

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

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION
425 NORTH CAPITOL ST., N.E. 2ND FLOOR
WASHINGTON D.C. 20002
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G203	(X2) MULTIPLE COMPLETE A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2010
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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6010 DIX STREET, NE WASHINGTON, DC 20019
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W 000	INITIAL COMMENTS A recertification survey was conducted from 5/19/2010 through 5/21/2010. The survey was initiated utilizing the fundamental survey process. A random sampling of four clients was selected from a residential population of six males and one female with varying degrees of disabilities. The findings of the survey were based on observations and interviews in the home and at two day programs, as well as a review of the client and administrative records, including the incident reports.	W 000		
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure day program staff properly implemented the mealtime feeding protocols for one of four sampled clients. [Client #4] The finding includes: The facility failed to ensure Client #4 received his meal in the manner prescribed on his mealtime feeding protocol. Observations on 5/20/2010, beginning at approximately 11:55 a.m., revealed the following: 1. Client #4's staff placed two teaspoons of thickener into small spout cup that was filled with juice and served it to him approximately 2 minutes later. The juice easily moved around in	W 120	<ol style="list-style-type: none"> The Speech Therapist conducted further evaluation and inservice training on the use of thickner. In addition, a measuring cup was purchased and marked to be used solely for the measuring of thickner in order to ensure more accurate measuring and proper consistency. The LPN staff, and Home Managers will also monitor meal preparation and implementation to further ensure compliance with this standard. The staff assigned to person #4 reported that it was the person's preference to eat a few spoonfuls prior to drinking. Further evaluation will be completed and reviewed at the next Feeding Team Meeting. Reference response to #1. The training conducted addressed the appropriate amount of thickner needed to ensure the proper consistency. 	6-10-10 ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>DPS</i>	(X6) DATE <i>6/21/10</i>
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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	<p>Continued From page 1</p> <p>the cup when the staff served it to the client during lunch. Interview with the staff at approximately 11:57 a.m. revealed he assessed the consistency of the juice to be "honey thick." Interviews with the day program's case manager (CM) and licensed practical nurse (LPN) on the same day at approximately 12:08 p.m. revealed there was no consensus between the three of them as to the consistency of the juice. The case manager lifted up the cup and indicated it was "nectar thick," the LPN indicated she was not sure of the consistency, but added Client #4 fluids should be "honey thick" and the attending staff reiterated it was "honey thick" after shaking the container of juice several more times. Upon further inspection, the CM confirmed the fluid in the cup was too thin to be "honey thick" and further stated she would get the Nutritionist in to conduct an in-service to address the problem.</p> <p>2. At approximately 11:56 a.m., Client #4's staff served him approximately three spoons of food before serving him some of his juice from a spout cup.</p> <p>3. At approximately 12:10 p.m., a container of Resource 2.0 was observed on the table in front of Client #4. Interview with the staff at approximately 12:11 p.m. revealed he was not going to add any thickener to the Resource 2.0 because he had no written documentation that stated he should do so. Further interview with the attending staff revealed he had never added any thickener to the Resource. The CM and the LPN interjected, "all of [Client #4's] fluids should be served at a Honey Thick consistency."</p> <p>Record review on 5/20/2010, at 3:32 p.m., revealed Resident #4's 5/2010 physician's orders</p>	W 120			

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W 120	Continued From page 2 prescribed that he receive "honey thick" liquids. Further record review on 5/21/2010, at 4:54 p.m. revealed Resident #4's Mealtime Feeding Protocol dated 10/16/2009, also recommended "Honey Thick Liquids". The consult goes on to further recommend that staff should "present 2-3 sips of liquid as often as you can between each spoonful of solid food." As noted above, the staff was not observed providing his liquids in the manner prescribed. Interview with the facility's qualified mental retardation professional (QMRP) and the facility coordinator (FC) on 5/20/2010, at 6:33 p.m., revealed they were not aware of the feeding problems observed at the day program. Both the QMRP and the FC agreed to revisit the day program and provide the necessary training to ensure the mealtime feeding protocol was being implemented as prescribed.	W 120		
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, staff interview and record review, the facility's qualified mental retardation professional (QMRP) failed to ensure the coordination of services to promote the health and safety of four of seven clients residing in the facility. [Clients #1, #3, #4 and #7] The findings include: 1. Cross-reference to W120. The QMRP failed to	W 159	W159 1. Cross reference response to W120. The QMRP has been provided additional training on adherence to monitoring and actions needed to ensure that outside services provide meals in the manner prescribed on the mealtime protocols. 2. Cross reference response to W194. 3. Cross reference responses to w436. 4. Cross reference responses to w474.	6/15/10 unpinning

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W 159 Continued From page 3
ensure outside services provide meals in the manner prescribed on the mealtime feeding protocols.

2. Cross-refer to W194. The QMRP failed to ensure staff was effectively trained to implement mealtime feeding protocols.

3. Cross-refer to W436. The QMRP failed to ensure clients were provided the use of their adaptive equipment in the manner prescribed on their habilitation plans.

4. Cross-refer to W474. The QMRP failed to ensure the residential staff provided meals in the form and texture as prescribed.

