

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

PRINTED: 07/27/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G172	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/16/2010
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NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 903 14TH STREET, SE WASHINGTON, DC 20019
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W 000 INITIAL COMMENTS

A recertification survey was conducted from July 15, 2010, through July 16, 2010. A sampling of three men was selected from a residential population of six men with various degrees of intellectual and developmental disabilities.

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

W 159 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL

Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.

This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the Qualified Mental Retardation Professional (QMRP) coordinated services, for one of three clients in the sample. (Client #2)

The finding includes:

The facility failed to coordinate services to ensure Client #2's mealtime protocol addressed his current positioning needs, as identified by staff as evidenced below:

On July 15, 2010 at 3:57 p.m. and 7:15 p.m. respectively, Client #2 was observed slightly reclined in his wheelchair, as he was fed his snack and his dinner. During this time, the client did not appear to experience any distress.

W 000

W 159

Client # 2 uses a custom made wheelchair that can be adjusted to 90 degree angle to enable him to sit upright at the dining table. Staff was retrained on 07-19-10 how to adjust the wheelchair to 90 degree angle during meal times. QMRP will closely monitor all clients at the dining table on a daily basis for two weeks and then monthly to ensure that staff implements all meal time protocols in the right way
(See Attachment "A")

Received 8/16/10

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

07-19-10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Masato Kubota</i>	TITLE <i>Deputy Director D.C.H.C.</i>	(X6) DATE <i>8/5/10</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 159	<p>Continued From page 1</p> <p>On July 16, 2010, at 12:10 p.m., interview with the staff and the QMRP revealed that due to Client #2's physical disability, he was unable to sit upright, at a 90 degree angle, as recommended in his mealtime protocol.</p> <p>On July 16, 2010, at 12:17 p.m., review of the client's speech and language assessment revealed client "presents with mild oral dysphagia." The subsequent review of the mealtime protocol dated November 1, 2009 revealed, "Positioning upright 90 degree angle." At the time of the survey, however, there was no evidence the client had been referred to the speech and language pathologist for further evaluation of his tolerated positioning when seated in his wheelchair and eating food.</p>	W 159		
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 the provision of nursing services in accordance with the needs of one of three clients in the sample (Client #1)</p> <p>The finding includes:</p> <p>The facility's nursing services failed to timely document the effectiveness of sedation administered to Client #1, prior to appointments, as evidenced below:</p> <p>1. Interview with the qualified mental retardation professional (QMRP) during the entrance</p>	W 331	<p>The nursing staff was retrained on 07-22-10 on how to document the effectiveness of all sedation medications. The R.N will monitor the documentation, administration and effectiveness of all sedation medication immediately after the appointment or at the earliest. PMD will be notified as needed. Also during monthly note above will be checked and referenced.</p> <p>See Attachment "B" 142"</p>	07-22-10

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W 331 Continued From page 2
conference on July 15, 2010, at 9:05 a.m., revealed Client #1 received several psychotropic medications to help manage his targeted maladaptive behaviors. Further interview with the QMRP on July 16, 2010 at 10:45 a.m., revealed Client #1 had been non-compliant for a Dexascan during several attempts, despite the administration of sedation.

Record review on July 16, 2010, at 10:57 a.m., revealed a physician's order dated March 1, 2010 for, "Ativan 3 mg P.O. x 1, 1-1 1/2 hour prior to Dexascan appointment on March 10, 2010". The review of the medication administration (MAR) record revealed that on March 10, 2010, the client received the prescribed sedation prior to his Dexascan appointment. Continued review of the MAR revealed it failed to include documentation of the effectiveness of the medication as required.

On July 16, 2010, at 3:03 p.m., review of a March 17, 2010 physician's order revealed, "Reschedule Dexascan and premedicate with lytic cocktail IM as follows: Demerol + Thorazine 25 mg + Phenergan 25 mg x 1, 1 hour prior to the appointment." The April 2010 MAR documented that the medication was administered to the client on April 1, 2010 at 12:50 p.m. Review of the MAR, however, revealed it failed to include documentation of the effectiveness of the medication as required.

