

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

PRINTED: 06/03/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/12/2011
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NAME OF PROVIDER OR SUPPLIER R C M OF WASHINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1318 45TH PLACE, NE WASHINGTON, DC 20019
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W 000	INITIAL COMMENTS A recertification survey was conducted from May 10, 2011 through May 12, 2011, utilizing the fundamental survey process. A random sample of three clients was selected from a population of four females and two males with various levels of intellectual disabilities. The findings of the survey were based on observations at the group home, one day program, interviews with clients and staff, and the review of clinical and administrative records including incident reports.	W 000		
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to establish a system that would ensure clients family members were informed of the risks and benefits of clients' treatment, for one of the three clients included in the sample. (Client #2) The finding includes: Observations during the medication administration, on May 10, 2011, beginning at 8:15 a.m., revealed that Client #2 received	W 124	Received 6/17/11 Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Angele E. Bamba</i>	TITLE <i>Program Director</i>	(X6) DATE <i>6/16/11</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 124	<p>Continued From page 1</p> <p>Carbamazepine 300 mg, and Geodon 40 mg. Interview with the Licensed Practical Nurse (LPN) after the medication administration indicated that the client received these medications for her maladaptive behaviors. During the entrance conference on May 10, 2011, beginning at 9:11 a.m., the qualified intellectual disabilities professional (QIDP) indicated that Client #2 received psychotropic medications to address his maladaptive behaviors.</p> <p>Review of the client's current physician orders (POS) dated May 2011, on May 11, 2011, at 9:30 a.m., confirmed the aforementioned medications.</p> <p>Review of Client #2's Psychological Assessment dated December 2, 2010, on May 11, 2011, at 11:10 a.m., revealed that the client was not competent to make decisions regarding his health, safety, financial or residential placement. Further review of the client's record revealed a consent form signed by the client's mother dated December 10, 2010, for the use of the medications, however, it did not indicate the medication dosage, time or route.</p> <p>On May 11, 2011, at 11:20 a.m., in an interview with the LPN coordinator and the QIDP they acknowledged that the consent form did not indicate the medication dosage, time or route. The QIDP further stated that a psychotropic medication review was scheduled in a couple of days and she would contact the family member and invite her to come and review Client #2's psychotropic medications.</p> <p>The facility failed to provide evidence that the potential risks involved in using the medications,</p>	W 124	<p>The medications on the consent form were filled by the Psychiatrist; however, he did not indicate the medication dosage, time or route.</p> <p>The psychiatrist did complete the consent with correct medication information on 5-13-11</p> <p>Individual #2's mother signed the consent form on 6-14-11</p> <p>Refer to attachment # 1</p> <p>In the future, the nursing team and the QIDP will ensure that all consent forms are completed with the correct information; additionally, the team must ensure that the rights to refuse treatment had been explained to the family members as well.</p> <p>The medications on the consent form were filled by the Psychiatrist; however, he did not indicate the medication dosage, time or route.</p> <p>The psychiatrist did complete the consent with correct medication information on 5-13-11</p> <p>Individual #2's mother signed the consent form on 6-14-11</p> <p>Refer to attachment # 1</p> <p>In the future, the nursing team and the QIDP will ensure that all consent forms are completed with the correct information; additionally, the team must ensure that the rights to refuse treatment had been explained to the family members as well.</p>	

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W 124 W 193	Continued From page 2 or his right to refuse treatment had been explained to the client and/or his family member. 483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's staff failed to demonstrate competency in implementing each client's behavior support plan (BSP), for one of the three clients in the sample. (Client #2) The finding includes: [Cross-refer to W249] Facility staff failed to implement "procedures to address target maladaptive behaviors" as outlined in Client #2's BSP. Staff in-service training records were reviewed in the facility on May 11, 2011, beginning at 4:00 p.m. The review revealed that staff had received training on Client #2's BSP, including prevention techniques and data collection on December 14, 2010. Observations during the survey, however, indicated that the in-service training had not been effective.	W 124 W 193		
W 231	483.440(c)(4)(iii) INDIVIDUAL PROGRAM PLAN The objectives of the individual program plan must be expressed in behavioral terms that provide measurable indices of performance.	W 231	Refer to W 249 PP #5,6 Refer to attachment # 3	5-14-11

