

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

PRINTED: 10/30/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/09/2008
NAME OF PROVIDER OR SUPPLIER  IDI			STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012	
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W 000	INITIAL COMMENTS  This recertification survey was conducted from October 7, 2008, through October 9, 2008. The survey was initiated using the fundamental survey process. Six female clients with varying degrees of disabilities reside in this facility. Three of the six clients were randomly selected for the sample.  The findings of the survey were based on observations at the group home and one day program, interviews with management and direct care staff in the residence and the review of the administrative records including the facility's incident management system.	W 000		
W 104	483.410(a)(1) GOVERNING BODY  The governing body must exercise general policy, budget, and operating direction over the facility.  This STANDARD is not met as evidenced by: Based on observation, interviews, and the review of records, the facility's governing body failed to provide general operating directions over the facility as evidenced by the following:  The findings include:  The governing body failed to ensure an effective system had been developed/implemented to maintain each client's rights by making certain door alarms were not used prior obtaining consent from the clients and/or their legally sanctioned representative and prior to being approved by the facility's Human Rights Committee. [See W125]	W 104	Received 11/19/08  GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002  W104  This Standard will be met as evidenced by: Reference response to W125	11/24/08
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS	W 125		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *[Signature]* (X6) DATE *11/24/08*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 125	Continued From page 1  The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to maintain client's rights and/or ensure each client was encouraged to exercise their rights, for one of six clients residing in the facility. (Clients #5)  The finding includes:  On October 8, 2008 at 2:42 PM, an alarm sounded after a direct care staff was observed closing and opening the kitchen door. The direct care staff commented, "The door alarm is to let us know when Client #5 goes into the kitchen to steal food".  Interview with the Program Coordinator that same morning, only minutes later, revealed that the alarm was placed on the kitchen door to keep Client #5 from going into the kitchen. Review of Client #5's behavior support plan, on the same day at approximately 1:30 PM, indicated food stealing was one of Client #5's target behavior. Review of the psychological assessment dated July 31, 2008 failed to evidence a recommendation for the use of a kitchen door alarm.  Review of the Human Rights Committee (HRC) minutes, for the entire survey period, did not	W 125	<b>W125</b> <b>This Standard will be met as evidenced by:</b>  The door alarm has been removed from the kitchen door. The QMRP will provide additional staff training on client rights and adherence to procedures and processes which protect the rights of the individuals.  The QMRP will determine if the possible use of a door alarm should be considered for further discussion by the team. The QMRP will discuss the status of client #5 at the next human rights review, personal advocate, psychologist, as well as the individual and other relevant members of the team.  All actions will be documented to reflect the decisions made related to the use of the door alarm to include the benefits and risks of this intervention. If implemented as a formal strategy the information will be incorporated into a formal support plan as needed.	10-10-08 engany  11-26-08 engany

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W 125	Continued From page 2 evidence that the alarm was presented and approved by its HRC committee prior to the alarm being used as a restrictive measure. Additionally, the minutes did not evidence that the committee addressed all the clients rights as it related to being free from the piercing noise experienced when the door alarm was activated. Furthermore, there was no evidence that the legally sanctioned representatives for any of the other clients had been made aware of the use of the door alarm.	W 125		
W 140	<p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and the review of records, the facility failed to establish and maintain a system that ensured a complete and accurate accounting of clients' funds that were entrusted to the facility, for three of the six clients residing in the facility. (Client #1, #2 and #3)</p> <p>The findings include:</p> <p>On October 8, 2008, at approximately 2:45 PM, interview with the QMRP and the review of Clients #1, #2, and #3's financial records revealed the following:</p> <p>a. Client #1's personal account documentation reflected withdrawals of \$75.00 on 1/30/08 and \$50.00 on 5/15/08 (totaling \$125.00). At the time of the survey, there were no receipts available to justify the expenditures.</p>	W 140	<p><b>W140</b> <b>This Standard will be met as evidenced by:</b></p> <ul style="list-style-type: none"> <li>• Home Manager reported that all receipts were filed in the record. Home Manager will further review all receipts to ensure that the records are in compliance with the required standards and policies.</li> <li>• The Home Manager is responsible for maintaining all receipts in the record to include a copy of check request, receipts, funds returned to the account, and reconciling accounts by the end of each month.</li> <li>• QA audits will be conducted at least quarterly to ensure ongoing compliance with this standard.</li> </ul>	10.15.08 ongoing

