

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/13/2010
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH CARE RESOURCES	STREET ADDRESS, CITY, STATE, ZIP CODE 2008 RITTENHOUSE ST, NW WASHINGTON, DC 20016
--	--

(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
--------------------	--	---------------	---	--------------------

1 000 INITIAL COMMENTS 1 000

A licensure survey was conducted from July 12, 2010, through July 13, 2010. A sampling of two residents was selected from a residential population of four women with various degrees of intellectual and/or developmental disabilities.

Received 7/30/10
GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION
825 NORTH CAPITOL ST., N.E., 2ND FLOOR
WASHINGTON, D.C. 20002

1 056 3502.14 MEAL SERVICE / DINING AREAS 1 056

Each GHMRP shall train staff in the storage, preparation and serving of food, the cleaning and care of equipment, and food preparation in order to maintain sanitary conditions at all times.

This Statute is not met as evidenced by: Based on staff interview and record review, the group home for mentally retarded persons (GHMRP) failed to ensure staff who prepared meals received their food handler's certification for six of the seven staff records reviewed. (Staff #1, #2, #3, #4, #6, and #7)

All staff shall be trained by August 15, 2010

The finding includes:

Interview with the Program Manager (PM) and review of seven personnel files on July 12, 2010 at approximately 10:30 a.m., revealed six of the seven staff who was assigned to prepare food for the home did not have a valid food handler's certification on file. (Staff #1, #2, #3, #4, #6 and #7)

All staff will receive training

By August 15, 2010

The Program Manager confirmed the findings the on July 13, 2010 a approximately 11:55 a.m.

1 090 3504.1 HOUSEKEEPING 1 090

The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive,

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]*

DATE FORM 580311

TITLE *Provider* (X6) DATE *7/29/10*

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/19/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HEALTH CARE RESOURCES	STREET ADDRESS, CITY, STATE, ZIP CODE 2008 RITTENHOUSE ST, NW WASHINGTON, DC 20015
---	--

(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

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 maintain the interior and exterior of the facility in a safe, clean, orderly, attractive, and sanitary manner for four of four residents in the facility. (Resident #1, #2, #3 and #4)

The findings include:

Observation and interview with the facility's Program Manager (PM) on July 12, 2010, beginning at 2:00 p.m. revealed the following:

Interior:

1. The rugs in the living room and dining room was frayed on the ends, which might cause a tripping hazard.
2. There was chipping and peeling paint on the living room wall near the thermostat.
3. The painted surface on the toilet seat in the second floor bathroom was worn down to the bare wood.

During a face-to-face interview on July 13, 2010, at approximately 11:45 am, the program manager acknowledged the findings.

1090

1. Rugs will be repaired by August 15, 2010
2. The chipping and peeling paint will be repaired by August 15, 2010.
3. New Toilet seat replaced by August 15, 2010

1206 3509.6 PERSONNEL POLICIES

1206

Each employee, prior to employment and annually thereafter, shall provide a physician's

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/13/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HEALTH CARE RESOURCES	STREET ADDRESS, CITY, STATE, ZIP CODE 2806 RITTENHOUSE ST, NW WASHINGTON, DC 20015
---	--

(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
--------------------	--	---------------	---	--------------------

I 206 Continued From page 2

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 mentally retarded persons (GHMRP) failed to ensure each staff and consultant had a current health certificate, for two of the seven direct care staff (Staff #5, and #6), and two of four consultants (registered nurse and licensed practical nurse #4).

The finding includes:

Interview with the Program Manager (PM), and review of the personnel records on July 12, 2010, revealed the GHMRP failed to provide evidence that current health certificates were on file for two of the seven staff (Staff #5, and #6) and two of the four consultants (registered nurse and licensed practical nurse).

The Program Manager confirmed the findings on July 13, 2010, at approximately 11:50 a.m.

I 206

All health certificates are on file and current. HRC will ensure that health certificates remain current in employee file by incorporating a system in HCR monthly audit by August 15, 2010

I 222 3510.3 STAFF TRAINING

There shall be continuous, ongoing in-service training programs scheduled for all personnel.

