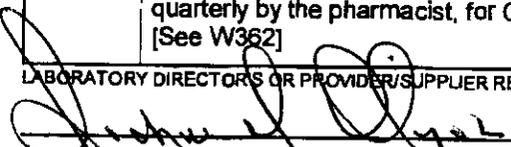
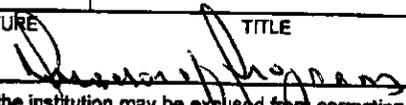


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2010
NAME OF PROVIDER OR SUPPLIER MY OWN PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 4141 ANACOSTIA AVE, NE WASHINGTON, DC 20019	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS An recertification survey was conducted from August 26, 2010 through August 27, 2010, utilizing the fundamental survey process. A random sampling of two clients was selected from a population of four males with various levels of mental retardation and disabilities. The findings of the survey were based on observations at the group home and two day programs; interviews with clients, staff, and the review of clinical and administrative records, including incident reports.	W 000	<p style="text-align: center;">GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002</p> <p style="text-align: center; font-size: 2em; color: blue;">9.21-10</p>	
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the governing body failed to maintain general operating direction over the facility as evidenced by the deficiencies cited throughout this report and the following: The findings include: 1. The governing body failed to exercise operating direction to ensure the maintenance of a bed mattress which met Client #3's comfort needs. [See W418] 2. The governing body failed to exercise operating direction to ensure that medication regimen reviews were conducted at least quarterly by the pharmacist, for Clients #1 and #2. [See W362]	W 104		<p>W104</p> <ol style="list-style-type: none"> The mattress has been assessed by the medical equipment provider and will be replaced by 9.24.10. In the future, the Program Manager/QDDP/Delegating RN will assess all equipment for proper fit and function on a monthly basis. Request for repair/replacement based on observed condition of the equipment will be forwarded immediately to the appropriate parties pending the assessed need. 9.24.10 The Pharmacist conducted reviews for client #1 and client #2 on 10/13/09, 01/25/10, 4/30/10 and 7/27/10 respectively. The related reports have been filed in their current medical records. On an ongoing basis the reports will be filed in the client's active medical records immediately following review by the Primary Care Physician and Delegating RN. 8.31.10 Ongoing
LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE
				9/14/10

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 159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>This STANDARD is not met as evidenced by: Based on interview, and record review, the facility failed to ensure that the Qualified Mental Retardation Professional (QMRP) coordinated services for two of four clients residing in the facility. (Clients #2 and #4)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. The QMRP failed to coordinate services to ensure that Client #2 received a timely nutritional assessment of an abnormal laboratory finding, as recommended by the primary care physician. [See W217] 2. The QMRP failed to ensure each staff was effectively trained for the accurate implementation of Client #4's therapeutic diet. [See W474] 	W 159	<p>W159</p> <ol style="list-style-type: none"> 1. See response to W 217. 2. See response to W 474. 	<p>9.17.10 9.24.10</p>
W 217	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN</p> <p>The comprehensive functional assessment must include nutritional status.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a comprehensive assessment of the nutritional needs of one of two clients in the sample. (Client #2)</p>	W 217	<p>W217</p> <p>See response to W217 on page 3 of 15.</p>	

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W 217	<p>Continued From page 2</p> <p>The findings include</p> <p>The facility failed to ensure a comprehensive reassessment of Client #2's nutritional needs a, as evidenced below:</p> <p>On August 26, 2010 at 11:48 a.m., Client #2 was observed to be edentulous as he ate peas from his plate at his day program. At 11:57 a.m., he requested that staff put ketchup on the chopped meat pattie he had been served. He continued to eat until 12:28 p.m., when he finished his meal.</p> <p>On August 26, 2010 at 6:45 p.m., a group home staff asked Client #2 if he wanted ketchup on his turkey burger at the beginning of his meal. The client responded "yes". At 7:10 p.m., he was observed to have eaten approximately one half of his chopped turkey burger, chopped vegetable salad, and baked potato. He again responded, "yes" when staff asked him if he was finished eating his meal.</p> <p>Interview staff on August 26, 2010 at the day program and the group home indicated that Client #2 usually ate most of his food, if it was something that he liked. Staff in both setting agreed that the client liked ketchup on his meat.</p> <p>Record on review on August 27, 2010 at 1:32 p.m. revealed the client was completely edentulous and did not wear dentures. Continued record review revealed a physician's order for a Low Fat/Low Cholesterol/No Added Salt, Bite Size Texture Diet. The review of the Dietary Instruction List dated August 1, 2010 provided by the nutritionist revealed, - Bite Size Texture - Sized between quarter and nickel".</p>	W 217	<p>W217</p> <p>The Delegating RN has scheduled a reassessment of Client #2's nutritional needs including but not limited to, texture modification and use of condiments as appropriate. Nutrition assessment will include a review of the lab results and will specify whether abnormality is related to inadequate nutritional intake as well as any recommendations necessary to improve laboratory results for Client #2.</p> <p>Delegating RN and Nutritionist will provide staff training on effectively implementing Client#2's therapeutic diet. Refresher training will be provided to staff on a quarterly basis and/or after any changes to the dietary orders occur to ensure adherence to Client #4's nutritional needs.</p> <p>The Delegating RN will continue to complete chart reviews monthly to ensure timely follow-up. Further, the Director of Health Services will establish and internal tracking system to ensure timely assessment and filing of intervention needed.</p>	9.17.10 Ongoing
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W 217	<p>Continued From page 3</p> <p>On August 27, 2010 at 1:48 p.m., a laboratory report dated February 2, 2010 revealed Client #4 had a low serum albumin of 2.6 gm. (reference range: 3.4 - 5.4 grams per deciliter (g/dL)). Upon review by the primary care physician (PCP) he noted, that the client's low serum albumin should be deferred to the nutritionist for follow-up. Continued record review revealed the next nutritional available for review was dated August 1, 2010. The August 1, 2010 nutrition review identified the February 2010 serum albumin of 2.6 as a "slight abnormality", however failed to note if it may be related to adequacy of dietary intake. Discussion with the QMRP on August 27, 2010 during the exit conference indicated that the client should have had a nutrition review in May 2010. At the time of the survey, however, there was no evidence that a nutritional review was available for May 2010, or that the August 2010 nutrition review included a follow-up after the PCP's recommendation to address the client's low serum albumin.</p>	W 217	<p>W217</p> <p>See response to W217 on page 3 of 15.</p>	
W 262	<p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE</p> <p>The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the committee designed to review, approve and monitor individual programs for management of inappropriate behavior and other programs that involve risks to client protection and rights were</p>	W 262	<p>W262</p> <p>See response to W262 on page 5 of 15.</p>	