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W 140	Continued From page 3	W 140		
W 159	<p>b. Client #2's personal account documentation reflected withdrawals of \$75.00 on 1/30/08 and \$50.00 on 5/15/08 (totaling \$125.00). At the time of the survey, there were no receipts available to justify the expenditures.</p> <p>c. Client #3's personal account documentation reflected withdrawals on 1/30/08 for \$48.96, \$75.00 and 100.00 and \$600.00 on 5/15/08 (totaling \$822.96). Additionally, an expenditure for a telephone bill dated 9/1/08 totaling \$96.60 was noted. At the time of the survey, there were no receipts available to justify these expenditures.</p> <p><b>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</b></p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP).</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. The QMRP failed to ensure that Client #2's behavior of hand biting was assessed. [See W214]</li> <li>2. The QMRP failed to ensure that data was collected in the form and required frequency. [See W252]</li> </ol>	W 159	<p><b>W159</b> <b>This Standard will be met as evidenced by:</b></p> <ol style="list-style-type: none"> <li>1. Reference response to W214.</li> <li>2. Reference response to W252.</li> <li>3. Reference response to W440.</li> </ol>	

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W 159	Continued From page 4	W 159		
W 189	<p>3. The QMRP failed to ensure that fire evaluation drills were conducted quarterly on all shifts. [See W440]</p> <p>483.430(e)(1) STAFF TRAINING PROGRAM</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure that each employee had been provided with adequate training that enabled the employee to perform his or her duties effectively, efficiently and competently.</p> <p>The finding includes:</p> <p>Observation on October 8, 2008 at approximately 4:40 PM revealed that the direct care staff assisted Client #4 from her wheelchair to the recliner chair in the living room for repositioning. Prior to the direct care staff performing a two man transfer, a disposable protective pad was placed in the seat of the recliner chair. The disposable protective pad was observed in the chair after the staff transferred Client #4 back into her wheelchair and rolled her to the dining room table.</p> <p>Interview with the QMRP revealed a dignity and rights training occurred several weeks ago and the staff were trained not to use disposable protective pads except for in the bedroom. The QMRP acknowledged that the training was not effective.</p>	W 189	<p><b>W189</b></p> <p><b>This Standard will be met as evidenced by:</b></p> <p>QMRP will conduct further training for all staff. QMRP/Home Manager will monitor home activities to further ensure compliance with this standard. Staff who fail to comply with the standards set forth will be subject to disciplinary action.</p>	11.21.08 ongoing
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN	W 214		

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W 214	<p>Continued From page 5</p> <p>The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a comprehensive functional assessment of behavioral needs was conducted for one of three clients included in the sample. (Client #2)</p> <p>The finding includes:</p> <p>The facility failed to assess Client #2's hand biting behavior as evidenced below:</p> <p>On October 7, 2008 at 5:31 PM, Client #2 was observed to engage in hand biting when the direct care staff wiped her mouth during the dinner meal. At 5:33 PM, Client #2 was observed again hand biting while the direct care staff removed her bib from her neck.</p> <p>Observations conducted at the day program on October 8, 2008 at 10:12 AM revealed Client #2 engaged in hand biting when the day program staff tried to rub lotion on her hands. Further observations at 10:27 AM revealed Client #2 engaged in hand biting again when the day program staff tried to shake her hand. At approximately 4:20 PM, continued observation of Client #2 at the group home, revealed Client #2 engaged in another episode of hand biting when the direct care staff tried to remove her sweater.</p> <p>Interview with the day program Case Manager (CM) and review of the Behavior Support Plan</p>	W 214	<p><b>W214</b> <b>This Standard will be met as evidenced by:</b></p> <p>QMRP will consult with the behavior specialist both at the day program and residential sites to obtain further assessment of the needs for client #2. QMRP will discuss implementation of baseline documentation if recommended. QMRP will also consult with day program to address areas of concerns related to ensure that all supports correspond with the needs of the person at both locations.</p>	11.26.08 ongam