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 continuing training program for nursing personnel on

I 222

-The nursing team was terminated and a Protocol put in place to review the MAR weekly and the end of each month. Schedule Training to be held on August 15, 2010.

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/13/2010
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEALTH CARE RESOURCES	STREET ADDRESS, CITY, STATE, ZIP CODE 2806 RITTENHOUSE ST, NW WASHINGTON, DC 20015
--	--

(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
--------------------	--	---------------	---	--------------------

1222 Continued From page 3 1222

medication administration, for four of four residents in the facility. (Residents #1, #2, #3 and #4)

The findings include:

Interview with the program manager on July 12, 2010 at 8:40 a.m. revealed there had been an unusual incident on 3/9/10 when Resident #1 did not receive her medication as prescribed prior to her colonoscopy on that date. The review of Resident #1's medication administration record (MAR) on July 12, 2010, at 2:40 p.m., confirmed that this medication error had occurred.

Continued review of Resident #1's March 2010 MAR on July 12, 2010, at 2:30 p.m., however, revealed missing nursing initials on the front of the MAR to verify that the resident had received Clonazepam 2 mg on those days. A closer review of the March 2010 MAR revealed that the nurse's initials were missing for 11 days in March (3, 4, 5, 6, 7, 13, 14, 20, 21, 26, 27, and 31), 2010. The back of the MAR also revealed no documented reason or explanation of why the resident did not receive the Clonazepam 2 mg on those dates.

Interview with the program manager on July 12, 2010, at 2:45 p.m., revealed that a similar incident had occurred in June 2009, wherein medication had been punched from the blister pack and the MAR was not signed. According to the program manager, an investigation had been completed and corrective measures recommended. Interview with the administrator during the exit conference on July 13, 2010, at 12:45 p.m., revealed that the staff involved had been reprimanded and that additional training on medication administration had been required and conducted.

The RN will review Policy and Procedure with the nurses and train on the pre-procedure management by August 15, 2010

Incidents report submitted
Nursing team terminated.
Incident reported to Board of Nursing. System put in place to monitor MAR by August 15, 2010.

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MFD12-0061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) BASE SURVEY COMPLETED 07/13/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HEALTH CARE RESOURCES	STREET ADDRESS, CITY, STATE, ZIP CODE 2608 RITTENHOUSE ST, NW WASHINGTON, DC 20016
---	--

(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
--------------------	--	---------------	---	--------------------

I 222 Continued From page 4

Record review revealed a sign sheet dated 4/30/10 for "Medication Administration Policy." There was no evidence, however, that the training had been provided timely after the June 2009 incident to prevent the occurrence of similar incidents involving medication documentation and/or errors.

I 222

The new RN will train all Nurses on Medication Administration Policy By August 15, 2010

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 interview and record review, the group home for mentally retarded persons (GHMRP) failed to ensure professional services were provided in accordance with the needs of two of four residents in the facility. (Residents #1 and #3)

The findings include:

1. The GHMRP failed to ensure Resident #1 received timely medical follow-up, as recommended during an emergency room evaluation for dehydration and a tooth ache, as evidenced below:

Interview with the program manager on July 12, 2010, at 8:40 a.m., revealed that Resident #1 was evaluated at the emergency room (ER) on February 2, 2010 for a swollen face. An unusual incident dated February 2, 2010, documented the

I 401

System will be put in place for medical appointments to be scheduled before leaving the doctors office if at all possible. If for any reason unable to schedule the appointment the LPN follows up with documentation-by August 15, 2010.

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/13/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HEALTH CARE RESOURCES	STREET ADDRESS, CITY, STATE, ZIP CODE 2606 RITTENHOUSE ST, NW WASHINGTON, DC 20015
---	--

(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
--------------------	--	---------------	---	--------------------

I 401 Continued From page 5

I 401

reason for the ER visit was a swollen face and complaint of toothache. The ER diagnosed the resident with dehydration (primary) and a periodontal abscess (secondary). She was then prescribed Penicillin V K. 500 mg 4 times a day. The ER recommended that the resident have follow-up with the primary care physician PCP in 2-4 days.

