

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

PRINTED: 11/29/2010
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 11/12/2010
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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012
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(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
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W 000	INITIAL COMMENTS A recertification survey was initiated on November 9, 2010 and was concluded on November 12, 2010. A sample of three clients was selected from a population of six women with various cognitive and intellectual disabilities. This survey was initiated utilizing the fundamental process. The findings of the survey were based on observations and interviews with clients and staff in the home and at one day program, as well as a review of client and administrative records, including 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, interviews, and record review, the facility failed to ensure that clients' day programs administered medications that had not expired, for one of the three clients in the sample. (Client #3) The finding includes: Cross-refer to W390. On November 10, 2010, an LPN at Client #3's day program was observed administering Albuterol via a nebulizer. Observation of the label revealed that the medication had expired. Interview with the day program RN indicated that a current supply of Albuterol vials had been delivered by the facility on November 5, 2010. There was no evidence, however, that the facility had removed the expired	W 120	W120 This Standard will be met as evidenced by: Expired medications were removed immediately from #3's possession and new medication ordered and delivered to the day program. The RN conducted training for all LPN staff on medication administration, review and discarding of all expired medications and delivery of medications to the day program. In accordance to IDI policy all medications will be delivered by the LPN staff and signed by the day program nurse to confirm receipt. The RN will conduct monthly day program visitations and document observations and interventions. RN will also conduct at least monthly medication checks to further ensure medications are current.	11-20-10

*RECEIVED
12-8-10*

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Mandy Wood</i>	TITLE <i>MCS</i>	(X6) DATE <i>12/9/10</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 Continued From page 1
medication or otherwise ensured that day program nurses would not administer it.
W 189 483.430(e)(1) STAFF TRAINING PROGRAM

W 189
This Standard will be met as evidenced by:

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.

1. QMRP conducted training on lifting and transfers/fall prevention. QMRP will follow-up to coordinate additional training with the Physical Therapist on safe lifting and transfers/fall prevention. The Incident Management Coordinator has received additional training to include but not limited to; follow-up on recommendations, securing supporting documentation as needed, and analyze systemic issues to be addressed in all homes and discussed in Safety Committee Meetings. The QMRP in coordination with the Physical Therapist and Home Manager will coordinate at least quarterly and/or as needed training with the Physical Therapist on fall preventions, programming and adaptive equipment.

12-9-10
ongoing

This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all staff providing care and support received ongoing training on transfer techniques and fall prevention, and the provision of effective perineal care to reduce the incidence of urinary tract infections, for four of the six clients residing in the facility. (Clients #1, #2, #3 and #6)

The findings include:
1. The facility failed to document the provision of in-service training on transfer techniques and fall prevention for all staff, as follows:

On November 10, 2010, at 9:14 a.m., review of incident reports revealed that on June 28, 2010, at 5:30 a.m., a staff person (S1) began transferring Client #6 from her bed into her wheelchair. The staff, however, was unable to fasten the seatbelt before the client began sliding downward, and off the wheelchair. The staff reportedly guided the client to the floor slowly and without injury. According to the corresponding investigation report, dated June 30, 2010, the client was morbidly obese and refused to allow staff to utilize the Hoyer lift as recommended by the physical therapist (PT). The report indicated that S1 had followed protocol while assisting the

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W 189	<p>Continued From page 2</p> <p>client that morning. Further review of the investigation report revealed that the sole recommendation made was "In-service training on transferring."</p> <p>Staff in-service training records were reviewed in the facility on November 10, 2010, beginning at 12:18 p.m. The review revealed that:</p> <p>a. There was no documented evidence that the staff person (S1) identified in the June 28, 2010 incident report involving Client #6 had received training on transfers and fall prevention prior to the incident. Additionally, there was no evidence that the facility provided training on transfers for all staff as recommended on June 30, 2010; and,</p> <p>b. There was no documented evidence that facility staff had received training on the proper use of the Hoyer lift. Interviews with the facility coordinator (FC) and the daytime LPN revealed that staff routinely used the Hoyer lift while transferring Client #1.</p> <p>During the Exit conference on November 12, 2010, the FC, RN and two LPNs present stated that the PT had conducted training on transfers and fall prevention. They acknowledged, however, that the most recent documentation available for review was dated August 21, 2009, with signatures indicating that the former FC and 5 of the 15 direct support staff (1/3) were in attendance.</p> <p>2. The facility failed to document the provision of in-service training on perineal care and prevention of urinary tract infections (UTIs), as follows:</p>	W 189	<p>2. The Nurse Practitioner conducted training on 12.2.10 on perennial care and prevention of urinary tract infections. The RN's have been charged with tracking and recording on a monthly basis all UTI infections for further analyzing. The MD and DON are developing and exploring additional interventions to be implemented in the upcoming year which will assist in tracking, trending and identification of infectious diseases to assist in reduction of UTI's. RN/LPN will conduct quarterly training or as needed to include but not limited to recognizing signs and symptoms of illness and UTI's.</p>	12-2-10 ongoing