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W 214	Continued From page 6 (BSP) dated November 2007 on October 8, 2008 revealed Client #2's targeted behaviors did not include hand biting. Interview with the direct care staff revealed that Client #2 will engage in hand biting when she's uncomfortable or when she "doesn't want to be bothered with anyone." Further interview with the direct care staff revealed that Client #2 exhibited hand biting weekly. Interview with the facility's Assistant Director (AD) on October 9, 2008 at approximately 10:40 AM revealed that Client #2 did not have a Behavior Support Plan at the day program or the residence that addressed the behavior of hand biting.  At the time of the survey, the facility failed to provide evidence that Client #2's observed hand biting behavior had been assessed and addressed.	W 214		
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 observations interview, and record review, the facility failed to ensure that data was collected in the form and required frequency for two of three clients included in the sample. (Client #1 and #2)  The findings include:  1. On October 7, 2008 at approximately 5:40 PM, Client #1 was observed to write down a list of	W 252	W252 <b>This Standard will be met as evidenced by:</b>  All staff will receive further training on program implementation and documentation. All data sheets will be highlighted to reflect the days each program should be implemented to further provide guidance for the staff. QMRP and Home Manager will monitor/check the program books on a weekly basis to further ensure documentation requirements are being met. QMRP/Home Manager will provide further training and/or disciplinary actions as warranted.	10-15-08 ongoing

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W 252	<p>Continued From page 7</p> <p>words on a sheet of white construction paper given to her by the direct care staff. At 6:10 PM, Client #1 was observed to ambulate around the interior of the house with staff assistance.</p> <p>Interview with the direct care staff on October 7, 2008, revealed that Client #1 had programs that required her to reduce of her maladaptive behaviors, ambulate around the facility, assist with dinner preparation, write words to express herself, and participate in arts and crafts activities.</p> <p>Review of Client #1's Individual Program Plans (IPP) on October 8, 2008 at approximately 4:30 PM revealed the client had the following program objectives:</p> <ul style="list-style-type: none"> <li>- The client will ambulate around the interior of the house every hour between 7 AM and 8 PM at 100% accuracy for on going basis. (Documentation required five days a week)</li> <li>- The client will utilize a written list of words to express her fundamental basic wants and needs to persons in her environment with 80% accuracy for six consecutive months. (Documentation required one day a week)</li> </ul> <p>Review of the data collection sheets on the same day at approximately 4:40 PM revealed no documentation for the month of October 2008. Interview with the Qualified Mental Retardation Professional (QMRP) on October 8, 2008 at approximately 4:50 PM acknowledged that the data was not being collected in accordance with the IPPs. It should be noted that Client #1 had three (3) other program objectives that had not been documented for the month of October 2008.</p>	W 252		

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W 252	Continued From page 8  2. On October 7, 2008 at 5:55 PM, Client #2 was observed being transported to her bedroom to listen to music. At 6:03 PM, Client #2 was observed lying in the recliner chair in her bedroom room listening to music. At 6:15 PM, the client was observed sitting up in the recliner chair listening to staff read her a story. Interview with staff on October 8, 2008 revealed that the aforementioned activities were part of Client #2's formal programs.  Review of Client #2's Individual Program Plan (IPP) on October 8, 2008 at approximately 3:00 PM revealed a program objective which read "the client will participate in an activity of her choice (listen to music, listening to staff read a story to her) on 80% of the trials per month for 6 consecutive months. Review of the corresponding data collection sheets on the same day at approximately 3:15 PM revealed that staff was to implement the program daily and document twice weekly. Further review of the data sheets revealed no documentation for the month of October 2008.  Interview with the Qualified Mental Retardation Professional (QMRP) on October 8, 2008 at approximately 4:15 PM acknowledged that the data was not being collected in accordance with the IPP. It should be noted that Client #2 had three (3) other program objectives that had not been documented for the month of October 2008.	W 252		
W 331	483.460(c) NURSING SERVICES  The facility must provide clients with nursing services in accordance with their needs.	W 331	<p><b>W331</b> <b>This Standard will be met as evidenced by:</b></p> <p>Reference response to W368.</p>	10-10-08 ongoing

