STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G037	A. BUILDING ______ B. WING ______ Received 5/2/18	03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MULTI SERVICES, INC	[redacted] WASHINGTON, DC 20008

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

W 000 INITIAL COMMENTS — W 000

A recertification survey was conducted from 03/13/18 through 03/16/18. A sample of three clients was randomly selected from a population of six men with varying degrees of intellectual disabilities. This survey was conducted utilizing the fundamental survey process.

The findings of the survey were based on observations, interviews and review of client and administrative records.

Note: The below are abbreviations that may appear throughout the body of this report.

% - Percent
D.C. - District of Columbia
DDS - Department on Disability Services
DPS - Day Program Staff
DSP - Direct Support Professional
ICF/IID - Intermediate Care Facility for Individuals with Intellectual Disabilities
IDT - Interdisciplinary Team
IPP - Individual Program Plan
ISP - Individual Support Plan
LPN - Licensed Practical Nurse
PCP - Primary Care Physician
POS - Physician's Order Sheets
QIDP - Qualified Intellectual Disabilities Professional
RN - Registered Nurse
SLP - Speech Language Pathologist

W 159 QIDP — W 159
CFR(s): 483.430(a)

Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Constance A. Reese — TITLE: Program Director — (X6) DATE: 5/2/18

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.

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W 159	Continued From page 1	W 159		

This STANDARD is not met as evidenced by:
Based on observation, interview and record review, the QIDP failed to ensure the integration, monitoring and coordination of each client'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 client's communication skills training program when indicated, for two of three sampled clients (Clients #2 and 3).

Findings included:

I. The QIDP failed to integrate, monitor and coordinate Client #2's safe swallow needs regarding the use of powdered thickener with all beverages, as follows:

A. [Cross-refer to W192] On 03/13/18 at 5:25 PM, staff was observed serving Client #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.

At 5:35 PM, review of Client #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 client was to receive "nectar thick liquids." The recommendation was due to a diagnosis of oral dysphasia, which placed Client #2 at risk of aspiration. Concurrent interview with the QIDP revealed that most staff had received training from the SLP on 05/30/17.

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W 159	Continued From page 2 Immediate review of the 05/30/17 signature sheet revealed the following: 1. The direct support staff, DSP #13, who prepared and served the client'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 Client #2's beverage consistency needs. The QIDP, who was present at that time, confirmed this. 2. Client #2's assigned one to one staff, DSP #22, who stood behind the client 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 client's beverages are not nectar-thick. 3. The in-service signature sheet dated 05/30/17 showed that Client #2's feeding protocol and "nectar thick consistency" were on the agenda. Although the QIDP stated that staff were to offer the client thickened beverages at the start of each meal, staff were not observed to offer thickened water or apple juice with the client'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 Client #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 Client #2 nectar thick beverages at the start of every meal. However, because the client was known to reject thickened	W 159	QIDP will provide DSP #13 and #22, ongoing training on Client #2. The RN/SLP will ensure that DSP#13 and #22 will be re-trained on Client #2's feeding protocol. QIDP will monitor on a weekly basis to ensure protocol is implemented.	5/10/18

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W 159	Continued From page 3 beverages, staff were trained by the SLP on 05/30/17 to offer the client regular, thin liquids in those circumstances, to ensure that Client #2 remained hydrated. Concurrent record review however, failed to show written evidence to verify what the QIDP had just stated, as follows: 1. The 05/30/17 in-service training sheet did not reflect allowing Client #2 to consume thin liquids if/when the client rejects nectar-thick beverages. 2. Allowing Client #2 to consume thin liquids if/when the client rejects nectar-thick beverages was not reflected anywhere in the client's medical record, including his POS. 3. Although the QIDP stated that Client #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. 4. During an interview with Client #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 client 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. 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	W 159	QIDP will notify the IDT of any new recommendation of Client #2. QIDP will request that the speech and pathologist update the feeding protocol to reflect the changes of Client #2's protocol. RN will review medical records monthly to review all specialist recommendations and inform the PCP of any new recommendtions.	5/10/18

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W 159	Continued From page 4 would contact Client #2's PCP to ask if he was aware that since June 2017, staff had been offering the client 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 Client #2's POS. She had not spoken yet with the PCP. The RN left a message for the PCP at 3:24 PM.	W 159		
	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 Client #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 request that the SLP update the feeding protocol to reflect the changes in Client #2 protocol.	5/10/18
	7. During an interview with Client #2's DDS Service Coordinator in the facility on 03/14/18 at 3:26 PM, she stated that she was unaware that the client 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 client 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.	4/10/18
	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.		RN will review medical records monthly to review all specialist recommendations and ensure the PCP is aware.	5/10/18