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W 189	<p>Continued From page 3</p> <p>On November 10, 2010, beginning at 3:00 p.m., review of Clients #1, #2 and #3's medical records revealed they had histories of recurrent UTIs. The clients' physician's orders (POs), dated September 1, 2010 revealed that each was prescribed Cranberry fruit supplements (475 mg capsules, two capsules three times daily) and had orders for urinalysis laboratory studies and urine microbial cultures every three months. Their POs and Medication Administration Records indicated that in spite of the ongoing monitoring and care, the three clients had experienced recent incidents of UTIs for which they received treatment with antibiotics. For example, Client #1 began a 10-day treatment with Cipro on August 3, 2010.</p> <p>Staff in-service training records were reviewed in the facility on November 10, 2010, beginning at 12:18 p.m. The review revealed that the most recent training on perineal care and UTI prevention had been presented on October 13, 2009 and October 19, 2009. Staff in-service training records also showed no evidence of training (past or recent) of infection control recognizing the signs and symptoms of illness.</p> <p>During the Exit conference on November 12, 2010, the FC, RN and two LPNs present stated that there had been training for staff on recognizing signs and symptoms of illness, including UTIs; however, they acknowledged that there was no documentation available to review for verification purposes.</p> <p>It should be noted that failure to ensure effective training for staff on perineal care and UTI prevention is a repeat deficiency. (See Federal Deficiency Report dated December 18, 2009 - Citation W192.4)</p>	W 189		
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W 214 483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN

W 214

The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs.

This STANDARD is not met as evidenced by:
Based on observation, interview and review of medical records, the facility failed to ensure that psychiatric assessments were conducted, for one of three clients in the sample. (Client #3)

The finding includes:

During the entrance conference on November 9, 2010, beginning at 4:10 p.m., the Facility Coordinator indicated that Client #3 received psychotropic medications for her maladaptive behavior. Observations during the medication administration on November 9, 2010, at 6:10 a.m., revealed that the client received Revia 50 mg. Interview with the medication nurse, during the medication administration verified that the client received this medication for her maladaptive behaviors.

During the record verification process on November 10, 2010 at approximately 3:00 p.m., it was confirmed by the client's current physician orders, that the client received Revia 50 mg, once a day and Zyprexa 15 mg, in the evening, for psychotic behavior. Further record review revealed no evidence of a psychiatric assessment. Interview with the qualified mental retardation professional on November 12, 2010, at approximately 10:30 a.m., confirmed that the facility failed to obtain a psychiatric assessment for Client #3. There was no evidence that the client had been assessed by a Psychiatrist to

W214

This Standard will be met as evidenced by:

Psychiatric Assessment was completed on 11.20.10 for person #3 which address her axis I, II, and III diagnosis, side effects of medications and response to interventions. The QMRP will request assessments in advance of expiration dates to ensure ongoing compliance with this standard. DON/DRS will conduct monthly record reviews to further ensure compliance with this standard.

11.24.10
ongoing

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W 214 Continued From page 5
determine the Axis I diagnosis to justify the use of the psychotropic medications.

W 214

W 249 483.440(d)(1) PROGRAM IMPLEMENTATION

W 249

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, staff interview and record review, the facility failed to implement each client's individual program plan (IPP), as accepted by the interdisciplinary team (IDT), for one of the three clients in the sample. (Client #3)

The finding includes:

During the Entrance conference on November 9, 2010, beginning at 4:10 p.m., the facility coordinator revealed that Client #3 had an Individual Support Plan (ISP) meeting on November 5, 2010. On November 12, 2010, at 2:30 p.m., review of Client #3's speech and language assessment dated November 3, 2010, revealed the following objective:

- Given verbal prompts, [the client] will compute coin and currency combinations up to \$5.00 needed to complete a simple purchase transaction in the community for 8/10 trials per session for six consecutive months as measured by program documentation.