On July 12, 2010, at 3:25 p.m., a nursing progress note dated February 5, 2010 revealed, the resident did not see the physician because the accompanying staff had to pick up the other individuals. There was no evidence the resident was seen timely by the PCP, as recommended by the ER to further monitor the status diagnoses.

2. The facility failed to ensure an effective system for the timely procurement of prescribed medications for Resident #1 as evidenced below:

On July 12, 2010, at 2:17 p.m., record review revealed a dental consultation report dated February 23, 2010. The diagnosis was "periodontally involved tooth #19. (non-restorable tooth #19 needs removal). A new order was given for Amoxicillin 500 mg BID x 20 tabs and Motrin 600 mg pm for pain. The dentist recommended that the resident return sedated for extraction of tooth 19 on March 9, 2010. [Note: Review of the MAR revealed no documentation to verify that the resident received the Amoxicillin 500 mg from March 1, 2010 until March 16, 2010.]

3. The GHMRP failed to ensure nursing oversight of and monitoring of medication administration records to verify the provision of medications as prescribed for Residents #1 and #3. [See I474]

RN will put a system in place to ensure follow up appointments are carried out in a timely manner according to doctor order.

By August 15, 2010

2. RN will put system in place to ensure prescribed medications are administered according to doctors orders-August 15, 2010

3. RN will put a system in place to monitor and provide Oversight of prescribed medication Administration. By August 15, 2010

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0951	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/13/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HEALTH CARE RESOURCES	STREET ADDRESS, CITY, STATE, ZIP CODE 2000 RITTENHOUSE ST, NW WASHINGTON, DC 20015
---	--

(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
--------------------	--	---------------	---	--------------------

I 474 Continued From page 6
I 474 3522.5 MEDICATIONS

I 474
I 474

Each GHMRP shall maintain an individual medication administration record for each resident.

This Statute is not met as evidenced by:
Based on observation, interview and record review, the group home for mentally retardation persons (GHMRP's) nursing staff failed to ensure medication administration records (MAR) were reviewed and accurately maintained, for two of four residents in the facility. (Resident #1 and #3)

The findings includes:

1. The facility failed to establish an effective system to ensure that hours of medication administration written on the MAR were in accordance with the physicians's orders for two of the four residents in the facility, as evidenced below:

a. On July 12, 2010, at approximately 5:13 p.m., the licensed practical nurse (LPN) was observed as he prepared to give Resident #1 her 6:00 p.m. medications. Resident #1's Physician's order specified that she was prescribed "Clonazepam 2 mg tab, to be taken at bedtime". A note on the medication card and on the MAR specified that the medication was to be given at "6:00 p.m."

Interview with the medication nurse on July 12, 2010, at 5:29 p.m., indicated that the "Clonazepam 2 mg tab, was prescribed to be taken at bedtime". He further stated that in error, he documented that the client had received this medication at "6:00 p.m.", on July 12, 2010, however he had not administered it to her. Review of the medication card confirmed that the

RN will review the individuals
MAR and PO to ensure all schedule
Medication times is documented and
Followed according to the doctors order
By August 15, 2010

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/13/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HEALTH CARE RESOURCES	STREET ADDRESS, CITY, STATE, ZIP CODE 2908 RITTENHOUSE ST, NW WASHINGTON, DC 20015
---	--

(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
--------------------	--	---------------	---	--------------------

I 474 Continued From page 6
I 474 3522.5 MEDICATIONS

I 474
I 474

Each GHMRP shall maintain an individual medication administration record for each resident.

This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for mentally retardation persons (GHMRP's) nursing staff failed to ensure medication administration records (MAR) were reviewed and accurately maintained, for two of four residents in the facility. (Resident #1 and #3)

The findings includes:

1. The facility failed to establish an effective system to ensure that hours of medication administration written on the MAR were in accordance with the physicians's orders for two of the four residents in the facility, as evidenced below:

a. On July 12, 2010, at approximately 5:13 p.m., the licensed practical nurse (LPN) was observed as he prepared to give Resident #1 her 6:00 p.m. medications. Resident #1's Physician's order specified that she was prescribed "Clonazepam 2 mg tab, to be taken at bedtime". A note on the medication card and on the MAR specified that the medication was to be given at "6:00 p.m."

