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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G124	A. BUILDING _____ B. WING _____	04/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	1230 CONGRESS STREET, SE WASHINGTON, DC 20020

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W 000	INITIAL COMMENTS A recertification survey was conducted from April 24, 2008 through April 25, 2008. The survey was initiated using the fundamental survey process. A random sample of four clients was selected from a resident population of eight men with profound mental retardation and other disabilities. The findings of the survey were based on observations, interviews with staff in the home and at two day programs, as well as a review of client and administrative records, including incident reports.	W 000	**W120** **This Standard will be met as evidenced by:** 1. QMRP in coordination with the Physical Therapist will provide additional training for the day program and residential staff on proper positioning of client #4's headrest. QMRP will continue to visit the day program, conduct routine observations and address concerns as they arise. 2. QMRP/RN will follow-up with the day program nursing staff to address the medical interventions/expectations for client #4. Residential LPN will maintain regular contact with the day program nurse. Day program nurses will be encouraged to contact the residential site for direction and feedback when problems arise. LPN/RN will continue to conduct routine visits to the day program, conduct observations and address concerns as they arise.	5.23.08 ongoing
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observations, staff interview, and record review, the facility failed to effectively monitor each client's day program to assure that the needs were met, for one of four clients in the sample. (Client #4) The findings include: On April 24, 2008, Client #4 was observed at his day program, between 10:42 AM - 12:07 PM. At the outset, the client's eyes were shut, his head was drooped over to the left side and his mouth was open. Day program stand staff stated that he had been sleeping since his arrival that morning at 9:30 AM. He kept his eyes shut for the majority of the observation period. The following deficient practices were observed: 1. At 10:42 AM, the headrest to Client #4's	W 120		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy Duncan — TITLE: DRS — (X6) DATE: 5/30/08

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 120	Continued From page 1 wheelchair was not effectively positioned to support his head. His head hung to the left and slightly back while the headrest was positioned higher and away from his head. At approximately 10:48 AM, a day program staff tried adjusting the headrest; however, it came loose. When she tightened it, the headrest was turned slightly to the right and the client's head still hung to the left. At 11:50 AM, the headrest remained turned slightly to the right and did not support the client's head. At no time during the observation period did staff position the headrest effectively to ensure head support. 2. The day program nurse did not check Client #4's vitals when he was showing signs/ symptoms of hypotension. At 10:42 AM, the client's eyes were closed, his mouth was open and his head hung to the side as if he were sleeping. The day program case manager rubbed his face and another staff person passed scented lotions under his nostrils but his eyes remained shut and he was non-responsive. The rubbing continued and at 10:44 AM, he groaned, opened his eyes for approximately 1 second, closed his eyes again and his head slumped down to his left. He remained in this position for the next 9 minutes. At 10:53 AM, the nurse applied a wet paper towel to Client #4's face. He became marginally responsive, making a few grimaces on his face; however, as soon as the nurse removed the paper towel, his head slumped over, eyes closed and it appeared as if he had fallen back asleep. The nurse then left the area. At 11:00 AM, direct support staff transferred the client from his wheelchair to a platform mat. The client's eyes had been closed since the nurse removed the wet paper towel. At 11:04 AM, the nurse informed the	W 120	W120 3. QMRP will coordinate implementation of similar goals and incorporate active treatment objectives which are consistent with those at his residence. QMRP will continue to monitor client #4's progress, and address concerns as they arise.	

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W 120	Continued From page 2 day program case manager that a residential nurse had suggested the sleepiness might be a side effect of his medication regimen. The most likely cause was drowsiness caused by Sudafed, which was prescribed for hypotension. After Client #4 was transferred to the mat, he remained non-responsive for 42 minutes, even when staff rubbed his hand, touched his face and spoke to him (at 11:13 AM). At 11:42 AM, another staff person rubbed his hands and arms and spoke to him. He stirred for approximately 1 second, but then closed his eyes again. At 11:52 AM, the nurse took his blood pressure (114/75). Client #4's medical chart was reviewed the next day, beginning at 8:15 AM. His physician's orders, dated March 1, 2008 (valid for 120 days), confirmed that he received Pseudoephedrine HCL (Sudafed) 30 mg three times daily for hypotension. For hypotension, the client's Health Management Care Plan, dated December 20, 2007, prescribed: "monitor blood pressure at least at every shift and more often as needed; monitor for hypotension (dizziness, lethargy, perspiration and low blood pulse rate)." Client #4 displayed signs and symptoms of possible hypotension (lethargy) or other medical concerns for 1 hour and 10 minutes (even longer, given the staff report that he was asleep when he arrived at 9:30 AM) before the day program nurse checked his blood pressure. In addition, the nurse was not observed to check the client's pulse rate. It should be noted that the nurse attempted to administer the client his crushed medications in pudding at approximately 11:55 AM. This had to	W 120		

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W 120	Continued From page 3 be deferred until later, as the client was groggy and noncompliant. It should be further noted that the day program nurse stated that Client #4 had been sleepy on the day before, and this was a frequent occurrence. Interviews in the home, however, revealed that the Qualified Mental Retardation Professional and the daytime nurse were previously unaware of the client's lethargy. 3. Client #4 did not receive continuous, aggressive active treatment during the day. On April 24, 2008, Client #4 did not engage in active treatment during the 85 minute observation period at the day program. At approximately 11:15 AM, review of the his daytime IPP revealed 3 objectives, as follows: (1) one community integration outing per month, (2) sensory stimulation and remaining on task, and (3) daily recreation/ leisure activities. Further review of the record and staff interview revealed the following: a. The day program had been without transportation until April 2008; therefore, Client #4 had not had the opportunity for community outings. Once a vehicle had been procured, the client missed the one outing scheduled for that month, on April 9, 2008 (reportedly due to a nurse recommendation; he was lethargic that day, resulting in a late medication pass and lunch); b. According to Client #4's activity schedule, sensory stimulation/ remaining on task was scheduled for one hour only, from 10:30 AM - 11:30 AM daily.	W 120		

