

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

PRINTED: 07/23/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G228	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/11/2012
NAME OF PROVIDER OR SUPPLIER RCM OF WASHINGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 2420 T STREET, SE WASHINGTON, DC 20020		
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W 159	<p>Continued From page 1</p> <p>At 10:42 a.m., day program staff #1 (DPS) tried to keep the client awake by engaging her in listening to music. Client #3 showed no interest. At 10:58 a.m., DPS #1 tried to keep the client awake by engaging her into group activities. Again, Client #3 showed no interest. This was observed by the day program registered nurse #1(DPRN) as well. At 11:20 a.m., Client #3 was awake and alert as she manipulated a tabletop game (Busy) that was presented to her. At approximately 11:40 p.m., DPS #1 was observed raising Client #3's up over her head repeatedly to complete range of motion exercises.</p> <p>Interview with the day program case manager/director #1 (CM/D) on July 10, 2012, at approximately 11:55 a.m., revealed that it had been a little challenging trying to engage Client #3 in morning activities due to her sleepiness. When asked if the day program staff had notified the client's home of her sleepiness, the CM/D #1 responded by saying, the group home had been made aware. Interview with the DPRN #1 on the same day at approximately 12:05 p.m. revealed that she was not aware that Client #3 had been sleeping on and off during that morning hours.</p> <p>Review of the day program's sleep records on July 10, 2012, at approximately 12:15 p.m., revealed a sleep chart for July 2012. According to the sleep chart, Client #3 was documented as sleeping on and off during the dates of July 6, 9 and 10, 2012. Further review revealed the most current physician's orders (POs) located in the record was dated January 2012. At approximately 12:20 p.m., DPRN #1 was asked if there was a more current PO that had not been filed in the record. The DPRN replied by saying</p>	W 159	<p>It is RCM policy for the individuals to be provided with the best possible care. Individual #3's POs is sent to the day program on a monthly basis; however, the day program did not receive the POs reflecting the increase of the seizure medication. There will be a constant communication between the facility nurse and the program each time there is a change in the individual's regimen. In the future, the facility's RN and QIDP will ensure that POs are delivered to the day program, and that there is constant communication between both entities especially when there is a change in the individuals' medical status. The hand delivered form will be signed by the day program to acknowledge receipt. Refer to attachment #1</p>	

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W 159	<p>Continued From page 2</p> <p>"no". DPRN #1 immediately stated that she would call the group today to request a copy of the current POs and to see if there has been any change in her medical status.</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) on July 10, 2012, at 1:15 p.m., revealed that she was not made aware that Client #3 was sleeping during the morning time within the past few days by the day program. The QIDP did state that she was aware of the increase in Client #3's recent seizure medications. Interview with the facility's registered nurse #1 (RN) on July 11, 2012, at approximately 11:20 a.m., revealed that Client #3 has had several seizures within the past month. Further interview revealed Client #3 was sent to the neurologist on July 3, 2012. The neurologist increased Client #3's seizure medication (Keppra) from 1000 mg twice a day to 1500 mg twice a day. The RN then stated that the increase in Client #3's medication could be a contributing factor in the client's sleepiness during the morning time. The RN indicated that one of the side effects of Keppra was somnolence (drowsiness, sleepiness). When asked, RN #1 stated that the day program had not been made aware of the change in Client #3's medication regimen.</p> <p>Review of Client #3's medical records on July 11, 2012, at approximately 1:58 p.m., revealed a written physician's order (POs) dated July 3, 2012. The POs confirmed the RN's interview that Keppra had been increased to 1500 twice a day.</p> <p>At the time of the survey, there was no evidence</p>	W 159	<p>It is RCM policy for the individuals to be provided with the best possible care. Individual #3's POs is sent to the day program on a monthly basis; however, the day program did not receive the POs reflecting the increase of the seizure medication.</p> <p>There will be a constant communication between the facility nurse and the program each time there is a change in the individual's regimen. In the future, the facility's RN and QIDP will ensure that POs are delivered to the day program, and that there is constant communication between both entities especially when there is a change in the individuals' medical status.</p> <p>The hand delivered form will be signed by the day program to acknowledge receipt. Refer to attachment #1</p>

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W 159 Continued From page 3
that the QIDP coordinated with Client #3's day program when there was a change in Client #3's medication regimen.

