| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| I 096 | Continued From page 2 | I 096 | | |
| I 096 | 3504.7 HOUSEKEEPING<br><br>No poisonous or hazardous agent shall be stored in a food preparation, storage or serving area.<br><br>This Statute is not met as evidenced by:<br>Based on observation and interview, the GHIID failed to store hazardous agents only in locations away from food preparation and storage areas, for six of six residents of the facility (Residents #1, 2, 3, 4, 5 and 6)<br><br>Findings included:<br><br>On 03/15/18 2:00 PM, observations revealed a one quart plastic container of charcoal lighter being stored in an unlocked cabinet beneath a kitchen counter.<br><br>At 2:14 PM, the QIDP, who was present at the time of the inspection, stated that facility staff had been instructed in the past to store the charcoal lighter in a pantry located in the basement.<br><br>At the time of the survey, the GHIID failed to ensure potentially hazardous agents were stored away from food preparation and storage areas. | I 096 | QIDP will train staff on safety and chemicals hazards. All hazardous agents will be removed from the pantry area and stored in a locked cabinet. | 5/10/18 |
| I 180 | 3508.1 ADMINISTRATIVE SUPPORT<br><br>Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans.<br><br>This Statute is not met as evidenced by:<br>Based on observation, interview and record review, the GHIID's QIDP failed to ensure the | I 180 | | |

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| I 180 | Continued From page 3<br>integration, monitoring and coordination of each resident's training and support needs to ensure they I) received beverages at the recommended consistency; II) received supplemental foods with dinner when requested by the family; III) engaged in culturally relevant outings in the community at the frequency recommended by the IDT; and IV) staff collected measurable performance data and received sign language training to support each resident's communication skills training program when indicated, for two of three sampled residents (Residents #2 and 3).<br><br>Findings included:<br><br>I. The QIDP failed to integrate, monitor and coordinate Resident #2's safe swallow needs regarding the use of powdered thickener with all beverages, as follows:<br><br>A. [Cross-refer to Federal Deficiency Report - Citation W192] On 03/13/18 at 5:25 PM, staff was observed serving Resident #2 water and apple juice that were a regular, thin consistency rather than "nectar-thick" as recommended by a speech pathologist in May 2017, following a bedside swallow study.<br><br>At 5:35 PM, review of Resident #2's feeding protocol, dated 05/16/17, speech and language evaluation, dated 07/02/17 and nutrition assessment, dated 06/13/17, showed the resident was to receive "nectar thick liquids." The recommendation was due to a diagnosis of oral dysphasia, which placed Resident #2 at risk of aspiration. Concurrent interview with the QIDP revealed that most staff had received training from the SLP on 05/30/17. Immediate review of the 05/30/17 signature sheet revealed the following: | I 180 | QIDP will request that the SLP update the feeding protocol to reflect the changes in Client #2 protocol.<br><br>RN/SLP will provide training on the feeding protocol on any changes on the documents. QIDP will monitor and implement feeding protocol. | 5/10/18 |

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| I 180 | Continued From page 4 | I 180 | | |

1. The direct support staff, DSP #13, who prepared and served the resident's beverages that evening had not been in attendance. At 5:40 PM, DSP #13 stated that she had been working in the facility for approximately one week and had not yet received training on Resident #2's beverage consistency needs. The QIDP, who was present at that time, confirmed this.

QIDP will request that DSP#13 and #22 receive ongoing training on Client #2. QIDP will ensure that DSP #13 and #22 be retrained on Client #2 feeding protocol ongoing and monitored on weekly basis to ensure protocol is implemented again. 5/10/18

2. Resident #2's assigned one to one staff, DSP #22, who stood behind the resident at dinner on 03/13/18, attended the in-service training on 05/30/17. The QIDP stated that in addition to training DSP #13, she would also retrain DSP #22 with the expectation that he will intervene if the resident's beverages are not nectar-thick.

3. The in-service signature sheet dated 05/30/17 showed that Resident #2's feeding protocol and "nectar thick consistency" were on the agenda. Although the QIDP stated that staff were to offer the resident thickened beverages at the start of each meal, staff were not observed to offer thickened water or apple juice with the resident's dinner on 03/13/18.