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W 331	Continued From page 9 . This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure Client #6 received medication in accordance with her needs.  The findings include:  The facility's nursing staff failed to ensure that Client #6 received her medication in the method of administration prescribed in her physician's orders. [See W368]	W 331		
W 368	483.460(k)(1) DRUG ADMINISTRATION  The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.  This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that medications were administered in accordance with physician's orders, for one of the six clients residing in the facility. [Clients #6]  The finding includes:  Observation of the medication pass on October 7, 2008 at approximately 5:15 PM revealed Client #6 received Glycopyrolate 1 mg by mouth. Interview with the nurse revealed that Client #6 had a G-Tube and was starting to receive her medication by mouth.  Review of the medication administration records for the month of October 2008 and the current physician's orders for the month of October failed to provide evidence that the medication was to be orally administered. According to the physician's	W 368	<b>W368</b> <b>This Standard will be met evidenced by:</b>  Review of the Medication Administration Records for the month of October 2008 and the current Physician's Orders for the month of October showed that there is an order that the medication could be given orally, if tolerated. (See attached orders and MAR's)	10.10.08 ONGOING

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W 368	Continued From page 10 order Client #6 was to receive her medication via G-Tube.	W 368		
W 393	<p>483.460(n)(1) LABORATORY SERVICES</p> <p>If a facility chooses to provide laboratory services, the laboratory must meet the requirements specified in part 493 of this chapter.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure it met the requirements for performing glucose monitoring testing, for one of the three clients (Client #3) included in the sample.</p> <p>The finding includes:</p> <p>Observation of the medication administration on October 7, 2008 at approximately 6:20 PM, revealed Client #3 had her blood glucose level checked (via fingerstick) by the medication nurse. The nurse was further observed using a glucose monitoring machine to ascertain the client's blood glucose level. Further interview with the nurse revealed that Client #3 was a diabetic and her blood sugar level was monitored twice daily. The nurse additionally revealed Client #3 was prescribed insulin to be administered at 8:00 PM.</p> <p>Review of Client #3's medical record on October 8, 2008 at approximately 11:30 AM, revealed a physician order that confirmed Client #3 had diagnosis of Diabetes Mellitus complicated by Ketoacidosis. On October 9, 2008 at approximately 12:00 PM, the facility's Registered Nurse was asked whether the facility had obtained a Certificate of Waiver, as required under the Clinical Laboratory Improvement</p>	W.393	<p><b>W393</b> <b>This Standard will be met as evidenced by:</b></p> <p>The facility completed the renewal application along with renewal fees. The Certificate of Waiver (CLIA) should be mailed within the next two weeks period.</p> <p>The RN will maintain a master of all CLIA applications to ensure timely renewals.</p>	10.21-08 ongoing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  09G130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/09/2008
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NAME OF PROVIDER OR SUPPLIER  IDI	STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012
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W 393	Continued From page 11 Amendments of 1988 Act (CLIA). The nurse indicated that she had not completed the application for the certification. The nurse further revealed that she would submit the application. At the time of the survey, the facility did not have a CLIA Certificate of Waiver.	W 393		
W 440	483 470(i)(1) EVACUATION DRILLS  The facility must hold evacuation drills at least quarterly for each shift of personnel.  This STANDARD is not met as evidenced by: Based on interview and the review of fire drill reports, the facility failed to hold evacuation drills at least quarterly for each shift of personnel.  The finding includes:  Interview with the direct care staff on October 8, 2008 at 11:37 AM revealed the facility had five shifts of direct care personnel. The shifts were identified as weekdays 6 AM - 2 PM, 6 AM - 12:30 PM, 2 PM - 9:30 PM, 2 PM - 10:00 PM, 10:00 PM - 6:30 AM and on weekends 6 AM - 6:30 PM and 6 PM - 6:30 AM.  Review of the fire drill reports from July 2008 to September 2008 on October 8, 2008 revealed that no fire drills conducted during the 2 PM - 10 PM or the 10 PM - 6:30 AM shifts during the week. At the time of the survey, the facility failed to provide evidence of fire drills conducted quarterly as required.	W 440	W440 This Standard will be met as evidenced by:  Fire drills have been conducted. The Home Manager will monitor the fire evacuation drills on a monthly basis to ensure that a drill is conducted monthly on each shift. The Home Manager will maintain copies of staff training and follow-up actions taken to ensure ongoing compliance with this standard.	10/30/08 ongoing

