

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

PRINTED: 04/13/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G185	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/18/2011
NAME OF PROVIDER OR SUPPLIER WHOLISTIC 04			STREET ADDRESS, CITY, STATE, ZIP CODE 1314 PERRY STREET, NE WASHINGTON, DC 20017	
(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 A recertification survey was conducted from March 16, 2011 through March 18, 2011, utilizing the fundamental survey process. A random sampling of three clients was selected from a residential population of five individuals with various levels of intellectual disability. The findings of the survey were based on observations in the home and two day program, interviews with staff in the home and two day programs, as well as a review of the clinical, administrative, and habilitation records, including a review of the unusual incident reports.	W 000	<p>Received 4/29/11 Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002</p>	
W 140	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that all clients' expenditures were documented for two of three sampled clients. [Clients #2 and #3] The findings include: The facility failed to ensure a full and accurate accounting of all clients' funds as evidence below: 1. Record review on March 17, 2011 at 3:45p.m. revealed the following financial transactions were documented in Client #2's financial statements: a. \$500.00 withdrawn from her checking	W 140		<p>On 4/1/11, all staff retrained on individuals finances pursuant to financial procedures attached and internal procedures. All receipts must be submitted to the house manager, who submits to main office, within 72 hrs of receipt of funds. In addition QDOP will ensure to review each individuals records on a quarterly basis to ensure company policy</p>

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

TITLE

(X6) DATE



COMPLIANCE SUPERVISOR 4/29/11

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 140 Continued From page 1
account on December 10, 2010. Receipts for the month of December 2010, January 2011 and February 2011 totaled \$412.39. There was no further documentation presented or on record at the time of survey to substantiate what happened to the \$87.61 balance.

Note: There was also no evidence presented or on file at the time of survey to explain why the balance from December 2010 was kept on hand for an additional two months, or how the facility was managing or tracking those funds over that period.

b. \$100.00 withdrawn from her checking account on July 29, 2010. There were no receipts on file to substantiate this withdrawal.

c. \$700.00 withdrawn from her checking account on June 16, 2010. Receipts for the month of June 2010 totaled \$385.56. There was no further documentation presented or on record to substantiate what happened to the balance of \$314.44.

2. Record review on March 18, 2011 at 11:31 a.m. revealed the following financial transactions were documented in Client #3's financial statements:

a. \$280.32 withdrawn from her checking account on June 11, 2010. There were no receipts on file to substantiate this withdrawal.

b. \$200.00 withdrawn from her checking account on March 24, 2010. Receipts for the months of March 2010 and April 2010 totaled \$182.08. There was no further documentation presented or on record at the time of survey to

W 140
with regards to individuals finances is implemented.
Please find receipts attached to substantiate missing balances.
Main office performed 4/25/11 an audit of balance of clients in this location to identify others that may have been affected.
Corrective plan noted above has been implemented where applicable
Main office will conduct spot checks in addition to overseeing QDDP review to ensure practice does not recur

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W 140	<p>Continued From page 2 substantiate what happened to the \$17.92 balance.</p> <p>Note: There was also no evidence presented or on file at the time of survey to explain why the balance from March 2010 was kept on hand for an additional month, or how the facility was managing or tracking those funds over that period.</p> <p>Interview with the facility's Qualified Developmental Disability Professional (QDDP) and House Manager (HM) on March 18, 2011 at approximately 1:50 p.m. revealed there was no additional documentation available at the facility to resolve the financial discrepancies. Further interview with the QDDP on the same day at 1:56p revealed there was also no policy on record to direct the facility's staff or HM on how to manage the keeping or documentation of client expenditures.</p> <p>The facility failed to ensure accurate documentation of all residents' financial transactions including the withdrawals and the receipts for said withdrawals.</p>	W 140		
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 observation, staff interview and record review, the facility's qualified developmental disabilities professional (QDDP) failed to ensure the integration, coordination and monitoring of the</p>	W 159	<p><i>Cross reference with W257</i></p>	

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W 159 Continued From page 3
active treatment services for one of three clients in the sample. (Client #2)

The findings include:

The QDDP failed to ensure the individual program plan (IPP) was reviewed and revised as necessary when the client failed to progress toward identified the behavioral objective for Client #2. [See W257]

W 257 483.440(f)(1)(iii) PROGRAM MONITORING & CHANGE

The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made.

This STANDARD is not met as evidenced by:
Based on interview, and record review, the facility failed to ensure the individual program plan (IPP) was reviewed at least by the qualified developmental disability professional (QDDP), and revised as necessary when the client failed to progress toward identified the behavioral objective, for one of three clients in the sample. (Client #2)

The finding includes:

On March 16, 2011 at 1:20 p.m., Client #2 was observed being constantly engaged by her one-on-one staff. The client was also observed to independently string beads with verbal prompts for approximately fifteen minutes. On the same day from 4:45 p.m. to 5:20 p.m., the client was

W 159

W 257

Quarterly reviews conducted by QMRP or psychologist will include justification for continued programmatic or behavioral protocol where applicable. And reviews where applicable data is reviewed on a monthly basis and increased behaviours addressed by psychiatrist. See attached psych review forms

QMRP will initiate review of mmp: POS with RN to ensure that IPP reviewed as necessary

4/25/11

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W 257	<p>Continued From page 4</p> <p>observed stringing beads at the group home. The staff indicated that stringing beads appeared to have a calming effect on the client.</p> <p>Interview with the QDDP during the entrance conference on March 16, 2011 at 9:40 a.m., revealed Client #2 had a behavior support plan (BSP) which required one-on-one supervision 24 hours a day, seven days a week. The QDDP also indicated that the client is prescribed psychotropic medications to address her maladaptive behaviors. On March 17, 2011 at 4:40 p.m., further discussion with the QDDP and the facility's home manager (HM) revealed that the staff document all incidents of the client's targeted behaviors. They further stated that staff had been retrained on how to implement the behavior support plan (BSP) and on how to document the targeted behaviors. The QDDP and the HM acknowledged documented increases in the client's targeted behaviors and attributed the increases in four of the client's eight targeted behaviors to improved data collection by staff.</p> <p>Record review on March 17, 2011 at 5:00 p.m., revealed Client #2's March 2011 physician's orders included Prozac 20 mg once a day and Geodon 40 mg twice daily for maladaptive behaviors. The client's BSP dated December 1, 2010 indicated it was an update to the December 1, 2009 BSP. The plan included a goal to improve the client's social behavior skills. The objective was to decrease incidents of self-injurious behavior (SIB) to zero incidents for twelve consecutive months. Identified sib behaviors included palm biting, skin picking, and self-poking. Review of data collected revealed none was available between September 2010 and February 2011 for self-poking.</p>	W 257	<p>Implementation of Precision Care System will ensure that record keeping and procedural objectives are satisfied. New system is scheduled to be accurate and complete by 6/1/11</p>	6/1/11

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W 257 Continued From page 5

Additional record review on the same day revealed significant increases in the client's other SIB from September 2010 to December 2010, as evidenced below:

- (a) palm biting (29 to 58)
- (b) skin picking (13 to 27)

Documented Incidents of SIB from December 2010 to February 2011 were the following:

- (a) palm biting (58 to 80)
- (b) skin picking (27 to 45)

The review of other targeted behaviors revealed the following increases from September 2010 to December 2010:

- (a) crying 45 to 138)
- (b) feet stomping: baselined - (9 in October to 93)

Documented Incidents of other targeted behaviors from December 2010 to February 2011 were the following:

- (a) crying 138 to 177)
- (b) feet stomping: baselined - (93 to 136)

Although the QDDP acknowledged that the documented increases in Client #2's targeted behaviors may be related to ongoing training and improved staff documentation, there was no evidence the objective was revised when the client failed to progress. Additionally, there was no evidence the increases in the behaviors had been addressed by the psychologist and the psychiatrist.