W 159

Note: According the RN, it was a shared responsibility between the qualified intellectual disabilities professional (QIDP) and RN in ensuring that the day program received current physician's orders and when there was a change in the client's medical status.

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

W 189

The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.

This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure staff was provided with initial and continuing training that enabled them to perform their duties effectively, efficiently, and competently, for one of the three clients who used adaptive feeding equipment. (Client #3)

The finding includes:

On July 9, 2012, beginning at 7:25 p.m., observations of the dinner meal revealed Staff #3 served Client #3 seafood salad, squash, crushed pineapples, bread and a beverage. At 7:35 p.m., Staff #4 (not assigned to Client #3) was observed to give Client #3 some ensure (nutritional supplement) using her nosey cup. Staff #4 held the nosey cup up to the client's mouth with the open area of the cup facing opposite of her face.

All staff were inserviced on individual #3's mealtime adaptive equipment on 7-13-12
Refer to attachment #2
The inservice was completed for the rest of the individuals' adaptive equipment as well on 7-13-12
Refer to attachment #3.
In addition, there was an agency wide inservice on the adaptive equipment conducted by the Speech and Language Pathologist on 7-27-12
Refer to attachment #4.
In the future, the facility will ensure that all staff are trained on the use of the individuals' adaptive equipment.

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W 189	<p>Continued From page 4</p> <p>As the client drank throughout the meal and staff held the cup, there was a notable amount of spillage. Shortly afterwards, Staff #5 intervene and fed Client #3 for the remainder of her dinner. The client was observed with minimal spillage as Staff #5 held the open end of the nose cup toward the client's face while she drank her fruit punch.</p> <p>Interview with Staff #4 on July 11, 2012, 4:56 p.m., revealed that she had been employed with the agency for approximately two (2) weeks. When asked about feeding Client #3 on July 9 and 10, 2012, during dinner, Staff #4 stated that she had a hard time preventing the client from spilling her Ensure and fruit punch. Admittedly, Staff #4 stated that she was not familiar with Client #3's adaptive equipment (nose cup). Continued interview with Staff #4 revealed that she had not had any formal training on the use of Client #3's adaptive feeding equipment.</p> <p>Review of the staff in-service training on July 11, 2012, at 5:20 p.m., revealed the last training on adaptive equipment was dated October 11, 2011. At the time of the survey, there was no evidence that Staff #4 had been trained on how to assist Client #3 with the use of her nose cup.</p>	W 189	<p>All staff were inserviced on individual #3's mealtime adaptive equipment on 7-13-12</p> <p>Refer to attachment #2</p> <p>The inservice was completed for the rest of the individuals' adaptive equipment as well on 7-13-12</p> <p>Refer to attachment #3.</p> <p>In addition, there was an agency wide inservice on the adaptive equipment conducted by the Speech and Language Pathologist on 7-27-12</p> <p>Refer to attachment #4.</p> <p>In the future, the facility will ensure that all staff are trained on the use of the individuals' adaptive equipment.</p>
W 249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p>	W 249	

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W 249	Continued From page 5 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that client's received continuous active treatment to support achievement of individual program plan (IPP) objectives identified by the interdisciplinary team (IDT), for one of three clients included in the sample. (Clients #1) The finding includes: On July 9, 2012, beginning at 2:58 p.m., Client #1 was observed sitting in a wheelchair. Continued observations throughout the remainder of the survey, which ended on July 11, 2012, revealed the client used her wheelchair for mobility. On July 11, 2012, at 10:50 a.m., review of Client #1's records revealed an individual program plan dated October 22, 2011, that included a goal to improve her standing mobility. The IPP stated "the client will stand for 5 minutes every hour that she is awake using the rolling walker at 100% accuracy for 6 months". Interview with Staff #1, who was assigned to Client #1, on July 11, 2012, at approximately 3:45 p.m., confirmed that Client #1 had an objective to stand for five minutes every hour that she is awake. Further interview with Staff #1 revealed that the objective was to be implemented and documented daily on the data sheets. When asked to see the client's rolling walker, Staff #1 was not sure where the walker was located. The program coordinator #1 (PC) who was present at	W 249	All staff were trained on the implementation and documentation of individual #1's PT goals (Standing Mobility) on 7-13-12 Refer to attachment #5 The rolling walker location was make known to all of the staff on 7-13-12 In the future, the facility will ensure that the staff implement, and document individual #1's PT program as prescribed. Additionally, all individuals in the facility programs will be documented, and implemented as prescribed.