The record review on July 16, 2010, at 3:04 p.m., revealed a monthly nursing summary dated April 12, 2010 which documented that sedation administered to Client #1 on March 10, 2010 and April 1, 2010 for the Dexascan, had not been effective. At the time of the survey, however, there was no evidence nursing services had

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W 331	<p>Continued From page 3</p> <p>ensured documentation of the effectiveness of sedation on the MAR, as required.</p> <p>2. Interview with the QMRP on July 16, 2010, at 10:57 a.m., revealed Client #1's non-compliant behavior during his eye appointment had prevented the ophthalmologist from completing a comprehensive examination of his vision status.</p> <p>On July 16, 2010, at 3:05 p.m., the review of a physician's order dated March 1, 2010 revealed, "Ativan 3 mg P.O. x 1, 1-1 1/2 hour prior to ophthalmology appointment." The physician's medical progress noted dated March 10, 2010 revealed the client's vision exam had determined him to be a glaucoma suspect and that he was to return to ophthalmology in 6 months. The March 2010 MAR documented that the medication was administered to the client March 4, 2010, at 1:30 p.m. for his 3:00 p.m. appointment. Continued review of the MAR, however, revealed it failed to include documentation of the effectiveness of the medication as required.</p>	W 331	<p>2. The nursing staff was retrained on 07-22-10 on how to document the sedation medications. The will monitor the documentation administration and effectiveness of all sedation medication immediately after the appointment or at the earliest. PMD will be notified as needed. Also during monthly note above will be checked and referenced. See Attachment "B1- B2"</p>	07-22-10
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W 436	<p>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 ensure the maintenance of a mobility device as recommended by the interdisciplinary team, for</p>	W 436		08-02-10
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W 436	<p>Continued From page 4 one of three clients in the sample. [Client #5]</p> <p>The finding includes:</p> <p>On July 15, 2010, at 12:40 p.m., Client #5's wheelchair was observed to have both arm rests covered with black tape, while at his day program.</p> <p>Interview with the day program instructor at that time (July 15, 2010, 12:40 p.m.) indicated that the tape had been applied because the vinyl covering on the armrests was torn. Continued discussion with the staff revealed also that the right footrest of the wheelchair did not lock securely in place. Observation of the right foot rest confirmed mobility at the location on the wheelchair, where the footrest was attached.</p> <p>On July 16, 2010, at 3:37 p.m., the qualified mental retardation professional (QMRP) provided a requisition for wheelchair repairs. He stated that the repairs had been delayed due to the vendor's reported large volume of work. Record review at the time confirmed that a requisition had been completed, however, the client continued to await the needed repairs to his wheelchair.</p> <p>At the time of the survey, there was no evidence that the facility had maintained Client #5's wheelchair in good repair.</p>	W 436	<p>Client # 5's Wheelchair arm table and right were retrained on 08-02-10. The initial repair request was submitted to the vendor by the QMRP in June 2010.</p> <p>QMRP and House Manager will check all adaptive equipment on weekly basis to ensure they are in good repair.</p> <p>QMRP will ensure that all repairs are completed in a timely manner in the future.</p>	08-02-10
W 460	<p>483.480(a)(1) FOOD AND NUTRITION SERVICES</p> <p>Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p>	W 460		