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W 231	<p>Continued From page 3</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that goals were written in measurable terms, for one of the three clients in the sample. (Client #2)</p> <p>The finding includes:</p> <p>During medication administration on May 10, 2011, at 8:15 a.m., the licensed practical nurse (LPN) was observed punching medications from a bubble pack, pouring a cup of prune juice and handing them to Client #2. He consumed the medication along with the water, requiring verbal prompts. After the medication administration, in an interview with the LPN, revealed that Client #2 had a self medication program.</p> <p>On May 11, 2011, at 12:40 p.m., review of Client #2's individual program plan (IPP) dated December 10, 2010, revealed a program goal, "to increase [the client's] participation in his self administration program." The steps included:</p> <ul style="list-style-type: none"> - [the client] will take his cup of water from the nurse; - [the client] will take his cup of medication from the nurse; and - [the client] will swallow his medications with beverage. <p>Interview with the registered nurse on May 11, 2011, at 1:10 p.m., verified that the aforementioned objective was the client's objective in the domain of self medication administration. The RN was queried to ascertain</p>	W 231	<p>The LPN did re-assess individual #2's self medication program; the program was revised to ensure that the goal and objective are written in measurable terms.</p> <p>Refer to attach # 2 A & B</p> <p>In the future, the nursing management will ensure that all individuals' self medication programs are written in measurable terms; additionally, the nurses will follow up on the individuals' progress to ensure that the criteria is met.</p>	6-6-11

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W 231	Continued From page 4 how the client's success with the program objective was measured. At the time of the survey, the nurse failed to provide evidence of how the client's success with the objective could be determined. The facility failed to ensure Client #2's self medication program objective was written in measurable terms.	W 231		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record verification, the facility failed to provide continuous active treatment, for one of the three clients in the sample. (Client #2) The finding includes: On May 10, 2011, from 3:40 p.m. until 4:07 p.m., Client #2 was observed sitting on the sofa, zipping and unzipping his pants while staff was seating in the area. At 3:46 p.m., the qualified intellectual disabilities professional (QIDP) asked the client to stop. At 4:10 p.m., the client went to the dining room and had a snack. After he completed his snack he played the keyboard requiring verbal prompts. From 4:35 p.m. until 5:00 p.m., the client was observed zipping and	W 249	All staff were trained on individual #2's BSP on 12-14-10; additional training was completed on 4-15-2011, then on 5-14-2011; however, the training deemed not to be effective. All staff were retrained by the QIDP 6-13-2011 Refer to attach # 3 In the future, the facility management will ensure that the staff implement the outlined procedures in individual #2's BSP; in addition, the staff will follow the procedure to address individual #2's fidgeting behavior.	