At the time of the survey, the facility failed to ensure that all staff was effectively trained to implement Resident #2's dietary recommendations, including nectar-thick beverages.

B. During the aforementioned dinner observations and staff interviews on 03/13/18, the QIDP stated that staff were to offer Resident #2 nectar thick beverages at the start of every meal. However, because the resident was known to reject thickened beverages, staff were trained by the SLP on 05/30/17 to offer the resident regular, thin

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| I 180 | Continued From page 5 liquids in those circumstances, to ensure that Resident #2 remained hydrated. Concurrent record review however, failed to show written evidence to verify what the QIDP had just stated, as follows: | I 180 | | |
| | 1. The 05/30/17 in-service training sheet did not reflect allowing Resident #2 to consume thin liquids if/when the resident rejects nectar-thick beverages. | | QIDP will request that the Speech and Language Pathologist update the feeding protocol to reflect the changes of Client #2 protocol. | 5/10/18 |
| | 2. Allowing Resident #2 to consume thin liquids if/when the resident rejects nectar-thick beverages was not reflected anywhere in the resident's medical record, including his POS. | | RN will ensure all recommendations are reflected on the POS monthly. | 5/10/18 |
| | 3. Although the QIDP stated that Resident #2's PCP was aware of the SLP's recommendation to allow thin beverages to ensure hydration, there was no written evidence that the PCP or others on the IDT had reviewed and approved the practice. | | The DON will develop a Medication Refusal Policy and train the nursing staff on the policy. Primary Care Nurse will review the Medication Administration Record weekly for compliance. | 5/10/18 |
| | 4. During an interview with Resident #2's SLP in the facility on 03/14/18 at 2:15 PM, the SLP confirmed that she had instructed staff on 05/30/17 to offer nectar thick beverages first but they could then offer thin liquids "in small sips." The SLP also stated that it was important to offer beverages that were chilled, as the resident was more likely to accept thickened beverages if they were cold. These instructions had not been included on the feeding protocol dated 05/16/17. | | QIDP will document training on the feeding protocol and any changes of the documents. QIDP will monitor and implement feeding protocol. | 5/10/18 |
| | 5. During the aforementioned interview with the SLP, she suggested providing more frequent staff in-service training would address staff turnover. The QIDP and RN were present during the aforementioned interview with the SLP on 03/14/18. At 2:50 PM, the RN stated that she | | RN will review medical records monthly to review all specialist recommendations and ensure the PCP is aware. | 5/10/18 |

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| I 180 | Continued From page 6<br>would contact Resident #2's PCP to ask if he was aware that since June 2017, staff had been offering the resident thin beverages if/when he refused to drink thickened. The RN also would ask the PCP if he agreed with the strategy. At 3:19 PM, the RN stated that she was adding nectar thick fluids to Resident #2's POS. She had not spoken yet with the PCP. The RN left a message for the PCP at 3:24 PM. | I 180 | | |
| | 6. On 03/14/18, the SLP presented a revised feeding protocol. The protocol now reflected the alternative to offer thin liquids in small sips if Resident #2 rejects nectar thick liquids. The protocol however, was a) back dated to 05/30/17, and b) did not reflect the recommendation that beverages be served cold, as the SLP had just suggested in person. | | QIDP will provide training on tlhe feeding protocol and any changes of the documents. QIDP will monitor and implement feeding protocol. | 5/10/18 |
| | 7. During an interview with Resident #2's DDS Service Coordinator in the facility on 03/14/18 at 3:26 PM, she stated that she was unaware that the resident might receive thin liquids if he refused to drink nectar-thick beverages. She stated that facility staff should adhere to what's prescribed on the feeding protocol (the protocol, dated 05/16/17, stated "nectar thick liquids," with no instructions provided regarding how staff should respond if the resident refuses to drink thickened beverages). When informed that the feeding protocol had just been revised, the Service Coordinator stated that it was not appropriate to back date a revised protocol by 10 months (05/30/17) and she had not yet received a copy for review. | | QIDP will notify service coordinator of any changes pertaining to Client #2 via email and/or phone calls. | 5/10/18 |
| | 8. During an interview on 03/15/18 at 11:31 AM, the RN stated that the PCP had returned her call between 4:30 PM and 5:00 PM the previous day. According to the RN, the PCP informed her that | | | |

