving her medications. 2. Observation of the evening medication administration on November 19, 2007 at 7:33 PM revealed Client #3 in her bedroom receiving her medications. While receiving her medications, Clients #1, #2 and #8 were also in her bedroom. Additionally, one staff and two surveyors were also present while Client #3's medication was being administered.. The client was observed to receive all of her oral medications; Trileptal U-D, Ascorbic Acid, Carvedilol, Cranberry Fruit, Keppra, Lactulose and Risperdal. At the time of the survey, the facility failed to maintain Client #3's right to privacy while receiving her medications.	W 130	W130, continued... RN will conduct routine observations to further verify compliance with this standard. (2) Reference response to W130 #1. W148	
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the client's legal guardian and/or	W 148	This Standard will be met as evidenced by:	12.31.07 ongoing

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W 148	Continued From page 4 family member was promptly made aware of an injury of unknown origin, for one of the eight clients (Client #7) that resided in the facility. The finding includes: Review of the incident reports and investigations on November 20, 2007 beginning at 2:01 PM revealed that on August 22, 2007, staff reported that while at the day program Client #7 was observed to have a swollen right elbow. Client #7 was taken to the emergency room and was subsequently diagnosed with a contusion of the elbow. Further review of the incident report revealed that the client's legal guardian was notified of the incident on September 14, 2007 (twenty-three days after the injury). Interview with the Qualified Mental Retardation Professional (QMRP) on November 20, 2007, at 12:06 PM revealed information regarding the facility's incident management system. According to the QMRP, the guardian was to be notified immediately of all allegations of abuse and injuries of unknown origin. At the time of the survey, the facility failed to ensure Client #7's guardian was made aware of the aforementioned incident in a timely manner.	W 148	■ QMRP will complete all notifications in accordance to company policy and Incident Management guidelines (DDS). ■ QMRP will continue to document notifications as indicated on the incident report/investigation ■ Incident Management Coordinator will continue to monitor and address issues as they arise.	12.31.07
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to establish and/or implement policies that ensured the client's health and safety, for three of	W 149	W149 This Standard will be met as evidenced by:	

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W 149	Continued From page 5 the eight clients (Clients #1, #2, and #7) that resided in the facility. The findings include: 1. The facility failed to ensure the timely reporting of incidents as documented in its "Incident Management" policy. Review of the incident reports and investigations on November 20, 2007 beginning at 2:01 PM revealed the following incidents (allegations of abuse and/or injuries of unknown source) were not reported as required: a. On August 22, 2007, staff reported that while at the day program Client #7 was observed to have a swollen right elbow at the day program. Client #7 was taken to the emergency room and was subsequently diagnosed with a contusion of the elbow. Further review of the incident report revealed that the administrator, the client's legal guardian and the Department of Health (DOH) were notified of the incident on September 14, 2007. b. On September 9, 2007, staff reported that Client #1 was observed with a blister on her left wrist. According to the incident report, the administrator was notified of the incident on September 9, 2007. On September 10, 2007, however, the Qualified Mental Retardation Professional (QMRP) documented an addendum on the incident report that revealed Client #1 had a second blister on her right wrist. It should be noted that there was no evidence the DOH was immediately notified of the aforementioned injuries. It should be additionally noted that there was no evidence that the administrator had been	W 149	W149 Reference response to W148. Incident Investigations have been completed for all reported incidents. QMRP will immediately initiate investigation and file information for review within the designated timelines. Appropriate disciplinary action will be applied for failure to adhere to policy.	

