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

PRINTED: 04/28/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G120	A. BUILDING _____ B. WING _____	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIVIDUAL DEVELOPMENT, INC.	2620 24TH STREET, NE WASHINGTON, DC 20018

(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 A recertification survey was conducted from April 5, 2011 through April 8, 2011, utilizing the fundamental survey process. A random sampling of three clients was selected from a residential population of five individuals with various levels of intellectual disability. The findings of the survey were based on observations in the home and three day programs, interviews with staff in the home and the day programs, as well as a review of the clinical, administrative, and habilitation records, including a review of the unusual incident reports.	W 000	Received 5/12/11 Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002	
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 observation, interview and record review, the facility failed to ensure that outside services met the needs, for one of the three clients included in the sample. (Client #3) The findings include: 1. The day program failed to ensure Client #3 remained in her wheelchair while she ate her lunch, as recommended by the occupational therapist. Observation on April 5, 2011, at 5:40 p.m., revealed Client #3 seated at a 90 degree angle in her wheelchair, while eating her dinner. Observations conducted at the day program on April 6, 2011, at 12:50 p.m., revealed the staff	W 120		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Director of Residential Services		5/12/11

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 transferred the client from her wheelchair to an arm chair at the cafeteria table to eat her meal. Continued observation revealed the client sat low in her chair, allowing her face to touch the table as she leaned over. At 12:53 p.m., the day program staff placed the client's lunch in front of her. Seconds later, the client began to eat her lunch with a raking motion to move the food from the plate into her mouth with hand over hand assistance. On April 7, 2011, at approximately 1:00 p.m., review of Client #3's occupational therapy reassessment dated December 19, 2010, revealed the client was required to sit in her wheelchair while eating, to allow her to be at her optimal height and distance from her plate. At approximately 1:15 p.m., review of her mealtime protocol revealed the client was required to be seated at 90 degrees in her wheelchair. On April 7, 2011, at 3:55 p.m., interview with the facility's qualified intellectual professional person (QIPD) revealed she had previously trained the the day program staff on Client #3's mealtime protocol. Record review on April 8, 2011 at approximately 11:00 a.m. revealed an in-service training form dated August 17, 2010 which verified the Mealtime Protocol training had been provided to the day program staff. Further record review at 1:10 p.m., revealed the day program staff were retrained by the QIPD on Client #3's Mealtime Protocol on April 8, 2011. 2. The day program failed to ensure that Client #3 received food in a form consistent with her prescribed dietary needs, as evidenced below:	W 120		

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W 120	Continued From page 2	W 120	**W120** **This Standard will be met as evidenced by:** On 4/8/11, the QDDP conducted an in-service training at Client #3's Day Program on her Mealtime Protocol, including mealtime positioning. In addition, the QDDP provided the day program with another copy of Client #3's Mealtime Protocol. The QDDP will conduct monthly day program visits to ensure compliance with the training as provided.	4/8/11 On-going
	On April 5, 2011, at 6:45 p.m., Client #3 was served ground chicken, collard greens and whole chili beans at her group home. On April 6, 2011, at 12:53 p.m., observations conducted at the day program revealed Client #3 was served a pureed meal for lunch that consisted of chicken, cabbage, rice and beans.			
	Interview with the facility's QIPD on April 7, 2011, at 3:55 p.m., revealed the day program was trained on Client #3's mealtime protocol. On April 8, 2011, at approximately 1:10 p.m., the QIPD presented a agenda and attendance sheet dated April 8, 2011, which documented retraining of day program staff on the mealtime protocol.			
W 169	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL	W 159		4/22/11 On-going
	Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.			
	This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility's qualified intellectual professional person (QIPD) failed to ensure the active treatment program was integrated, coordinated, and monitored for two of three clients in the sample. (Clients #1 and #3)			
	The findings include:			
	1. The QIPD failed to ensure continuous active treatment was provided for Clients #1 and #3. (See W249)			