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| I 180 | Continued From page 7<br>he would review "the changes or additions" to the resident's feeding protocol on Friday, 03/16/18 when he comes for a scheduled review in the home.<br><br>At the time of the survey, there was no evidence that the facility made the PCP and others on the IDT aware that since June 2017, Resident #2 might receive thin liquids if/when he rejected nectar thick liquids.<br><br>II. There was no evidence that the QIDP ensured that facility offered Resident #2 beans and rice with his dinner, as recommended by the nutritionist and the resident's IDT, as follows:<br><br>On 03/13/18 at 7:05 AM, Resident #2 was observed seated at the dining room table. He spoke a few words of Spanish while his one to one staff (DSP #6) was chopping the food on his plate. At 5:25 PM, the resident was again heard speaking Spanish while his assigned one to one staff (DSP #22) was assisting him with getting settled at the dinner table. The meal consisted of baked fish, broccoli, rice, sliced bread with margarine, all of which was cut to a finely chopped consistency. The staff person (DSP #13) who prepared and served the beverages indicated that Resident #2's water and apple juice were a regular, thin consistency. [Note: Earlier that day, at 12:25 PM, review of an incident investigation report, dated 05/31/17, showed that while hospitalized for "possible pneumonia," Resident #2 received a bedside swallow study. The SLP noted coughing when the resident drank thin liquids and had subsequently recommended "nectar thick" liquids.]<br><br>On 03/13/18 at approximately 5:35 PM, review of Resident #2's nutrition assessment, dated | I 180 | QIDP will immediately notify the IDT of any recommedation for Client #2, made by SLP and Nutrionist. | 5/10/18 |

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| I 180 | Continued From page 8 | I 180 | | |

06/13/17, showed a recommendation to "serve rice and beans at dinner meal," as per a request made by the resident's family. The assessment showed the resident also enjoyed eating tacos, burritos and pork chops. On 03/14/18 at 2:05 PM, review of Resident #2's ISP, dated 07/11/17, showed the IDT accepted the nutritionist's recommendations.

During an interview on 03/15/18 at 12:01 PM, the QIDP stated that staff "sometimes" substituted beans and rice for other starchy foods but "it's not every day." When asked if staff documented food substitutions, the QIDP replied "no." [Note: Resident #2 did not respond to inquiries and his speech assessment, dated 07/05/17, showed he had "limited verbal skills."] Concurrent review of that week's menu showed no evidence that Mexican-styled foods were offered. The QIDP replied "no" when asked if the nutritionist had developed a menu specific to Resident #2's known preferences. A few minutes later, DSP #18 presented some frozen burritos and boxes of black beans and rice which she stated were being stored in the basement. The date 01/18/17 was written on the boxes of black beans and rice with a magic marker (purchased more than a year earlier).

At the time of the survey, the QIDP failed to instruct staff to document offering Resident #2 beans and rice with his dinner, in accordance with his known food preferences and as recommended by the IDT.

III. The QIDP failed to ensure that facility staff took Resident #2 on culturally relevant outings in the community at least twice a month, as follows:

[Cross-refer to I422] On 03/14/18 at 2:05 PM,

**Provider's Plan of Correction:**

| Corrective action | Complete date |
|---|---|
| QIDP will provide documentation for substitution of side dishes for Client #2. | 5/10/18 |
| Nutritionist will provide an alternative list for food substitutions for Client #2. | 4/30/18 |
| Nutritionist will provide an alternate list of foods for Client #2 to be used in the home 2 times a week. The QIDP will monitor documentation and implementation. | 5/10/18 |