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W 249	<p>Continued From page 5</p> <p>unzipping his pants, with no staff intervention.</p> <p>On May 11, 2011, at 2:00 p.m., review of Client #2's behavior support plan (BSP) dated December 2010, included a target behavior of fidgeting (playing with the closures of his pants - belts and zippers.) Further review revealed the following procedures to address the aforementioned target behavior:</p> <ul style="list-style-type: none"> - Staff were required to immediately intervene and direct him to stop and ask if he needs to use the bathroom. If so assist him to the bathroom. - If the client continues and there is no indications that he needs to use the bathroom staff should verbally and firmly prompt him to stop and sign the word "stop." - Staff should shift his attention to an activity that requires him to move about the home or to go outside; - Staff should put their hand over his forearm: apply gentle pressure and direct him to stop once again. - If the client should forcibly push staff hands away, staff should wait a few seconds and try again. Immediately recommend an activity that requires him to move around. If he should ignore your direction and continue to pull the zipper up and down; and - Staff should assist him to his room and he may change out of those pants and into another pair of pants with no zippers or belt. 	W 249	<p>All staff were trained on individual #2's BSP on 12-14-10; additional training was completed on 4-15-2011, then on 5-14-2011; however, the training deemed not to be effective. All staff were retrained by the QIDP 6-13-2011 Refer to attach # 3</p> <p>In the future, the facility management will ensure that the staff implement the outlined procedures in individual #2's BSP; in addition, the staff will follow the procedure to address individual #2's fidgeting behavior.</p> <p>All staff were trained on individual #2's BSP on 12-14-10; additional training was completed on 4-15-2011, then on 5-14-2011; however, the training deemed not to be effective. All staff were retrained by the QIDP 6-13-2011 Refer to attach # 3</p> <p>In the future, the facility management will ensure that the staff implement the outlined procedures in individual #2's BSP; in addition, the staff will follow the procedure to address individual #2's fidgeting behavior.</p>		

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W 262	<p>Continued From page 7</p> <p>- On October 28, 2011, Xanax 2 mg, prior to dental and podiatry appointment.</p> <p>Review of Client #2's medication administration record on May 11, 2011, at approximately 10:00 a.m., confirmed that the client received the aforementioned sedations.</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) on May 11, 2011, at approximately 3:30 p.m., revealed that Client #2 received the sedation to address his non-compliance prior to the medical appointments. Further review revealed no evidence that the HRC reviewed and or approved the use of the aforementioned sedations for Client #2. The QIDP confirmed the above findings as stated.</p>	W 262	<p>The proper system for the use of sedatives Xanax 3mg, and Xanax 2mg was followed: consent forms were completed, family member informed of the risk of treatment and the rights to refuse, emergency HRC (since the medical appointment took place after the HRC meeting held on 2-14-2011. The nurse omitted to present the sedative to the HRC that took place on November 15, 2010 and March 14, 2011, reasons why they were not included in the minutes. These consents were represented to the HRC on</p> <p>The details are included in the minutes. Refer to attachment #4.</p> <p>In the future, the house management will ensure that the proper system for the use of sedatives is followed as stipulated.</p>	5-16-2011
W 381	<p>483.460(I)(1) DRUG STORAGE AND RECORDKEEPING</p> <p>The facility must store drugs under proper conditions of security.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure all medications were properly secured, for one of the six residents residing in the facility. (Client #5)</p> <p>The finding includes:</p> <p>On May 10, 2011, at 8:45 a.m., a compact refrigerator was observed in the dining room. Seconds later, five tubes of Promethegan 25 mg suppositories were observed in the refrigerator. Further observations revealed no evidence of a</p>	W 381	<p>The LPN indicated that Promethegan 25mg suppositories were not supposed to be stored inside the refrigerator in the dining room; he stated that the medication was placed there by another nurse. All of the facility nurses were inserviced by the DON on the proper drug storage.</p> <p>Refer to attach # 5</p> <p>In the future, the house nursing team will ensure that all medications are stored as stipulated in the nursing policy.</p>	5-12-11