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W 120	Continued From page 4 c. The remainder of the day was spent with leisure activities, repositioning or meals (Note: none of which involved objectives for the acquisition of skills). Upon return to the home, interview with the Qualified Mental Retardation Professional (QMRP), followed later by record review, revealed that staff in the home were implementing other goals, such as hand washing and tolerating tooth brushing. Further interview did not reveal why the client's daytime programming did not incorporate hand washing, tooth brushing or similar goals, to provide a more aggressive active treatment regimen and to reinforce what he was engaged in at home.	W 120		5-9-08 ongoing
W 137	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that two of three clients were provided adequate clothing for the weather. (Clients #3 and #7) The finding includes: Observation on April 25, 2008, at 4:25 PM, revealed Clients #3 and #7 wearing heavy sweaters while being transported off the van. Staff was overheard asking the clients if they were happy to be indoors from the afternoon heat. Weather reports for the day indicated the	W 137	**W137** **This Standard will be met as evidenced by:** QMRP/Home Manager will conduct additional training to ensure that clients right to retain and use appropriate clothing for the weather are implemented at all times. QMRP/Home Manager will also conduct additional training on client rights and sensitivity. It should also be noted that the weather has been consistently changing and some winter clothing items have remained in client #4's closet to meet his needs. All winter items have been removed/stored and replaced with Spring/Summer clothing to further ensure compliance with this standard.	

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W 137	Continued From page 5 high temperature to be 82°F. Two of the other staff in the home were also observed / heard making comments about the client's clothing being too warm and inappropriate for the weather. Interview with the facility's Qualified Mental Retardation Professional (QMRP) on April 25, 2008, at 4:49 PM, revealed he did not take into consideration the fluctuating weather temperatures and would do a better job at ensuring the clients were dressed for the day according to the forecasted weather conditions. There was no evidence presented or on file at the time of survey to substantiate that the facility had taken the measures to ensure clients be properly dressed according to the weather conditions.	W 137		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure the investigation of a client ' s injury as required by this section for one (1) of four (4) randomly sampled clients. (Client #1) The findings include: 1. Record review on April 25, 2008 revealed Client #1 sustained an injury where he fell out of his wheelchair and injured his lip. He was taken to the Emergency Room (ER) for treatment and discharged accordingly. Observations on April 25, 2008 and on April 25, 2008 revealed Client #1 was totally dependent on staff for mobility and his wheelchair was equipped with a chest strap to	W 154	**W154** **This Standard will be met as evidenced by:** An investigation was initiated and completed. QMRP will ensure that all investigations are filed and faxed to in accordance to policy. Incident Manager will also follow-up to ensure that all incidents are investigated and every measure is taken to protect the safety of the individuals.	5.23.08 ongoing

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W 154	Continued From page 6 keep him in his wheelchair. It was not clear how he was able to fall out of his chair and sustain an injury to his face. There was also no evidence on file to substantiate that an investigation was initiated to ascertain the nature and reason for the fall to ensure that the health and safety of the client could be protected. 2. Record review on April 25, 2008, at 2:05 PM, revealed that Client #1 arrived to the day program on January 14, 2008 with an "abrasion to his face near the left corner of his mouth." The day program documented that they did not receive any communication from the home explaining how that injury took place and that they submitted an "Interagency Communication" detailing their observation of the injury. Record review at Client #1 ' s home on 4/25/2008 at 4:01pm revealed there was no incident on file addressing this injury. Interview with the facility's Nurse on April 25, 2008, at 4:06 PM, revealed she was not aware of the injury to Client #1's face. She was also not aware of the Interagency Communication detailing the injury. There was no evidence on file at the time of survey to substantiate that an investigation was initiated to ascertain the nature and reason for the fall to ensure that the health and safety of the client could be protected.	W 154		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility's Qualified Mental Retardation	W 159	**W159** **This Standard will be met as Evidenced by:** 1. 2. Cross-reference response to W249 and W252. 3. Cross reference response to W436. 4. Cross references response to W120. 5. Cross reference response to W192.	5.23.08 on going

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W 159	Continued From page 7 Professional (QMRP) failed to ensure the coordination of services as required by this section. The findings include: 1. Interview with the Nurse at Client #1's day program on April 25, 2008, at 1:55 PM, revealed Client #1 had experienced three seizures since the start of the year. He had one seizure in February (2008) and two seizures in March (2008) at his day program. Record review at Client #1's home revealed only one of the seizures was documented in his personal records. Interview with the Nurse at Client #1's home revealed she was only aware of the one seizure he sustained in March (March 3, 2008) at his day program. She was not aware of any others. It was not clear from the records if Client #1's seizures were being accurately documented and that information was being communicated to the medical team responsible for his care. There was no evidence on file at the time of survey to substantiate that the Qualified Mental Retardation Professional (QMRP) maintained the proper and necessary coordination of services between the day program and the home to ensure that Client #1's seizures be accurately documented and communicated as such. 2. Cross-refer to W249 and W252. The QMRP failed to ensure the oversight, implementation and documentation of client's habilitative programming. 3. Cross-refer to W436. The QMRP failed to ensure the oversight and repair of clients' adaptive equipment.	W 159		