W249

This Standard will be met as evidenced by:

The QMRP has received additional training on monitoring and cross checking the IPP document at the time of the ISP and monthly thereafter, timely implementation of program objectives. The QMRP has implemented the speech program and updated the IPP. QMRP will follow-up and address concerns as they arise. DRS will conduct monthly record reviews and provide feedback and direction for the QMRP.

12-8-10
ongoing

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W 249 Continued From page 6

On November 12, 2010, at approximately 2:50 p.m., review of Client #3's IPP, dated November 5, 2010, revealed no evidence of the aforementioned objective.

W 249

In a follow-up interview on November 12, 2010, at 2:55 p.m., the facility coordinator and acting qualified mental retardation professional (AQMRP) acknowledged that the objective was not included on the IPP. She then indicated that she would inform the QMRP upon her return.

W 325 482.460(a)(3)(iii) PHYSICIAN SERVICES

W 325

W325

The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician.

This Standard will be met as evidenced by:

This STANDARD is not met as evidenced by: Based on interview, and record review, the facility provided routine laboratory testing as determined necessary by the physician, except for the following finding, affecting one of the three clients in the sample. (Client #1)

The finding includes:

On November 12, 2010, beginning at 9:24 a.m., review of Client #1's physician's orders (POs) from December 1, 2009 to September 1, 2010, revealed that beginning on June 1, 2010, the primary care physician (PCP) ordered for the client to have CBC - SMAC 24 laboratory studies performed every three months. Subsequent review of his medical records revealed the last CBC - SMAC 24 laboratory study was completed

CBC is indicated every six months for person #1 as clarified by the PCP (see attached order). The RN/LPN will develop a tracking format for laboratory studies schedules and update in accordance to PCP recommendations. RN will conduct weekly monitoring and provide direction and feedback to include training and other corrective actions to ensure ongoing compliance with this standard.

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W 325	Continued From page 7 on May 6, 2010. Interview with the licensed practical nurse (LPN) on later that day, at 2:34 p.m., confirmed that the studies were not completed as ordered. The CBC - SMAC 24 orders previously had been ordered for every six months. Further interview revealed that a calendar that was maintained by the nursing staff for scheduling laboratory studies had not been amended to reflect the June 1, 2010 change in frequency. The LPN then presented a calendar on which Client #1's next laboratory studies were scheduled for November 18, 2010.	W 325		
	The facility's nursing services failed to maintain an effective internal system to ensure that clients' laboratory studies were performed at the frequencies ordered by the PCP.		<p>W378</p> <p>This Standard will be met as evidenced by:</p> <p>The medication has been properly stored. The RN conducted training for LPN staff to include medication storage. The RN will conduct medication administration observations/competency reviews at least q 6 months for all LPNs. The RN will check individual's medications at least monthly to ensure that all drugs are stored under proper conditions. DON will conduct random checks at least quarterly of medications supplies to further ensure compliance with the standards set forth.</p>	
W 378	483 460(1)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of temperature. This STANDARD is not met as evidenced by: Based on observation, the facility failed to store all drugs under proper conditions of temperature, for one of the six clients residing in the facility. (Client #6) The finding includes: During the morning medication administration observation on November 9, 2010, at approximately 7:35 a.m., the Licensed Practical Nurse (LPN) was observed removing Client #6's bottle of Foradil 12 mcg capsule from the medication cabinet. Further observation of the blue pharmacy label attached to the container	W 378		11/20/10 organizing

