

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

PRINTED: 09/11/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/28/2013
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NAME OF PROVIDER OR SUPPLIER  COMMUNITY MULTI SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6300 9TH STREET NW WASHINGTON, DC 20011
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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) COMPLETION DATE
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<p>W 000 INITIAL COMMENTS</p> <p>A recertification survey was conducted from August 26, 2013 through August 28, 2013. A sample of three clients was selected from a population of six females with varying degrees of intellectual disabilities. This survey was initiated utilizing the fundamental survey process.</p> <p>The findings of the survey were based on observations in the home and two day programs, interviews with one guardian, direct support staff, nursing and administrative staff, as well as a review of client and administrative records, including incident reports.</p> <p>[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]</p> <p>W 120 483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>The facility must assure that outside services meet the needs of each client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure each staff was trained on behavior support plan (BSP), for one of the three clients that required one to one (1:1) supervision during awaking hours. (Client #1)</p> <p>The finding includes:</p> <p>The day program staff failed to ensure all staff was trained on Client #1's BSP, as evidenced below:</p>	<p>W 000</p> <p>W 120</p> <p>The facility's psychologist will be requested to visit Client #1's day program to make observations and provide training for all of her staff.</p> <p>9/12/13</p>
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*Received 9/18/13*  
 Department of Health  
 Health Regulation & Licensing Administration  
 Intermediate Care Facilities Division  
 899 North Capitol St., N.E.  
 Washington, D.C. 20002

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Constance A. Reese* TITLE: *Program Director* (X6) DATE: *9/18/13*

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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NAME OF PROVIDER OR SUPPLIER  COMMUNITY MULTI SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6300 9TH STREET NW WASHINGTON, DC 20011	
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W 120	Continued From page 1  On August 26, 2013, at 11:08 a.m., observations conducted at the day program revealed Client #1's 1:1 staff (Staff #5) asked the day program staff (DPS) #1 if he would watch the client while she stepped out of the classroom for a couple of minutes. DPS #1 agreed to do so. While Client #1 remained seated at the computer, DPS #1 was observed to step outside the classroom to assist another staff with a client. During this time, Client #1 was observed patting down her computer chair. DPS #1 stepped back inside the classroom and provided no intervention. Approximately thirty seconds later, Staff #6 re-entered the classroom and immediately redirected the client to stop. Staff #5 stated that patting down chairs was one of her targeted behaviors.  At approximately 11:10 a.m., Interview with DPS #1 revealed that he was aware that Client #1 required 1:1 services at all times while at the day program. Further Interview with DPS #1 stated that he had not been trained on Client #1's BSP. When asked, DPS #1 could not identify Client #1's specific targeted behaviors. At 11:21 a.m., interview with the day program case manager (DPCM) #1 revealed that all staff were trained on all clients BSPs including Client #2.  Review of the day program's training records on August 26, 2013, beginning at approximately 11:22 a.m. revealed DPCM #1 could not produce any written documented evidence that DPS #1 had received training on Client #1's BSP.	W 120	QIDP and Residential Manager will visit the day program monthly to make observation of Client #1's day program to ensure that training from the Psychologist was effective.	9/28/13
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS  The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as	W 153		

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W 153	<p>Continued From page 2</p> <p>injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>This STANDARD is not met as evidenced by: Based on interview and review record, the facility failed to ensure that all allegations of abuse were reported immediately to the administrator and the Department of Health, Health Regulation and Licensing Administration (HRLA) timely, for one of the three clients included in the sample. (Client #1)</p> <p>The finding includes:</p> <p>On August 26, 2013, beginning at 2:04 p.m., review of an incident report dated June 8, 2013, revealed that Client #1's guardian visited her during a recent hospitalization. The guardian reported that she observed Client #1's one to one (1:1) staff pulling the client by the arm. The client was observed to resist by leaning in the opposite direction away from the staff.</p> <p>Interview with the incident management coordinator (IMC) #1 on August 26, 2013, at approximately 2:40 p.m., revealed that he notified the facility's administrator of the allegation of abuse on July 10, 2013, thirty-two (32) days later. Further interview with IMC #1 revealed that she notified HRLA on July 12, 2013, 34 days later after the incident.</p>	W 153	<p>In the future all allegations of abuse will be documented and immediately reported to the Administrator and Department of Health Regulation and Licensing Administration. The Incident Management Coordinator (IMC) will provide additional training to staff and test for competence.</p> <p>9/20/13</p>