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W 159	Continued From page 8 4. Cross-refer to W120. The QMRP failed to ensure that Client #4's day program met his active treatment and health needs. 5. Cross-refer to W192. The QMRP failed to ensure that each employee was provided with continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently. 6. Cross-refer to W252. The QMRP failed to ensure that data relative to the clients' performance was documented in accordance with prescribed programs. In addition, the QMRP acknowledged that he had not followed up with the speech pathologist after Client #4's Second Quarterly Review meeting, April 11, 2008, regarding establishing a new social work objective.	W 159		
W 192	483.430(e)(2) STAFF TRAINING PROGRAM 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 interview and record review, the facility failed to ensure that all staff were trained and competent to provide assistance in accordance with the Individual Support Plan (ISP), for one of the four residents in the sample. (Client #1) The findings include: 1. During the April 24, 2008 entrance conference, at approximately 9:40 AM, the Qualified Mental	W 192		

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W 192	Continued From page 9 Retardation Professional (QMRP) stated that he was not aware of any instance when a resident did not receive services as prescribed in his ISP. Incident reports were reviewed in the facility later that day, beginning at 3:17 PM. One incident report documented that on March 9, 2008, Client #1 was taken to a hospital emergency room (ER) after sustaining an injury due to a fall. Beginning at approximately 5:00 PM, the QMRP said that a staff person who had been working directly with the client that day admitted to having left him alone in his bed, unsupervised and with the protective bed rail in the "down" position. When she returned to the bedroom, she found him on the floor. According to the QMRP, the bed rails were to remain in the "up" position whenever the resident was in bed. This was later confirmed through record verification. On April 25, 2008, at 4:03 PM, review of the investigation report, dated March 14, 2008, revealed that on the day before the incident, the Facility Coordinator (aka House Manager) had observed this same staff person leaving bed rails down. He had discussed this issue with her and she reportedly stated that she understood that this was necessary to ensure resident safety. The report also indicated that "despite previous trainings about two person lifts at all times," the staff person lifted the resident from the floor and placed him back in his bed without assistance from others. In the process, the resident reportedly "bit her on her right thumb." a. There was no evidence that in-service training on utilizing a two-person lift at all times, prior to the March 9, 2008 incident, had been effective.	W 192	**W192** **This Standard will be met as Evidenced by:** The incident was reviewed by the Human Rights Committee. Determination was made to provide further training on safety, transfer techniques, bedrail safety, client rights, etc… As stated the individual is a new employee who would benefit from additional training. In addition, to prevent accidents of this nature from reoccurring IDI has implemented a shadowing program which would require that all employees successfully complete the designated days of shadowing as evidenced by a competency review and test. Any employee who does not meet the standards will not be allowed to work directly with the clients.	S-3008 ongoing

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W 192	Continued From page 10 b. There was no evidence that in-service training on the proper use of bed rails, prior to the March 9, 2008 incident, had been effective. 2. Review of incident reports also revealed an incident on March 29, 2008 at which time staff discovered a bruise of unknown origin under Client #1's left arm pit. The QMRP investigation report, dated April 3, 2008, indicated that the injury most likely occurred while staff were lifting and transferring the client from his wheelchair. The QMRP included a recommendation for additional staff training on lifting and transfers. On April 24, 2008, at approximately 4:57 PM, the QMRP stated that they had provided such training; however, he could not be certain that it had been conducted since the March 29, 2008 bruising incident. On April 25, 2008, beginning at 3:00 PM, review of staff in-service training records revealed no evidence that staff received additional training on lifting and transfer techniques since a March 12, 2008 session. 3. Interviews with administrative staff regarding the March 9, 2008 incident whereby Client #1 fell from his bed, sustained injuries and was taken to the ER revealed an across-the-board failure of the facility to recognize and report neglect. The staff person who was working with the client that day admitted her negligence by leaving his protective bed rail in the down position. However, both the QMRP (interviewed at 4:58 PM on April 24, 2008) and the Assistant Director of Residential Services (interviewed at 11:40 AM on April 25, 2008) stated that because the staff was new and it had been an accident, it did not constitute neglect. In addition, they both indicated that the Director of Residential Services had reviewed the investigative findings. Both the	W 192		

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W 192	Continued From page 11 investigation report and initial incident report cited the incident as a "physical injury" due to a fall. On April 25, 2008, at 6:22 PM, review of the facility's Abuse and Neglect Policy revealed a definition for "Neglect" that included the following: "Any allegation of neglect will be treated as a serious reportable incident. This means failure to provide sufficient, ... services, treatment, or care that harms or jeopardizes the customer's health, safety, or welfare, such as... (d) Failure to provide services or supports as indicated by the individual's plan of care, or (e) Failure to provide proper supervision to the customer as required within a plan..."	W 192		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION 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 staff interview and record review, the facility failed to ensure the implementation of a client's approved habilitation plan, for one (1) of four (4) randomly sampled clients. (Client #1) The finding includes: Record review on April 25, 2008, at 4:16 PM, revealed Client #1's Speech Assessment dated March 24, 2008 recommended the following	W 249	**W249** **This Standard will be met as Evidenced by:** QMRP will follow-up to obtain necessary adaptive equipment needed to implement the program plan as outlined. QMRP will train staff as needed and provide ongoing oversight and supervision to ensure that the program is being implemented. In the future, QMRP will review all recommendations as soon as the interdisciplinary team has formulated the program plans. Additionally, if for some reason a delay is anticipated due to ordering of equipment, QMRP will discuss with the team and coordinate a start date consistent with the recommendations made by the team.	5.23.08 ongoing