W 194 483.430(e)(1) 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: Based on observation, staff interview and record review, the facility failed to ensure all staff were competent in implementing a client's mealtime feeding protocol and repositioning for two of the seven clients residing in the facility. [Clients #4 and #7]

The findings include:

1. Cross-refer to W474. On 5/20/2010, between 6:10 p.m. -6:43 p.m., observations and interviews with two direct support staff and the evening licensed practical nurse (LPN) during dinner revealed the three employees serving the evening

W 159

W194

This Standard will be met as evidenced by:

1. Cross reference response to W474.
2. Reference response to W120.
3. Mealtime protocols and expectations have been reviewed and discussed with all staff. The QMRP/Home Manager and Nursing staff will continue to monitor meal implementation, and provide feedback and direction as needed to ensure that meals are carried out as outlined. Mixing foods is prohibited unless indicated on the meal protocol. Also reference responses to W120.

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W 194	<p>Continued From page 4</p> <p>meal could not discern if the fluids being served during dinner were of nectar or honey-thickened consistency. Clients #4 and #7, both of whom were at risk of aspiration due to dysphasia, were offered water thickened to a nectar consistency instead of honey-thickened, as ordered.</p> <p>On 5/21/2010 beginning at 2:44 p.m., review of the facility's staff in-service training records revealed no evidence of training on Client #4's and #7's Mealtime Protocols. The facility had, however, documented a 3/23/2010, training by the RN on Dysphasia and Client #6's Mealtime Protocol. Observations on 5/20/2010, indicated the training had not been effective. In addition, review of the 3/23/2010, signature sheets revealed no indication that the nurse that observed dinner on 5/20/2010, had been in attendance for the training.</p> <p>[Note: The most recent documented training by the nutritionist was more than a year earlier (3/5/2009 and 3/7/2009). The QMRP indicated that the nutritionist had provided training shortly before the survey. There was no documentation, however, made available to verify said training.]</p> <p>2. The facility failed to ensure Client #4 received his dinner in the manner prescribed on his mealtime feeding protocol as evidenced below:</p> <p>Dinner observations on 5/20/2010, at 6:10 p.m., and record review on 5/21/2010, at 3:32 p.m., revealed Client #4's mealtime feeding protocol was not implemented as prescribed. Evidence of the deficient practices is presented below:</p> <p>a. Client #4's 10/16/2009 Mealtime Feeding Protocol and 5/2010 physician's orders prescribed:</p>	W 194			

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W 194	<p>Continued From page 5</p> <p>he receive "honey thick liquids." However, during dinner, the water in Client #4's spout cup easily moved around as the staff swirled the cup before serving it to him. The water appeared very thin, slightly thinner than nectar consistency. The staff feeding Client #4 his meal, the two other staff at the table feeding the other clients and the attending nurse all indicated the fluid in the cup being served to Client #4 was at a "honey thick" consistency. Initially the nurse observing the dinner indicated he was not sure what the consistency of the water was in Client #4's cup. Upon further inspection, he concluded it was "honey thick."</p> <p>b. Client #4's 10/16/2009 Mealtime Feeding Protocol prescribed that staff should "not mix food items together." During dinner, Client #4's staff took small sections of each food item and mixed them together for each spoonful of food.</p> <p>c. The staff also fed Client #4 at a steady pace. Each spoon of food was placed into the client's mouth even though there were still residuals left from the previous spoon of food. Client #4's staff also fed him five spoons of food before serving him a sip of water on one occasion and approximately another 4-6 spoons of food before serving him some water on another occasion.</p> <p>Review of Client #4's 10/16/2009 Mealtime Feeding Protocol prescribed the following interventions:</p> <p>1) Look for a swallow as indicated by the raising then lowering of his Adam's Apple located in the center front neck. Allow multiple swallows with each spoonful until all of the pocketed food behind his tongue is cleared from his mouth.</p>	W 194		

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W 194	<p>Continued From page 6</p> <p>2) Be certain he swallowed all of the food before presenting another spoonful.</p> <p>3) Present 2-3 sips of liquid as often as you can between each spoonful of solid food.</p> <p>Interview with the facility's qualified mental retardation professional (QMRP) and the facility coordinator (FC) on 5/20/2010, at 6:33 p.m., revealed they were not aware the facility's staff was feeding Client #4 incorrectly. Both the QMRP and the FC agreed that additional training was necessary to ensure the mealtime feeding protocol was being implemented as prescribed.</p> <p>3. The facility failed to ensure Client #4 was provided the proper support when repositioned to a supine position as evidenced below:</p> <p>Evening observations on 5/20/2010, at 5:27 p.m., revealed Client #4 was repositioned from his wheelchair and onto the couch facing the patio. He was placed in a supine position with his buttocks against the left arm of the couch and his feet were allowed to hang over the left arm rest as well.</p> <p>Record review on 5/21/2010, at 12:49 pm revealed Client #4's 10/1/2009 Physical Therapy (PT) assessment recommended that staff "use a bolster under his knees in supine." Interview with the PT on 5/21/2010, at 4:18 p.m., revealed he would rather the staff not place Client #4 in a supine position by using the couch and the armrest. This was not a suitable "bolster" especially regarding the number of cushioned wedges available in the home of various angles, sizes and shapes that could be used.</p> <p>Interview with the QMRP, the licensed practical</p>	W 194		

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W 194 Continued From page 7
nurse (LPN) and the FC on 5/21/2010, at 12:52 pm confirmed the couch should not have been used to place Client #4 in a supine position. In addition, all three of the managing team agreed staff would be provided additional training to ensure the proper measures to address the PT's recommendations.