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<p>W 391 Continued From page 9</p> <p>2. Similarity, the LPN was observed administering one eye drop in Client #2's eyes. Further observations revealed no evidence of a pharmacy label on the bottle or box of the medication. In an interview, after the medication administration the nurse indicated that the medication was a sample from the client's ophthalmologist appointment on April 27, 2011.</p> <p>There was no evidence that the facility ensured that all prescribed medications were labeled.</p> <p>W 436 483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to maintain in good repair clients adaptive shower equipment, for two of the six clients residing in the facility. (Clients #1 and #6)</p> <p>The finding includes:</p> <p>During the environmental inspection on May 12, 2011, beginning at 11:00 a.m., revealed a shower chair in handicapped accessible bathroom. Further observations revealed that the seat was torn at the back base of the seat. Inquiry during the inspections, from the qualified intellectual disabilities professional (QIDP)</p>	<p>W 391</p> <p>W 436</p>	<p>The eye drop bottle used on 5-10-11 was the sample obtained from individual #2's Ophthalmologist on April 27, 2011. The DON called the pharmacy to find out why the eye drop prescription was not filled on time. The Pharmacy personnel indicated that they had problem transcribing the prescription. The prescribed eye drop bottle with label was obtained from the Pharmacy on _____ In the future, the facility nursing team will ensure that all prescribed drugs have a pharmacy label.</p> <p>The recommendation for a new shower chair was presented to the PCP on _____ A 719-A form was completed, and signed by the PCP. The form was sent to the vendor American Rehab Refer to attach # 6 In the future, the facility management will ensure that all of the individuals' adaptive equipment are in good repair, and available for use.</p>	<p>5-12-11</p> <p>5-25-11</p> <p>6-7-11</p>	

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W 436 Continued From page 10 indicated that staff use the shower chair to assist Clients #1 and #6 during personal hygiene tasks.	W 436			

Health Regulation & Licensing Administration

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I 000	INITIAL COMMENTS A licensure survey was conducted from May 10, 2011 through May 12, 2011. A random sample of three residents was selected from a population of four females and two males with various levels of intellectual disabilities. The findings of the survey were based on observations at the group home, one day program, interviews with residents and staff, and the review of clinical and administrative records including incident reports.	I 000		
I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Persons with Intellectual Disability (GHPID) failed to ensure adequate administrative support to meet the habilitation needs, for one of two residents in the sample. (Resident #2) The findings include: 1. During medication administration on May 10, 2011, at 8:15 a.m., the licensed practical nurse (LPN) was observed punching medications from a bubble pack, pouring a cup of prune juice and handing them to Resident #2. He consumed the medication along with the water, requiring verbal prompts. After the medication administration, in an interview with the LPN, revealed that Resident #2 had a self medication program.	I 180	The LPN did re-assess individual #2's self medication program; the program was revised to ensure that the goal and objective are written in measurable terms. Refer to attach # 2 A & B In the future, the nursing management will ensure that all individuals' self medication programs are written in measurable terms; additionally, the nurses will follow up on the individuals' progress to ensure that the criteria is met.	6-6-11

Health Regulation & Licensing Administration

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

Program Director

(X8) DATE
6/16/11

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I 180	<p>Continued From page 2</p> <p>On May 11, 2011, at 2:00 p.m., review of Resident #2's behavior support plan (BSP) dated December 2010, included a target behavior of fidgeting (playing with the closures of his pants - belts and zippers.) Further review revealed the following procedures to address the aforementioned target behavior:</p> <ul style="list-style-type: none"> - Staff were required to immediately intervene and direct him to stop and ask if he needs to use the bathroom. If so assist him to the bathroom. - If the resident continues and there is no indications that he needs to use the bathroom staff should verbally and firmly prompt him to stop and sign the word "stop." - Staff should shift his attention to an activity that requires him to move about the home or to go outside; - Staff should put their hand over his forearm; apply gentle pressure and direct him to stop once again. - If the resident should forcibly push staff hands away, staff should wait a few seconds and try again. Immediately recommend an activity that requires him to move around. If he should ignore your direction and continue to pull the zipper up and down; and - Staff should assist him to his room and he may change out of those pants and into another pair of pants with no zippers or belt. <p>At no time did the staff follow the outlined procedures in Resident #2's BSP.</p> <p>In an interview with the QIDP on May 11, 2010, at</p>	I 180	<p>All staff were trained on individual #2's BSP on 12-14-10; additional training was completed on 4-15-2011, then on 5-14-2011; however, the training deemed not to be effective. All staff were retrained by the QIDP 6-13-2011 Refer to attach # 3</p> <p>In the future, the facility management will ensure that the staff implement the outlined procedures in individual #2's BSP; in addition, the staff will follow the procedure to address individual #2's fidgeting behavior.</p> <p>All staff were trained on individual #2's BSP on 12-14-10; additional training was completed on 4-15-2011, then on 5-14-2011; however, the training deemed not to be effective. All staff were retrained by the QIDP 6-13-2011 Refer to attach # 3</p> <p>In the future, the facility management will ensure that the staff implement the outlined procedures in individual #2's BSP; in addition, the staff will follow the procedure to address individual #2's fidgeting behavior.</p>