Interview with the medication nurse on July 12, 2010, at 5:29 p.m., indicated that the "Clonazepam 2 mg tab, was prescribed to be taken at bedtime". He further stated that in error, he documented that the client had received this medication at "6:00 p.m.", on July 12, 2010, however he had not administered it to her. Review of the medication card confirmed that the

The RN will train the nurses on the Policy of administrating HS medication.

RN will put a system in place

By August 15, 2010.

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/13/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HEALTH CARE RESOURCES	STREET ADDRESS, CITY, STATE, ZIP CODE 2808 RITTENHOUSE ST, NW WASHINGTON, DC 20015
---	--

(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
--------------------	--	---------------	---	--------------------

I 474 Continued From page 7

I 474

medication was still in the bubble pack for the HS dosage of the medication.

The review of the physician's order and the medication order on the bubble packet both confirmed "Clonazepam 2 mg, take 1 tab at bedtime. At the time of the survey, however, the facility failed to ensure that the time written on the MAR to give the medication coincided with the time written in the physician's order and on the printed order on the medication order.

b. On July 12, 2010, at approximately 5:13 p.m., the licensed practical nurse (LPN) was observed as he prepared to give Resident #3 her 6:00 p.m. medications.

Interview with the LPN revealed that Resident #3 evening medications included two medications (Divalproex 500 mg tab and Paroxetine 10 mg) that were to be administered at HS. The nurse stated that he would return to the facility around 7:15 p.m., which was closer to the resident's bedtime, to give her the two medications.

On July 12, 2010 at 5:23 p.m., review of the hand written time on the backs of the two medication cards was "6:00 p.m." Review of the MAR revealed "6:00 p.m." was the time written and documented for the administration time. At the time of the survey, there was no evidence the GHMRP's nursing staff provided accurate instructions for the administration of Resident #3's HS medications.

2. The facility's nursing services failed to accurately document the medication administration record as evidenced below:

Interview with the LPN on July 12, 2010, at 5:23

The RN will train the nurses on documentation of Medication and the policy of administrating HS medication. RN will put a system in place By August 15, 2010.

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD12-0051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/13/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HEALTH CARE RESOURCES	STREET ADDRESS, CITY, STATE, ZIP CODE 2908 RITTENHOUSE ST, NW WASHINGTON, DC 20016
---	--

(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
--------------------	--	---------------	---	--------------------

I 474 Continued From page 8

I 474

p.m., revealed that Resident #1 was prescribed Clonazepam 2 mg, 1 tab at HS (bedtime). The review of the physician's orders confirmed that the resident was prescribed this medication.

The review of the MAR for March 2010, on July 12, 2010, at 2:30 p.m., however, revealed missing nursing initials on the front of the MAR to verify that Resident #1 had received the Clonazepam 2 mg on those days. A closer review of the March 2010 MAR revealed that the nurse's initials were missing for 11 days in March (3, 4, 5, 6, 7, 13, 14, 20, 21, 26, 27, and 31), 2010. The review of the back of the MAR revealed no documented reason or explanation why the resident did not receive the Clonazepam 2 mg on those dates.

Interview with the program manager QMRP on July 12, 2010, at 2:42 p.m. revealed that she was not aware of the missing documentation on the MAR for the administration of the Clonazepam in March 2010. She stated that she would immediately write an unusual incident to document the medication variance and would notify the administrator. At the time of the survey, however, there was no evidence that the facility had maintained an effective system to prevent the aforementioned medication administration and/or medication administration record keeping error.

- The nursing team was terminated and a System put in place to review the MAR's weekly and at the end of each month. A Schedule Training is to be held on August 15, 2010.

Incident Report written and submitted

Nursing team terminated and system

Will be put in to provide more oversight

Of the MAR. By August 15, 2010