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0033</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/09/2008</b>
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I 000	<b>INITIAL COMMENTS</b>  This licensure survey was conducted from October 7, 2008, through October 9, 2008. Six female clients with varying degrees of disabilities reside in this facility. Three of the six clients were randomly selected for the sample.  The findings of the survey were based on observations at the group home and one day program, interviews with management and direct care staff in the residence and the review of the administrative records including the facility's incident management system.	I 000		
I 022	<b>3501.5 ENVIRONMENTAL REQ / USE OF SPACE</b>  Each window shall be supplied with curtains, shades or blinds, which are kept clean, and in good repair.  This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure blinds and curtains at each window.  The finding includes:  An environmental walk-through was conducted on October 9, 2008 at approximately 10:50 AM that revealed the following:  Client #1 and Client #2's bedroom curtains were soiled and stained with an unknown substance.	I 022	<b>1022 3501.5 This Statute will be met as evidenced by:</b>  The bedroom curtains will be removed, replaced and/or cleaned.  The Home Manager will conduct environmental checks of the home at least monthly to ensure that all environmental concerns are addressed in a timely manner to include outside and interior of the home as well as each window is supplied with curtains/shades or blinds that are kept clean in good repair.	<b>11/14/08 ongoing</b>
I 090	<b>3504.1 HOUSEKEEPING</b>  The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of	I 090		

Health Regulation Administration

*Marilyn M... [Signature]*

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

TITLE  
*Pres*

(X6) DATE

*11/14/08*

STATE FORM

8899

MQMV11

If continuation sheet 1 of 7



Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HFD03-0033</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/09/2008</b>
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1096	Continued From page 2  This Statute is not met as evidenced by: Observation and interview revealed that the GHMRP failed to ensure that caustic agents were not stored in the food preparation and serviced area  The finding includes:  During the environmental walk-through on October 9, 2008, beginning at approximately 10:55 AM revealed a caustic agent was observed being stored in an unlocked cabinet beneath the sink.	1096	<b>1096 3504.7</b>  <b>This Statute will be met as evidenced by:</b>  Poisonous hazardous materials have been removed from the food preparation, storage area. The items have been properly stored in a locked cabinet.	10/10/08
1135	<b>3505.5 FIRE SAFETY</b>  Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift.  This Statute is not met as evidenced by: Based on interview and the review of fire drill reports, the GHMRP failed to hold evacuation drills at least quarterly for each shift of personnel.  The finding includes:  Interview with the direct care staff on October 8, 2008 at 11:37 AM revealed the facility had five shifts of direct care personnel. The shifts were identified as weekdays 6 AM - 2 PM, 6 AM - 12:30 PM, 2 PM - 9:30 PM, 2 PM - 10:00 PM, 10:00 PM - 6:30 AM and on weekends 6 AM - 6:30 PM and 6 PM - 6:30 AM.  Review of the fire drill reports from July 2008 to September 2008 on October 8, 2008 revealed that no fire drills conducted during the 2 PM - 10 PM	1135	<b>1135 3505.5</b> <b>This Statute will be met as evidenced by:</b>  The Home Manager will provide additional in-service training as needed and monitor the home environment closely to ensure ongoing compliance with this standard.  <b>Reference response to W440 of the federal deficiency report.</b>	