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| I 180 | Continued From page 9<br>review of Resident #2's ISP, dated 07/11/17, showed his "primary language" was Spanish and the IDT recommended that facility staff take him on "community outings specific to his culture such as the Spanish American Museum and restaurants at least twice a month."<br><br>On 03/15/18 at 10:37 AM, review of the applicable data collection sheets for Resident #2's Spanish culture community outings revealed the following:<br>- October 2017 - one outing to an ethnic restaurant;<br>- November 2017 - 2 outings to ethnic restaurants;<br>- December 2017 - no (0) outings documented;<br>- January 2018 - one outing to a Mexican restaurant; and<br>- February 2018 - no (0) outings documented.<br><br>During an interview on 03/15/18 at 11:45 AM, the QIDP stated that she was "going by once a month, so I'll have to look at that." The QIDP monthly reports showed the goal was one outing per month, rather than "at least twice a month," as recommended in the ISP.<br><br>At the time of the survey, the QIDP failed to ensure that staff took Resident #2 on community outings "specific to his culture" at least twice per month.<br><br>IV. The QIDP failed to effectively monitor and coordinate Resident #3's communication skills training program, as follows:<br><br>On 03/14/18 beginning at 11:02 AM, Resident #3 was observed at his day program. His assigned one to one staff (DSP #3) and a day program staff (DPS #1) were with the resident as he | I 180 | QIDP will schedule a minimum of two monthly community outings pertaining to Client #2's cultural background. QIDP will monitor documentation and implementation. | 5/10/18 |

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| I 180 | Continued From page 10<br>colored in a coloring book. During the joint interview, at 11:10 AM, DSP #3 stated that Resident #3's IPP included a communication goal, adding "he knows all the signs... I learn from him." The two staff described his communication program as encouraging the resident to express his needs or wants. For example, the resident might sign that he needs to use the men's room. Both staff stated that the resident was not learning any new vocabulary.<br><br>A. At 11:15 AM, DSP #3 replied "no" when asked if data was collected regarding Resident #3's expressing his wants and needs. DPS #1 stated that she maintained a record of the resident's activities throughout the day; however, neither staff was documenting data specific to the resident's communication goal.<br><br>At 11:40 AM, review of Resident #3's day program IPP, dated 08/01/17, in the day program case manager's office, showed the following: "Goal #3: (Resident #3) will enhance his communication skills. In order to improve his level of communication, daily, (Resident #3) will use sign language/gestures/facial expressions to make his basic wants and needs (eat, drink, toilet/bathroom, more, pain/hurt, help, go for a walk) known in 8 out of 10 opportunities provided over six consecutive months within 1 year."<br>"Action steps:<br>1- (Resident #3) will be informed by staff that it is time for the activity.<br>2- (Resident #3) will make his needs known through sign language/gestures/facial expressions.<br>3 - (Resident #3) will do this in 8 out of 10 opportunities provided.<br>4 - (Resident #3) will be praised for participating in the activity." | I 180 | QIDP will meet with Client #3 IDT, including Day Program Coordinator and discuss communication goals, trainings and establish and implement a communication goal for the remainder of the ISP year. The residential and day program DSPs will be trained on sign language and communication goal for Client #3.<br>QIDP will visit the day program quarterly to ensure implementation of day program goals. The one/one staff will receive additional sign language training. | 5/10/18 |

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A signature sheet was attached, showing that DPS #1 and other day program staff received training by the day program case manager (DPS #2) on Resident #3's goals and objectives on 09/01/17. A quarterly progress report, dated 12/12/17, for the period 09/3/17 through 12/02/17, showed:

Sign Language
+ = 33%
- = 0%

Gestures:
+ = 33%
- = 0%

Facial expressions:
+ = 33%
- = 0%

R = 0%.

The associated key showed that a plus sign meant the resident accomplished the task, a minus meant he attempted a task, an R meant he refused and an A stood for absent. There was no other information available to explain the 33% performance data being reported. Concurrent review of Resident #3's speech and language evaluation, dated 08/30/16, revealed the resident primarily used signs and gestures, with facial expressions "minimally used to convey moods and feelings." DPS #2 was unavailable for a clarification interview before the surveyor left the day program at 11:55 AM.