W 257		
W 322	483.460(a)(3) PHYSICIAN SERVICES	

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W 322	<p>Continued From page 6</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 preventive health services were implemented in accordance with the needs of two of three clients in the sample. (Client # 2 and #3)</p> <p>The findings include:</p> <p>I. On March 16, 2011 at 12:25 p.m., Client #3 was observed eating a soft textured diet at his day program which he tolerated well. On March 16, 2011 at approximately 6:10 p.m., the client was observed to consume 100% of a meal of the same texture. Interview with staff during both of the observations revealed that Client #3 was able to communicate his food preferences and usually eats 100% of meals. The staff also stated that if the client desired, he was provided his meal in a pureed texture.</p> <p>On March 17, 2011 at 11:05 a.m., interview with the qualified developmental disability professional (QDDP) indicated that the nurses monitor the clients' weight, ensure they are accurately documented, and refer weight losses to the nutritionist for follow-up.</p> <p>A. Further interview and record review revealed the facility failed to implement timely measures to address Client #3's weight loss, as evidenced below:</p>	W 322	<p>Physician has been notified of this survey deficiency and RN will ensure any weight fluctuation of \pm 5lbs within a months time frame will result in specific documentation by the primary care physician and modifications to BSP where applicable. Staff will be re-trained on 4/7/11 on reporting and documenting weight fluctuations and timely reporting of such to POP a</p>	4/19/11
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W 322	<p>Continued From page 7</p> <p>On March 17, 2011 at 11:25 a.m., record review revealed Client #3 had a 7% weight loss of eight pounds from November 2010 (116.4) to December 2010 (108.3 pounds). Continued record review revealed no interventions to address the weight loss prior to his admission to the hospital on January 11, 2011, which resulted in a ten day stay.</p> <p>On March 17, 2011 at 2:16 p.m., Client #3's monthly medical assessment dated December 30, 2010 noted his monthly weight of 108.3 pounds, however did not address the eight pound (7%) weight loss from the previous month (November 2010).</p> <p>On March 17, 2011 at 4:13 p.m., record review revealed Client #3's annual nutritional assessment dated January 11, 2011, was conducted for the scheduled January 22, 2011 individual support plan (ISP) meeting. The assessment revealed that the client was currently hospitalized, however failed to address the eight pound weight loss from November 2010 to December 2010. The assessment noted that the client would be further assessed upon readmission from the hospital.</p> <p>At the time of the survey, there was no evidence the facility had coordinated services with the primary care physician and the nutritionist prior to Client #3 ' s hospitalization to ensure a timely assessment and interventions to address his weight loss identified in December 2010.</p> <p>B. On March 17, 2011 at 2:39 p.m., review of Client #3's readmission physician's orders dated January 21, 2011 revealed to " ... continue diet orders prior to</p>	W 322		

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W 322	<p>Continued From page 8</p> <p>hospitalization ... " The previous dietary order (dated March 30, 2009), was High fiber -Low fat - Low Cholesterol- Chopped Meat - 2 gm Sodium - Low Acid orange at meal with Iron Supplement was continued; (1/8/10) Pureed if refusing consistency.</p> <p>Interview with the facility's nurse on March 17, 2011 at 3:23 p.m., indicated that after Client #3 was readmitted to facility from the hospital on January 21, 2011, the nutritionist was notified. On March 17, 2011 at 3:35 p.m., review of the Registered Nurse's (RN's) readmission note dated January 21, 2011 revealed Client #3 weighed 108.5 pounds and that the nutritionist would be notified.</p> <p>A Post Hospitalization Discharge Nutritional Assessment was conducted on February 5, 2011, fifteen days after Client #3 was readmitted to the group home. Assessment of the client's eight pound weight loss from November 2010 to December 2010 indicated the client "no longer needs a calorie restriction." The nutritional assessment also documented that the client's weight was within normal limits (IBW of 94 to 123 pounds for height of 4' 11"). The identified nutrition goals were to maintain the client's weight within his healthy body weight range, monitor appetite and weight quarterly, "May benefit from a nutrition supplement</p> <p>On March 17, 2011 at p.m. at 4:45, p.m., review of Client #3 ' s menu plan revealed no changes in his previous plan and that it continued as Low fat, Low Cholesterol, High fiber, 2 gm Sodium - Chopped Meat, No acidic foods. [Note: The quarterly nutritional assessment dated April 23, 2010 stated the client weighed 132 pounds and</p>	W 322		

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W 322	<p>Continued From page 9</p> <p>that he was prescribed a High Fiber, Low Fat, Low cholesterol, 2 gm Na, Pureed texture by choice (1500 - 1700 calories)."] At the time of the survey, however, there was no evidence that a caloric requirement had been determined to maintain the client within his IBW.</p> <p>Record review on March 18, 2011 at 11:50 a.m., revealed Client #3's March 2011 physician's orders stated, "High Fiber - Low Fat - Low Cholesterol - Chopped Meats - 2 GM NA - Low Acid Orange juice at meal and with Iron Supplement; Pureed if refusing." The client's March 2011 weight of 107 pounds reflected a 1.5 pound decrease from his February 2011 weight.</p> <p>At the time of the survey, however, there was no evidence the nutritionist's suggestion, "May benefit from a nutrition supplement" had been addressed. Also, there was no evidence the interdisciplinary team had collaborated to ensure specific preventive measures had been identified and implemented to address Client #3 weight management concerns.</p> <p>II. The facility failed to ensure follow-up to address Client #2's chronic dermatological diagnoses, as evidenced below:</p> <p>On March 16, 2011 at 1:20 p.m., observation of Client #2 revealed numerous dark discolorations on her face, arms and hands.</p> <p>On the March 17, 2011 at 4:02 p.m., the licensed practical nurse (LPN) revealed that Client #2 had a history of skin blisters and openings which had resulted in the dark areas on her skin after healing. Further discussion with the LPN and the RN at approximately 4:15 p.m., indicated that</p>	W 322	<p>Nurse to schedule dermatological visit for client #2 and ensure yearly prn visits. 5/9/11</p> <p>QDOP will review to ensure that visits</p>