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I 180	Continued From page 3 approximately 3:00 p.m., it was acknowledged that the staff failed to follow the procedures to address the Resident #2's fidgeting behavior.	I 180		
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 interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure that each employee, prior to employment and annually thereafter, provided a physician's certification that a health inventory had been performed and that the employee's health status allowed him or her to perform the required duties, for four of ten consultants contracted to provided services (psychologist, nutritionist, social worker and occupational therapist.)</p> <p>The finding includes:</p> <p>During the entrance conference on May 10, 2011, at 9:11 a.m., the qualified intellectual disabilities professional (QIDP) was requested to provide a current health certificate for each consultant providing services to the residents at the home.</p> <p>On May 12, 2011, at 9:10 a.m., the provided health certificates were reviewed by the surveyor and revealed the health certificates were either</p>	I 206	<p>The consultants' health certificates are currently on files Refer to attachment # 7 In the future, the provider will ensure that all of personnel files are updated, and record are available upon request.</p>	5-31-11

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I 206	Continued From page 4 expired or not available for psychologist, nutritionist, social worker and occupational therapist. The QIDP acknowledged that current health certificates were not available.	I 206	
I 271	<p>3513.1(b) ADMINISTRATIVE RECORDS</p> <p>Each GHMRP shall maintain for each authorized agency's inspection, at any time, the following administrative records:</p> <p>(b) Personnel records for all staff including job descriptions either at the GHMRP or in a central office and made available upon request;</p> <p>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 that all the required administrative records were available for inspection, for two of the four nurses providing services. (Staff #1 and #2)</p> <p>The finding includes:</p> <p>On May 10, 2011, during the entrance conference beginning at 9:11 a.m., the qualified intellectual disabilities professional (QIDP) agreed to make available for review the personnel records of all employees, including licensed professional health consultants. On May 12, 2011, at beginning at 9:10 a.m., review of the personnel records revealed the GHPID failed to provide evidence of personnel records for two nurse (Staff #1 and #2).</p> <p>On May 12, 2011, at approximately 10:15 a.m., the QIDP acknowledged that there were no personnel files available for review.</p>	I 271	<p>LPN #1 and # 2's records are currently available on file. 5-31-11 Refer to attachment # 8. In the future, the provider will ensure that all of personnel files are updated, and record are available upon request.</p> <p>LPN #1 and # 2's records are currently available on file. 5-31-11 Refer to attachment # 8. In the future, the provider will ensure that all of personnel files are updated, and record are available upon request.</p>