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W 149	Continued From page 6 made aware of the blister on Client #1's right wrist documented via addendum on September 10, 2007. Review of incidents during pre-survey activities revealed staff reported that on July 23, 2007, Client #7 sustained a skin tear on her right elbow with some swelling noted. During the survey process, there was neither any evidence of an incident report for the aforementioned incident nor any evidence that the administrator was made aware of the incident. Additionally, the DOH was not made aware of the incident until September 14, 2007. Interview with the QMRP on November 20, 2007, at 12:06 PM revealed information regarding the facility's incident management system. According to the QMRP, the administrator and the Department of Health were to be notified immediately of all allegations of abuse and injuries of unknown origin. It should be further noted that the QMRP revealed that immediate notifications were also to made to each client's next of kin and/or legal guardian. Review of the facility " Incident Management " policy on November 20, 2007, revealed that serious reportable incidents must be immediately verbally reported to the Department of Health (DOH) followed by written notification within twenty-four hours. Additionally, the policy documented that immediate verbal notification was to be made to the client's involved family members or guardians. At the time of the survey, the facility failed to ensure timely notifications as required by their "Incident Management" policy. 2. The facility failed to ensure investigations were conducted as specified in their "Incident	W 149	QMRP will ensure that all notifications are made in accordance to policy and information documented. QMRP will provide additional staff training on incident reporting policy and procedures.	1.5.08

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W 149	Continued From page 7 Management" policy. Review of the incident reports and investigations on November 20, 2007 beginning at 2:01 PM revealed the following incidents (allegations of abuse and/or injuries of unknown source) were not thoroughly investigated as required: a. On August 22, 2007, staff reported that Client #7 was observed to have a swollen right elbow at the day program. Client #7 was taken to the emergency room and was subsequently diagnosed with a contusion of the elbow. At the time of the survey, there was no evidence that the aforementioned incident was investigated. b. On November 7, 2007, staff reported that Client #2 was observed with a " superficial skin breakdown on the inner right hand above her thumb". At the time of the survey, there was no evidence that the aforementioned incident was investigated. It should be noted that interview with the QMRP on November 20, 2007, at 12:06 PM revealed information regarding the facility ' s incident management system. According to the QMRP, the facility is required to immediately initiate investigations for injuries of unknown source. Review of the facility' s "Incident Management" policy on November 20, 2007, verified the interview with the QMRP by indicating that all serious reportable incidents were to be investigated upon notification of the incident. At the time of the survey, the facility failed to ensure investigations were conducted as specified in their "Incident Management" policy.	W 149		

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W 149	Continued From page 8 3. The facility failed to ensure that investigation results were reported as specified in their "Incident Management" policy. Review of the incident reports and investigations on November 20, 2007 beginning at 2:01 PM revealed the following incidents (allegations of abuse and/or injuries of unknown source): a. On August 22, 2007, staff reported that Client #7 was observed to have a swollen right elbow at the day program. Client #7 was taken to the emergency room and was subsequently diagnosed with a contusion of the elbow. b. On September 9, 2007, staff reported that Client #1 was observed with a blister on her left wrist. According to the incident report, the administrator was notified of the incident on September 9, 2007. On September 10, 2007, however, the QMRP documented an addendum on the incident report that revealed Client #1 had a second blister on her right wrist. There was no evidence that the aforementioned investigation results were reviewed by the facility's administrator or designee. Interview with the QMRP on November 20, 2007, at 12:06 PM revealed information regarding the facility's incident management system. According to the QMRP, the facility is required to immediately initiate an investigation for injuries of unknown source and complete the investigation within five working days. Review of the facility's "Incident Management" policy on November 20, 2007, revealed that all investigations were to be reported to the provider's Incident Management Coordinator within four days for review and	W 149		

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W 149	Continued From page 9 approval and ensure that it reaches the Health Regulatory Administration and MRDDA Incident Management Unit within five working days." At the time of the survey, the facility failed to ensure it's "Incident Management" policy was implemented as outlined making certain that investigations were reviewed and forwarded as specified.	W 149		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all allegations of abuse and injuries of unknown origin were reported immediately to the administrator or to other officials in accordance with state law [22 DCMR Chapter 35 3519.10] through established procedures, for two of the eight clients (Clients #1, and #7) that reside in the facility. The findings include: 1. Review of the incident reports and investigations on November 20, 2007 beginning at 2:01 PM revealed the following incidents (allegations of abuse and/or injuries of unknown source) were not reported as required: a. On August 22, 2007, staff reported that Client #7 was observed to have a swollen	W 153	W153 This Standard will be met as evidenced by: Reference responses to W148 & W149. QMEP will report all incidents to the administrator or other officials in accordance with State law. Routine file/ record reviews will be completed to further ensure compliance with this standard.	1.5.08 ongoing