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W 153	Continued From page 3 At the time of the survey, the facility failed to ensure that an allegation of abuse was reported immediately to the administrator and the Department of Health timely.	W 153			
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 report the results of investigations to the administrator or designated representative within five working days for an incident of abuse, for one of the three clients included in the sample. (Client #1)  The finding includes:  The facility failed to provide documented evidence the administrator was notified of the results of the investigation within 5 working days of the incident, as required by federal regulation.  Review of the facility's incident management records on August 26, 2013, beginning at 2:04 p.m., revealed that on June 8, 2013, Client #1's guardian visited her during a recent hospitalization. The guardian reported that she observed Client #1's one to one (1:1) staff pulling the client by the arm. The client was observed to resist by leaning in the opposite direction away	W 156	Investigations will be completed within five working days of the incident. The Administrator will review and sign all incidents. The Incident Management Coordinator will monitor for completion within required time.	9/20/13	

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W 156	Continued From page 4 from the staff. Review of the corresponding investigative report revealed the investigation was completed on July 24, 2013. (46 days after the incident occurred). There was no documented evidence that the administrator was informed of the investigation results prior to July 24, 2013.  Interview with the house manager (HM) #1 on August 26, 2013, at approximately 2:40 p.m., confirmed that the result for the aforementioned incident was not reviewed by administrator within five working days.	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 review, the facility's qualified Intellectual disabilities professional (QIDP) failed to ensure new behaviors were identified and communicated to the psychologist, for one out the three clients in the sample. (Clients #2)  The finding includes:  The QIDP failed to ensure that Client #3's known behavior of food stealing was incorporated as part of the behavior support plan (BSP).  On August 26, 2013, at 4:05 p.m., evening observations revealed Client #3 reached over on	W 159	The facility's Psychologist will instruct staff to collect baseline data on food snatching for Client # 3. QIDP and Residential Manager will monitor at mealtime.	9/28/13	

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W 159	<p>Continued From page 5</p> <p>two (2) occasions and attempted to grab Client #6's snack but was redirected by Staff #2. At approximately 5:14 p.m., during dinner, Client #2 reached over to Client #6's plate and grabbed a piece of chicken off of the plate and ate it. Staff #2 verbally prompted Client #3 not to "snatch" food off of her housemates' plate.</p> <p>On August 27, 2013, at approximately 10:50 a.m., interview with Staff #1 revealed that she was aware of Client #2's food stealing and indicate it occurred frequently. Interview with Staff #6 on August 27, 2013, at approximately 11:00 a.m., also revealed that she has observed Client #3 attempting to snatch food from her housemates. Interview with Staff #2 on August 27, 2013, at 4:10 p.m., revealed she was assigned as Client #3's 1:1 staff 5 days a week from 4:00 p.m. to 8:00 p.m. due to her maladaptive behaviors of intermittent explosive disorders and yelling. Further interview with Staff #2 revealed that food "snatching" was not part of Client #3's behavior support plan (BSP). When asked, Staff #2 stated that Client #3 attempts to snatch/grab her housemates' food occurs at least once a day during snacks and meals.</p> <p>On August 28, 2013, at approximately 10:30 a.m., interview with QIDP #1 revealed that she observed on August 26, 2013, during dinner Client #3 reach over and grabbed a piece of chicken off of Client #6's plate. Further interview with QIDP #1 revealed that this behavior of food snatching was not one of Client #3's targeted behaviors. Continued interview with QIDP #1 revealed she had observed this behavior sporadically. Further discussion with QIDP #1</p>	W 159	<p>QIDP will meet with IDT on Client #3 food snatching. Baseline data will be collected for 30 days.</p> <p>9/28/13</p>

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W 159	Continued From page 6 revealed that she had been employed as the QIDP of the facility since December 2012. When asked, QIDP #1 stated that she had not coordinated with the psychologist to address Client #3's behavior of food snatching. The QIDP #1 stated that she would address this issue with the teams at the next pre-individual support plan meeting on September 9, 2013.	W 159			
W 242	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN  The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop and implement a communication training objective, for one of the three clients in the sample. (Client #2)  The finding includes:  On August 26, 2013, beginning at 12:04 p.m., Client #2 was observed sitting at the day program table working on arts and crafts. As the surveyor introduced himself to the client, Client #2 looked up and waved. Day program staff (DPS) #1 responded immediately by saying that Client #2 was non-verbal. On August 27, 2013 at 3:45 p.m.,	W 242			