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W 249	<p>Continued From page 6</p> <p>the time of the interview with Staff #1, revealed that the rolling walker was located in Client #1's bedroom closet. Staff #1 then went on to say that she had not used the rolling walker to implement Client #1's standing mobility program.</p> <p>At the time of the survey, there was no evidence that the facility implemented Client #1's standing mobility program as recommended.</p> <p>This is a repeat deficiency.</p> <p>W 263 483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE</p> <p>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility's specially-constituted committee (Human Rights Committee) failed to ensure that restrictive programs were used only with written consent, for one of the three clients in the sample. (Client #1)</p> <p>The finding includes:</p> <p>The facility's human rights committee (HRC) failed to ensure that informed consent had been obtained prior to the use of sedation for Client #1's dental appointment.</p> <p>During the entrance conference on July 9, 2012, at approximately 1:45 p.m., interview with the qualified intellectual disabilities professional (QIPD) revealed that Client #1 had a limited</p>	W 249	<p>All staff were trained on the implementation and documentation of individual #1's PT goals (Standing Mobility) on 7-13-12</p> <p>Refer to attachment #5</p> <p>The rolling walker location was make known to all of the staff on 7-13-12</p> <p>In the future, the facility will ensure that the staff implement, and document individuals individual #1's PT program as prescribed. Additionally, all individuals in the facility programs will be documented, and implemented as prescribed.</p>	7-13-12

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W 263	<p>Continued From page 7</p> <p>medical guardian that operated as the clients designated surrogate healthcare decision-maker due to the client's inability to give informed consent for the use of her medications.</p> <p>On July 11, 2012, at 1:03 p.m., review of Client #1's medical record revealed consent for Xanax 5mg prior to a dental appointment on July 21, 2011. The consent was signed by the client's attorney on August 4, 2011, who was not listed as her court appointed guardian. Continued review of Client #1's medication administration record confirmed that the client received the Xanax sedation. Further review of the client's medical record revealed a behavioral objective that address combative behaviors prior to and during medical appointments. There was no evidence that her limited medical guardian had signed a written consent form for the use of Xanax for sedation prior to the client's dental appointment on July 21, 2011.</p> <p>On July 11, 2012, at approximately 6:10 p.m., review of the minutes for meetings held by the facility's HRC revealed no evidence that the HRC had discussed whether Client #1's medical guardian provided written consent for the sedation.</p> <p>Interview with the facility's program director (PD) and registered nurse (RN) on July 11, 2012, at approximately 6:25 p.m., confirmed that Client #1's limited medical guardian had not signed consent for the use of Xanax prior to the client's dental appointment. When asked, the RN stated that she could not explain why the consent was obtained by the attorney and not the legal guardian. The RN stated that she would have to</p>	W 263	<p>It is RCM's policy for all consents for the use of the anxiolytic medications to be approved by the individual's guardian, limited medical guardian, or by the medical decision maker; additionally, the use of the anxiolytic medications must be approved by the HRC. Individual's #1 consent for the use of Xanax for sedation prior to the dental appointment on July 21, 2011 was signed by the Attorney instead. This writer asked the former QIDP why the Attorney signed on the consent form, she stated that the LPN could not reach the medical guardian, the Attorney happened to be in the facility, and the LPN asked him to sign on the consent form. It can be noted that the LPN in question is no longer employed by RCM as of 7-17-12 for other reasons. This is a unique situation since this has never happened before; however, in the future, the facility management will ensure that all consents for the use of anxiolytic medications are approved by the individual's guardian, limited medical guardian, or by the medical decision maker; additionally, the use of the anxiolytic medications must be approved by the HRC.</p>	