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W 378	Continued From page 8 revealed Foradil 12 mcg capsules should be refrigerated. During a face to face interview with the LPN on November 9, 2010, at approximately 7:45 a.m., the LPN stated that the pharmacist had advised nursing staff to remove Client #6's Foradil 12 mcg. capsules from the refrigerator. On November 9, 2010, at approximately 9:35 a.m., review of Client #6's medical chart revealed that the consulting pharmacist had documented a review of the client's medication regimen every three months. However, review of the pharmacist's notes revealed no evidence that he had instructed nurses to remove the Foradil from refrigeration, as reported earlier by the LPN. There was no evidence an effective system to store all drugs under proper conditions of temperature was implemented.	W 378		
W 381	483.460(I)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security This STANDARD is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure that all drugs were stored under proper security, for one of the three clients in the sample. (Client #3) The finding includes Cross-refer to W378. On November 10, 2010, at 11:55 a.m., Client #3's day program licensed practical nurse (LPN) was observed removing a plastic bag from the back of the client's wheelchair. The LPN was observed retrieving a nebulizer machine and four tubes of Albuterol	W 381	W381 This Standard will be met as evidenced by: Reference response to W378 and W120.	11-20-10 ongoing

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W 381 Continued From page 9
Sulfate UD from a plastic bag. Seconds later, the LPN was observed pouring a tube of Albuterol Sulfate UD into the nebulizer machine and administering it to the client. After the medication administration pass, interview with the LPN revealed that the Albuterol was transported to and from the day program by the residential staff. At the time of the survey, the medication was being transported in a manner that failed to ensure it was accessible to authorized personnel only.

W 381

W 390 483.460(m)(2)(i) DRUG LABELING

The facility must remove from use outdated drugs

This STANDARD is not met as evidenced by:
Based on observation, staff interview and record review, the facility failed to ensure outdated medications were removed from usage, for one of the three clients included in the sample (Client #3)

The finding includes

Observations were conducted at Client #3's day program on November 10, 2010, from 11:15 a.m., until 12:25 p.m. At 11:55 a.m., the day program's licensed practical nurse (LPN) was observed retrieving a nebulizer machine and four tubes of Albuterol Sulfate UD from the plastic bag. Seconds later, the LPN was observed pouring a tube of Albuterol Sulfate UD into the nebulizer machine and administering it to the client. Interview with the LPN revealed that the client received nebulizer treatment once a day while at the day program. It should be noted that Client

W 390

W390

This Standard will be met as evidenced by:

Reference responses to W120. RN will conduct training and monitor medication administration monthly. RN will conduct monthly day program visitations, and review medications records and medical supplies for compliance. Feedback and corrective actions will be taken as the need arises. Medications shall be delivered to the day program to ensure proper handling of medication by authorized personnel only.

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1 000 INITIAL COMMENTS 1 000

A licensure was initiated on November 9, 2010 and was concluded on November 12, 2010. A sample of three residents was selected from a population of six women with various cognitive and intellectual disabilities. This survey was initiated utilizing the fundamental process.

The findings of the survey were based on observations and interviews with clients and staff in the home and at one day program, as well as a review of resident and administrative records, including incident reports.

1 090 3504.1 HOUSEKEEPING 1 090

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 Group Home for Persons with Mental Retardation (GHMRP) 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 in the facility. (Residents #1, #2, #3, #4, #5 and #6)

The findings include:

Observation and interview with the facility coordinator (FC) on November 10, 2010, beginning at approximately 1:30 p.m., revealed the following:

1. A gurney observed in the bathroom located on

3504.1 Housekeeping

This Statute will be met as evidenced by:

1. The leather covering on the gurney has been replaced.
2. The carpet in the room. A request has been sent to maintenance department for follow-up assessment to determine if new carpet is required or the existing carpet can be repaired/professionally cleaned.

12/3/10
ongoing

12/10/10
ongoing

The Home Manager will conduct weekly environmental checks of the home and report all maintenance concerns to the maintenance department. The QMRP will monitor at least monthly to ensure ongoing compliance with this standard.

Health Regulation Administration
William M. [Signature]
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE
WPS

(X6) DATE
12/9/10

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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL DEVELOPMENT, INC.		STREET ADDRESS, CITY, STATE, ZIP CODE 6520 1ST STREET, NW WASHINGTON, DC 20012		
(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) COMPLETE DATE
1090	Continued From page 1 the left side of the GHMRP had cracks in its leather covering. 2. The carpet in the living room had noticeable soiled stains. The FC acknowledged the above-cited deficiencies at the conclusion of the environmental walk-through.	1090	3504,1 Both the QMRP and Home Manager will check and monitor the adaptive equipment needs of the people to ensure that equipment is maintained in good repair and condition at all times.	
1206	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 Mental Retardation (GHMRP) failed to show evidence of a physician's certification that documented a health inventory had been performed for 2 out of 12 professional consultants. The finding includes: On November 10, 2010, at approximately 1:00 p.m., the facility coordinator provided personnel records for all employees and consultants for review. The personnel records revealed no evidence of current health certificates for the social worker and the occupational therapist. No additional information was presented for review before the survey ended on November 12, 2010.	1206	QMRP/Home Manager will document actions taken to address and secure the necessary equipment and report to DRS any concerns follow-up.	