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W 262	<p>Continued From page 4</p> <p>reviewed timely for two of four clients residing in the facility. (Clients #1 and #4)</p> <p>The finding includes:</p> <p>1. On August 26, 2010, at 9:10 a.m., a male staff was observed providing direct and close proximity supervision to Client #4. The staff indicated that he was the client's 1:1 staff and went with him to his day program. Interview with the qualified mental retardation professional (QMRP) on August 26, 2010 at approximately 9:30 a.m. revealed that Client #4 had a behavior support plan, which included 1:1 supervision from 6:00 a.m. until 11:00 p.m.</p> <p>On August 26, 2010 at 6:40 p.m., the nurse was observed to administer Valproic Acid 250 mg/5 ml syrup, 10 ml (500 g) and Zyprexa 20 mg tab by mouth to the client.</p> <p>Interview with the medication nurse on August 26, 2010 at 6:41 p.m. revealed the Client #4 was prescribed the medications for his behaviors. Record review on August 26, 2010 at 6:52 p.m. revealed the aforementioned Zyprexa and Valproic Acid were prescribed for behavior and as a mood stabilizer.</p> <p>Interview with the QMRP on August 27, 2010 at 10:37 a.m. indicated that the prescribed Valproic Acid and Zyprexa and the implementation of the BSP had been reviewed and approved by the facility's human rights committee (HRC). Further discussion with the QMRP revealed there should be minutes showing the HRC approval.</p> <p>On August 27, 2010 at 11.30 a.m., the record review revealed a behavior support plan (BSP</p>	W 262	<p>W262</p> <p>1. The BSP for Client #4 was reviewed and discussed on 07/06/10 during the HRC meeting on 7/6/10. The committee asked for specific changes in the plan prior to their approval. The revised BSP to include restrictive measures and psychotropic medications for Client #4 was approved on 08/20/10 using the agency's emergency review procedures. Signature sheet and minutes were unavailable at the time of review, but were in the master HRC meeting book at the time of the survey. In the future, signature sheets from emergency HRC meetings will be generated by the HRC chair and diled in the individual's record as well as the HRC master meeting book within 24 hours of the HRC meeting and/or approval.</p>	8.30.10- Ongoing	

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W 262	<p>Continued From page 5 and psychotropic medications) implemented for Client #4 dated July 5, 2010 and approval form signed by the HRC chairperson.</p> <p>On August 27, 2010 at 4:47 p.m., the available HRC minutes failed to provide discussion and signatures, as evidence of review and approval by the committee, which monitors programs designed to manage inappropriate behavior and other programs that may involve risks to client protection and rights. At the time of the survey, however, records were not provided to verify the HRC committee review and approval of Client #4's restrictive measures.</p> <p>2. Interview with staff on August 26, 2010, at 3:39 p.m., revealed that Client #1 was sometimes agitated during appointments, which prevented them from being successfully completed.</p> <p>Interview with the QMRP and the residential director on August 26, 2010, at 3:10 p.m. revealed that the client psychological assessment dated February 9, 2010, discussed the need for a desensitization to address his agitation/non-compliance during medical appointments/procedures.</p> <p>On August 26, 2010 at 3:42 p.m., the review of Client #1's aforementioned psychological assessment revealed a recommendation to implement a behavior support plan/desensitization plan, including the use of sedation to complete appointments, when prior attempts without sedation were unsuccessful.</p> <p>Continued record review on August 26, 2010 at 3:51 p.m., revealed Client #1 was prescribed sedation by the primary care physician on the</p>	W 262	<p>W 262 continued</p> <p>2. Delegating RN and QDDP will obtain evidence of informed consent from Client #1 and/or court appointed legal guardian prior to the administration of a sedative during medical appointments. This evidence of informed consent will be obtained prior to administering the sedative.</p> <p>Consent document will include potential risks versus the benefits involved in administering the prescribed medication. Once obtained, the provider will file evidence of informed consent in the Client's active medical records.</p> <p>On an ongoing basis, sedation will not be administered until consent is obtained. Additionally, the HRC will review /approve all programs to manage inappropriate behavior. Results/ meeting minutes will be filed in the individual's records.</p>	8.30.10- Ongoing
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W 262	<p>Continued From page 6 following dates for appointments:</p> <p>a. November 17, 2010 - Ativan 3 mg po 30 minutes prior to dental appointment.</p> <p>b. April 14, 2010 - Ativan 3 mg po 1/2 hour prior to ENT appointment x 1. (ENT appointment date April 16, 2010)</p> <p>c. June 30, 2010 - Ativan 2 mg po 1 hour prior to medical appointment. (for preop EKG and Chest x-ray on July 19, 2010)</p> <p>Interview with the QMRP on August 27, 2010 at approximately 4:45 p.m. indicated that the desensitization plan and the Ativan were reviewed and approved by the facility's human rights committee (HRC) prior to implementation and administration.</p> <p>On August 27, 2010 at 4:47 p.m., the available HRC minutes failed to provide discussion and signatures as evidence of review and approval by the committee, which monitors programs designed to manage inappropriate behavior and other programs that may involve risks to client protection and rights. At the time of the survey, however, records were not provided to verify the HRC committee review and approval of the restrictive measures (desensitization plan and sedation) used for Client #1.</p>	W 262	<p>W262</p> <p>See response to W262 on page 5 of 15.</p>	
W 322	<p>483.460(a)(3) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain preventive and general medical care.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure timely</p>	W 322		