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I 422	Continued From page 5	I 422	
I 422	<p>3521.3 HABILITATION AND TRAINING</p> <p>Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure that residents received habilitation and assistance as prescribed in their Individual Support Plan, for one of the three residents in the sample. (Resident #2)</p> <p>The finding includes:</p> <p>On May 10, 2011, from 3:40 p.m. until 4:07 p.m., Resident #2 was observed sitting on the sofa, zipping and unzipping his pants while staff was seated in the room. At 3:46 p.m., the qualified intellectual disabilities professional (QIDP) asked the resident to stop. At 4:10 p.m., the resident went to the dining room and had a snack. After he completed his snack he played the keyboard requiring verbal prompts. From 4:35 p.m. until 5:00 p.m., the resident was observed zipping and unzipping his pants, with no staff intervention.</p> <p>On May 11, 2011, at 2:00 p.m., review of Resident #2's behavior support plan (BSP) dated December 2010, included a target behavior fidgeting (playing with the closures of his pants) Further review revealed that following procedures to address the aforementioned target behavior:</p> <p>- Staff were required to immediately intervene and direct him to stop and ask if he needs to use the bathroom. If so assist him to the bathroom.</p>	I 422	<p>All staff were trained on individual #2's BSP on 12-14-10; additional training was completed on 4-15-2011, then on 5-14-2011; however, the training deemed not to be effective. All staff were retrained by the QIDP 6-13-2011 Refer to attach # 3</p> <p>In the future, the facility management will ensure that the staff implement the outlined procedures in individual #2's BSP; in addition, the staff will follow the procedure to address individual #2's fidgeting behavior.</p>

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I 422	<p>Continued From page 6</p> <ul style="list-style-type: none"> - If the resident continues and there is no indications that he needs to use the bathroom staff should verbally and firmly prompt him to stop and sign the word "stop." - Staff should shift his attention to an activity that requires him to move about the home or to go outside; - Staff should put their hand over his forearm: apply gentle pressure and direct him to stop once again. - If the resident should forcibly push staff hands away, staff should wait a few seconds and try again. Immediately recommend an activity that requires him to move around. If he should ignore your direction and continue to pull the zipper up and down; and - Staff should assist him to his room and he may change out of those pants and into another pair of pants with no zippers or belt. <p>At no time did the staff follow the outlined procedures in Resident #2's BSP.</p> <p>In an interview with the QIDP on May 11, 2010, at approximately 3:00 p.m., it was acknowledged that the staff failed to follow the procedures to address the Resident #2's fidgeting behavior.</p>	I 422	<p>All staff were trained on individual #2's BSP on 12-14-10; additional training was completed on 4-15-2011, then on 5-14-2011; however, the training deemed not to be effective. All staff were retrained by the QIDP 6-13-2011 Refer to attach # 3</p> <p>In the future, the facility management will ensure that the staff implement the outlined procedures in individual #2's BSP; in addition, the staff will follow the procedure to address individual #2's fidgeting behavior.</p>	6-13-2011
I 480	<p>3522.7 MEDICATIONS</p> <p>Medication, requiring refrigeration shall be maintained either in a separate and secure medication refrigerator or, if in a refrigerator with foods, shall be in a secure and closed compartment or container so as to prevent cross contamination.</p>	I 480	<p>The LPN indicated that Promethegan 25mg suppositories were not supposed to be stored inside the refrigerator in the dining room; he stated that the medication was placed there by another nurse. All of the facility nurses were inserviced by the DON on the proper drug storage.</p> <p>Refer to attach # 5</p> <p>In the future, the house nursing team will ensure that all medications are stored as stipulated in the nursing policy.</p>	5-12-11