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W 460	<p>Continued From page 5</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that modified/and specially-prescribed diets was provided as ordered for one of three clients in the sample. (Client #3)</p> <p>The finding includes:</p> <p>The facility's nutritionist failed to coordinate Client #3's modified/and specially-prescribed diet, to ensure that his meal plan addressed his specific health care needs, as evidenced below:</p> <p>On July 15, 2010 at 8:42 a.m., Client #3 was observed wearing an una boot. Interview with the qualified mental retardation professional (QMRP) at 8:49 a.m., revealed that the client had a history of leg ulcers due to cellulitis. Later that day, on July 15, 2010 at 7:10 p.m., Client #3 was observed to eat 3 ounces of chicken, carrots, a slice of whole wheat bread, 8 ounces of low fat milk, and 2 servings of finely chopped salad.</p> <p>The record review on July 16, 2010 at 2:29 p.m., revealed Client #3 was hospitalized from April 21, 2010 to April 27, 2010 due to chronic osteomyelitis and that surgical procedures had included skin grafting.</p> <p>On July 16, 2010 at 2:45 p.m., Client #3's annual nutritional assessment dated July 2, 2010 revealed a recommendation for a 1500 calorie diet with salad for lunch and dinner. Review of the meal plan revealed the nutritionist requested the staff to follow the 1500 kcal, low chol, low salt, high fiber meal plan. According to the client's meal plan, he was to receive 7 ounces of protein equivalent and 2 cups of milk daily. The review of</p>	W 460	<p>Staff were retrained by the Nutritionist on 07-19-10 on Client # 3 specially prescribed diet. QMRP will monitor all individuals diets on daily basis for two weeks and then monthly. Also meal times monitoring will be done by nutritionist at least once a month.</p> <p>(See Attachment C1-C3)</p>	07-19-10

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W 460	Continued From page 6 the meal pattern on the menu, however, failed to evidence a plan for a high protein diet, as recommended by the nutritionist for the client and prescribed by the primary care physician.	W 460		

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1 000	<p>INITIAL COMMENTS</p> <p>A licensure survey was conducted from July 15, 2010, through July 16, 2010. A sampling of three men was selected from a residential population of six men with various degrees of intellectual and/or developmental disabilities.</p> <p>The findings of the survey were based on observations, interviews with residents and staff in the home and at three day programs, as well as a review of resident and administrative records, including incident reports.</p>	1 000		
1 056	<p>3502.14 MEAL SERVICE / DINING AREAS</p> <p>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.</p> <p>This Statute is not met as evidenced by: Based on observations, interview and review of staff training records, the GHMRP failed to ensure sanitary food handling and storage practices.</p> <p>The findings include:</p> <p>1. On July 15, 2010, at 3:57 p.m., Resident #2 was observed to be unable to use his hands due to physical disability. At this time, a staff was observed feeding picking up potato chips from a saucer with his hand and feeding them the resident and giving him juice from a spout cup. The staff continued this process until the client had finished his snack.</p> <p>On July 15, 2010, at 6:25 p.m., a staff was observed holding down the chicken fingers on the</p>	1 056	<p>1. Staff was retrained on 07-19-10 by the nutritionist on food handling and sanitation. QMRP/ House Manager will ensure all staff implement the instructions regarding food handling by monitoring on daily basis for 2 weeks then monthly to maintain the above. (See Attachment "C 1")</p>	07-19-10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Mauritawan</i>	TITLE Deputy Director / DC-HC	(X6) DATE 8/5/10
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1056	<p>Continued From page 1</p> <p>clients' plates with her hands, as she chopped them to the texture required by their mealtime protocols.</p> <p>Interview with the qualified mental retardation professional on July 16, 2010, at 3:30 p.m., revealed that a staff certified in food handling was in the facility during this time. Further discussion with the QMRP indicated that although not other staff were certified in food handling and sanitation, the nutritionist provided general training to staff in this area.</p> <p>The review of training records on July 16, 2010, at approximately 1:40 p.m. revealed that the staff had been provided general training on how to handle food. According to the literature provided during the training on food handling, the written in revealed "Do not touch ready to eat foods with your bare hands." At the time of the survey, there was no evidence the general training provided to staff on food handling had been effective to ensure food was handling as recommended to prevent the potential transmission of food borne organisms.</p> <p>2. The group home for mentally retarded persons (GHMRP) failed to ensure staff who prepared meals received their food handler's certification for twelve of the thirteen staff records reviewed. (Staff #1, #2, #3, #4, #5, #7, #8, #9, #10, #11, #12, and #13), as evidenced below:</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) and review of thirteen personnel files on July 15, 2010 at approximately 10:30 a.m., revealed that twelve of the thirteen staff who was assigned to prepare food for the home did not have valid food handler's certifications on file. (Staff #1, #2, #3, #4, #5, #7,</p>	1056	<p>2. A Food Handlers Certification was completed on 07-22-10 for those staff who are directly involved with food preparation for individuals. This Agency trains one staff in every shift on food Handler certification including House Manager. QMRP and House Manager will monitor meal preparation and serving on a daily basis for two weeks and then monthly unannounced oversight to ensure staff adhere to food safety, handling and servings. (See Attachment D1&D2& C1-C3)</p>	7-22-10
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1056	Continued From page 2 #8, #9, #10, #11, #12, and #13) The Qualified Mental Retardation Professional confirmed the findings on July 16, 2010, at approximately 3:55 p.m.	1056		
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 the Mentally Retarded Persons (GHMRP) failed to ensure the exterior of the GHMRP was maintained in a safe, orderly, and attractive manner for six of six residents in the facility. The findings include: The inspection of the environment was conducted on July 15, 2010, beginning at approximately 11:00 a.m. During the inspection, the surveyor was accompanied by the qualified mental retardation professional (QMRP) and the building engineer. The following concerns were identified: Exterior: 1. The wood railings in front of the GHMRP were loose and had nails protruding outwards creating the potential of injury of hands. (This deficiency was corrected by the end the day) 2. A metal railing, directly in front of the upper	1090	<ol style="list-style-type: none"> 1. The wood railing were replaced on 07-16-10. This deficiency was corrected before the end of the survey. 07-16-10 2. The metal railing was also repaired on 07-16-10 07-16-10 3. The gutters surrounding the facility were cleaned on 07-16-10 07-16-10 4. The floor covering on the van was repaired on 07-16-10 and the upholstery on the arm of the sofa was repaired same day (07-16-10) 07-16-10 The QMRP will ensure that a daily walk through of the interior and exterior of the facility will be done by the staff, House Manager and QMRP. All needful repairs will be done by the maintenance department immediately when a problem is discovered. 	