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W 322	<p>Continued From page 7</p> <p>preventive health services, for two of the four clients residing in the facility. (Clients #2 and #4)</p> <p>The findings include:</p> <p>1. The review of an unusual incident reports (UIR) on August 26, 2010, at 2:27 p.m., revealed on July 13, 2010, at 6:30 a.m., Client #4 was observed bleeding from his right nostril. Further review of the UIR revealed the staff were unsuccessful in stopping the bleeding. Staff first attempted to reach the nurse, telephoned the residential director, then telephoned 911 for emergency medical services (EMS). EMS promptly responded to the telephone call, and at 7:20 a.m., transported Client #4 to the emergency room.</p> <p>Interview with the primary registered nurse (RN) on August 27, 2010, at 11:28 a.m., indicated that the cause of the client's nose bleed had not been determined, however, he had experienced no further nose bleeding after his ER visit.</p> <p>Review of the discharge summary on August 27, 2010, at 12:40 p.m. revealed the patient was assessed and treated for the urgent problem and recommended to have medical follow-up with the primary care physician (PCP) in two to four days. The client's primary diagnosis was "nose bleed", and he was discharged to the home in good condition. The discharge summary instructed that documents from the emergency room, including the list of studies performed during the visit be provided to the PCP during the follow-up visit.</p> <p>Record review on August 27, 2010, at 12:52 p.m., revealed Client #4 went for post- ER follow-up with the PCP on July 15, 2010. Review of the</p>	W 322	<p>W322</p> <p>1. a. PCP was notified of ER visit on 7.13.10. Individual was evaluated by Primary Care Physician on 7.15.10. However, the PCP failed to mention post ER visit evaluation in his notes. PCP has been notified of this omission and will make notification of the nose bleed in his monthly visit. In future the RN will review the PCP's documentation to ensure that it adequately documents that recommendations have been completed.</p> <p>2. b. The procedure scheduled for Client #2 was rescheduled by the doctor's office on more than one occasion. Only one of these rescheduled dates was documented. In the future, RN, Program Manager and QMRP will ensure that an appointment cancellation form is completed and filed in the medical record to explain any delay in treatment. The Nurse QMRP and Program Manager will monitor outstanding appointments and follow-up as necessary at monthly meetings.</p> <p>Additionally efforts to locate a new ENT will be explored by the Delegating RN with the hopes of obtaining an ENT that provides timely follow up appointments.</p>	9/21/10

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W 322	<p>Continued From page 8</p> <p>consultation report however revealed no information concerning the client's emergency room visit. At the time of the survey, there was no evidence the client had received the recommended follow-up after the ER visit for nose bleeding.</p> <p>2. The facility failed to ensure that Client #2 received timely treatment services to address his cerumen impaction, as evidenced below:</p> <p>Observation of Client #2 on August 26, 2010, at 6:27 p.m., revealed that he was administered Cipro HC otc suspension, 4 drops in his left ear, by the licensed practical nurse (LPN).</p> <p>On August 26, 2010, at 6:29 p.m., interview with the LPN revealed that Client #2 was prescribed the eardrops for seven days, during his August 23, 2010 clinic appointment for cerumen. Interview with the primary registered nurse (RN) on August 27, 2010 at 1:45 p.m. revealed an earlier follow-up appointment with the ear, nose and throat (ENT) appointment had been cancelled by the clinic. The verification of the cancellation(s), however, were not provided during the survey.</p> <p>Record review on August 27, 2010, at 1:37 p.m., revealed that on November 2, 2009, Client #2 went for his annual hearing test and ENT clinic assessment. The ENT clinic diagnosed the client with a severe bilateral ear wax impaction. Due to the client's uncooperative behavior, the clinic recommended that the client be sedated for cleaning or irrigation of his ears in a hospital setting. The clinic also recommended that the client be administered Debrox 6 drops to ear three times a day for one month, which was</p>	W 322	<p>W322</p> <p>See response to W322 on page 8 of 15.</p>	
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W 322	Continued From page 9 prescribed. On August 27, 2010, at 2:50 p.m., continued record review revealed that on August 23, 2010, Client #2 went for wax removal from his ears under local anesthesia. The consultation report revealed that both of the client's ears remained severely impacted with wax, with the left ear being more severely impacted than the right. He was recommended to be treated with Cipro Otic drops, 4 drops to left ear twice daily for 10 days. At the time of the survey, however, there was no evidence Client #2 had received timely treatment services for the removal of his cerumen impaction.	W 322	W322 See resp to W322 on page 8 of 15.	
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the provision of nursing services in accordance with the needs for three of four clients residing in the facility. (Clients #1, #2, and #4) The findings include: 1. The facility's nursing services failed to implement a system to ensure that Client #4's nasal spray was continuously available, as evidenced below: Observation of Client #4 on August 26, 2010 at 6:42 p.m., revealed that he was administered Desmopressin Acetate 10 mcg/0.1 ml, 1 spray into each nostril by the medication nurse.	W 331	W331 Reference response to W331 on page 11 of 15.	