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I 222	<p>3510.3 STAFF TRAINING</p> <p>There shall be continuous, ongoing in-service training programs scheduled for all personnel.</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all staff providing care and support received ongoing training on transfer techniques and fall prevention, infection control and the provision of effective perineal care to reduce the incidence of urinary tract infections, for four of the six residents of the facility. (Residents #1, #2, #3 and #6)</p> <p>The findings include:</p> <p>1. The facility failed to document the provision of in-service training on transfer techniques and fall prevention for all staff, as follows:</p> <p>On November 10, 2010, at 9:14 a.m., review of incident reports revealed that on June 28, 2010, at 5:30 a.m., a staff person (S1) began transferring Resident #6 from her bed into her wheelchair. The staff, however, was unable to fasten the seatbelt before the resident began sliding downward, and off the wheelchair. The staff reportedly guided the resident to the floor slowly and without injury. According to the corresponding investigation report, dated June 30, 2010, the resident was morbidly obese and refused to allow staff to utilize the Hoyer lift as recommended by the physical therapist (PT). The report indicated that S1 had followed protocol while assisting the resident that morning. Further review of the investigation report revealed that the sole recommendation made was "in-service training on transferring."</p>	I 222	<p>3509.6</p> <p>This Statute will be met as evidenced by:</p> <p>Both the Social Worker and OT have current health certificates on file. It appears the information was filed under another consultant.</p> <p>Administrative Assistant will continue to monitor and track compliance. DRS will conduct monthly reviews to further ensure that all documents are filed and current.</p>	11.15.10 ongoing

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I 222	<p>Continued From page 3</p> <p>Staff in-service training records were reviewed in the facility on November 10, 2010, beginning at 12:18 p.m. The review revealed that:</p> <p>a. There was no documented evidence that the staff person (S1) identified in the June 28, 2010 incident report involving Resident #6 had received training on transfers and fall prevention prior to the incident. Additionally, there was no evidence that the facility provided training on transfers for all staff as recommended on June 30, 2010; and,</p> <p>b. There was no documented evidence that facility staff had received training on the proper use of the Hoyer lift. Interviews with the facility coordinator (FC) and the daytime LPN revealed that staff routinely used the Hoyer lift while transferring Resident #1.</p> <p>During the Exit conference on November 12, 2010, the FC, RN and two LPNs present stated that the PT had conducted training on transfers and fall prevention. They acknowledged, however, that the most recent documentation available for review was dated August 21, 2009, with signatures indicating that the former FC and 5 of the 15 direct support staff (1/3) were in attendance.</p> <p>2. The facility failed to document the provision of in-service training on perineal care and prevention of urinary tract infections (UTIs), as follows:</p> <p>On November 10, 2010, beginning at 3:00 p.m., review of Residents #1, #2 and #3's medical records revealed they had histories of recurrent UTIs. The residents' physician's orders (POs), dated September 1, 2010 revealed that each was</p>	I 222		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 11/12/2010
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W 390	<p>Continued From page 10</p> <p>#3 had been hospitalized from September 26, 2010 through October 21, 2010, and returned to the day program on November 10, 2010.</p> <p>Review of Client #3's physician orders dated November 23, 2010, on November 10, 2010, at 12:10 p.m., revealed that the client was prescribed Albuterol 2.5/3 ml vial neb, one vial every four hours while awake for shortness of breath (SOB) or wheezing. Review of the medication package revealed that the pharmacy label had an expiration date of May 15 2009, and the box label had an expiration date of February 2010. Interview with the day program LPN and registered nurse (RN) after the medication administration, confirmed the expired dates. In addition, the day program RN acknowledged that the facility had delivered new medications (Albuterol) on November 5, 2010, at the case conference meeting.</p>	W 390		
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I 222 Continued From page 4 I 222

prescribed Cranberry fruit supplements (475 mg capsules, two capsules three times daily) and had orders for urinalysis laboratory studies and urine microbial cultures every three months. Their POs and Medication Administration Records indicated that in spite of the ongoing monitoring and care, the three residents had experienced recent incidents of UTIs for which they received treatment with antibiotics. For example, Resident #1 began a 10-day treatment with Cipro on August 3, 2010.