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W 153	Continued From page 10 right elbow at the day program. Client#7 was taken to the emergency room and was subsequently diagnosed with a contusion of the elbow. Further review of the incident report revealed that both the administrator and the Department of Health (DOH) were notified of the incident on September 14, 2007. b. On September 9, 2007, staff reported that Client #1 was observed with a blister on her left wrist. According to the incident report, the administrator was notified of the incident on September 9, 2007. On September 10, 2007, however, the Qualified Mental Retardation Professional (QMRP) documented an addendum on the incident report that revealed Client #1 had a second blister on her right wrist. It should be noted that there was no evidence the DOH was notified of the aforementioned injuries. 2. Additionally, interview and review of Client 1's medical record on November 21, 2007 at 7:32 PM revealed that the client was seen by the Podiatrist on February 26, 2007. Further review of the record revealed that the Podiatrist discovered a "black discoloration" of the client's right great toe and indicated that if the discoloration was not healed in one week refer the client to a Dermatologist. On November 21, 2007 at 7:40 PM, an interview was conducted with the nurse to ascertain if there was an incident report regarding the aforementioned incident. According to the facility's nurse there was no documented evidence of an incident report. 3. Review of incidents during pre-survey activities revealed staff reported that on July 23, 2007, Client #7 sustained a skin tear on her right elbow	W 153		

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W 153	Continued From page 11 with some swelling noted. During the survey process, there was neither any evidence of an incident report for the aforementioned incident nor any evidence that the administrator was made aware of the incident. Additionally, the DOH was not made aware of the incident until September 14, 2007. Interview with the QMRP on November 20, 2007, at 12:06 PM revealed information regarding the facility's incident management system. According to the QMRP, the administrator was to be notified immediately of all allegations of abuse and injuries of unknown origin. At the time of the survey, the facility failed to ensure the administrator and the Department of Health were notified timely of allegations of abuse and/or injuries of unknown origin as required.	W 153		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure all allegations of abuse and injuries of unknown origin were thoroughly investigated, for three of the eight clients (Clients #1, #2 and #7) that resided in the facility. The finding includes: 1. Review of the incident reports and investigations on November 20, 2007 beginning at 2:01 PM revealed the following incidents (allegations of abuse and/or injuries of unknown source) were not thoroughly investigated as	W 154	W154 This Standard will be met as evidenced by: Reference responses to W148, W149, & W153, QMRP will address all alleged violations and develop process to ensure prompt reporting and	1.5.08 ongoing

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G123	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/21/2007
NAME OF PROVIDER OR SUPPLIER: IDI		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 154	Continued From page 12 required: a. On August 22, 2007, staff reported that Client #7 was observed to have a swollen right elbow,at the day program. Client#7 was taken to the emergency room and was subsequently diagnosed with a contusion of the elbow. At the time of the survey, there was no evidence that the aforementioned incident was investigated. b. On November 7, 2007, staff reported that Client #2 was observed with a "superficial skin breakdown on the inner right hand above her thumb". At the time of the survey, there was no evidence that the aforementioned incident was investigated. 2. Interview and review of Client 1's medical record on November 21, 2007 at 7:32 PM revealed that the client was seen by the Podiatrist on February 26, 2007. Further review of the record revealed that the Podiatrist discovered a "black discoloration" of the client's right great toe and indicated that if the discoloration was not healed in one week refer the client to a Dermatologist. On November 21, 2007 at 7:40 PM, an interview was conducted with the nurse to ascertain if there was an incident report regarding the aforementioned incident. According to the facility's nurse, there was no documented evidence of an incident report. Additionally, there was not evidence the aforementioned intident was investigated. It should be noted that interview with the Qualified Mental Retardation Professional (QMRP) on November 20, 2007, at 12:06 PM revealed information regarding the facility's incident	W 154	W154, continued... follow-up.	