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W 331	<p>Continued From page 10</p> <p>Record review on August 26, 2010 at 6:52 p.m. revealed a physician's order, with an initial date of April 23, 2010 for Desmopressin Acetate (50 doses of 10 mcg), 10 mcg/0.1 ml spray/pump, one spray into each nostril twice daily, for Client #4. This medication continued to be prescribed him.</p> <p>On August 27, 2010 at 12:16 p.m., interview with the designated registered nurse (RN) revealed Client #4 was prescribed the Desmopressin Acetate two times a day to aid in the management of his diagnosis of diabetes insipidus.</p> <p>Record review on August 27, 2010 at 12:27 p.m. revealed Client #4 had not received his Desmopressin Acetate nose drops eight times during July 2010, on the dates below:</p> <p>a. July 23, 24, and 25, 2010 at 7:00 a.m. b. July 17, 18, 23, 24, and 25, 2010 at 6:00 p.m.</p> <p>Review of the MAR medication comment section on August 27, 2010 at 12:39 p.m. revealed that the nasal drops were ordered on July 17, 2010, when the bottle was discovered empty.</p> <p>On August 27, 2010 at 12:20 p.m., the designated RN stated that the usual procedure was to order more medication from the pharmacy before the supply of the medication was completely used. Further discussion with the designated RN, however, confirmed that Client #4's nasal drops were not available on the aforementioned dates.</p> <p>At the time of the survey, there was no evidence that an effective system had been implemented to</p>	W331	<p>W331</p> <ol style="list-style-type: none"> 1. TME's will receive additional training on re-ordering medications prior to their depletion. This training will be conducted by the Delegating RN. The Delegating RN/Medication nurses/TME's will monitor medication supplies on a weekly basis and order/reorder medication as needed to ensure prescribed medication is continuously available. Any delay in medication deliver will be immediately reported to the Director of Health Services for further assistance/intervention. 2. Reference response to W104 #2 	9.20.10-Ongoing

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W 331	Continued From page 11 ensure that Client #4's nasal drops were available continuously during the aforementioned period.	W 331		
W 362	<p>2. The facility's nursing services failed to coordinate services for timely review the medication regimens of Clients #1 and #2. [See W362]</p> <p>483.460(j)(1) DRUG REGIMEN REVIEW</p> <p>A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that drug regimen reviews were conducted at least quarterly for two of two clients in the sample. (Clients #1 and #2)</p> <p>The findings include:</p> <p>Interview with the primary registered nurse (RN) on August 27, 2010, at 6:02 p.m., revealed the pharmacist come to the facility every three months to review of the clients' medications.</p> <p>Record review on August 27, 2010 at 11:39 a.m. and 12:35 p.m. respectively revealed documentation of pharmacy reviews for the seven month period between October 13, 2009 and April 30, 2010 for Clients #1 and #2 respectively.</p> <p>At the time of the survey, the facility failed to ensure medication regimens reviews were conducted quarterly as required, to obtain relevant input from the pharmacist.</p>	W 362	<p>W362</p> <p>See response to W104 #2.</p>	
W 368	483.460(k)(1) DRUG ADMINISTRATION	W 368		

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W 368	<p>Continued From page 12</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all drugs were administered in compliance with the physician's orders for one four clients residing in the facility. (Client #4)</p> <p>The finding includes:</p> <p>[Cross refer to W331] Observation of Client #4 on August 26, 2010 at 6:42 p.m., revealed that he was administered Desmopressin Acetate 10 mcg/0.1 ml, 1 spray into each nostril.</p> <p>On August 26, 2010 at 6:46 p.m., interview with the medication nurse, (licensed practical nurse) revealed Client #4 was prescribed the Desmopressin Acetate two times a day. The review of the medication record (MAR) at 6:48 p.m. confirmed that this medication was prescribed for the client.</p> <p>Record review on August 27, 2010 at 12:27 p.m., failed to evidence, however, that Client #4 was administered Desmopressin Acetate nose drops, as prescribed eight times during July 2010, on the dates below:</p> <p>a. July 23, 24, and 25, 2010 at 7:00 a.m. b. July 17, 18, 23, 24, and 25, 2010 at 6:00 p.m.</p>	W 368	<p>W368</p> <p>Reference response to W331 #1.</p>	
W 418	<p>483.470(b)(4)(ii) CLIENT BEDROOMS</p> <p>The facility must provide each client with a clean, comfortable mattress.</p>	W 418		

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W 418	Continued From page 13 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that clients in the facility was provided with a comfortable mattress for one of the four clients residing in the facility. (Client #3) The finding include: On August 27, 2010, beginning at 3:05 p.m., the qualified mental retardation professional (QMRP) accompanied the surveyor through the facility to conduct environmental observations. At 3:08 p.m., multiple palpable springs were felt underneath the vinyl covering on Client #3's bed mattress, when it was touched. On August 27, 2010, at approximately 4:00 p.m., interview with the QMRP and the residential director indicated that they thought that Client #3's mattress had been replaced during the past year. At the time of the survey, however, there was no evidence that the mattress currently observed on Client #3's bed would ensure his comfort when in bed.	W 418	W418 Reference response to W104 #1.	
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 prescribed for one of four clients residing in the facility. (Client #4) The findings include:	W 474	W 474 See response to W474 on page 15 of 15.	

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W 474	<p>Continued From page 14</p> <p>Observation on the evening of August 26, 2010 at 6:45 p.m., revealed Client #4 was served ground turkey pattie, baked potato, and chopped salad for dinner.</p> <p>On August 26, 2010 at 6:57 p.m., interview with the staff who prepared and served the meal indicated the client was on a ground diet and was not supposed to have salt in his food.</p> <p>Record review on August 27, 2010 at 9:47 a.m. revealed, Client #4's physician's order for a "Low Sodium, Ground Texture Diet" Instructions on the dietary list dated August 1, 2010 revealed, "Chopped texture is about dime sized...Ground Texture - resembles chunky ground beef or corn beef hash."</p> <p>On August 26, 2010 at 7:10 p.m., the staff and the Qualified Mental Retardation Professional (QMRP) acknowledged that Client #4's tossed salad had not been provided in the prescribed ground texture. At the time of the survey, there was no evidence the facility had ensure that Client #4 receive his food in a ground textures at all times as prescribed.</p>	W 474	<p>W 474</p> <p>Delegating RN and Nutritionist will provide staff training on effectively implementing Client#2's therapeutic diet. Refresher training will be provided to staff on a quarterly basis and/or after any changes to the dietary orders occur to ensure adherence to Client #4's nutritional needs.</p> <p>The RN QDDP and Program Manager will conduct on site moitoring during mealtimes to ensure that meals compliant with PCP/Nutritionist recommendations</p>	9/17/10- Ongoing
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1000	INITIAL COMMENTS An relicensure survey was conducted from August 26, 2010, through August 27, 2010. A random sampling of two residents was selected from a population of four males with various levels of mental retardation and disabilities. The findings of the survey were based on observations at the group home and two day programs, interviews with residents and staff, and the review of clinical and administrative records, including incident reports.	1000		
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 Group Home for Mentally Retarded Persons (GHMRP) failed to ensure the interior and exterior of the facility were maintained in a safe and attractive manner, for four of four residents. (Residents #1, #2, #3, and #4) The findings include: On August 27, 2010 beginning at 3:05 p.m., the qualified mental retardation professional (QMRP) accompanied the surveyor through the GHMRP to conduct environmental observations. The following concerns were identified: 1. Interior:	1090	1090 1. a.. Mattress for Client #3 will be replaced. b. The ceramic tiles from the platform to which the commode have been secured. c. A request will be submitted to reupholster or replace the leather chair in the family room. d. A maintenance request has been submitted to replace the control required to open and close the right bathroom window in the large bathroom. Repairs will be completed by 10.1.10 e. The bulbs in the light fixture above the sink in the hallway have been replaced.	9.24.10 10.1.10 9.15.10 10.1.10 8.30.10

