STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G056	A. BUILDING _____ B. WING _____	07/20/2011

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COMP CARE I I	1321 EMERSON STREET NW WASHINGTON, DC 20011

(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 Surveyor: 18886 A recertification survey was conducted from July 18, 2011 through July 20, 2011, utilizing the fundamental survey process. A random sample of three clients was selected from a population of five males with various levels of intellectual and developmental disabilities. The findings of the survey were based on observations at the group home and at one day program, interviews clients and staff and the review of clinical and administrative records, including incident reports.	W 000	Received 8/15/11 Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002	
W 194	483.430(e)(4) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible. This STANDARD is not met as evidenced by: Surveyor: 18886 Based on observation, staff interview and record verification, the facility failed to demonstrate competency in implementing clients eating precautions protocol, for one of the three clients included in the sample. (Client #2) The finding includes: During meal observation on July 18, 2011, at 6:03 p.m., Client #2 was observed eating dinner. After he completed his meal, he went to the living room and laid on the living room floor. Seconds later, a direct care support staff pulled a blanket out and asked the client to lay on it.	W 194		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Debra Hankins	Adm. Asst.	8/15/11

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 194	Continued From page 1 Interview with the direct care staff on July 18, 2011, at 6:36 p.m., revealed that the client likes to lay on the floor. Interview with the qualified intellectual disabilities professional (QIDP) at 6:45 p.m., indicated that he is allowed to lay on the floor, however the staff must ensure that a blanket/mat is placed under him. Review of the Client #2's mealtime guidelines dated June 2011, on July 19, 2011, at approximately 10:30 a.m., revealed the client is to maintain an upright position for at least one hour after meal. Interview with the QIDP on July 19, 2011, at approximately 11:00 a.m., confirmed that the facility failed to implement Client #2's eating protocol.	W 194	**W 194** - **The speech and language pathologist will in-service staff on implementation of eating protocols for all clients in the facility** - **Training on mealtime protocols/guidelines will be conducted by the speech and language pathologist quarterly to enhance staff capability in implementing the guidelines outlined** - **Once weekly for the next three months, the facility's House Manager will monitor staff during meals to ensure that all mealtime guidelines are adhered to as outlined**	09/04/11
W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Surveyor: 18886 Based on observation, interview and record review, the facility failed to ensure that the Individual Program Plan (IPP) included objectives to meet the client's needs as recommended from the comprehensive functional assessments, for one of the three clients in the sample. (Clients #1 and #3)	W 227		

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W 227	Continued From page 2 The findings include: 1. During dinner observations on July 18, 2011, at 6:00 p.m., revealed Client #1 with missing top teeth. Interview with the staff indicated that he does not require a modified diet texture during meals. Review of Client #1's medical record on July 19, 2011, beginning at approximately 8:45 a.m., revealed a dental consultation form dated February 8, 2011. The consultation form noted that the client had heavy tarter with heavy bleeding. It was recommended that he needed assistance with brushing his teeth two to three times per day. Review of the Client #1's Community & Home Life Assessment dated October 6, 2008, on July 19, 2011, at 10:00 a.m., revealed a section labeled oral hygiene. The assessment indicated that the client required physical assistance to brush his teeth thoroughly and flossing. Review of the IPP dated October 5, 2010, on July 19, 2011, at 11:00 a.m., revealed no evidence of training programs to address the aforementioned recommendations included in the comprehensive functional assessment. The qualified intellectual disabilities professional (QIDP) verified on July 19, 2011, at approximately 12:45 p.m., that no training programs had been developed for the client to participate in a toothbrushing program as recommended in the assessments. 2. During dinner observations on July 18, 2011, at 6:03 p.m., revealed Client #3 eating a finely	W 227	W 227, 1 - The Qualified Intellectual Disabilities Professional (QIDP) will review dental consults for all clients in the facility - Individual Program Plan (IPP) of tooth brushing will be developed for Client #1 and others affected by this deficiency - The QIDP will train staff on implementation of the program goals - Program goals will be reviewed quarterly by the QIDP for progress or lack of progress and modification made as deemed fit.	09/04/11

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W 227	Continued From page 3 chopped dinner. He was also observed with missing teeth. Interview with the staff indicated that he does required a finely chopped diet. Review of Client #3's medical record on July 19, 2011, beginning at approximately 2:50 p.m., revealed a dental consultation form dated March 15, 2011. The consultation form noted that the client had heavy tarter with moderate bleeding. It was recommended that he needed assistance with brushing his teeth two to three times per day. Review of the Client #3's Community & Home Life Assessment dated January 9, 2009, on July 19, 2011, at 4:00 p.m., revealed a section labeled oral hygiene. The assessment indicated that the client required physical assistance to brush his teeth thoroughly and flossing. Review of the IPP dated January 11, 2011, on July 19, 2011, at 4:30 p.m., revealed no evidence of training programs to address the aforementioned recommendations included in the comprehensive functional assessment. The QIDP verified on July 19, 2011, at approximately 12:45 p.m., that no training programs had been developed for the client to participate in a toothbrushing program as recommended in the assessments.	W 227	W 227, 2 - The Qualified Intellectual Disabilities Professional (QIDP) will review dental consults for all clients in the facility - Individual Program Plan (IPP) of tooth brushing will be developed for Client #3 and others affected by this deficiency - The QIDP will train staff on implementation of the program goals - Program goals will be reviewed quarterly by the QIDP for progress or lack of progress and modification made as deemed fit.	09/04/11
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	W 249		

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W 249	Continued From page 4 plan. This STANDARD is not met as evidenced by: Surveyor: 18886 Based on observation, staff interview and record review, the facility failed to ensure clients received continuous active treatment, for one of the three clients in the sample. (Client #3) The finding includes: Observations, interviews and record review revealed that Client #3 did not participate in his exercise program to ride a stationary bike, as evidenced by the following: Client #3 was observed on July 18, 2011, from 4:12 p.m. (when he and his peers arrived home from day program) until 8:00 p.m. Upon his arrival home, he went to his bedroom and used the bathroom. At 4:30 p.m., his housemates had a snack. Staff went up to the clients bedroom and asked if he wanted to have a snack. From 4:36 p.m., until 5:20 p.m., the client stayed in his bedroom. At 5:30 p.m., the client came downstairs and watched television. Staff attempted to get the client to play table top games. He played for approximately 10 minutes and then indicated he "played enough." At 5:50 p.m., Client #3 assisted with setting the table for dinner. He put the placemats and glasses on the table in preparation for dinner. At 6:03 p.m., the client and his peers ate dinner until 6:30 p.m. At 6:40 p.m., the medication nurse arrived in the facility and began administering medications at 6:50 p.m. At 7:35 p.m., the client went upstairs.	W 249		

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W 249	Continued From page 5 Interview with the direct care staff on July 18, 2011, at 7:45 p.m., revealed that Client #3 requested to have his shower and staff assisted him. On July 19, 2011, at 1:00 p.m., review of Client #2's Individual Program Plan (IPP) dated October 25, 2010, revealed a program objective which stated, "Three times per week, given physical assistance, he will ride a stationary bike for five minutes per session, times three sessions (15 minutes) 60% of recorded trials per month." He was to receive said training on Mondays, Wednesdays and Fridays. However, Client #2 and facility staff were observed on Monday, July 18, 2011, from 4:12 p.m. until 8:15 p.m. and at no time was an exercise activity observed during the observation period. Interview with the House Manager and QIDP on July 19, 2011, at approximately 10:30 a.m., confirmed that the client did not participate in the exercise activity.	W 249	**W 249** - **The QIDP will train staff on accurate documentation of program goals** - **The facility's House Manager and QIDP will on a weekly basis monitor implementation and documentation of program goals for all clients in the facility to ensure accurate data collection. Monitoring of program implementation and data collection will be carried out for three months to ensure that significant emphasis is put on accurate data collection by staff** - **Data on program goals will be reviewed monthly by the QIDP to ensure consistency in program implementation and data collection**	09/04/11
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: Surveyor: 18886 Based on observation, staff interview and record review, the facility's nurse failed to provide each client with nursing services in accordance with their needs, for two of the clients residing in the facility. (Clients #1 and #4) The findings includes:	W 331		

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W 331	Continued From page 6 1. On July 18, 2011, at 4:25 p.m., Client #1 was observed entering the facility using a seated roller walker. During medication observations on July 18, 2011, at 7:15 p.m., revealed Client #1 receiving Seroquel 25 mg. Interview with the licensed practical nurse (LPN) after the medication administration revealed that the client received the medication for his diagnosis of schizophrenia. Review of Client #1's medical record on July 19, 2011, beginning at 8:45 a.m., revealed a psychotropic medication review consultation form dated May 16, 2011. The psychiatrist recommended that the client see a neurologist due to his deterioration in gait. Further review of the medical record revealed a neurologist consult dated March 2011. Interview with the LPN on July 19, 2011, at approximately 10:30 a.m., indicated that she schedules all medical appointments for Client #1. She further confirmed that a neurology consult had not been schedule. There was no evidence that a neurology consult had been made after the psychiatrist made the recommendation for consultation. 2. The facility's nurse failed to ensure that medications were properly destroyed, for one of the three clients in the sample. During medication administration on July 18, 2011, at 7:15 p.m., revealed the medication nurse dropped two of Client #1's Divalproex ER tablets (one on the counter top and one on the floor).	W 331	**W 331, 1** - **The facility's Registered Nurse, will on a weekly basis review all medical records to ensure that recommendations are carried out in a timely manner for all clients in the facility.** - **A tracking system will be put in place to capture recommendations and timely follow-ups.** - **On a quarterly basis, the facility's RN and QIDP will review all medical records to ensure that recommendations are adhered to in a timely manner.**	09/04/11

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W 331	Continued From page 7 Interview with the medication nurse at 7:42 p.m., indicated that she was going to flush the tablets down the toilet. At 7:58 p.m., the medication nurse was observed putting the two tablets in a medicine cup and adding water. In an interview she indicated she put the water in the medicine cup to dissolve the tablets. At 8:01 p.m., the medication nurse flushed the undissolved tablets down the toilet. Interview with the Registered Nurse (RN) on July 19, 2011, at approximately 10:30 a.m., revealed that medications should be disposed of by crushing the medications, putting it into a zip lock bag, along with coffee or tea grounds. Review of the facility's policy on July 20, 2011, at 11:15 a.m., confirmed the RN's interview on discarding/disposing of medications. 3. [See W386]. The facility failed to maintain records of the receipt and disposition of all controlled drugs, for one of three clients in the sample. 4. [See W369] The facility failed to ensure that medications were administered without error, for one of the five clients residing in the facility.	W 331	W 331, 2 - The medication nurses will be in-serviced on the facility's policy of discarding medication - Once monthly, the facility's RN will request the LPNs of the facility to demonstrate the proper procedure for discarding medication W 331, 3 - Cross Reference W 386 W 331, 4 - Cross Reference W 369	09/04/11
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Surveyor: 18886 Based on observation, interview and record	W 369		

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W 369	Continued From page 8 review, the facility failed to ensure that medications were administered without error, for one of the five clients residing in the facility. (Client #4) The finding includes: Observation of the medication administration on July 18, 2011, at 6:50 p.m., revealed Client #4 was administered Lactulose, Simvastatin, Zyprexa, Mirtazapine, Tegretol, Benztropine and Metoprolol tart. On the same day, at 7:40 p.m., review of the client's medication administration record (MAR) and current physician orders, revealed that Theophylline ER was ordered, but not administered during the evening medication pass. Interview with the nurse on July 18, 2011, at 7:45 p.m., revealed that Theophylline ER was not available. Further interview revealed that the Registered Nurse (RN) contacted the Primary Care Physician and he ordered to skip the medication. A telephone order dated July 18, 2010, at 8:00 p.m., revealed a telephone order to skip the medication until pharmacy deliver. The MAR, however, failed to document why the client did not receive his prescribed medications.	W 369	W 369 - The facility's medication nurses (LPNs) will be in-serviced on proper documentation of medication not administered - The facility's RN will on a weekly basis review all Medication Administration Records (MAR) to ensure that medications are correctly charted as specified - Once monthly, the facility's RN will request the LPNs to demonstrate the proper charting of medications not administered.	09/04/11
W 386	483.460(l)(4) DRUG STORAGE AND RECORDKEEPING The facility must, on a sample basis, periodically reconcile the receipt and disposition of all controlled drugs in schedules II through IV (drugs subject to the Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. 801 et seq., as implemented by 21 CFR Part 308).	W 386		

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W 386	Continued From page 9	W 386		

This STANDARD is not met as evidenced by:
Surveyor: 18886
Based on observation, staff interview, and record verification, the facility failed to maintain accurate records of the receipt and disposition of all controlled drugs, for one of three clients in the sample. (Client #3).

The finding includes:

The facility failed to provide evidence of the accurate disposition of the Controlled Schedule III Drug (Vicodin) prescribed for Client #1 as evidenced by:

Observation of the evening medication pass on July 18, 2011, at 7:15 p.m., revealed that Client #1 was administered Phenobarbital 60 mg.

Interview with the licensed practical nurse (LPN) after the medication administration revealed that the client received the aforementioned medication for his diagnosis of seizure disorder. She further indicated that the medication was a Scheduled III controlled substance. Review of the individual resident's controlled substance record on July 18, 2011, revealed that there were thirteen tablets in the package. Seconds later, the surveyor counted the Phenobarbital pills and there were fifteen pills. The LPN confirmed the that there was a total of fifteen pills.

Interview with the registered nurse (RN) and LPN on July 19, 2011, at approximately 11:50 a.m., revealed that the pharmacist had sent three pills in late June 2011. Further interview indicated that

W 386

- **The facility's RN will train the LPNs on correct charting of the receipt and disposition of controlled substances**
- **Once monthly, the facility's RN will request the LPNs to demonstrate the proper procedure for charting of controlled substances**
- **The RN will conduct monthly audits of all MARs and controlled substances to ensure proper documentation**

09/04/11

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W 386	Continued From page 10 a separate individual resident's controlled substance sheet should have been completed for the additional three tablets sent in June 2011. However there was no individual resident's controlled substance record to verify the nurse' interview. There was no evidence that the facility's staff correctly recorded the receipt, disposition and monitoring of the receipt or disposition for the Controlled Schedule III Drug (Phenobarbital).	W 386		

Health Regulation & Licensing Administration

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I 000	INITIAL COMMENTS Surveyor: 18886 A licensure survey was conducted from July 18, 2011 through July 20, 2011. A sample of three residents was selected from a population of five men with various intellectual and developmental disabilities. The findings of the survey were based on observations at the group home and at one day program, interviews clients and staff and the review of clinical and administrative records, including incident reports.	I 000		
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: Surveyor: 19326 Based on observation and interview, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to maintained the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner. The findings include: Observations during the environmental walk-thru and interview with the House Manager (HM) on July 19, 2011, beginning at approximately 11:20 a.m., revealed the following: 1. The kitchen wall above the stove had grease on it. The hood above the stove had grease on it.	I 090		

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I 090	Continued From page 1 2. The second floor hall bathroom ceiling has water damage and chipping and peeling paint. 3. In resident #4's bedroom there was an accumulation of dead bugs on the ceiling light lens cover. 4. In the basement behind the washing machine, an accumulation of dust was observed. The above cited deficiencies were acknowledged by the facility House Manager on July 21, 2011 at approximately 1:00 p.m. who indicated she would get on these deficiencies right away.	I 090	I 090 1. The hood has been cleaned 2. The second floor hall bathroom has been repainted 3. The ceiling light lens cover has been cleaned 4. The area behind the washing machine has been cleaned - Once monthly, the facility's maintenance division and the House Manager will conduct internal and external environmental audits to ensure compliance with regulatory standards	08/12/11
I 092	3504.3 HOUSEKEEPING Each GHMRP shall be free of insects, rodents and vermin. This Statute is not met as evidenced by: Surveyor: 19326 Based on observation, the facility failed to ensure the environment was free of insects, rodents and vermin, to ensure the health and safety of all residents. The finding includes: On July 19, 2011, at approximately 11:30 a.m., it was revealed by a survey team member that roaches were observed crawling on the kitchen counter top. At approximately 11:45 a.m., while conducting an environmental inspection, roaches were again observed crawling under the kitchen sink and there were dead roaches observed in the same area.	I 092		

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COMP CARE I I	1321 EMERSON STREET NW WASHINGTON, DC 20011

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I 092	Continued From page 2 Following the environmental inspection, interview with the house manager (HM) revealed that the facility was just sprayed for the roaches on July 18, 2011, and that the facility had a current contract with a pest control company. On July 19, 2011, at approximately 12:15 p.m., review of the previous invoices revealed the facility had been treated for roaches on June 6, 2011, June 20, 2011, July 5, 2011, and July 11, 2011. It was pointed out to the HM the invoices only indicated that these services took place and did not indicate what was used to eliminate the condition. Also, it was brought to the attention of the HM that the pest control company failed to sign the visitor's log when they were in the facility. The HM acknowledged these findings this same day, and feels that they have a contract with a pest control company not able to provide a insect free environment. The facility failed to ensure an insect free environment as required by this section.	I 092	I 092 - A meeting was held with the pest control contractor to discuss the deficient finding. A rigorous approach to pest termination was promised by the exterminator - Once monthly, the exterminator will conduct environmental audits to determine the effectiveness of treatment - The facility's House Manager will also conduct monthly environmental inspection to ensure effectiveness of treatment.	
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. This Statute is not met as evidenced by: Surveyor: 19326 Based on interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to show evidence of a physician's	I 206		08/12/11

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I 206	Continued From page 3 certification that documented a health inventory had been performed, for one (1) of twelve (12) employee records reviewed. (Employees #3). Further, no current physicians certification was documented for consultants, two LPNs the Pharmacist or the Occupational Therapist. The findings include: On July 19, 2011, beginning at approximately 12:30 p.m., a review of the personnel records revealed that one of twelve employees did not have a current health certificate, for employees #3, nor was there evidence that two LPN's, the Pharmacist or the Occupational Therapist had been certified free from communicable diseases. This was acknowledged by the Program Manager (PM) on the same day at approximately 3:00 p.m.	I 206	I 206 - The employee has submitted a current health certificate - The LPNs, the pharmacist, and the occupational therapist have submitted health certificates certifying that they are free of communicable diseases - The facility's Assistant Administrator will conduct monthly audits of personnel and consultant records to ensure compliance with regulatory standards.	08/12/11
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: Surveyor: 18886 Based on observation, interview and record review, the Group Home for with Intellectually Disabilities (GHPID) failed to ensure professional services were provided in accordance with the recommended needs, for two of the five residents residing in the facility. (Residents #1 and #4) The findings include:	I 401		

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I 401	Continued From page 4 1. On July 18, 2011, at 4:25 p.m., Resident #1 was observed entering the facility using a seated roller walker. During medication observations on July 18, 2011, at 7:15 p.m., revealed Resident #1 receiving Seroquel 25 mg. Interview with the licensed practical nurse (LPN) after the medication administration revealed that the resident received the medication for his diagnosis of schizophrenia. Review of Resident #1's medical record on July 19, 2011, beginning at 8:45 a.m., revealed a psychotropic medication review consultation form dated May 16, 2011. The psychiatrist recommended that the resident see a neurologist due to his deterioration in gait. Further review of the medical record revealed a neurologist consult dated March 2011. Interview with the LPN on July 19, 2011, at approximately 10:30 a.m., indicated that she schedules all medical appointments for Resident #1. She further confirmed that a neurology consult had not been schedule. There was no evidence that a neurology consult had been made after the psychiatrist made the recommendation for consultation. 2. The facility's nurse failed to ensure that medications were properly destroyed, for one of the three residents in the sample. During medication administration on July 18, 2011, at 7:15 p.m., revealed the medication nurse dropped two of Resident #1's Divalproex ER tablets (one on the counter top and one on the floor). Interview with the medication nurse at 7:42 p.m., indicated that she was going to flush the tablets	I 401	I 401, 1 - The facility's Registered Nurse will, on a weekly basis review all medical records to ensure that recommendations are carried out in a timely manner for all clients in the facility. - A tracking system will be put in place to capture recommendations and timely follow-up. - On a quarterly basis, the facility's RN and QIDP will review all medical records to ensure that recommendations are adhered to in a timely manner.	09/04/11

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I 401	Continued From page 5 down the toilet. At 7:58 p.m., the medication nurse was observed putting the two tablets in a medicine cup and adding water. In an interview she indicated she put the water in the medicine cup to dissolve the tablets. At 8:01 p.m., the medication nurse flushed the undissolved tablets down the toilet. Interview with the Registered Nurse (RN) on July 19, 2011, at approximately 10:30 a.m., revealed that medications should be disposed of by crushing the medications, putting it into a zip lock bag, along with coffee or tea grounds. Review of the facility's policy on July 20, 2011, at 11:15 a.m., confirmed the RN's interview on discarding/disposing of medications. 3. [See W386]. The facility failed to maintain records of the receipt and disposition of all controlled drugs, for one of three residents in the sample. 4. [See W369]. The facility failed to ensure that medications were administered without error, for one of the five residents residing in the facility.	I 401	I 401, 2 - The medication nurses or LPNs will be in-serviced on the facility's policy of discarding medication - Once monthly, the facility's RN will request the mediation nurses to demonstrate the proper procedure for discarding medication I 401, 3 - Please refer to W 386 I 401, 4 - Please refer to W369	09/04/11
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: Surveyor: 18886 Based on observation, staff interviews, and record review, the Group Home for Mentally	I 420		

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I 420	Continued From page 6 Retarded Persons (GHMRP) failed to ensure that residents received continuous active treatment program in accordance with recommendations made by the interdisciplinary team (IDT), for two of the three residents in the sample. (Residents #1 and #2) The findings include: 1. During dinner observations on July 18, 2011, at 6:00 p.m., revealed Resident #1 with missing top teeth. Interview with the staff indicated that he does not require a modified diet texture during meals. Review of Resident #1's medical record on July 19, 2011, beginning at approximately 8:45 a.m., revealed a dental consultation form dated February 8, 2011. The consultation form noted that the resident had heavy tarter with heavy bleeding. It was recommended that he needed assistance with brushing his teeth two to three times per day. Review of the Resident #1's Community & Home Life Assessment dated October 6, 2008, on July 19, 2011, at 10:00 a.m., revealed a section labeled oral hygiene. The assessment indicated that the resident required physical assistance to brush his teeth thoroughly and flossing. Review of the IPP dated October 5, 2010, on July 19, 2011, at 11:00 a.m., revealed no evidence of training programs to address the aforementioned recommendations included in the comprehensive functional assessment. The Qualified Intellectual Disabilities Professional (QIDP) verified on July 19, 2011, at approximately 12:45 p.m., that no training programs had been developed for the resident to participate in a	I 420		

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I 420	Continued From page 7 toothbrushing program as recommended in the assessments. 2. During dinner observations on July 18, 2011, at 6:03 p.m., revealed Resident #3 eating a finely chopped dinner. He was also observed with missing teeth. Interview with the staff indicated that he does required a finely chopped diet. Review of Resident #3's medical record on July 19, 2011, beginning at approximately 2:50 p.m., revealed a dental consultation form dated March 15, 2011. The consultation form noted that the resident had heavy tarter with moderate bleeding. It was recommended that he needed assistance with brushing his teeth two to three times per day. Review of the Resident #3's Community & Home Life Assessment dated January 9, 2009, on July 19, 2011, at 4:00 p.m., revealed a section labeled oral hygiene. The assessment indicated that the resident required physical assistance to brush his teeth thoroughly and flossing. Review of the IPP dated January 11, 2011, on July 19, 2011, at 4:30 p.m., revealed no evidence of training programs to address the aforementioned recommendations included in the comprehensive functional assessment. The Qualified Intellectual Disabilities Professional (QIDP) verified on July 19, 2011, at approximately 12:45 p.m., that no training programs had been developed for the resident to participate in a toothbrushing program as recommended in the assessments.	I 420	**I 420, 1 & 2** - **The Quallfied Intellectual Disabilities Professional (QIDP) will review dental consults for all clients in the facility** - **Individual Program Plan (IPP) of tooth brushing will be developed for Clients # 1, # 3, and others affected by this deficiency** - **The QIDP will train staff on implementation of the program goals** - **Program goals will be reviewed quarterly by the QIDP for progress or lack of progress and modification made as deemed fit.**	**09/04/11**
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with	I 422		

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I 422	Continued From page 8 the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Surveyor: 18886 Based on observation, interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure that residents received habilitation and assistance as prescribed in their Individual Support Plan, for one of the three residents in the sample. (Resident #3) The findings include: Observations, interviews and record review revealed that Resident #3 did not participate in his exercise program to ride a stationary bike, as evidenced by the following: Resident #3 was observed on July 18, 2011, from 4:12 p.m. (when he and his peers arrived home from day program) until 8:00 p.m. Upon his arrival home, he went to his bedroom and used the bathroom. At 4:30 p.m., his housemates had a snack. Staff went up to the residents bedroom and asked if he wanted to have a snack. From 4:36 p.m., until 5:20 p.m., the resident stayed in his bedroom. At 5:30 p.m., the resident came downstairs and watched television. Staff attempted to get the resident to play table top games. He played for approximately 10 minutes and then indicated he "played enough." At 5:50 p.m., Resident #3 assisted with setting the table for dinner. He put the placemats and glasses on the table in preparation for dinner. At 6:03 p.m., the resident and his peers ate dinner until 6:30 p.m. At 6:40 p.m., the medication nurse arrived in the facility and began administering medications at 6:50 p.m. At 7:35 p.m., the resident went upstairs. Interview with the direct	I 422		

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I 422	Continued From page 9 care staff on July 18, 2011, at 7:45 p.m., revealed that Resident #3 requested to have his shower and staff assisted him. On July 19, 2011, at 1:00 p.m., review of Resident #2's Individual Program Plan (IPP) dated October 25, 2010, revealed a program objective which stated, "Three times per week, given physical assistance, he will ride a stationary bike for five minutes per session, times three sessions (15 minutes) 60% of recorded trials per month." He was to receive said training on Mondays, Wednesdays and Fridays. However, Resident #2 and facility staff were observed on Monday, July 18, 2011, from 4:12 p.m. until 8:15 p.m. and at no time was an exercise activity observed during the observation period. Interview with the House Manager and QIDP on July 19, 2011, at approximately 10:30 a.m., confirmed that the resident did not participate in the exercise activity.	I 422	I 422 - The facility's QIDP will train staff on accurate documentation of program goals - The facility's House Manager and QIDP will on a weekly basis monitor implementation and documentation of program goals for all clients in the facility to ensure accurate data collection. Monitoring of program implementation and data collection will be carried out for three months to ensure that significant emphasis is put on accurate data collection by staff - Data on program goals will be reviewed monthly by the QIDP to ensure consistency in program implementation and data collection.	09/04/11