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W 263 W 455	<p>Continued From page 8 follow up with the previous qualified intellectual disabilities professional (QIDP).</p> <p>483.470(I)(1) INFECTION CONTROL</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure effective infection control procedures were implemented, for one of the three clients included in the sample. (Client #1)</p> <p>The finding includes:</p> <p>On July 9, 2012, beginning at 2:58 p.m., Client #1 was observed sitting in a wheelchair at the dining table coloring in her coloring book. The client retrieved several different crayons from a container for coloring. At 3:11 p.m., Client #1 propelled herself using her wheelchair from the dining table to the living room area using mainly her left hand. At 3:28 p.m., Client #1 was observed sitting back at the dining table working with staff on arts and crafts activities. At 3:49 p.m., the client assisted Staff #1 with returning all tabletop activities back to the bookshelf. At approximately 4:10 p.m. Staff #1 asked Client #1 to wash her hand prior to her snack. The client refused to go to the bathroom to wash her hands. At 4:18 p.m., Client #1 was then observed eating bite size graham crackers with applesauce. The client used her left hand to scoop the graham crackers onto the spoon while eating independently. At no time was Client #1 observed to wash her hands prior to eating.</p>	W 263 W 455	<p>All staff were trained on the infection control by the QIDP on 7-13-12</p> <p>Refer to attachment #6</p> <p>In the future, the facility management and staff will ensure that the individuals wash their hands prior to mealtime; additionally, if the individuals refuse to wash their hands other mean of sanitation such as hand sanitizer will be provided.</p>	

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W 455	Continued From page 9 On July 10, 2012, at approximately 4:30 p.m., interview with Staff #1 (assigned to Client #1) confirmed that Client #1 refused to wash her hands prior to her snack on July 9, 2012. Staff #1 stated that she should have provided Client #1 with a hand wipe and/or sanitizer prior to her eating her snack. At the time of the survey, the facility failed to ensure that Client #1 washed her hands prior to eating her snack.	W 455	All staff were trained on the infection control by the QIDP on Refer to attachment #6 In the future, the facility management and staff will ensure that the individuals wash their hands prior to mealtime; additionally, if the individuals refuse to wash their hands other mean of sanitation such as hand sanitizer will be provided.	7-13-12

Health Regulation & Licensing Administration

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I 000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from July 9, 2012 through July 11, 2012. 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 at three day programs, interviews with one resident, 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>3508.1 ADMINISTRATIVE SUPPORT</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 interview and record review, the GHPID's qualified intellectual disabilities professional (QIDP) failed to coordinate services, for one of the three residents included in the sample. (Resident #3)</p> <p>The finding includes:</p> <p>On July 10, 2012, beginning at 10:25 a.m., observations conducted at the day program revealed Resident #3 appeared to be very sleepy. At 10:42 a.m., day program staff #1 (DPS) tried to keep the resident awake by engaging her in listening to music. Resident #3 showed no</p>	I 180	<p>It is RCM policy for the individuals to be provided with the best possible care.</p> <p>Individual #3's POs is sent to the day program on a monthly basis; however, the day program did not receive the POs reflecting the increase of the seizure medication.</p> <p>There will be a constant communication between the facility nurse and the program each time there is a change in the individual's regimen. In the future, the facility's RN and QIDP will ensure that POs are delivered to the day program, and that there is constant communication between both entities especially when there is a change in the individuals' medical status.</p> <p>The hand delivered form will be signed by the day program to acknowledge receipt. Refer to attachment #1</p>

Health Regulation & Licensing Administration

Angela E. ...
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Program Director
TITLE

(X6) DATE
8-2-12

Health Regulation & Licensing Administration

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I 180	<p>Continued From page 1</p> <p>interest. At 10:58 a.m., DPS #1 tried to keep the resident awake by engaging her into group activities. Again, Resident #3 showed no interest. This was observed by the day program registered nurse #1(DPRN) as well. At 11:20 a.m., Resident #3 was awake and alert as she manipulated a tabletop game (Busy) that was presented to her. At approximately 11:40 p.m., DPS #1 was observed raising Resident #3's up over her head repeatedly.</p> <p>Interview with the day program case manager/director #1 (CM/D) on July 10, 2012, at approximately 11:55 a.m., revealed that it had been a little challenging trying to engage Resident #3 in morning activities due to her sleepiness. When asked if the day program staff had notified the resident's home of her sleepiness, the CM/D #1 responded by saying, the group home had been made aware. Interview with the DPRN #1 on the same day at approximately 12:05 p.m. revealed that she was not aware that Resident #3 had been sleeping on and off during that morning hours.</p> <p>Review of the day program's sleep records on July 10, 2012, at approximately 12:15 p.m., revealed a sleep chart for July 2012. According to the sleep chart, Resident #3 was documented as sleeping on and off during the dates of July 6, 9 and 10, 2012. Further review revealed the most current physician's orders (POs) located in the record was dated January 2012. At approximately 12:20 p.m., DPRN #1 was asked if there was a more current PO that had not been filed in the record. The DPRN replied by saying "no". DPRN #1 immediately stated that she would call the group today to request a copy of the current POs and to see if there has been any change in her medical status.</p>	I 180	<p>It is RCM policy for the individuals to be provided with the best possible care. Individual #3's POs is sent to the day program on a monthly basis; however, the day program did not receive the POs reflecting the increase of the seizure medication.</p> <p>There will be a constant communication between the facility nurse and the program each time there is a change in the individual's regimen. In the future, the facility's RN and QIDP will ensure that POs are delivered to the day program, and that there is constant communication between both entities especially when there is a change in the individuals' medical status.</p> <p>The hand delivered form will be signed by the day program to acknowledge receipt. Refer to attachment #1</p>