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W 159	Continued From page 3 2. The QIPD failed to ensure data relative to accomplishment of criteria specified in the individual program plan was documented in measurable terms, to the monitor Client #3's targeted behaviors. (See W252)	W 159	**W159** **This Standard will be met as evidenced by:** QDDP provided additional training to DSP staff on client #3 behavior guidelines documentation and implementation. Individual #3 has a behavior guideline that shows proactive strategies to redirect hand mouthing/hand biting behavior. This is not a formal BSP. QDDP will continue to discuss guidelines with IDT for input/update on quarterly basis and changes will be made as deemed necessary by IDT.	4/22/11 On-going
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 observation, staff interview and record review, the facility failed to ensure staff demonstrated competency to address the needs of the clients, for one of three clients in the sample. (Client #3) The finding includes: The facility failed to ensure staff were adequately trained to implement Client #3's prescribed diet. On April 6, 2011, at 5:45 p.m., Client #3 was observed eating ground chicken nuggets, collard greens, and whole chili beans. On April 6, 2011, at 3:55 p.m., the client was observed eating unbroken sun chips for snack. Review of the nutrition assessment at 4:10 p.m., revealed a recommendation for a low fat, low cholesterol, high fiber, 1500 calorie, moist ground meat, finely chopped firm and string vegetables (i.e. greens and string beans) diet. Minutes later, the qualified intellectual professional person (QIPD) indicated that the sun chips were required to be in small bite size pieces and that the chili beans should have been finely chopped.	W 192		

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W 192	Continued From page 4 On April 7, 2011, at approximately 4:00 p.m., review of the physician's orders dated March 1, 2011, revealed the client's prescribed dietary order was low fat, low cholesterol, high fiber, 1500 calorie, moist ground meat, finely chopped firm and string vegetables (i.e. greens and string beans), and small bite size bread, pastries, cookies, crackers, canned and fresh fruit. Minutes later, review of the mealtime protocol revealed, "[the client] has poor range of movement of the oral peripheral mechanism and lack of natural dentition. This impacts her safe and adequate dietary intake. Strict adherence to the established mealtime guidelines will increase [the client] safe and adequate nutritional intake as well as decrease the likelihood of her experiencing choking, aspiration and aspiration related illnesses." Review of the facility's in-service training records on April 6, 2011, at approximately 4:30 p.m., revealed that all staff had received nutrition training on November 19, 2010. There was no evidence that training had been effective.	W 192	**W192** **This Standard will be met as evidenced by:** On April 7, 2011, an in-service training was conducted by QDDP on Client # 3's Mealtime Protocol, including diet and meal texture/consistency. In addition, April 22, 2011, the Speech and Language Pathologist conducted an in-service training on all Client Mealtime Protocols, including food/liquid textures. The facility management/Speech Pathologist will routinely train staff on Client # 3's Diet and provide on-going monitoring to ensure compliance with training as set forth and will administer a test to determine the effectiveness of the training.	**4/22/11** **On-going**
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 observation, staff interview and record	W 249		

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W 249	Continued From page 5 review, the facility's qualified intellectual professional person (QIPD) failed to ensure clients received continuous active treatment, for two of the three clients included in the sample. (Clients #1 and #3) The findings include: 1. Observation on April 5, 2011, at 5:17 p.m., revealed the licensed practical nurse (LPN) assisted Client #1 from the living room to the kitchen to select a snack. As they walked to the kitchen, the LPN told the client she was going to get her a snack; however, the LPN decided not to give her the snack. In an interview with the LPN she stated "I gave her a snack in her bedroom around 2:00 p.m., so I decided to wait until after dinner." At 5:38 p.m., the direct support staff assisted the client to the dining room for dinner. Review of Client #1's individual program plan (IPP) dated July 2010, on April 7, 2011, at 8:50 a.m., revealed an objective for Client #1 to use her low tech communication device accompanied by manual signs and tactile cues to express her wants and needs. On April 7, 2011, at 9:25 a.m., review of the client's speech and language evaluation dated April 6, 2010, revealed a recommendation that stated "Given touch prompts accompanied by manual signs and tactile cues, [the client] will utilize a low tech voice output communication device (Go Talk) on a daily basis to express four basic wants and needs." Interview with the QIPD and the house manager on the same day at 5:00 p.m., acknowledged that the direct support staff did not implement Client #1's communication goal, which required the use of the client's "Go Talk" device.	W 249	**W249** **This Standard will be met as evidenced by:** _____ 1. QDDP has provided refresher training to DSP staff on Client #1's communication device and Client #1's Individual Program Plan. QDDP will routinely review program implementation /documentation and conduct on shift visits to ensure compliance with training as outlined. 2. Cross reference W192. In addition, QDDP has provided refresher training to DSP staff on Client #3's choice making strategies. QDDP will review documentation ~~and conduct~~ routine monitoring of program to ensure compliance with training as outlined.	**4/22/11 On-going**

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W 249	Continued From page 6	W 249		

At no time during the survey was any staff observed implementing the client's communication goal.

There was no evidence that the facility implemented Client #1's communication training program as recommended in the IPP.