Health Regulation Administration

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I 135	Continued From page 3  or the 10 PM - 6:30 AM shifts during the week. At the time of the survey, the facility failed to provide evidence of fire drills conducted quarterly as required.	I 135	<b>3509.3</b> <b>This Statute will be met as evidenced by:</b>  The job description book was at the main office for auditing. The job descriptions for all fifteen direct care staff and the QMRP/Home Manager are current and have been filed back into the home.	10-10-08
I 203	<b>3509.3 PERSONNEL POLICIES</b>  Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter.  This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current job descriptions for all employees annually.  The finding includes:  Review of the personnel files conducted on 10/8/08 revealed that GHMRP failed to provide evidence of current signed job descriptions for the fifteen (15) direct care staff (Staff #1 - #15), the QMRP and the House Manager.	I 203	<b>1206</b> <b>3509.6</b> <b>This Statute will be met as evidenced by:</b>  The facility will follow-up to secure the necessary physical examination information. The Administrative Assistant is directly responsible for monitoring and tracking all required documents.  Current strategies and systems will be further evaluated to determine if changes are needed to ensure ongoing compliance with this standard.	10-30-08 ongoing
I 206	<b>3509.6 PERSONNEL POLICIES</b>  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 staff interview and record review, the GHMRP failed to ensure its staff received annual	I 206		

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I 206	Continued From page 4  health screenings in the form and manner as required by this section.  The findings include:  Interview with the QMRP and review of the personnel records on October 8, 2008 revealed the GHMRP failed to have evidence of physical examination for the following: the QMRP, the primary care physician, the Pharmacist, the Speech Therapist and the Occupational Therapist.	I 206		
I 222	<b>3510.3 STAFF TRAINING</b>  There shall be continuous, ongoing in-service training programs scheduled for all personnel.  This Statute is not met as evidenced by: Based on observations, interview and record verification, the GHMRP failed to ensure continuous, ongoing in-service training programs were conducted for all personnel.  The finding includes:  Observation on October 8, 2008 at approximately 4:40 PM revealed that the direct care staff assisted Client #4 from her wheelchair to the recliner chair in the living room for repositioning. Prior to the direct care staff performing a two man transfer, a disposable protective pad was placed in the seat of the recliner chair. The disposable protective pad was observed in the chair after the staff transferred Client #4 back into her wheelchair and rolled her to the dining room table.  Interview with the QMRP revealed a dignity and rights training occurred several weeks ago and the staff were trained not to use disposable	I 222	<b>1222 3510.3 This Statute will be met as evidenced by:</b>  <b>Reference response to federal deficiency report W189.</b>	<b>11-24-08</b>

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I 222	Continued From page 5 protective pads except for in the bedroom. The QMRP acknowledged that the training was not effective.	I 222		
I 229	<b>3510.5(f) STAFF TRAINING</b>  Each training program shall include, but not be limited to, the following:  (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies;  This Statute is not met as evidenced by: Based on interview and review of training documents, the GHMRP failed to provide evidence of staff training in communication and recreation.  The findings include:  Interview with the QMRP and review of the in service training records on October 9, 2008, at approximately 11:00 AM, revealed the GHMRP failed to provide evidence of training to its staff on in the domains of recreation and communication.	I 229	<b>1232 3510.5(i) This Statute will be met as evidenced by:</b>  The QMRP/Home Manager will coordinate additional staff training in the area of oral health and hygiene.	<b>11-21-08</b> <i>ongoing</i>
I 232	<b>3510.5(i) STAFF TRAINING</b>  Each training program shall include, but not be limited to, the following:  (i) Training of the residents in the maintenance of oral health and hygiene.  This Statute is not met as evidenced by: Based on interview and review of training	I 232	<b>Training records will be reviewed and audited at least quarterly by the Training Manager to further ensure ongoing compliance with this standard.</b>	

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I 232	Continued From page 6  documents, the GHMRP failed to provide evidence of staff training in oral health and hygiene.  The finding includes:  On October 9, 2008 at approximately 11:00 AM, interview with the QMRP and review of the in-service records failed to provide evidence staff training in the domain of oral health and hygiene.	I 232		