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W 322	<p>Continued From page 10</p> <p>although the client continued to have blisters and minor skin disturbances, they were usually short term. The nurses also revealed the client was receiving oral medications, special bath treatments, and topical medications to prevent itching and scratching. According to the nurse, the dermatologist recommended that the client return for follow-up as needed.</p> <p>Record review on March 17, 2011 at 4:30 p.m., revealed a dermatology consultation report dated June 23, 2009, which stated the visit was a follow-up to the March 20, 2009 appointment. During the June 23, 2009 consultation, the dermatologist diagnosed "neurodermatitis and traumatic ecchymosis." Recommendations included discussing the client's medications with the psychiatrist and to follow-up prn.</p> <p>On March 17, 2011 at 4:49 p.m., a review of Client #2's March 2011 physician's orders revealed the client had diagnoses of eczema, chronic pruritis, and neurodermatitis. Continued review of the March 2011 physician's orders during this time revealed the client was prescribed the following medications:</p> <ul style="list-style-type: none"> - Hydroxyzine HCL 25 mg tab - 1 tab 3 times a day for itching (4/13/2009) - Doxepin HCL 25 mg Cap for pruritis/itching, 1 tab morning; 2 tabs (50 mg) in the evening - (9/20/2010) - Econazole nitrate 1% Cream (11/10/2010) - Eucerin Unscented Cream - four times a day to lubricate skin(7/21/2005) - Hydrophor Ointment - Apply to body twice daily (12/20/2005) - Mupirocin 2% ointment - Apply to open areas twice daily as needed until healed (9/28/2007) 	W 322	<p>to the dermatologist are scheduled during yearly review.</p> <p>Client sees pcp each time she has an outbreak of blisters and is given clearance to return to day program when deemed ready. Psychiatrist continues to review medication on a monthly basis. Hydroxide is monitored closely.</p> <p>QMRP will also review all individual records during quarterly visits to ensure follow-ups are scheduled in a timely prompt manner.</p>

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W 322	<p>Continued From page 11</p> <ul style="list-style-type: none"> - Sama lotion 0.5% lotion - to pruritic areas three times daily (7/21/2005) - Triamcinolone 0.1% - apply to right hand and body twice daily (1/7/2011) - Aveeno Soothing bath treatment twice a week (7/21/2005) <p>On March 17, 2011 at 5:10 p.m., review of monthly nursing assessments revealed a total of six documented episodes of skin blisters (August, September, October, November, December 2010, and February 2011).</p> <p>At the time of the survey, however, there was no evidence Client #2 was referred to the dermatologist for follow-up to determine the continued effectiveness of her current treatment regimen.</p> <p>III. The facility failed to ensure that Client #3 received a timely medical assessment for his peri-anal abscess after a change in status, as evidenced below:</p> <p>Review of the facility's incident reports on March 16, 2011 beginning at 9:46 a.m., revealed Client #3 had a urology appointment for a peri-anal abscess on January 10, 2011. The urologist referred the client directly to the emergency room (ER) for further evaluation, which resulted in his hospitalization for ten days.</p> <p>Interview with the RN on March 17, 2011 at 3:25 p.m., revealed the following information concerning the Client #3's peri-anal area:</p> <p>On January 7, 2011, the LPN observed that Client #3's perianal area was hard and swollen. Although the client was not expressing discomfort</p>	W 322	<p>Jan 7th, LPN observed perianal area was hard and swollen. Client is verbal and expresses pain and discomfort. As client was not expressing discomfort, RN assessed client and</p> <p>2/10/11</p>

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W 322	<p>Continued From page 12</p> <p>at that time, an appointment was made with the urologist for the earliest available date which was January 10, 2011.</p> <p>The review of nursing notes on March 17, 2011 at 3:30 p.m., revealed the status of Client #3's peri-anal area was monitored daily from January 7, 2011 until his January 10, 2011 urology appointment and the following changes:</p> <ul style="list-style-type: none"> - January 7, 2011 (overnight): Rectal scratching and a small amount of blood on his finger and diaper and that his peri-anal area continued to be hard and swollen. - January 9 and 10, 2011 - Progress notes and the medication administration record revealed the client received Tylenol 5 ml for pain and that his peri-anal area continued to be hard and swollen. - January 10, 2011 at 7:30 a.m.: Drainage was observed coming from the peri-anal area, which continued to be hard and swollen. <p>There was no evidence, however, that Client #3 received a medical assessment of his peri-anal swelling to determine a course of treatment prior to his January 10, 2011 appointment.</p>	W 322	<p>relayed findings to PCP and Urologist who did not deem it necessary to take client to the emergency room. First available appointment on Jan 10th was made. Staff continued to monitor the area daily. Drainage was not noted until 1/10/11 at 7:30am which was the day appt. was scheduled. Tylenol was administered on 1/9 and am 1/10 but deem it nec. to visit the emergency room as there was still no drainage and appt was scheduled for the following day.</p>	
W 331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure nursing services were provided in accordance with the needs of two of three clients in the sample</p>	W 331		

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W 331	Continued From page 13 (Clients #2 and #3) The findings include: 1. [Cross Reference W368 and W369] Observation on the evening of March 16, 2011 and staff interviews on the evenings of March 17, 2011 and March 18, 2011 revealed the facility's nursing staff failed to ensure all medications were administered in accordance with the physician's orders and administered at the prescribed time. 2. [Cross refer to W322.3] The facility's nursing services failed to ensure that Client #3 was referred for assessment timely to determine a course of treatment after the status change of his peri-anal abscess.	W 331	W368 see W322	
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that all medications were administered in accordance with the physician's orders for two of three sampled clients. (Clients #2 and #3) The findings include: The facility failed to ensure that all clients received their medications in the manner prescribed on their physician's order sheets as evidence below: 1. Observation of the evening medication	W 368	Provider has taken corrective action and retrained staff on the MAR * Moving forward, any issue with respect to the implementation of drug administration will be addressed directly by the prescribing physician and any and all	4/18/11

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W 368	<p>Continued From page 14</p> <p>administration on March 16, 2011 at 7:49 p.m. revealed, Client #2 was administered the following medications:</p> <ul style="list-style-type: none"> a. Doxepin HCL 25mg / 2 Caps b. Ferrous Sulfate 325(65) mg / 1 Tab c. Geodon 40mg / 1 Cap d. Hydroxyzine 25mg / 1 Tab e. Metoclopramide HCL 10mg / 1 Tab f. Simvastatin 20mg / 1 Tab <p>Record review on March 18, 2011 at 2:28 p.m. revealed Client #2's March 2011 physician's orders sheet (POS) confirmed she was prescribed Ferrous Sulfate 325(65) mg "1 tab by mouth every evening for iron supplement" (July 21, 2005). Further review of the POS on the same day at approximately 2:30 p.m., revealed Client #2 was also prescribed Synthroid 50 mcg tablet "1 cap by mouth every day - give on empty stomach one hour before Iron supplement" (June 28, 2010).</p> <p>On March 18, 2011 at approximately 3:09 p.m., the facility's registered nurse (RN) confirmed that the Synthroid 50 mcg was not being administered in the evening with the Ferrous Sulfate 325(65) mg as prescribed.</p> <p>2. During dinner observations on March 16, 2011 at approximately 6:05 p.m., Client #2 was observed eating her meal. Interview with the facility's house manager (HM) on the same day at 6:06 p.m. revealed dinner was usually served between 5:00 and 5:30 p.m. Observation of the evening medication administration on the same day at 7:49 p.m., revealed Client #2 received her prescribed dosage of Geodon 40mg.</p>	W 368	<p><i>adjustments made accordingly:</i></p> <p><i>RN will ensure that staff trained to follow any and all updated physician orders as noted.</i></p> <p><i>See attached sign in sheets...</i></p> <p><i>QDDP will review during quarterly meeting to ensure proper oversight.</i></p>	4/26/11