2. Observation on April 5, 2011, at 4:40 p.m., revealed the direct support staff asked Client #3 what she wanted for a snack. Shortly afterwards, a second direct care staff asked, "What did she say?" The direct support staff did not respond and placed a bowl of apple sauce in front of the client. At approximately 5:00 p.m., the direct support staff indicated that Client #3 was nonverbal. However, the client was not observed to be provided a choice of snacks. At 4:56 p.m., the direct support staff placed a communication device in front of the client and pressed the, "I'm hungry" button. The direct support staff then stated, "How do you feel?" At 4:57 p.m., the direct support staff took the communication device away from the client. At 5:03 p.m., the direct support staff placed a "Busy Bee" game in front of the client. At 5:40 p.m., the direct support staff placed the client's dinner in front of her.

Review of Client #3's IPP dated July 2010, on April 7, 2011, at 2:00 p.m., revealed a training objective for Client #3 to use a low tech voice output (cheap talk) with touch prompts to communicate basic wants and emotional status and well being to persons in her environment. On the same day at approximately 2:30 p.m., review of the client's speech and language evaluation dated July 8, 2010, revealed a recommendation that stated, "Given touch prompts [the client] will

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W 249	Continued From page 7 utilize a low tech voice output device (cheap talk) to communicate basic wants and emotional status and well being to persons in her environment ". Interview with the QIPD and the house manager on the same day at 5:00 p.m., acknowledged that the direct support staff did not implement Client #3's communication goal, which required the use of her "Cheap Talk" device. During the survey, the direct support staff were observed to use the communication device with the client for only one minute. There was no evidence that the facility implemented Client #3's communication program as recommended in the IPP.	W 249		
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 observation, interview and record review, the facility failed to ensure direct support staff documented all target behaviors in accordance with the behavior support plan (BSP), for one of the three clients in the sample. (Client #3) The finding includes: Observation on April 5, 2011, at 4:38 p.m., revealed Client #3 biting her hand as she played with her "busy bee" game. The direct support staff	W 252	**W252** **This Standard will be met as evidenced by:** On April 22,2011, QDDP conducted an in-service training on the implementation and documentation of Client # 3's Behavioral Guidelines. The RD will review the documentation weekly to ensure compliance with training as set forth. The QDDP will monitor the documentation monthly and coordinate routine training for staff annually and as needed.	

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W 252	Continued From page 8 immediately removed her hand from her mouth. At 5:06 a.m., the client began to bite her hand again. The direct support staff asked the client to stop, and then removed her hand from her mouth. However, a couple minutes later, the client continued to bite her hand. On April 7, 2011, at 10:15 a.m., review of Client #3's BSP, dated August 1, 2010, confirmed that hand mouthing and hand biting were two of her primary targeted maladaptive behaviors. The BSP also instructed staff to document each of the behaviors on the "data sheets". At approximately 11:30 a.m., review of the client's behavior data sheets for April 7, 2011 revealed the staff had failed to document each time Client #3 displayed her maladaptive behaviors. In an interview with the qualified developmental disability professional on April 7, 2011, at 3:25 p.m., it was acknowledged that the direct support staff is required to document all target maladaptive behaviors. The facility failed to evidence that Client #3's primary targeted maladaptive behaviors were documented as required by the psychologist.	W 252		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure preventive health services were implemented in accordance with the needs of one of three clients in the	W 322		

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W 322	Continued From page 9 sample. (Client #3) The finding includes: [Cross refer to W331] The facility failed to timely implement measures to address recommendations by the neurologist, to decrease Client #3's elevated serum dilantin, as evidenced below: Review of Client #3's medical record on April 7, 2011, at 12:11 p.m., revealed on March 23, 2011, the client had a Dilantin level of 54.5 (therapeutic range: 10 -20 mcg/ml), which was documented as "toxic." Continued review of the record revealed on March 23, 2011, the primary care physician (PCP) ordered to hold the Dilantin for three days, and that the order was implemented. On March 25, 2011, the Client #3 was evaluated by the neurologist. The neurologist recommended to repeat the Dilantin level, and if level falls between 10 -20, resume Dilantin at 100 mg TID. Interview with the nurse on April 7, 2011 at 1:15 p.m. revealed that on March 25, 2011, the neurologist's recommendation were discussed with the primary care physician. Review of the MAR on April 7, 2011 at 1:15 p.m. revealed that the client's Dilantin was resumed on March 26, 2011 and was continued until March 30, 2011. The review of a lab report dated March 31, 2011 revealed the client's serum dilantin was still elevated (45.3 mcg/ml). There was no evidence the neurologist's recommendation to "... repeat the Dilantin level, and if level falls between 10 -20, resume Dilantin at 100 mg TID," was addressed, prior to resuming	W 322	W322 **This Standard will be met as evidenced by:** Pursuant to IDI Policies and Procedures (see listed below) all nursing staff will be retrained on communication with PCP in collaboration with consultant specialist recommendations, subsequent orders, lab work and seizure management records. Section L, Number 1: Laboratory Work Section M, Number 1: Medical Appointments Section P, Number 1: Physician Order Sheets and Medication Administration Records Section S, Number 1: Seizure Management Section S, Number 5:	**4/22/11 On-going**