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

TITLE

(X6) DATE

STATE FORM

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If continuation sheet 1 of 14

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I 090	Continued From page 1 a. When touched, multiple palpable springs were felt underneath the vinyl covering on Resident #3's bed mattress. b. The ceramic tiles were detached from the platform, to which the commode was secured in the large bathroom. c. The left padded armrest was detached from the leather recliner in the family room. This caused the foam to be exposed underneath the armrest. The staff indicated that Resident #3 caused the damaged to the armrest on the recliner, when he held onto it and rocked from side to side. d. The control required to open and close the right bathroom window was not available. This window was located in the large bathroom. e. Three of the four sockets in the light fixture, located above the hallway sink, lacked operable bulbs. f. The bottom shelf of lower kitchen cabinets contained operational soil. g. The carpet on the floor of the walk-in closet was soiled. h. Uncovered toothbrushes were observed in the hygiene kits of the residents. 2. Exterior: a. The downspout attached to the left rear corner of the GHMRP was bent near the bottom, creating a potential for slow drainage of water from the attached gutter. The residential director indicated that the damage was caused when it	I 090	f. The lower kitchen cabinets have been cleaned. g. The carpet on the floor of the walk-in closet has been scheduled for steam cleaning. h. The hygiene items have been placed/stored appropriately in the hygiene kits. Program Manager met with staff and provided a retraining on sanitary storing of hygiene items. 2. a. The QDDP/Program Manager has submitted a request for the repair/replacement of the downspout attached to the left rear corner of the house. b. The QDDP/Program Manager has submitted a request for repair of the cracked and uneven areas of pavement on the walkway around the steps at the front entrance. 1 a-h and 2 a&b. The QDDP/Program Manager will complete weekly environmental check, document findings and submit requests for maintenances as applicable and in a timely manner based upon findings. The Environmental Checklist will be forwarded to the Director of Programs for further follow up. The Director of Programs will conduct random environmental quality checks to ensure compliance.	8.30.10 9.9.10 9.9.10 9.9.10 9.9.10 Ongoing

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I 090	Continued From page 2 was struck by the trash truck. b. Cracked and uneven areas of pavement were observed on the walkway around the steps at the front entrance of the GHMRP, which created a potential trip hazard.	I 090		
I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on interview, and record review, the GHMRP failed to ensure that the Qualified Mental Retardation Professional (QMRP) coordinated services for two of four individuals residing in the GHMRP. (Residents #2 and #4) The findings include: 1. The QMRP failed to coordinate services to ensure that Resident #2 received a timely nutritional assessment of an abnormal laboratory finding, as recommended by the primary care physician. [See W217] 2. The QMRP failed to ensure each staff was effectively trained for the accurate implementation of Resident #4's therapeutic diet. [See W474]	I 180	I180 1. The Delegating RN has scheduled a reassessment of Client #2's nutritional needs including but not limited to, texture modification and use of condiments as appropriate. Nutrition assessment will include a review of the lab results and will specify whether abnormality is related to inadequate nutritional intake as well as any recommendations necessary to improve laboratory results for Client #2. 2. Delegating RN and Nutritionist will provide staff training on effectively implementing Client#2's therapeutic diet. Refresher training will be provided to staff on a quarterly basis and/or after any changes to the dietary orders occur to ensure adherence to Client #4's nutritional needs. The Delegating RN will continue to complete chart reviews monthly to ensure timely follow-up. Further, the Director of Health Services will establish and internal tracking system to ensure timely assessment and filing of intervention needed.	9/17/10- Ongoing
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been	I 206		

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1 206	<p>Continued From page 3</p> <p>performed and that the employee ' s health status would allow him or her to perform the required duties.</p> <p>This Statute is not met as evidenced by: Based on interview and record, the group home for mentally retarded person's (GHMRP) failed to obtain an annual health screening, as required by this section for two direct support personal and three consultants.</p> <p>The findings include:</p> <p>On August 26, 2010, at approximately 9:30 a.m., the qualified mental retardation professional (QMRP) was requested to obtain various records from the administrative office for review during the survey.</p> <p>On August 27, 2010, at 4:08 p.m. and 4:50 p.m., respectively, the review of health certificates revealed they were expired for two direct support personnel, DSP #1 and DSP #2, and three consultants (C1,C2, and C3) providing services to the residents in the group home. A discussion with the QMRP during these times confirmed that the administrative office had not provided current health certificates for the aforementioned staff and consultants.</p>	1 206	<p>1 206</p> <p>Outstanding Annual Health Screening Certificates will be obtained and placed on file for all staff and consultants. All staff not in compliance with required health certificates/inventories by the indicated completion date will be suspended until compliance is met. To monitor compliance on a ongoing basis, Human Resources will develop and implement a training compliance checklist to be utilized by QMRP/Residence Managers and reviewed with staff. All new employees will be required to present a valid health certificate prior to the first day of employment.</p> <p>In conjunction with Health Services and Human Resources a training compliance checklist will be implemented to monitor compliance. All consultants with outstanding health certificates/inventories will not be employed until compliance is made. The QDDP/Residence Manager will review with Human Resources residential staff personnel files quarterly for compliance.</p>	9.30.10
1 401	<p>3520.3 PROFESSION SERVICES: GENERAL PROVISIONS</p> <p>Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent</p>	1 401		