During an interview in the home on 03/15/18 at 12:15 PM, the QIDP stated that DSP #3 was tasked with documenting Resident #3's activities

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and DPS #1 was not expected to collect data. During a follow-up interview at 3:20 PM, the QIDP examined the day program quarterly report and stated that she did not know what the 33% figures represented. At 3:25 PM, the QIDP reported having just spoken with DPS #1 by telephone. The day program had assigned 33% for each of the three methods of communicating (signs, gestures, facial expressions) equally, with the combined total coming to 100%. The QIDP then added she would visit the day program to address data collection with the DSP #3 and DPS #1.

At the time of the survey, the QIDP failed to ensure accurate data collection at Resident #3's day program regarding his communication skills objective.

B. During observations at Resident #3's day program on 03/14/18 at 11:10 AM, DSP #3 stated that he (the staff) was learning sign language from the resident. According to DSP #3, Resident #3, who was non-verbal, already knew signs for "bathroom" and "go for a walk." Neither he nor the resident was receiving sign language training at the day program.

At 11:40 AM, review of Resident #3's speech language evaluation, dated 08/30/16, in the day program case manager's office, showed the resident "would benefit from a communication partner who can engage him in using his sign language skills on a daily basis. Thus sign language training should be implemented on a routinely scheduled basis at least with his one on one staff." Resident #3 would be re-assessed in two years (2018). [Note: Attached to the evaluation was a staff in-service training sheet, dated 08/03/17, showing that 15 day program employees received sign language training that

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| I 180 | Continued From page 13<br>was specific to Resident #3. Neither DPS #1 nor DSP #3's signatures were on the attendance sheet.]<br><br>During an interview in the home on 03/15/18 at 12:12 PM, the QIDP stated that DSP #3 and other residential staff used to receive sign language training in the home. She described the sessions as "one hour in-service training" by the SLP where she would train on basic signs. The training however, hadn't been offered in a while. The QIDP agreed to provide for review documentation of the staff in-service training on sign language; however, no additional information was presented before the survey ended on the evening of 03/16/18.<br><br>At the time of the survey, the QIDP failed to effectively monitor and coordinate Resident #3's communication training needs, including in-service training for the resident's assigned one to one staff. | I 180 | | |
| I 206 | 3509.6 PERSONNEL POLICIES<br><br>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.<br><br>This Statute is not met as evidenced by:<br>Based on interview and record review, the GHIID failed to ensure that all employees and consultants had current health certificates that | I 206 | | |

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| | HFD03-0095 | A. BUILDING: ______ B. WING ______ | 03/16/2018 |

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| I 206 | Continued From page 14 | I 206 | | |
| | were signed and dated by a physician on file, for six of 22 DSPs, one of one QA, one of two evening and night supervisor and one of one RN. (DSPs #2, 3, 8, 10, and 20, evening and night supervisor #1, the QA and RN) | | | |
| | Findings included: | | | |
| | On 03/15/18 beginning at 9:17 AM, review of the personnel records for all employees and consultants revealed the following: | | | |
| | 1. There was no evidence of a physician's health inventory/certificate for DSPs #2, 3, 8, 10, and 20 who provided direct support to six of the six residents of the facility. | | DSP #2, #3, #8 and #10 obtained their physician health certificates. | 3/16/18 |
| | 2. There was no evidence of a physician's health inventory/certificate for the RN, who provided nursing services to six of the six residents of the facility. | | RN obtained her physician health certificate | 3/23/18 |
| | 3. There was no evidence of a physician's health inventory/certificate for evening and night supervisor #1 and the QA, who provided management services and quality assurance services for six of six residents. | | Evening Manager and QA obtained their physical health certificate. | 3/16/18 |
| | When queried about the missing physician's health inventories on 03/15/18 at approximately 11:00 AM, the QIDP stated that she would request the aforementioned health inventories from the main office. No additional information was made available for review before the survey ended. | | QIDP will send e-mail notifications/reminders 30 days prior to expiration of health certificates for all staff. | 3/16/18 |
| I 227 | 3510.5(d) STAFF TRAINING | I 227 | | |
| | Each training program shall include, but not be | | | |