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W 159	Continued From page 5 According to the RN, the PCP informed her that he would review "the changes or additions" to the client's feeding protocol on Friday, 03/16/18 when he comes for a scheduled review in the home.	W 159		
	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, Client #2 might receive thin liquids if/when he rejected nectar thick liquids.		RN/SLP will provide training to DSPs on the feeding protocol and any changes/ new recommendations. QIDP will monitor and implement feeding protocol.	5/10/18
	II. There was no evidence that the QIDP ensured that facility offered Client #2 beans and rice with his dinner, as recommended by the nutritionist and the client's IDT, as follows:			
	On 03/13/18 at 7:05 AM, Client #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 client 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 Client #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," Client #2 received a bedside swallow study. The SLP noted coughing when the client drank thin liquids and had subsequently recommended "nectar thick" liquids.]		QIDP will provide documentation for substitution of side dishes for Client #2 Nutritionist will provide an alternative list for food substitutions for Client #2	4/29/18 5/20/18
	On 03/13/18 at approximately 5:35 PM, review of			

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W 159	Continued From page 6 Client #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 client's family. The assessment showed the client also enjoyed eating tacos, burritos and pork chops. On 03/14/18 at 2:05 PM, review of Client #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: Client #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 Client #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 Client #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 Client #2 on culturally relevant outings in the community at least twice a month, as follows:	W 159	Nutritionist will provide an alternate list of foods for Client #2 to be implemented 2 times a week. The QIDP will ensure documentation will be implemented and monitored.	4/30/18

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W 159 Continued From page 7

W 159

[Cross-refer to W249] On 03/14/18 at 2:05 PM, review of Client #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."

On 03/15/18 at 10:37 AM, review of the applicable data collection sheets for Client #2's Spanish culture community outings revealed the following:
- October 2017 - one outing to an ethnic restaurant;
- November 2017 - 2 outings to ethnic restaurants;
- December 2017 - no (0) outings documented;
- January 2018 - one outing to a Mexican restaurant; and
- February 2018 - no (0) outings documented.

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.

At the time of the survey, the QIDP failed to ensure that staff took Client #2 on community outings "specific to his culture" at least twice per month.

IV. The QIDP failed to effectively monitor and coordinate Client #3's communication skills training program, as follows:

On 03/14/18 beginning at 11:02 AM, Client #3 was observed at his day program. His assigned

Plan of correction:

QIDP will schedule monthly community outings pertaining to Client #2 cultural background. QIDP will ensure that the community outings are documented as written in the ISP. QIDP will train DSPs on documentation. — 4/30/18

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W 159	Continued From page 8 one to one staff (DSP #3) and a day program staff (DPS #1) were with the client as he colored in a coloring book. During the joint interview, at 11:10 AM, DSP #3 stated that Client #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 client to express his needs or wants. For example, the client might sign that he needs to use the men's room. Both staff stated that the client was not learning any new vocabulary. A. At 11:15 AM, DSP #3 replied "no" when asked if data was collected regarding Client #3's expressing his wants and needs. DPS #1 stated that she maintained a record of the client's activities throughout the day; however, neither staff was documenting data specific to the client's communication goal. At 11:40 AM, review of Client #3's day program IPP, dated 08/01/17, in the day program case manager's office, showed the following: "Goal #3: (Client #3) will enhance his communication skills. In order to improve his level of communication, daily, (Client #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." "Action steps: 1- (Client #3) will be informed by staff that it is time for the activity. 2- (Client #3) will make his needs known through sign language/gestures/facial expressions. 3 - (Client #3) will do this in 8 out of 10 opportunities provided.	W 159	QIDP will meet with Client #3 IDT, including Day Program Coordinator to discuss communication goals and 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.	5/21/18

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W 159

4 - (Client #3) will be praised for participating in the activity."

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 Client #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 client 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 Client #3's speech and language evaluation, dated 08/30/16, revealed the client 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.

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During an interview in the home on 03/15/18 at 12:15 PM, the QIDP stated that DSP #3 was tasked with documenting Client #3's activities 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 Client #3's day program regarding his communication skills objective.

B. During observations at Client #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 client. According to DSP #3, Client #3, who was non-verbal, already knew signs for "bathroom" and "go for a walk." Neither he nor the client was receiving sign language training at the day program.