W 249 483.440(d)(1) PROGRAM IMPLEMENTATION

As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure implementation of prescribed training programs, for one of four sampled clients. (Client #3)

The finding includes:

Cross-refer to W268. On 5/20/2010, Client #3 was observed on the patio with several staff and peers, from 4:32 p.m. - 4:50 p.m. The client was 100% reliant on staff for mobilizing his wheel chair. At approximately 4:38 p.m., a staff placed a Go Talk 9+ communication device onto his lap. Beginning at approximately 4:42 p.m., the client pushed a button to play the statement "I would like to go for a stroll please." Staff acknowledged hearing repeated requests for a stroll during the 8 minutes that followed. However, at 4:50 p.m.,

W 194

W 249

W249

This Standard will be met as evidenced by:

Cross reference response to w268.

All of the staff have received further training on communication, communication devices, respect and promoting independence and development of the people served. Corrective actions, to include additional training, and competency review has been implemented with the QMRP. QMRP will monitor staff implementation of programs and provide additional training and supports as needed to ensure compliance.

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W 249 Continued From page 8
Client #3 was wheeled back into the facility without being taken for a stroll.

On 5/21/2010, beginning at 10:36 a.m., review of Client #3's Individual Support Plan (ISP) dated August 26, 2009, revealed that he had a formal program to learn how to make four "I want..." statements using his voice output (Go Talk) device.

Observations on 5/20/2010 revealed that staff failed to implement activities to support accomplishment of Client #3's functional communication objective.

W 249

W268

W 268 483.450(a)(1)(i) CONDUCT TOWARD CLIENT

These policies and procedures must promote the growth, development and independence of the client.

This STANDARD is not met as evidenced by: Based on observation and record review, facility staff failed to consistently promote client independence and development, for one of four sampled clients. (Client #3)

The finding includes:

On 5/20/2010, at 4:32 p.m., a direct support staff person pushed Client #3, who was seated in a wheelchair, out to the facility's patio. The staff went back indoors, leaving Client #3 outside with three other direct support staff, three other clients and the qualified mental retardation professional (QMRP). At approximately 4:38 p.m., another (male) staff placed a Go Talk 9+ communication device onto Client #3's lap and began prompting him to push the button that offered a greeting and

W 268

This Standard will be met as evidenced by:

Cross reference response to W249.

QMRP and Home Manager have received additional training on expectations of program implementation, communication devices, promoting respect and dignity amongst the people served, as well as independence toward accomplishing outcomes.

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W 268	Continued From page 9 the client's name. He pushed the button after receiving a few prompts. At approximately 4:42 p.m. the client pushed another button triggering the recording "I would like to go for a stroll please." Some of the staff chuckled when they heard the recording, with one stating aloud that the client was "already outside." The client pushed the button again, then paused. He pushed the same button another four or five times during the next two minutes, receiving no response. At 4:46 p.m. a female staff said "He really wants to go..." in response to Client #3's requests on the communication device. Another female staff with them on the patio concurred. The QMRP asked who was going to take him; however, there was no response. The facility coordinator, who had come outside a few minutes earlier, went back inside. At 4:50 p.m., a male staff came out to the patio and greeted everyone. There was no mention of Client #3's requests to go for a stroll. The staff person wheeled Client #3 into the facility. For the next 35 minutes, the staff provided the client hand over hand assistance with playing video games in his bedroom. On 5/21/2010, beginning at 10:36 a.m., review of Client #3's Individual Support Plan (ISP) dated 8/26/2009, revealed that he had a formal program to learn how to make four "I want..." statements using his voice output (Go Talk) device. Observations on 5/20/2010 revealed that staff failed to respond appropriately when Client #3 made requests using his augmentative communication device.	W 268		
W 436	483.470(g)(2) SPACE AND EQUIPMENT	W 436	W436 This Standard will be met as evidenced by: The QMRP will coordinate additional training with all staff. The QMRP in coordination with the medical staff will monitor the implementation and seek clarification with the PT regarding the wearing of the hand cone.	6-21-10 ongoing

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W 436	<p>Continued From page 10</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and/or other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure the provision of adaptive equipment for three of four sampled clients. [Clients #1, #3 and #4]</p> <p>The findings include:</p> <p>1. On 5/20/2010, at 7:05 p.m., Client #3 was observed with a hand cone placed in his right hand. He had not been observed with a hand cone previously in the survey. On 5/21/2010, at 11:45 a.m., review of Client #3's physician's orders (POs) revealed that since 4/1/2006, he was "to tolerate his cone for four hours and have it off for two hours." The survey, however, revealed that the facility had not implemented his POs correctly, as follows:</p> <p>a. Although the orders stated that he should wear the cone four hours on, with two hours off, interview with the two direct support staff who were with Client #3 on the patio on 5/20/2010, at 7:05 p.m., revealed that they thought he was to wear the cone from 8 p.m., - 12:00 a.m., and from 8 a.m., - 12:00 p.m., daily. However, interview with the daytime LPN and the qualified mental retardation professional (QMRP) on the following day (5/21/2010,) beginning at 11:35 a.m., revealed that the four hours on, two hours off</p>	W 436	<p>2. The QMRP and Coordinator are directly responsible for monitoring all adaptive equipment needs of the persons served. A checklist has been established which requires review and signature of the QMRP and Coordinator verifying review and actions taken to secure adaptive equipment. In addition, both the QMRP and Coordinator are expected to document all interventions and maintain record of completed repairs in the adaptive equipment book for review. DRS will take actions for the QMRP and Coordinator who failed to address the adaptive equipment needs in an effective and timely manner. DRS will conduct random reviews of the equipment along with other assigned staff to ensure compliance with this standard.</p>	