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I 401	<p>Continued From page 4</p> <p>deterioration or further loss of function by the resident.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure professional services 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 three of the four residents in the GHMRP.(Residents #1, #2 and #4)</p> <p>The findings include:</p> <p>1. The GHMRP's nursing services failed to ensure Resident #4's nasal spray was continuously available, as evidenced below:</p> <p>Observation of Resident #4 on August 26, 2010, at 6:42 p.m., revealed that he was administered Desmopressin Acetate 10 mcg/0.1 ml, 1 spray into each nostril by the medication nurse.</p> <p>Record review on August 26, 2010, at 6:52 p.m. revealed a physician's order, with an initial date of April 23, 2010 for Desmopressin Acetate (50 doses of 10 mcg), 10 mcg/0.1 ml spray/pump, one spray into each nostril twice daily, for Resident #4. This medication continued to be prescribed him.</p> <p>On August 27, 2010, at 12:16 p.m., interview with the designated registered nurse (RN) revealed Resident #4 was prescribed the Desmopressin Acetate two times a day to aid in the management of his diagnosis of diabetes insipidus.</p> <p>Record review on August 27, 2010, at 12:27 p.m.,</p>	I 401	<p>I 401</p> <p>1. TME's will receive additional training on re-ordering medications prior to their depletion. This training will be conducted by the Delegating RN. The Delegating RN/Medication nurses/TME's will monitor medication supplies on a weekly basis and order/reorder medication as needed to ensure prescribed medication is continuously available. Any delay in medication delivery will be immediately reported to the Director of Health Services for further assistance/intervention.</p>	9.20.10

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I 401	<p>Continued From page 5</p> <p>revealed Resident #4 had not received his Desmopressin Acetate nose drops eight times during July 2010, on the dates below:</p> <p>a. July 23, 24, and 25, 2010 at 7:00 a.m. b. July 17, 18, 23, 24, and 25, 2010 at 6:00 p.m.</p> <p>Review of the MAR medication comment section on August 27, 2010, at 12:39 p.m., revealed that the nasal drops were ordered on July 17, 2010, when the bottle was discovered empty.</p> <p>On August 27, 2010, at 12:20 p.m., the designated RN stated that the usual procedure was to order more medication from the pharmacy before the supply of the medication was completely used. Further discussion with the designated RN, however, confirmed that Resident #4's nasal drops were not available on the aforementioned dates.</p> <p>At the time of the survey, there was no evidence that an effective system had been implemented to ensure that Resident #4's nasal drops were available continuously during the aforementioned period.</p> <p>2. The GHMRP failed to ensure that drug regimen reviews were conducted at least quarterly for two of two residents in the sample. (Residents #1 and #2), as evidenced below:</p> <p>Interview with the primary registered nurse (RN) on August 27, 2010, at 6:02 p.m., revealed the pharmacist come to the GHMRP every three months to review of the residents' medications.</p> <p>Record review on August 27, 2010, at 11:39 a.m. and 12:35 p.m. respectively, revealed documentation of pharmacy reviews for the</p>	I 401	<p>I 401 continued</p> <p>2. The Pharmacist conducted reviews for client #1 and client #2 on 10/13/09, 01/25/10, 4/30/10 and 7/27/10 respectively. The related reports have been filed in their current medical records. On an ongoing basis the reports will be filed in the client's active medical records immediately following review by the Primary Care Physician and Delegating RN.</p>	8.31.10-ongoing

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NAME OF PROVIDER OR SUPPLIER MY OWN PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 4141 ANACOSTIA AVE, NE WASHINGTON, DC 20019		
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I 401	<p>Continued From page 6</p> <p>seven month period between October 13, 2009 and April 30, 2010 for Residents #1 and #2 respectively.</p> <p>At the time of the survey, the GHMRP failed to ensure medication regimens reviews were conducted quarterly as required, to obtain relevant input from the pharmacist.</p> <p>3. The GHMRP failed to ensure timely preventive health services, for two of the four residents residing in the GHMRP. (Residents #2 and #4), as evidenced below:</p> <p>a. The review of an unusual incident reports (UIR) on August 26, 2010, at 2:27 p.m., revealed on July 13, 2010 at 6:30 a.m., Resident #4 was observed bleeding from his right nostril. Further review of the UIR revealed the staff were unsuccessful in stopping the bleeding. Staff first attempted to reach the nurse, telephoned the residential director, then telephoned 911 for emergency medical services (EMS). EMS promptly responded to the telephone call, and at 7:20 a.m., transported Resident #4 to the emergency room.</p> <p>Interview with the primary registered nurse (RN) on August 27, 2010, at 11:28 a.m. indicated that the cause of the resident's nose bleed had not been determined, however, he had experienced no further nose bleeding after his ER visit.</p> <p>Review of the discharge summary on August 27, 2010, at 12:40 p.m. revealed the patient was assessed and treated for the urgent problem and recommended to have medical follow-up with the primary care physician (PCP) in two to four days. The resident's primary diagnosis was "nose bleed", and he was discharged to the home in</p>	I 401	See response to I 401 # 3 on page 8 of 14.		