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I 090	Continued From page 3 landing of the GHMRP, had cross support rails missing, which created a potential safety hazard. (This deficiency was corrected by the end of the day) 3. The gutters surrounding the GHMRP were full of leaves and twigs. (This deficiency was corrected by the end of the day) 4. The floor covering on the van was observed to have a bare area on the floor, which was approximately 2 inches in diameter. This area was located behind the front passenger seat, and was in front of the sliding door where the clients boarder the van. Additionally, the vinyl in the same area was noted to be rolled upward, creating a potential trip hazard. Interior: The upholstery (vinyl/leather) covering on the arms of the living room couch was observed to be heavily cracked. The Qualified Mental Retardation Professional confirmed the findings on July 16, 2010 at 4:00 p.m.	I 090		
I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the Qualified Mental Retardation Professional (QMRP) coordinated services, for one of three residents in the sample. (Resident #2)	I 180		

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NAME OF PROVIDER OR SUPPLIER D C HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 903 14TH STREET, SE WASHINGTON, DC 20019
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I 180	<p>Continued From page 4</p> <p>The finding includes:</p> <p>The facility failed to coordinate services to ensure Resident #2's mealtime protocol addressed his current positioning needs, as identified by staff as evidenced below:</p> <p>On July 15, 2010 at 3:57 p.m. and 7:15 p.m., respectively, Resident #2 was observed slightly reclined in his wheelchair, as he was fed his snack and his dinner. During this time, the resident did not appear to experience any distress.</p> <p>On July 16, 2010 at 12:10 p.m., interview with the staff and the QMRP revealed that due to Resident #2's physical disability, he was unable to sit upright, at a 90 degree angle, as recommended in his mealtime protocol.</p> <p>On July 16, 2010 at 12:17 p.m., review of the resident's speech and language assessment revealed resident "presents with mild oral dysphagia." The subsequent review of the mealtime protocol dated November 1, 2009 revealed, "Positioning upright 90 degree angle." At the time of the survey, however, there was no evidence the resident had been referred to the speech and language pathologist for further evaluation of his tolerated positioning when seated in his wheelchair and eating food.</p>	I 180	<p>Client # 2 uses a custom made wheelchair that can be adjusted to 90 degree angle to enable him to sit upright at the dining table. Staff was retrained on 07-19-10 how to adjust the wheelchair to 90 degree angle during meal times. QMRP will closely monitor all clients at the dining table on a daily basis for two weeks and then monthly to ensure that staff implements all meal time protocols in the right way (See Attachment "A")</p>	07-19-10
I 204	<p>3509.4 PERSONNEL POLICIES</p> <p>Each employee shall be given a copy of his or her job description to review and sign at the beginning of employment.</p> <p>This Statute is not met as evidenced by:</p>	I 204		