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

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W 154	Continued From page 13 management system. According to the QMRP, the facility is required to immediately initiate investigations for injuries of unknown source. At the time of the survey, the facility failed to ensure that all injuries of unknown origin were investigated.	W 154		
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS 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 interview and record review, the facility failed to ensure that the results of all investigations were reported to the administrator or designee within five working days, for two of the eight clients (Clients #1 and #7) residing in the facility. The finding includes: Review of the incident reports and investigations on November 20, 2007 beginning at 2:01 PM revealed the following incidents (allegations of abuse and/or injuries of unknown source): a. On August 22, 2007, staff reported that Client #7 was observed to have a swollen right elbow at the day program. Client #7 was taken to the emergency room and was subsequently diagnosed with a contusion of the elbow. b. On September 9, 2007, staff reported that Client #1 was observed with a blister on her left	W 156	W156 Reference responses to W148, W149, W153, & W154.	1.8.08 ongoing

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 156	Continued From page 14 wrist. According to the incident report, the administrator was notified of the incident on September 9, 2007. On September 10, 2007, however, the Qualified Mental Retardation Professional (QMRP) documented an addendum on the incident report that revealed Client #1 had a second blister on her right wrist. Interview with the Qualified Mental Retardation Professional (QMRP) on November 20, 2007, at 12:06 PM revealed information regarding the facility's incident management system. According to the QMRP, the facility is required to immediately initiate an investigation for injuries of unknown source and complete the investigation within five working days. Review of the investigations for aforementioned incidents however, failed to provide evidence that the administrator or designee was made aware of the results of the investigations.	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, interview and record verification, the facility failed to ensure each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP) for two of the eight clients (Clients #4 and #8) residing in the facility. The findings include:	W 159	W159 This Standard will be met as evidenced by:	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 159	Continued From page 15 1. The QMRP failed to ensure that the staff received effective training on preparing Resident #6's food in accordance with her prescribed dietary texture (pureed). [See W189] 2. The QMRP failed to ensure that the staff received effective training on monitoring and reporting malfunctioning assistive devices. [See W436]	W 159	W159, continued... (1) Reference response to W189 (2) Reference response to W436.	
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each employee was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently. The findings include: 1. The facility failed to ensure that the staff were effectively trained on the " Incident Management " policy. [See W149] 2. The facility failed to ensure staff were effectively trained on providing meals in accordance with each client's dietary needs. 3. The facility failed to ensure staff were trained to identify and immediately report client dignity issues as evidenced below:	W 189	W189 This Standard will be met as evidenced by: (1) Reference response to W149 (2) QMRP will provide/coordinate additional staff training to ensure that each clients dietary needs are met.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 189	Continued From page 16 Interview with the Director of Residential Services, the Assistant Director of Residential Services, and the QMRP and review of the facility records on November 20, 2007 revealed that a facility nurse, in an attempt to prevent Client #1 from picking at an injury, placed socksion each of the client's hands which were secured by rubber bands. The socks were removed priorto the client's evening shower at approximately 6:30 PM, and blisters were found around her wrists. There was no evidence that staff reported how Client #1's hands were being restrained until the socks were removed. (Also See W153)	W 189	(3) Reference response to W153.	
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's nursing services failed to ensure that each client received nursing services in accordance with their needs, for one of the four clients included in the sample. (Clients #1) The finding includes: Review of the incident reports and investigations on November 20, 2007 beginning at 2:01 PM revealed the following incident (allegations of abuse and/or injuries of unknown source) involving Client #1: On September 9, 2007, staff reported that Client #1 was observed with a blister on her left wrist. On September 10, 2007, the Qualified Mental Retardation Professional (QMRP) documented an addendum on the incident report that revealed	W 331	W331 This Standard will be met as evidenced by: Nurse no longer is employed with the agency. RN will continue to monitor and supervise nursing services and provide training and feedback as needed to ensure	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 331	Continued From page 17 Client #1 had a second blister on her right wrist. An investigation was conducted dated September 11, 2007 to ascertain the cause of the injuries. According to the investigation the source of the injuries appeared to be caused by socks and rubber bands placed on Client #1's hands but the person that placed the socks and rubber bands on the client's wrists remained unknown. On September 13, 2007, the provider agency was notified of an allegation of abuse involving Client #1. According to interview with the Assistant Director of Residential Services and the QMRP, a staff member alleged that Client #1 was abused and received the aforementioned injuries to her wrist as a result of the abuse. Interview with the Director of Residential Services on November 20, 2007 and further record review revealed a second investigation was conducted by the facility to address the allegation of abuse. Interview with the Director of Residential Services and review of the investigation summary dated September 24, 2007 revealed that the facility's Licensed Practical Nurse was responsible for placing the socks and rubber bands on the client's hands that subsequently caused the injury. The investigation summary further revealed that the socks were place on Client #1's hands to prevent her from causing injury to her forehead. Note: On September 6, 2007, Client #1 fell from a shower chair and was noted to receive a laceration to the forehead that was treated with Derma bond. Client #1 was observed to pick at the Derma bond causing the adhesive to be removed and re-opened the wound. At the time of the survey, the facility failed to ensure that appropriate nursing services were	W 331	W331 - continued... compliance with this standard.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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W 331	Continued From page 18 provided in accordance with the the client's needs.	W 331		
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, interview and record verification, the facility failed to ensure the maintenance of each client's adaptive equipment (communication device) for one of four clients (Client #4) included in the sample. The findings include: Observations on November 21, 2007 at approximately 6:45 PM revealed a communication device for Client #4. The surveyor interviewed the staff and noted that the device was inoperable. Further interview and review of the habilitation records revealed the client had an objective to use a "low-tech communication device touching a picture of her bedroom 3 of 5 trials while pressing the desired button with hand over hand assistance 1 time daily. At the time of the survey, the facility failed to ensure Client #4's communication device was maintained in good repair.	W 436	W 436 This Standard will be met as evidenced by QMRP will follow-up to ensure that the low-tech communication device is in good working order.	12.3.07 ongoing
W 460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing,	W 460	W460	