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I 401	<p>Continued From page 7</p> <p>good condition. The discharge summary instructed that documents from the emergency room, including the list of studies performed during the visit be provided to the PCP during the follow-up visit.</p> <p>Record review on August 27, 2010, at 12:52 p.m., revealed Resident #4 went for post- ER follow-up with the PCP on July 15, 2010. Review of the consultation report however revealed no information concerning the resident's emergency room visit. At the time of the survey, there was no evidence the resident had received the recommended follow-up after the ER visit for nose bleeding.</p> <p>b. The GHMRP failed to ensure that Resident #2 received timely treatment services to address his cerumen impaction, as evidenced below:</p> <p>Observation of Resident #2 on August 26, 2010, at 6:27 p.m., revealed that he was administered Cipro HC otic suspension, 4 drops in his left ear, by the licensed practical nurse (LPN).</p> <p>On August 26, 2010, at 6:29 p.m., interview with the LPN revealed that Resident #2 was prescribed the eardrops for seven days, during his August 23, 2010 clinic appointment for cerumen. Interview with the primary registered nurse (RN) on August 27, 2010 at 1:45 p.m. revealed an earlier follow-up appointment with the ear, nose and throat (ENT) appointment had been cancelled by the clinic. The verification of the cancellation(s), however, were not provided during the survey.</p> <p>Record review on August 27, 2010, at 1:37 p.m., revealed that on November 2, 2009, Resident #2 went for his annual hearing test and ENT clinic</p>	I 401	<p>I401</p> <p>3a. PCP was notified of ER visit on 7.13.10. Individual was evaluated by Primary Care Physician on 7.15.10. However, the PCP failed to mention post ER visit evaluation in his notes. PCP has been notified of this omission and will make notification of the nose bleed in his monthly visit. In future the RN will review the PCP's documentation to ensure that it adequately documents that recommendations have been completed.</p> <p>3b. The procedure scheduled for Client #2 was rescheduled by the doctor's office on more than one occasion. Only one of these rescheduled dates was documented. In the future, RN, Program Manager and QMRP will ensure that an appointment cancellation form is completed and filed in the medical record to explain any delay in treatment. The Nurse QMRP and Program Manager will monitor outstanding appointments and follow-up as necessary at monthly meetings.</p> <p>Additionally efforts to locate a new ENT will be explored by the Delegating RN with the hopes of obtaining an ENT that provides timely follow up appointments.</p>	9/21/10

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I 401	<p>Continued From page 8</p> <p>assessment. The ENT clinic diagnosed the resident with a severe bilateral ear wax impaction. Due to the resident's uncooperative behavior, the clinic recommended that the resident be sedated for cleaning or irrigation of his ears in a hospital setting. The clinic also recommended that the resident be administered Debrox 6 drops to ear three times a day for one month, which was prescribed.</p> <p>On August 27, 2010, at 2:50 p.m., continued record review revealed that on August 23, 2010, Resident #2 went for wax removal from his ears under local anesthesia. The consultation report revealed that both of the resident's ears remained severely impacted with wax, with the left ear being more severely impacted than the right. He was recommended to be treated with Cipro Otic drops, 4 drops to left ear twice daily for 10 days. At the time of the survey, however, there was no evidence Resident #2 had received timely treatment services for the removal of his cerumen impaction:</p> <p>4. The GHMRP failed to ensure a comprehensive assessment of the nutritional needs of one of two residents in the sample. (Resident #2), as evidenced below:</p> <p>The GHMRP failed to ensure a comprehensive reassessment of Resident #2's nutritional needs a, as evidenced below:</p> <p>On August 26, 2010 at 11:48 a.m., Resident #2 was observed to be edentulous as he ate peas from his plate at his day program. At 11:57 a.m., he requested that staff put ketchup on the chopped meat pattie he had been served. He continued to eat until 12:28 p.m., when he finished his meal.</p>	I 401		

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I 401	Continued From page 10 2.6 as a "slight abnormality", however failed to note if it may be related to adequacy of dietary intake. Discussion with the QMRP on August 27, 2010 during the exit conference indicated that the resident should have had a nutrition review in May 2010. At the time of the survey, however, there was no evidence that a nutritional review was available for May 2010, or that the August 2010 nutrition review included a follow-up after the PCP's recommendation to address the resident's low serum albumin.	I 401		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure 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. This Statute is not met as evidenced by: Each GHMRP residence director shall ensure 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. The findings include: The facility failed to ensure the committee designed to review, approve and monitor individual programs for management of inappropriate behavior and other programs that involve risks to resident protection and rights were reviewed timely for Residents #1 and #4, as evidenced below: 1. On August 26, 2010 at 9:10 a.m. a male staff was observed providing direct and close proximity	I 500	See response to I 500 on page 12 of 14.	

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I 500	<p>Continued From page 11</p> <p>supervision to Resident #4. The staff indicated that he was the resident's 1:1 staff and went with him to his day program. Interview with the qualified mental retardation professional (QMRP) on August 26, 2010 at approximately 9:30 a.m. revealed that Resident #4 had a behavior support plan, which included 1:1 supervision from 6:00 a.m. until 11:00 p.m.</p> <p>On August 26, 2010 at 6:40 p.m., the nurse was observed to administer Valproic Acid 250 mg/5 ml syrup, 10 ml (500 g) and Zyprexa 20 mg tab by mouth to the resident.</p> <p>Interview with the medication nurse on August 26, 2010 at 6:41 p.m. revealed the Resident #4 was prescribed the medications for his behaviors. Record review on August 26, 2010 at 6:52 p.m. revealed the aforementioned Zyprexa and Valproic Acid were prescribed for behavior and as a mood stabilizer.</p> <p>Interview with the QMRP on August 27, 2010 at 10:37 a.m. indicated that the prescribed Valproic Acid and Zyprexa and the implementation of the BSP had been reviewed and approved by the facility's human rights committee (HRC). Further discussion with the QMRP revealed there should be minutes showing the HRC approval.</p> <p>On August 27, 2010 at 11.30 a.m., the record review revealed a behavior support plan dated July 5, 2010 and approval form signed by the HRC chairperson. At the time of the survey, however, records were not provided to verify the HRC committee review and approval of the restrictive measures (BSP and psychotropic medications) implemented for Resident #4.</p> <p>On August 27, 2010 at 4:47 p.m., the available</p>	I 500	<p>I500</p> <p>The BSP for Client #4 was reviewed and discussed on 07/06/10 during the HRC meeting on 7/6/10. The committee asked for specific changes in the plan prior to their approval. The revised BSP to include restrictive measures and psychotropic medications for Client #4 was approved on 08/20/10 using the agency's emergency review procedures. Signature sheet and minutes were unavailable at the time of review, but were in the master HRC meeting book at the time of the survey. In the future, signature sheets from emergency HRC meetings will be generated by the HRC chair and diled in the individual's record as well as the HRC master meeting book within 24 hours of the HRC meeting and/or approval.</p>	8.30.10-Ongoing