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W 368	<p>Continued From page 15</p> <p>Record review on March 17, 2011 at approximately 3:00 p.m. revealed Client #2's physician's order dated March 2011, reflected she was prescribed Geodon 40mg capsule "1 cap by mouth twice daily **take with meals**." Client #2 received her prescribed dosage of Geodon 40mg approximately one (1) hour and forty-five (45) minutes after she ate dinner.</p> <p>On March 18, 2011 at 3:28 p.m., the facility's registered nurse (RN) confirmed that the Geodon 40mg capsule was not being administered with Client #2's meals, but was being administered in the evenings after dinner at approximately 7:00 p.m. as listed on the March 2011 medication administration record (MAR).</p> <p>3. During dinner observations on March 16, 2011 at approximately 6:04 p.m., Client #3 was observed eating his meal. Further observation on the same day at 7:55 p.m., revealed Client #3 received his prescribed dosage of Feosol 45mg with a small cup of orange juice.</p> <p>Record review on March 17, 2011 at 2:44 p.m. revealed Client #3's March 2011 physician's order reflected he was prescribed the Feosol 45mg capsule "1 cap by mouth twice daily with meals for supplement, give with low acid orange juice" (October 29, 2008).</p> <p>Client #2 received his prescribed dosage of Feosol approximately one (1) hour and fifty-five (55) minutes after his evening meal. Interview with the RN on March 18, 2011 at 3:28 p.m. revealed she interpreted the written orders to provide Client #2 and #3's medications with meals to mean "not to give on an empty stomach" and not necessarily "with meals" as written.</p>	W 368		
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W 368	Continued From page 16 The facility failed to ensure that all medications were administered as prescribed.	W 368		
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that all medications were administered at the time indicated on the physician's orders for one of three sampled clients. (Client #2) The finding includes: [Cross Reference W368] Observation of the evening medication administration on March 16, 2011 at 7:49 p.m. revealed, Client #2 was administered Ferrous Sulfate 325(65) mg / 1 Tab. Review of Client #2's March 2011 physician's orders sheet (POS) on March 18, 2011 at 2:28 p.m., confirmed she was prescribed Ferrous Sulfate 325(65) mg "1 tab by mouth every evening for iron supplement" (July 21, 2005). Further review of the POS on the same day at approximately 2:30 p.m., revealed Client #2 was also prescribed Synthroid 50 mcg tablet "1 cap by mouth every day - give on empty stomach one hour before iron supplement" (June 28, 2010). On March 18, 2011 at approximately 3:09 p.m., the facility's registered nurse (RN) confirmed that the Synthroid 50 mcg was scheduled to be	W 369	See W368	4/26/11

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W 369	Continued From page 17 administered at 7:00 a.m. and the Ferrous Sulfate 325(65) mg was being administered at 7:00 p.m. in the evening. Review of Client #2's Medication Administration Record (MARs) confirmed the Synthroid 50 mcg was being administered at 7 a.m. instead of "one hour before iron supplement" in the evening as prescribed. The facility failed to ensure all medications were being administered in the order and timing as prescribed.	W 369		
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure all three shifts took part in evacuation drills over the past three months (quarter) to ensure the health and safety of all clients residing in the facility during emergent situations. [Clients #1, #2, #3, #4 and #5] The finding includes: Review of the fire drill logs on March 18, 2011 at approximately 1:45 p.m. revealed the majority of the drills were being conducted at 8:00 a.m. for the months of December 2010, January 2011 and February 2011. The only drills on record at the time of inspection were as follows: 1. Saturday December 18, 2010, at 8:00 a.m. 2. Monday December 20, 2010, at 8:00 a.m.	W 440	<i>Please see attached schedule of fire drills with specific fire drill logs.</i> <i>Fire drills taking place at various times/ varied condition.</i> <i>Meeting scheduled with Ms Thomas upon her return to address amending fire drill schedules to increase variance of times and conditions across the</i>	<i>5/11/11</i>

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W 440	<p>Continued From page 18</p> <ol style="list-style-type: none"> 3. Sunday January 02, 2011, at 8:00 a.m. 4. Monday January 03, 2011, at 8:00 a.m. 5. Wednesday February 09, 2011, at 4:40 p.m. 6. Saturday February 12, 2011, at 4:30 p.m. <p>A cursory review of the facility's written schedule revealed two staff on duty during the 12-8 a.m. shift to manage the five clients. Interview with the qualified development disability professional (QDDP) on March 18, 2011 at approximately 11:50 a.m., however, revealed an additional staff works from 6 a.m. - 10 a.m. Monday through Friday to assist the overnight staff with the morning routine.</p> <p>Client #1 and #4 both utilize a wheelchair for ambulation and are fully dependent on staff for mobility and ADLs. Client #2 is ambulatory but requires one-to-one assistance due to her self-injurious behaviors and blind in her left eye. This client is also fully dependent on staff for all ADLs. Client #3 utilizes a wheelchair for ambulation, requires assistance with mobility, and is fully dependent of staff for all ADLs. Client #5 is able to ambulate independently without the need of any adaptive equipment, but requires assistance from staff with her ADLs.</p> <p>Interview with the facility's QDDP on March 18, 2011 at 2:22 p.m. revealed the 8:00 a.m. drills are for the 8 - 4 p.m. shift and also confirmed the information presented above. Further interview revealed there was no other documentation of fire drills on record other than what was presented during the survey.</p>	W 440	<p><i>various facilities. As noted facilities are in neighbors and warrant careful consideration, and thoughtful actions regarding implementation of fire drills as our goal is to become meaningful members of our communities</i></p>	
W 441	<p>483.470(i)(1) EVACUATION DRILLS</p> <p>The facility must hold evacuation drills under varied conditions.</p>	W 441		

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W 441	Continued From page 19 This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure all fire drills were scheduled or implemented under varying conditions to ensure the health and safety of all clients residing in the facility during emergent situations. [Clients #1, #2, #3, #4 and #5] The finding includes: [Cross Reference W440) Interview with the facility's qualified developmental disability professional (QDDP) on March 18, 2011, at approximately 3:30 p.m., revealed the facility's staffing patterns consisted of three eight hour shifts per day. The shifts were blocked to cover 12 a.m. to 8 a.m., 8 a.m. to 4 p.m., and 4 p.m. to 12 a.m. daily. In addition, one staff comes on at 6 a.m. and works until 10 a.m. Monday thru Friday to assist with the morning routine. According to the HM, the same staffing pattern was also mirrored over the weekends, with the exception of short 6 - 10 a.m. shift. Review of the fire drill policy on March 18, 2011 at approximately 3:45 p.m. revealed two (2) drills were scheduled for each month totaling twenty-four (24) fire drills for the year. The facility failed to ensure that drills were held under varied conditions between the months of December 2010 and February 2011. Four (4) of the six (6) drills were scheduled to take place at 8:00 a.m. (December 2010/January 2011) and the other two drills were scheduled for 4:30 p.m. (February 2011). Further interview with the facility's QDDP on	W 441	See W440	3/11/11