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W 460	Continued From page 19 well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that each client received their meals in accordance with their dietary needs for one of the eight clients (Client #8) that resides in the facility. The finding includes: Observation of the dinner meal on November 20, 2007 at approximately 6:09 PM revealed that Client #8 was served coleslaw, beans, and beef. The direct care staff was observed to attempt to feed the client, however she refused to eat. At 6:15 PM, the direct care staff was observed to ask the facility's nurse to rewarm Client #8's food in the microwave. At 6:24 PM, interview with the nurse revealed that the texture of the client's food should be pureed. However, at the time of the observation, the client's food appeared to be the consistency of soup. The nurse was observed to review Client #8's mealtime protocol and verified that the recommended texture of her food was pureed. At 6:32 PM, the direct care staff was observed to attempt to offer to feed Client #8 again, but she continued to refuse to eat. Interview with the direct care staff at 6:35 PM revealed that the staff mixed three scoops of the client's supplement (beneprotein) into her food. The staff member indicated that the added supplement was probably the cause of the food's soupy consistency. Review of the Mealtime	W 460	W460, continued... This Standard will be met as evidenced by: QMRP will coordinate additional staff training in nutrition management. QMRP/Home Manager will conduct mealtime observations and provide direction and feedback for staff as needed to ensure ongoing compliance with this standard. Medical/Nursing staff will also monitor meal preparation/feeding	

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W 460	Continued From page 20 Protocol on November 20, 2007 at 6:35 PM however, revealed that the client was recommended to receive two scoops of the supplement (beneprotein) instead of three. Review of training records on November 21, 2007 at approximately 1:30 PM revealed that staff had nutritional training on June 30, 2006. Further review of the agenda revealed that the training included training in each client's mealtime protocol. At the time of the survey, however, the facility failed to provide evidence that client's received their meals in accordance with their dietary needs.	W 460	to ensure compliance with each individual's dietary needs.	1.8.08 ongoing