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1 422	<p>Continued From page 6</p> <ul style="list-style-type: none"> - If the resident continues and there is no indications that he needs to use the bathroom staff should verbally and firmly prompt him to stop and sign the word "stop." - Staff should shift his attention to an activity that requires him to move about the home or to go outside; - Staff should put their hand over his forearm; apply gentle pressure and direct him to stop once again. - If the resident should forcibly push staff hands away, staff should wait a few seconds and try again. Immediately recommend an activity that requires him to move around. If he should ignore your direction and continue to pull the zipper up and down; and - Staff should assist him to his room and he may change out of those pants and into another pair of pants with no zippers or belt. <p>At no time did the staff follow the outlined procedures in Resident #2's BSP.</p> <p>In an interview with the QIDP on May 11, 2010, at approximately 3:00 p.m., it was acknowledged that the staff failed to follow the procedures to address the Resident #2's fidgeting behavior.</p>	1 422	<p>All staff were trained on individual #2's BSP on 12-14-10; additional training was completed on 4-15-2011, then on 5-14-2011; however, the training deemed not to be effective. All staff were retrained by the QIDP 6-13-2011 Refer to attach # 3</p> <p>In the future, the facility management will ensure that the staff implement the outlined procedures in individual #2's BSP; in addition, the staff will follow the procedure to address individual #2's fidgeting behavior.</p>	
1 480	<p>3522.7 MEDICATIONS</p> <p>Medication, requiring refrigeration shall be maintained either in a separate and secure medication refrigerator or, if in a refrigerator with foods, shall be in a secure and closed compartment or container so as to prevent cross contamination.</p>	1 480	<p>The LPN indicated that Promethegan 25mg suppositories were not supposed to be stored inside the refrigerator in the dining room; he stated that the medication was placed there by another nurse. All of the facility nurses were inserviced by the DON on the proper drug storage.</p> <p>Refer to attach # 5</p> <p>In the future, the house nursing team will ensure that all medications are stored as stipulated in the nursing policy.</p>	5-12-11

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I 480	<p>Continued From page 7</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to store medications, requiring refrigeration under proper condition of security, for one of the three residents in the sample. (Resident #2)</p> <p>The finding includes:</p> <p>On May 10, 2011, at 8:45 a.m., a compact refrigerator was observed in the dining room. Seconds later, five tubes of Promethegan 25 mg suppositories were observed in the refrigerator. Further observations revealed no evidence of a lock on the refrigerator or that the medication was secured by a lock box. Minutes later, the licensed practical nurse (LPN) and LPN Coordinator were informed that the refrigerator that contained Resident #5's medications was unsecured. Interview with the LPN Coordinator at 8:50 a.m., revealed that the refrigerator was used to store the staff food. The LPN acknowledged the unsecured medication.</p>	I 480	<p>The LPN indicated that Promethegan 25mg suppositories were not supposed to be stored inside the refrigerator in the dining room; he stated that the medication was placed there by another nurse. All of the facility nurses were inserviced by the DON on the proper drug storage.</p> <p>Refer to attach # 5</p> <p>In the future, the house nursing team will ensure that all medications are stored as stipulated in the nursing policy.</p>	5-12-11
I 484	<p>3522.11 MEDICATIONS</p> <p>Each GHMRP shall promptly destroy prescribed medication that is discontinued by the physician or has reached the expiration date, or has a worn, illegible, or missing label.</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview and record review, the Group Home for Persons with Intellectually Disabilities (GHPID) nurse failed to remove medications with missing labels from use, for one of the three residents in the sample. (Resident #1)</p>	I 484		

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1500	<p>Continued From page 9</p> <p>review, the Group Home for Persons with Intellectually Disabilities (GHPID) failed to observe and protect residents' rights in accordance with Title 7, Chapter 13 of the D.C. Code (formerly called D.C. Law 2-137, D.C. Code, Title 6, Chapter 19) and other District and federal laws that govern the care and rights of persons with intellectually disabilities, for one of the three residents in the sample. (Resident #2)</p> <p>The findings include:</p> <p>1. Observations during the medication administration, on May 10, 2011, beginning at 8:15 a.m., revealed that Resident #2 received Carbamazepine 300 mg, and Geodon 40 mg. Interview with the Licensed Practical Nurse (LPN) after the medication administration indicated that the resident received these medications for her maladaptive behaviors. During the entrance conference on May 10, 2011, beginning at 9:11 a.m., the qualified intellectual disabilities professional (QIDP) indicated that Resident #2 received psychotropic medications to address his maladaptive behaviors.</p> <p>Review of the Resident #2's current physician orders (POS) dated May 2011, on May 11, 2011, at 9:30 a.m., confirmed the aforementioned medications.</p> <p>Review of Resident #2's Psychological Assessment dated December 2, 2010, on May 11, 2011, at 11:10 a.m., revealed that the resident was not competent to make decisions regarding his health, safety, financial or residential placement. Further review of the client's record revealed a consent form signed by the resident's mother dated December 10, 2010, for the use of the medications, however, it did not</p>	1500	<p>The proper system for the use of sedatives Xanax 3mg, and Xanax 2mg was followed: consent forms were completed, family member informed of the risk of treatment and the rights to refuse, emergency HRC (since the medical appointment took place after the HRC meeting held on 2-14-2011. The nurse omitted to present the sedative to the HRC that took place on November 15, 2010 and March 14, 2011, reasons why they were not included in the minutes. These consents were represented to the HRC on</p> <p>The details are included in the minutes. Refer to attachment #4.</p> <p>In the future, the house management will ensure that the proper system for the use of sedatives is followed as stipulated.</p>
			5-16-2011

