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

PRINTED: 03/06/2007
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
	09G129	A. BUILDING _____ B. WING _____	R 02/21/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDI	3112 WALNUT STREET, NE WASHINGTON, DC 20018

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{W 000}	INITIAL COMMENTS A follow-up survey was conducted on February 21, 2007 to determine if the facility had come into compliance with the Conditions of Participation of Governing Body and Client Protections which were cited during the January 8, 2007 through January 10, 2007 annual recertification survey. A random sampling of two clients was selected for the follow-up survey. Findings were based on observations, interviews with group home and administrative staff and the review of records. At 3:30 PM the Director of Residential Services was informed at the facility that the Conditions of Participation of Governing Body and Client Protections had been met, however there were continuing sandard level deficiencies.	{W 000}		
{W 124}	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that a system had been established to obtain consent for treatments that may cause risk to the rights of one of two clients in the sample. (Clients #3) The finding includes:	{W 124}	**W124** **This Standard will be met as evidenced by:** Reference response to W263.	3-16-07 ongoing

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2007 MAR 27 P 2:52

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary Brown — TITLE: CHS — (X6) DATE: 3/16/07

For 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 124}	Continued From page 1 The facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity for the use of Client #3 psychotropic medication and behavior support plan. [See W263]	{W 124}		
{W 189}	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. The finding includes: A follow-up survey was conducted at the facility on February 21, 2007 determined all previously training had been completed except Mandt Training. Interview with the Qualified Mental Retardation Professional at 12:57 PM revealed the Mandt Training had been scheduled twice in February 2007 because of inclement weather (snow and ice). During the survey, the Mandt Training was rescheduled for February 26th and 27th, 2007. The QMRP indicated that the training agenda and roster will be faxed to DOH immediately after the training is held.	{W 189}	**W189** **This Standard will be met as evidenced by:** MANDT training was held on 3/1/07 - 3/2/07. QMRP/Home Manager will continue to schedule staff training ongoing and/or as needed to ensure that staff demonstrate the necessary skills to perform duties effectively, efficiently and competently.	3-2-07 ongoing
{W 263}	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed	{W 263}		

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{W 263}	Continued From page 2 consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's specially-constituted committee (Human Rights Committee, HRC) failed to ensure that restrictive programs were used only with written consents, for one of the two clients in the sample. (Client #3) The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) revealed the client #3 was prescribed a behavior support plan (BSP) that included Zyprexa to manage the client's agitation. Further interview revealed the client had family involvement in his affairs, but did not have an advocate or guardian to give consent for the use of restrictive measures. Although the Human Rights Committee (HRC) approved the implementation of the BSP, there was no evidence written consent was obtained from a legally-sanctioned guardian and/or a surrogate health care decision-maker to implement these restrictive programs/strategies.	{W 263}	**W263** **This Standard will be met as evidenced by:** QMRP along with medical staff will ensure that informed written consent is obtained prior implementation of restrictive measures. QMRP will contact family member to obtain informed consent. QMRP will ensure that client #3's family member is fully knowledgeable and understands risks and benefits of treatment. If necessary, QMRP will seek legal guardianship for client #3 to further assist him in the decision making process. QMRP will review all restrictive programs at the Human Rights Committee meeting and maintain record on file to support review discussions and recommendations.	3.28.07 ongoing
{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 interview and record review, the facility failed to ensure timely preventive care for two of	{W 322}		

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{W 322}	Continued From page 3 two clients in the sample. (Clients #1 and #2) The findings include: 1. On May 31, 2006 Client #1 had his annual urology consultation. The urologist diagnosed frequent urination. Uroxatral 10 mg tab SR 24H was prescribed. The urologist further recommended that bladder out obstruction be ruled out. At the time of the revisit, February 21, 2007, this procedure had not been performed. 2. The facility failed to ensure Client #2 received extra depth shoes to wear during the use of his AFOs. (See W436, 2) 3. Interview with the on Supervisory LPN on February 21, 2007 at 3:27 PM revealed Client #3 had a podiatry consultation on December 15, 2007. The review of the consultation report indicated "open wound-severe tinea of second left toes". The review of the consultation report indicated "open wound-severe tinea of second left toe". The Podiatrist diagnosed "Severe tinea Pedis. Apply Lotrimin 1-4 web spaces both feet daily x 2 weeks". Further record review indicated the podiatrist wrote a prescription for Penicillin ad recommended follow-up with the dermatologist. The review of the Medication Administration Record revealed the Client #3 began to receive the Lotrimin Cream on December 2, 2006. Further record review failed to evidence that the recommendations for the Penicillin and the dermatology consult were addressed by the PCP or that the PCP had ensured the client received the medication for treatment of his feet timely.	{W 322}	**W322** **This Standard will be met as evidenced by:** 1. Client #1 has been scheduled for annual Urologist examination. Nurses will continue to monitor appointment schedules, maintain master listing to track appointments and schedule prior to expiration dates. RN will continue to conduct routine file audits to further ensure compliance with this standard. 2. Reference response to W436, 2. 3. LPN will follow-up with the primary care physician to ensure that all recommendations as are addressed as outlined. Also, reference response to W322.1.	3-29-07 ongoing 3-14-07 ongoing
{W 331}	483.460(c) NURSING SERVICES The facility must provide clients with nursing	{W 331}		