At 11:40 AM, review of Client #3's speech language evaluation, dated 08/30/16, in the day program case manager's office, showed the client "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." Client #3 would be re-assessed in two years (2018). [Note:

Provider's plan of correction (W 159):

Data collection will be reviewed monthly from day program.

The QIDP will visit day program quarterly to ensure implementation of day program goals.

The One/One staff will receive additional sign language training. — 5/20/18

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W 159	Continued From page 11 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 was specific to Client #3. Neither DPS #1 nor DSP #3's signatures were on the attendance sheet.] 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. At the time of the survey, the QIDP failed to effectively monitor and coordinate Client #3's communication training needs, including in-service training for the client's assigned one to one staff.	W 159		
W 192	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on observations, interview and record review, the facility failed to ensure that each staff was trained effectively to implement each client's mealtime protocol, for one of three sampled	W 192		

W 192 Continued From page 12
clients (Client #2).

W 192

Findings included:

On 03/13/18 at 12:25 PM, review of an incident investigation report, dated 05/31/17, showed that while Client #2 was hospitalized for "possible pneumonia," he received a bedside swallow study. The SLP noted coughing when the client drank thin liquids and subsequently recommended "nectar thick" liquids. When asked at 12:46 PM, the facility's RN stated that the client's dietary food texture and change to "nectar thick liquids was initiated upon his readmission from the hospital and Client #2 had not experienced any recurrence of pneumonia since the May 2017 hospitalization.

On 03/13/18 at 5:25 PM, observations of Client #2 at the dining room table revealed that his food, which consisted of baked fish, broccoli, rice, sliced bread with margarine, had been cut to a finely chopped consistency. Client #2's apple juice and water were a regular, thin consistency. When asked at 5:30 PM if anyone's water or apple juice had been thickened, the staff person (DSP #13) who prepared and served the beverages didn't respond. When asked if everyone's beverages were to be served at a regular, thin consistency, DSP #13 immediately responded "as far as I know." When Client #2's one to one staff, (DSP #22), who was standing behind the client to his left, was asked if the client's beverages should be thickened, he failed to respond. Another staff who was present at the time, DSP #2 stated that at one time, Client #2's beverages were to be thickened to a nectar consistency; however, she did not know if the diet order had been changed. Immediate review of the

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	09G037	A. BUILDING ______ B. WING ______	03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MULTI SERVICES, INC	[redacted] WASHINGTON, DC 20008

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 192	Continued From page 13 client's IPP book, which was kept in the dining room, showed there was no feeding protocol in the book. [It should be noted that although facility staff were asked to hold Client #2's beverages for a moment, while the question regarding beverage thickener was resolved, Client #2 was allowed to drink the thin beverages before leaving the dinner table. No coughing or signs of aspiration were observed.] On 03/13/18 at approximately 5:35 PM, review of Client #2's medical record in the basement revealed that his feeding protocol, dated 05/16/17, speech and language evaluation, dated 07/02/17 and nutrition assessment, dated 06/13/17, showed the client was to receive "nectar thick liquids." When the QIDP was asked immediately about Client #2's beverage thickener, she stated that staff were to offer the client nectar-thick beverages at first. If the client rejected the thickened beverages, staff had been trained by the SLP on 05/30/17 to offer him regular, thin liquids to ensure hydration. The QIDP acknowledged that this strategy (offer thin liquids if the client rejects nectar-thick) was not documented on the 05/30/17 in-service training sheet she presented or in Client #2's medical record.	W 192	The QIDP will file the feeding protocol for Client #2 in his IPP Active TX book. The QIDP will monitor daily implementation and documentation of Client #2 IPP goals.	5/10/18
	Immediate review of the 05/30/17 signature sheets revealed that while DSP #22 had been in attendance, DSP #13 had not. DSP #13 stated that she had started work in the facility approximately one week prior to the survey and she had not been trained on Client #2's beverages. The QIDP, who was present at the time, confirmed this, stating that in addition to		DSP #13 and DSP #22 has received training on Client #2 dated 3/28/18 and will receive ongoing training on Client #2's feeding protocol.	5/10/18

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W 192	Continued From page 14 training DSP #13 she would also retrain DSP #22 and other staff to ensure they present nectar-thick beverages at the start of every meal. At the time of the survey, the facility failed to ensure that all staff was effectively trained to implement Client #2's dietary recommendations.	W 192		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) 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. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each client's goals and recommendations made by the IDT were implemented as written, for one of three sampled clients (Client #2). Findings included: Facility staff failed to take Client #2 on culturally relevant outings at least twice a month, as follows: On 03/14/18 at 2:05 PM, review of Client #2's ISP, dated 07/11/17, showed his "primary language" was Spanish and the IDT recommended that facility staff take him on	W 249	QIDP will schedule monthly community outings pertaining to Client #2's cultural background. QIDP will monitor documentations and implementation monthly.	5/10/18

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W 249	Continued From page 15	W 249		

"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 client "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 Client #2's social work quarterly reports, dated 11/17/17 and 02/11/18, showed no evidence that the social worker had monitored the client's culturally-specific outings.]