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| I 227 | Continued From page 15<br>limited to, the following:<br><br>(d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans;<br><br>This Statute is not met as evidenced by:<br>Based on interview and record review, the GHIID failed to have on file for review, evidence of current certification in CPR, for one of 22 DSPs (DSP #16).<br><br>Findings included:<br><br>Review of the personnel records on 03/15/18 beginning at 9:17 AM, revealed no evidence of a current CPR certification for DSP #16.<br><br>When queried about the expired CPR card on 03/15/18 at approximately 2:00 PM, the QIDP indicated that she would request the aforementioned CPR certificate from the main office. No additional information was made available for review before the survey ended. | I 227 | CPR Certificate has been obtained for DSP#16. | 3/16/18 |
| I 422 | 3521.3 HABILITATION AND TRAINING<br><br>Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan.<br><br>This Statute is not met as evidenced by:<br>Based on observation, interview and record review, the GHIID failed to ensure that each resident's IDT recommendations were implemented as written in the ISP, for one of three sampled residents (Resident #2). | I 422 | | |

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| I 422 | Continued From page 16<br><br>Findings included:<br><br>Facility staff failed to take Resident #2 on culturally relevant outings at least twice a month, as follows:<br><br>On 03/14/18 at 2:05 PM, review of Resident #2's ISP, dated 07/11/17, showed his "primary language" was Spanish and the IDT recommended that facility staff take him on "community outings specific to his culture such as the Spanish American Museum and restaurants at least twice a month." At 4:20 PM, review of a QIDP quarterly review, dated 02/12/18, showed the QIDP wrote the resident "met his goal by going to museum and Spanish American restaurant." The report did not provide measurable information such as the dates of outings, or the total number of outings during the three-month period of November 2017 through January 2018. The QIDP monthly notes also did not provide the dates or number of outings. [Note: Review of Resident #2's social work quarterly reports, dated 11/17/17 and 02/11/18, showed no evidence that the social worker had monitored the resident's culturally-specific outings.]<br><br>On 03/15/18 at 10:37 AM, review of the applicable data collection sheets for Resident #2's Spanish culture community outings revealed the following:<br>- October 2017 - one outing to an ethnic restaurant;<br>- November 2017 - 2 outings to ethnic restaurants;<br>- December 2017 - no (0) outings documented;<br>- January 2018 - one outing to a Mexican restaurant; and,<br>- February 2018 - no (0) outings documented. | I 422 | QIDP will schedule a minimum of two cultural community outings per month for Client #2. QIDP will monitor documentation and implementation. | 5/10/18 |

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| I 422 | Continued From page 17<br><br>During an interview on 03/15/18 at 11:45 AM, the QIDP stated that she was "going by once a month, so I'll have to look at that." The QIDP monthly reports showed the goal was one outing per month, rather than "at least twice" per month, as recommended in the ISP.<br><br>At the time of the survey, there was no evidence that facility staff implemented Resident #2's ISP goal to engage in outings specific to his culture, such as the Spanish American Museum and restaurants, at least twice per month. | I 422 | | |
| I 473 | 3522.4 MEDICATIONS<br><br>The Residence Director shall report any irregularities in the resident ' s drug regimens to the prescribing physician.<br><br>This Statute is not met as evidenced by:<br>Based on observation, staff interview and record review, the GHIID failed to enforce and implement an effective system to ensure that the primary care physician was informed of all missed medications to ensure the health and safety of one of six residents residing in the facility (Resident #2).<br><br>The finding includes:<br><br>On 03/13/18 at 8:58 PM, LPN #2 punched poured Constulose into a medication cup then punched Olanzapine, Polyethylene, Divalproex, Calcium and Oxcarbazepine from Client #2's blister packs. LPN #2 then attempted to administer the medications, but the resident refused after several attempts. LPN #2 then stated she would call and inform the PCP that the resident refused | I 473 | The DON will develop Medication Refusal Policy and train the nursing staff on the policy. | 5/10/18 |