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W 436	<p>Continued From page 11</p> <p>order was for round-the-clock support.</p> <p>b. On 5/21/2010, at approximately 11:50 a.m., review of Client #3's May 2010, Medication Administration Record (MAR) revealed the following schedule for wearing the cone: 8a.m., - 12 p.m., 4 p.m., - 6 p.m., 9 p.m., - 12 a.m., and 3 a.m., - 6 a.m.. The schedule did not comply with the POs (four hours on, two hours off).</p> <p>c. On 5/21/2010, at 10:38 a.m., review of Client #3's Individual Support Plan (ISP) dated 8/26/2009, revealed that the client was to "wear his right hand cone for four hours, twice daily." This frequency, however, did not comply with the POs (four hours on, two hours off).</p> <p>d. On 5/20/2010, Client #3 was observed in the facility between 7:30 a.m., - 8:30 a.m.. He was not wearing the cone at the time and was not observed with the cone at his day program later that day, at approximately 12:48p.m.. The physical therapist (PT) was in the facility the next day (5/21/2010.). At approximately 3:35 p.m., the PT stated that he "would prefer" that Client #3 not bring the cone to his day program, for fear of the cone "disappearing." [Note: Staff had earlier stated that the client wore the cone from 8:00 a.m., - 12:00 p.m.,] At 3:59 p.m., the PT indicated that he had just reviewed the client's POs, MARs and other documentation and he acknowledged there were some discrepancies. He further stated that "we'll straighten that out."</p> <p>It should be noted that Client #3's May 2010, MAR had a nurse's initials indicating that he had worn the cone from 4 p.m., - 6 p.m.. The client, however, had not been observed wearing the cone during that period. He was only seen</p>	W 436		

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W 436	<p>Continued From page 12</p> <p>wearing it later that evening, at 7:05 p.m.,</p> <p>2. On 5/20/2010, at approximately 7:40 a.m., all seven clients were observed sitting in their wheelchairs in the living room area. Further observations revealed the following:</p> <p>The covering of foot box on Client #3's wheelchair was torn, with the metal and internal cushioning material exposed. In addition, the left arm rest was missing a portion of its covering; the tear measured approximately 1 1/2 inches x 2 inches. When interviewed later that day, at 2:30 p.m., the QMRP and facility coordinator (FC) both indicated that they were previously unaware of damage to Client #3's wheelchair. They stated that direct support staff had been instructed to inform the FC of any problems with clients' wheelchairs. They acknowledged that staff had not informed them of the damage. The FC stated that he inspected each client's wheelchair on weekly basis. He then presented two adaptive equipment checklists, dated 5/9/2010, and 5/16/2010; neither checklist indicated damage to the wheelchair.</p> <p>At 4:35 p.m., interview with a direct support staff person revealed that damage to the arm rest had been observed 9 days earlier and the foot box tears were observed approximately 15 days earlier. Later that day, at 5:32 p.m., a wheelchair repair technician replaced the torn arm rest and stabilized the cushion in Client #3's foot box. The front edge of the box, however, remained torn.</p> <p>It should be noted that the State agency survey team observed identical damage to Client #3's foot box and left arm rest during the last recertification survey. [Note: The same individual was identified as Client #5 in the last survey.]</p>	W 436			

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W 436	<p>Continued From page 13</p> <p>The June 12, 2010, deficiency report included the following:</p> <p>"The covering of foot box on Client #5's wheelchair was torn, with the metal and internal cushioning material exposed. In addition, the left arm rest was missing a portion of its covering; the tear measured approximately 1 1/2 inches x 2 inches." The survey revealed that the tears had been identified two months earlier, on April 16, 2009.</p> <p>3. The facility failed to ensure staff provided Client #4 with the proper "bolster" under his knees when placed in a supine position. [See W194]</p> <p>4. The facility failed to ensure staff provided Client #4 with a "rolled washcloth" and ensure he wore it in four (4) hour intervals throughout the day as evidenced below.</p> <p>During the day program observations on 5/20/2010, at 10:30 a.m., the attending staff revealed Client #4 did not have his "washcloth" to use that day. A quick interview with the staff revealed Client #4 was usually sent to the day program with a washcloth that he was supposed to "roll up" and place in his left hand. The staff further indicated the washcloth was a measure of keeping Client #4's hands clean and dry.</p> <p>Client #4 arrived home from day program at approximately 3:40 p.m., on 5/20/2010. From that point until after dinner at approximately 6:40 p.m., Client #4 was not observing with a "rolled washcloth" in his left hand.</p> <p>Record review on 5/20/2010, at approximately 3:19 p.m., revealed Client #4's 3/2010, POs listed</p>	W 436			

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W 436	<p>Continued From page 14</p> <p>an order which read, "use rolled wash cloth in his left hand for 4 hours [on] and [4] hours off during the day." A cursory review on the same day and time revealed Client #4's PT assessment dated 10/1/2009 also recommended that staff "keep the skin dry and clean on his left hand. Consider using a rolled washcloth in his hand for 4 hours on, 4 hours off during the day."</p> <p>Interview with the QMRP, FC, and the licensed practical nurse (LPN) on 5/21/2010, at 12:53 p.m., confirmed that Client #4 was not provided his rolled washcloth when he got home from the day program on the day before. In addition, they all agreed additional training would be provided to staff to ensure Client #4 was provided his "rolled washcloth" as recommended by the PT. Staff in attendance was informed of the washcloth not being provided at the day program and later on at the home on 5/20/2010.</p> <p>5. The facility failed to ensure staff provided Client #1 with a new "foot box" to protect her feet as evidenced below:</p> <p>Review of the unusual incident reports on 5/21/2010, at 1:59 p.m., revealed Client #1 complained of pain in her right foot on 3/27/2010. The incident report indicated the facility's nurse assessed the painful area and observed "slight swelling in the middle of her right foot." Further record review revealed Client #4 fractured the toe on her right foot on 9/6/2009. The incident report detailed Client #4 "hit her right foot on the door exiting the weighing room" of the facility.</p> <p>Review of Client #4's PT assessments on 5/21/2010, at 1:18 p.m., revealed the following:</p>	W 436		