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W 249	Continued From page 12 interventions: 1. Provide exposure to cause-effect activities through switch-activated objects and items (radio, CD player, cassette player, blender, etc) 2. Implement the following speech & language program, which should start at the beginning of the 2nd quarter: a. Goal: Increase functional pre-language skills involving switch use. b. Objective: [Client #1] will be able to access switch-operated devices/voice output in order to make choices and for stimulation purposes given physical assistance on 3 out of 5 trials. Interview with the facility's Qualified Mental Retardation Professional (QMRP) on April 25, 2008, at 4:20 PM, revealed the speech/ language program was not being implemented. Instead, Client #1 had been provided a "Go Talk" device and this was what was being used. There was no evidence on file or presented at the time of survey to substantiate that the facility ensured the implementation of this habilitative program as recommended.	W 249	**W252** **This Standard will be met as evidenced by:** QMRP will review and revise program goals as needed to ensure that the criteria are measurable. QMRP will continue to document client #1's progress on a monthly basis. QMRP will review program goals/ objectives on an ongoing and consistent basis for client #4. QMRP will effectively address and document follow-up actions taken to resolve concerns when they arise. QMRP/Home Manager will consult with various professionals as needed to coordinate training and other interventions.	5-9-08 ongoing
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on staff interview and record review, the	W 252	QMRP will be responsible for highlighting the dates of program implementation to serve as guide for staff to follow monthly. QA audits will be continue to be conducted on a consistent basis to further ensure compliance in this area.	

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W 252	Continued From page 13 facility failed to ensure the accurate documentation of a clients's progress on an approved habilitation plan, for two of the four sampled clients. (Clients #1 and #4) The findings include: 1. Record review on April 25, 2008, at 4:16 PM, revealed Client #1's Speech Assessment dated March 24, 2008 recommended the following goal and the expected frequency of documentation: " Goal: Given 3 pictures of objects / manipulate placed on his low tech device, <Client #1's name> will be exposed to the notion of making a choice with regards to an activity that he may wish to engage in each evening Monday thru Friday as measured by Active Treatment Documentation in 3 of 5 trials with physical assistance." Further record review revealed the facility's staff was documenting the trials by initialing their names on the data collection sheets whenever the program was implemented. There was no way to ascertain in "measureable" terms the level of progress this client may have had with regards to the implementation of the program. Interview with the facility's Qualified Mental Retardation Professional (QMRP) on April 25, 2008, at 4:22 PM, revealed that Client #1 was currently using a "Go Talk" device and staff had documented the use of it accordingly. There was no evidence presented or on file at the time of survey to substantiate that the facility's staff ensured that Client #1's progress was documented in measureable terms. 2. On April 25, 2008, beginning at 11:18 AM,	W 252		

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W 252	Continued From page 14 review of Client #4's Second Quarterly Review documents revealed a Social Work update, dated April 11, 2008. The client's program included an objective to send a greeting card to his family once a month. On April 11, 2008, the social worker wrote: "There was no data recorded for January - March 2008... This consultant will recommend a new social work program for the next six (6) months." Review of the client's program book revealed that the Qualified Mental Retardation Professional (QMRP) had used a highlighter to mark the dates on which staff were to document performance data for each program. Further review of the program book revealed the following: a. The April 2008 data sheet in the tabbed section for the greeting card objective was blank, and there was no evidence that an alternate social program had been established. b. The April 2008 data sheet for Client #4's hand washing objective indicated that staff were to implement it on April 21 and 23, 2008. There was no data, however, recorded for those dates. c. The April 2008 data sheet for Client #4's passive range of motion exercises objective indicated that staff were to implement it on April 21 and 23, 2008. There was no data, however, recorded for those dates. d. The April 2008 data sheet for Client #4's "wear comfy splints for 2 hours per day" objective indicated that staff were to implement it on April 19, 20 and 23, 2008. There was no data, however, recorded for those dates. e. The April 2008 data sheet for Client #4's "low	W 252		

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W 252	Continued From page 15 tech augmentative communication device" objective indicated that staff were to implement it on April 24, 2008 (the day before). There was no data, however, recorded for this objective on the previous day. At 12:02 PM, the QMRP was asked about the program data. He stated that he thought staff had assisted Client #4 with sending a greeting card to his family every month; however, staff had failed to document the activity in the client's program book. He further stated that there was no new social work program established since the April 11, 2008 review. He also acknowledged that staff had not recorded program data for the client's oother objectives during the immediate past 7 days.	W 252		5.9.08 ongoing
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure nursing services in accordance with client needs, for one of the four clients in the sample. (Client #4) The findings include: 1. The facility's nursing staff failed to update/revise Client #4's Health Management Care Plan (HMCP) to reflect changes in his dental care needs, as follows: Review of Client #4's dental records on April 25, 2008, at approximately 10:15 AM, revealed that on February 13, 2008, his dentist recommended	W 331	**W331** **This Standard will be met as Evidenced by:** 1.RN has made the necessary changes/ adjustments to the HMCP. In addition, the QMRP has made changes to client #4's activity schedule to reflect the frequency of oral hygiene care. LPN staff have received ongoing training on HMCP and the importance of updating the information as changes and/or recommendation occur. RN will continue to monitor and provide oversight to ensure that the HMCP is updated as needed and in a timely manner. 2. Cross reference response to W120.2 3.Cross reference response to W120.2	5.22.08 ongoing

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W 331	Continued From page 16 Increasing the number of times he brushed his teeth to "after every meal and before bedtime." At 10:22 AM, review of his HMCP, dated March 4, 2008, revealed that it continued the previous recommendation of "Assist with oral hygiene twice daily." The client's "Typical Weekly Activity Schedule," dated October 2007 and incorporated into the Individual Support Plan of the same date, had reflected twice daily oral care, at 6:00 AM and at 8:00 PM. 2. Cross-refer to W120.2 The facility's nursing staff failed to document an April 24, 2008 telephone call received from Client #4's day program, as follows: At approximately 11:00 AM, the day program nurse reported having telephoned the home to discuss Client #4's lethargy and inability to stay awake. He said that the residential nurse thought this might be due to the side effects of one (Sudafed) or more of his medication regimen. On April 25, 2008, beginning at 10:52 AM, review of the Nurse Progress Notes revealed no evidence of the call received from day program on the previous day. The residential day nurse was interviewed in the facility, beginning at 12:07 PM. She confirmed that the day program nurse had telephoned and that they had discussed the client's sleepiness. She reportedly instructed the day program to "monitor" him. She further indicated that any nurse "should check vital signs if <an individual> is unresponsive." She acknowledged that she did not know whether the client's vitals had been taken. She also acknowledged not having recorded the phone call in the client's chart. 3. Cross-refer to W120.2. The facility's overnight	W 331		