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W 322	Continued From page 10 Client's Dilantin dosage.	W 322		
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 interview and record review, the facility failed to ensure nursing services were provided in accordance with the needs of one of three clients in the sample.(Client #3) The finding includes: Review of Client #3's record on April 5, 2011, at 2:25 p.m., revealed an incident report dated February 7, 2011. According to the report, the client was evaluated at the emergency room due to having two brief seizures within fifteen minutes. Observation during the medication administration on April 5, 2011 at 8:16 p.m., revealed the client did not receive Dilantin, one of her seizure medications. Interview with the nurse on April 5, 2011 at 8:30 p.m. revealed the client was prescribed Dilantin to address her seizure disorder, however the medication was on hold due to an elevated blood level. Further interview with the nurse on April 6, 2011 at 2:40 p.m., revealed the client's Dilantin had been on hold since March 31, 2011. Review of Client #3's medical record on April 7, 2011, at 12:11 p.m., revealed on March 23, 2011, the client had a Dilantin level of 54.5 (therapeutic range: 10 -20 mcg/ml), which was documented as "toxic." Continued review of the record revealed	W 331	**W331** **This Standard will be met as evidenced by:** Pursuant to IDI Policies and Procedures (see listed below) all nursing staff will be retrained on communication with PCP in collaboration with consultant specialist recommendations, subsequent orders, lab work and seizure management records. Section L, Number 1: Laboratory Work Section M, Number 1: Medical Appointments Section P, Number 1: Physician Order Sheets and Medication Administration Records Section S, Number 1: Seizure Management Section S, Number 5: Shift Duties and Responsibilities	**5/13/11 On-going**

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G120	A. BUILDING _____ B. WING _____	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIVIDUAL DEVELOPMENT, INC.	2620 24TH STREET, NE WASHINGTON, DC 20018

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W 331	Continued From page 11 on March 23, 2011, the primary care physician (PCP) ordered to hold the Dilantin for three days, and that the order was implemented. Further record review on April 7, 2011, at 12:25 p.m., however, revealed on March 25, 2011, the Client #3 was evaluated by the neurologist. The neurologist recommended to repeat the Dilantin level and if level falls between 10 -20, resume Dilantin at 100 mg TID. Review of the MAR on April 7, 2011 at 1:15 p.m. revealed that the client's Dilantin was resumed on March 26, 2011 and was continued until March 30, 2011. The review of a lab report dated March 31, 2011 revealed the client's serum dilantin was still elevated (45.3 mcg/ml). At the time of the survey, there was no evidence that the a repeat serum Dilantin was obtained as recommended by the neurologist, prior to resuming Client's Dilantin dosage.	W 331	**W331** **This Standard will be met as evidenced by:** Pursuant to IDI Policies and Procedures (see listed below) all nursing staff will be retrained on communication with PCP in collaboration with consultant specialist recommendations, subsequent orders, lab work and seizure management records. Section L, Number 1: Laboratory Work Section M, Number 1: Medical Appointments Section P, Number 1: Physician Order Sheets and Medication Administration Records Section S, Number 1: Seizure Management Section S, Number 5: Shift Duties and Responsibilities	5/13/11 On-going
W 381	483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to store drugs under proper conditions of security for one of six clients residing in the facility. (Client #3) The finding includes: During the medication administration on April 5, 2011, at 8:12 p.m., the license practical nurse (LPN) was observed to leave the medication cart	W 381		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 381	Continued From page 12 in the dining room to retrieve water from the kitchen. Further observation revealed Client #3's medications were on the medication cart unsecured. Continued observation revealed the direct care staff and the house manager were sitting at the dining room table next to the medication cart. Interview with the LPN on April 5, 2011, at approximately 8:45 p.m., revealed that Client #3's medications should have been secured when the nurse was away from the medication cart. The LPN failed to evidence that all drugs were stored under proper conditions of security.	W 381	**W381** **This Standard will be met as evidenced by:** Pursuant to IDI Policies and Procedures (*Healthcare Protocol Manual:* Section M, Number 3; Medication Variance Report) all medications are received, stored, and controlled by nursing staff. IDI will retrain nursing staff on IDI's Policies and Procedures for securing medications, including specifically the security of medication carts during medication administration.	**5/13/11** **On-going**
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure proper infection control procedures, for one of the three clients in the sample. (Client #3) The finding includes: On April 5, 2011, at 4:30 p.m., Client #3 arrived home from her day program. Upon entering the facility, the direct support staff pushed the client in her wheelchair to the dining room table. At 4:38 p.m., the client began to play with her "busy bee" game as she bit her hand. At 4:43 p.m., the direct support staff took the "busy bee" away and placed a bowl of applesauce in front of the client. Seconds later, the client was observed eating her	W 455		