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W 436	Continued From page 15 a. PT assessment dated 10/12/2009 recommended that the facility "contact wheelchair vendor to explore foot support options, ie split foot boxes." b. PT assessment dated 11/6/2009 recommended that the facility "contact wheelchair vendor to explore foot support options, ie split foot boxes." c. PT assessment dated 4/6/2010, recommended that the facility look to secure "angle adjustable footplates" and also to "contact wheelchair vendor to explore foot support options; ie split foot boxes." Interview with the facility's FC on 5/21/2010, at 1:32 pm revealed he was not sure if the QMRP had followed up on these recommendations. According to the FC, the recommendation for the changes in the foot box was due to several incidents regarding Client #1 injuring her foot while ambulating around the home. Interview with the QMRP and the LPN on 5/21/2010: at approximately 5:30 p.m., revealed they had not addressed the PT's recommendations to date.	W 436	W436, Continued... 3. Reference response to W194. 4. Additional training has been coordinated with the PT on the wearing of the rolled washcloth. The QMRP, Nurses and Home Manager will also monitor to ensure ongoing compliance with this standard. 5. Corrective actions taken for QMRP who failed to provide appropriate follow-up on adaptive equipment needs of the individuals. Also, reference response to #2.	6/21/10 ongoing
W 474	483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure all clients received their meals in the form and consistency as prescribed, for two of seven clients residing in	W 474		

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W 474	<p>Continued From page 16 the facility. (Clients #4 and #7)</p> <p>The findings include:</p> <p>1. The facility failed to ensure Client #4 was provided his fluids in a "honey thick" consistency as prescribed in his current physician's orders and as prescribed in his 10/2009 mealttime feeding protocol. [See W194]</p> <p>2. Similarly, Client #7's Mealttime Protocol, dated 1/15/2010, and a physician's order dated 5/4/2010, reflected an order for "honey thickened liquids." During dinner on 5/20/2010, at approximately 6:15 p.m., a direct support staff person was observed giving him water from a covered spout cup; the water had been thickened to a nectar consistency. When asked about the consistency, both the staff person feeding him as well as the nurse who was observing the meal stated that the water appeared to be honey thick. Minutes later, after surveyors asked the nurse a second time, the nurse took the cup to the kitchen, added more thickener and brought it back to the dining room. [Note: Approximately 5 minutes after his beverage had more thickener added, Client #7 coughed once. The staff person stopped immediately. He resumed feeding the client after the nurse assessed the client and determined that he was not showing signs of distress.]</p>	W 474	<p>W 474</p> <p>This Standard will be met as evidenced by:</p> <p>1. Reference response to W194.</p> <p>2. Reference response to W120 and W194.</p>	6-17-10 ongoing

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1000	INITIAL COMMENTS A licensure survey was conducted from 5/19/2010 through 5/21/2010. A random sampling of four residents was selected from a residential population of six males and one female with varying degrees of disabilities. The findings of the survey were based on observations and interviews in the home and at two day programs, as well as a review of the resident and administrative records, including the incident reports.	1000		
1047	3502.5 MEAL SERVICE / DINING AREAS Each GHMRP shall be responsible for ensuring that meals, which are served away from the GHMRP, are suited to the dietary needs of residents as indicated in the Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the group home for the mentally retarded persons (GHMRP) failed to ensure day program staff properly implemented the mealtime feeding protocols for one of four sampled residents. [Resident #4] The finding includes: [Cross Reference Federal Deficiency Report Citation 12C] The GHMRP failed to ensure Resident #4 received his meal in the manner prescribed on his mealtime feeding protocol. Observations on 5/20/2010, beginning at approximately 11:55 a.m., revealed the following:	1047	3502.5 This Statute will be met as evidenced by: Cross reference response to federal deficiency report citation W120.	6-10-10 ongoing

Health Regulation Administration

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

STATE FORM

6899

Y55T11

TITLE
DRS

(X6) DATE

6-21-10

If continuation sheet 1 of 14

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1047	Continued From page 1 1. Resident #4's staff placed two teaspoons of thickener into small spout cup that was filled with juice and served it to him approximately 2 minutes later. The juice easily moved around in the cup when the staff served it to the resident during lunch. Interview with the staff at approximately 11:57 a.m. revealed he assessed the consistency of the juice to be "honey thick." Interviews with the day program's case manager (CM) and licensed practical nurse (LPN) on the same day at approximately 12:08 p.m. revealed there was no consensus between the three of them as to the consistency of the juice. The case manager lifted up the cup and indicated it was "nectar thick," the LPN indicated she was not sure of the consistency, but added Resident #4 fluids should be "honey thick" and the attending staff reiterated it was "honey thick" after shaking the container of juice several more times. Upon further inspection, the CM confirmed the fluid in the cup was too thin to be "honey thick" and further stated she would get the Nutritionist in to conduct an in-service to address the problem. 2. At approximately 11:56 a.m., Resident #4's staff served him approximately three spoons of food before serving him some of his juice from a spout cup. 3. At approximately 12:10 p.m., a container of Resource 2.0 was observed on the table in front of Resident #4. Interview with the staff at approximately 12:11 p.m., revealed he was not going to add any thickener to the Resource 2.0 because he had no written documentation that stated he should do so. Further interview with the attending staff revealed he had never added any thickener to the Resource. The CM and the LPN interjected, "all of [Resident #4's] fluids should be served at a Honey Thick consistency."	1047		