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W 441	Continued From page 20 March 18, 2011, at approximately 3:55 p.m., confirmed the information presented in the policy and indicated all fire drills were being conducted as outlined in the policy.	W 441			
W9999	FINAL OBSERVATIONS The facility failed to ensure the scheduling of fire drills allowed for varying conditions with regards to time. The following observations were made during the survey process. It is recommended that this area be reviewed and a determination be made regarding appropriate action to prevent a potential non-compliant practice: On March 16, 2011 at 3:51 p.m., the licensed practical nurse (LPN) was observed to administer Client #1's tube feeding. Prior to starting the feeding the nurse administered 200 cc of water bolus, which the client tolerated well. The feeding container was dated and the feeding pump was set to provide enteral formula 2 Cal HN at 55 cc/hr for 13 hours. The nurse then initialed the medication administration record for the hanging of the feeding and the water given. Interview with the LPN on the same day at 4:02 p.m., revealed that the client received his medications only at 6:00 a.m. and 9:00 p.m. The nurse further indicated Client #1 should receive 5 cc of water between each medication. The nurse also explained that after the feeding, water, and medications are administered to the client, the MAR is initialed by the nurse to reflect that it was given in accordance with the physician's orders. On March 16, 2011 at at 4:27 p.m., revealed Client #1's March 2011 physician's orders	W9999	<i>This recommendation will be taken under advisement. Provider will review and address accordingly</i>		

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W9999	<p>Continued From page 21</p> <p>prescribed Polyethylene Glycol Powder (Give 17 gm mixed 4 - 8 ounces of water via G-tube) every evening for constipation.</p> <p>Review of the medication administration record (MAR) revealed the nurses had initialed after giving the Maralax in water via g-tube daily. The MAR, however, failed to specify how many ounces of water were mixed with the Miralax prior to administration.</p> <p>On March 17, 2011 at approximately 3:30 p.m., discussion with the facility's Registered Nurse (RN) on at p.m. revealed that the nurse was required to initial on the MAR to verify that the fluids were given.</p> <p>Further discussion, however, revealed there was no requirement to document the total daily fluid intake on the MAR.</p> <p>Continued review of the MAR revealed the total amount of water the client received with medications or of the sum (total) of fluids received by the client daily was not documented.</p>	W9999		

Health Regulation Administration

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1 000	INITIAL COMMENTS A licensure survey was conducted from March 16, 2011 through March 18, 2011, utilizing the fundamental survey process. A random sampling of three residents was selected from a residential population of five individuals with various levels of intellectual disability. The findings of the survey were based on observations in the home and two day program, interviews with staff in the home and two day programs, as well as a review of the clinical, administrative, and habilitation records, including a review of the unusual incident reports.	1 000		
1 056	3502.14 MEAL SERVICE / DINING AREAS 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 observation, staff interview and record review, the facility failed to ensure all staff who prepare meals were trained in the cleaning and preparation of food to ensure sanitary conditions at all times. The finding includes: Observation on during the survey on March 16, 2011 and again on March 17, 2011 revealed Staff #3 cooked dinner on both evenings. Interview with the facility's qualified developmental disability professional (QDDP) on March 18, 2011 at approximately 5:28 p.m. revealed Staff #2, #3, #8 and Nurse #4 all	1 056	Staff have been trained in food handling on a) 4/11-4/12 2011 b) 4/18-4/19 2011 (see attached sign in sheets) QmRP's House mgs will review staffing and ensure all staff who prepare meals are	

Health Regulation Administration

TITLE

(X6) DATE

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

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NAME OF PROVIDER OR SUPPLIER WHOLISTIC 04	STREET ADDRESS, CITY, STATE, ZIP CODE 1314 PERRY STREET, NE WASHINGTON, DC 20017
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TITLE

(X6) DATE

STATE FORM

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If continuation sheet 1 of 21

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1056	Continued From page 1 engaged in cooking meals at the home. The QDDP acknowledged that none of the staff currently employed and who cook the meals had completed training and obtained a food handler's certificate. The QDDP also confirmed that none of the staff had received training on the storage, preparation and serving of food, the cleaning and care of equipment to maintain sanitary conditions at all times. Record review on March 18, 2011 at approximately 5:15 p.m., revealed none of the staff or contract workers currently employed at the facility had a valid Food Handler's certification on file.	1056	trained as required with valid Food Handlers Certificates	5/17/11
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 Persons with Intellectual Disability (GHPID) failed to ensure the environment was maintained in a safe, clean and orderly manner to meet the needs of five of five residents residing in the facility (Residents #1, #2, #3, #4 and #5) The findings include: During the environmental walk-through on March 17, 2011 at approximately 9:55 a.m., the surveyor was accompanied by the maintenance supervisor, the qualified developmental disability professional (QDDP) and the house manager	1090	Referenced Bathroom was cleaned and freed of accumulations of dirt, rubbish and objectionable odors. The bathroom is being consistently maintained in a safe and sanitary manner in accordance with best practices.	3/17/11

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1 090	Continued From page 2 (HM). The following concerns were identified: 1. The facility failed to ensure a source of ventilation for the basement bathroom. Observation revealed a sealed window in the bathroom. Interview with the maintenance supervisor revealed that the window could not be opened. Through observation, and interview with the maintenance supervisor, it was confirmed that there was also no mechanical ventilation source in the bathroom. 2. A tube of Resident #4's topical medication (Proshield) was observed in Resident #5's topical medication storage container. The review of the resident's medication orders revealed both clients were prescribed to have "Proshield Plus Skin Protectant" applied to their gastrostomy tube sites. 3. During the observations in the master bedroom on March 17, 2011 at 10:32 a.m., a closed door was observed behind Client #3's bed. Staff indicated that the door led to a bathroom that had not been used for several years. The door was opened and revealed a full bathroom, which included a toilet, hand sink with cabinet, and a shower. Further observation of the master bathroom during this time revealed the following: a. An accumulation of black dropping, approximately 1/3 inch in length, were on the floor. The droppings appeared to be have come from a rodent, however, at the time of the survey, the source could not be verified. b. The water supply to the bathroom was turned off, and there was no water in the commode. c. Dirt and stains were in the toilet and on the	1 090			

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I 090	Continued From page 3 floor of the bathroom, including the shower. d. The toilet seat cover was broken off and on the floor. Closer observation of the bathroom at this time revealed no holes in the wall or floor, as a possible entrance for rodents or other such pests. Discussion with the qualified developmental disability professional (QDDP) during the aforementioned observations in the bathroom revealed that it was never used by anyone. The maintenance supervisor indicated that the water supply was turned off because the bathroom was not being used at any time. Both individuals stated that the facility was regularly inspected by a pest control specialist (PCS), however, acknowledged that the bathroom had not been recently inspected by anyone. Upon observation of the above concerns, at approximately 10:35 a.m., the facility contacted the PCS to address the concern. On March 17, 2011 at approximately 11:05 a.m., the PCS arrived at the facility to conduct an evaluation of the bathroom. He was observed to remove the droppings from the floor and to begin an inspection of the facility to determine how the pests may have entered the bathroom. Direct interview with the PCS at the facility on March 17, 2011 at approximately 11:10 a.m., revealed that he was the regular pest control professional for the facility. The PCS stated that due to the absence of any odor of urine, he thought the culprits may be squirrels. The PCS indicated that the pest may also have entered the bathroom through the plumbing system, due to there being no water in the line to the master bathroom. Further discussion with the PCS	I 090		