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W 331	Continued From page 17 nursing staff failed to consistently document Client #4's sleep pattern, as follows: On April 24, 2008, at 10:49 AM, Client #4's day program case manager stated that she was going to ask the home whether the client "stayed up late last night." She and the direct support staff were unable to rouse him. The case manager did not indicate whether she had obtained the information prior to this surveyor's departure from day program at 12:07 PM. On April 25, 2008, at approximately 12:15 PM, the Qualified Mental Retardation Professional stated that because there is 24-hour nursing in the facility, the overnight nurses would document the client's sleep pattern. The day nurse was present at the time. She stated that nurses would document if/when the client did not sleep through the night. At 12:31 PM, review of Client #4's "Nurses 24-Hour Report" for April 2008 revealed inconsistent data collection. Nurses had documented "rest well," "slept well" or "slept all night" on 5 nights thus far in April (4/4, 6, 8, 9 and 4/19/08). They had not, however, documented sleep patterns on the other 19 nights.	W 331	**W436** **This Standard will be met as Evidenced by:** 1. Reference response to W249 and W252. 2. QMRP will seek another assessment of client #3's wheelchair and specifically address the "sliding". All recommendations will be addressed in a timely manner. Staff are expected to report wheelchair concerns immediately. Further, staff are wheelchair on the wheelchair monitoring form on a weekly basis. QMRP/Home Manager must then follow-up to address the specific issue/concern. . QMRP/Home Manager will maintain documentation pertaining to repairs, request for repairs, ordering supplies, etc... QMRP will also document the progress and status in the individual's monthly and quarterly progress notes. 3 Reference response to W436.2. The bed has been repaired and currently is in good working condition. 4.Reference response to W436.2.	5.23.08 ongoing
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on staff interview and record review, the	W 436		

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W 436	Continued From page 18 facility failed to ensure the provision of and maintain a client's adaptive equipment, for one (1) of four (4) randomly sampled clients. (Client #1) The findings include: 1. Record review on April 25, 2008, at 4:16 PM, revealed Client #1's Speech Assessment dated March 24, 2008 recommended the following interventions: a. Provide exposure to cause-effect activities through switch-activated objects and items (radio, CD player, cassette player, blender, etc) b. Implement the following speech & language program, which should start at the beginning of the 2nd quarter: i. Goal: Increase functional pre-language skills involving switch use. ii. Objective: <Client #1's name> will be able to access switch-operated devices/voice output in order to make choices and for stimulation purposes given physical assistance on 3 out of 5 trials. Interview with the facility's Qualified Mental Retardation Professional (QMRP) on April 25, 2008, at 4:20 PM, revealed te speech/ language program hadn't been implemented and none of the "switched" devices have been purchased for Client #1's use. The facility failed to provide the proper and necessary communication tools as recommended. Also see W249. 2. Observations during dinner on April 24, 2008, at 5:27 PM, revealed Client #3 had to be	W 436		

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W 436	Continued From page 19 repositioned approximately 12 times during dinner because he kept sliding down his gurney. He consistently slid down his gurney (due to the angle of 45 degrees) and into a position not optimal for feeding. Staff repeatedly commented on how poorly the current "chair" fits Client #3's body. At 5:47 PM, the staff feeding Client #3 stated that the previous chair fit him better, because it prevented him from sliding down when she tilted him up (approximately 45 - 60 degrees) for feeding. On each occasion when Client #3 slid forward, his supportive chest brace tightened around his neck. Review of Client #3's Physical Therapy assessment dated November 2, 2007 revealed the following recommendations: a. Staff should monitor wheelchair for repairs b. Physical therapist will monitor client as needed. There was no evidence on file or presented at the time of survey to substantiate that the "sliding" problem with Client #3's gurney had been assessed and/or addressed. There was also no evidence presented or on file at the time of survey to substantiate that the QMRP had monitored this problem and provided the necessary supports and oversight to correct it. 3. Interview with the facility's QMRP on April 24, 2008, at 5:55 PM, revealed Client #2's hospital bed was inoperable and didn't function properly. Record review on April 25, 2008, at 5:17 PM, failed to provide any documentation to support that the QMRP had provided the necessary oversight and follow-up to ensure that this client's bed was assessed and/or repaired.	W 436		

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W 436	Continued From page 20 4. Observations at the residential facility on both April 24, 2008 and April 25, 2008 revealed the footrests on both Client #6's and #8's wheelchairs were in poor condition. The outer layer was torn and the supportive foam was exposed in several areas on both footrests. In addition, interview with the facility's QMRP on April 24, 2008, at 5:57 PM, revealed Client #8's wheelchair had been recommended to be remolded. This remolding was necessary because he had gained weight and the chair no longer properly supported his frame. Record review on April 25, 2008, at 5:17 PM, failed to provide any documentation to support that the QMRP had provided the necessary oversight and follow-up to ensure that these clients' wheelchairs were assessed and/or repaired.	W 436		