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W 455	Continued From page 13 applesauce. The client was not observed to, or asked to wash her hands prior to putting her hand in her mouth and consuming her snack. Review of the training records on April 5, 2011, at approximately 6:30 p.m., revealed that staff received infection control training on December 1, 2010. On April 6, 2011, at 9:35 a.m., the qualified intellectual professional person (QIPD) provided documentation of staff training on April 5, 2011 (6:15 p.m.) and April 6, 2011 (7:30 a.m. and 2:00 p.m.) on the use of hand sanitizer and wipes. On April 5, 2011, at approximately 3:30 p.m., interview with the house manager revealed that staff are required to clean and sanitize Client #3's hands due to her maladaptive behaviors of hand mouthing and hand biting.	W 455	**W455** **This Standard will be met as evidenced by:** On April 5, 2011, and April 6, 2011, in-service training was conducted on the usage of hand sanitizer. The QDDP will ensure that all staff receives infection control training at least annually and as needed to ensure compliance with training as outlined.	**4/6/11** **On-going**

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I 000	INITIAL COMMENTS A licensure survey was conducted from April 5, 2011 through April 8, 2011. A random sampling of three residents was selected from a residential population of six individuals with various levels of intellectual disability. The findings of the survey were based on observations in the home and three day program, interviews with staff in the home and the day programs, as well as a review of the clinical, administrative, and habilitation records, including a review of the unusual incident reports.	I 000		
I 042	3502.2(b) MEAL SERVICE / DINING AREAS Modified diets shall be as follows: (b) Planned, prepared, and served by individuals who have received instruction from a dietitian; and... This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Persons with Intellectual Disability (GHPID) failed to ensure that modified diets were served as prescribed, for one of the three residents (Resident #3) included in the sample. The finding includes: The facility failed to ensure staff was adequately trained to implement Resident #3's prescribed diet, as evidenced below: On April 5, 2011, at 5:45 p.m., Resident #3 was observed eating ground chicken nuggets, collard greens, and whole chili beans. On April 6, 2011, at 3:55 p.m., the resident was observed eating	I 042	3502.2(b) **This status will be met as evidenced by:** Cross reference W192	4/22/11

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I 042	Continued From page 1 unbroken sun chips for snack. Review of the nutrition assessment at 4:10 p.m., revealed a recommendation for a low fat, low cholesterol, high fiber, 1500 calorie, moist ground meat, finely chopped firm and string vegetables (i.e. greens and sting beans) diet. Minutes later, the qualified intellectual professional person (QIPD) indicated that the sun chips were required to be in small bite size pieces and that the chili beans should have been finely chopped. On April 7, 2011, at approximately 4:00 p.m., review of the physician's orders dated March 1, 2011, revealed the resident's prescribed dietary order was low fat, low cholesterol, high fiber, 1500 calorie, moist ground meat, finely chopped firm and string vegetables (i.e. greens and sting beans), and small bite size bread, pastries, cookies, crackers, canned and fresh fruit. Review of the facility's in-service training records on April 8, 2011, at approximately 4:30 p.m., revealed that all staff had received nutrition training on November 19, 2010. There was no evidence that training had been effective.	I 042		
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: Based on observation and interview, the Group Home for Persons with Intellectual Disability (GHPID) failed to ensure the environment was maintained in a safe, clean and orderly manner to	I 090		