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1047	<p>Continued From page 2</p> <p>Record review on 5/20/2010, at 3:32 p.m., revealed Resident #4's 5/2010 physician's orders prescribed that he receive "honey thick" liquids. Further record review on 5/21/2010, at 4:54 p.m. revealed Resident #4's Mealtime Feeding Protocol dated 10/16/2009, also recommended "Honey Thick Liquids". The consult goes on to further recommend that staff should "present 2-3 sips of liquid as often as you can between each spoonful of solid food." As noted above, the staff was not observed providing his liquids in the manner prescribed.</p> <p>Interview with the GHMRP's qualified mental retardation professional (QMRP) and the facility coordinator (FC) on 5/20/2010, at 6:33 p.m., revealed they were not aware of the feeding problems observed at the day program. Both the QMRP and the FC agreed to revisit the day program and provide the necessary training to ensure the mealtime feeding protocol was being implemented as prescribed.</p>	1047		
1055	<p>3502.13 MEAL SERVICE / DINING AREAS</p> <p>Each GHMRP shall train the staff in the use of proper feeding techniques and monitor their appropriate use to assist residents who require special feeding procedures or utensils.</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview and record review, the group home for the mentally retarded persons (GHMRP) failed to ensure all staff were competent in implementing a resident's mealtime feeding protocol and repositioning for two of the seven residents residing in the GHMRP. [Residents #4 and #7]</p>	1055	<p>3502.13</p> <p>This Statute will be met as evidenced by:</p> <p>Cross reference response to Federal Deficiency Report Citation W474.</p>	6.17.10 ongoing

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1055	<p>Continued From page 3</p> <p>The findings include:</p> <p>[Cross Reference Federal Deficiency Report Citation W474]</p> <p>1. On 5/20/2010, between 6:10 p.m. - 6:43 p.m., observations and interviews with two direct support staff and the evening licensed practical nurse (LPN) during dinner revealed the three employees serving the evening meal could not discern if the fluids being served during dinner were of nectar or honey-thickened consistency. Residents #4 and #7, both of whom were at risk of aspiration due to dysphasia, were offered water thickened to a nectar consistency instead of honey-thickened, as ordered.</p> <p>On 5/21/2010, beginning at 2:44 p.m., review of the GHMRF's staff in-service training records revealed no evidence of training on Resident #4's and #7's Mealtime Protocols. The GHMRP had, however, documented a 3/23/2010, training by the RN on Dysphasia and Resident #6's Mealtime Protocol. Observations on 5/20/2010, indicated the training had not been effective. In addition, review of the 3/23/2010, signature sheets revealed no indication that the nurse that observed dinner on 5/20/2010, had been in attendance for the training.</p> <p>[Note: The most recent documented training by the nutritionist was more than a year earlier (3/5/2009 and 3/7/2009). The QMRP indicated that the nutritionist had provided training shortly before the survey. There was no documentation, however, made available to verify said training.]</p> <p>2. The GHMRP failed to ensure Resident #4 received his dinner in the manner prescribed on</p>	1055		

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1055	Continued from page 4 his mealtime feeding protocol as evidenced below: Dinner observations on 5/20/2010, at 6:10 p.m., and record review on 5/21/2010, at 3:32 p.m., revealed Resident #4's mealtime feeding protocol was not implemented as prescribed. Evidence of the deficient practices is presented below: a. Resident #4's 10/16/2009 Mealtime Feeding Protocol and 5/2010 physician's orders prescribed he receive "honey thick liquids." However, during dinner, the water in Resident #4's spout cup easily moved around as the staff swirled the cup before serving it to him. The water appeared very thin, slightly thinner than nectar consistency. The staff feeding Resident #4 his meal, the two other staff at the table feeding the other residents and the attending nurse all indicated the fluid in the cup being served to Resident #4 was at a "honey thick" consistency. Initially the nurse observing the dinner indicated he was not sure what the consistency of the water was in Resident #4's cup. Upon further inspection, he concluded it was "honey thick." b. Resident #4's 10/16/2009 Mealtime Feeding Protocol prescribed that staff should "not mix food items together." During dinner, Resident #4's staff took small sections of each food item and mixed them together for each spoonful of food. c. The staff also fed Resident #4 at a steady pace. Each spoon of food was placed into the resident's mouth even though there were still residuals left from the previous spoon of food. Resident #4's staff also fed him five spoons of food before serving him a sip of water on one	1055		

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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 8010 DIX STREET, NE WASHINGTON, DC 20019		
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I 055	<p>Continued From page 5</p> <p>occasion and approximately another 4-5 spoons of food before serving him some water on another occasion.</p> <p>Review of Resident #4's 10/16/2009 Mealtime Feeding Protocol prescribed the following interventions:</p> <ol style="list-style-type: none"> 1) Look for a swallow as indicated by the raising then lowering of his Adam's Apple located in the center front neck. Allow multiple swallows with each spoonful until all of the pocketed food behind his tongue is cleared from his mouth. 2) Be certain he swallowed all of the food before presenting another spoonful. 3) Present 2-3 sips of liquid as often as you can between each spoonful of solid food. <p>Interview with the GHMRP's qualified mental retardation professional (QMRP) and the GHMRP coordinator (FC) on 5/20/2010, at 6:33 p.m., revealed they were not aware the GHMRP's staff was feeding Resident #4 incorrectly. Both the QMRP and the FC agreed that additional training was necessary to ensure the mealtime feeding protocol was being implemented as prescribed.</p> <p>3. The GHMRP failed to ensure Resident #4 was provided the proper support when repositioned to a supine position as evidenced below:</p> <p>Evening observations on 5/20/2010, at 5:27 p.m., revealed Resident #4 was repositioned from his wheelchair and onto the couch facing the patio. He was placed in a supine position with his buttocks against the left arm of the couch and his feet were allowed to hang over the left arm rest as well.</p>	I 055		