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I 000	INITIAL COMMENTS A licensure survey was conducted from April 24, 2008 through April 25, 2008. A random sample of four residents was selected from a resident population of eight men with profound mental retardation and other disabilities. The findings of this survey were based on observations at the group home and at two day programs, interviews with day program and residential staff as well as the review of clinical and administrative records, including incident reports.	I 000	**3504.1 Housekeeping** **This Statute will be met as evidenced by:** Repairs have been completed. The running toilet, damaged tile and broken fixtures have been repaired/replaced. In addition, the old wheelchairs have been removed from the home and the kitchen dining room table has been stabilized. The Home Manager has purchased additional pots and pans and discarded the rusted cooking equipment. Also reference response to W436 in regards to client #3's gurney and hospital bed, as well as general repairs to the wheelchairs. QMRP/Home Manager will continue to complete routine home inspections and document maintenance request weekly. QMRP/Home Manager will provide additional staff training on reporting concerns related to wheelchair repairs and adaptive equipment needs of the individuals.	5.7.08 ongoing
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Observation and staff interview on April 24, 2008, at 2:15 PM, revealed the following environmental deficiencies: 1. The following problems were observed in Bathroom #1 near Resident #3's bedroom: a. Running toilet; water continued to flow after the tank had filled to capacity. b. Damaged structure; broken and water damaged tile observed along the base of the tub and along the adjacent walls/support structures. c. Broken fixtures; the hot water knob on the sink leaked when opened to allow water to flow. 2. The following problem was observed in Bathroom #2 near Resident #5's bedroom:	I 090		

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I 090	Continued From page 1 a. Several old wheelchairs with various structural problems and other adaptive equipment were being stored in the bathroom. Interview with the facility's Qualified Mental Retardation Professional (QMRP) on April 24, 2008, at 2:30 PM, revealed the adaptive equipment in that bathroom was not being used by any of the residents. 3. The following problem was observed in the kitchen/dining area: a. Rusted cooking surfaces observed in several of the pots and pans being stored in the cabinets. b. The dining room table wobbled when pushed and did not appear to be structurally stable. 4. The following problems were observed with the resident's adaptive equipment [Reference Federal Deficiency Citation W436]: a. Client #3's gurney did not support his frame and he slid very easily in his chair when it was tilted at the recommended angle of 45 degrees during feeding. b. Client #2's hospital bed was inoperable and didn't function as it should. c. The footrests on both Client #6's and #8's wheelchairs were in poor condition. The outer layer was torn and the supportive foam was exposed in several areas on both footrests.	I 090		
I 108	3504.15 HOUSEKEEPING Each GHMRP shall assure that each resident has at least seven (7) changes of clothing appropriate to his or her daily activities. This Statute is not met as evidenced by:	I 108	**3504.15** **This Statute will be met as evidenced by:** Reference response to W137.	5.23.08 ongoing

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I 108	Continued From page 2 Based on observation and staff interview, the facility failed to ensure that two of three sampled residents were provided clothing appropriate for the season/weather. (Residents #3 and #7) The finding includes: Observation on April 25, 2008, at 4:25 PM, revealed Residents #3 and #7 wearing heavy sweaters while being transported off the van. Staff was overheard asking the residents if they were happy to be indoors from the afternoon heat. Weather reports for the day indicated the high temperature to be 82°F. Two of the other staff in the home were also observed / heard making comments about the residents' clothing being too warm and inappropriate for the weather. Interview with the facility's Qualified Mental Retardation Professional (QMRP) on April 25, 2008, at 4:49 PM, revealed he did not take into consideration the fluctuating weather temperatures and would do a better job at ensuring the residents were dressed for the day according to the forecasted weather conditions. There was no evidence presented or on file at the time of survey to substantiate that the facility had taken the measures to ensure residents were properly dressed according to the weather conditions.	I 108	**3507.1** **This Statute will be met as evidenced by:** A copy of the policy and procedure has been placed in the home. QMRP will ensure that a written policy and procedure manual remains on site at all times.	
I 160	3507.1 POLICIES AND PROCEDURES Each GHMRP shall have on site a written manual describing the policies and procedures it will follow which shall be as detailed as is necessary to meet the needs of each resident served and provide guidance to each staff member.	I 160		5.1.08 ongoing

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I 160	Continued From page 3 This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to have a written policies and procedures manual on site and available for review by staff on the first day of survey. The finding includes: On April 24, 2008, at 9:32 AM, the Qualified Mental Retardation Professional stated that there was no policies and procedures manual available for review on site. He brought a manual from the other facility in which he worked on the following day.	I 160		
I 161	3507.2 POLICIES AND PROCEDURES The manual shall be approved by the governing body of the GHMRP and shall be reviewed at least annually. This Statute is not met as evidenced by: Based on record review, the GHMRP failed to document an annual review of the policies and procedures manual. The finding includes: Although the QMRP stated on April 25, 2008 that policies and procedures were reviewed by the governing body at least annually, the most recent review date documented in the GHMRP was March 15, 2007. No additional information was presented prior to the end of the survey that evening. This is a repeat deficiency. See deficiency report dated April 19, 2007.	I 161	**3507.2** **This Statute will be met as evidenced by:** The policy and procedure manual has been review twice since the March 2007. The most recent review occurred in March 2008.	5.1.08 ongoing

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I 203	Continued From page 4	I 203		
I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on review of personnel records that were made available, the GHMRP failed to document having discussed the contents of job descriptions with every employee at least annually. The findings include: On April 25, 2007, beginning at 12:43 PM, review of personnel records revealed no evidence of annual job description reviews for 5 of the 8 facility nurses (N1, N2, N3, N4 and N5).	I 203	**3509.3** **This Statute will be met as evidenced by:** The annual job descriptions are maintained on site for each nurse. The RN will ensure that each job description is reviewed at the time of hire and annually thereafter. Job descriptions for N1, N2, N3, N4 and N5 have been filed.	5.1.08 ongoing
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (c) Infection control for staff and residents; This Statute is not met as evidenced by: Based on interview and review of personnel records made available, the GHMRP failed to ensure that all staff had received certification in Cardiopulmonary resuscitation (CPR), in accordance with agency policies. The findings include: During the April 24, 2008 entrance conference, at 9:37 AM, the Qualified Mental Retardation Professional stated that it was agency policy that all staff maintain current CPR certification. On	I 227	**3510.5(d)** **This Statute will be met as evidenced by:** All CPR/First aid certification are up to date for the identified staff. The training Director will continue to monitor and track certification. Employees who fail to maintain compliance will be removed from the work schedule.	5.14.08 ongoing