Health Regulation & Licensing Administration

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| I 473 | Continued From page 18<br>all the medications.<br><br>On 03/14/18 at approximately 11:00 AM, review of Resident #2's medical record failed to evidence that the primary care physician was informed that the resident refused his medications.<br><br>Interview with the RN on 03/14/18 at approximately 3:00 PM, verified that there was no documented evidence that showed the missed medications were reported to the primary care physician.<br><br>At the time of survey, the facility failed to show evidence that the primary care physician was notified of the missed medication. | I 473 | Primary Care Nurse will review the Medication Administration Record weekly for compliance. Medical Record Consultant will review MAR's for compliance. | 5/10/18 |
| I 500 | 3523.1 RESIDENT'S RIGHTS<br><br>Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws.<br><br>This Statute is not met as evidenced by:<br>Based on observations, interviews and record review, the GHIID failed to observe and protect each resident's rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and these regulations (Title 22, Chapter 35 Group Homes for Individuals with Intellectual Disabilities), for one of the three sampled residents (Resident #2).<br><br>Findings included: | I 500 | | |

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| I 500 | Continued From page 19 | I 500 | | |
| | On 03/13/18 at 7:05 AM, Resident #2 was observed seated at the dining room table. He spoke a few words of Spanish while his one to one staff (DSP #6) was chopping the food on his plate. At 5:25 PM, the resident was again heard speaking Spanish while his assigned one to one staff (DSP #22) was assisting him with getting settled at the dinner table. The meal consisted of baked fish, broccoli, rice, sliced bread with margarine (all finely chopped). | | QIDP will provide documentation for DSPs to provide substitution of side dishes for Client #2 and will monitor weekly for compliance. | 4/30/18 |
| | On 03/13/18 at approximately 5:35 PM, review of Resident #2's nutrition assessment, dated 06/13/17, showed a recommendation to "serve rice and beans at dinner meal," as per a request made by the resident's family. The assessment showed the resident also enjoyed eating tacos, burritos and pork chops. On 03/14/18 at 2:05 PM, review of Resident #2's ISP, dated 07/11/17, showed the IDT accepted the nutritionist's recommendations. | | Nutritionist will provide an alternative list for food substitution for Client #2. Alternative List will be reviewed with DSP's. | 5/10/18 |
| | During an interview on 03/15/18 at 12:01 PM, the QIDP stated that staff "sometimes" substituted beans and rice for other starchy foods but "it's not every day." When asked if staff documented food substitutions, the QIDP replied "no." [Note: Resident #2 did not respond to inquiries and his speech assessment, dated 07/05/17, showed he had "limited verbal skills."] Concurrent review of that week's menu showed no evidence that Mexican-styled foods were offered. The QIDP replied "no" when asked if the nutritionist had developed a menu specific to Resident #2's known preferences. A few minutes later, DSP #18 presented some frozen burritos and boxes of black beans and rice which she stated were being stored in the basement. The date 01/18/17 was written on the boxes of black beans and rice with a magic marker (purchased more than a year | | | |

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| I 500 | Continued From page 20<br>earlier).<br><br>At the time of the survey, there was no evidence that facility staff ensured Resident #2's right to have beans and rice served with his dinner, in accordance with his known food preferences and as recommended by the IDT. | I 500 | | |

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| E 000 | Initial Comments<br><br>An emergency preparedness survey was conducted from 03/13/18 through 03/16/18.<br><br>The findings of the survey were based on interviews and review of the emergency preparedness program.<br><br>Note: The below are abbreviations that may appear throughout the body of this report.<br><br>% - Percent<br>COOP - Continuity of Operations Plan<br>CP - Communication Plan<br>DC - District of Columbia<br>DDS - Department on Disability Services<br>DSP - Direct Support Professional<br>E Tag - Evacuation Tag<br>EP - Emergency Plan<br>EPP - Emergency Preparedness Program<br>HIPAA - Health Insurance Portability and Accountability Act<br>ICF/IID - Intermediate Care Facility for Individuals with Intellectual Disabilities<br>PEP - Personal Emergency Plan<br>QIDP - Qualified Intellectual Disabilities Professional<br>RA - Risk Assessment<br>RN - Registered Nurse<br>USB - Universal Serial Bus | E 000 | | |
| E 006 | Plan Based on All Hazards Risk Assessment<br>CFR(s): 483.475(a)(1)-(2)<br><br>[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] | E 006 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Courtance A. Reese | TITLE: Program Director | (X6) DATE: 5/1/18

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.