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I 180	Continued From page 2 Interview with the qualified intellectual disabilities professional (QIDP) on July 10, 2012, at 1:15 p.m., revealed that she was not made aware that Resident #3 was sleeping during the morning time within the past few days by the day program. The QIDP did state that she was aware of the increase in Resident #3's recent seizure medications. Interview with the GHPID's registered nurse #1 (RN) on July 11, 2012, at approximately 11:20 a.m., revealed that Resident #3 has had several seizures within the past month. Further interview revealed Resident #3 was sent to the neurologist on July 3, 2012. The neurologist increased Resident #3's seizure medication (Keppra) from 1000 mg twice a day to 1500 mg twice a day. The RN then stated that the increase in Resident #3's medication could be a contributing factor in the resident's sleepiness during the morning time. The RN indicated that one of the side effects of Keppra was somnolence (drowsiness, sleepiness). When asked, RN #1 stated that the day program had not been made aware of the change in Resident #3's medication regimen. Review of Resident #3's medical records on July 11, 2012, at approximately 1:58 p.m., revealed a written physician's order (POs) dated July 3, 2012. The POs confirmed the RN's interview that Keppra had been increased to 1500 twice a day. At the time of the survey, there was no evidence that the QIDP coordinated with Resident #3's day program when there was a change in Resident #3's medication regimen. Note: According the RN, it was a shared responsibility between the qualified intellectual	I 180	It is RCM policy for the individuals to be provided with the best possible care. Individual #3's POs is sent to the day program on a monthly basis; however, the day program did not receive the POs reflecting the increase of the seizure medication. There will be a constant communication between the facility nurse and the program each time there is a change in the individual's regimen. In the future, the facility's RN and QIDP will ensure that POs are delivered to the day program, and that there is constant communication between both entities especially when there is a change in the individuals' medical status. The hand delivered form will be signed by the day program to acknowledge receipt. Refer to attachment #1	

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I 180	Continued From page 3 disabilities professional (QIDP) and RN in ensuring that the day program received current physician's orders and when there was a change in the resident's medical status.	I 180		
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that all employees and health care professionals had current health certificates, for 3 out of 18 direct support staff. (Staffs #6, #15, and #17) The findings include: On July 11, 2012, beginning at 9:46 p.m., review of the personnel records revealed there was no evidence of a current physician's health inventory/ certificates for Staffs #5 and #17 located in the records. Further review revealed Staff #15 was without a current physical examination. This was acknowledged by the program director (PD) on July 11, 2012, at approximately 5:00 p.m. The PD stated that she believe that the aforementioned staff did have current health inventory/certificates. However, no additional information was presented before the survey ended on the same day at approximately 6:30	I 206	Staff # 6 &15's health certificates are currently on file. Refer to attachment # 7a & 7b Staff # 17 was terminated as of 7-1-12 Refer to attachment # 8 In the future, the provider will ensure that the staff's records are on file, and provided upon request.	7-18-12

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I 206	Continued From page 4 p.m.	I 206		
I 229	<p>3510.5(f) STAFF TRAINING</p> <p>Each training program shall include, but not be limited to, the following:</p> <p>(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;</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that staff received training on resident's adaptive equipment, for one of the three residents in the sample. (Resident #3)</p> <p>The finding includes:</p> <p>On July 9, 2012, beginning at 7:25 p.m., observations of the dinner meal revealed Staff #3 served Resident #3 seafood salad, squash, crushed pineapples, bread and a beverage. At 7:35 p.m., Staff #4 (not assigned to Resident #3) was observed to give Resident #3 some ensure (nutritional supplement) using her nosey cup. Staff #4 held the nosey cup up to the resident's mouth with the open area of the cup facing opposite of her face. As the resident drank throughout the meal and staff held the cup, there was a notable amount of spillage. Shortly afterwards, Staff #5 intervene and fed Resident #3 for the remainder of her dinner. The resident was observed with minimal spillage as Staff #5 held the open end of the nosey cup toward the</p>	I 229	<p>All staff were inserviced on individual #3's mealtime adaptive equipment on 7-13-12 Refer to attachment #2</p> <p>The inservice was completed for the rest of the individuals' adaptive equipment as well on 7-13-12 Refer to attachment #3.</p> <p>In addition, there was an agency wide inservice on the adaptive equipment conducted by the Speech and Language Pathologist on 7-27-12 Refer to attachment #4.</p> <p>In the future, the facility will ensure that all staff are trained on the use of the individuals' adaptive equipment.</p>	