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1222	Continued From page 6 plates, the staff stated she thought that she had cooked enough chicken, however she needed more chicken to provide the number of ounces required by the menu. More baked chicken fingers were immediately obtained from the GHMRP next door, and the staff continued to serve the plates. Discussion with the qualified mental retardation professional (QMRP) on July 16, 2010 at 3:15 p.m., revealed that more raw chicken had been available and that he did not know why the staff had not cooked enough chicken for dinner on July 15, 2010 Record review on July 16, 2010, at 1:40 p.m. revealed that the nutritionist had provided general training to staff on the menus and food preparation. At the time of the survey, however, there was no evidence that staff had been effectively trained on how much raw meat to cook to yield the amount of cooked product required to served to residents during a meal.	1222	2. A food handlers certification was completed on 07-22-10 for those staff who are directly involved with food preparation for individuals. This Agency trains one staff in every shift on food Handler certification including House Manager. QMRP and House Manager will monitor meal preparation and serving on a daily basis for two weeks and then monthly unannounced oversight to ensure staff adhere to food safety, handling and servings. (See Attachment D1&D2& C1-C3)	07-22-10a
1227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans; This Statute is not met as evidenced by: Based on interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to have on file for review, current training on emergency procedures, for one of the thirteen	1227		

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I 227	Continued From page 7 employees. (Employee #7) The finding includes: Review of the personnel and training records on July 15, 2010, at approximately 1:15 p.m., revealed the GHMRP failed to provide documentation of staff training on emergency procedures for Employee #7. The Qualified Mental Retardation Professional confirmed the findings on July 16, 2010 at 4:10 p.m.	I 227	An In-Service training was done in the facility on 7-21-10 for emergency procedures including First Aid, CPR, Heimlich Maneuver, disaster plans and fire evacuations for all staff including staff #7. QMRP will continue with quarterly training program and earlier if warranted. See Attachment "F"	07-21-10
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on interview and record review, the group home for menally retarded persons (GHMRP) failed to ensure professional services were provided in accordance with the needs of two of six residents in the GHMRP. (Residents #1 and #3) The findings include: 1. The GHMRP's nursing services failed to timely document the effectiveness of sedation administered to Resident #1, prior to appointments, as evidenced below: a. Interview with the qualified mental retardation	I 401	The nursing staff was retrained on 07-22-10 on how to document the sedation medications. The will monitor the documentation administration and effectiveness of all sedation medication immediately after the appointment or at the earliest. PMD will be notified as needed. Also during monthly note above will be checked and referenced./ See Attachment "B"	07-22-10