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I 000	INITIAL COMMENTS A re-licensure survey was conducted from November 19, 2007 through November21, 2007. A random sample of four residents was selected from a residential population of eight females with mental retardation and other disabilities. The survey findings were based on observations in the group home and at one day program, interviews and a review of records, including unusual incident reports.	I 000	This Statute will be met as evidenced by:	
I 044	3502.3 MEAL SERVICE / DINING AREAS All food and drink shall be clean, wholesome, free from spoilage, and properly prepared. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the GHMRP failed to ensure that resident's received meals in a form and consistency as ordered for one of eight residents (Resident #8) residing in the facility. The finding includes: Observation of the dinner meal on November 20, 2007 at approximately 6:09 PM revealed that Client #8 was served coleslaw, beans, and beef. The direct care staff was observed to attempt to feed the client, however she refused to eat. At 6:15 PM, the direct care staff was observed to ask the facility's nurse to rewarm Client#8's food in the microwave. At 6:24 PM, interview with the nurse revealed that the texture of the client's food should be pureed. However, at the time of the observation, the client's food appeared to be the consistency of	I 044	1044 3502.3 Reference response to Federal Deficiency Report W189 and W460.	1.8.08

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE 12.14.07

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I 044	Continued From page 1 soup. The nurse was observed to review Client #8's mealtime protocol and verified that the recommended texture of her food was pureed. At 6:32 PM, the direct care staff was observed to attempt to offer to feed Client #8 again, but she continued to refuse to eat. Interview with the direct care staff at 6:35 PM revealed that the staff mixed three scoops of the client's supplement (beneprotein) into her food. The staff member indicated that the added supplement was probably the cause of the food's soupy consistency. Review of the Mealtime Protocol on November 20, 2007 at 6:36 PM however, revealed that the client was recommended to receive two scoops of the supplement (beneprotein) instead of three. Review of training records on November 21, 2007 at approximately 1:30 PM revealed that staff had nutritional training on June 30, 2006. Further review of the agenda revealed that the training included training in each client's mealtime protocol. At the time of the survey, however, the facility failed to provide evidence that client's received their meals in accordance with their dietary needs.	I 044		
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:	I 229	1229 3510.(f) Reference response to W189 Federal Deficiency Report.	

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I 229	Continued From page 2 Based on observation, interview, and record review, the GHMRP failed to ensure staff were effectively trained on each resident's dietary plan for one of the eight residents (Resident #8) residing in the facility. The finding includes: Observation of the dinner meal on November 20, 2007 at approximately 6:09 PM revealed that Client #8 was served coleslaw, beans, and beef. The direct care staff was observed to attempt to feed the client, however she refused to eat. At 6:15 PM, the direct care staff was observed to ask the facility's nurse to rewarm Client #8's food in the microwave. At 6:24 PM, interview with the nurse revealed that the texture of the client's food should be pureed. However, at the time of the observation, the client's food appeared to be the consistency of soup. The nurse was observed to review Client #8's mealtime protocol and verified that the recommended texture of her food was pureed. At 6:32 PM, the direct care staff was observed to attempt to offer to feed Client #8 again, but she continued to refuse to eat. Interview with the direct care staff at 6:35 PM revealed that the staff mixed three scoops of the client's supplement (beneprotein) into her food. The staff member indicated that the added supplement was probably the cause of the food's soupy consistency. Review of the Mealtime Protocol on November 20, 2007 at 6:36 PM however, revealed that the client was recommended to receive two scoops of the supplement (beneprotein) instead of three. Review of training records on November 21, 2007	I 229	1229 Also reference responses to W460 Federal Deficiency report.	1.5.08 ongu