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I 500	<p>Continued From page 10</p> <p>indicated the medication dosage, time or route.</p> <p>On May 11, 2011, at 11:20 a.m., in an interview with the LPN coordinator and the QIDP they acknowledged that the consent form did not indicate the medication dosage, time or route. The QIDP further stated that a psychotropic medication review was scheduled in a couple of days and she would contact the family member and invite her to come and review Resident #2's psychotropic medications.</p> <p>The GHPID failed to provide evidence that the potential risks involved in using the medications, or his right to refuse treatment had been explained to the resident and/or his family member.</p> <p>2. The GHPID failed to ensure that restrictive measures had been reviewed and/or approved by the Human Rights Committee (HRC), for Resident #2.</p> <p>Minutes taken at meetings of the facility's HRC for the period September 2010 through February 2011, were reviewed on May 11, 2011, beginning at 12:05 p.m.</p> <p>Review of Resident #2's medical chart on May 11, 2011, beginning 9:30 a.m., revealed the following orders:</p> <ul style="list-style-type: none"> - On February 23, 2011, Xanax 3 mg, for sedation for repeat Dexa scan; and - On October 28, 2011, Xanax 2 mg, prior to dental and podiatry appointment. <p>Review of Resident #2's medication administration record on May 11, 2011, at</p>	I 500	<p>The proper system for the use of sedatives Xanax 3mg, and Xanax 2mg was followed: consent forms were completed, family member informed of the risk of treatment and the rights to refuse, emergency HRC (since the medical appointment took place after the HRC meeting held on 2-14-2011. The nurse omitted to present the sedative to the HRC that took place on November 15, 2010 and March 14, 2011, reasons why they were not included in the minutes. These consents were represented to the HRC on</p> <p>The details are included in the minutes. Refer to attachment #4.</p> <p>In the future, the house management will ensure that the proper system for the use of sedatives is followed as stipulated.</p>
			5-16-2011

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I 500	Continued From page 11 approximately 10:00 a.m., confirmed that the resident received the aforementioned sedations. Interview with the qualified intellectual disabilities professional (QIDP) on May 11, 2011, at approximately 3:30 p.m., revealed that Resident #2 received the sedation to address his non-compliance prior to the medical appointments. Further review revealed no evidence that the HRC reviewed and or approved the use of the aforementioned sedations for Resident #2. The QIDP confirmed the above findings as stated.	I 500	The proper system for the use of sedatives Xanax 3mg, and Xanax 2mg was followed: consent forms were completed, family member informed of the risk of treatment and the rights to refuse, emergency HRC (since the medical appointment took place after the HRC meeting held on 2-14-2011. The nurse omitted to present the sedative to the HRC that took place on November 15, 2010 and March 14, 2011, reasons why they were not included in the minutes. These consents were represented to the HRC on The details are included in the minutes. Refer to attachment #4. In the future, the house management will ensure that the proper system for the use of sedatives is followed as stipulated.	5-16-2011