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1090	<p>Continued From page 4</p> <p>revealed that he discovered several possible points of entry during his inspection.</p> <p>On March 17, 2011 at approximately 11:45 a.m., the PCS revealed that he identified two small holes at the base of the exterior wall at the rear of the facility. The small holes were behind the trash cans storage area, which was located near the basement entrance door. The PCS also identified space at the ceiling to wall junction in the garage, and at the garage door.</p> <p>Further discussion and additional observations with the PCS on March 17, 2011 at 12:20 p.m., verified that he had applied caulking to close the the open spaces identified in the basement exterior wall and at the garage ceiling to wall junction. He acknowledged, however, that the space at the garage door still needed to be addressed. At 12:51 p.m., the PCS indicated the water supply to the master bathroom had been restored. He then instructed the home manager to thoroughly clean and disinfect the bathroom.</p> <p>On March 17, 2011 at 12:51 p.m., the HM was observed cleaning the bathroom and disinfecting it with chlorine bleach. The bathroom was re-inspected by the surveyors on March 17, 2011 at approximately 4:30 p.m. This inspection revealed the following:</p> <ol style="list-style-type: none"> The floor of bathroom was clean and without evidence of droppings. The water supply had been restored to the bathroom. The cover for the toilet seat was still broken off. The water flowed around the faucet handle when the water was turned on at the hand sink. 	1090			

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1090	Continued From page 5 At the time of the survey, the master bathroom was clean and functional. There was no evidence, however, that the facility had consistently maintained the bathroom in as safe and sanitary manner.	1090		
1189	3508.7 ADMINISTRATIVE SUPPORT Each GHMRP shall maintain records of residents' funds received and disbursed. This Statute is not met as evidenced by: Based on staff interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that all residents' expenditures were documented for two of three sampled residents. [Residents #2 and #3] The findings include: [Reference Federal Deficiency Report Citation W140 - §483.420.b.1.i] The GHPID failed to ensure an accurate and full accounting of the financial records for two of the three residents identified for the survey sample as evidenced below: 1. Record review on March 17, 2011 at 3:45 p.m., revealed the GHPID failed to ensure an accurate accounting of Resident #2's financial records. \$1300.00 was withdrawn from Resident #1's bank accounts between the dates of June 16, 2010 and December 10, 2010. The records failed to present a full accounting of the \$1300.00. 2. Record review on March 18, 2011 at 11:31 a.m., revealed \$480.32 was withdrawn from	1189	Cross Reference with W140	

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I 189	<p>Continued From page 6</p> <p>Resident #3's bank accounts between the dates of March 24, 2010 and June 11, 2010. The records failed to present a full accounting of the \$480.32.</p> <p>Interview with the facility's qualified developmental disability professional (QDDP) and house manager (HM) on March 18, 2011 at approximately 1:50 p.m., revealed there was no additional documentation available at the facility to resolve the financial discrepancies. Further interview with the QDDP on the same day at 1:56 p.m., revealed there was also no policy on record to direct the facility's staff or HM on how to manage the keeping or documentation of resident expenditures.</p> <p>The GHPID failed to ensure accurate documentation of all residents' financial transactions including the withdrawals and the receipts for said withdrawals.</p>	I 189		
I 206	<p>3509.6 PERSONNEL POLICIES</p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on staff interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that all staff secured an annual health screening to ensure the health and safety of its residents for three of</p>	I 206		

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I 206	<p>Continued From page 7</p> <p>thirteen staff, for one of five nurses, and for one contracted professional. (Staff #2, #9 #10, Nurse #3, and Contractor #1)</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of Staff #2's personnel record on March 18, 2011 at 1:23 p.m., revealed there was no health certificate on file. 2. Review of Staff #9's personnel record on March 18, 2011 at 1:15 p.m., revealed there was no health certificate on file. 3. Review of Staff #10's personnel record on March 18, 2011 at 1:11 p.m., revealed there was no health certificate on file. 4. Review of Nurse #3's personnel record on March 18, 2011 at 12:37 p.m., revealed there was no health certificate on file. 5. The review of Contractor #1's personnel record on March 17, 2011 at 2:45 p.m., revealed there was no health certificate on file. <p>Interview with the facility's qualified development disability professional (QDDP) on March 18, 2011 at 4:45 p.m., confirmed the above findings. The QDDP indicated she would meet with the human resources department and resolve the discrepancies.</p>	I 206	<p><i>-Health certificate attached</i></p>	<i>4/29/11</i>
I 260	<p>3512.1 RECORDKEEPING: GENERAL PROVISIONS</p> <p>Each Residence Director shall maintain current and accurate records and reports as required by this section.</p>	I 260	<p><i>See W140</i></p>	

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I 260	Continued From page 8 This Statute is not met as evidenced by: Based on staff interview and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that all residents' financial records and staffs' personnel records remained updated and accurate. The findings include: 1. The financial records for Residents #2 and #4 which were presented at the time of survey failed to reflect an accurate accounting of all expenditures. Interview with the facility's qualified development disability professional (QDDP) and the house manager (HM) on March 18, 2011 at approximately 1:50 p.m., confirmed the financial records presented during the survey did not account for all the residents' expenditures. The HM indicated he would review the financial records and resolve the discrepancies. (Reference Licensure Citation 3508.7) 2. The personnel records for Staffs #2, #9 and #10, Nurse #3 and Contractor #1 which were presented at the time of survey failed to reflect an accurate health screening history. Interview with the facility's QDDP and the HM on March 18, 2011 at approximately 1:55 p.m., confirmed the personnel and contractor records presented during the survey were not updated to reflect the correct information. The QDDP indicated she would meet with the human resources department and resolve the discrepancies. (Reference Licensure Citation 3509.6)	I 260	Cross reference W140 4/1/11 W140 Contractor health certificate attached 4/29 Camp Valid Health Cert for staff attached 5/2 H. Conch: test confirming free of communicable disease re-taken 4/28. Results due 5/2. J. Sankoh / Burke March same as above. Awoh Anagho was pregnant at time of test and advised against travel. Currently on maternity leave. Will take test prior to her return.
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other	I 379	

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I 379	<p>Continued From page 9</p> <p>unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day.</p> <p>This Statute is not met as evidenced by: Based on interview and review of incident reports, the group home for persons with intellectual disability (GHPID) failed to notify the Department of Health (DOH), Health Regulation and Licensing Administration (HRLA) of an unusual incident or event which substantially interfered with the resident's health, welfare, living arrangements, well-being or in any other way places the resident at risk, by telephone immediately and followed up by written notification within twenty-four (24) hours or the next work day for one of the five residents in the GHPID (Resident #3).</p> <p>The finding includes:</p> <p>Review of the facility's incident reports on March 16, 2011 beginning at 9:46 a.m., revealed that during a urology appointment for a peri-anal abscess on January 10, 2011, Resident #5 was referred to the emergency room (ER) for further evaluation. The ER visit resulted in the resident's admission to the hospital for further evaluation and treatment. He remained hospitalized until January 21, 2011 for and Incision and Drainage of the abscess and for intravenous antibiotics to treat his infection. The review of the unusual incident report form revealed no evidence that DOH was informed.</p>	I 379	<p>see W322 iii. See attached NCLIS report that shows incident was submitted 1/11/11. Also internal incident report dated 1/10/11</p>	<p>1/10/11</p> <p>1/11/11</p>