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I 229	Continued From page 3 at approximately 1:30 PM revealed that staff had nutritional training on June 30, 2006. Further review of the agenda revealed that the training included training in each client's mealtime protocol. At the time of the survey, however, the facility failed to provide evidence that client's received their meals in accordance with their dietary needs.	I 229		
I 374	3519.5 EMERGENCIES After medical services have been secured, each GHMRP shall promptly notify the resident's guardian, his or her next of kin if the resident has no guardian, or the representative of the sponsoring agency of the resident's status as soon as possible, followed by written notice and documentation no later than forty-eight (48) hours after the incident. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that after medical services were secured, prompt notification of the resident's status would be made as soon as possible to the resident's guardian, his or her next of kin if the resident had no guardian, or the representative of the sponsoring agency, followed by written notice and documentation no later than forty-eight (48) hours after the incident, for one of the eight residents (Resident #7) included in the sample. The findings include: Review of the incident reports and investigations on November 20, 2007 beginning at 2:01 PM revealed that on August 22, 2007, staff reported that while at the day program Client #7 was observed to have a swollen right elbow. Client	I 374	3519.5 Emergencies 1374 This Statute will be met as evidenced by: Reference responses to Federal Deficiency Report W148, W149 W153, W154, W156 W159 and W169.	1.8.08 ongoing

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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 374	Continued From page 4 #7 was taken to the emergency room and was subsequently diagnosed with a contusion of the elbow. Further review of the incident report revealed that the client's legal guardian was notified of the incident on September 14, 2007 (twenty-three days after the injury). Interview with the Qualified Mental Retardation Professional (QMRP) on November 20, 2007, at 12:06 PM revealed information regarding the facility's incident management system. According to the QMRP, the guardian was to be notified immediately of all allegations of abuse and injuries of unknown origin. At the time of the survey, the facility failed to ensure Client #7's guardian was made aware of the aforementioned incident in a timely manner.	I 374		
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure the Department of Health, Health Facilities Division was immediately, followed by written notification within 24 hours, notified of unusual incidents that substantially interfered with a residents health, for one of the eight residents (Residents #1 and	I 379		

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I 379	Continued From page 5 #7) that resided in the facility. The findings include: 1. Review of the incident reports and investigations on November 20, 2007 beginning at 2:01 PM revealed the following incidents (allegations of abuse and/or injuries of unknown source) were not reported as required: a. On August 22, 2007, staff reported that Client #7 was observed to have a swollen right elbow at the day program. Client #7 was taken to the emergency room and was subsequently diagnosed with a contusion of the elbow. Further review of the incident report revealed that both the administrator and the Department of Health (DOH) were notified of the incident on September 14, 2007. b. On September 9, 2007, staff reported that Client #1 was observed with a blister on her left wrist. According to the incident report, the administrator was notified of the incident on September 9, 2007. On September 10, 2007, however, the Qualified Mental Retardation Professional (QMRP) documented an addendum on the incident report that revealed Client #1 had a second blister on her right wrist. It should be noted that there was no evidence the DOH was notified of the aforementioned injuries. 2. Additionally, interview and review of Client 1's medical record on November 21, 2007 at 7:32 PM revealed that the client was seen by the Podiatrist on February 26, 2007. Further review of the record revealed that the Podiatrist discovered a "black discoloration" of the client's right great toe and indicated that if the discoloration was not healed in one week refer	I 379		

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I 379	Continued From page 6 the client to a Dermatologist. On November 21, 2007 at 7:40 PM, an interview was conducted with the nurse to ascertain if there was an incident report regarding the aforementioned incident. According to the facility's nurse there was no documented evidence of an incident report. 3. Review of incidents during pre-survey activities revealed staff reported that on July 23, 2007, Client #7 sustained a skin tear on her right elbow with some swelling noted. During the survey process, there was neither any evidence of an incident report for the aforementioned incident nor any evidence that the administrator was made aware of the incident. Additionally, the DOH was not made aware of the incident until September 14, 2007. Interview with the QMRP on November 20, 2007, at 12:06 PM revealed information regarding the facility's incident management system. According to the QMRP, the administrator was to be notified immediately of all allegations of abuse and injuries of unknown origin. At the time of the survey, the facility failed to ensure the administrator and the Department of Health were notified timely of allegations of abuse and/or injuries of unknown origin as required.	I 379		