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I 227	Continued From page 5 April 25, 2008, beginning at 12:43 PM, review of personnel files and staff in-service training records revealed no documented evidence of CPR certification for 1 of the 10 direct support staff (S1) and 3 of the 8 facility nurses (N1, N2 and N3).	I 227		
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that all staff were trained and competent to provide assistance in accordance with the Individual Support Plan (ISP), for one of the four residents in the sample. (Resident #1) The findings include: 1. During the April 24, 2008 entrance conference, at approximately 9:40 AM, the Qualified Mental Retardation Professional (QMRP) stated that he was not aware of any instance when a resident did not receive services as prescribed in his ISP. Incident reports were reviewed in the facility later that day, beginning at 3:17 PM. One incident report documented that on March 9, 2008, Resident #1 was taken to a hospital emergency room (ER) after sustaining an injury due to a fall.	I 229	3510.5(f) **This Statute will be met as evidenced by:** QMRP/Home Manager will conduct and coordinate additional training for all staff in the area of lifting/transfers, proper use of bed rails, incident reporting procedures, abuse and neglect and client rights. QA audits will be conducted on a regular basis to further ensure compliance with this standard.	5.27.08 ongoing

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I 229	Continued From page 6 Beginning at approximately 5:00 PM, the QMRP said that a staff person who had been working directly with the resident that day admitted to having left him alone in his bed, unsupervised and with the protective bed rail in the "down" position. When she returned to the bedroom, she found him on the floor. According to the QMRP, the bed rails were to remain in the "up" position whenever the resident was in bed. This was later confirmed through record verification. On April 25, 2008, at 4:03 PM, review of the investigation report, dated March 14, 2008, revealed that on the day before the incident, the Facility Coordinator (aka House Manager) had observed this same staff person leaving bed rails down. He had discussed this issue with her and she reportedly stated that she understood that this was necessary to ensure resident safety. The report also indicated that "despite previous trainings about two person lifts at all times," the staff person lifted the resident from the floor and placed him back in his bed without assistance from others. In the process, the resident reportedly "bit her on her right thumb." a. There was no evidence that in-service training on utilizing a two-person lift at all times, prior to the March 9, 2008 incident, had been effective. b. There was no evidence that in-service training on the proper use of bed rails, prior to the March 9, 2008 incident, had been effective. 2. Review of incident reports also revealed an incident on March 29, 2008 at which time staff discovered a bruise of unknown origin under Resident #1's left arm pit. The QMRP investigation report, dated April 3, 2008, indicated that the injury most likely occurred while staff	I 229		

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I 229	Continued From page 7 were lifting and transferring the resident from his wheelchair. The QMRP included a recommendation for additional staff training on lifting and transfers. On April 24, 2008, at approximately 4:57 PM, the QMRP stated that they had provided such training; however, he could not be certain that it had been conducted since the March 29, 2008 bruising incident. On April 25, 2008, beginning at 3:00 PM, review of staff in-service training records revealed no evidence that staff received additional training on lifting and transfer techniques since March 12, 2008. 3. Interviews with administrative staff regarding the March 9, 2008 incident whereby Resident #1 fell from his bed, sustained injuries and was taken to the ER revealed an across-the-board failure of the facility to recognize and report neglect. The staff person who was working with the resident that day admitted her negligence by leaving his protective bed rail in the down position. However, both the QMRP (interviewed at 4:58 PM on April 24, 2008) and the Assistant Director of Residential Services (interviewed at 11:40 AM on April 25, 2008) stated that because the staff was new and it had been an accident, it did not constitute neglect. In addition, they both indicated that the Director of Residential Services had reviewed the investigative findings. Both the investigation report and initial incident report cited the incident as a "physical injury" due to a fall. On April 25, 2008, at 6:22 PM, review of the facility's Abuse and Neglect Policy revealed a definition for "Neglect" that included the following: "Any allegation of neglect will be treated as a serious reportable incident. This means failure to provide sufficient, ... services, treatment, or care that harms or jeopardizes the customer's health,	I 229		

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I 229	Continued From page 8 safety, or welfare, such as... (d) Failure to provide services or supports as indicated by the individual's plan of care, or (e) Failure to provide proper supervision to the customer as required within a plan..."	I 229		
I 274	3513.1(e) ADMINISTRATIVE RECORDS Each GHMRP shall maintain for each authorized agency ' s inspection, at any time, the following administrative records: (e) Signed agreements or contracts for professional services; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide evidence of a signed agreement or contract with each consultant providing professional services. The findings include: Interview with the Qualified Mental Retardation Professional and review of personnel records on April 25, 2008 revealed no evidence that the GHMRP had entered into written agreements or contracts with the consulting: 1. podiatrist, and 2. speech therapist.	I 274	**3513 (e)** **This Statute will be met as evidenced by:** GHMRP will ensure that a copy of the written contract agreements for the podiatrist and speech therapist are on file and available for review.	5.30.08 ongoing
I 375	3519.6 EMERGENCIES Each GHMRP shall document each emergency and enter the follow-up actions into the resident ' s permanent record, which shall be made available for review by authorized individuals.	I 375	**3519.6** **This Statute will be met as evidenced by:** Reference response to W154, 189, and W192.	5.21.08 ongoing