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W 331	Continued From page 4 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 two of two clients (Clients #1 and #2) in the sample. The findings include: 1. Interview with the on Supervisory LPN on February 21, 2007 at 3:27 PM revealed Client #3 had a podiatry consultation on December 15, 2007. The review of the consultation report indicated "open wound-severe tinea of second left toe". The Podiatrist diagnosed "Severe tinea Pedis, Apply Lotrimin 1-4 web spaces both feet daily x 2 weeks". Further record review indicated the podiatrist wrote a prescription for penicillin and recommended follow-up with the dermatologist. There was no nursing documentation that the nurse was aware of the podiatrist's assessment and recommendations. The review of the medication administration record (MAR) on February 21, 2007 revealed the client did not begin to receive the Lotrimin Cream until December 22, 2006. Interview with the nurse on February 21, 2007 revealed the client's feet got better and that the podiatrist was expected at the group home on February 21, 2007. There was no evidence the nurse provided timely follow-up to address the podiatrist's treatment recommendations for Client #3.	W 331	**W331** **This Standard will be met as evidenced by:** RN will address timely follow-up with LPN staff. Additional training will also be conducted to further ensure compliance with this standard.	
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	W 436	**W436** **This Standard will be met as evidenced by:** 1. Client #3's orthopedic shoes were picked up on 2/27/07. Physical Therapist is scheduled to assess repair by 3/14/07. QMRP will ensure timely follow-up of needed repairs to all client's adaptive equipment.	3-23-07 ongoing

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W 436}	Continued From page 5 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 observation, interview and record review, the facility failed to ensure special shoes were obtained for Client #2; failed to ensure special shoes were maintained in good repair for Client #1; and failed to ensure that Client #1 was provided with dentures as recommended by the interdisciplinary team (IDT). The findings include: 1. On February 21, 2007 Client #2 was observed wearing boots. Interview with the home manager revealed that the client's orthopedic shoes were in the shoe shop for repairs. 2. The facility failed to ensure Client #2 received recommended extra depth shoes to fit over his AFO's. (Status) Interviews with the QMRP, the home manager, and the supervisory LPN on February 21, 2007 at 10:30 AM revealed the facility had made progress in the area of adaptive equipment. One of two new AFOs recommended for Client #3's was delivered to the facility on February 21, 2007. Follow-up by the QMRP with the vendor on February 21, 2007 revealed the second AFO had been shipped. The physical therapist (PT) had been scheduled to evaluate the effectiveness of the new AFOs after both have been received at the facility. Interview with The QMRP on	{W 436}		

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W 436	Continued From page 6 February 21, 2007 at 5:30 PM revealed she will notify DOH after the PT assesses the new AFOs. Once the assessment of the AFOs is completed the PT will be able to determine the type of shoes needed by the client to compliment the new AFOs 1. The facility failed to ensure Client #2 orthopedic shoes were maintained in good repair. Observation of Client #1's orthopedic shoes on January 10, 2006 revealed that both shoes were very runover. Approximately 50% of the both of the heels were worn off on the outer edges. Interview with the home manager indicated the client had received the special shoes approximately three months prior to the survey. Further interview with the home manager indicated the client wears his shoes out quickly, however the the funding agency only pays for the purchase of one pair of special shoes a year. Record verification revealed on October 28, 2006 the Physical Therapist commented,"Absence of normal arm swing and trunk rotation in his gait. Elbow and wrist flexion during ambulation. He lands on the lateral border of his foot which causes increased lateral shoe wearing". There was no evidence Client #2 orthopedic shoes were closely monitored for the wear on the heels to ensure timely maintenance. 2. The facility failed to ensure Client #2 received recommended extra depth shoes to fit over his AFO's. On January 8, 2007,Client was observed to	W 436		

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W 436}	Continued From page 7 ambulate with Loftstrand crutches as he left for his day program at 9:15 AM. Interview with staff indicated that he wears bilateral braces, Ankle Foot Orthoses (AFOs) to provide additional support during ambulation. Record review indicated the client had a follow-up consultation post custom fitting of bilateral AFOs on June, 27, 2006 during which staff were reinstructed on proper donning. The consultant indicated the AFOs fit well, recommended proper donning for AFOs and follow-up in six months. Further record review revealed a recommendation by the Physical Therapist (PT) dated January 25, 2006 which stated to ensure well fitting socks to decrease risk of skin breakdowns and to monitor lower extremities for foot breakdown. Record review revealed Client #2 was evaluated on September 14, 2006 for the use of molded shoes with the AFOs. At that time the adaptive equipment provider recommended extra depth shoes to fit over the AFOs. The facility was requested to submit an original 719A approving the special shoes. Record verification reflected an Adaptive Equipment Assessment dated November 7, 2006 which recommended molded shoes to be used with crutches. A corresponding 719A dated November 21, 2006 signed by the Primary Care Physician (PCP) was also noted. Further record review revealed a medical consultation report from the podiatrist dated November 1, 2006. The report indicated a diagnosis of "Ulcer to left mid lateral foot. Necrotic tissue noted ulcer 3 cm. erythema noted. Ulcer debrided. Started on Keflex 500 mg BID During the follow-up visit on November 14, 2006, the podiatrist indicated that the ulcer was healing. Interview with the nurse on January 10, 2006 at	{W 436}		

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W 436	Continued From page 8 approximately 5:10 PM indicated the foot ulcer may have been related to the AFO which the client is prescribed to wear at all times during ambulation. Interview on January 9, 2007 with the Qualified Mental Retardation Professional (QMRP) indicated the 719A had been submitted to vendor for the extra depth shoes, however it takes a while to get the shoes because they are specially made. At the time of the survey, there was no evidence Client #2 had received the extra depth shoes recommended to fit over the AFOs or that a date had been provided for the delivery of the shoes for the client.	W 436		