Staff in-service training records were reviewed in the facility on November 10, 2010, beginning at 12:18 p.m. The review revealed that the most recent training on perineal care and UTI prevention had been presented on October 13, 2009 and October 19, 2009. Staff in-service training records also showed no evidence of training (past or recent) on infection control and recognizing the signs and symptoms of illness.

During the Exit conference on November 12, 2010, the FC, RN and two LPNs present stated that there had been training for staff on infection control and recognizing signs and symptoms of illness, including UTIs; however, they acknowledged that there was no documentation available to review for verification purposes.

It should be noted that failure to ensure effective training for staff on perineal care and UTI prevention is a repeat deficiency.

Previously, the State Licensure Deficiency Report, dated December 19, 2009, included the following:

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1 222 Continued From page 5 1 222

"Review of Resident #1's Medical Assessment dated November 5, 2009... revealed Resident #1 had diagnoses that include Acute Cystitis, and a history of recurrent Urinary Tract Infections. (UTI's)... laboratory studies and review of physician orders from December 2008 through December 2009 revealed Resident #1 had urinary tract infections that required treatment in December 2008, February 2009 x 2, April 2009, June 2009, October 2009, and December 2009.

...the only documented staff training on incontinence/peri-care was on October 13, 2009. During a face-to-face interview with the consulting mental retardation professional on December 18, 2009, at approximately 3:58 p.m., it was acknowledged additional training was needed in the area of incontinence/peri-care. There was no documented evidence of continuing training enabling the employees to perform their duties effectively, efficiently, and competently."

3510.5(d)

This Statute will be met as evidenced by;

The Human Resource Department in coordination with the Training Department will monitor and track compliance for CPR/First Aid. Staff are provided reasonable notification that their documents will expire. Any staff who fails to attend the scheduled training which is provided on a bi-weekly basis and periodic weekends will be removed from the work schedule until the training has been completed.

11.22.10
ongoing

1 227 3510.5(d) STAFF TRAINING 1 227

Each training program shall include, but not be limited to, the following:

(d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR) the Heimlich maneuver, disaster plans and fire evacuation plans;

This Statute is not met as evidenced by: Based on record review, the Group Home for Persons with Mental Retardation (GHMRP) failed to have on file for review, evidence of current training in cardiopulmonary resuscitation (CPR), for two of the twenty-three staff. (Staff #4 and #20)

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I 227	Continued From page 6 The finding includes: Review of the personnel and training records on November 10, 2010, beginning at approximately 2:15 p.m., revealed the GHMRP failed to provide documentation of CPR certification for Staff #4 (a direct support staff) and Staff #20 (an LPN). The facility coordinator acknowledged these deficiencies at approximately 3:10 p.m.	I 227		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that psychiatric assessments were conducted, for one of three residents in the sample. (Resident #3) The finding includes: During the entrance conference on November 9, 2010, beginning at 4:10 p.m., the Facility Coordinator indicated that Resident #3 received psychotropic medications for her maladaptive behavior. Observations during the medication administration on November 9, 2010, at 6:10 a.m., revealed that the resident received Revia 50 mg. Interview with the medication nurse, during the medication administration verified that the	I 401	3520.3 This Statute will be met as evidenced by: Reference response to W214.	11.24.10 ongoing

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401	Continued From page 7 resident received this medication for her maladaptive behaviors.	401		
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422	<p>3521.3 HABILITATION AND TRAINING</p> <p>Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident's Individual Habilitation Plan.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure habilitation, training and assistance were provided to its residents in accordance with their Individual Habilitation Plan (IHP), for one of the three residents in the sample. (Resident #3)</p> <p>The finding includes.</p> <p>During the Entrance conference on November 9, 2010, beginning at 4:10 p.m., the facility coordinator revealed that Resident #3 had an Individual Support Plan (ISP) meeting on</p>	422	<p>3521.3</p> <p>This Statute will be met as evidenced by:</p> <p>Reference response to W249.</p>	<p>12.8.10</p> <p>ongoing</p>
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3521.3

This Statute will be met as evidenced by:

Reference response to W249.