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I 375	Continued From page 9 This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure the investigation and/or the follow-up actions of a resident's injury was documented as required by this section, for one (1) of four (4) randomly sampled residents. (Resident #1) The findings include: 1. Record review on April 25, 2008 revealed that Resident #1 sustained an injury when he fell out of his wheelchair and injured his lip. He was taken to the Emergency Room (ER) for treatment and discharged accordingly. Observations on April 24, 2008 and on April 25, 2008 revealed Resident #1 was totally dependent on staff for mobility and his wheelchair was equipped with a chest strap to keep him in his wheelchair. It was not clear how he was able to fall out of his chair and sustain an injury to his face. There was also no evidence on file to substantiate that an investigation was initiated to ascertain the nature and reason for the fall to ensure that the health and safety of the resident could be protected. 2. Record review on April 25, 2008, at 2:05 PM, revealed that Resident #1arrived at the day program on January 14, 2008 with an "abrasion to his face near the left corner of his mouth." The day program documented that they did not receive any communication from the home explaining how that injury took place and that they submitted an "Interagency Communication" detailing their observation of the injury. Record review at Resident #1's home on April 25, 2008, at 4:01 PM revealed there was no incident on file addressing this injury. Interview with the facility's Nurse on April 25, 2008, at 4:06 PM, revealed	I 375		

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I 375	Continued From page 10 that she was not aware of the injury to Resident #1's face. She was also not aware of the Interagency Communication detailing the injury. There was no evidence on file at the time of survey to substantiate that an investigation was initiated to ascertain the nature and reason for the fall to ensure that the health and safety of the resident could be protected.	I 375		
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 staff interview and record review, the facility failed to ensure the implementation of a resident's approved habilitation plan for one of the four sampled residents. (Resident #1) The findings include: 1. Record review on April 25, 2008, at 4:16 PM, revealed Resident #1's Speech Assessment dated March 24, 2008 recommended the following interventions: a. Provide exposure to cause-effect activities through switch-activated objects and items (radio, CD player, cassette player, blender, etc) b. Implement the following speech & language program, which should start at the beginning of the 2nd quarter: a. Goal: Increase functional pre-language skills involving switch use. b. Objective: [Resident #1] will be able to	I 422	**3521.3** **This Statute will be met as evidenced by:** Reference response to W89, W154, W192, W249.	5-30-08 ongoing

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I 422	Continued From page 11 access switch-operated devices/voice output in order to make choices and for stimulation purposes given physical assistance on 3 out of 5 trials. Interview with the facility's Qualified Mental Retardation Professional (QMRP) on April 25, 2008, at 4:20 PM, revealed the speech/ language program was not being implemented. Instead, Resident #1 had been provided a "Go Talk" device and this was what was being used. There was no evidence on file or presented at the time of survey to substantiate that the facility ensured the implementation of this habilitative program as recommended. 2. During the April 24, 2008 entrance conference, at approximately 9:40 AM, the QMRP stated that he was not aware of any instance when a resident did not receive services as prescribed in his ISP. Incident reports were reviewed in the facility later that day, beginning at 3:17 PM. One incident report documented that on March 9, 2008, Resident #1 was taken to a hospital emergency room (ER) after sustaining an injury due to a fall. Beginning at approximately 5:00 PM, the QMRP said he had investigated the incident. A staff person who had been working directly with Resident #1 admitted to having left him alone in his bed, unsupervised and with the protective bed rail in the "down" position. When she returned to the bedroom, she found him on the floor. According to the QMRP, the bed rails were to remain in the "up" position whenever the resident was in bed.	I 422		

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I 422	Continued From page 12 On April 25, 2008, at 4:03 PM, review of the investigation report, dated March 14, 2008, revealed that on the day before the incident, the Facility Coordinator (aka House Manager) had observed this same staff person leaving bed rails down. He had discussed this issue with her and she reportedly stated that she understood that this was necessary to ensure resident safety. The report also indicated that "despite previous trainings about two person lifts at all times," the staff person lifted the resident from the floor and placed him back in his bed without assistance from others. In the process, the resident reportedly "bit her on her right thumb."	I 422		

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I 000	INITIAL COMMENTS A licensure survey was conducted from April 24, 2008 through April 25, 2008. A random sample of four residents was selected from a resident population of eight men with profound mental retardation and other disabilities. The findings of this survey were based on observations at the group home and at two day programs, interviews with day program and residential staff as well as the review of clinical and administrative records, including incident reports.	I 000	**3504.1 Housekeeping** **This Statute will be met as evidenced by:** Repairs have been completed. The running toilet, damaged tile and broken fixtures have been repaired/replaced. In addition, the old wheelchairs have been removed from the home and the kitchen dining room table has been stabilized. The Home Manager has purchased additional pots and pans and discarded the rusted cooking equipment. Also reference response to W436 in regards to client #3's gurney and hospital bed, as well as general repairs to the wheelchairs. QMRP/Home Manager will continue to complete routine home inspections and document maintenance request weekly. QMRP/Home Manager will provide additional staff training on reporting concerns related to wheelchair repairs and adaptive equipment needs of the individuals.	5.7.08 ongoing
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Observation and staff interview on April 24, 2008, at 2:15 PM, revealed the following environmental deficiencies: 1. The following problems were observed in Bathroom #1 near Resident #3's bedroom: a. Running toilet; water continued to flow after the tank had filled to capacity. b. Damaged structure; broken and water damaged tile observed along the base of the tub and along the adjacent walls/support structures. c. Broken fixtures; the hot water knob on the sink leaked when opened to allow water to flow. 2. The following problem was observed in Bathroom #2 near Resident #5's bedroom:	I 090		

Health Regulation Administration

Nancy Branch — TITLE OES — (X6) DATE 5/30/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE