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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	09G027		10/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY OWN PLACE	3215 20TH 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	W 000		
	A recertification survey was conducted from October 23, 2012 through October 25, 2012. A sample of two clients was selected from a population of four women with varying degrees of intellectual disabilities. This survey was initiated utilizing the fundamental survey process.		Received 12/14/12	
	The findings of the survey were based on observations in the home and one day program, interviews with one client, direct support staff, nursing and administrative staff, as well as a review of client and administrative records, including incident reports.		Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002	
	[Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]			
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES	W 120		
	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 of each client, for one of the two clients in the sample. (Client #2)		**Response to W120.1 on page 2 of 9**	
	The findings include:			
	1. On October 24, 2012, at 10:28 a.m., Client #2's physician's order sheets (POS) were reviewed to verify observations made during a medication administration in the home. The client's October 2012 POS included: Loratadine D SR 24H			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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 10mg-240mg (WF Claritin D 24H) one tab by mouth every day as needed for allergies." [Note: The client was observed sneezing several times in the home on the morning of October 23, 2012. She was not, however, observed sneezing during evening observations in the home later that day, from 4:10 p.m. - 5:27 p.m.] On October 24, 2012, at 11:10 a.m., Client #2 was observed sneezing at her day program. The staff (DP#1) working directly with her said "bless you." Moments later, DP#1 offered the client tissues and saniwipes as she continued sneezing and coughing. Mucous and the sound of nasal congestion were observed. The sneezing and coughing continued for 25 minutes, and staff gave her more tissues. At 11:23 a.m., DP#1 indicated the client had coughed and sneezed "off and on" earlier that week. When asked at 12:00 p.m., a day program nurse (DP#2) stated that Client #2 did not receive any medications at day program. He retrieved the client's POS. When asked specifically if the client was prescribed cold or allergy medications, DP#2 repeated that she did not receive medications at the day program, adding "only at home." On October 25, 2012, at 10:59 a.m., the qualified intellectual disabilities professional (QIDP), Staff #3, stated that the program manager (PM) Staff #4 was the primary contact between the home and clients' day programs. If there were "an immediate medical need" the day program would ask to speak with the registered nurse (RN) Staff #5. The QIDP said she was unaware of any communications received from Client #2's day program that week. When interviewed by	W 120	**W120** The facility must ensure that outside services meet the needs of each client 1. The QIDP in conjunction with the RN will schedule an case conference to ensure that Resident #2's day program provides the necessary assessment and possible treatment in accordance with her POS. QIDP/RN will monitor day program quarterly using the Day Program Monitoring Form to ensure compliance	12/15/12 Ongoing

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W 120	Continued From page 2 telephone on October 25, 2012, at 11:30 a.m., the RN said she had not received any communications from the day program that week. At 11:41 a.m., the PM said the client's sneezing and coughing was due to allergies. Her understanding was that the day program "generally gives her Sudafed or something like that and lets us know." She further stated she had not received any communications from Client #2's day program that week. On October 25, 2012, at 4:33 p.m., review of Client #2's medication administration records for October 2012 revealed no documented administrations of Loratadine D24 for allergies that month. There was no evidence that Client #2's day program staff reported signs/ symptoms of allergies to the home, to ensure the client received assessment and possible treatment, in accordance with her POS. 2. During breakfast observations on October 23, 2012, at 6:43 a.m. an elevated tray was observed placed beneath Client #2's plate of food. The client was observed drinking apple juice and water from adaptive "sipper" cups with lids. By contrast, Client #2 was not observed using adaptive equipment while eating lunch at her day program. On October 24, 2012, at 11:17 a.m., day program staff placed a bowl of pureed lasagna directly on the table. There was no elevated tray. Client #2 was observed slouching forward, lowering her face in order to eat. She drank water from a disposable styrofoam cup. When asked about mealtime adaptive equipment	W 120	2. The QIDP will ensure that Resident #2's day program utilized the mealtime adaptive equipment as recommended by the Resident's interdisciplinary team (IDT) which includes elevated tray beneath the food plate and sipper cup by providing in-service training to day program staff. QIDP will monitor day program quarterly using the Day Program Monitoring Form to ensure compliance	11/19/12 Ongoing

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W 120	Continued From page 3 on October 24, 2012, at 11:26 a.m. the day program staff (DP#1) assisting Client #2 with lunch retrieved a sipper cup from a cabinet. It remained stored in its original plastic bag. She explained that they would not implement the use of adaptive equipment such as the sipper cup, without first receiving training on its proper use. The home reportedly had not provided training. On October 25, 2012, at 11:42 p.m., telephone interview with the PM confirmed the aforementioned findings. She reported having brought a sipper cup and elevated tray to Client #2's day program after the client's annual meeting on June 7, 2012. She acknowledged that there had been no training on their use since that time. She also acknowledged that the home had not verified whether the day program utilized the mealtime adaptive equipment since she had delivered it in June 2012.	W 120	**Response to W120.2 on page 3 of 9**	
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's qualified intellectual disabilities professional (QIDP) failed to ensure the monitoring and coordination of each client's habilitation and active treatment needs, for two of the two clients in the sample. (Clients #1 and #2) The findings include:	W 159		

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W 159	Continued From page 4 1. The QIDP failed to ensure that Client #2's day program utilized the mealtime adaptive equipment as recommended by the client's interdisciplinary team (IDT), as follows: [Cross-refer to W120.2] During breakfast observations on October 23, 2012, at 6:43 a.m. an elevated tray was observed placed beneath Client #2's plate of food. The client was observed drinking apple juice and water from adaptive "sipper" cups with lids. By contrast, Client #2 was not observed using adaptive equipment while eating lunch at her day program. On October 24, 2012, at 11:17 a.m., day program staff placed a bowl of pureed lasagna directly on the table. There was no elevated tray. Client #2 was observed slouching forward, lowering her face in order to eat. She drank water from a disposable styrofoam cup. When asked about mealtime adaptive equipment on October 24, 2012, at 11:26 a.m. the day program staff (DP#1) assisting Client #2 with lunch retrieved a sipper cup from a cabinet. It remained stored in its original plastic bag. She explained that they would not implement the use of adaptive equipment such as the sipper cup, without first receiving training on its proper use. The home reportedly had not provided training. When asked about communications between the home and clients' day programs on October 25, 2012, at 10:59 a.m., the QIDP stated that the program manager (PM) Staff #4 was the "primary contact." On October 25, 2012, at 11:42 p.m., telephone interview with the PM confirmed the	W 159	**W159** Ensure that the Qualified Intellectual disabilities Professional (QIDP) coordinates and monitors services for one of the two clients in the sample (Client #2) 1. The QIDP will ensure that Resident #2's day program utilized the mealtime adaptive equipment as recommended by the Resident's interdisciplinary team (IDT) which includes elevated tray beneath the food plate and sipper cup by providing in-service training to day program staff. QIDP will monitor day program quarterly using the Day Program Monitoring Form to ensure compliance.	11/19/12 Ongoing

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W 159	Continued From page 5 aforementioned findings. She reported having brought a sipper cup and elevated tray to Client #2's day program after the client's annual meeting on June 7, 2012. She acknowledged that there had been no training on their use since that time. She also acknowledged that the home had not verified whether the day program utilized the mealtime adaptive equipment since she had delivered it in June 2012. It should be noted that on October 25, 2012, beginning at 11:48 a.m., review of the QIDP's job description revealed the following responsibility: "Communicates with individuals' employers and/or day programs at least monthly to discuss individuals' performance and documents results of visits." Subsequent review of the PM's job description did not reveal a comparable responsibility. 2. The QIDP failed to ensure that each client's habilitation records reflected all adaptive equipment that the primary care physician (PCP) agreed was necessary and appropriate for that client, as follows: While reviewing Client #1's swallow safety needs on October 23, 2012, beginning at 10:26 a.m., review of her physician's order sheets (POS) dated October 2012, and her annual medical evaluation, dated March 20, 2012, failed to show evidence of PCP orders for adaptive equipment. Continued review of the client's medical and habilitation records failed to show evidence that the PCP had agreed with the speech pathologist's recommendation that Client #1 use a straw when drinking thin liquids. Similarly, review of Client #2's medical and habilitation records on October	W 159	**W159** 2. The QIDP in conjunction with RN will ensure that each resident's habilitation records (POS) reflect all adaptive equipment that the primary care physician (PCP) agreed was necessary and appropriate for that resident including Resident #1 use of straw when drinking thin liquids, Resident #2 use of elevated tray and sipper cup. QIDP/RN will monitor POS quarterly to ensure compliance.	12/15/12 Ongoing

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W 159	Continued From page 6 24, 2012, between 3:55 p.m. - 5:51 p.m., revealed no evidence that the PCP ws in agreement with the interdisciplinary team recommendations for use of an elevated tray and a sipper cup at meals. On October 25, 2012, at 11:10 a.m., the QIDP was asked for evidence that the PCP was in agreement with the use of Client #2's adaptive equipment. The QIDP acknowledged that there were no written orders. The RN had obtained a telephone order from the PCP on October 23, 2012 for Client #1's adaptive equipment, after questions arose regarding the use of a straw for swallow safety. The QIDP looked through Client #2's record and acknowledged that the records did not include documentation to show that the PCP had approved the use of Client #2's sipper cup and elevated tray prior to the survey. She explained that it had not been their practice to ask the PCP to include adaptive equipment in clients' POS. She then acknowledged that she had not ensured that each client's record reflected the adaptive equipment that was approved by the PCP. 3. The QIDP failed to ensure staff was effectively trained to manage the swallow safety needs as outlined in each client's mealtime protocol as evidenced below: During breakfast observations on October 23, 2012, beginning at 7:18 a.m. Client #1 was observed using a straw while drinking apple juice and Ensure from beverage tumblers. By contrast, Client #1 was not given a straw when the morning nurse (Staff #6) presented a glass of water with	W 159	Response to W159.3 on page 9 of 9.	

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W 159	Continued From page 7 her medications at 8:11 a.m. When asked at 8:12 a.m., the nurse stated that drinking water without a straw was "not a problem...not a doctor's order...they puree her foods." She also confirmed Client #1 had dysphasia. The client drank her water without a straw and without any visible sign of distress. Interview with the qualified intellectual disabilities professional (QIDP) Staff #3 later that morning (October 23, 2012), at 9:45 a.m. revealed that two recent Barium Swallow studies indicated Client #1 was a silent aspirator. The interdisciplinary team had met to discuss the issue with the client's family. According to the QIDP, the family rejected a recommendation for tube feeding and instead wanted her to continue receiving pureed food and use a straw when drinking thin liquids. The QIDP further stated that direct support staff in the home had all received training on the Mealtime Protocol, which had been modified by the speech consultant (C#1) to include the use of a drinking straw. On October 23, 2012, interview with the RN at approximately 11:00 a.m., revealed the morning medication nurse (Staff #6) had "not been formally trained" on recent changes to Client #1's mealtime protocol, including the use of a straw when the client drinks liquids. The RN further stated the use of the straw should have been utilized in all settings to include during the medication administration. On October 25, 2012, beginning at 4:01 p.m., review of the facility's staff in-service training records, including signature sheets, confirmed that direct support staff had received training on	W 159	**Response to W159.3 on page 9 of 9**	

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W 159	Continued From page 8 Client #1's meal safety needs, however there was no evidence that the morning medication nurse had received training on Client #1's swallow safety needs.	W 159	**W159** **3.** The QIDP in conjunction with the RN will ensure that all staff including LPN (Staff#6) are effectively trained to manage the swallow safety needs as outlined in each residents' mealtime protocol QIDP and RN will observe and monitor staff quarterly to ensure compliance.	12/15/12 Ongoing

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0238	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/25/2012
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I 000	INITIAL COMMENTS A licensure survey was conducted from October 23, 2012 through October 25, 2012. A sample of two residents was selected from a population of four women with varying degrees of intellectual disabilities. The findings of the survey were based on observations in the home and at one day program, interviews with one resident, direct support staff, nursing and administrative staff, as well as a review of resident and administrative records, including incident reports. [Qualified mental retardation professional (QMRP) will be referred to as qualified intellectual disabilities professional (QIDP) within this report.]	I 000		
I 075	3503.3(d) BEDROOMS AND BATHROOMS Each bedroom shall be equipped with at least the following items for each resident: (d) Night stand. This Statute is not met as evidenced by: Based on observation, the facility failed to provide a night stand for each resident. The finding includes: On October 25, 2012, at 10:05 a.m., only one night stand was found in the bedroom shared by Residents #2 and #4. The program manager, who was present at the time, acknowledged this finding.	I 075	**I075** Each Bedroom shall be equipped with at least the following items for each resident 1. The QIDP/Program will have a night stand placed installed in the bedroom of Residents #2 and #4. The QIDP/Program Manager will monitor residence weekly using the Environmental Compliance Form to ensure that all furnishes are in good working order and replacing as necessary	12/15/12 Ongoing

Health Regulation & Licensing Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE 12/7/2012

Health Regulation & Licensing Administration

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I 082	Continued From page 1	I 082		
I 082	3503.10 BEDROOMS AND BATHROOMS Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting. This Statute is not met as evidenced by: Based on observation and interview, the group home for persons with intellectual disabilities (GHPID) failed to equip bathrooms used by residents with paper cups, for three of three bathrooms. The findings include: 1. On October 25, 2012, at 9:39 a.m., observation of the powder room located in the main hallway revealed that there were no paper cups available and no paper cup holder. 2. At 9:55 a.m., there were no paper cups available in the restroom located at the far end of the main hallway. 3. Similarly, at 10:05 a.m., there were no paper cups available in the restroom accessed from within the bedroom shared by Residents #2 and #4 The program manager (PM) Staff #4, who was present at the time, acknowledged that there were no paper cups available for resident use in any of the three bathrooms.	I 082	**I 082** Each bathroom shall be equipped with toilet tissue, paper towel and cup dispenser, soap for hand washing and adequate lighting. 1. The QIDP/Program will have installed paper cup dispenser and paper cups available in the powder room located in the main hallway. The QIDP/Program Manager will monitor residence weekly using the Environmental Compliance Form to ensure that all furnishes are in good working order and replacing as necessary 2. The QIDP/Program will have paper cups available in the restroom located at the far end of the main hallway. The QIDP/Program Manager will monitor residence weekly using the Environmental Compliance Form to ensure that all furnishes are in good working order and replacing as necessary 3. The QIDP/Program will have paper cups available in the restroom accessed from within the bedroom shared by Residents #2 and #4. The QIDP/Program Manager will monitor residence weekly using the Environmental Compliance Form to ensure that all furnishes are in good working order and replacing as necessary	12/15/12 Ongoing 12/15/12 Ongoing 12/15/12 Ongoing
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be	I 090		

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I 090	Continued From page 2 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 disabilities (GHPID) maintained the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner, except for the following observations, for four of the four residents of the facility. (Residents #1, #2, #3 and #4) The findings include: 1. During the inspection of the environment on October 25, 2012, at 9:36 a.m., the floor around the toilet located in the "powder room" in the main hallway sagged when this surveyor stood on it. The program manager, who was present at the time, explained there was damaged caused by a flooding episode approximately two months earlier. When asked if the water leak had been fixed, she said the plumber had not lifted the floor tiles to determine if there were any continuing leaks. 2. At 9:48 a.m., a knob was missing from the lower compartment of the wardrobe used by Resident #1. The bottom drawer of the resident's dresser was off track. 3. At 10:20 a.m., in the backyard, damage was observed to a wooden structure that covered the entrance to the crawl space beneath the house. There were deep gouges in the wood where a tree branch reportedly fell on it. The wood also was in need of repainting.	I 090	**I090** Maintain GHMRP in a safe, clean, orderly, attractive and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. 1. The QIDP/Program Manager will have repaired/replaced the sagging floor around the toilet located in the "powder" room in the main hall The QIDP/Program Manager will monitor residence weekly using the Environmental Compliance Form to ensure that all furnishes are in good working order and replacing as necessary 2. The QIDP/Program Manager will have repaired/replaced the a missing knob from the lower compartment of the wardrobe used by Resident #1 and the bottom drawer of resident's dresser placed back on the track. The QIDP/Program Manager will monitor residence weekly using the Environmental Compliance Form to ensure that all furnishes are in good working order and replacing as necessary 3. The QIDP/Program Manager will have repaired/replaced and painted the damaged wooden structure that covered the entrance to the crawl space beneath the house. The QIDP/Program Manager will monitor residence weekly using the Environmental Compliance Form to ensure that all furnishes are in good working order and replacing as necessary	12/15/12 Ongoing 12/15/12 Ongoing 12/15/12 Ongoing

Health Regulation & Licensing Administration

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NAME OF PROVIDER OR SUPPLIER MY OWN PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 3215 20TH STREET, NE WASHINGTON, DC 20018		

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I 090	Continued From page 3	I 090		
	4. At 10:23 a.m., paint on the outside wood trim around windows of the facility, as well as the front door frame, was cracked, peeling and in need of repair. On October 25, 2012, at 10:25 a.m., the program manager, who was present during the environmental walk through, acknowledged the aforementioned findings.		4. . The QIDP/Program Manager will have repaired/replaced/painted the outside trim around windows of the facility as well as the front door frame. The QIDP/Program Manager will monitor residence weekly using the Environmental Compliance Form to ensure that all furnishes are in good working order and repairing as necessary.	12/15/12 Ongoing
I 095	3504.6 HOUSEKEEPING	I 095		
	Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach of each resident.			
	This Statute is not met as evidenced by: Based on observation and interview, the group home for persons with intellectual disabilities (GHPID) failed to store caustic agents in a locked cabinet and/or out of direct reach of each resident, for two of the four residents of the facility. (Residents #2 and #4) The finding includes: During the environmental walk-thru on October 25, 2012, at 10:05 a.m., a spray bottle of Clorox Clean-Up with Bleach was observed in an unlocked cabinet beneath the vanity in the restroom accessed through the bedroom shared by Residents #2 and #4. The program manager (PM) Staff #4, who was present at the time, removed the bottle immediately.		**I095** Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach of each resident The QIDP/Program Manager will ensure that all caustic agents such as Clorox are stored in a locked cabinet and/or out of direct reach of each resident – four out of four residents. The QIDP/Program Manager will monitor residence weekly using the Environmental Compliance Form to ensure that all furnishes are in good working order and replacing as necessary	10/25/12 Ongoing

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I 180	Continued From page 4	I 180		
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 Habilitation plans. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that the qualified intellectual disabilities professional (QIDP) coordinated and monitored adaptive equipment needs timely, for two of the two residents in the sample. (Residents #1 and #2) The findings include: 1.The QIDP failed to ensure that Resident #2's day program utilized the mealtime adaptive equipment as recommended by the resident's interdisciplinary team (IDT), as follows: [Cross-refer to W120.2] During breakfast observations on October 23, 2012, at 6:43 a.m. an elevated tray was observed placed beneath Resident #2's plate of food. The resident was observed drinking apple juice and water from adaptive "sipper" cups with lids. By contrast, Resident #2 was not observed using adaptive equipment while eating lunch at her day program. On October 24, 2012, at 11:17 a.m., day program staff placed a bowl of pureed lasagna directly on the table. There was no elevated tray. Resident #2 was observed slouching forward, lowering her face in order to eat. She drank water from a disposable styrofoam cup.	I 180	**I180** 1. The QIDP in conjunction with the RN will schedule an case conference to ensure that Resident #2's day program provides the necessary assessment and possible treatment in accordance with her POS. QIDP/RN will monitor day program quarterly using the Day Program Monitoring Form to ensure compliance	11/19/12 Ongoing

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	HFD03-0238		10/25/2012

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I 180	Continued From page 5 When asked about mealtime adaptive equipment on October 24, 2012, at 11:26 a.m. the day program staff (DP#1) assisting Resident #2 with lunch retrieved a sipper cup from a cabinet. It remained stored in its original plastic bag. She explained that they would not implement the use of adaptive equipment such as the sipper cup, without first receiving training on its proper use. The home reportedly had not provided training. When asked about communications between the home and residents' day programs on October 25, 2012, at 10:59 a.m., the QIDP stated that the program manager (PM) Staff #4 was the "primary contact." On October 25, 2012, at 11:42 p.m., telephone interview with the PM confirmed the aforementioned findings. She reported having brought a sipper cup and elevated tray to Resident #2's day program after the resident's annual meeting on June 7, 2012. She acknowledged that there had been no training on their use since that time. She also acknowledged that the home had not verified whether the day program utilized the mealtime adaptive equipment since she had delivered it in June 2012. It should be noted that on October 25, 2012, beginning at 11:48 a.m., review of the QIDP's job description revealed the following responsibility: "Communicates with individuals' employers and/or day programs at least monthly to discuss individuals' performance and documents results of visits." Subsequent review of the PM's job description did not reveal a comparable responsibility. 2. The QIDP failed to ensure that each resident's	I 180	Response to I180.1 on page 5 of 11.	

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I 180	Continued From page 6 habilitation records reflected all adaptive equipment that the primary care physician (PCP) agreed was necessary and appropriate for that resident, as follows: While reviewing Resident #1's swallow safety needs on October 23, 2012, beginning at 10:26 a.m., review of her physician's order sheets (POS) dated October 2012, and her annual medical evaluation, dated March 20, 2012, failed to show evidence of PCP orders for adaptive equipment. Continued review of the resident's medical and habilitation records failed to show evidence that the PCP had agreed with the speech pathologist's recommendation that Resident #1 use a straw when drinking thin liquids. Similarly, review of Resident #2's medical and habilitation records on October 24, 2012, between 3:55 p.m. - 5:51 p.m., revealed no evidence that the PCP ws in agreement with the interdisciplinary team recommendations for use of an elevated tray and a sipper cup at meals. On October 25, 2012, at 11:10 a.m., the QIDP was asked for evidence that the PCP was in agreement with the use of Resident #2's adaptive equipment. The QIDP acknowledged that there were no written orders. The RN had obtained a telephone order from the PCP on October 23, 2012 for Resident #1's adaptive equipment, after questions arose regarding the use of a straw for swallow safety. The QIDP looked through Resident #2's record and acknowledged that the records did not include documentation to show that the PCP had approved the use of Resident #2's sipper cup and elevated tray prior to the survey. She explained that it had not been their practice to ask the PCP to include adaptive equipment in residents' POS. She then acknowledged that she had not ensured that	I 180	**I180** 2. The QIDP in conjunction with RN will ensure that each resident's habilitation records (POS) reflect all adaptive equipment that the primary care physician (PCP) agreed was necessary and appropriate for that resident including Resident #1 use of straw when drinking thin liquids, Resident #2 use of elevated tray and sipper cup. QIDP/RN will monitor POS quarterly to ensure compliance.	12/15/12 Ongoing

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I 180	Continued From page 7 each resident's record reflected the adaptive equipment that was approved by the PCP. 3. The QIDP failed to ensure staff was effectively trained to manage the swallow safety needs as outlined in each resident's mealtime protocol as evidenced below: During breakfast observations on October 23, 2012, beginning at 7:18 a.m. Resident #1 was observed using a straw while drinking apple juice and Ensure from beverage tumblers. By contrast, Resident #1 was not given a straw when the morning nurse (Staff #6) presented a glass of water with her medications at 8:11 a.m. When asked at 8:12 a.m., the nurse stated that drinking water without a straw was "not a problem...not a doctor's order...they puree her foods." She also confirmed Resident #1 had dysphasia. The client drank her water without a straw and without any visible sign of distress. Interview with the qualified intellectual disabilities professional (QIDP) Staff #3 later that morning (October 23, 2012), at 9:45 a.m. revealed that two recent Barium Swallow studies indicated Resident #1 was a silent aspirator. The interdisciplinary team had met to discuss the issue with the resident's family. According to the QIDP, the family rejected a recommendation for tube feeding and instead wanted her to continue receiving pureed food and use a straw when drinking thin liquids. The QIDP further stated that direct support staff in the home had all received training on the Mealtime Protocol, which had been modified by the speech consultant (C#1) to include the use of a drinking straw. On October 23, 2012, interview with the RN at approximately 11:00 a.m., revealed the morning	I 180	**I180** **3.** The QIDP in conjunction with the RN will ensure that all staff including LPN (Staff#6) are effectively trained to manage the swallow safety needs as outlined in each residents' mealtime protocol QIDP and RN will observe and monitor staff quarterly to ensure compliance.	12/15/12 Ongoing

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I 206	Continued From page 9 On October 25, 2012, beginning at 11:48 a.m., review of the personnel records for all employees, including licensed professional health consultants, revealed the following: 1. The most recent documented health inventory/certificate on file for Staff #2 was dated September 28, 2011; 2. The most recent documented health inventory/certificate on file for Staff #9 was dated July 12, 2011; 3. The most recent documented health inventory/certificate on file for Staff #10 was dated December 1, 2010; 4. The most recent documented health inventory/certificate on file for Staff #2 was dated September 28, 2011; 5. The health inventory/certificate on file for C#1 was dated October 25, 2011 and therefore had just expired; 6. There was no health inventory/certificate on file for C#2; and 7. There was no health inventory/certificate on file for C#3. On October 25, 2012, at 2:30 p.m., the director of health services (Staff #7), who had facilitated the review, acknowledged the aforementioned findings. No additional information was made available for review before the survey ended later that day at 4:43 p.m. This is a repeat deficiency. See Licensure Survey Report dated September 22, 2011.	I 206	**I206** Ensure that all employees and health care professional have current health certificates. 1-7. QIDP/Personnel Administrator will ensure that all employees and health care professional have current health certificates including Direct Support Professionals and consultants. Personnel Administrator will perform quarterly monitoring to ensure compliance and adequate notification to employees of upcoming expiration dates. Failure to maintain a current health inventory/certificate will result in removal from the schedule and or consulting until the health certification is updated and on file.	12/20/12 Ongoing

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I 180	Continued From page 8 medication nurse (Staff #6) had "not been formally trained" on recent changes to Resident #1's mealtime protocol, including the use of a straw when the client drinks liquids. The RN further stated the use of the straw should have been utilized in all settings to include during the medication administration. On October 25, 2012, beginning at 4:01 p.m., review of the facility's staff in-service training records, including signature sheets, confirmed that direct support staff had received training on Resident #1's meal safety needs, however there was no evidence that the morning medication nurse had received training on Resident #1's swallow safety needs.	I 180		
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: Based on interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that all employees and health care professionals had current health certificates on file, for 7 of 12 direct support staff (Staff #2, #9 and #10) and 3 of 7 consultants. (C#1, #2 and #3) The findings include:	I 206	**Response to I206 on page 10 of 11**	

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