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W 242	<p>Continued From page 7</p> <p>Client #2 was observed completing an alphabet puzzle without assistance for approximately five minutes. While completing the puzzle, Client #2 attempted to place the "Q" puzzle piece into the letter "O" slot but was unsuccessful. Client #2 was then observed to bang the "Q" puzzle piece into the "O" puzzle slot several times and appeared to show signs of agitation and frustration. Staff #3 (who was assigned to Client #2) assisted Client #2 by pointing to the correct placement for the letter "Q" on the puzzle board. Client #2 immediately returned a smile to Staff #3. Continued observations of the client throughout the survey verified that the client could not verbally or orally communicate. The client was observed to make undistinguishable vocalizations.</p> <p>Interview with Staff #3 on August 27, 2013, at approximately 3:50 p.m., revealed that Client #2 had a functional communication book to assist her with communicating. Staff #3 revealed that the communication book should be used by showing the item consistent with the picture, repeat the name of the item, and encourage Client #3 to point to the same item shown on the page. Interview with QIDP #1 on the same day 3:45 p.m. confirmed that Client #2 had a functional communication book. QIDP #1 revealed that the communication book should be used by presenting the book to Client #2 and encouraging the client to make request by pointing to the picture (drink, bathroom, food) randomly throughout the day. The communication book, however was not available to Client #2 at the day program.</p> <p>On August 28, 2013, at approximately 9:30 a.m. review of Client #2's clinical records revealed a</p>	W 242	<p>The facility's Speech Pathologist will visit the day program to make observation and provide training to staff at the day program and home on Client #2 communication book. QIDP and Residential Manager will monitor the use of the communication book at the day program and home monthly.</p>	9/18/13

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W 242	<p>Continued From page 8</p> <p>Speech and Language Assessment dated November 23, 2012. According to the assessment, a recommendation was made to continue use of the functional communication book daily. At 11:40 a.m., interview with the QIDP revealed that Client #2 did not have a formal goal or training objective program for the use of the communication book. At approximately 12:15 p.m. review of the Client #2's Individual Program Plan (IPP), dated January 15, 2013) confirmed the QIDP's aforementioned interview.</p> <p>At the time of the survey, there was no documented evidenced that the facility developed a training program that is essential for Client #2 to communicate basic needs.</p>	W 242		

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NAME OF PROVIDER OR SUPPLIER  <b>COMMUNITY MULTI SERVICES, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6300 9TH STREET NW WASHINGTON, DC 20011</b>
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I 000	<p><b>INITIAL COMMENTS</b></p> <p>A licensure survey was conducted from August 26, 2013 through August 28, 2013. A sample of three residents was selected from a population of six females with varying degrees of intellectual disabilities.</p> <p>The findings of the survey were based on observations in the home and two day programs, interviews with one guardian, direct support staff, nursing and administrative staff, as well as a review of resident and administrative records, including incident reports.</p> <p>[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]</p>	I 000		
I 180	<p><b>3508.1 ADMINISTRATIVE SUPPORT</b></p> <p>Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for individuals with Intellectual disabilities (GHIID) qualified intellectual disabilities professional (QIDP) failed to ensure new behaviors were identified and communicated to the psychologist, for one out the three residents in the sample. (Residents #3)</p> <p>The finding includes:</p> <p>The QIDP failed to ensure that Resident #3's known behavior of food stealing was incorporated as part of the behavior support plan (BSP).</p>	I 180	Cross-reference W120 W159	9/28/13

Health Regulation & Licensing Administration  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Constantine A. Reese* Program Director

TITLE

(X6) DATE

9/18/13

STATE FORM

FPZH11

Continuation sheet 1 of 6

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I 180	<p>Continued From page 1</p> <p>On August 26, 2013, at 4:05 p.m., evening observations revealed Resident #3 reached over on two (2) occasions and attempted to grab Resident #6's snack but was redirected by Staff #2. At approximately 5:14 p.m., during dinner, Resident #2 reached over to Resident #6's plate and grabbed a piece of chicken off of the plate and ate it. Staff #2 verbally prompted Resident #3 not to "snatch" food off of her housemates' plate.</p> <p>On August 27, 2013, at approximately 10:50 a.m., interview with Staff #1 revealed that she was aware of Resident #2's food stealing and indicate it occurred frequently. Interview with Staff #8 on August 27, 2013, at approximately 11:00 a.m., also revealed that she has observed Resident #3 attempting to snatch food from her housemates. Interview with Staff #2 on August 27, 2013, at 4:10 p.m., revealed she was assigned as Resident #3's 1:1 staff 5 days a week from 4:00 p.m. to 8:00 p.m. due to her maladaptive behaviors of Intermittent explosive disorders and yelling. Further interview with Staff #2 revealed that food "snatching" was not part of Resident #3's behavior support plan (BSP). When asked, Staff #2 stated that Resident #3 attempts to snatch/grab her housemates' food occurs at least once a day during snacks and meals.</p> <p>On August 28, 2013, at approximately 10:30 a.m., interview with QIDP #1 revealed that she observed on August 26, 2013, during dinner Resident #3 reach over and grabbed a piece of chicken off of Resident 6's plate. Further interview with QIDP #1 revealed that this behavior of food snatching was not one of Resident #3's</p>	I 180	