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HFD03-0207		A. BUILDING _____	B. WING _____	05/21/2010
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		
INDIVIDUAL DEVELOPMENT, INC		6010 DIX STREET, NE WASHINGTON, DC 20019		
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1055	Continued From page 6 Record review on 5/21/2010, at 12:49 pm revealed Resident #4's 10/1/2009 Physical Therapy (PT) assessment recommended that staff "use a bolster under his knees in supine." Interview with the PT on 5/21/2010, at 4:18 p.m., revealed he would rather the staff not place Resident #4 in a supine position by using the couch and the armrest. This was not a suitable "bolster" especially regarding the number of cushioned wedges available in the home of various angles, sizes and shapes that could be used. Interview with the QMRP, the licensed practical nurse (LPN) and the FC on 5/21/2010, at 12:52 pm confirmed the couch should not have been used to place Resident #4 in a supine position. In addition, all three of the managing team agreed staff would be provided additional training to ensure the proper measures to address the PT's recommendations.	1055	3504.1 This Statute will be met as evidenced by: 1. The broken cement at the end of the front walkway has been repaired. 2. ^{Painting} Painting on the wooden privacy fence has been repainted and peeling removed. 3. rust stains on the jam of the door have been repaired. 4. paint on the lower portion of the to the nurses office has been repaired. 5. Maintenance went throughout the home to address the knicks and scratches. 6. the drain in the hand sink in the bathroom has been unclogged.	6.17.10 ongoing
1090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to maintain the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner, for seven of the seven residents in the facility. (Residents #1, #2, #3, #4, #5, #6 and #7) The findings include:	1090		

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I 090	<p>Continued From page 7</p> <p>Observation and interview with the facility's qualified mental retardation professional (QMRP) on May 21, 2010, beginning at 4:33 p.m. revealed the following:</p> <p>Exterior:</p> <ol style="list-style-type: none"> 1. There was a large (3 ft. x 2 ft.) area of broken cement at the end of the front walkway, where it reached the driveway. The damaged area provided an uneven surface, creating a potential trip hazard. 2. Paint on the wooden privacy fence around the side patio was peeling. <p>Interior:</p> <ol style="list-style-type: none"> 3. Rust stains were observed on the jam of the door leading from the living room to the side patio outdoors. 4. Paint on the lower portion of the door to the nurse's office was severely damaged. Scrapes covered the bottom 19 inches of the door surface. 5. There were knicks, scrapes and scratches on the paint on door jams throughout the GHMRP. 6. The drain in the hand sink in the bathroom across from the kitchen was clogged or otherwise did not provide adequate drainage. 7. There was an accumulation of grease on the ventilation fan in the kitchen. 8. There were knobs missing from bedroom dresser drawers used by Residents #1, #2, and 	I 090	<ol style="list-style-type: none"> 7. The grease accumulation has been addressed. 8. the knobs have been replaced on the dresser drawer. 9. the front panel of the drawer in the laundry room has been repaired. <p>Home Manager will conduct weekly walk through and document environmental concerns, needed repairs and submit a maintenance request form to have work completed as needed. QMRP will also monitor to ensure that such repairs and environmental checks are occurring as outlined.</p>	

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1090	Continued From page 8 #3. 9. The front panel of a drawer in the laundry room was removed. The QMRP acknowledged the above-cited deficiencies at the conclusion of the environmental walk-through.	1090		
1186	3508.5(c) ADMINISTRATIVE SUPPORT Each GHMRP shall have an organization chart that shows the following: (c) The categories and numbers of supportive and direct care staff, and... This Statute is not met as evidenced by: Based on review of the organizational chart that was presented, the Group for Mentally Retarded Persons (GHMRP) failed to ensure that the organizational chart showed the numbers of supportive and direct care staff. The findings include: 1. On 5/20/2010, at approximately 4:05 p.m., the former assistant director of residential services presented two organizational charts (dated January 2010). Review of the two charts revealed that neither one showed the number of direct support staff employed by the GHMRP. 2. Further review of the organizational charts revealed that neither chart indicated the number of LPNs employed by the GHMRP. At 4:28 p.m. the former assistant director of residential services acknowledged that the organizational charts did not indicate the numbers	1186	3508.5 This Statute will be met as evidenced by: 1. Number of direct support staff employed at the group home has been added to the organizational chart. 2. The number of LPN staff have been added to the organizational chart. Human Resource Director will ensure all documents are filed in the books for review.	6-10-10 ongoing