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I 090	Continued From page 2 meet the needs of six of six residents in the facility. (Residents #1, #2, #3, #4, #5, and #6) The findings include: 1. Observation, during the environmental walk-through on April 7, 2011 at approximately 10:55 a.m., revealed the bed made the same type of noise when it was lowered with the electrical control. The surveyor was accompanied by the house manager (HM), who acknowledged the finding. 2. On April 7, 2011, at approximately 2:15 p.m., the surveyor sustained a splinter on her leg from the dining room table. At approximately 4:30 p.m., the surveyor sustained another splinter on her leg from the opposite side of the dining room table. Continued observation of the dining table at the same time revealed other edges with splinters. The aforementioned findings were acknowledged by the house manager. 3. During the observations on April 7, 2011, at approximately 10:45 a.m., the following findings were observed by the surveyor and acknowledged by the home manager: a. The vinyl upholstery on the chair located in Resident #1's bedroom was torn in multiple places. b. The upholstery on the arms of the love seat located in the foyer area was torn.	I 090	**3504.1:** **This status will be met as evidenced by:** 1. On April 25, 2011, the bed identified to have made a noise when lowered with the electrical control was assessed by the adaptive equipment technician. During that assessment, no issues or concerns were identified with the bed. The bed was found to be working condition. 2. The dining room table will be assessed for safety from IDI's maintenance department repair or replacement will be done based on the evaluation. 3. (A) The torn chair has been removed from client#1's room. The RD will ensure there is no damaged furniture in the home. (b).The RD has submitted a check request for a new chair.	4/25/11
I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their	I 180		

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I 180	Continued From page 3 Habilitation plans. This Statute is not met as evidenced by: Based on observation, interview, and record review, the Group Home for Persons with Intellectual Disability (GHPID) failed to ensure adequate administrative support to meet the habilitation needs of two of three residents in the sample. (Residents #1 and #3) The finding includes: The qualified intellectual professional person (QIPD) failed to coordinate and monitor the active treatment programs of Residents #1 and #3. 1. The QIPD failed to ensure continuous active treatment was provided for Residents #1 and #3. (See federal deficiency report - Citation W249) 2. The QIPD failed to ensure data relative to accomplishment of criteria specified in the individual program plan was documented in measurable terms, for the monitoring of Resident #3's targeted behaviors. (See federal deficiency report - Citation W252)	I 180	**3508.1:** **This status will be met as evidenced by:** Cross reference W249 Cross reference W252	**4/22/11 On-going**
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties.	I 206	**3509.6:** **This status will be met as evidenced by:** Health Certificates will be obtained for Consultant #1 and Consultant #2. IDI Human Resources will continue to track the expiration dates of Consultant's Health Certificates.	**5/13/11 On-going**

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I 206	Continued From page 4 This Statute is not met as evidenced by: Based on staff interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure an annual health screening was provided for two (2) of fourteen (14) consultants contracted to provide professional services. Consultants #1 and #2) The finding includes: On April 6, 2011, at approximately 4:00 p.m., review of the facility's files revealed there were no current health certificates on file for Consultant #1 or Consultant #2. On April 6, 2011, at approximately 4:30 p.m., the administrative office was notified and acknowledged that the health certificates were expired for both consultants, and indicated current health certificates would be obtained. At the time of the survey exit, current health certificates had not been provided for the aforementioned consultants.	I 206		
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the GHPID failed to ensure a continuous, ongoing in-service training program to address the needs of one of three residents in the sample. (Resident #3) The finding includes: The GHPID failed to ongoing training to staff on infection control measures for Resident #3, as evidenced below:	I 222	3510.3: **This status will be met as evidenced by:** Cross reference W455	4/6/11 **On-going**

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I 401	Continued From page 6 failed to ensure that treatment services were provided in accordance with the need of one of three clients in the sample. (Resident #3) The finding includes: The GHPID failed to timely implement measures to address recommendations by the neurologist, to decrease Resident #3's elevated serum dilantin, as evidenced below: Review of Resident #3's record on April 5, 2011, at 2:25 p.m., revealed an incident report dated February 7, 2011. According to the report, the client was evaluated at the emergency room due to having two brief seizures within fifteen minutes. Observation during the medication administration on April 5, 2011 at 8:16 p.m., revealed the client did not receive Dilantin, one of her seizure medications. Interview with the nurse on April 5, 2011 at 8:30 p.m. revealed the client was prescribed Dilantin to address her seizure disorder, however the medication was on hold due to an elevated blood level. Further interview with the nurse on April 6, 2011 at 2:40 p.m., indicated the client's Dilantin had been on hold since March 31, 2011. Interview with the nurse on April 7, 2011 at 1:15 p.m. revealed that on March 25, 2011, the neurologist's recommendation were discussed with the primary care physician. Review of Resident #3's medical record on April 7, 2011, at 12:11 p.m., revealed on March 23, 2011, the client had a Dilantin level of 54.5 (therapeutic range: 10 -20 mcg/ml), which was documented as "toxic." Continued review of the record revealed on March 23, 2011, the primary	I 401		