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I 180	Continued From page 2  targeted behaviors. Continued interview with QIDP #1 revealed she had observed this behavior sporadically. Further discussion with QIDP #1 revealed that she had been employed as the QIDP of the GHIID since December 2012. When asked, QIDP #1 stated that she had not coordinated with the psychologist to address Resident #3's behavior of food snatching. The QIDP #1 stated that she would address this issue with the teams at the next pre-individual support plan meeting on September 9, 2013.	I 180		
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 review of resident records, including incident reports and investigations, the group home for individuals with intellectual disabilities (GHIID) failed to ensure that all incidents that present a risk to residents' health and safety were reported immediately to the Department of Health, Health Regulation and Licensing Administration (DOH/HRLA), for one of the three residents of the facility. (Resident #1)	I 379	Cross-reference W153 W156	9/20/13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0083	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  08/28/2013
NAME OF PROVIDER OR SUPPLIER  COMMUNITY MULTI SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 6300 9TH STREET NW WASHINGTON, DC 20011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 379	Continued From page 3  The finding includes:  The facility failed to ensure that an allegation of abuse was reported immediately to the DOH, as evidenced below:  On August 26, 2013, beginning at 2:04 p.m., review of an incident report dated June 8, 2013, revealed that Client #1's guardian visited her during a recent hospitalization. The guardian reported that she observed Client #1's one to one (1:1) staff pulling the client by the arm. The client was observed to resist by leaning in the opposite direction away from the staff.  Interview with the incident management coordinator (IMC) #1 on August 26, 2013, at approximately 2:40 p.m., revealed that he notified HRLA on July 12, 2013, 34 days later.	I 379		
I 422	3521.3 HABILITATION AND TRAINING  Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident 's Individual Habilitation Plan.  This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for individuals with intellectual disabilities (GHID) failed to develop and implement a communication training objective, for one of the three residents in the sample. (Resident #2)  The finding includes:	I 422	Cross-reference W242	9/18/13

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NAME OF PROVIDER OR SUPPLIER  COMMUNITY MULTI SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 6300 9TH STREET NW WASHINGTON, DC 20011	
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I 422	<p>Continued From page 4</p> <p>On August 26, 2013, beginning at 12:04 p.m., Resident #2 was observed sitting at the day program table working on arts and crafts. As the surveyor introduced himself to the resident, Resident #2 looked up and waved. Day program staff (DPS) #1 responded immediately by saying that Resident #2 was non-verbal. On August 27, 2013 at 3:45 p.m., Resident #2 was observed completing an alphabet puzzle without assistance for approximately five minutes. While completing the puzzle, Resident #2 attempted to place the "Q" puzzle piece into the letter "O" slot but was unsuccessful. Resident #2 was then observed to bang the "Q" puzzle piece into the "O" puzzle slot several times and appeared to show signs of agitation and frustration. Staff #3 (who was assigned to Resident #2) assisted Resident #2 by pointing to the correct placement for the letter "Q" on the puzzle board. Resident #2 immediately returned a smile to Staff #3. Continued observations of the resident throughout the survey verified that the resident could not verbally or orally communicate. The resident was observed to make undistinguishable vocalizations.</p> <p>Interview with Staff #3 on August 27, 2013, at approximately 3:50 p.m., revealed that Resident #2 had a functional communication book to assist her with communicating. Staff #3 revealed that the communication book should be used by showing the item consistent with the picture, repeat the name of the item, and encourage Resident #3 to point to the same item shown on the page. Interview with QIDP #1 on the same day 3:45 p.m. confirmed that Resident #2 had a functional communication book. QIDP #1</p>	I 422	

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NAME OF PROVIDER OR SUPPLIER  COMMUNITY MULTI SERVICES, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 6300 9TH STREET NW WASHINGTON, DC 20011	
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1422	<p>Continued From page 5</p> <p>revealed that the communication book should be used by presenting the book to Resident #2 and encouraging the resident to a make request by pointing to the picture (drink, bathroom, food) randomly throughout the day. The communication book, however was not available to Resident #2 at the day program.</p> <p>On August 28, 2013, at approximately 9:30 a.m. review of Resident #2's clinical records revealed a Speech and Language Assessment dated November 23, 2012. According to the assessment, a recommendation was made to continue use of the functional communication book daily. At 11:40 a.m., interview with the QIDP revealed that Resident #2 did not have a formal goal or training objective program for the use of the communication book. At approximately 12:15 p.m. review of the Resident #2's Individual Program Plan (IPP), dated January 15, 2013) confirmed the QIDP's aforementioned interview.</p> <p>At the time of the survey, there was no documented evidenced that the GHIID developed a training program that is essential for Resident #2 to communicate basic needs.</p>	1422	