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1401	<p>Continued From page 8</p> <p>professional (QMRP) during the entrance conference on July 15, 2010, at 9:05 a.m., revealed Resident #1 received several psychotropic medications to help manage his targeted maladaptive behaviors. Further interview with the QMRP on July 16, 2010, at 10:45 a.m., revealed Resident #1 had been non-compliant for a Dexascan during several attempts, despite the administration of sedation.</p> <p>Record review on July 16, 2010, at 10:57 a.m., revealed a physician's order dated March 1, 2010 for, "Ativan 3 mg P.O. x 1, 1-1 1/2 hour prior to Dexascan appointment on March 10, 2010". The review of the medication administration (MAR) record revealed that on March 10, 2010, the resident received the prescribed as sedation prior to his Dexascan appointment. Continued review of the MAR revealed it failed to include documentation of the effectiveness of the medication as required.</p> <p>On July 16, 2010, at 3:03 p.m., review of a March 17, 2010 physician's order revealed, "Reschedule Dexascan and premedicate with lytic cocktail IM as follows: Demerol + Thorazine 25 mg + Phenergan 25 mg x 1, 1 hour prior to the appointment." The April 2010 MAR documented that the medication was administered to the resident on April 1, 2010, at 12:50 p.m. Review of the MAR, however, revealed it failed to include documentation of the effectiveness of the medication as required.</p> <p>The record review on July 16, 2010, at 3:04 p.m., revealed a monthly nursing summary dated April 12, 2010 which documented that sedation administered to Resident #1 on March 10, 2010 and April 1, 2010 for the Dexascan, had not been effective. At the time of the survey, however,</p>	1401		

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1401	Continued From page 9 there was no evidence nursing services had ensured documentation of the effectiveness of sedation on the MAR, as required. b. Interview with the QMRP on July 16, 2010, at 10:57 a.m., revealed Resident #1's non-compliant behavior during his eye appointment had prevented the ophthalmologist from completing a comprehensive examination of his vision status. On July 16, 2010, at 3:05 p.m., the review of a physician's order dated March 1, 2010 revealed, "Ativan 3 mg P.O. x 1, 1-1 1/2 hour prior to ophthalmology appointment." The physician's medical progress noted dated March 10, 2010 revealed, the resident's vision exam had determined him to be a glaucoma suspect and that he was to return to ophthalmology in 6 months. The March 2010 MAR documented that the medication was administered to the resident March 4, 2010, at 1:30 p.m. for his 3:00 p.m. appointment. Continued review of the MAR, however, revealed it failed to include documentation of the effectiveness of the medication as required.	1401	B. The nursing staff was retrained on 07-22-10 on how to document the sedation medications. The will monitor the documentation administration and effectiveness of all sedation medication immediately after the appointment or at the earliest. PMD will be notified as needed. Also during monthly note above will be checked and referenced. See Attachment "B"	07-22-10
	2. The GHMRP's nutritionist failed to coordinate Resident #3's modified/and specially-prescribed diet, to ensure that his meal plan addressed his specific health care needs, as evidenced below: On July 15, 2010, at 8:42 a.m., Resident #3 was observed wearing an una boot. Interview with the qualified mental retardation professional (QMRP) at 8:49 a.m., revealed that the resident had a history of leg ulcers due to cellulitis. Later that day, on July 15, 2010 at 7:10 p.m., Resident #3 was observed to eat 3 ounces of chicken, carrots, a slice of whole wheat bread, 8 ounces of low fat	2.	Staff were retrained by the Nutritionist on 07-19-10 on Client # 3 specially prescribed diet. QMRP will monitor all individuals diets on daily basis for two weeks and then monthly. Also meal times monitoring will be done by nutritionist at least once a month. (See Attachment C1-C3)	07-19-10

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1401	<p>Continued From page 10</p> <p>milk, and 2 servings of finely chopped salad.</p> <p>The record review on July 16, 2010, at 2:29 p.m., revealed Resident #3 was hospitalized from April 21, 2010 to April 27, 2010 due to chronic osteomyelitis and that surgical procedures had included skin grafting.</p> <p>On July 16, 2010, at 2:45 p.m., Resident #3's annual nutritional assessment dated July 2, 2010 revealed a recommendation for a 1500 calorie diet with salad for lunch and dinner. Review of the meal plan revealed the nutritionist requested the staff to follow the 1500 kcal, low chol, low salt, high fiber meal plan. According to the resident's meal plan, he was to receive 7 ounces of protein equivalent and 2 cups of milk daily. The review of the meal pattern on the menu, however, failed to evidence a plan for a high protein diet, as recommended by the nutritionist for the resident and prescribed by the primary care physician.</p>	1401		
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