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I 222	Continued From page 5 On April 5, 2011, at 4:30 p.m., Resident #3 arrived home from her day program. Upon entering the GHPID, the direct support staff pushed the resident in her wheelchair to the dining room table. At 4:38 p.m., the resident began to play with her "busy bee" game as she bit her hand. At 4:43 p.m., the direct support staff took the "busy bee" away and placed a bowl of applesauce in front of the resident. Seconds later, the resident was observed eating her applesauce. The resident was not observed to, or asked to wash her hands prior to putting her hand in her mouth and consuming her snack. Review of the training records on April 5, 2010, at approximately 6:30 p.m., revealed that staff was trained on infection control on December 1, 2010. On April 6, 2011 and 9:35 am, the QIPD provided documentation of staff training on April 5, 2011 (6:15 p.m.) and April 6, 2011 (2:00 a.m. and 7:30 a.m.), on the use of hand sanitizer and wipes. On April 5, 2011, at approximately 3:30 p.m., interview with the house manager revealed that staff are required to sanitize Resident #3's hands due to her maladaptive behaviors of hand mouthing and hand biting.	I 222		4/8/11 On-going
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on interview and record review, the GHPID	I 401	3520.3: **This status will be met as evidenced by:** Cross reference W322	

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I 401	Continued From page 7 care physician (PCP) ordered to hold the Dilantin for three days, and that the order was implemented. Further record review on April 7, 2011, at 12:25 p.m., however, revealed on March 25, 2011, the Resident #3 was evaluated by the neurologist. The neurologist recommended to repeat the Dilantin level and if level falls between 10 -20, resume Dilantin at 100 mg TID. Review of the medication administration record (MAR) on April 7, 2011 at 1:15 p.m. revealed that the client's Dilantin was resumed on March 26, 2011 and was continued until March 30, 2011. The review of a lab report dated March 31, 2011, revealed the client's serum dilantin was still elevated (45.3 mcg/ml). At the time of the survey, there was no evidence that the a repeat serum Dilantin was obtained as recommended by the neurologist, prior to resuming Resident's Dilantin dosage.	I 401		
I 404	3520.6 PROFESSION SERVICES: GENERAL PROVISIONS Each professional service provider shall assist, as appropriate, each other person who is working with a resident in the GHMRP so that relevant professional instructions can be implemented through-out the resident ' s programs and daily activities. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHPID failed to ensure that outside services met the needs, for one of the three residents included in the sample. (Resident #3) The findings include:	I 404	3520.6: **This status will be met as evidenced by:** Cross reference W120	

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I 404	Continued From page 8	I 404		

1. The day program failed to ensure Resident #3 remained in her wheelchair while she ate her lunch, as recommended by the occupational therapist.

Observation on April 5, 2011, at 5:40 p.m., revealed Resident #3 seated at a 90 degree angle in her wheelchair, while eating her dinner. Observations conducted at the day program on April 6, 2011, at 12:50 p.m., revealed the staff transferred the resident from her wheelchair to an arm chair at the cafeteria table to eat her meal. Continued observation revealed the resident sat low in her chair, allowing her face to touch the table as she leaned over. At 12:53 p.m., the day program staff placed the residents' lunch in front of her. Seconds later, the resident began to eat her lunch, raking the food from the plate into her mouth, with hand over hand assistance.

On April 7, 2011, at approximately 1:00 p.m., review of Resident #3's occupational reassessment dated December 19, 2010, revealed the resident is required to sit in her wheelchair while eating, to allow her to be at her optimal height and distance from her plate. At approximately 1:15 p.m., review of her mealtime protocol revealed the resident is required to be seated at 90 degrees in her wheelchair.

On April 7, 2011, at 3:55 p.m., interview with the GHPID's qualified intellectual professional person (QIPD) revealed she had previously trained the the day program staff on Resident #3's mealtime protocol.