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I 500	<p>Continued From page 12</p> <p>HRC minutes failed to provide discussion and signatures, as evidence of review and approval by the committee, which monitors programs designed to manage inappropriate behavior and other programs that may involve risks to resident protection and rights. At the time of the survey, however, records were not provided to verify the HRC committee review and approval of Resident #4's restrictive measures.</p> <p>2. Interview with staff on August 26, 2010 at 3:39 p.m., revealed that Resident #1 was sometimes agitated during appointments, which prevented them from being successfully completed.</p> <p>Interview with the QMRP and the residential director on August 26, 2010 at 3:10 p.m. revealed that the resident psychological assessment dated February 9, 2010 discussed the need for a desensitization to address his agitation/non-compliance during medical appointments/procedures.</p> <p>On August 26, 2010 at 3:42 p.m., the review of Resident #1's aforementioned psychological assessment revealed a recommendation to implement a behavior support plan/desensitization plan, including the use of sedation to complete appointments, when prior attempts without sedation were unsuccessful.</p> <p>Continued record review on August 26, 2010 at 3:51 p.m., revealed Resident #1 was prescribed sedation by the primary care physician on the following dates for appointments:</p> <p>a. November 17, 2010 - Ativan 3 mg po 30 minutes prior to dental appointment b. April 14, 2010 - Ativan 3 mg po 1/2 hour prior to ENT appointment x 1. (ENT appointment date</p>	I 500	<p>I 500 continued</p> <p>2 Delegating RN and QDDP will obtain evidence of informed consent from Client #1 and/or court appointed legal guardian prior to the administration of a sedative during medical appointments. This evidence of informed consent will be obtained prior to administering the sedative.</p> <p>Consent document will include potential risks versus the benefits involved in administering the prescribed medication. Once obtained, the provider will file evidence of informed consent in the Client's active medical records.</p> <p>On an ongoing basis, sedation will not be administered until consent is obtained. Additionally, the HRC will review /approve all programs to manage inappropriate behavior. Results/ meeting minutes will be filed in the individual's records.</p>	8.30.10-Ongoing

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I 500	Continued From page 13 April 16, 2010) c. June 30, 2010 - Ativan 2 mg po 1 hour prior to medical appointment. (for preoperative EKG and Chest x-ray on July 19, 2010) Interview with the QMRP on August 27, 2010 at approximately 4:45 p.m. indicated that the desensitization plan and the Ativan were reviewed and approved by the facility's human rights committee (HRC) prior to implementation and administration. On August 27, 2010 at 4:47 p.m., the available HRC minutes failed to provide discussion and signatures as evidence of review and approval by the committee, which monitors programs designed to manage inappropriate behavior and other programs that may involve risks to resident protection and rights. At the time of the survey, however, records were not provided to verify the HRC committee review and approval of the restrictive measures (desensitization plan and sedation) used for Resident #1.	I 500	See 500 #2 on page 13 of 14.		

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I 401	<p>Continued From page 9</p> <p>On August 26, 2010, at 6:45 p.m., a group home staff asked Resident #2 if he wanted ketchup on his turkey burger at the beginning of his meal. The resident responded "yes". At 7:10 p.m., he was observed to have eaten approximately one half of his chopped turkey burger, chopped vegetable salad, and baked potato. He again responded, "yes" when staff asked him if he was finished eating his meal.</p> <p>Interview staff on August 26, 2010 at the day program and the group home indicated that Resident #2 usually ate most of his food, if it was something that he liked. Staff in both setting agreed that the resident liked ketchup on his meat.</p> <p>Record on review on August 27, 2010, at 1:32 p.m. revealed the resident was completely edentulous and did not wear dentures. Continued record review revealed a physician's order for a Low Fat/Low Cholesterol/No Added Salt, Bite Size Texture Diet. The review of the Dietary Instruction List dated August 1, 2010 provided by the nutritionist revealed, - Bite Size Texture - Sized between quarter and nickel".</p> <p>On August 27, 2010 at 1:48 p.m., a laboratory report dated February 2, 2010 revealed Resident #4 had a low serum albumin of 2.6 gm. (reference range: 3.4 - 5.4 grams per deciliter (g/dL)).</p> <p>Upon review by the primary care physician (PCP) he noted, that the resident's low serum albumin should be deferred to the nutritionist for follow-up. Continued record review revealed the next nutritional available for review was dated August 1, 2010. The August 1, 2010 nutrition review identified the February 2010 serum albumin of</p>	I 401	<p>I401 continued</p> <p>4. The Delegating RN has scheduled a reassessment of Client #2's nutritional needs including but not limited to, texture modification and use of condiments as appropriate. Nutrition assessment will include a review of the lab results and will specify whether abnormality is related to inadequate nutritional intake as well as any recommendations necessary to improve laboratory results for Client #2.</p> <p>Delegating RN and Nutritionist will provide staff training on effectively implementing Client#2's therapeutic diet. Refresher training will be provided to staff on a quarterly basis and/or after any changes to the dietary orders occur to ensure adherence to Client #4's nutritional needs.</p> <p>The Delegating RN will continue to complete chart reviews monthly to ensure timely follow-up. Further, the Director of Health Services will establish and internal tracking system to ensure timely assessment and filing of intervention needed.</p>	9/17/10- Ongoing