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I 379	Continued From page 10 Interview conducted with the Qualified Developmental Disability Professional) QDDP on March 16, 2011 at 1:40 p.m., revealed that unusual incidents are supposed to be reported to administrative office and to other entities as appropriate within 24 hours. At the time of the survey, there was no documentation to verify that DOH was informed of the the resident's unusual incident involving his change in health status.	I 379		
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 GHPID failed to ensure professional services were provided in accordance with the needs of two of three residents in the sample. (Resident # 2 and #3) The findings include: I. On March 16, 2011 at 12:25 p.m., Resident #3 was observed eating a soft textured diet at his day program which he tolerated well. On March 16, 2011 at approximately 6:10 p.m., the resident was observed to consume 100% of a meal of the same texture. Interview with staff during both of the observations revealed that Resident #3 was able to communicate his food preferences and	I 401	<i>Documentation that incident was reported to DOH attached.</i> <i>See W322</i>	<i>4/18/11</i>

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I 401	<p>Continued From page 11</p> <p>usually eats 100% of meals. The staff also stated that if the resident desired, he was provided his meal in a pureed texture.</p> <p>On March 17, 2011 at 11:05 a.m., interview with the qualified developmental disability professional (QDDP) indicated that the nurses monitor the residents' weight, ensure they are accurately documented, and refer weight losses to the nutritionist for follow-up.</p> <p>A. Further interview and record review revealed the GHPID failed to implement timely measures to address Resident #3's weight loss, as evidenced below:</p> <p>On March 17, 2011 at 11:25 a.m., record review revealed Resident #3 had a 7% weight loss of eight pounds from November 2010 (116.4) to December 2010 (108.3 pounds). Continued record review revealed no interventions to address the weight loss prior to his admission to the hospital on January 11, 2011, which resulted in a ten day stay.</p> <p>On March 17, 2011 at 2:16 p.m., Resident #3's monthly medical assessment dated December 30, 2010 noted his monthly weight of 108.3 pounds, however did not address the eight pound (7%) weight loss from the previous month (November 2010).</p> <p>On March 17, 2011 at 4:13 p.m., record review revealed Resident #3's annual nutritional assessment dated January 11, 2011, was conducted for the scheduled January 22, 2011 individual support plan (ISP) meeting. The assessment revealed that the resident was currently hospitalized, however failed to address the eight pound weight loss from November 2010</p>	I 401	W322	4/18/11

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I 401	<p>Continued From page 12</p> <p>to December 2010. The assessment noted that the resident would be further assessed upon readmission from the hospital.</p> <p>At the time of the survey, there was no evidence the GHPID had coordinated services with the primary care physician and the nutritionist prior to Resident #3's hospitalization to ensure a timely assessment and interventions to address his weight loss identified in December 2010.</p> <p>B. On March 17, 2011 at 2:39 p.m., review of Resident #3's readmission physician's orders dated January 21, 2011 revealed to "... continue diet orders prior to hospitalization ...". The previous dietary order (dated March 30, 2009), was High fiber -Low fat - Low Cholesterol- Chopped Meat - 2 gm Sodium - Low Acid orange at meal with Iron Supplement was continued; (1/8/10) Pureed if refusing consistency.</p> <p>Interview with the GHPID's nurse on March 17, 2011 at 3:23 p.m., indicated that after Resident #3 was readmitted to GHPID from the hospital on January 21, 2011, the nutritionist was notified. On March 17, 2011 at 3:35 p.m., review of the Registered Nurse's (RN's) readmission note dated January 21, 2011 revealed Resident #3 weighed 108.5 pounds and that the nutritionist would be notified.</p> <p>A Post Hospitalization Discharge Nutritional Assessment was conducted on February 5, 2011, fifteen days after Resident #3 was readmitted to the group home. Assessment of the resident's eight pound weight loss from November 2010 to December 2010 indicated the resident "no longer needs a calorie restriction." The nutritional assessment also documented that the resident's</p>	I 401	

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I 401	<p>Continued From page 13</p> <p>weight was within normal limits (IBW of 94 to 123 pounds for height of 4' 11"). The identified nutrition goals were to maintain the resident's weight within his healthy body weight range, monitor appetite and weight quarterly, "May benefit from a nutrition supplement</p> <p>On March 17, 2011 at p.m. at 4:45, p.m., review of Resident #3 's menu plan revealed no changes in his previous plan and that it continued as Low fat, Low Cholesterol, High fiber, 2 gm Sodium - Chopped Meat, No acidic foods. [Note: The quarterly nutritional assessment dated April 23, 2010 stated the resident weighed 132 pounds and that he was prescribed a High Fiber, Low Fat, Low cholesterol, 2 gm Na, Pureed texture by choice (1500 - 1700 calories)."] At the time of the survey, however, there was no evidence that a caloric requirement had been determined to maintain the resident within his IBW.</p> <p>Record review on March 18, 2011 at 11:50 a.m., revealed Resident #3's March 2011 physician's orders stated, "High Fiber - Low Fat - Low Cholesterol - Chopped Meats - 2 GM NA - Low Acid Orange juice at meal and with Iron Supplement; Pureed if refusing." The resident's March 2011 weight of 107 pounds reflected a 1.5 pound decrease from his February 2011 weight.</p> <p>At the time of the survey, however, there was no evidence the nutritionist's suggestion, "May benefit from a nutrition supplement" had been addressed. Also, there was no evidence the interdisciplinary team had collaborated to ensure specific preventive measures had been identified and implemented to address Resident #3 weight management concerns.</p> <p>II. The GHPID failed to ensure follow-up to</p>	I 401		

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I 401	Continued From page 14 address Resident #2's chronic dermatological diagnoses, as evidenced below: On March 16, 2011 at 1:20 p.m., observation of Resident #2 revealed numerous dark discolorations on her face, arms and hands. On the March 17, 2011 at 4:02 p.m., the licensed practical nurse (LPN) revealed that Resident #2 had a history of skin blisters and openings which had resulted in the dark areas on her skin after healing. Further discussion with the LPN and the RN at approximately 4:15 p.m., indicated that although the resident continued to have blisters and minor skin disturbances, they were usually short term. The nurses also revealed the resident was receiving oral medications, special bath treatments, and topical medications to prevent itching and scratching. According to the nurse, the dermatologist recommended that the resident return for follow-up as needed. Record review on March 17, 2011 at 4:30 p.m., revealed a dermatology consultation report dated June 23, 2009, which stated the visit was a follow-up to the March 20, 2009 appointment. During the June 23, 2009 consultation, the dermatologist diagnosed "neurodermatitis and traumatic ecchymosis." Recommendations included discussing the resident's medications with the psychiatrist and to follow-up pm. On March 17, 2011 at 4:49 p.m., a review of Resident #2's March 2011 physician's orders revealed the resident had diagnoses of eczema, chronic pruritis, and neurodermatitis. Continued review of the March 2011 physician's orders during this time revealed the resident was prescribed the following medications:	I 401	See 0302 .ii S	3/9/11