On 03/15/18 at 10:37 AM, review of the applicable data collection sheets for Client #2's Spanish culture community outings revealed the following:
- October 2017 - one outing to an ethnic restaurant;
- November 2017 - 2 outings to ethnic restaurants;
- December 2017 - no (0) outings documented;
- January 2018 - one outing to a Mexican restaurant; and,
- February 2018 - no (0) outings documented.

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.

At the time of the survey, there was no evidence that facility staff implemented Client #2's ISP goal

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W 249	Continued From page 16 to engage in outings specific to his culture, such as the Spanish American Museum and restaurants, at least twice per month.	W 249		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review the facility failed to ensure the primary care physician was informed of missed medications to ensure the health and safety of one of six residents residing in the facility (Client #2). Finding included: The facility's nursing staff 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 its residents as follows: On 03/13/18 at 8:58 PM, LPN #2 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 client refused after several attempts. LPN #2 then stated she would call and inform the PCP that the client refused all the medications. On 03/14/18 at approximately 11:00 AM, review of Client #2's medical record failed to evidence	W 331	The Director of Nursing will develop a Medication Refusal Policy and train the nursing staff on the policy. The Primary Care Nurse will review the Medication Administration Record weekly for compliance. The PCP will be notified when medication is missed.	5/10/18

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W 331	Continued From page 17	W 331		

that the primary care physician was informed that the client refused his medications.

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. Continued interview revealed the facility did not have a policy on medication refusals.

At the time of survey, the facility failed to show evidence that the primary care physician was notified of the missed medication.

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

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I 000 INITIAL COMMENTS — I 000

A licensure survey was conducted from 03/13/18 through 03/16/18. A sample of three residents was randomly selected from a population of six men with varying degrees of intellectual disabilities.

The findings of the survey were based on observations, interviews and review of resident and administrative records.

Note: The below are abbreviations that may appear throughout the body of this report.

% - Percent
CPR - Cardio-Pulmonary Resuscitation
D.C. - District of Columbia
DDS - Department on Disability Services
DPS - Day Program Staff
DSP - Direct Support Professional
ENS - Evening/Night Supervisor
GHIID - Group Home for Individuals with Disabilities
ICF/IID - Intermediate Care Facility for Individuals with Intellectual Disabilities
IDT - Interdisciplinary Team
IPP - Individual Program Plan
ISP - Individual Support Plan
LPN - Licensed Practical Nurse
PCP - Primary Care Physician
POS - Physician's Order Sheets
QA - Quality Assurance
QIDP - Qualified Intellectual Disabilities Professional
RN - Registered Nurse
SLP - Speech Language Pathologist

I 082 3503.10 BEDROOMS AND BATHROOMS — I 082

Each bathroom that is used by residents shall be

Health Regulation & Licensing Administration

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I 082	Continued From page 1 equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting. This Statute is not met as evidenced by: Based on observation and interview, the GHIID failed to equip each bathroom with paper cups, for bathrooms used by six of six residents of the facility (Residents #1, 2, 3, 4, 5 and 6). Findings included: A. On 03/15/18 at 2:23 PM, observation of the bathroom located on the second floor revealed there was no paper cup dispenser and there were no paper cups available for resident use. The QIDP, who was present at the time, acknowledged there was no paper cup holder and there were no paper cups available in the bathroom. She stated that this bathroom was used by Residents #2, 3 and 4. B. On 03/15/18 at 2:32 PM, observation of the bathroom located on the third floor revealed there was no paper cup dispenser and there were no paper cups available for resident use. The QIDP acknowledged there was no paper cup holder and there were no paper cups available in the bathroom used by Residents #1, 5 and 6. When asked, she was unaware of any conversation in the past regarding equipping bathrooms with paper cups. At the time of the survey, the GHIID failed to equip all bathrooms used by residents with paper cup dispensers to foster independence and self-management.	I 082	QIDP will purchase the paper cups/dispensers and place them in all bathrooms.	5/1/18