12.8.10
ongoing

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1422	Continued From page 8 November 5, 2010. On November 12, 2010, at 2:30 p.m., review of Resident #3's speech and language assessment, dated November 3, 2010, revealed the following objective: - Given verbal prompts, [the resident] will compute coin and currency combinations up to \$5.00 needed to complete a simple purchase transaction in the community for 8/10 trials per session for six consecutive months as measured by program documentation. On November 12, 2010, at approximately 2:50 p.m., review of Resident #3's IPP, dated November 5, 2010, revealed no evidence of the aforementioned objective. In a follow-up interview on November 12, 2010, at 2:55 p.m., the facility coordinator and acting qualified mental retardation professional (AQMRP) acknowledged that the objective was not included on the IPP. She then indicated that she would inform the QMRP upon her return.	1422	
1484	3522.11 MEDICATIONS Each GHMRP shall promptly destroy prescribed medication that is discontinued by the physician or has reached the expiration date, or has a worn, illegible, or missing label. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group Home for Persons with Mental Retardation (GHMRP) failed to remove from use medications that reached an expired date, for one of the three residents in the sample (Resident #3) The finding includes:	1484	3522.11 This Statute will be met as evidenced by: Reference responses to 378 and W120. 12.8.10 ongoing

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I 484 Continued From page 9 I 484

Observations were conducted at Resident #3's day program on November 10, 2010, from 11:15 a.m., until 12:25 p.m. At 11:55 a.m., the day program's licensed practical nurse (LPN) was observed removing a plastic bag from the back of Resident #3's wheelchair. The LPN was observed retrieving a nebulizer machine and four tubes of Albuterol Sulfate UD from the plastic bag. Seconds later, the LPN was observed pouring a tube of Albuterol Sulfate UD into a nebulizer machine and administering it to the resident. Interview with the LPN revealed that the resident received nebulizer treatment once a day while at the day program. It should be noted that Resident #3 had been hospitalized from September 26, 2010 through October 21, 2010, and returned to the day program on November 10, 2010.

Review of Resident #3's physician orders dated November 23, 2010, on November 10, 2010, at 12:10 p.m., revealed that the resident was prescribed Albuterol 2.5/3 ml vial neb, one vial every four hours while awake for shortness of breath (SOB) or wheezing. Review of the medication package revealed that the pharmacy label had an expiration date of May 15, 2009, and the box label had an expiration date of February 2010. Interview with the day program LPN and registered nurse (RN), after the medication administration, confirmed the expired dates. In addition, the day program RN acknowledged that the facility had delivered new medications (Albuterol) on November 5, 2010, at the case conference meeting.

I 500 3523.1 RESIDENT'S RIGHTS I 500

Each GHMRP residence director shall ensure

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I 500	<p>Continued From page 10</p> <p>that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Mentally Retardation Persons (GHMRP) failed to ensure the rights of residents were observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and Federal Laws, for one of three residents included in the sample. (Resident #3)</p> <p>The finding includes:</p> <p>7-1305.05 (h)"All prescriptions for psychotropic medications shall be written with a termination date, which shall not exceed thirty days"...</p> <p>The GHMRP's primary care physician failed to ensure orders for psychotropic medications had a termination date which did not exceed thirty days as for sign physician orders (POS), for one of the three residents in the sample. (Resident #3)</p> <p>Observations during the medication administration on November 9, 2010, at 6:10 a.m., revealed that the resident received Revia 50 mg. Interview with the medication nurse revealed that the resident received this medication for her maladaptive behaviors.</p> <p>Review of Client #3's FOS dated September 1, 2010, on November 10, 2010 at approximately 3:00 p.m., revealed that the resident was prescribed Revia 50 mg, once a day and Zyprexa</p>	I 500	<p>3523.1 Residents Rights</p> <p>This Statute will be met as evidenced by:</p> <p>The order for psychotropic medications is written to reflect a termination date which does not exceed thirty days. The RN will review all orders at least once a month and/or when new orders are prescribed to ensure ongoing compliance with this standard.</p> <p>11.20.10 ongoing</p>

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I 500	Continued From page 11 15 mg, every day. Interview with the licensed practical nurse on November 12, 2010, at approximately 10:00 a.m., confirmed that the last POS were dated September 1, 2010.	I 500		
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