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I 401	<p>Continued From page 15</p> <ul style="list-style-type: none"> - Hydroxyzine HCL 25 mg tab - 1 tab 3 times a day for itching (4/13/2009) - Doxepin HCL 25 mg Cap for pruritis/itching, 1 tab morning; 2 tabs (50 mg) in the evening - (9/20/2010) - Econazole nitrate 1% Cream (11/10/2010) - Eucerin Unscented Cream - four times a day to lubricate skin(7/21/2005) - Hydrophor Ointment - Apply to body twice daily (12/20/2005) - Mupirocin 2% ointment - Apply to open areas twice daily as needed until healed (9/28/2007) - Sarna lotion 0.5% lotion - to pruritic areas three times daily (7/21/2005) - Triamcinolone 0.1% - apply to right hand and body twice daily (1/7/2011) - Aveeno Soothing bath treatment twice a week (7/21/2005) <p>On March 17, 2011 at 5:10 p.m., review of monthly nursing assessments revealed a total of six documented episodes of skin blisters (August, September, October, November, December 2010, and February 2011).</p> <p>At the time of the survey, however, there was no evidence Resident #2 was referred to the dermatologist for follow-up to determine the continued effectiveness of her current treatment regimen.</p> <p>III. The GHPID failed to ensure that Resident #3 received a timely medical assessment for his peri-anal abscess after a change in status, as evidenced below:</p> <p>Review of the GHPID's incident reports on March 16, 2011 beginning at 9:46 a.m., revealed Resident #3 had a urology appointment for a peri-anal abscess on January 10, 2011. The</p>	I 401	<p>See W322 iii)</p>	1/10/11

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I 401	<p>Continued From page 16</p> <p>urologist referred the resident directly to the emergency room (ER) for further evaluation, which resulted in his hospitalization for ten days.</p> <p>Interview with the RN on March 17, 2011 at 3:25 p.m., revealed the following information concerning the Resident #3's peri-anal area:</p> <p>On January 7, 2011, the LPN observed that Resident #3's perianal area was hard and swollen. Although the resident was not expressing discomfort at that time, an appointment was made with the urologist for the earliest available date which was January 10, 2011.</p> <p>The review of nursing notes on March 17, 2011 at 3:30 p.m., revealed the status of Resident #3's peri-anal area was monitored daily from January 7, 2011 until his January 10, 2011 urology appointment and the following changes:</p> <ul style="list-style-type: none"> - January 7, 2011 (overnight): Rectal scratching and a small amount of blood on his finger and diaper and that his peri-anal area continued to be hard and swollen. - January 9 and 10, 2011 - Progress notes and the medication administration record revealed the resident received Tylenol 5 ml for pain and that his peri-anal area continued to be hard and swollen. - January 10, 2011 at 7:30 a.m.: Drainage was observed coming from the peri-anal area, which continued to be hard and swollen. <p>There was no evidence, however, that Resident #3 received a medical assessment of his peri-anal swelling to determine a course of</p>	I 401	see W 322	

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I 401	Continued From page 17 treatment prior to his January 10, 2011 appointment. IV. [Cross Refer to Federal Deficiency Citations W368 and W369] Observation on the evening of March 16, 2011, and staff interviews on the evenings of March 17, 2011 and March 18, 2011, revealed the GHPID's nursing staff failed to ensure all medications were administered in accordance with the physician's orders and administered at the prescribed time for Residents #2 and #3.	I 401		
I 426	3521.5(c) HABILITATION AND TRAINING Each GHMRP shall make modifications to the resident ' s program at least every six (6) months or when the client: (c) Is failing to progress toward identified objectives after reasonable efforts have been made: This Statute is not met as evidenced by: Based on interview, and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure the individual program plan (IPP) was reviewed at least by the qualified developmental disability professional (QDDP), and revised as necessary when the resident failed to progress toward identified the behavioral objective, for one of three residents in the sample. (Resident #2) The finding includes: On March 16, 2011 at 1:20 p.m., Resident #2 was observed being constantly engaged by her one-on-one staff. The resident was also observed	I 426	See W257	

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I 426	Continued From page 18 to independently string beads with verbal prompts for approximately fifteen minutes. On the same day from 4:45 p.m. to 5:20 p.m., the resident was observed stringing beads at the group home. The staff indicated that stringing beads appeared to have a calming effect on the resident. Interview with the QDDP during the entrance conference on March 16, 2011 at 9:40 a.m., revealed Resident #2 had a behavior support plan (BSP) which required one-on-one supervision 24 hours a day, seven days a week. The QDDP also indicated that the resident is prescribed psychotropic medications to address her maladaptive behaviors. On March 17, 2011 at 4:40 p.m., further discussion with the QDDP and the GHPID's home manager (HM) revealed that the staff document all incidents of the resident's targeted behaviors. They further stated that staff had been retrained on how to implement the behavior support plan (BSP) and on how to document the targeted behaviors. The QDDP and the HM acknowledged documented increases in the resident's targeted behaviors and attributed the increases in four of the resident's eight targeted behaviors to improved data collection by staff. Record review on March 17, 2011 at 5:00 p.m., revealed Resident #2's March 2011 physician's orders included Prozac 20 mg once a day and Geodon 40 mg twice daily for maladaptive behaviors. The resident's BSP dated December 1, 2010 indicated it was an update to the December 1, 2009 BSP. The plan included a goal to improve the resident's social behavior skills. The objective was to decrease incidents of self-injurious behavior (SIB) to zero incidents for twelve consecutive months. Identified sib behaviors included palm biting, skin picking, and	I 426	<i>See w257</i>	

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I 426	<p>Continued From page 19</p> <p>self-poking. Review of data collected revealed none was available between September 2010 and February 2011 for self-poking.</p> <p>Additional record review on the same day revealed significant increases in the resident's other SIB from September 2010 to December 2010, as evidenced below:</p> <p>(a) palm biting (29 to 58) (b) skin picking (13 to 27)</p> <p>Documented Incidents of SIB from December 2010 to February 2011 were the following:</p> <p>(a) palm biting (58 to 80) (b) skin picking (27 to 45)</p> <p>The review of other targeted behaviors revealed the following increases from September 2010 to December 2010:</p> <p>(a) crying 45 to 138 (b) feet stomping: baselined - (9 in October to 93)</p> <p>Documented Incidents of other targeted behaviors from December 2010 to February 2011 were the following:</p> <p>(a) crying 138 to 177 (b) feet stomping: baselined - (93 to 136)</p> <p>Although the QDDP acknowledged that the documented increases in Resident #2's targeted behaviors may be related to ongoing training and improved staff documentation, there was no evidence the objective was revised when the resident failed to progress. Additionally, there was no evidence the increases in the behaviors had been addressed by the psychologist and the</p>	I 426	<p><i>see w257</i></p>	

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I 426	Continued From page 20 psychiatrist.	I 426		