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I 186	Continued from page 9 of nursing and direct support staff.	I 186		
I 229	3510.5(f) STAFF TRAINING 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 observation, staff interview and record review, the facility failed to ensure all staff were competent in implementing a client's mealtime feeding protocol and repositioning for two of the seven clients residing in the facility. [Clients #4 and #7] The findings include: 1. [Cross Reference 3502.13] There was no evidence that the staff who was observed feeding Clients #4 and #7 their dinner on 5/20/2010, and the LPN who was monitoring the meal, had received effective training to ensure implementation of their mealtime protocols. 2. The facility failed to provide effective staff training to ensure Client #4 was provided the proper support when repositioned to a supine position as evidenced below: Evening observations on 5/20/2010 at 5:27 p.m. revealed Client #4 was repositioned from his wheelchair and onto the couch facing the patio. He was placed in a supine position with his buttocks against the left arm of the couch and his	I 229	3510.5 This Statute will be met as evidenced by: 1. Cross reference 3502.13 2. Cross reference responses to W249 and W268.	6.17.10 ongoing

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1229	<p>Continued from page 10</p> <p>feet were allowed to hang over the left armrest as well.</p> <p>Record review on 5/21/2010 at 12:49 pm revealed Client #4's 10/1/2009 Physical Therapy (PT) assessment recommended that staff "use a bolster under his knees in supine." Interview with the PT on 5/21/2010 at 4:18 p.m. revealed he would rather the staff not place Client #4 in a supine position by using the couch and the arm rest. This was not a suitable "bolster" especially regarding the number of cushioned wedges available in the home of various angles, sizes and shapes that could be used.</p> <p>Interview with the QMRP, the licensed practical nurse (LPN) and the FC on 5/21/2010 at 12:52 pm confirmed the couch should not have been used to place Client #4 in a supine position. In addition, all three of the managing team agreed staff would be provided additional training to ensure the proper measures to address the PT's recommendations.</p>	1229	<p>3508.5</p> <p>This Statute will be met as evidenced by:</p> <ol style="list-style-type: none"> 1. Number of direct support staff employed at the group home has been added to the organizational chart. 2. The number of LPN staff have been added to the organizational chart. <p>Human Resource Director will ensure all documents are filed in the books for review.</p>	
1261	<p>3512.2 RECORDKEEPING: GENERAL PROVISIONS</p> <p>Each record shall be kept in a centralized file and made available at all times for inspection and review by personnel of authorized regulatory agencies.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure records were available for inspection by personnel of the Department of Health, Health Regulation and Licensing Administration.</p> <p>The findings include:</p>	1261	<p>6-10-10 ongoing</p>	

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1261	<p>Continued From page 11</p> <p>1. On 5/20/2010, at approximately 2:50 p.m., the qualified mental retardation professional (QMRP) and the facility coordinator (FC) agreed to make available for review the records of all fire/emergency evacuation drills that were conducted during the preceding 12 months. On 5/21/2010, beginning at 8:35 a.m., review of the Fire Drill log book presented revealed that drill records were available for the period November 11, 2009 - May 21, 2010 only. At 9:17 a.m., the QMRP stated that drills had been conducted during the period June 2009 - October 2009; he agreed to locate drill records for that five-month period. At 1:53 p.m., and again at 2:40 p.m., the FC stated that he was "looking for" the missing drill reports. No additional fire drill records were made available for review before the survey ended later that day.</p> <p>[Note: On 5/25/2010 (post-survey), the facility submitted 11 fire drill reports from the period 6/8/2009 - 11/26/2009. No explanation for the delay in locating the records was offered.]</p> <p>2. On 5/21/2010, at 1:53 p.m., the FC was asked about the following notation on a Fire Drill record dated November 11, 2009, "trouble light on the alarm box in the nurse station continues to blink on and off." He recalled receiving a telephone call from the company that maintains their alarm system. When the person asked if the QMRP was experiencing any trouble, he told them about the blinking red light. The alarm company reportedly sent a repair technician to the facility to fix the alarm. The FC agreed to locate the repair receipt or invoice for verification purposes. At 2:40 p.m., the FC stated that he had not yet located the receipt in the facility and would make an inquiry at the corporate office. No receipt or</p>	1261	<p>3512.2</p> <p>This Statute will be met as evidenced by:</p> <p>Home Manager and QMRP will monitor drills on a monthly basis, file information accordingly and provide additional staff training as needed.</p> <p>Home Manager received additional training on monitoring and address life safety code hazards and maintaining receipt of repairs on file. Maintenance department also will monitor for life safety code violations and coordinate repairs as needed.</p>	6.18.10 ongoing

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1261	Continued From page 12 other form of documentation was presented before the survey ended later that day. It should be noted that on 5/21/2010, at approximately 5:30 p.m., inspection of the alarm box in the nurse station revealed no evidence of any current problems.	1261		
1422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure implementation of prescribed training programs, for one of four sampled residents. (Resident #3) The finding includes: [Cross Reference Federal Deficiency Report Citation W258] On 5/20/2010, Resident #3 was observed on the patio with several staff and peers, from 4:32 p.m. - 4:50 p.m. The resident was 100% reliant on staff for mobilizing his wheel chair. At approximately 4:38 p.m., a staff placed a Go Talk 9+ communication device onto his lap. Beginning at approximately 4:42 p.m., the resident pushed a button to play the statement "I would like to go for a stroll please." Staff acknowledged hearing repeated requests for a stroll during the 6 minutes that followed. However, at 4:50 p.m., Resident #3 was wheeled back into the facility without being taken for a stroll. On 5/21/2010, beginning at 10:36 a.m., review of	1422	3521.3 This Statute will be met as evidenced by: Cross reference responses to W268.	6/8/10 mgp/ah

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1422	Continued From page 13 Resident #3's Individual Support Plan (ISP) dated August 26, 2009, revealed that he had a formal program to learn how to make four "I want..." statements using his voice output (Go Talk) device.	1422			