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I 229	Continued From page 5 resident's face while she drank her fruit punch. Interview with Staff #4 on July 11, 2012, 4:56 p.m., revealed that she had been employed with the agency for approximately two (2) weeks. When asked about feeding Resident #3 on July 9 and 10, 2012, during dinner, Staff #4 stated that she had a hard time preventing the resident from spilling her Ensure and fruit punch. Admittedly, Staff #4 stated that she was not familiar with Resident #3's adaptive equipment (nosey cup). Continued interview with Staff #4 revealed that she had not had any formal training on the use of Resident #3's adaptive feeding equipment. Review of the staff in-service training on July 11, 2012, at 5:20 p.m., revealed the last training on adaptive equipment was dated October 11, 2011. At the time of the survey, there was no evidence that Staff #4 had been trained on how to assist Resident #3 with the use of her nosey cup.	I 229	All staff were inserviced on individual #3's mealtime adaptive equipment on 7-13-12 Refer to attachment #2 The inservice was completed for the rest of the individuals' adaptive equipment as well on 7-13-12 Refer to attachment #3. In addition, there was an agency wide inservice on the adaptive equipment conducted by the Speech and Language Pathologist on 7-27-12 Refer to attachment #4. In the future, the facility will ensure that all staff are trained on the use of the individuals' adaptive equipment.	
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 persons with intellectual disabilities (GHPID) failed to ensure that residents' training objectives were implemented in accordance with their individual support plan (ISP), for one of the three residents included in the sample. (Resident #1) The finding includes: On July 9, 2012, beginning at 2:58 p.m., Resident	I 422	All staff were trained on the implementation and documentation of individual #1's PT goals (Standing Mobility) on 7-13-12 Refer to attachment #5 The rolling walker location was made known to all of the staff on 7-13-12 In the future, the facility will ensure that the staff implement, and document individual #1's PT program as prescribed. Additionally, all individuals in the facility programs will be documented, and implemented as prescribed.	

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I 422	<p>Continued From page 6</p> <p>#1 was observed sitting in a wheelchair. Continued observations throughout the remainder of the survey, which ended on July 11, 2012, revealed the resident used her wheelchair for mobility.</p> <p>On July 11, 2012, at 10:50 a.m., review of Resident #1's records revealed an individual program plan dated October 22, 2011, that included a goal to improve her standing mobility. The IPP stated "the resident will stand for 5 minutes every hour that she is awake using the rolling walker at 100% accuracy for 6 months".</p> <p>Interview with Staff #1, who was assigned to Resident #1, on July 11, 2012, at approximately 3:45 p.m., confirmed that Resident #1 had an objective to stand for five minutes every hour that she is awake. Further interview with Staff #1 revealed that the objective was to be implemented and documented daily on the data sheets. When asked to see the resident's rolling walker, Staff #1 was not sure where the walker was located. The program coordinator #1 (PC) who was present at the time of the interview with Staff #1, revealed that the rolling walker was located in Resident #1's bedroom closet. Staff #1 then went on to say that she had not used the rolling walker to implement Resident #1's standing mobility program.</p> <p>At the time of the survey, there was no evidence that the GHPID implemented Resident #1's standing mobility program as recommended.</p> <p>This is a repeat deficiency.</p>	I 422	<p>All staff were trained on the implementation and documentation of individual #1's PT goals (Standing Mobility) on 7-13-12</p> <p>Refer to attachment #5</p> <p>The rolling walker location was make known to all of the staff on 7-13-12</p> <p>In the future, the facility will ensure that the staff implement, and document individuals individual #1's PT program as prescribed. Additionally, all individuals in the facility programs will be documented, and implemented as prescribed.</p>	