Record review on April 8, 2011 at approximately 11:00 a.m. revealed an in-service training form dated August 17, 2010 which verified the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 404	Continued From page 9 Mealtime Protocol training had been provided to the day program staff. Further record review at 1:10 p.m., revealed the day program staff were retrained by the QIPD on Resident #3's Mealtime Protocol on April 8, 2011. 2. The day program failed to ensure that Resident #3 received food in a form consistent with her prescribed dietary needs, as evidenced below: On April 5, 2011, at 5:45 p.m., Resident #3 was served ground chicken, collard greens and whole chili beans at her group home. On April 6, 2011, at 12:53 p.m., observations conducted at the day program revealed Resident #3 was served a pureed meal for lunch that consisted of chicken, cabbage, rice and beans. Interview with the GHPID's (QDDP) on April 7, 2011, at 3:55 p.m., revealed the day program was trained on Resident #3's mealtime protocol. On April 8, 2011, at approximately 1:10 p.m., the QDDP presented a agenda and attendance sheet dated April 8, 2011, which documented retraining of day program staff on the feeding protocol.	I 404		
I 420	3521.1 HABILITATION AND TRAINING Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHPID failed each resident was provided with habilitation and training to enable them to cope more effectively with the demands	I 420	3521.1 **This status will be met as evidenced by:** Cross reference W249	4/22//11 **On-going**

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0051	A. BUILDING _____ B. WING _____	04/08/2011

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I 420	Continued From page 10 of their environments and to achieve their optimum levels of physical, mental and social functioning for two of three residents in the sample. (Residents #1 and #3) The findings include: 1. Observation on April 5, 2011, at 5:17 p.m., revealed the licensed practical nurse (LPN) assisted Resident #1 from the living room to the kitchen to select a snack. As they walked to the kitchen, the LPN told the resident she was going to get her a snack. However, the LPN decided not to give her a snack. In an interview with the LPN at the same time, the LPN stated "I gave her a snack in her bedroom around 2:00 p.m., so I decided to wait until after dinner. On the same day, at 5:31 p.m., the direct support staff handed the resident a tambourine. At 5:38 p.m., the direct support staff assisted the resident to the dining room for dinner. Review of Resident #1's individual program plan (IPP) dated July 2010, on April 7, 2011, at 8:50 a.m., revealed an objective for Resident #1 to use her low tech communication device accompanied by manual signs and tactile cues to express her wants and needs. On April 7, 2011, at 9:25 a.m., review of the resident's speech and language evaluation dated April 6, 2010, revealed a recommendation that stated "Given touch prompts accompanied by manual signs and tactile cues, [the resident] will utilize a low tech voice output communication device (Go Talk) on a daily basis to express four basic wants and needs." Interview with the QIPD and the house manager on the same day at 5:00 p.m., acknowledged that	I 420		

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I 420	Continued From page 11	I 420		

the direct support staff did not implement Resident #1's communication goal, which required the use of the resident's "Go Talk" device.

At no time during the survey was any staff observed implementing the resident's communication goal.

There was no evidence that the GHPID implemented Resident #1's communication training program as recommended in the IPP.

2. Observation on April 5, 2011, at 4:40 p.m., revealed the direct support staff asked Resident #3 what she wanted for a snack. Shortly afterwards, a second direct care staff asked, "What did she say?" The direct support staff did not respond and placed a bowl of apple sauce in front of the resident. At approximately 5:00 p.m., the direct support staff indicated that Resident #3 was nonverbal. However, the resident was not observed to be provided a choice of snacks. At 4:56 p.m., the direct support staff placed a communication device in front of the resident and pressed the, "I'm hungry" button. The direct support staff then stated, "How do you feel?" At 4:57 p.m., the direct support staff took the communication device away from the resident. At 5:03 p.m., the direct support staff placed a "Busy Bee" game in front of the resident. At 5:40 p.m., the direct support staff placed the resident's dinner in front of her.

Review of Resident #3's IPP dated July 2010, on April 7, 2011, at 2:00 p.m., revealed a training objective for Resident #3 to use a low tech voice output (cheap talk) with touch prompts to communicate basic wants and emotional status and well being to persons in her environment. On

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I 420	Continued From page 12 the same day at approximately 2:30 p.m., review of the resident's speech and language evaluation dated July 8, 2010, revealed a recommendation that stated, "Given touch prompts [the resident] will utilize a low tech voice output device (cheap talk) to communicate basic wants and emotional status and well being to persons in her environment ". Interview with the QIPD and the house manager on the same day at 5:00 p.m., acknowledged that the direct support staff did not implement Resident #3's communication goal, which required the use of her "Cheap Talk" device. During the survey, the direct support staff were observed to use the communication device with the resident for only one minute. There was no evidence that the GHPID implemented Resident #3's communication program as recommended in the IPP.	I 420		